

2011 EHR Measure Specification for the Electronic Prescribing Incentive Program

The specification listed in this document reflects clinical practice guidelines and applicable health informatics standards that are the most current available as of July 1, 2010. This specification may be available for potential use in physician quality initiatives, including but not limited to the Electronic Health Record (EHR) submission under the 2011 Electronic Prescribing Incentive Program (eRx). This document does not guarantee that this measure will be used in any specific CMS program in 2011 or any subsequent year.

To determine which measures are included in any specific CMS program or demonstration, interested parties should refer to the official documentation for that program or demonstration. Please refer to the Medicare Physician Fee Schedule 2011 Proposed Rule (published in the Federal Register in June, 2010) to identify measures that may be available for data submission through EHRs under the 2011 Electronic Prescribing Incentive Program.

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ANALYTIC NARRATIVE

✦ **Measure Title:** Adoption/Use of Medication Electronic Prescribing Measure

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

Description: Document 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).

Denominator: Any patient visit for which one (or more) of the following denominator codes applies

Denominator Inclusions:

Any patient visit. To be eligible for performance calculations, patients must have at least one face-to-face office visit with the clinician during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) and HCPCS (HCPCS) codes for inclusion:

ENCOUNTER CODE (C4)
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, 99241 ➤, 99242 ➤, 99243 ➤, 99244 ➤, 99245 ➤, 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

OR

ENCOUNTER CODE (HCPCS)
G0101, G0108, G0109

Numerator: A qualified eRx system (as specified above) has been adopted and at least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system during this patient visit

Numerator Inclusions:

Patient visit with documentation substantiating a qualified eRx system has been adopted and at least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system during this patient visit during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable HCPCS (HCPCS) codes for inclusion:

ERX CODE (HCPCS)
G8553

➤ Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services may not be counted in the denominator population for PQRI reporting calculations.

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 any prescriptions electronically prescribed during a patient visit.

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.

Rationale:

Automation of the ambulatory prescribing process has many potential benefits including:

- Improve patient safety through computerized transmission of legible prescriptions directly to the pharmacy and checks for harmful interactions.
- Increase patient satisfaction in a process that results in fewer errors and less waiting time
- Improve communication between eligible professionals and Pharmacies.
- Facilitate data collection of physician prescribing patterns and improved formulary compliance for Health plans, pharmacy benefit managers and employers.

When effectively integrated into the practice workflow, electronic prescribing (e-Rx) has the potential to improve medication safety in the ambulatory care setting. Although e-Rx has not been shown to reduce the number of adverse drug events (ADE), studies have demonstrated that information technology may prevent medical errors by improving communication, making drug information more available, requiring 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)

David W. Bates, M.D., and Atul Gawande, M.D., M.P.H. Improving Safety with Information Technology. *N Engl J Med* 2003; 348:2526-34.

Evidence Supporting the Criterion of 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)

– *List of Data Elements located in Appendix A*

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1. The following notice applies to each of the measures that contain a spade (♠) before the title:

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APPENDIX A
EHR MEASURE WITH CORRESPONDING DATA ELEMENTS

2011 Measure	Data Element Short Name	Data Element Description
Measure Title: Adoption/Use of Medication Electronic Prescribing Measure		
	TOPIC TYPE	Topic that is being reported
	TOPIC INDICATOR	The specific indicator or measure
	MEASURE START DATE	Date the measurement period begins
	MEASURE END DATE	Date the measurement period ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT, HCPCS)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	ERX CODING SYSTEM	Type of coding system used to document use of e-prescribing system (HCPCS)
	ERX CODE	Code used for e-prescribing system
	ERX DATE	Date e-prescribing system was identified