PQRS and e-Rx Incentives and Penalties for 2013 and 2014

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PQRS Incentives for 2013 and 2014

Physician Quality Reporting System (PQRS) continues to be a voluntary individual reporting program that provides an incentive payment to identified eligible professionals (EPs) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Medicare Advantage (Part C) beneficiaries are not included in claims-based reporting of individual measures or measures groups; however, we recommend physicians report measures for these patients as well.

2014 is the last year an incentive can be earned for PQRS. The Affordable Care Act authorized incentive payments through 2014;

- 2012 PQRS – 0.5%
- 2013 PQRS – 0.5%
- 2014 PQRS – 0.5%

Eligible Professionals

Under Physician Quality Reporting System, covered professional services are those paid under or based on the Medicare Physician Fee Schedule (PFS). To the extent that eligible professionals are providing services which get paid under or based on the PFS, those services are eligible for Physician Quality Reporting System.

Eligible and Able to Participate

The following professionals are eligible to participate in Physician Quality Reporting System:

1. Medicare physicians
   - Doctor of Medicine
   - Doctor of Osteopathy
   - Doctor of Podiatric Medicine
   - Doctor of Optometry
   - Doctor of Oral Surgery
   - Doctor of Dental Medicine
   - Doctor of Chiropractic

2. Practitioners
   - Physician Assistant
   - Nurse Practitioner
   - Clinical Nurse Specialist
   - Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant)
   - Certified Nurse Midwife
   - Clinical Social Worker
   - Clinical Psychologist
   - Registered Dietician
   - Nutrition Professional
   - Audiologists

3. Therapists
   - Physical Therapist
   - Occupational Therapist
   - Qualified Speech-Language Therapist

PQRS Payment Adjustment (Penalty)
Beginning in 2015, EPs who do not satisfactorily report under the PQRS will be subject to a payment adjustment equal to 1.5 percent of their Medicare PFS allowed charges. The payment adjustment increases to 2.0 percent in 2016 and beyond.

To avoid the 2015 payment penalty, an eligible professional must successfully report PQRS measures during the 2013 reporting period (January 1-December 31, 2013). Additional information on how to avoid future PQRS payment adjustments can be found through supporting documentation available on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS*

2013 PQRS submission of quality data may be performed via claims or registry, each of which includes multiple reporting options for each method of submission. 2013 PQRS submission of quality data may also be performed via a qualified electronic health record (EHR) or via the group practice reporting option (GPRO). Appendix C, starting on page 19 of the *2013 PQRS Implementation Guide* (2013 PQRS Participation for Incentive Payment Decision Tree), is a tool designed by CMS to help eligible professionals/practices review the multiple reporting options available. Select the reporting option best suited for the individual EP/Group.

In lieu of reporting at least three (3) individual measures, eligible professionals may choose to report a measures group if all of the measures within the group are applicable to services provided to Medicare patients. Instructions for reporting measures groups are included in a separate document, 2013 Physician Quality Reporting System (PQRS) Measures Groups Specifications Manual, which can be found at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html*.

The practice should ensure that all cases for the measures selected by the practice are identified and reported by the practice. Practices may consider implementing an edit on the billing software that will flag each claim every time a combination of codes listed in a measure's denominator is billed to remind the coder to ensure the appropriate measures are reported on the claim. Additional PQRS educational resources are available as downloads at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS*.

Another Option for Avoiding the 2015 Payment Penalty
For EPs that have never reported PQRS measures or if the EP has previously reported the measures, but did not achieve the required reporting percentage (50% for claims; 80% for registry reporting), the EP must select one measure and report it at least one time when the measure is applicable to the encounter.

> For example, an EP could select the diabetic patient having a dilated eye exam. The EP can report the code to indicate whether or not the patient has had a dilated eye exam within the last 12 months, on at least one claim during January 1, 2013 and June 30, 2013. By reporting this one measure, one time, during the first six months in 2013, the EP will not be subject to the 2015 payment penalty.

Although one time should be sufficient, we recommend you report the chosen measure when applicable at least five times during this time period to ensure at least one claim is received for processing. Since some clearinghouses do not submit line items that do not have charges, please remember to charge 1¢ for the measure codes so the fee is submitted on the claim.

At this time, CMS states the acceptance of one measure for one patient to prevent PQRS payment penalty is only effective for the 2013/2015 PQRS period. It is our understanding the CMS expects Meaningful Use Stage 2 will be in effect and during 2014 PQRS measures will be reported through the EP's electronic health record (EHR). If this expectation is met, we anticipate EPs who are not on an EHR in 2014 will be required to successfully report 3 individual measures or 1 measures group to prevent the 2016 payment penalty.

If you do not anticipate implementation of an EHR prior to 2014, we recommend you use the remainder of 2013 to develop the process to capture PQRS data to report on claims during 2014 to prevent the 2016 payment penalty. Another option is to plan on using a registry to report 2014 quality measures or measures group. As noted above the differences between claims-based and registry-based PQRS is in the percentage of applicable encounters that need to be reported and the fact that claims-based reporting has no additional external cost. When using a registry, the EP will pay for the use of the registry. The benefit of using a registry is that you can report the data at any time during the reporting period and do not have to worry about making sure the measure codes are included on each applicable claim.

e-Rx Incentives and Penalties for 2013 and 2014

While 2013 is the last year for earning an e-Rx incentive payment, the penalties associated with not meeting the e-Rx requirements will continue well past 2014. Under the Medicare Improvements for Patients and Providers Act (MIPPA) the two (2) percent payment penalty is effective for 2014 and beyond. There is no expiration date for e-Rx penalties.

Not all providers who are eligible to participate in the e-Rx Incentive Program for the incentive payment will be subject to e-Rx payment adjustments. The following professionals (in normal text) are eligible to participate in the e-Rx Incentive Program for the incentive payment and are subject to payment adjustments (in bold text) if not successful at reporting the e-Rx Incentive Program measure:

1. Medicare physicians
   - Doctor of Medicine (MD) – **subject to payment adjustment**
   - Doctor of Osteopathy (DO) – **subject to payment adjustment**
   - Doctor of Podiatric Medicine (DPM) – **subject to payment adjustment**
   - Doctor of Optometry
   - Doctor of Oral Surgery
   - Doctor of Dental Medicine
   - Doctor of Chiropractic

2. Practitioners
   - Physician Assistant (PA) – **subject to payment adjustment**
   - Nurse Practitioner* (NP) – **subject to payment adjustment**
   - Clinical Nurse Specialist*
   - Certified Registered Nurse Anesthetist* (and Anesthesiologist Assistant)
   - Certified Nurse Midwife*
   - Clinical Social Worker
   - Clinical Psychologist
   - Registered Dietician
   - Nutrition Professional
   - Audiologists

   *Includes Advanced Practice Registered Nurse (APRN)

3. Therapists
   - Physical Therapist
   - Occupational Therapist
   - Qualified Speech-Language Therapist

Reporting Mechanisms

For 2013, there are three different reporting mechanisms

- Claims-Based
- Registry
- Electronic Health Records

2013 e-Rx Payment Incentives
EPs can earn a 0.5% incentive for successfully reporting 25 e-Rx events during 2013. For individual EPs, an e-Rx event is submitting G8553 on the same clam as the visit code to indicate that during the visit, the physician submitted at least one electronic prescription during the specific encounter. See additional information below for using the Group Practice Reporting Option (GPRO).

Incentives are paid in the third quarter of the year following the eligible professional's successful reporting. This means incentives earned during 2012 will be paid during the third quarter of 2013.

E-Rx Claims-Based Reporting
The basics of the e-Rx Incentive Program have not changed.

For successful reporting under the 2013 e-Rx Incentive Program, a single quality-data code (G8553) should be reported, according to the following coding and reporting principles: Report the following e-Rx numerator G-code, when applicable:

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

- The e-Rx G-code, which supplies the numerator, must be reported:
  - for the same beneficiary
  - for the same date of service (DOS)
  - by the same eligible professional (individual NPI) who performed the covered service as the payment codes, usually *CPT* Category I or *HCPCS* codes, which supply the denominator
  - on the claim(s) with the denominator billing code(s) that represent the eligible encounter for the 2013 e-Rx Incentive Program incentive payment

  OR
  - on the claim(s) with any billing code(s) that represents the encounter to avoid the 2014 e-Rx payment adjustment

NOTE: For purposes of reporting the e-Rx G-code to avoid the 2014 e-Rx payment adjustment, the e-Rx G-code can be reported on any billable service during the reporting period, regardless of whether the code for such service appears in the e-Rx Incentive Program measure's denominator.

2013 Payment Adjustment
Any EP or group practice that did not successfully submit the required number of e-Rx events in 2011, did not report the required number of e-Rx events between January 1 and June 30, 2012, or did not apply for and receive an exemption from 2013 payment adjustments are currently receiving a 1.5 percent penalty. The penalty is applicable to the payment for all services included on the Medicare Physician Fee Schedule (PFS).

Avoiding the 2014 e-Rx Payment Adjustments
Individual EPs who are subject to the payment adjustment can avoid the 2014 penalty by meeting one of the following criteria:

- Successfully reported at least 25 e-Rx events between January 1 and December 31, 2012;
- Reported G8553 at least 25 times on any claim for a covered service between January 1 and December 31, 2012;
- Report a minimum of 10 e-Rx events between January 1 and June 30, 2013);
- Report G8553 at least 10 times on any claim for a covered service between January 1 and June 30, 2013 ; or
- Request a 2013 e-Rx significant hardship exemption, or submit a lack of prescribing privileges G-code.

An EP subject to the payment adjustment can avoid the 2015 penalty by submitting *HCPCS* code G8553 on the same claim as a visit code or any other *CPT* code representing a Medicare covered service at least 25 times between January 1 and December 31, 2013

2014 Payment Adjustments
The 2014 electronic prescribing payment adjustment is a two (2) percent penalty that will be applied to all services paid on the Medicare Physician Fee Schedule. The 2014 payment adjustment is not applicable if the eligible professional meets one of the following exceptions:

- Has less than 10 percent of their allowed charges for the January 1, 2013 through June 30, 2013 reporting period comprised of codes in the denominator of the 2013 e-Rx measure.
- Has less than 100 cases containing an encounter code in the measure's denominator for the same January 1, 2013, through June 30, 2013, reporting period.

  Denominator
  - Psychiatric Codes 90791, 90792, 90832, 90834, 90837, 90839
  - Eye Codes 92002 through 92014
  - Health and Behavior Assessment/Intervention Codes 96150 through 96152
  - Office and Other Outpatient Codes 99201 through 99215
  - Nursing Facility Codes 99304 through 99316
  - Domiciliary or Rest Home Visit Codes 99324 through 99337
  - Home Visit Codes 99341 through 99350
  - Cervical or Vaginal Cancer Screening; Pelvic and Clinical Breast Examination Code G0101
  - Diabetes outpatient self-management training services G0108 and G0109

- Is not a physician (MD, DO, or podiatrist), Nurse Practitioner, or Physician Assistant as of June 30, 2013, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES)
- Claims a hardship exemption as described below

2014 eRx Hardship Codes and Hardship Exemption Requests
CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2014 eRx payment adjustment if it is determined that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship.

Hardship Exemptions

- Inability to electronically prescribe due to state, or federal law, or local law or regulation
- The eligible professional prescribes fewer than 100 prescriptions during a 6-month payment adjustment reporting period
- The eligible professional practices in a rural area without sufficient high-speed Internet access (reportable via claims as G8642)
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (reportable via claims as G8643)
- Eligible professionals and members within a group practice participating in eRx GPRO who achieve Meaningful Use under the Medicare or Medicaid EHR Incentive Program during the 12-month eRx reporting period (1/1/2012-12/31/2012) or the 6-month eRx reporting period (1/1/2013-6/30/2013)

  Determined by CMS through review of the EHR Incentive Program Attestation and Registration system and will be automatically processed by CMS

- Eligible professionals and members within a group practice participating in eRx GPRO who demonstrate intent to participate in the Medicare or Medicaid EHR Incentive Program by 6/30/13

Determined by CMS through review of the EHR Incentive Program Attestation and Registration system and will be automatically processed by CMS

In addition, eligible professionals who do not have prescribing privileges during the first six months of the 2014 eRx payment adjustment reporting period, 1/1/13-6/30/13, can report G8644 on a payable Medicare Part B service at least once on a claim between 1/1/13-6/30/13 to avoid the 2014 eRx payment adjustment.

Submitting a Hardship Request

CMS established the Communication Support Page at *http://www.qualitynet.org/pqrs* (see link in upper-left hand corner) for eligible professionals and 2013 eRx GPRO primary contacts to submit hardship requests, including those associated with a G-code.

- For more information on how to navigate the Communication Support Page, please reference the following documents:
  - Quality Reporting Communication Support Page User Guide posted on the QualityNet website at *https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234*
  - Tips for Using the Quality Reporting Communication Support Page on the CMS website at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/20_Payment_Adjustment_Information.html*
- Those hardships with G-codes may also be submitted by individual eligible professionals at least once on a claim during the 6-month 2014 eRx payment adjustment reporting period, if applicable (1/1/13-6/30/13).
  - The hardship G-code must be submitted on a claim with a payable Medicare Part B service.
  - The hardship G-code does not need to be submitted on a claim that contains eRx measure denominator codes.
- Those eligible professionals and members within a group practice participating in eRx GPRO who achieve Meaningful Use under the Medicare or Medicaid EHR Incentive Program during the applicable reporting periods, or demonstrate intent to participate in the Medicare or Medicaid EHR Incentive Program by 6/30/13, will be determined by CMS through review of the EHR Incentive Program Attestation and Registration system and will be automatically processed by CMS.
- Group practices participating in 2013 eRx GPRO must indicate hardship exemptions during self-nomination/registration or submit an exemption request via the Communication Support Page.

Automatic Exemptions

The following 2014 eRx payment adjustment exemptions will be determined by CMS through review of the EHR Incentive Program Attestation and Registration system, and will be automatically processed by CMS:

- Those eligible professionals and every member within a group practice participating in eRx GPRO who achieve Meaningful Use under the Medicare or Medicaid EHR Incentive Program during the 12-month eRx reporting period (1/1/12-12/31/12) or the 6-month eRx reporting period (1/1/13-6/30/13).
- Those eligible professionals and every member within a group practice participating in eRx GPRO who demonstrate intent to participate in the Medicare or Medicaid EHR Incentive Program by registering (providing EHR certification ID) by 6/30/13 and adopting certified EHR technology.

Note: If CMS subsequently determines a payment adjustment was applied in error, the claim will be re-processed to return the 2.0% adjustment, and the Remittance Advice for the re-processed claim will indicate that the payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program. Please allow a couple months for claims to be re-processed and adjustments to be corrected.