

## ♣ Measure #125: HIT - Adoption/Use of e-Prescribing

### 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 (defined below)
- 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

### INSTRUCTIONS:

This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted a qualified e-Prescribing system.

### **This measure is reported using G-codes:**

CPT E/M codes, CPT service codes and HCPCS G-codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

### NUMERATOR:

A qualified e-Prescribing system has been adopted capable of generating a medication list and selecting/printing/transmitting/performing safety checks of prescriptions

#### **Definitions:**

**Qualified e-Prescribing system** – an e-Prescribing system that is 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 (defined below)
- 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

**e-Prescribing** – Entering a prescription for a medication into an automated data entry system that generates a prescription electronically instead of handwriting the prescription on paper

**Safety checks** – Automated prompts that offer the provider information on the drug being prescribed, potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions

**Numerator Coding:**

**Prescriptions Generated via Qualified e-Prescribing System**

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

OR

**Qualified e-Prescribing System Available, Prescription(s) not Generated or not Generated Via Qualified e- Prescribing System for System/Patient Reasons**

**G8445:** No prescriptions were generated during the encounter. Provider does have access to a qualified e- Prescribing system

**OR**

**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

**DENOMINATOR:**

All patients aged 18 years and older

**Denominator Coding:**

A CPT service code, CPT E/M code, or G-code is required to identify patients for denominator inclusion.

**CPT service codes, CPT E/M codes, or HCPCS G-codes:** 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.

**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)