Incentives Await Early E-Prescribing Adopters

BY SHERRY BOSCHERT

LONG BEACH, CALIF. — The inability to prescribe controlled substances electronically is slowing adoption of electronic prescribing, but financial incentives could make it worthwhile for physicians who see patients covered by Medicare to start "e-prescribing" now if they can, a consultant said.

The Centers for Medicare and Medicaid Services in 2009 began offering Medicare physicians, nurse practitioners, and physician assistants a 2% bonus in payments for participation in its electronic prescribing incentives program for 2009-2010. The bonus for early adopters of e-prescribing drops to 1% in 2011-2012 and 0.5% in 2013, Rachelle F. Spiro said at the annual meeting of the American Medical Directors Association.

Physicians who do not e-prescribe by 2012 will see a 1% reduction in payments for that year, a 1.5% drop for 2013, and a 2% reduction for 2014 and each year afterward.

The early e-prescriber incentives were extended to long-term care settings this year. The incentives are not yet available for non-Medicare e-prescribers.

"Here's the hard part," she added: Physicians who do not successfully adopt e-prescribing by 2012 will see a 1% reduction in Medicare payments for that year, a 1.5% drop for 2013, and a 2% reduction for 2014 and each subsequent year. The Department of Health and Human Services may exempt physicians with hardships, on a case-by-case basis only.

The Drug Enforcement Agency (DEA) does not allow controlled substances to be electronically prescribed, however, which "has hindered the adoption of electronic prescribing," said Ms. Spiro, a pharmacist and consultant based in Las Vegas. "We've been told that CMS will be working with the DEA to put out final rules for electronic prescribing" of controlled substances, she said. Only a few days after she spoke, the agency published a proposed rule to that effect.

A pilot program for e-prescribing of controlled substances was conducted in Massachusetts, but not in long-term care settings.

Physicians do not need to preregister for the CMS e-prescribing incentive program and do not need to participate in the Physician Quality Reporting Initiative to participate, Ms. Spiro said.

Instructions and examples of how to submit claims under the e-prescribing incentive program are available on the CMS Web site at www.cms.hhs.gov/ERxIncentive. Assistance also is available through the CMS QualityNet help desk at qnetsupport@sdps.org or 866-288-8912.

Physicians can use their facility's electronic health records (EHR) system to send a prescription and to document it in the medical record, then bill for the incentive in much the same way they already handle billing.

Or physicians can turn to certified practice management systems that have an e-prescribing component or to standalone e-prescribing systems, if they come from an entity on the CMS list of qualified EHR vendors, she advised. She warned that prescriptions from these two types of systems generally go directly to the pharmacy and not necessarily to the nursing home, "so you're going to have to work out some other mechanism to get that communication to the facility."

To file claims in the e-prescribing incentives program, report the e-prescribing numerator G-code G8553 to denote that at least one prescription was created during the patient encounter that was transmitted using a qualified e-prescribing system. Report the G-code on the same claim as the denominator billing code for the same beneficiary and the same date of service. Submit the e-prescribing G-code with a line-item charge of zero dollars ($0.00).

Denominator billing codes for e-prescribing include codes for services in nursing facilities (99304-99310 and 99315-99316), home visits (99341-99350), and others including domiciliary codes (99324-99328, 99334-99337, and 99346).

As of 2011, Medicare will be offering incentives for physicians in hospitals and ambulatory settings to switch all of their records to EHR, but these incentives won't be available to long-term and post–acute care settings until 2013, Ms. Spiro said. Physicians must choose between the Medicare e-prescribing incentives and complete EHR incentives programs and cannot participate in both (because presumably the EHR would include an e-prescribing component).

However, the same Health Information Technology for Economic and Clinical Health Act that established the EHR incentives included a provision for state Medicaid programs to incentivize early adoption of e-prescribing. "Actually, those incentives are a lot better" than Medicare incentives, she said. Physicians in long-term care settings who see patients covered by Medicare and Medicaid may want to participate in both e-prescribing early-adopter programs rather than wait for the 2013 EHR incentives under Medicare.

For the long-term care setting, that's "probably a better value," said Ms. Spiro. She reported having no relevant conflicts of interest. ■

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Filling Slots Takes 6 Months

Recruiters took an average 180 days to fill an internal medicine or family medicine physician position in 2008, according to the Medical Group Management Association. Since this was the first time MGMA collected such data, it's not clear how 2008 compared to previous years, an MGMA spokesperson said. The cost of filling positions in these and other specialties declined, which the group attributed to the economic downturn and a marked increase in the use of Internet job boards in recruiting. The time to fill positions in nonmetropolitan areas, where the impact of the primary care shortage is greatest, was longer than that needed in large population centers, according to MGMA.

On-Call Pay for Primary Care

More than 43% of primary care providers received some form of additional compensation for on-call coverage, according to another MGMA survey. Family practitioners with and without OB/GYN coverage earned between $100 and $110 per day and $588 on holidays, MGMA said, while internists earned about $200 per day. In comparison, general surgeons earned $905 per day and $3,000 on holidays, the group said. Almost half of nonsurgical specialists responding to the MGMA survey reported no additional compensation for their on-call coverage, while nearly three-fourths of surgery specialists were compensated for on-call services.

Push for FDA Drug Enforcement

Two minority advocacy groups are urging the Food and Drug Administration to work harder to remove unapproved drugs from the market. The National Minority Quality Forum and MANA, a national Hispanic-American organization, both asked the FDA to push harder on its unapproved drug initiative, launched in 2006. MANA said that only 400 of what could be thousands of unapproved drugs have been removed from the market since 2006, and NMQF warned that patients and physicians may not know that some drugs are unapproved. "These unapproved drugs, which have not been evaluated by FDA's rigorous approval process, may compromise the health of patients and create increased liability for the physicians who prescribe them," the NMQF said in its letter.

CDC to States: Stop Smoking

The Centers for Disease Control and Prevention has urged a 50-state antismoking effort to reduce the more than 400,000 annual tobacco-related deaths in the United States, saying that if all states utilized proven strategies, smoking-related diseases, deaths, and costs could fall substantially. Worthwhile strategies include hard-hitting education and media campaigns, smoke-free air laws, and higher cigarette prices, the CDC said in a report. Nearly one in five American deaths is caused by cigarette smoking, and reductions in adult and teen smoking rates have stalled since 2004, the CDC said. "This report shows that states know how to end the smoking epidemic," Dr. Thomas R. Frieden, CDC director, said in a statement. "Smoke-free laws, hard-hitting ads, and higher cigarette prices are among our strongest weapons in this fight against tobacco use."

Chemical Reforms Introduced

After months of hearings, Sen. Frank Lautenberg (D-N.J.), chairman of a Senate environmental health subcommittee, has introduced legislation that would significantly strengthen federal enforcement powers over potentially toxic chemicals and their uses. The Safe Chemicals Act of 2010 would grant the Environmental Protection Agency additional powers to get safety information from chemical manufacturers, to categorize chemicals based on risk, and to remove dangerous chemicals from the market. Laws governing chemical regulation have not been updated in 34 years and currently give the EPA little regulatory authority, according to the group Health Care Without Harm. "The EPA has been able to require comprehensive testing on just 200 of the more than 80,000 chemicals produced and used in the U.S., and only five chemical groups have been regulated under this law," the group said in a statement.

Liability Fund Shift Was Illegal

Pennsylvania should not have sought help from state budget difficulties by diverting funds from compensation of victims of medical malpractice, the state's Commonwealth Court ruled in two separate cases. Between 2003 and 2007, Pennsylvania officials failed to transfer up to $616 million to a fund that pays malpractice awards beyond what health providers' insurance covers. The state also wrongly transferred $100 million from the fund to the state's general fund, the court found. The Pennsylvania Medical Society and the Hospital and Health System Association of Pennsylvania filed the two lawsuits, arguing that the money was intended to control the cost of malpractice coverage. State officials have said they will appeal the two decisions.

—Jane Anderson