Medicare News for the Week of February 13, 2012: PQRS, eRX and EHR, EHR and EHR

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AM News Reports 2012 Last Year for Physicians to Voluntarily Report Quality Data

According to coverage in AM News, "…doctors have only this year to report data to the program voluntarily." …doctors who don't report data will not only not be eligible for a bonus but may be dinged with a 1.5% penalty on their payments in 2015." **Read more in AM News.**

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National Provider Call: Claims-Based Reporting for the Physician Quality Reporting System & Electronic Prescribing Incentive Program – Registration Now Open

Tue Feb 21; 1:30-3pm ET

CMS will host a National Provider Call on the Physician Quality Reporting System & Electronic Prescribing (eRx) Incentive Program. Subject matter experts will provide an overview on claims-based reporting for both programs, followed by a question and answer session.

Target Audience: All Medicare Fee-For-Service Providers, Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

Agenda:

- Opening Remarks
- Program Announcements
- Overview of claims-based reporting for the Physician Quality Reporting System
- Overview of claims-based reporting for the eRx Incentive Program
- Question & Answer Session

Registration Information: In order to receive the call-in

information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit **http://www.eventsvc.com/blhtechnologies**.

Presentation: The presentation for this call will be posted at least one day in advance at **http://www.CMS.gov/PQRS/04_-CMSSponsoredCalls.asp** in the "Downloads" section of the page.

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National Provider Call: Hospital Value-Based Purchasing Program – Registration Now Open

Tue Feb 28; 1:30-3pm ET

The Centers for Medicare & Medicaid Services (CMS) will be creating hospital-specific performance reports that simulate the FY2013 Hospital Value-Based Purchasing Program for each hospital to review; the simulated reports will employ hospital data from prior years to construct each hospital's baseline period and performance period scores. To prepare providers for interpreting the simulated report, this National Provider Call will discuss a sample report that shows what hospitals can expect when they receive their own reports.

Target Audience: Hospitals, Quality Improvement Organizations, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare Fee-For-Service providers.

Agenda:

- Opening Remarks

- Program Announcements
- Overview of the Hospital Value-Based Purchasing Program
- Presentation and Walkthrough of the Hospital-Specific Report
- Question & Answer Session

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit **http://www.eventsvc.com/blhtechnologies**.

Presentation: The presentation for this call will be posted at least one day in advance at **http://www.CMS.gov/Hospital--Value-Based-Purchasing** in the "Downloads" section of the page.

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Electronic Prescribing (eRx) Incentive Program: Updates for 2012

The Medicare Electronic Prescribing (eRx) Incentive Program, which began January 1, 2009 and is authorized under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, provides incentives for eligible professionals who are successful electronic prescribers. A web page dedicated to providing all the latest news on the eRx Incentive Program is available on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/ERxIncentive.

Under section 1848(a)(5)(A) of the Social Security Act, for years 2012 through 2014, a Physician Fee Schedule (PFS) payment adjustment applies to eligible professionals who are

not successful electronic prescribers at an increasing rate through 2014. Specifically, if the eligible professional is not a successful electronic prescriber for the respective reporting period for the appropriate program year, the PFS amount for covered professional services during the year shall be a percentage less than the PFS amount that would otherwise apply.

The following are key changes for the 2012 eRx Incentive Program:

Group Practice Reporting Option (GPRO) changes

Group practices (who self-nominated and were selected by CMS to participate in the Group Practice Reporting Option) can qualify to earn an eRx incentive if it is determined that the practice is a successful electronic prescriber. This incentive payment is equal to 1.0 percent of the total estimated Medicare Part B PFS allowed charges under the group practice's Taxpayer Identification Number (TIN). The minimum number of times a group must report the eRx measure is 2,500 for large group practices participating in eRx GPRO participants (100 or more individual eligible professionals), 625 for small group practices participating in eRx GPRO (25-99 individual eligible professionals).

Important Changes for the 2013 eRx Payment Adjustment

- Added a second reporting period to avoid the 2013 eRx payment adjustment (6-month reporting period, January 1-June 30, 2012)
- Eligible professionals can report on any billable Medicare Part B PFS service to avoid the 2013 payment adjustment.
- Hardship exemption requests are available for eligible professionals who are unable to report the eRx measure.

Avoiding the 2013 eRx Payment Adjustment

- In order to avoid the 2013 payment adjustment, eligible

professionals are now able to report the eRx Quality-Data Code (QDC) on any billable Medicare Part B PFS service. In previous program years, eRx events could only be reported with specified encounter codes. Please note that reporting denominator- eligible events is still required to earn an incentive payment for 2012.

- Additional information on how to avoid future eRx payment adjustments can be found in the Electronic Prescribing (eRx) Incentive Program – Future Payment Adjustments document located on the CMS eRx website at http://www.cms.gov/ERxIncentive.asp, under the "Educational Resources" section.

2012 Hardship Exemption Requests to Avoid the 2013 Payment Adjustment

- Individual eligible professionals requesting hardship exemptions from the 2013 eRx payment adjustment will be able to submit their request using the CMS Quality Reporting Communication Support Page located at https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234.
- CMS will announce when the Quality Reporting Communication Support Page becomes available for requesting a hardship exemption for the 2013 eRx payment adjustment.
- For more information on the 2012 eRx hardship exemption categories and on the process for requesting an exemption visit the CMS Electronic Prescribing Incentive Program at http://www.cms.gov/ERxIncentive.

Additional Information

- For more information on the 2012 eRx Incentive Program, go to https://www.cms.gov/ERxIncentive/06_E-Prescribing_Measure.asp
- For more information on avoiding future payment

adjustments, go to https://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp

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Some Medicare Beneficiaries Receive Large Bills Over "Observation Care" Status.

CMS, in an effort to reduce spending, requires medical necessity for a patient to be admitted to the hospital. Many times, however, it cannot be determined immediately if patients do require admission to the hospital. In these cases, patients are admitted to observation (today commonly called the CDU, or Clinical Decision Unit) to try to determine if the patient does need to be admitted or can be released. Observation is considered an Outpatient Service (even though the patient is in a hospital bed in the hospital), just as Emergency Room care is considered outpatient service. Patients who have received Observation Care, once they return home and receive a bill, are stunned to find that they are paying according to Medicare Part B. Part B has a deductible plus a 20% co-insurance for all services they received in the hospital as an outpatient. Read more here: **Wall Street Journal**

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CMS Gives Consumers Access to More Details about Infection Rates at America's Hospitals – Data Will Save Lives, Cut Costs

Central line-associated bloodstream infections (CLABSIs) are among the most serious of all healthcare-associated infections, resulting in thousands of deaths each year and nearly $700 million in added costs to the US healthcare

system. On Tue Feb 7, CMS announced that *Hospital Compare* will now include data about how often these preventable infections occur in hospital intensive care units across the country. This step will hold hospitals accountable for bringing down these rates, saving thousands of lives and millions of dollars each year.

The Centers for Disease Control and Prevention estimates that in 2009, there were about 41,000 CLABSIs in US hospitals. Studies show that up to 25 percent of patients who get a CLABSI will die from the infection. Caring for a patient with a CLABSI adds about $17,000 to a hospitalization. These infections prolong hospitalizations and can cause death.

Hospital Compare is one of Medicare's most popular web tools. The site receives about 1 million page views each month and is available in English and in Spanish. More information about *Hospital Compare* is online at **http://www.HospitalCompare.-HHS.gov**.

To view the CMS video of Nancy Foster, Vice President of Quality and Patient Safety Policy at the American Hospital Association, discussing *Hospital Compare*, visit the **CMS YouTube channel**.

The full text of this excerpted CMS press release (issued Tue Feb 7) can be found at **http://www.CMS.gov/apps/media/-press/release.asp?Counter=4260**.

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CMS Has Updated the EHR Information Center with New Self-Service Option

Following months of review and collective input, the Electronic Health Record (EHR) Information Center Interactive Voice Response (IVR) system has been enhanced to provide users

with an increased number of options and services to make accessing and reviewing data easier than ever before.

For eligible professionals (EPs), eligible hospitals, or critical access hospitals (CAHs), the revised functionality vastly improves the efficiency in obtaining desired information, while also offering a more varied amount of information and options for callers. CMS is proud to announce that providers can now obtain information through an extensive IVR Self-Service option. Included in this option is a reinforced privacy protection module that requires your individual National Provider Identifier (NPI), the last five digits of your Tax Identification Number (TIN), and your EHR registration ID. Once accepted, this newly enhanced Self-Service tool allows you to:

- Obtain registration status
- Acquire attestation status
- Review payment information
- Check progress towards meeting the $24,000 threshold amount

Users may access these new options by dialing **888-734-6433**, pressing 3 for Self-Service, and entering the authentication elements. These options will be available on the IVR effective Thu Feb 16.

EHR Information Center Hours of Operation: 7:30am-6:30pm CT, Monday through Friday, except federal holidays. (Note that General Information and Self-Service options may be reached via IVR 24 hours a day, except during periods of planned system maintenance or upgrades).

Supplementary information on the program may also be viewed by visiting the **FAQs section of the EHR Incentive Programs website, where users can search for any questions they have about the Medicare or Medicaid EHR Incentive Programs.**

Want more information about the EHR Incentive Programs? Make

sure to visit the **EHR Incentive Programs website** for the latest news and updates on the EHR Incentive Programs.

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Updated and New FAQs Added to the CMS EHR Website

CMS wants to help keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, and has recently updated previously-posted FAQs and added new FAQs on several incentive program topics, including reporting periods and incentive payments. Take a minute and review these FAQs:

- For the 2011 payment year, how and when will incentive payments for the Medicare EHR Incentive Programs be made? Read the answer.
- What are the EHR reporting periods for eligible hospitals participating in both the Medicare and the Medicaid EHR Incentive Programs, as well as the requirements for receiving an EHR incentive payment? Read the answer.
- For the Medicare and Medicaid EHR Incentive Programs, how will non-standard (or irregular) cost reporting periods be taken into account in determining the appropriate cost reporting periods to employ during the Medicare and Medicaid EHR Hospital Calculations? Read the answer.
- In order to qualify for payment under the Medicaid EHR Incentive Program for having adopted, implemented, or upgraded to (AIU) certified EHR technology, an eligible professional (EP) working at an Indian Health Services (IHS) clinic may be asked to submit to their State Medicaid Agency an official letter containing information about the clinic's electronic health record

from IHS (which is an Operating Division of the United States Department of Health and Human Services). The information in this letter identifies the EHR vendor, the ONC Certified Heath IT Product List (CHPL) number of the EHR, as well as other information regarding the EHR product version and licensure. Does this letter meet states' documentation requirements for AIU? Read the answer.

- For the Medicaid EHR Incentive Program, how do we determine Medicaid patient volume for procedures that are billed globally, such as obstetrician (OB) visits or some surgeries? Such procedures are billed to Medicaid at a global rate where one global rate might cover several visits. Read the answer.

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.

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Stay Informed via the CMS EHR Incentive Programs Listserv

CMS wants to invite you to join a free email service to receive the latest news on the EHR Incentive Programs. The **CMS EHR Incentive Program listserv** provides timely information on program requirements and changes in the EHR Incentive Programs.

By subscribing to this listserv, you will receive early notification of new program developments, the availability of new resources, and the addition of any new **Frequently Asked Questions** that are published on the CMS EHR Incentive Programs website. **Join** the listserv and visit the **listserv section** of the EHR Incentive Programs website to take a review some of the recent messages we have sent. We encourage you to let

others know about the CMS EHR Incentive Program listserv, and to share its messages.

Want more information about the EHR Incentive Programs? Make sure to visit the **EHR Incentive Programs** website for complete information about the CMS Medicare and Medicaid EHR Incentive Programs.

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How to Apply Online for the CMS Hardship Exemption from the 2012 eRx Medicare Payment Reduction

UPDATE: CMS has announced a second window for applying for the 2013 hardship exemption from 11/1/2012 through 1/31/2013. Click Here for more info.

UPDATE: CMS has released information for applying for the 2013 hardship exemption. Check out our "Medicare This Week" post from 6/8/2012 for more info.

UPDATE: The submission period for applying for a 2012 hardship exemption for failing to e-prescribe in 2011 is over.

CMS has just announced the process for applying for a hardship exemption from the 2012 1% Medicare payment adjustment (i.e. reduction.)

If you are participating as an individual Eligible Professional…

…use the new CMS provider webpage, called the **Quality Reporting Communication Support Page**, to enter the request and supporting rationale. Your request must be submitted by **November 1, 2011.** **A Quality Communications Support Page User Manual**is available to answer questions eligible professionals may have.

If you are participating using the Group Practice Reporting Option (GPRO)…

…Group practices selected for and participating in the 2011 GPRO I or II reporting option wishing to submit a 2012 exemption request should submit a letter to: Significant Hardship Exemptions, Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group, 7500 Security Boulevard, Mail Stop S3-02-01, Baltimore, MD 21244-1850. This letter must be postmarked no later than **November 1, 2011**.

To help eligible professionals and group practices understand the key provisions and impact of the 2011 Medicare Electronic Prescribing (eRx) Incentive Program Final Rule, **A Quick Reference Guide** has been posted to the eRx Incentive Program website on the **"Educational Resources"** page. Frequently asked questions (FAQs) addressing the 2011 eRx Final Rule, as well as other information and resources about the eRx Incentive Program can be found at the eRx Incentive Program website **here.**

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