

## 2009 Electronic Prescribing Incentive Program – Adoption/Use of Medication Electronic Prescribing Measure

IN ORDER TO REPORT THIS MEASURE, AN ELECTRONIC PRESCRIBING (e-prescribing) SYSTEM MUST HAVE BEEN ADOPTED

### DESCRIPTION:

Documents whether the provider has adopted a qualified e-prescribing system and the extent of use in the ambulatory setting. A qualified e-prescribing 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 e-prescribing system to receive tiered formulary information, if available, would meet this requirement for 2009)
- 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 e-prescribing standards adopted by the Secretary for Part D by virtue of the 2003 Medicare Modernization Act (MMA).

### INSTRUCTIONS:

In order to report this measure, an e-prescribing system must have been adopted. This measure is to be reported for each patient visit during the reporting period that meets the denominator coding criteria. Denominator coding criteria for this measure include various ambulatory care settings. There is no specific diagnosis required for this measure. When reporting the measure, include both a denominator code and a numerator G-code on the claim.

### REPORTING NUMERATOR:

A qualified e-prescribing system (as specified above) has been adopted and one of the G-codes that follow applies to the patient visit.

#### Numerator Quality-Data Coding Options for Successful Reporting:

##### **Prescriptions Generated via Qualified E-prescribing System**

**G8443:** All prescriptions created during the encounter were generated using a qualified e-prescribing system

**OR**

##### **E-prescribing System Available, but not Used for One or More Prescriptions Due to Patient/System Reasons**

**G8446:** Provider does have access to a qualified e-prescribing system. Some or all prescriptions generated during the encounter were printed or phoned in as required by state or federal law or regulations, patient request, or pharmacy system being unable to receive electronic transmission; OR because they were for narcotics or other controlled substances

OR

**Qualified E-prescribing System Available, but no Prescription(s) were Generated During the Encounter**

**G8445:** No prescriptions were generated during the encounter. Provider does have access to a qualified e-prescribing 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 encounter during the reporting period (CPT or HCPCS):** 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 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 Providers and Pharmacies
- Easier data collection of physician prescribing patterns and improved formulary compliance for Health plans, pharmacy benefit managers and employers

**DEFINITIONS:**

**E-prescribing** – 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 e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser.

**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

**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.