2010 Electronic Prescribing Incentive Program – Adoption/Use of Medication Electronic Prescribing Measure

2010 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). (The availability of an eRx system to receive tiered formulary information, if available, would meet this requirement for 2010)
- 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 must 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 diagnosis associated with the patient encounter that requires the eRx may be used to report the eRx G-code. 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 will be eligible for incentive payment.

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 SAME CLAIM (Faxes do not qualify as electronic prescribing).

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

REPORTING NUMERATOR:
A qualified eRx system (as specified above) has been adopted and the following G-code applies to 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

REPORTING 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

RATIONALE:
Automation of the ambulatory prescribing process has many potential benefits including:
- Patient safety through computerized transmission of legible prescriptions directly to the pharmacy and checks for harmful interactions
- Patient satisfaction in a process that results in fewer errors and less waiting time
- Avoidance of unnecessary phone calls for clarification between eligible professionals and Pharmacies
- Easier data collection of physician prescribing patterns and improved formulary compliance for Health plans, pharmacy benefit managers and employers

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 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

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

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. Study quality level 2 (limited-quality patient-oriented evidence)

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

Roland, M. O., et al. (1985). "Evaluation of computer assisted repeat prescribing program in a general practice." British Medical Journal (Clin Res Ed) 291(6493): 456-458. Roland et al. showed that EMRs with electronic prescribing saved provider time and reduced costs.

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.