CMS Roundup of 17 Announcements: More Information Than You Can Shake a Stick At!

Hospital Wage Index Reform Call

Special Open Door Forum: Presentation and Listening Session on Hospital Wage Index Reform

Tuesday, April 12, 2011, 1:30 PM – 3:00 PM ET.

Section 3137(b) of the Affordable Care Act requires CMS to submit to Congress, by December 31, 2011, a report that includes a plan to reform the wage index under the Medicare hospital inpatient prospective payment system (IPPS). CMS acquired the services of Acumen, LLC to assist in its study of the wage index. During the first part of this special open door forum, Acumen will present its concept of an alternative methodology for the wage index. The second part will be a listening session, during which CMS would like to hear from you regarding your opinions about Acumen's concept, as well as any suggestions on alternative methods for computing the wage index. If you wish to participate via conference call, dial **1-800-837-1935** Conference ID 50101623. Please see the full participation announcement in the Downloads section **here**.

Electronic Health Record Incentive

Program Attestation Begins This Week

Attestation for the Medicare Electronic Health Record (EHR) Incentive Program begins on Monday, April 18, 2011. In order to receive your Medicare EHR incentive payment, you must attest through CMS's web-based Medicare and Medicaid EHR Incentive Programs Registration and Attestation System.

You can **preview selected screenshots** of the Attestation System to help you understand what the attestation process will involve. Please note that these screenshots are only examples – the final appearance and language may incorporate additional changes. CMS will release additional information about the Medicare attestation process soon, including User Guides that provide step-by-step instructions for completing attestation and educational webinars that describe the attestation process in depth.

You need to understand the required meaningful use criteria to successfully attest. Meaningful use requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare EHR Incentive Program are different:

- EP Meaningful Use Criteria – Must report on 15 core measures, 5 of 10 menu measures, and 6 clinical quality measures, consisting of 3 required core measures and 3 additional measures.
    - Visit the **Stage 1 EHR Meaningful Use Specification Sheets for EPs** for information on core and menu measures for EPs.
    - Visit the **Clinical Quality Measures page** for information on the required clinical quality measures for EPs.

- Eligible Hospital and CAH Meaningful Use Criteria – Must report on 14 core measures, 5 of 10 menu measures, and 15 clinical quality measures.
    - Visit the **Stage 1 EHR Meaningful Use Specification Sheets for Eligible Hospitals and CAHs** for information on core and menu measures for eligible hospitals and CAHs.
    - Visit the **Clinical Quality Measures page** for information on the required clinical quality measures for eligible hospitals and CAHs.

You should also make sure that you begin your 90-day reporting period in time to attest and receive a Medicare payment in 2011. The last days to begin 90-day reporting periods for 2011 incentive payments are:

- Sunday, July 3, 2011, for eligible hospitals and CAHs; and
- Saturday, October 1, 2011, for EPs.

Under the Medicaid EHR Incentive Programs, the date when participants can begin attestation for adopting, implementing, upgrading, or demonstrating meaningful use of certified EHR technology varies by state. Visit the **Medicaid State EHR Incentive Program web-tool** for more information about your state's participation in the Medicaid EHR Incentive Program.

Want more information about the EHR Incentive Programs? Make sure to visit the **CMS EHR Incentive Programs website** for the latest news and updates on the EHR Incentive Programs; also read the new EHR Incentive Program **FAQs from CMS.**

Preventive Services, Preventive Physical Examinations and Annual

Wellness Visits Quick Reference Charts

The ABCs of Providing the Initial Preventive Physical Examination Quick Reference Chart provides Medicare Fee-For-Service providers a list of the elements of the IPPE, as well as coverage and coding information. View the chart **here.**

The ABCs of Providing the Annual Wellness Visit Quick Reference Chart provides Medicare Fee-For-Service providers a list of the elements of the AWV, as well as coverage and coding information. View the chart **here.**

The *Medicare Preventive Services* Quick Reference Chart provides Medicare Fee-For-Service providers coverage, coding, and payment information on the variety of preventive services covered by Medicare. View the chart **here.**

A hardcopy booklet containing all three charts, as well as the *Quick Reference Information: Medicare Immunization Billing* chart, will be available at a later date.

Latest HCPCS Code Set Changes

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS web page **here**. Changes are effective on the date indicated on the update.

Revisions to ASP Pricing Files

The Centers for Medicare and Medicaid Services (CMS) has posted revised October 2010 and January 2011 ASP (average sales price) files, which are available for download **here** (see

left menu for year-specific links).

Physician or NPP Signatures on Lab Requisitions

In the Monday, November 29, 2010, Medicare Physician Fee Schedule final rule, the Centers for Medicare & Medicaid Services (CMS) finalized its proposed policy to require a physician's or qualified non-physician practitioner's (NPP) signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule effective Saturday, January 1, 2011. (A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.)

On Monday, December 20, 2010, CMS informed its contractors of concerns that some physicians, NPPs, and clinical diagnostic laboratories are not aware of or do not understand this policy. As such, CMS indicated that it will focus in the first quarter of 2011 on developing educational and outreach materials to educate those affected by this policy. CMS indicated that once the first quarter educational campaign is fully underway, it will expect requisitions to be signed.

After further input from community, CMS has decided to focus for the remainder of 2011 on changing the regulation that requires signatures on laboratory requisitions because of concerns that physicians, NPPs, and clinical diagnostic laboratories are having difficulty complying with this policy.

Face-to-Face Encounter Requirements

for Home Health and Hospice

Effective April 1, 2011, the Centers for Medicare & Medicaid Services (CMS) expects home health agencies and hospices have fully established internal processes to comply with the face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services.

Section 6407 of the ACA established a face-to-face encounter requirement for certification of eligibility for Medicare home health services, by requiring the certifying physician to document that he or she, or a non-physician practitioner working with the physician, has seen the patient. **The encounter must occur within the 90 days prior to the start of care, or within the 30 days after the start of care.** Documentation of such an encounter must be present on certifications for patients with starts of care on or after January 1, 2011.

Similarly, section 3131(b) of the ACA requires a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient prior to the patient's 180th-day recertification, and each subsequent recertification. The encounter must occur no more than 30 calendar days prior to the start of the hospice patient's third benefit period. The provision applies to recertifications on and after January 1, 2011.

On December 23, 2010, due to concerns that some providers needed additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services, CMS announced that it will expect full compliance

with the requirements, beginning with the second quarter of CY2011.

Throughout the first quarter of 2011, CMS has continued outreach efforts to educate providers, physicians, and other stakeholders affected by these new requirements. CMS has posted guidance materials including a MLN Matters article, questions and answers documents, training slides, and manual instructions which are available via CMS' Home Health Agency Center and Hospice webpages. CMS' Office of External Affairs and Regional Offices contacted state and local associations for physicians and home health agencies and advocacy groups to ensure awareness about the face-to-face encounter laws, and to distribute the educational materials.

CMS will continue to address industry questions concerning the new requirements, and will update information on the Web site here for **home health** and here for **hospice**.

Federally Qualified Health Center Fact Sheet Revised

The revised publication titled *Federally Qualified Health Center* (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education about Federally Qualified Health Centers (FQHC), including background; FQHC designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC Prospective Payment System; FQHC payments; and *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* provisions that impact FQHCs.

Avoiding the Adjustment 2012 Medicare Payment Adjustment for Not ePrescribing in 2011

In November 2010, the Centers for Medicare & Medicaid Services announced that, beginning in calendar year 2012, eligible professionals who are not successful electronic prescribers based on claims submitted between Sat Jan 1 and Thu June 30, 2011, may be subject to a payment adjustment on their Medicare Part-B Physician Fee Schedule-covered professional services. Section 132 of the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)* authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx Incentive Program.

From 2012 through 2014, the payment adjustment will increase each calendar year. In 2012, the payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice receiving 99% of their Medicare Part-B PFS amount that would otherwise apply to such services. In 2013, an eligible professional or group practice will receive 98.5% of their Medicare Part-B PFS-covered professional services for not being a successful electronic prescriber in 2011 or as defined in a future regulation. In 2014, the payment adjustment for not being a successful electronic prescriber is 2%, resulting in an eligible professional or group practice receiving 98% of their Medicare Part-B PFS-covered professional services. (The payment adjustment does not apply if less than 10% of an eligible professional's or group practice's allowed charges for the Sat Jan 1, 2011 through Thu June 30, 2011, reporting period are comprised of codes in the denominator of the 2011 eRx measure.) Also note that earning an eRx incentive for 2011 will NOT necessarily exempt an eligible professional or group practice from the payment adjustment in 2012.

How to Avoid the 2012 eRx Payment Adjustment:

- Eligible professionals – An eligible professional can avoid the 2012 eRx Payment adjustment if (s)he:
  - Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of Thu June 30, 2011, based on primary taxonomy code in NPPES;
  - Does not have prescribing privileges. Note that (s)he must report **G8644** at least one time on an eligible claim prior to Thu June 30, 2011;
  - Does not have at least 100 cases containing an encounter code in the measure denominator;
  - Becomes a successful e-prescriber; and reports the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure.

NOTE: Group Practices – For group practices that are participating in eRx GPRO-I or GPRO-II during 2011, the group practice MUST become a successful e-prescriber. Depending on the group's size, the group practice must report the eRx measure for 75-2500 unique eRx events for patients in the denominator of the measure. For additional information, please visit the "Getting Started" webpage **here** or download the "Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program" under "Educational Resources" on the same website.

Implementation of Errata for Version 5010 of HIPAA Transactions

BTW, **errata** is a list or lists of errors and their corrections. Errata is plural and the singular is erratum.

CMS does not have a version 4010A1 direct data entry and a separate version 5010 direct data entry. The Priority (Type)

of Admission or Visit code is now required on all version 4010A1 institutional claims submitted or corrected via direct data entry, as well as on version 5010 institutional claims, regardless of how they are submitted. Providers that are unsure which code to use are to use code 9 (Information not Available). Additional Priority (Type) of Admission or Visit code values and descriptions are available from the **National Uniform Billing Committee** or from your servicing MAC. The Priority (Type) of Admission or Visit code is not required on 4010A1 institutional claims submitted or corrected via an 837. More information on Version 5010 **here.**

IMPORTANT 5010/D.0 IMPLEMENTATION ITEMS

**REMINDER – ** 5010/D.0 Errata requirements and testing schedule can be found here

**REMINDER – ** Contact your MAC for their testing schedule

**READINESS ASSESSMENT – ** Have you done the following to be ready for 5010/D.0?

**READINESS ASSESSMENT – ** What do you need to have in place to test with your MAC?

**READINESS ASSESSMENT – ** Do you know the implications of not being ready?

New Mental Health Services Booklet

A new publication titled “Mental Health Services” is now available in downloadable format from the Medicare Learning Network® **here**. This booklet is designed to provide education on mental health services, including covered mental health services, mental health services that are not covered, mental health professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services.

Ambulance Fee Schedule Fact Sheet Revised

The revised publication titled “Ambulance Fee Schedule” (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education about the Ambulance Fee Schedule including background, ambulance providers and suppliers, ambulance services payments, and how payment rates are set.

Health Professional Shortage Area Fact Sheet Revised

The revised publication titled “Health Professional Shortage Area” (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education on the Health Professional Shortage Area (HPSA) payment system and includes an overview of the program and general requirements.

Medicare Disproportionate Share Hospital Fact Sheet Revised

The revised publication titled “Medicare Disproportionate Share Hospital” (revised March 2011) is now available in downloadable format **here**. This fact sheet is designed to provide education on Medicare Disproportionate Share Hospitals

(DSH) including background; methods to qualify for the Medicare DSH adjustment; *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* and *Deficit Reduction Act of 2005* provisions that impact Medicare DSHs; number of beds in hospital determination; and Medicare DSH hospital payment adjustment formulas.

G0431QW is Deleted and G0434QW is Added to CLIA Waived Test Schedule

The Centers for Medicare & Medicaid Services (CMS) is updating the status of two codes on the Clinical Laboratory Fee Schedule (CLFS).

- Effective April 1, 2011, code G0431QW is deleted from the CLFS. Code G0431 describes a high complexity test, and should not be reported with a QW modifier; the QW modifier indicates a CLIA waived test.
- Effective April 1, 2011, code G0434QW is added to the CLFS. Code G0434 can describe a CLIA waived test. The use of the QW modifier to indicate a CLIA waived test is necessary for accurate claims processing.

Codes G0431 and G0434 will remain on the CLFS.

CMS Launches a Dedicated Web Page for the Medicare Shared Savings Program/Requirements for ACOs

On March 31, 2011, The Centers for Medicare & Medicaid

Services (CMS) published in the Federal Register proposed rule ***CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations*** that implements the Medicare Shared Savings Program (Shared Savings Program) and establishes the requirements for Accountable Care Organizations. CMS has launched a dedicated web page **here** for Medicare FFS providers and other providers of services and suppliers. Bookmark the web page and check back often, as CMS continues to add information on the program.

Program for Evaluating Payment Patterns Electronic Report (PEPPER) for CAHs

Beginning in April 2011, the Centers for Medicare & Medicaid Services (CMS) will make available free hospital-specific comparative data reports for critical access hospitals (CAHs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) provides hospital-specific data statistics for Medicare discharges at risk for improper payments. Hospitals can use the data to support internal auditing and monitoring activities. PEPPER is the only free report comparing a CAH's Medicare billing practices with other CAHs by state, Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI) jurisdiction and the nation. CMS has contracted with TMF Health Quality Institute to develop and distribute the reports.

PEPPER will be distributed electronically to CAH QualityNet Administrators and those who have basic user accounts with the PEPPER Recipient role on or about Monday, April 25, via a My QualityNet secure file exchange. In preparation for receiving and downloading PEPPER from My QualityNet, these individuals should verify that their computer systems are equipped with the software and configuration required to use My QualityNet by following the steps at **www.qualitynet.org** (see "Getting

Started With QualityNet" and "Test Your System.") Additional information about downloading PEPPER from My QualityNet can be found **here** (includes System Setup and Test Guide, Troubleshooting Tips and a guide for Configuration Changes for Compatibility with QualityNet).

CAHs may work with their Quality Improvement Organization (QIO) to obtain a QualityNet administrator account by visiting **www.qualitynet.org** and clicking on the Hospitals – Inpatient link. Obtaining a My QualityNet account may take several weeks; CAHs should plan accordingly.

TMF will conduct a web-based training session for CAH staff providing information on PEPPER and how to use it on Thursday, April 28, at 1 p.m. central time. To register for the training, CAH staff should visit https://tmfevents.webex.com. The training will be recorded and posted on http://www.pepperresources.org.

For more information, including the PEPPER distribution schedule, a sample PEPPER for CAHs and information about QualityNet accounts, visit the PEPPER website. CAH staff are encouraged to join the e-mail list on this website to receive important notifications about upcoming PEPPER distribution and training opportunities.

Image by The Library of Congress via Flickr

My Notes on the March 22,

2011 CMS Open Door Forum on Physician Quality Reporting System (PQRI) for the Beginner

Today's CMS Open Door Forum was a good one. The slides (**pdf here**), although reviewed quickly during the call, are a comprehensive resource for anyone needing in-depth information on qualifying for incentives through PQRI. The information is complex, but anyone can start the process tomorrow and successfully get their check (next year.)

PQRI has been renamed PQRS.

These are the key points of the information presented:

1. You can tell if you are **eligible** for the incentive program by checking the main PQRS site **here**. Scroll down to Downloads and click on "List of Eligible Professionals."
2. There is **no registration** required to report quality data.
3. PQRS should not be confused with incentives offered for ePrescribing or meaningful use of a certified Electronic Health Record – these are three distinct systems.
4. There are new Physician Quality Reporting Measure Specifications every year – use the correct year.
5. Reporting can be done as **individual eligible providers or as groups,** however groups needed to be self-nominated by January 31, 2011, so that door is closed for this year.

6. Eligible providers can choose to report for 12 months: January 1”“December 31, 2011 or for 6 months: July 1-December 31, 2011 (claims and registry-based reporting only.)
7. There are **two reporting methods for submission of measures groups** that involve a patient sample selection: 30-patient sample method and 50% patient sample method. An “intent G-code” must be submitted for either method to initiate intent to report measures groups via claims. If a patient selected for inclusion in the 30-patient sample did not receive all the quality actions and that patient returns at a subsequent encounter, QDC(s) may be added (where applicable) to the subsequent claim to indicate that the quality action was performed during the reporting period.
   Physician Quality Reporting analysis will consider all QDCs submitted across multiple claims for patients included in the 30-patient samples.
8. Eligible professionals who have contracted with Medicare Advantage (MA) health plans should not include their MA patients in claims-based reporting of measures groups using the 30 unique patient sample method. **Only Medicare Part B FFS patients** (primary and secondary coverage including Railroad Medicare) should be included in claims-based reporting of measures groups.
9. **Choose which group measures** OR individual measures (3 minimum) you want to report on based on your method of reporting. Review your choices **here.**
10. If you plan to report using a registry or EHR, make sure the systems are qualified by checking **here.**
11. Here is the **schedule** for PQRS incentives and “payment adjustments” (financial dings.)

- Incentives (based on the eligible professional’s or group’s estimated total Medicare Part B PFS allowed charges)
  - 2007 ”“1.5% subject to a cap

        - 2008 ”“1.5%
        - 2009, 2010 ”“2.0%
        - 2011 ”“1%
        - 2012, 2013, 2014 ”“0.5%
    - Payment Adjustments (you lose money)
        - 2015 ”“98.5%
        - 2016 and subsequent years ”“98.0%

What follows are the Questions and Answers from the listeners.

Q: Do PQRS measures need to be reported once per encounter or once per episode?

A: It depends on the measure. Check the list to see what each measure requires.

Q: Is there a code to submit if we cannot qualify due to low numbers of Medicare patients?

A: No, CMS will calculate this and will know you cannot qualify and you will be exempt from the payment adjustment.

Q: Can both admitting physicians and consulting physicians submit the same quality codes?

A: Yes, all eligible providers working with a patient can report the same code if appropriate.

Q: How do we know if we qualified for the eRx incentive for 2010?

A: Payments will come early fall and feedback reports will be available that break down each provider’s incentive.

Q: For the eRx incentive, is it 10 eRxs before June 30, 2011 and 25 before January 31, 2011 for each PROVIDER or each PRACTICE?

A: Each provider.

Q: What is the difference between the numerator and the denominator in PQRS?

A: The numerator is the clinical quality action (for instance, putting a patient on a beta blocker) and the denominator is the group of patients for whom the quality action applies (which patients with appropriate diagnoses are eligible for beta blocker therapy.)

Q: Do all the preventive measures in this group have to be utilized?

A: Not all measures will apply to all patients, for instance mammograms for females only.

Q: Is there a code to be placed on the claim that says a measure is not applicable for this patient?

A: No.

Q: How do you know if a measure code on a claim has been accepted?

A: You will receive a rejection code on your EOB that indicates the code was submitted for information purposes only. Remittance Advice (RA) with denial code N365 is your indication that Physician Quality Reporting codes were passed into the National Claims History (NCH) file for use in calculating incentive eligibility.

Q: How can a new provider get started with quality reporting?

A: Any provider can start any time by reporting through claims, a registry or an EHR.

Q: Should providers bill for PQRI under their individual number or under their group number?

A: Under their individual number.

Q: Can a physician delegate the eRx process to a staff member,

just as they might have a nurse write a prescription for them?

A: Yes.

Q: Can you clarify the three incentive programs and which a practice can participate in at the same time?

A: The Physician Quality Reporting System, eRx Incentive Program, and EHR Incentive Program are three distinctly separate CMS programs.

The Physician Quality Reporting System incentive can be received regardless of an eligible professional's participation in the other programs.

There are three ways to participate in the EHR Incentive Program: through Medicare, Medicare Advantage, or Medicaid.

If participating in the EHR Incentive Program through the Medicaid option, eligible professionals are able to also receive the eRx incentive.

If participating in the Medicare or Medicare Advantage options for the EHR Incentive Program, eligible professionals can still report the eRx measure but are only eligible to receive one incentive payment. Eligible professionals successfully participating in both programs will receive the EHR incentive.

Eligible professionals should continue to report the eRx measure in 2011 even if their practice is also participating in the Medicare or Medicare Advantage EHR Incentive Program because claims data for the first six months of 2011 will be analyzed to determine if a 2012 eRx Payment Adjustment will apply to the eligible professional.

If an eligible professional successfully generates and reports electronically prescribing 25 times (at least 10 of which are in the first 6 months of 2011 and submitted via claims to CMS) for eRx measure denominator eligible services, (s)he would also be exempt from the 2013 eRx payment adjustment.

The transcript and a recording of today's call will be posted on the CMS website within a few weeks.

Image via Wikipedia

E-prescribing: Use it 10 times for Medicare Patients Between Now and June 30, 2011 or Lose Money in 2012

Should I consider ePrescribing in 2011 if I'm not ready to install an EMR?

- In 2012 eligible professionals who are not successful eprescribers, based on claims submitted between January 1, 2011 "" June 30, 2011, may be subject to a "payment adjustment" (read payment cut) in their Medicare Part B Physician Fee Schedule (PFS) for covered professional services.
- Those that don't eprescribe as a part of 10 Medicare patient encounters by June 30, 2011 will only receive 99% of their Medicare payment for all encounters in 2012.

- Those that don’t ePrescribe as a part of 25 encounters by December 31, 2011, will only receive 98.5% of their Medicare payments for all encounters in 2013 and only 98% of their Medicare payments for encounters during 2014 and going forward.
- The payment adjustment does not apply if <10% of an eligible professional’s (or group practice’s) allowed charges for the January 1, 2011 through June 30, 2011 reporting period are comprised of codes in the denominator of the 2011 eRx measure.

The **DENOMINATOR** is the visit code that is eligible for an eprescribing code (see list below.)

Patient visit during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

The **NUMERATOR** is a prescription generated and transmitted via a qualified eRx system and reported using a quality data code.

G8553: At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system (reported via claims, a registry, or an EHR.)

Please note that earning an eRx incentive for 2011 will **NOT** necessarily exempt an eligible professional or group practice from the payment adjustment in 2012.

How to Avoid the 2012 Payment

Adjustment

An eligible professional can avoid losing 1% in 2012 if (s)he:

- Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011 based on primary taxonomy code in NPPES,
- Does not have prescribing privileges. (S)he must report (**G8644**) at least one time on an eligible claim prior to June 30, 2011;
- Does not have at least 100 cases containing an encounter code in the measure denominator;
- Becomes a successful e-prescriber; and
- Reports the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure.

Exemptions from the Medicare Payment Adjustment in 2012

- An (EP) eligible professional or selected group practice may request an exemption from the eRx Incentive Program and from the payment adjustment based upon a significant hardship.
- The qualifying circumstances are based upon two "hardship codes" that need reported on at least one claim prior to June 30, 2011 should one of the following situations apply:

G8642 – The eligible professional practices in a rural area without sufficient high speed internet access and requests a hardship exemption from the application of the payment adjustment under section 1848(a)(5)(A) of the Social Security Act.

G8643 – The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and

requests a hardship exemption from the application of the payment adjustment under
section 1848(a)(5)(A) of the Social Security Act

To Recap:

1. Each Physician or practice that does not currently ePrescribe should consider whether or not ePrescribing is worthwhile. (Note: For group practices participating in eRx GPRO I or GPRO II during 2011, the group practice **MUST** become a successful e-prescriber. Depending on the group's size, the group practice must report the eRx measure for 75-2,500 unique eRx events for patients in the denominator of the measure. Check out the Group Practice Reporting Option **here**.)
2. In estimating the value of ePrescribing, the practice manager must consider on one hand the expense (which there is, even for free standalone eRx systems) surrounding the implementation of ePrescribing, and the potential income from the ePrescribing Incentive.
3. The practice must also determine if an EMR is in their future, and if so, if the installation will take place soon enough to report the 10 encounters with Medicare patients.
4. Individual eligible professionals (EPs) may choose to participate in either the PQRI, *eRx*, or both. PQRI and *eRx* are separate incentive programs.
5. If an eligible professional (EP) earns an incentive under the Medicare EHR Incentive Program, he or she cannot receive an incentive payment under the *eRx* Incentive Program in the same program year, and vice versa. However, if an EP earns an incentive under the Medicaid EHR Incentive Program, he or she can receive an incentive payment under the *eRx* Incentive Program in the same program year.
6. Eligible professionals must have adopted a "qualified" *eRx* system. There are two types of systems: a system for

eRx only (stand-alone) or an electronic health record (EHR system) with *eRx* functionality. Regardless of the type of system used, to be considered "qualified" it must be based on **ALL** of the following capabilities:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacies and benefit managers (PBMs) if available.
- Providing information related to lower cost, therapeutically appropriate alternatives (if any). Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts.
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available.

For a list of qualified registries and qualified EHR vendors and products, click **here.**

An excellent article, ***Choosing the Right E-prescribing Application: Should you buy a standalone app or an EHR-integrated module?*** was published in January 2011 by Physicians Practice **here.**

Image courtesy of Wikipedia