# Medicare Quality Reporting Incentive Programs Manual

## Chapter 2 – The Electronic Prescribing (eRx) Incentive Program

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***(Rev. 31, 08-29-14)***

### Transmittals for Chapter 2

## 10 - Background
**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

Chapter 2 of this manual focuses on the requirements for the Electronic Prescribing (eRx) Incentive Program, a quality reporting program which promotes the adoption and use of eRx systems through a combination of incentives and payment adjustments. ERx is the transmission of prescription or prescription-related information through electronic media. ERx takes place between a prescriber, dispenser, pharmacy benefit manager, or health plan. It can take place directly or through an intermediary (such as a network).

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required the Secretary to establish a new reporting program for individual eligible professionals who are successful electronic prescribers as defined by MIPPA, beginning on January 1, 2009. While the eRx Incentive Program has similarities in structure and processes to the Physician Quality Reporting System (formerly the Physician Quality Reporting Initiative or PQRI) described in Chapter 1 of this Publication, this program is a stand alone program with distinct reporting requirements and associated incentive payment and payment adjustment.

The eRx Incentive Program encourages significant expansion of the use of eRx by authorizing a combination of financial incentives and payment differentials. Any incentive payment earned through the eRx Incentive Program is separate from and in addition to any incentive payment that eligible professionals may earn through the Physician Quality Reporting System program. Except for eligible professionals who wish to participate in the eRx Incentive Program under the group practice reporting option (GPRO) beginning 2010 (see §20.2), eligible professionals do not have to participate in Physician Quality Reporting System to participate in the eRx Incentive Program or vice-versa.

See Chapter 1, "Physician Quality Reporting System," for information on the Physician Quality Reporting System.

## 20 – Eligibility
**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

## 20.1 – Individual Eligible Professionals
**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

For purposes of the eRx Incentive Program, the definition of "eligible professional" is identical to that for the Physician Quality Reporting System. An eligible professional is any one of the following:

- Physician
    - Doctor of Medicine
    - Doctor of Osteopathy
    - Doctor of Podiatric Medicine

    - Doctor of Optometry
    - Doctor of Dental Surgery
    - Doctor of Dental Medicine
    - Doctor of Chiropractic

- Practitioner
    - Physician assistant
    - Nurse Practitioner
    - Clinical nurse specialist
    - Certified registered nurse anesthetist (and Anesthesiologist Assistant)
    - Certified nurse midwife
    - Clinical social worker
    - Clinical psychologist
    - Registered dietitian
    - Nutrition professional
    - Audiologists (as of January 1, 2009)

- Therapist
    - Physical therapist
    - Occupational therapist
    - Qualified speech-language therapist (began billing Medicare directly as of July 1, 2009)

All Medicare-enrolled professionals in these categories are eligible to participate in the eRx Incentive Program regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims. However, eligibility is further restricted by scope of practice to those professionals who have prescribing authority under their respective state practice laws.

## 20.1.1 – Professionals Eligible to Participate But Not Able to Participate

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Some professionals who are included in the definition of "eligible professional" above are eligible to participate but are not able to participate for one or more reasons. These include: eligible professionals in certain settings in which Medicare Physician Fee Schedule billing is processed by Medicare fiscal intermediaries (FIs)/AB Medicare Administrative Contractors (MACs). The FI/MAC claims processing systems for the following settings currently cannot accommodate billing at the individual eligible professional level:

- Critical access hospitals (CAHs), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the regular FI or Part A MAC for the covered professional services furnished by the eligible professional.

- All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.

## 20.1.2 – Professionals Not Eligible to Participate

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Providers and professionals not defined as eligible professionals are not eligible to participate in the eRx Incentive Program do not qualify for an incentive, and are not subject to a payment adjustment. Services payable under or based on fee schedules or methodologies other than the PFS are not included in the eRx Incentive Program (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, portable x-ray suppliers, independent laboratories, hospitals [including critical access], rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for the eRx Incentive Program since DME is not based on or paid under the PFS.

## 20.1.3 – Professionals Eligible to Participate But For Whom the Payment Adjustment Does Not Apply

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The payment adjustment does not apply to an eligible professional if any of the following apply:

- Based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES),the eligible professional is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of –

    - June 30, 2011 for the 2012 payment adjustment,
    - June 30, 2012 for the 2013 payment adjustment, or
    - June 30, 2013 for the 2014 payment adjustment.

- The eligible professional does not have prescribing privileges and reports G-code G8644 (defined as not having prescribing privileges) at least one time on a Medicare Part B claim prior to –

    - June 30, 2011 for the 2012 payment adjustment,
    - June 30, 2012 for the 2013 payment adjustment, and/or
    - June 30, 2013 for the 2014 payment adjustment.

- The eligible professional does not have at least 100 cases containing an encounter code in the eRx measure's denominator for dates of service between –

    - January 1, 2011 and June 30, 2011 for the 2012 payment adjustment,

- January 1, 2012 and June 30, 2012 for the 2013 payment adjustment, and/or
- January 1, 2013 and June 30, 2013 for the 2014 payment adjustment.

## 20.2 – Participation by Group Practices Using the eRx Group Practice Reporting Option (GPRO)

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

Prior to 2010, the eRx Incentive Program was limited to participating as an individual eligible professional and the determination of whether an eligible professional is a successful electronic prescriber was made at the individual professional level, based on the National Provider Identifier (NPI). No incentive payments were available to a group practice based on a determination that the group practice, as a whole, was a successful electronic prescriber. To the extent that individual eligible professionals (based on individuals' NPIs) are associated with more than one practice, or Taxpayer Identification Number (TIN), the determination of whether an eligible professional is a successful electronic prescriber was made for each unique TIN/NPI combination. Therefore, the incentive payment amount was calculated for each unique TIN/NPI combination and payment was made to the holder of the applicable TIN (see §40 below).

As required by the MIPPA, beginning in 2010, group practices, by participating in the eRx group practice reporting option (GPRO), are eligible to qualify for an eRx incentive payment based on the determination that the group practice, as a whole, is a successful electronic prescriber. The criteria for determining whether a group practice is a successful electronic prescriber and the process for reporting by group practices under the eRx GPRO are discussed in §60.2 below.

In 2010, for purposes of being able to participate in the eRx Incentive Program under the eRx GPRO, a "group practice" was defined as a TIN with at least 200 or more individual eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN.

However, in 2011, with the addition of "GPRO II" described in Chapter 1, § 20.3, the definition of group practice was expanded to include a TIN with at least 2 or more individual eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN.

In 2012, the definition of group practice for the eRx Incentive Program was further modified to mirror the 2012 definition of group practice for the 2012 Physician Quality Reporting System as described in Chapter 1, § 20.3 of this manual. Therefore, a group practice was defined as a TIN with at least 25 or more individual eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN. In 2012, the definition of group practice also includes those groups participating in certain Medicare-approved demonstrations projects or various other CMS programs, under which Physician Quality Reporting System requirements and incentives have been incorporated, such as groups participating in the Medicare Shared Savings Program.

In order to participate in the eRx Incentive Program through the GPRO, including those groups that are deemed participating in the Physician Quality Reporting System, group practices must have self-nominated and been selected to participate in the Physician Quality Reporting System GPRO (see Chapter 1, §20 for information on the requirements for participation in the Physician Quality Reporting System GPRO). CMS assesses whether the participation requirements are met by each self-nominated group practice and notifies group practices of a decision.

As required by section 1848(m)(3)(C)(iii) of the Social Security Act (the Act), an individual eligible professional who is a member of a group practice selected to participate in the eRx GPRO for a particular program year is not eligible to separately earn an eRx incentive payment as an individual eligible professional under that same TIN (that is, for the same TIN/NPI combination) for that year. Once a group practice (TIN) is selected to participate in the GPRO for a particular program year, this is the only method of eRx Incentive Program participation available to the group and all individual NPIs who bill Medicare under the group's TIN for that program year.

In addition, the group practice will be assessed for applicability of the payment adjustment, beginning in 2012, discussed in § 60.2.2 below under the GPRO criteria as well. Although the determination of whether a GPRO is a successful electronic prescriber will be analyzed at the TIN level, if group practices elect to participate in the eRx GPRO for a particular program year and the group practice fails to meeting the reporting thresholds for reporting its eRx activities (i.e., fails to become a successful electronic prescriber), each eligible professional who belongs to the group practice will be subject to the payment adjustment, regardless of whether or not the eligible professional, as an individual, successfully reports . For example, for purposes of the 2012 payment adjustment, if a group practice consisting of 2 individual eligible professionals elects to participate in the eRx GPRO under the 2011 eRx GPRO II option, based on the size of this group practice (which is 2), this group practice must report the eRx measure via claims on 75 unique events for patients in the denominator of the measure for services occurring between January 1, 2011 and June 30, 2011. If an eligible professional within the group practice reports the eRx measure on 25 unique events during the January 1, 2011 and June 30, 2011 reporting period and the other eligible professional does so for only 5 unique events , provided a limitation or significant hardship exemption does not apply to the group practice, the group practice as a whole (i.e., both individual eligible's) will be subject to a 1.0% payment adjustment on all their Medicare Part B PFS allowed charges for covered professional services furnished in 2012. Although the first eligible professional would have successfully reported as an individual, the entire group practice (i.e., both eligible professionals) will be subject to the 2012 payment adjustment for failing to reach the reporting threshold of 75 unique events that was required for groups with 2 eligible professionals.

## 30 – Reporting Period

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

## 30.1 – Reporting Period for the Incentive Payments
**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

The reporting period for the eRx Incentive Program incentive payments is the entire calendar year. Specifically, the reporting periods for the following incentive payments are as follows:

| Incentive Payment | 12-month Reporting Period |
|---|---|
| 2009 | January 1, 2009 – December 31, 2009 |
| 2010 | January 1, 2010 – December 31, 2010 |
| 2011 | January 1, 2011 – December 31, 2011 |
| 2012 | January 1, 2012 – December 31, 2012 |
| 2013 | January 1, 2013 – December 31, 2013 |

## 30.2 – Reporting Period for the Payment Adjustments
**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

Except for the 2012 payment adjustment, there are two reporting periods for purposes of the eRx Incentive Program payment adjustments: (1) the 12-month calendar year 2 years prior to the applicable payment adjustment and (2) a 6-month reporting period occurring during the first 6 months of the calendar year prior to the applicable payment adjustment. For the 2012 payment adjustment, there was only one reporting period: the 6-month reporting occurring during the first 6 months of 2011. Specifically, the reporting periods for the following payment adjustments are as follows:

| Payment Adjustment | 12-month Reporting Period | 6-month Reporting Period |
|---|---|---|
| 2012 | N/A | January 1, 2011 – June 30, 2011 |
| 2013 | January 1, 2011-December 31, 2011 | January 1, 2012 – June 30, 2012 |
| 2014 | January 1, 2012 – December 31, 2012 | January 1, 2013 – June 30, 2013 |

## 40 – Payment for Reporting
**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

A participating individual eligible professional or group practice (see §20) who is determined to be a "successful electronic prescriber" (see §60) may earn an incentive payment or receive a payment adjustment with respect to covered professional services furnished by the eligible professional (or group practice) during a specified reporting period (see §30). Section 1848(k)(3)(A) of the Act defines "covered professional services" as services for which payment is made under, or is based on, the Medicare Part B PFS and which are furnished by an eligible professional (or group practice).

An eligible professional who is determined to be a successful electronic prescriber may qualify to earn an incentive payment or receive a payment adjustment equal to a percentage of the total estimated Medicare Part B allowed charges for covered professional services furnished by the eligible professional during the respective reporting period. The incentive payments for successful electronic prescribers for each authorized year are as follows:

- 2.0 percent for 2009;
- 2.0 percent for 2010;
- 1.0 percent for 2011;
- 1.0 percent for 2012; and
- 0.5 percent for 2013.

In addition to the eRx incentive payment, under § 1848(a)(5)(A) of the Act, a PFS payment adjustment applies beginning in 2012 to those who are not successful electronic prescribers for 2012. The payment adjustments for eligible professionals who are not successful electronic prescribers for each authorized year are as follows:

- 1.0 percent for 2012;
- 1.5 percent for 2013; and
- 2.0 percent for 2014.

The eRx incentive payment amount is calculated based on an eligible professional's (or group practice's) total estimated allowed charges for all covered professional services: (1) furnished during the applicable reporting period, (2) received into the National Claims History (NCH) file by no later than 2 months after the end of the reporting period, and (3) paid under or based upon the Medicare PFS. Because claims processing times may vary by time of the year and Medicare Carrier/AB MAC, eligible professionals should submit claims from the end of the reporting period promptly, so that if, for example, the reporting period ends on December 31st of a particular year, claims from the end of the reporting period will reach the NCH file by February 28th of the following year. The eRx incentive payments are paid as a lump sum. Eligible professionals and group practices who receive an eRx incentive will see the following statement on their paper remittance advice: "This is an E-Rx incentive payment." On electronic remittance statements, the code "LE" and a year indicator (e.g., "RX10 for a 2010 incentive payment) appears on the remittance advice to indicate the amount provided is for an eRx incentive earned. A glossary of these codes is provided for eligible professionals or group practices.

The eRx payment adjustment amount is calculated based on the Secretary's total estimated allowed part B charges for all covered professional services: (1) furnished by the eligible professional (or group practice) during the applicable payment adjustment year and (2) paid under or based upon the Medicare PFS. Eligible professionals and group practices that are subject to a payment adjustment will see the following codes on their remittance advice: CARC #237 ("Legislated/Regulatory Penalty") and RARC #N545 ("Payment reduced based on status as an unsuccessful eprescriber per the ERx Incentive Program"). If a payment adjustment was applied in error and an eligible

professional or group practice is reimbursed due to this error, CARC #237 and RARC #N546 ("Payment represents a previous reduction based on the ERx Incentive Program") will appear on the remittance advice. A glossary of these codes is provided for the eligible professionals or group practices.

Payment for this program is calculated at the individual eligible professional level using individual NPI data and beginning in 2010, for group practices participating in the eRx GPRO, at the group practice level using TIN data. CMS uses the TIN as the billing unit so that any eRx incentive payment earned (regardless of whether the incentive payment was earned by an individual eligible professional or a group practice) is paid to the TIN holder of record. Individual incentive payments for groups that bill under one TIN are aggregated and paid to the holder of the TIN. Some individuals (NPIs) may be associated with more than one practice or TIN, and thus CMS groups claims by TIN for purposes of the incentive. In other words, the incentive payment is made for each unique TIN/NPI combination so that an eligible professional who qualifies for the eRx incentive payment under more than one TIN would receive a separate eRx incentive payment associated with each TIN.

Under the statute, however, there is a limitation with regard to the application of the incentive and payment adjustment. The incentive and payment adjustment does not apply to eligible professionals (and group practices participating in the eRx GPRO), for the reporting period, if the Medicare allowed charges for all covered professional services for the codes to which the eRx quality measure applies are less than 10% of the total allowed charges under Medicare Part B for all such covered professional services furnished by the eligible professional (or group practice).

The eRx incentive payment and payment adjustment amount is calculated using allowed charges for all covered professional services, not just those charges associated with eRx events. The term "allowed charges" refers to total charges, including the beneficiary deductible and co-payment, not just the 80% paid by Medicare or the portion covered by Medicare where Medicare is a secondary payer. Note that the amounts billed above the Medicare PFS amounts for assigned and non-assigned claims do not apply to the incentive and/or payment adjustment. The statute defines eRx covered professional services as those paid under or based upon the Medicare PFS only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology.

Other Part B services and items that may be billed by eligible professionals but are not paid under or based upon the Medicare PFS are not included in the calculation of the eRx incentive and/or payment adjustment amount.

Please note that, according to section 1848(m)(2)(D) of the Act, an eligible professional cannot receive an incentive payments under both the Medicare eRx Incentive Program and Medicare EHR Incentive Program.

For information on operational payment instructions related to the eRx Incentive Program, please see Chapter 3(§30) of this manual titled "Contractor Incentive Program Payment Operational Instructions."

## 50 – Form and Manner of Reporting for the Purpose of Receiving Incentive Payments and Payment Adjustments

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

Prior to the 2010 eRx Incentive Program, participation in the eRx Incentive Program was limited to the submission of quality data codes (QDCs) for the eRx measure through Medicare's claim processing system. Beginning with the 2010 eRx Incentive Program, eligible professionals may choose to report the eRx measure to CMS using one of the following reporting mechanisms:

- Claims-based reporting;
- Registry-based reporting; or
- EHR-based reporting.

## 50.1 – Claims-based Reporting Mechanism

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

Individual eligible professionals and group practices who choose to participate in the eRx Incentive Program via the claims-based reporting mechanism do not have to enroll or register to begin claims-based reporting of the eRx measure to CMS.

Participating eligible professionals or group practices who bill for the services or procedures included in the denominator of the eRx measure report the corresponding appropriate numerator G-code on their claim. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P. The specifications for the eRx measure are available on the E-Prescribing Measure section page of the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive and may be updated on an annual basis.

The applicable G-code quality data must be reported on the same claim as the billable service or procedure to which the QDC applies. The eRx measure does not require a specific diagnosis to help determine the denominator; therefore, any diagnosis reported on the claim is sufficient. The analysis algorithms that are used to determine whether an eligible professional is a "successful electronic prescriber" match the QDCs to the service and/or procedure codes on the claim. Thus, QDCs that are not submitted on the same claim as the applicable service and/or procedure codes do not count toward an eligible professional meeting the requirements of being a "successful electronic prescriber." Claims-based reporting is the only reporting mechanism available for purposes of reporting on the eRx measure for the 2012 payment adjustment and for the 6-month reporting periods for the 2013 and 2014 payment adjustments.

## 50.1.1 - Coding and Reporting Principles for Claims-based Reporting Coding and Reporting Principles for Claims-*B*ased Reporting

***(Rev. 31, Issued: 08-29-14, Effective: ASC 12X: January 1, 2012; ICD – 10: Upon Implementation of ICD – 10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 09 -30-14)***

The following principles apply for claims-based reporting of the eRx measure:

For the eRx measure used for the reporting period that occurred during calendar year 2009, report one of the three eRx codes listed below as the claim numerator, when applicable:

- G8443 - "All prescriptions created during the encounter were generated using a qualified eRx system."

- G8445 - "No prescriptions were generated during the encounter."

- G8446 - "Provider does have access to a qualified eRx system and some or all of the prescriptions generated during the encounter were printed or phoned in as required by the State or Federal Law or regulations, patient request or pharmacy system being unable to receive electronic transmission; or because they were for narcotics or other controlled substances."

One of these codes must be reported on at least 50% of patients who meet the denominator criteria of the measure.

For the eRx measure used for the reporting period that occurred during calendar year 2010 the eRx measure's numerator includes only 1 G-code (CMS eliminated the 3 numerator G-codes used for the 2009 reporting period). To report the eRx measure for the 2010 reporting period, report the following eRx numerator G-code, when applicable:

- G8553 – At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.

For the eRx measure for reporting periods that occurred during calendar year 2011, the eRx measure's numerator is the same G-code used in the 2010 reporting period. To report the eRx measure for 2011 reporting periods, report the following eRx numerator G-code, when applicable:

- G8553 – "At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system."

For the eRx measure used for reporting periods that occur during the 2012 or 2013 calendar year, the eRx measure's numerator code is the same G-code used in 2010 and 2011 reporting periods. To report the eRx measure for the 2012 or 2013 reporting periods, report the following eRx numerator G-code, when applicable:

- G8553 – "At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system (faxes do not count)."

The eRx G-code, which supplies the numerator, must be reported for the applicable amount of unique visits (for services in the denominator) to successfully report for incentive payment purposes:

- on the claim(s) with the denominator billing code(s) that represent the eligible encounter for the 2012 eRx incentive payment; **OR** on the claim(s) with any billing code(s) that represent the encounter to avoid the 2013 eRx payment adjustment,
- for the same beneficiary,
- for the same date of service (DOS), and
- by the same eligible professional (individual NPI) who performed the covered service as the payment codes, CPT Category I or

The eRx G-code must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed:

- The submitted charge field cannot be blank.
- The line item charge should be $0.00.
- If an eligible professional's billing software does not allow a $0.00 line-item charge, a nominal amount, such as $0.01, can be substituted - the beneficiary is not liable for this nominal amount.
- Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)
- Whether a $0.00 charge or a nominal amount is submitted to the Medicare Administrative Contractor (MAC) *(B)*, the eRx G-code line is denied and tracked.

ERx line items will be denied for payment, but are passed through the claims processing system to the NCH database and used for eRx claims analysis. Eligible professionals will receive a Remittance Advice (RA) which includes a standard remark code (N365). N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does NOT indicate whether the eRx G-code is accurate for that claim or for the measure the eligible professional is attempting to report. N365 only indicates that the eRx G-code passed into NCH.

When a group bills, the group NPI is submitted at the claim level, the individual rendering/performing physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.

Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, (*on the ASC X12 837 professional claim format or item* 33 on the *Form* CMS-1500).

Claims may **NOT** be resubmitted for the sole purpose of adding or correcting an eRx code.

**Submission Through *A/B MACs (B)***

ERx G-codes shall be submitted to *A/B MACs (B)* either through: Electronic submission using the *current version of the* ASC X12 837 *professional claim*, or via paper-based submission, using the *Form* CMS-1500 claim.

**Electronic-based Submission:**

Physician Quality Reporting QDCs are submitted on the claim just like any other code; however, QDCs will have a $0.00 (or nominal) charge. Electronic submission, which is accomplished using the ASC *X12 837 professional claim format*, should follow the current HIPAA standard version of the ASC *X12 837* technical report 3.

**Paper-based Submission:**

Paper-based submissions are accomplished using the *Form* CMS-1500 claim (version 02-12). Relevant diagnosis codes are entered in Field 21. Service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in Field 24D with a single reference *letter* in the diagnosis pointer Field 24E that corresponds with the diagnosis *letter* in Field 21.

For group billing, the NPI of the rendering/performing provider is entered in Field 24J and the TIN of the employer is entered in Field 25.

**Timeliness of Quality Data Submission**

Claims processed by the must reach the National Claims History (NCH) file by no later than 2 months after the end of the reporting period to be included in the analysis. For the 2011 eRx Incentive Program, for example, claims processed by the *A/B MAC (B)* must reach the NCH file by no later than February 28, 2011 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

## 50.2 – Registry-based Reporting Mechanism

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

Beginning with the 2010 eRx Incentive Program, individual eligible professionals and group practices Individual eligible professionals and group practices may choose to participate in the eRx Incentive Program via the registry-based reporting mechanism for all reporting periods except those 6-month reporting periods associated with a payment adjustment. Eligible professionals and group practices that choose to participate in the eRx Incentive Program via the registry-based reporting mechanism do not have to enroll or register to begin registry-based reporting of the eRx measure to CMS. However, to report eRx measure data via the registry-based reporting mechanism, an eligible professional or group practice must select a qualified clinical data registry and must enter into and maintain an appropriate legal arrangement with a qualified clinical data registry. Such arrangements should provide for the registry's receipt of patient-specific data from the eligible professional and the registry's disclosure of eRx measure results and numerator and denominator data on behalf of the eligible professional or group practice to CMS. An eligible professional or group practice choosing the registry-based reporting mechanism must submit information on the eRx measure to their selected registry in the form and manner and by the deadline specified by the registry. Thus the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L.104-191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as "data submission vendors." The "data submission vendors" would have the requisite legal authority to provide information on eRx measure results and numerator and denominator data on the eRx measure on behalf of the eligible professional for the eRx.

Only a registry that is qualified to submit Physician Quality Reporting System quality measures information to CMS on behalf of eligible professionals for the applicable program year is eligible to become a qualified registry for the purpose of submitting eRx measure information to CMS on behalf of eligible professionals or group practices. CMS qualifies registries for the Physician Quality Reporting System for each program year through a self-nomination process (see Chapter 1, §50.2). The list of qualified registries for a specific program year are made available on the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive. For a specific program year, this list usually is made available in the summer of that same year. For example, we anticipate the list of qualified registries for the 2010 eRx Incentive Program was anticipated to be made available in the summer of 2010.

Please note that, for all 6-month reporting periods associated with a payment adjustment, only the claims-based reporting mechanism may be used for purposes of the eRx payment adjustment. For example, for purposes of the 6-month reporting period for the 2013 payment adjustment (i.e., January 1, 2012-June 30, 2012, only the claims-based reporting mechanism may be used for purposes of the 2013 eRx payment adjustment even though the registry-based reporting mechanism was finalized for use by eligible professionals for the 12-month reporting period for the 2013 payment adjustment (i.e., January 1, 2011 – December 31, 2011) and for purposes of the reporting period for the 2012 incentive (i.e., January 1, 2012-December 31, 2012). As such, to the extent an eligible professional intends to use a registry to submit eRx measure data for purposes of qualifying for the

2012 eRx payment incentive, the eligible professional would still need to submit eRx measure data on claims for services furnished between January 1, 2012 and June 30, 2012, in order to avoid the 2013 eRx payment adjustment.

## 50.3 – Electronic Health Record-based (EHR-based) Reporting Mechanism

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

Beginning with the 2010 eRx Incentive Program, Individual eligible professionals and group practices may choose to participate in the eRx Incentive Program via the EHR-based reporting mechanism for all reporting periods except those 6-month reporting periods associated with a payment adjustment. Beginning in 2012, as described in further detail in Chapter 1, section 50.3, eligible professionals and group practices may participate in the eRx Incentive Program via two EHR-based reporting mechanisms: (1) a qualified direct EHR or (2) a qualified EHR data submission vendor.

Eligible professionals and group practices that choose to participate in the eRx Incentive Program via the EHR-based reporting mechanism do not have to enroll or register to begin EHR-based reporting of the eRx measure to CMS.

Likewise, eligible professionals and group practices that choose to participate in the eRx Incentive Program via EHR data submission vendors do not have to enroll or register to begin EHR-based reporting of the eRx measure to CMS.

However, to report eRx measure data via the EHR-based reporting mechanism, an eligible professional or group practice must select a qualified EHR product. An eligible professional or group practice choosing the EHR-based reporting mechanism must:

- Have an active Individuals Authorized Access to CMS Systems (IACS) user account that will be used to submit the eRx measure data extracted from the EHR to CMS;

- Submit a test file containing real or dummy clinical quality data extracted from the EHR to a CMS clinical data warehouse; and

- Submit a file containing the eligible professional's or group practice's eRx measure data extracted from the EHR for the entire reporting period via IACS by no later than 2 months after the end of the reporting period. (For the 2010 incentive, the submission period will be 02/01/11 – 03/31/11).

Only an EHR product that is qualified for use by eligible professionals to submit Physician Quality Reporting System quality measures information to CMS is eligible to become a qualified EHR product for the purpose of an eligible professional or group practice using the product to submit eRx measure information to CMS. CMS qualifies EHR vendors and their specific product(s) for use by eligible professionals to submit Physician Quality Reporting System quality measures data to CMS (see Chapter 1,

§50.3). The list of qualified EHR direct and data submission vendors and their qualified products for a specific program year are made available on the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive.

Please note that, for all 6-month reporting periods associated with a payment adjustment, only the claims-based reporting mechanism may be used for purposes of the eRx payment adjustment. For example, for purposes of the 6-month reporting period for the 2013 payment adjustment (i.e., January 1, 2012-June 30, 2012, only the claims-based reporting mechanism may be used for purposes of the 2013 eRx payment adjustment even though the EHR-based reporting mechanism was finalized for use by eligible professionals for the 12-month reporting period for the 2013 payment adjustment (i.e., January 1, 2011 – December 31, 2011) and for purposes of the reporting period for the 2012 incentive (i.e., January 1, 2012-December 31, 2012). As such, to the extent an eligible professional intended to use an EHR or EHR data submission vendor to submit eRx measure data for purposes of qualifying for the 2012 eRx payment incentive, the eligible professional would still need to submit eRx measure data on claims for services furnished between January 1, 2012 and June 30, 2012, in order to avoid the 2013 eRx payment adjustment unless the eligible professional was a successful prescriber for the 12-month 2011 reporting period or a hardship exemption or other exclusion applies.

## 60 – Criteria for Determination of Successful Electronic Prescriber
**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

In order to qualify to earn an eRx incentive payment and/or avoid a payment adjustment for a particular program year, unless an exception applies, eligible professionals and group practices must be considered a "successful electronic prescriber." The criteria that will be used to determine whether an eligible professional or group practice is a successful electronic prescriber differ depending on whether participation is at the individual eligible professional level or at the group practice level and may differ from one program year to another.

## 60.1 – Eligible Professionals
**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

The criteria for the determination of a successful electronic prescriber for individual eligible professionals with respect to receiving incentive payments and/or avoiding payment adjustments are described in §§ 60.1.1 and 60.1.2 of this manual. See below.

## 60.1.1 – Criteria for Determination of Successful Electronic Prescriber for the Incentive Payments – Individual Eligible Professionals
**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

For the 2009 incentive, an individual eligible professional was considered a "successful electronic prescriber" if he/she reported the eRx measure (as specified for 2009) on at least 50% of the cases in which the measure is reportable by the eligible professional during the 2009 reporting period.

For the 2010 through 2013 incentives, an individual eligible professional was/is considered a "successful electronic prescriber" if he/she reports the eRx measure (as specified for the year) for at least 25 unique denominator-eligible events during respective incentive reporting periods.

## 60.1.2 – Criteria for Determination of Successful Electronic Prescriber for the Payment Adjustments – Individual Eligible Professionals

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

For the 2012 payment adjustment, an individual eligible professional is considered a "successful electronic prescriber" if the eligible professional reports the eRx measure's numerator via claims for at least 10 unique eRx events for patients in the denominator of the measure between January 1, 2011 and June 30, 2011.

For the 2013 payment adjustment, an individual eligible professional is considered a "successful electronic prescriber" if the eligible professional meets the criteria for being a successful electronic prescriber for the 2011 incentive. Additionally, an individual eligible professional may also be considered a "successful electronic prescriber" if the eligible professional reports the eRx measure's numerator via claims for at least 10 unique eRx events (regardless of whether the event is one associated with the eRx measure's denominator) between January 1, 2012 and June 30, 2012.

For the 2014 payment adjustment, an individual eligible professional is considered a "successful electronic prescriber" if the eligible professional meets the criteria for being a successful electronic prescriber for the 2012 incentive. Additionally, an individual eligible professional may also be considered a "successful electronic prescriber" if the eligible professional reports the eRx measure's numerator via claims for at least 10 unique eRx events (regardless of whether the event is one associated with the eRx measure's denominator) between January 1, 2013 and June 30, 2013.

## 60.2 –Group Practices

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

The criteria for the determination of a successful electronic prescriber for group practices with respect to receiving incentive payments and/or avoiding payment adjustments are described in §§ 60.2.1 and 60.2.2 of this manual. See below.

## 60.2.1 – Criteria for Determination of Successful Electronic Prescriber for the Purpose of Receiving Incentive Payments – Group Practices

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

For the 2010 incentive, a group practice selected to participate in the eRx GPRO is considered a "successful electronic prescriber" if the practice reports the eRx measure (as specified for 2010) for at least 2,500 unique denominator-eligible events during the 2010 reporting period.

For the 2011 incentive, a group practice selected to participate in the eRx GPRO is considered a "successful electronic prescriber" if the practice reports the eRx measure (as specified for 2011) for at least 75-2,500 unique denominator-eligible events, depending on the group practice's size, during the 2011 incentive reporting period. The following is a table showing the required number of instances a group practice must report the eRx measure in order to be deemed a successful electronic prescriber according to group size:

| Group size (Number of Eligible Professionals) | Required Number of Unique Visits Where an Electronic Prescription was Generated to be a Successful Electronic Prescriber |
|---|---|
| 2-10 | 75 |
| 11-25 | 225 |
| 26-50 | 475 |
| 51-100 | 925 |
| 101-199 | 1875 |
| 200+ | 2500 |

For the 2012 and 2013 incentives, a group practice selected to participate in the eRx GPRO is considered a "successful electronic prescriber" if the practice reports the eRx measure (as specified for the year) for the following number of instances, depending on the group practice's size, during the respective 2012 and 2013 incentive reporting periods:

- 625 unique denominator-eligible events for group practices comprised of 25-99 eligible professionals or

- 2,500 unique denominator-eligible events for group practices comprised of 100+ eligible professionals.

## 60.2.2 – Criteria for Determination of Successful Electronic Prescriber for the Payment Adjustments – Group Practices

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

For the 2012 payment adjustment, a group practice is considered a "successful electronic prescriber" if, depending on the group's size, the group practice reports the eRx measure via claims on 75-2,500 unique eRx events for patients in the denominator of the measure for services occurring between January 1, 2011 and June 30, 2011. The following table shows the required number of instances a group practice must report the eRx measure according to group size:

| Group size (Number of Eligible Professionals) | Required Number of Unique Visits Where an Electronic Prescription was Generated to be a Successful Electronic Prescriber |
|---|---|
| 2-10 | 75 |
| 11-25 | 225 |
| 26-50 | 475 |
| 51-100 | 925 |
| 101-199 | 1875 |
| 200+ | 2500 |

For the 2013 payment adjustment, a group practice is considered a "successful electronic prescriber" if the group meets the criteria for the 2011 incentive. A group practice may also be considered a "successful electronic prescriber" if, depending on the group's size, the group practice reports the eRx measure's numerator via claims on 625 (for group practices comprised of 25-99 eligible professionals) or 2,500 (for group practices comprised of 100+ eligible professionals) unique eRx events, regardless of whether the event is associated with the eRx measure's denominator, between January 1, 2012 and June 30, 2012.

For the 2014 payment adjustment, a group practice is considered a "successful electronic prescriber" if the group meets the criteria for the 2012 incentive. A group practice may also be considered a "successful electronic prescriber" if, depending on the group's size, the group practice reports the eRx measure's numerator via claims on 625 (for group practices comprised of 25-99 eligible professionals) or 2,500 (for group practices comprised of 100+ eligible professionals) unique eRx events, regardless of whether the event is indicated in the eRx measure's denominator, between January 1, 2013 and June 30, 2013.

## 70 – Significant Hardship Exemptions for the Purposes of the Payment Adjustments

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

## 70.1 – Significant Hardship Exemptions for the Purposes of the Payment Adjustments – Individual Eligible Professionals and Group Practices

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

For the 2012 payment adjustment, an eligible professional or group practice may request a significant hardship exemption via the Quality Reporting Communication Support Page if any of the following situations apply:

- The eligible professional practices in a rural area without sufficient high speed internet access (also reportable via reporting G-code G8642 on claims)

- The eligible professional practices in an area without sufficient available pharmacies for eRx (also reportable via reporting G-code G8643on claims)

- Eligible professionals who register to participate in the Medicare or Medicaid EHR Incentive Programs and adopt Certified EHR Technology

- Inability to electronically prescribe due to local, state, or federal law or regulation

- Limited prescribing activity

- Insufficient opportunities to report the eRx measure due to limitations of the measure's denominator

For the 2012 payment adjustment, the initial deadline for submitting a request for the first two significant hardship exemption categories via submission of the appropriate G-code on at least one claim was the end of the 2012-6-month payment adjustment reporting period (that is, June 30, 2011). For group practices that self-nominated to participate in the 2011 GPRO, group practices were required to request a significant hardship exemption for these first two significant hardship exemption categories at the time that they self-nominated to participate in either GPRO I or II for 2011. However, with the addition of the last four significant hardship exemption categories to the 2012 payment adjustment in September 2011, the deadline for individual eligible professionals to submit a request for a significant hardship exemption under all significant hardship exemption categories via the Quality Reporting Communication Support Page was extended to November 1, 2011. Similarly, group practices that participated in the eRx GPRO for 2011 were given until November 1, 2011 to submit a letter requesting a significant hardship exemption under all significant hardship exemption categories.

For the 2013 and 2014 payment adjustments, an eligible professional or group practice may request a significant hardship exemption via the Quality Reporting Communication Support Page if any of the following situations apply:

- The eligible professional or group practice practices in a rural area without sufficient high speed internet access (also reportable via reporting G-code G8642 on claims)

- The eligible professional or group practice practices in an area without sufficient available pharmacies for eRx (also reportable via reporting G-code G8643on claims)

- The eligible professional or group practice is unable to electronically prescribe due to local, state, or Federal law or regulation

- The eligible professional who prescribes fewer than 100 prescriptions during a 6-month, payment adjustment reporting period

The deadline for eligible professionals and group practices to report the first two hardships via the respective G-code on a claim is June 30, 2012 for the 2013 payment adjustment and June 30, 2013 for the 2014 payment adjustment. For eligible professionals, the deadline for submitting a request for a significant hardship exemption to the 2013 and 2014 payment adjustment via the Quality Reporting Communication Support Page is June 30, 2012 and June 30, 2013 respectively.

Group practices wishing to request a significant hardship exemption to the 2013 and 2014 payment adjustment must indicate its request for a significant hardship exemption due to one of the above significant hardship exemption categories in its self-nomination letter to participate in the eRx GPRO for the 2012 and/or 2013 respective program year. Therefore, the deadline for group practices to submit a significant hardship exemption letter via its self-nomination letter is the date in which the self-nomination letter is due for the respective program year.

## 80 – Confidential Feedback Reports

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

CMS provides confidential feedback reports to participating eligible professionals for a particular program year on or about the time that the lump sum incentive payments are made for the program year. For example, eligible professionals who participate in the 2009 eRx Incentive Program can expect to receive confidential feedback reports with respect to the 2009 program year after the 2009 incentive payments are made in 2010. Access to confidential feedback reports may require eligible professionals to complete an identity-verification process. Receipt of a report is not a requirement for participation in the eRx Incentive Program or to receive an incentive payment.

To receive a feedback report the eligible professional must have had at least one valid eRx measure submission. A valid submission is defined as receipt by CMS of the correct numerator, denominator, age and gender (where applicable) as listed in the eRx measure specifications. The eRx measure specifications are subject to change for each program year. The eRx measure specifications for the current or an upcoming program year, as well as those for prior program years are posted or archived on the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive.

## 90 – Direct Mailings

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

At the request of CMS, contractors shall print and distribute hardcopy mailings to all or a subset of their active providers related to the eRx Incentive Program. Mailings shall be sent to the best address to reach the provider, not the billing agency used by the provider. As such, contractors should consider using the correspondence address in PECOS if it is available.

## 100 – Public Posting of Program Performance

**(Rev. 10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)**

In addition, section 1848(m)(5)(G) of the Act requires CMS to post on the CMS website, in an easily understandable format, a list of the names of the eligible professionals (or group practices) who are successful electronic prescribers. Therefore, beginning with the 2009 eRx Incentive Program the names of eligible professionals group practices who are determined to be successful electronic prescribers for the eRx Incentive Program are required to be posted on http://www.medicare.gov. The names of eligible professionals and group practices who are successful electronic prescribers for a particular year will be publicly posted after the lump sum incentive payments for that program year are made in the following year. CMS will also indicate whether an eligible professional is a successful electronic prescriber on the Physician Compare website, available at http://www.medicare.gov/Default.aspx.

Note: The eRx measure specifications are subject to change for each program year. The eRx measure specifications for the current or an upcoming program year, as well as those for prior program years are posted or archived on the appropriate eRx Incentive Program page of the CMS eRx Incentive Program website at http://www.cms.gov/eRxincentive.

## Transmittals Issued for this Chapter

| Rev # | Issue Date | Subject | Impl Date | CR# |
|---|---|---|---|---|
| R31QRI | 08/29/2014 | Language-Only Changes for Updating ICD-10 and ASC X12 Language in Pub 100-22, Chapters 1 and 2 | 09/30/2014 | 8787 |
| R10QRI | 07/27/2012 | Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program | 10/29/2012 | 7879 |
| R1QRI | 06/11/2010 | Physician Quality Reporting Initiative (PQRI) and E-Prescribing (eRx) Medicare Quality Reporting Incentive Programs Manual | 09/13/2010 | 6935 |