Adoption/Use of e-Prescribing

*This measure is to be reported at **each** visit occurring during the reporting period for all patients aged 18 years and older. This measure may be reported by clinicians who have adopted a qualified e-Prescribing system.*

Measure description

Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting. To qualify this system must be capable of ALL of the following:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacy drug plan(s) if available
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks
- Providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any)
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan

What will you need to report for each visit for this measure?

If you select this measure for reporting, you will report:

- Whether or not all prescriptions created during the encounter were generated using a qualified e-Prescribing system (as described above)

What if the e-Prescribing system was not used for this visit?

There may be times when it is not possible to generate a prescription using an e-Prescribing system, due to:

- No prescriptions generated during the encounter
- System/Patient Reasons (eg, some or all prescriptions generated during the encounter were handwritten or phoned in due to one of the following: required by state law, patient request, or qualified e-Prescribing system being temporarily inoperable)

In these cases, you will need to indicate which reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

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Health Information Technology (HIT)

Adoption/Use of e-Prescribing

PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	Gender ☐ Male ☐ Female
National Provider Identifier (NPI)		Date of Service	

Clinical Information | **Billing Information**

Step 1 Is patient eligible for this measure?

	Yes	No	Code Required on Claim Form
Patient is aged 18 years and older.	☐	☐	Verify date of birth on claim form.
There is a CPT E/M Service Code or G-code for this visit.	☐	☐	Refer to coding specifications document for list of applicable codes.
If **No** is checked for any of the above, STOP. Do not report a G-code.			

Step 2 Does patient meet or have an acceptable reason for not meeting the measure?

Patient Prescription	Yes	No	Code to be Reported on Line 24D of Paper Claim Form, if *Yes* (or Service Line 24 of Electronic Claim Form)
Generated using qualified e-Prescribing system[1]	☐	☐	G8443
Not generated using qualified e-Prescribing system for one of the following reasons:			
• No prescriptions were generated during the encounter	☐	☐	G8445
• System/Patient (ie, some or all of the prescriptions generated during the encounter were handwritten or phoned in due to one of the following: required by state law, patient request or qualified e-Prescribing system being temporarily inoperable)	☐	☐	G8446
Document reason here and in medical chart. _____ _____			

[1]To qualify this system must be capable of ALL of the following: generating a complete active medication list incorporating electronic data received from applicable pharmacy drug plan(s) if available; selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks; providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any); providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan

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Coding Specifications

Codes required to document a visit occurred:

A CPT service code, CPT E/M service code or HCPCS G-code is required to identify patients to be included in this measure.

CPT service codes

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 90804, 90805, 90806, 90807, 90808, 90809 (individual psychotherapy),
- 92002, 92004 (ophthalmological services — new patient),
- 92012, 92014 (ophthalmological services — established patient),
- 96150, 96151, 96152 (health and behavior intervention)

OR

CPT E/M service codes

- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99211, 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult)

OR

HCPCS G-codes

- G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination),
- G0108, G0109 (diabetes services)

Quality codes for this measure (one of the following for every eligible patient):

G-code descriptors

(Data Collection sheet should be used to determine appropriate combination of codes.)

- ***G8443:*** All prescriptions created during the encounter were generated using a qualified e-Prescribing system
- ***G8445:*** No prescriptions were generated during the encounter. Provider does have access to a qualified e-Prescribing system
- ***G8446:*** Some or all prescriptions generated during the encounter were handwritten or phoned in due to one of the following: required by state law, patient request, or qualified e-Prescribing system being temporarily inoperable

These measures were developed by Quality Insights of Pennsylvania as a special project under the Quality Insights' Medicare Quality Improvement Organization (QIO) contract HHSM-500-2005-PA001C with the Centers for Medicare & Medicaid Services. These measures are in the public domain.

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