

CMS Extends Incentives For Early E-Prescribing

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, Rachele F. Spiro said at the annual meeting of the American Medical Directors Association.

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.

Instructions and examples of how to submit claims under the e-prescribing incentive program are available from CMS 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, and 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 stand-alone 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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NIMH Director Denies Conflict

Dr. Thomas R. Insel, director of the National Institute of Mental Health, is denying a report in the Chronicle of Higher Education that he assisted a former colleague in securing a new position after the person was removed as principal investigator on an NIMH-funded grant because of conflicts of interest. The story alleged that Dr. Insel helped Dr. Charles B. Nemeroff get a new position at the University of Miami after he left Emory University and that Dr. Insel helped Dr. Nemeroff avoid sanctioning by the National Institutes of Health. Dr. Nemeroff is under investigation for not disclosing payments from Glaxo-SmithKline while he was leading studies of the company’s drugs escitalopram and duloxetine at Emory. Dr. Insel has been leading the NIH’s latest effort to weed out conflicts among employees. In a post on his “Director’s Blog” in mid-June, he said that “Having been one of the most outspoken proponents for developing tougher conflict of interest policies at NIH, the allegations that I would help anyone avoid penalties struck me as surreal.” He added, “I realize that my tenure at Emory and a previous association with Dr. Nemeroff will, for some, be ‘guilt by association.’ To avoid such allegations, I recused myself from all matters involving Dr. Nemeroff during the conflict of interest investigation at NIH... and from future applications or NIH matters involving Dr. Nemeroff.”

APA Beefs Up Conflict Policy

The American Psychiatric Association has approved a new code of conduct to govern its relationships with other organizations. The policy requires that any financial relationship with any entity that develops educational programs or subsidizes research should be clearly stated by APA staff and members working on behalf of the organization. It also requires all APA educational programs follow the American College of Continuing Medical Education standards for independent and unbiased presentations. A new conflict of interest committee will be charged with overseeing the organization’s relationships with industry and other groups. The code is available at www.psych.org/Resources/Governance/Disclosure-of-Interests-and-Affiliations/APA-Code-of-Conduct.aspx.

Judge Hands Down Topamax Fine

Ortho-McNeil Pharmaceutical LLC, a subsidiary of Johnson & Johnson, recently pleaded guilty to one misdemeanor count of violating the Food, Drug & Cosmetic Act, for the illegal promotion of Topamax for psychiatric uses. Under a sentence

delivered by a U.S. District Court judge in Boston last month, the company will pay a criminal fine of \$6.14 million. The sentence is consistent with an agreement the company reached with the Justice Department in April. Prosecutors alleged that Ortho-McNeil used a program called “Doctor for a Day” to promote the epilepsy and migraine treatment Topamax among psychiatrists for off-label uses. The company paid physicians to accompany sales representatives meeting with psychiatrists. In its plea, the company acknowledged promoting the drug for certain unapproved uses between 2001 and 2003, but it said that it voluntarily discontinued the program before receiving the first subpoena in the government’s investigation.

Tobacco Coverage to Be Broader

The Centers for Medicare and Medicaid Services is proposing to cover tobacco counseling services for all adults and pregnant women who are entitled to benefits under Part A or Part B of Medicare. Such counseling has been covered only for people with signs or symptoms of tobacco-related disease. Under the new plan, anyone who uses tobacco or desires the counseling would be entitled to two counseling “attempts” per year, which would include a maximum of eight intermediate (3-minute) or intensive (10-minute) sessions per year. A final coverage decision is pending, after comments on the proposal were taken through late June.

House Probes Home Gene Testing

Three key House lawmakers have launched an investigation into personal genetic testing kits that are being marketed directly to the public. The investigation, spearheaded by House Energy and Commerce Committee Chairman Henry A. Waxman (D-Calif.) and supported by Rep. Joe Barton (R-Tex.), Rep. Bart Stupak (D-Mich.), and Rep. Michael C. Burgess (R-Tex.), has targeted the companies 23andMe Inc., Navigenics Inc., and Pathway Genomics Corp. The companies already offer their tests to consumers by phone or online, and San Diego-based Pathway announced that it is seeking to sell testing kits in retail locations, despite concerns from the scientific community about the accuracy of test results. In letters to the companies, the lawmakers said they want information on how the companies analyze test results and identify potential genetic risks. The three lawmakers also want to know how the companies collect, store, and process individual genetic samples collected from consumers.

—Alicia Ault

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