

Step by Step Directions for Getting the EHR Incentive Money: My Notes From Last Week's CMS Call

First the facts on what has taken place so far in the 2011 EHR Incentive Programs.

- As of June 30th, the total of **Medicare** EHR Incentive Program payments is over \$94 million.
- As of June 30th, over \$166 million has been paid in **Medicaid** EHR incentives since the program began in January. In May and June, four states launched Medicaid EHR Incentive Programs – Indiana, Ohio, Pennsylvania, and Washington, bringing the total states with Medicaid EHR Incentive Programs to 21. More states will launch in July.
- There are 68,001 active registrations of eligible professionals and eligible hospitals for the Medicare and Medicaid EHR Incentive Programs.

If your group hasn't received a check and hasn't registered for the Medicare or Medicaid Incentive Program, then this blog post is for you! For anyone who is really just beginning their EHR journey, today's presentation clarified previous information given by CMS, as well as giving listeners new information about the programs.

The two primary steps to obtaining incentive payments are:

1. **Register** for the EHR Incentive Program
2. **Attest** to meeting all the incentive payment eligibility criteria

Let's start with information on the two different incentive

programs. Remember that an eligible professional (EP) is defined differently for Medicare than it is for Medicaid.



Step One: Are You Eligible for the EHR Incentive Programs?

Medicare Eligible Professionals:

- Must be a physician (defined as MD, DO, DDM/DDS, optometrist, podiatrist, or chiropractor) – mid-levels do not qualify
- Must have Part B Medicare allowed charges
- Must not be hospital-based which is defined as having 90% or more of their covered professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital
- Must be enrolled in PECOS
- Must be living (Social Security records are examined)

Medicaid Eligible Professionals:

- Must be a MD, DO, DDM/DDS or a Nurse Practitioner, a Certified Nurse Midwife, **OR** a Physician Assistant who is the lead provider for a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
- Must either have 30% or more Medicaid patient volume (pediatricians must have 20% or more Medicaid patient volume) **OR** must practice predominantly in a FQHC or RHC with 30% or more needy individual patient volume. Needy is defined as patients who are Medicaid, Medicare, uninsured, under-insured, charity care and indigent care.
- Must be licensed and credentialed
- Must have no OIG exclusions
- Must be living (Social Security records are examined)

- Must not be hospital-based, which is defined as having 90% or more of their covered professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital



Step Two: How much EHR Incentive Money is Available From the Two Programs?

Medicare Incentive Payments:

- First eligible year for the program is 2011.
- Incentive amounts are based on the EP's Medicare Fee-for-Service allowable charges.
- Maximum incentives are \$44,000 over 5 years.
- Incentives decrease if the EP does not start until after 2012.
- EPs must begin using an EHR by 2014 to receive incentive payments.
- Last payment year is 2016.
- An extra 10% bonus amount based on actual payments from Medicare, not allowables, is available for EPs practicing predominantly in a Health Professional Shortage Area (HPSA). **Go here to see if you practice in a HPSA.**
- EPs will receive only 1 incentive payment per year.

Medicaid Incentive Payments:

- First eligible year for the program is 2011.
- Maximum incentives are \$63,750 over 6 years.
- Incentives are the same regardless of the year started.
- The first year's payment is \$21,250.
- Must begin by 2016 to receive incentive payments.
- No extra bonus for health professional shortage areas.

- Incentives are available through 2021.
- EPs will receive only 1 incentive payment per year.



How Do You Choose Which Program to Qualify For?

1. First, determine which programs you can qualify for based on the **type of eligible professional** you are.
2. Then, determine which programs you can qualify for based on **your patient population**.
3. Next, review the **requirements and potential payments and/or reductions** for each program – get your calculator out!
 - Once an eligible professional has demonstrated meaningful use in the first participation year, they may receive an incentive payment equal to 75% of Medicare allowable charges for covered professional services furnished by the eligible professional in a payment year **VERSUS** Once an eligible professional has demonstrated adoption, implementation, upgrading, or meaningful use of certified EHR technology in the first participation year, they may receive an incentive payment of \$21,250 from Medicaid. Remember the payments are for each provider. Don't forget the 10% HPSA bonus if you participate in the Medicare program.
 - Medicare requires EPs to escalate meaningful use participation and reporting and ultimately plans to impose payment reductions for EPs not engaged in using a certified EHR and implementing meaningful use. For Medicaid, each state has some leeway in defining the criteria for eligibility for incentives and there are no plans for payment

reductions as a part of the program.

4. If you not up to speed on meaningful use and want to collect incentive money for 2011, it will be easier to you to meet the requirements of the Medicaid program than the Medicare program, if you are eligible for the Medicaid program and there is one offered in your state.
5. Remember that EPs can switch programs once after their first year in either program.



Getting Ready for the Registration Process

1. Make sure you have your provider's **National Plan and Provider Enumeration System (NPPES)** User ID and Password. If the provider does not know this information, s/he will have to call and get the information. **The NPI, NPPES User ID and password are the basis for everything else.** While you're in that record, make sure all the provider's information is correct and completely up-to-date. You'll have an opportunity to update this information during the registration process, but it will not backfill the NPPES record.
2. Make sure your provider's enrollment record in the **Provider Enrollment, Chain and Ownership System (PECOS)**. You can see if s/he has a record in PECOS here – scroll down this page to "OrderingReferringReport". This is a 16,000+ page pdf file and as of this post it was updated June 27, 2011. (Note: Eligible professionals who are only participating in the **Medicaid** EHR Incentive Program are not required to be enrolled in PECOS.)
3. If you do not have an active User ID and Password for NPPES or PECOS, request them via **Identity & Access Management**. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from IRS

Form CP-575. You will also need to mail a copy of IRS Form CP-575 as directed.

4. Payee Tax Identification Number (if you are reassigning your benefits to a group or a hospital).
5. Payee National Provider Identifier (NPI) if you are reassigning your benefits. Note that many independent physicians are reassigning their benefits to their practice and almost all hospital-sponsored physicians are reassigning their benefits to the hospital.



Step by Step Directions to Register for the Medicare/Medicaid EHR Incentive Programs

NOTE! You can register before you have a certified EHR. Register even if you do not have an enrollment record in PECOS which is required for all Medicare eligible professionals. If you plan to register for the Medicaid program, your state's Medicaid program must be up and running. Check to see if your state has launched a Medicaid EHR Incentive Program here.

1. Go to the **registration site here**. The Login page instructs the user on what is required for a valid User ID and Password combination. EPs are required to have an active NPI and must have a National Plan and Provider Enumeration System (NPPES) user account to login. For users who do not have either of these requirements, click on the link provided to you in the program.
2. A link to the Identity and Access Management System, I&A, is also provided. The I&A system allows EP users use to reset their passwords and edit their account information. Any additional login issues can be resolved by contacting the help desk (see info at the bottom of this post.) At the bottom of the page the user enters

their User ID and Password combination. Please keep in mind that both of the fields are case-sensitive.

3. Once the user has logged into the system, the links and tabs displayed in the top right hand corner are shown on every page.
 - The **Home** hyperlink navigates the user to the Welcome page.
 - The **Help** hyperlink opens a PDF User Manual that assists the user throughout the Registration process.
 - If at anytime you wish to logout of the system, click the **Log Out** link and select yes in the pop-up window.
 - The **Instructions** section on the Welcome page describes the actions that can be performed under each of the tabs. The EP submits and maintains their registration under the Registration tab and completes their Attestation under the Attestation tab.
 - The **Status Tab** provides a snapshot of the user's current standing in the EHR Incentive Program. This includes the status of their registration and any attestations and payments associated with their account.
 - The **Account Management** tab allows the user to proceed to the I&A system in order to change their account information.
 - Clicking the **Registration** tab will reveal a set of instructions about the actions that can be performed. These options will differ depending on the status of the registration.
4. The EP's name, social security number, and NPI are retrieved from their NPPES account. If they have not started their registration, the status will be blank and **Register** will be the only available action.
5. Select the **Register** link to begin.
6. The Registration ID is displayed on the "Topics for this

Registration” page. **Write this number down** for tracking purposes.

7. There are three topics that an Eligible Professional must complete before submitting their Registration. They are EHR Incentive Program, Personal Information, and Business Address and Phone. The “Begin Submission” button cannot be selected until all of the topics are complete. Select the **“Start Registration”** button to navigate to the first topic.
8. On the EHR Incentive Program page, EPs are given the option to receive either a **Medicare or Medicaid EHR Incentive Payment**. For additional information about the two EHR Incentive Programs select the link that is provided. By selecting the Medicare option and clicking the “Apply” button, the EP type field page cursor moves across screen to highlight information. Provider Types that are eligible in the Medicare EHR Incentive Program are displayed in the dropdown. Selecting the Medicaid option and then the “Apply” button refreshes the page with two fields, Medicaid State/Territory and Eligible Professional Type. Only those states and territories participating in the Medicaid EHR Incentive Program are displayed in the Medicaid State/Territory dropdown. Provider types that are eligible for the Medicaid EHR Incentive Program are displayed in the dropdown.
9. Two additional links on the EHR Incentive Program page provide the user with information on certified EHRs and the EHR Certification Number. The Eligible Professional is required to indicate whether they are currently using a certified EHR.
A provider’s EHR system is not required to be certified prior to registration; however, an EHR Certification Number will be required at the time of attestation. See the **Certified Health IT Product List (CHPL)** for a listing of “certified” EHR products and to identify a product’s corresponding certification number. Select the “Save and Continue”

button to navigate to the next topic.

10. The Name and Identifiers displayed on the Personal Information page are retrieved from the user's NPI record on the NPES system. These fields cannot be modified in the EHR Incentive Program System. The Payee TIN Type field provides the user with two options in terms of who receives the EHR Incentive Payments. If the payments should be sent directly to the Eligible Professional, the SSN tab should be selected in the Payee TIN Type field. If the payments should be sent to a group associated with the Eligible Professional, the user should select E-I-N in the Payee TIN Type field and then select the "Apply" button. After the page is refreshed, three additional fields are displayed.
11. The next step is to select the Group that should receive the payments. A Group Name will only appear in the dropdown if the EP's Medicare enrollment in the Provider Enrollment, Chain, and Ownership System, or PECOS, has reassigned benefits to the Group. After the Group Name is selected, the Group's TIN is retrieved from PECOS and displayed in the Payee TIN field. It is also required that the user enters the NPI associated with the Group in the Payee NPI field. If the user had selected to register for the Medicaid EHR Incentive Program, the system requires the user to manually enter the Group Name, Payee TIN, and Payee NPI. A dropdown list of Group Names would not be provided. Select the "Save and Continue" button to navigate to the next topic.
12. The address and phone number displayed on the Business Address and Phone page is consistent with the Practice Location on the Eligible Professional's NPI record. Unlike the Personal Information page, the address and phone number fields can be modified here. However, if changes are made to the address and phone number in the EHR Incentive Program System, the changes will not be reflected on the Eligible Professional's NPI record. E-mail Address is also a required field and must be

entered with the correct email address format. Select the "Save and Continue" button to complete the last topic.

13. Once the user has entered the required registration information, all three of the topics are marked as completed. To initiate the submission process, select the "Begin Submission" button.
14. The Verify Registration page displays a summary of the registration information. It displays Personal Information, Business Address, as well as the Incentive Program that was chosen for this registration. The "Reason for Submission" section describes the action that the user is currently performing on the registration. If any of the information on this page is incorrect, the user should select the "Previous Page" button and make the appropriate modification.
15. After verifying that all of the information is correct, please select the "Submit" button to proceed. Before the registration can be submitted, the user must review and agree to the Registration Disclaimer. Agreeing to the legal notice means that the EP is certifying that the information provided in the registration is true and accurate. Please take the time to review each line of the disclaimer. Select the "Agree" button to proceed.
16. If the registration passes all validations, the submission will be successful. Please keep in mind that things like a non-approved Medicare enrollment in PECOS or OIG Exclusions can result in registration failure. Contact the help desk to resolve any of these issues.
17. The Submission Receipt page reminds users that they will not receive an e-mail confirmation and that attestation information must be submitted in order to qualify for an incentive payment. **Print the Submission Receipt page** by selecting the "Print" button at the bottom of the page. Select the "Return to Home" button to proceed.
18. A registration must be Active in order to proceed with

Attestation and Payment. If any changes need to be made to the registration, the user would select the Modify link and navigate back to the topics page. The registration can also be cancelled, which would end the Eligible Professional's participation in the EHR Incentive Program.

19. Selecting the Status tab navigates the user to the Status Summary page. The Select link navigates to the Status Detail page which displays all of the registration information in one location. The Additional Information link expands to display more registration information and the status of validations that are performed during submission.



Q & A from the listeners (always the best part!)

Q: Do you have to have paid for an EHR to receive the money? Can you use a Free EHR and still receive the incentive money?

A: Yes, you can use a free EHR and still receive the incentive money. The incentive money is to assist EPs implement EHRs and is not intended to be used only to purchase the software. Remember that the EHR must be certified by one of the certifying bodies and must be certified for ambulatory care.

Q: Is there a certain amount of time after registering that an EP must attest for Medicaid?

A: Once an EP registers, there is no deadline for attesting. Once an EP has attested, payment will be received in 45 days or less.

Q: Is the denominator for the meaningful use measures all patients that an EP sees, or just all Medicare or Medicaid

patients seen during a specific period?

A: The denominator is all patients that the EP sees during the applicable period.

Q: Are radiologists eligible?

A: Yes. The radiologist must use a certified ambulatory care EHR. There is no guideline as to where the information going into the EMR comes from, with the exception of the CPOE measure. Many radiologists have expressed concerns as they do not actually “see” patients – CMS will be addressing this in the future.

Q: Where does the certification number needed for the EHR Incentive Program registration come from?

A: The certification number comes from the **CHPL website**. Get the EHR Vendor’s certification number, enter that number into the CHPL site and a registration/attestation number will be provided from the CHPL program to enter into the registration/certification program.

nursing home visits

Q: Is attestation the last step after completing the 90-day reporting period and collecting the data for the Medicare meaningful use program?

A: Yes.

Q: Do visits count if an EP sees patients in nursing homes?

A. Nursing home visits can count if a certified ambulatory EHR is being used, for instance if the EP carries a laptop with him, or if the visit information is later entered into the EP’s EHR.

Q: Can an administrator or other third party complete the registration and attestation?

A: Yes, if the third party goes through the Identity and Authority Management system, they can register and attest. The system will ask for the third party's social security number as they will be legally attesting to the information entered.

Q: What is the latest 90-day period an EP can use a certified EHR to receive an incentive payment for 2011?

A: October 1, 2011 – December 31, 2011 is the latest 90-day period. EPs must start using a certified EHR by October 1, 2011 and must demonstrate meaningful use by providing data via the attestation process before 60 days after the close of the 2011 calendar year.

Q: What if due to the EP's specialty none of the meaningful use measures can be met?

A: The EP must exhaust all core, alternate and menu measures by answering "0", exhausting all 38 of the measures by attesting "0" to all 38.

Q: If state does not accept any electronic submission of public health information, is the EP excluded from having to meet this requirement?

A: Yes.

Resources:

EHR Information Center

Hours of Operation: 7:30 a.m. – 6:30 p.m. (Central Time)

Monday through Friday, except federal holidays.

1-888-734-6433 (primary number) or 888-734-6563 (TTY number)



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 eRx 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 NPES,
- 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

