2011 Electronic Prescribing Incentive Program

Hardship Codes

In 2012, the Physician Fee Schedule amount for covered professional services furnished by an eligible professional who is not a successful electronic prescriber will be reduced by 1 percent. CMS introduced new codes referred to as hardship codes, to be reported at least one time on a denominator-eligible claim during the *2012 payment adjustment reporting period* (**January 1 through June 30, *2011***), if applicable. These codes are to be used ONLY when an eligible professional wishes to request a significant hardship exemption from the application of the 2012 payment adjustment because the professional is unable to submit prescriptions electronically due to a system hardship (e.g., rural without internet, limited available pharmacies for electronic prescribing, or does not have prescribing privileges). Hardship codes are represented by the G-codes listed below.

If a hardship applies to you, below, are the two hardship G-codes from which eligible professionals may choose.

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

Payment Adjustment

Another reporting option: When the eligible professional does not have prescribing privileges, report **G8644** via claims. If this code is utilized, the eligible professional may not be considered for a payment adjustment.

2011 REPORTING OPTIONS FOR THE ELECTRONIC PRESCRIBING MEASURE: ONLY FOR INDIVIDUAL CLAIMS-BASED AND REGISTRY-BASED REPORTING
(THESE SPECIFICATIONS DO NOT APPLY TO THE FOLLOWING REPORTING OPTIONS: EHR-BASED SUBMISSION OR GROUP PRACTICE REPORTING OPTION [GPRO].)

IN ORDER TO REPORT THIS MEASURE, A QUALIFIED ELECTRONIC PRESCRIBING (eRx) SYSTEM MUST HAVE BEEN ADOPTED

DESCRIPTION:
Documents whether the eligible professional has adopted a qualified electronic prescribing (eRx) system and the extent of use in the ambulatory setting. A qualified eRx system is one that is capable of **ALL** of the following:

- Generate a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs) if available
- Select medications, print prescriptions, electronically transmit prescriptions, and conduct all alerts (defined below)
- Provide information related to lower cost, therapeutically appropriate alternatives (if any).
- Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available)

The system must employ, for the capabilities listed, the eRx standards adopted by the Secretary for Part D by virtue of the 2003 Medicare Modernization Act (MMA).

INSTRUCTIONS:
In order to report this measure, a qualified eRx system that meets the above requirements <u>must</u> have been adopted. The measure is to be reported for those patient visits that meet the denominator coding criteria for which an individual eligible professional has electronically prescribed at least one prescription for a patient with Medicare Part B. Denominator coding criteria for this measure includes various ambulatory care settings. There is no specific diagnosis required for this measure. The individual eligible professional who generates at least one eRx associated with a patient visit on 25 or more unique events during the reporting period (January 1 through December 31) will be considered successful electronic prescribers. Faxes do not qualify as successful electronic prescribing. Successful electronic prescribers who also have at least 10% of their Medicare Part B charges comprised of the codes in the denominator of the measure will be incentive eligible.

Measure Reporting via Claims:
Submit both a denominator CPT code and the numerator G-code on the claim. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
A denominator CPT code and an electronically generated and transmitted prescription (not faxed) are required to report the measure.

DENOMINATOR:

Any patient visit for which one (or more) of the following denominator codes applies and is included on the claim

Denominator Criteria (Eligible Cases):

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

NUMERATOR:

A qualified eRx system (as specified above) has been adopted and an eRx event has occurred during the patient visit

Numerator eRx Quality-Data Code for Successful Reporting:

Prescription(s) Generated and Transmitted via Qualified eRx System
G8553: At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system

RATIONALE:

Because of eRx's proven potential to reduce medication errors and the cost of medical care, in the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, Congress mandated that all plans and pharmacies participating in the new Medicare prescription drug benefit (Part D) support an electronic prescription program. To address the multiple formats and vocabularies that present barriers to implementation, the MMA directed the Secretary of Health and Human Services (HHS) to establish federal standards that all eRx prescribers must follow for Part D patients. HHS made grants to five pilot sites to test the standards. These pilots were set up to test initial standards and their interoperability with foundation standards as well as clinical and economic outcomes associated with eRx. The Agency for Healthcare Research and Quality (AHRQ) National Resource Center for Health IT (NRC) was then charged with compiling the current report which summarizes and synthesizes findings across these pilot sites with the goal of advising the federal government on standards adoption and disseminating key data on eRx outcomes among the policy community. Positive findings from the pilots included:

- Prescriber uptake and satisfaction. Adoption and retention of eRx among providers was generally good.
- Patient Satisfaction. According to surveys from one pilot site, most patients are satisfied with eRx.
- Changes in prescription renewal and new prescription rates. The long term care site reported a reduction in new prescription rates, indicating the possibility that eRx may reduce the tendency for such patients to accumulate unnecessary active medications.
- Improved security and reliability of prescriptions. Only one of the sites investigated this issue; however, the security architecture they developed shows that the industry is taking important steps towards implementing systems that are secure and reliable.

DEFINITIONS:

Electronic Prescribing (eRx) – The transmission, using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or health plan either directly or through an intermediary, including an eRx network. Electronic prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser. **(Faxes initiated from the eligible professional's office do not qualify as electronic prescribing).**

Electronic Prescribing Event – For the purposes of this measure, an electronic prescribing event includes all prescriptions electronically prescribed during a patient visit.

Successful Individual Electronic Prescriber - Incentive Eligible – A successful individual eRx prescriber, eligible to receive an incentive payment, must generate and report one or more eRxs associated with a patient visit, a minimum of 25 unique visits per year. Each visit must be accompanied by the eRx G-code attesting that during the patient visit at least one prescription was electronically prescribed. Electronically generated prescriptions not associated with a denominator eligible patient visit do not count towards the minimum of 25 different eRx events. Additionally, 10% of an eligible professional's Medicare Part B charges must be comprised of the codes in the denominator of the measure to be incentive eligible.

Alerts – Written or acoustic signals to warn prescriber of possible undesirable or unsafe situations, including potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions.

Durable Medical Equipment (DME) Supplies – Prescriptions for diabetic supplies may be electronically prescribed. Some pharmacies may require additional documentation secondary to internal policies which may be mandatory in case of audits; others may require a signed copy of the order with signature to be kept for verification purposes.

EVIDENCE SUPPORTING THE CRITERION OF THE QUALITY MEASURE:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: reduction of adverse drug events, reduction of unnecessary utilization, and improved patient safety, but not consistently high quality evidence.

Alerts and prompts represent promising types of decision support in electronic prescribing to tackle inadequacies in prescribing. A systematic review was conducted to evaluate the efficacy of computerized drug alerts and prompts searching EMBASE, CINHAL, MEDLINE, and PsychINFO up to May 2007. Studies assessing the impact of electronic alerts and prompts on clinicians' prescribing behavior were selected and categorized by decision support type. Most alerts and prompts (23 out of 27) demonstrated benefit in improving prescribing behavior and/or reducing error rates. The impact appeared to vary based on the type of decision support. Some of these alerts (n=5) reported a positive impact on clinical and health service management outcomes.

Bates, DW & Gawande, A.A. (2003) Improving Safety with Information Technology. *N Engl J Med* 2003; 348:2526-34
Health care is growing increasingly complex, and most clinical research focuses on new approaches to diagnosis and treatment. In contrast, relatively little effort has been targeted at the perfection of operational systems, which are partly responsible for the well-documented problems with medical safety. Safe care now requires a degree of individualization that is becoming unimaginable without computerized decision support. For example, computer systems can instantaneously identify interactions among a patient's medications. Multiple studies now demonstrate that computer-based decision support can improve physicians' performance and, in some instances, patient outcomes. In the past decade, the risk of harm caused by medical care has received increasing scrutiny. The growing sophistication of computers and software should allow information technology to play a vital part in reducing that risk — by streamlining care, catching and correcting errors, assisting with decisions, and providing feedback on performance. Given the large potential risks and benefits as well as the costs involved, in this article Bates et al (2003) analyzed what is known about the role and effect of information technology with respect to safety and

consider the implications for medical care, research, and policy. Information technology can reduce the rate of errors in three ways: by preventing errors and adverse events, by facilitating a more rapid response after an adverse event has occurred, and by tracking and providing feedback about adverse events. Data shows that information technology can reduce the frequency of errors of different types and probably the frequency of associated adverse events. The main classes of strategies for preventing errors and adverse events include tools that can improve communication, make knowledge more readily accessible, require key pieces of information (such as the dose of a drug), assist with calculations, perform checks in real time, assist with monitoring, and provide decision support. (Bates et al 2003)

Corley, S. T. (2003). "Electronic prescribing: a review of costs and benefits." Topics in Health Information Management 24(1): 29-38. Corley estimated cost savings from reduction of adverse drug events following implementation of electronic prescribing.

Hillestad, R., et al. (2005). "Can electronic medical record systems transform health care? Potential health benefits, savings and costs." Health Affairs 24(5): 1103-1117. This article concludes that two-thirds of the approximately 8 million adverse drug events that occur in the outpatient setting would be avoided through the widespread use of computerized order entry (CPOE). Study quality level 2 (limited-quality patient-oriented evidence)

Kohn, L., et al. (1999). To err is human: Building a safer health system. Washington, D.C., National Academy Press. This report concluded, from a case analysis, that there is supporting evidence to show that adverse drug events (ADE) resulted in an increase in physician office and emergency department visits, and of those physician office visits, more than 50% were "judged to be unnecessary and potentially avoidable." Additionally, the report stated, "Physicians do not routinely screen for potential drug interactions, even when medication history information is readily available." Study quality level 2 (limited-quality patient-oriented evidence)

Middleton, B. (2005). The value of health information technology in clinical practice. Pennsylvania eHealth Initiative, Harrisburg. Dr. Middleton discusses the value of ambulatory computerized order entry (ACPOE). A model was developed based on data derived from HIT implementation in the Partners Healthcare System. When applied nationally, this model predicts a potential savings of $44 billion and the prevention of 2 million adverse drug events per year. Study quality level 2 (limited-quality patient-oriented evidence)

Shekelle, P., Morton, S., Keeler, E. (2006). Costs and benefits of health information technology. Evidence Report/Technology Assessment, AHRQ. 132. Electronic prescribing is widely believed to improve accuracy of the prescription process and thereby reduce potential for medical errors and increase health care quality. Shekelle et al. observe that EMRs with electronic prescribing improve patient safety by reducing adverse drug events in the inpatient setting. Study quality level 2 (limited-quality patient-oriented evidence)

Bell, D. S., Friedman, M. A. (2005). "E-Prescribing and the Medicare Modernization Act of 2003." Health Affairs 24(5): 1159-1169. This article discusses the potential impact that e-Prescribing could have on improving patient safety by decreasing adverse drug events (ADE) as well as the cost benefits.

Schade, C. P., et al. (2006). "e-Prescribing, efficiency, quality: Lessons from the computerization of UK family practice." Journal of American Medical Informatics Association 13(5): 470-475. General practitioners in the UK generally report improved practice efficiency using computerized prescription systems.

Teich, J., et al. (2004). Electronic prescribing: Toward maximum value and rapid adoption. eHealth Initiative, Washington, D.C. In 2004, the Electronic Health Initiative published a study of e-Prescribing concluding that it could improve safety, quality, efficiency, and cost of medical care.