2013 ELECTRONIC PRESCRIBING (eRx) INCENTIVE PROGRAM
OVERVIEW FOR OPHTHALMIC PRACTICES

HOW TO GET THE 2013 PAYMENT INCENTIVE (BONUS)

How to Get an eRx Incentive Payment in 2013?

To earn an incentive payment of 0.5%: successfully report at least 25 unique denominator eligible eRx events for services provided January 1, 2013 through June 30, 2013 for encounters associated with at least 1 of the denominator codes (listed in the ‘How to Report Section’) using a qualified electronic prescribing system.

- 2013 → Incentive is 0.5% of the EPs total estimated Medicare Part B allowed charges
- 2013 → Reporting minimum is 25 unique encounters
- 2013 → Reporting Period is January 1, 2013 through December 31, 2013
- There are three reporting mechanisms: claims, registries, or EHRs. (See ‘Reporting Mechanisms’ Section)
- You will receive the bonus payment in 2014 after the conclusion of the CY2013 in which you e-prescribed for your Medicare patients, not as an immediate payment, equal to .5 percent of your total Medicare payments for 2013.

To receive an incentive payment in 2013, a group practice (GPRO) must report the e-Rx measure’s numerator as follows:

- for at least 625 unique visits for group practices comprised of 25-99 EPs
- for at least 2,500 unique visits for group practices comprised of 100 or more EPs

HOW TO AVOID THE 2014 PAYMENT REDUCTION

How to Avoid the -2% Payment Reduction in 2014?

To avoid the -2% payment reduction on total estimated Medicare Part B allowed charges in 2014, an EP must report the G8553 code at least 10 times for any Medicare Part B physician fee schedule service using a qualified electronic prescribing system.

- 2014 → Reduction is -2% of the EPs total estimated Medicare Part B allowed charges.
- 2014 → Reporting minimum is 10 encounters for any Medicare Part B physician fee schedule service.
- 2014 → Reporting Period is January 1, 2013 and June 30, 2013
- There is one reporting mechanism: claims (See ‘Reporting Mechanisms’ Section).
REPORTING TO RECEIVE THE E-RX INCENTIVE (BONUS) AND AVOID THE REDUCTION

Numerator
As in prior years, when reporting the measure for the incentive, the numerator G-code for the e-Rx measure will be G-8553 (at least one prescription created during the encounter was generated and transmitted electronically using a qualified e-Rx system).

Denominator
The e-Rx prescribing measure is reportable by an EP any time an EP bills for one of the procedure codes for Part B services included in the measure’s denominator. The measure denominator consists of specific billing codes for covered professional services. Those codes are as follows:

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

REPORTING TO ONLY AVOID THE E-RX REDUCTION (WILL NOT RECEIVE A BONUS)

Numerator
When reporting to avoid the reduction to total estimated Medicare Part B allowed charges, the numerator G-code for the e-Rx measure will be G-8553 (at least one prescription created during the encounter was generated and transmitted electronically using a qualified e-Rx system).

Denominator
For EPs and group practices that are reporting only the minimum of 10 encounters to avoid the 2013 and 2014 payment adjustments (but not to receive the bonus), they are permitted to report the measure’s numerator for any Medicare Part B physician fee schedule service provided during the reporting period regardless of whether the code for such service appears in the denominator. CMS recognizes that EPs may generate prescriptions during encounters that are not necessarily included in the measure’s denominator.

PAYMENT REDUCTION EXEMPTIONS

The payment reductions will not apply if:

- The EP is a successful electronic prescriber.
- The EP is not a physician, nurse practitioner or physician assistant as of June 30, 2012 for the 2013 payment adjustment, and as of June 30, 2013 for the 2014 payment adjustment.
- Less than 10 percent of an individual EP’s Medicare Part B allowed charges for the reporting period are comprised of codes in the denominator for the e-Rx measure.
- The EP does not have at least 100 cases (100 claims for patient services) containing an encounter code that falls within the denominator of the e-Rx measure for dates of services during the six-month 2013 payment adjustment period (January 1, 2012-June 30, 2012) and the six-month 2014 payment adjustment period (January 1, 2013-June 30, 2013).


To request a significant hardship exemption, the EP or group practice must provide all necessary information to CMS by June 30, 2013 for the 2014 payment adjustment. EPs may submit requests for a significant hardship exemption through CMS’ Communication Support Page.
Report the following G-codes for the following significant hardship exemption categories on claims for services rendered during the respective 2013 and 2014 six-month reporting periods:

- The EP or group practice practices in a rural area with limited high speed internet access (report G-code G8642).
- The EP or group practice practices in an area with limited available pharmacies for e-Rx (report G-code G8643).
- Inability to electronically prescribe due to local, state, or federal law or regulation.
- EPs who prescribe fewer than 100 prescriptions during a 6-month payment adjustment reporting period.
- **New** - Successfully achieving Meaningful Use in the CMS Electronic Health Record (EHR) Meaningful Use Incentive Program
- **New** - Demonstrating intent to participate in the EHR Incentive Program for the first time by registering for the program and adopting certified EHR technology.

### REPORTING MECHANISMS

Individual EPs and group practices can report on the eRx measure using one of three reporting mechanisms: claims, registries, or EHRs. An EP or group practice must make sure that the required number of e-Rx events for the incentive payment is reported to CMS via a single reporting mechanism. CMS will not combine data from multiple reporting sources.

**Claims-Based Reporting**

The EP or group practice must directly submit data on the e-Rx measure on the CMS Claim Form. All claims for services must be processed by CMS no later than two months after the respective reporting period for the claim to be included in CMS’ data analysis.

**Registry-Based Reporting**

Only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for PQRS will be qualified to submit the e-Rx measure for the e-Rx Incentive Program.

**EHR-Based Reporting**

Direct EHR technology, as well as EHR submission vendors qualified to submit extracted Medicare clinical quality data to CMS for PQRS, can be used by an EP or group practice to submit data on the e-Rx measure. A list of approved EHR technology and vendors for the e-Rx Program will be posted on CMS’ Web site at http://www.cms.gov/ERXIncentive.

### ERX SYSTEM REQUIREMENTS

CMS expanded the definition of a qualified eRx system to include certified EHR technology for all future years of the eRx program.

**Required Functionalities**

Required functionalities for a qualified electronic prescribing system are:

- **A.** Generate a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs), if available.
- **B.** Allow EPs to select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts (written or acoustic signals to warn the prescriber of possible undesirable or unsafe situations including potentially inappropriate dose or route of administration of a drug, drug-drug interaction, allergy concerns, or warnings and cautions). This functionality must be enabled.
- **C.** Provide information related to lower cost, therapeutically appropriate alternatives (if any). The ability of an e-Rx system to receive tiered formulary information, if available, would again suffice for this requirement for CYs 2012 and 2013 until this function is more widely available in the marketplace.
D. Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient’s drug plan (if available).

**PARTICIPATING IN ERX, PQRS, and EHR**

- Providers can participate in and receive bonus payments simultaneously for Medicare eRx and PQRS.
- Providers can participate in and receive bonus payments simultaneously for PQRS and Medicare EHR incentive programs.
- Providers CANNOT obtain incentives from both the Medicare eRx and the Medicare EHR incentive programs simultaneously.

**FEEDBACK REPORTS**

TBD