ePrescribing Survivial Guide: Getting Your Ten Electronic Prescriptions Done in the Next 30 Days

Image via Wikipedia

This is a busy time for most practices. Managers are preparing for the annual juggling act of getting staff and physicians coordinated for summer vacations. Practices are ramping up for new doctors joining their practice at the traditional end of residency programs in the summer. Many practices are in the midst of shopping for, negotiating for or implementing EMRs. And most everyone without an existing EMR is struggling with the e-prescribing deadline looming in 30 days. Read my first post on this topic **here.**

As a reminder:

- Eligible professionals who are not successful e-prescribers, based on claims submitted between January 1, 2011 and 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 in 2012.
- Those that do not e-prescribe 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 do not e-prescribe 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.

Here are the problems practices have encountered trying to get their ten:

- Physicians seeing patients in facilities and using the codes that are eligible for eRx, but not having the ability to e-prescribe during the visit
- Physicians in specialties not prescribing many medications
- Physicians in specialties prescribing predominantly controlled drugs, which are not currently eligible for electronic prescribing

Today, the AMA released this announcement

> ***May 31, 2011***
>
> *On May 26 the Center for Medicare and Medicaid Services (CMS) responded to AMA concerns about the e-prescribing penalty program and issued a proposed rule that makes significant changes to it by adding more exemption categories. These changes will assure that physicians are not unfairly penalized for failing to meet the requirements under the 2012 e-prescribing penalty program.*
>
> *Physicians are still required to e-prescribe using a qualifying e-prescribing system and report the G8553 code on at least 10 Medicare Part B claims from Jan. 1, 2011, through June 30, 2011, to avoid the 2012 e-prescribing penalty.*

*However, to avoid the 2012 e-prescribing penalty, physicians now **will have an opportunity to attest through an on-line web portal that they are eligible for one of the following penalty exemptions**:*

- *Physician's practice is located in a rural area without high speed internet access*
- *Physician's practice is located in an area without sufficient available pharmacies for electronic prescribing*
- *Physician is registered to participate in the Medicare or Medicaid EHR Incentive Program and has adopted certified EHR technology **(New)***
- *Physician is unable to electronically prescribe due to local, State, or Federal law or Regulation (e.g., prescribes controlled substances) **(New)***
- *Physician infrequently prescribes (e.g., prescribe fewer than 10 prescriptions between January 1, 2011 –June 30, 2011) **(New)***
- *There are insufficient opportunities to report the e-prescribing measure due to program limitations (e.g., surgeons) **(New)***

Physicians will have to apply for an exemption from the 2012 e-prescribing penalty via the web-portal tool by Oct. 1.

What if you don't fall into one of these new categories?

It's time to tap into one of the free electronic prescribing packages available. Here are two choices:

1. **The National ePrescribing Patient Safety Initiative (NEPSI)** – Free, Allscripts Software
2. **Practice Fusion** – Free, probably will have advertising and your data will be mined (all 10 prescriptions!) but

you may be able to get it up and running very quickly

Some other thoughts on getting your ten done

1. Prescribe over-the-counter drugs including stool softeners and anti-emetics.
2. Prescribe Tylenol3 or another non-controlled pain reliever – patients do not need to pick these prescriptions up or pay for them.
3. Ask your Medicare patients if they have any prescriptions they would like you to refill while they are in the office. Over-the-phone refills do not count as there is no associated face-to-face service.

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