

(n) *Limitations on review.* Except as specified in paragraph (i) of this section, there is no administrative or judicial review under section 1869 or 1879 of the Act, or otherwise of—

(1) The determination of measures applicable to services furnished by eligible professionals under the PQRS;

(2) The determination of satisfactory reporting; and

(3) The determination of any Physician Quality Reporting System incentive payment and the PQRS payment adjustment.

(o) *Public reporting of an eligible professional's or group practice's PQRS data.* For each program year, CMS will post on a public Web site, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (g) of this section, group practices) who satisfactorily submitted PQRS quality measures.

[78 FR 74812, Dec. 10, 2013, as amended at 79 FR 68003, Nov. 13, 2014; 81 FR 34913, June 1, 2016; 81 FR 77537, Nov. 4, 2016; 81 FR 80554, Nov. 15, 2016; 82 FR 53362, Nov. 15, 2017]

**§ 414.92 Electronic Prescribing Incentive Program.**

(a) *Basis and scope.* This section implements the following provisions of the Act:

(1) Section 1848(a)—Payment Based on Fee Schedule.

(2) Section 1848(m)—Incentive Payments for Quality Reporting.

(b) *Definitions.* As used in this section, unless otherwise indicated—

*Certified electronic health record technology* means an electronic health record vendor's product and version as described in 45 CFR 170.102.

*Covered professional services* means services for which payment is made under, or is based on, the Medicare physician fee schedule which are furnished by an eligible professional.

*Electronic Prescribing Incentive Program* means the incentive payment program established under section 1848(m) of the Act for the adoption and use of electronic prescribing technology by eligible professionals.

*Eligible professional* means any of the following healthcare professionals who have prescribing authority:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C) of the Act.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) A qualified audiologist (as defined in section 1861(11)(3)(B) of the Act).

*Group practice* means a group practice that is—

(i)(A) Defined at § 414.90(b), that is participating in the Physician Quality Reporting System; or

(B) In a Medicare-approved demonstration project or other Medicare program, under which Physician Quality Reporting System requirements and incentives have been incorporated; and

(ii) Has indicated its desire to participate in the electronic prescribing group practice option.

*Qualified electronic health record product* means an electronic health record product and version that, with respect to a particular program year, is designated by CMS as a qualified electronic health record product for the purpose of the Physician Quality Reporting System (as described in § 414.90) and the product's vendor has indicated a desire to have the product qualified for purposes of the product's users to submit information related to the electronic prescribing measure.

*Qualified registry* means a medical registry or a Maintenance of Certification Program operated by a specialty body of the American Board of Medical Specialties that, with respect to a particular program year, is designated by CMS as a qualified registry for the purpose of the Physician Quality Reporting System (as described in § 414.90) and that has indicated its desire to be qualified to submit the electronic prescribing measure on behalf of eligible professionals for the purposes of the Electronic Prescribing Incentive Program.

(c) *Incentive payments and payment adjustments.* (1) *Incentive payments.* Subject to paragraph (c)(3) of this section, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting

period, in addition to the amount otherwise paid under section 1848 of the Act, there also must be paid to the eligible professional (or to an employer or facility in the cases described in section 1842(b)(6)(A) of the Act) or, in the case of a group practice under paragraph (e) of this section, to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Act an amount equal to the applicable electronic prescribing percent (as specified in paragraph (c)(1)(ii) of this section) of the eligible professional's (or, in the case of a group practice under paragraph (e) of this section, the group practice's) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (e) of this section, by the group practice) during the applicable reporting period.

(i) For purposes of paragraph (c)(1) of this section,

(A) The eligible professional's (or, in the case of a group practice under paragraph (e) of this section, the group practice's) total estimated allowed charges for covered professional services furnished during a reporting period are determined based on claims processed in the National Claims History (NCH) no later than 2 months after the end of the applicable reporting period;

(B) In the case of an eligible professional who furnishes covered professional services in more than one practice, incentive payments are separately determined for each practice based on claims submitted for the eligible professional for each practice;

(C) Incentive payments earned by an eligible professional (or in the case of a group practice under paragraph (e) of this section, by a group practice) for a particular program year will be paid as a single consolidated payment to the TIN holder of record.

(ii) *Applicable electronic prescribing percent.* The applicable electronic prescribing percent is as follows:

(A) For the 2011 and 2012 program years, 1.0 percent.

(B) For the 2013 program year, 0.5 percent.

(iii) *Limitation with respect to electronic health record (EHR) incentive pay-*

*ments.* The provisions of this paragraph do not apply to an eligible professional (or, in the case of a group practice under paragraph (e) of this section, a group practice) if, for the electronic health record reporting period the eligible professional (or group practice) receives an incentive payment under section 1848(o)(1)(A) of the Act with respect to a certified electronic health record technology (as defined in section 1848(o)(4) of the Act) that has the capability of electronic prescribing.

(2) *Payment adjustment.* Subject to paragraphs (c)(1)(ii) and (c)(3) of this section, with respect to covered professional services furnished by an eligible professional during 2012, 2013, or 2014, if the eligible professional (or in the case of a group practice under paragraph (e) of this section, the group practice) is not a successful electronic prescriber (as specified by CMS for purposes of the payment adjustment) for an applicable reporting period (as specified by CMS) the fee schedule amount for such services furnished by such professional (or group practice) during the program year (including the fee schedule amount for purposes of determining a payment based on such amount) is equal to the applicable percent (as specified in paragraph (c)(2)(i) of this section) of the fee schedule amount that would otherwise apply to such services under section 1848 of the Act.

(i) *Applicable percent.* The applicable percent is as follows:

(A) For 2012, 99 percent;

(B) For 2013, 98.5 percent; and

(C) For 2014, 98 percent.

(ii) *Significant hardship exception.* CMS may, on a case-by-case basis, exempt an eligible professional (or in the case of a group practice under paragraph (e) of this section, a group practice) from the application of the payment adjustment under paragraph (c)(2) of this section if, CMS determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship. Eligible professionals (or, in the case of a group practice under paragraph (e) of this section, a group practice) may request consideration for a significant

hardship exemption from a eRx payment adjustment if one of the following circumstances apply:

(A) From the 2012 payment adjustments by meeting one of the following:

(1) The practice is located in a rural area without high speed internet access.

(2) The practice is located in an area without sufficient available pharmacies for electronic prescribing.

(3) Registration to participate in the Medicare or Medicaid EHR Incentive Program and adoption of Certified EHR Technology.

(4) Inability to electronically prescribe due to local, State or Federal law or regulation.

(5) Eligible professionals who achieve meaningful use during the respective 6 or 12-month payment adjustment reporting periods.

(6) Eligible professionals who have registered to participate in the EHR Incentive Program and adopted Certified EHR Technology prior to application of the respective payment adjustment.

(B) From the 2013 and 2014 payment adjustments by meeting one of the following:

(1) The eligible professional or group practice is located in a rural area without high speed internet access.

(2) The eligible professional or group practice is located in an area without sufficient available pharmacies for electronic prescribing.

(3) The eligible professional or group practice is unable to electronically prescribe due to local, State, or Federal law or regulation.

(4) The eligible professional or group practice has limited prescribing activity, as defined by an eligible professional generating fewer than 100 prescriptions during a 6-month reporting period.

(iii) *Other limitations to the payment adjustment.* An eligible professional (or in the case of a group practice under paragraph (b) of this section, a group practice) is exempt from the application of the payment adjustment under paragraph (c)(2) of this section if one of the following applies:

(A) The eligible professional is not an MD, DO, podiatrist, nurse practitioner, or physician assistant.

(B) The eligible professional does not have at least 100 cases containing an encounter code that falls within the denominator of the electronic prescribing measure for dates of service during the 6-month reporting period specified in paragraph (f)(1) of this section.

(3) *Limitation with respect to electronic prescribing quality measures.* The provisions of paragraphs (c)(1) and (c)(2) of this section do not apply to an eligible professional (or, in the case of a group practice under paragraph (e) of this section, a group practice) if for the reporting period the allowed charges under section 1848 of the Act for all covered professional services furnished by the eligible professional (or group, as applicable) for the codes to which the electronic prescribing measure applies are less than 10 percent of the total of the allowed charges under section 1848 of the Act for all such covered professional services furnished by the eligible professional (or the group practice, as applicable).

(d) *Requirements for individual eligible professionals to qualify to receive an incentive payment.* In order to be considered a successful electronic prescriber and qualify to earn an electronic prescribing incentive payment (subject to paragraph (c)(3) of this section), an individual eligible professional, as identified by a unique TIN/NPI combination, must meet the criteria for being a successful electronic prescriber under section 1848(m)(3)(B) of the Act and as specified by CMS during the reporting period specified in paragraph (d)(1) of this section and using one of the reporting mechanisms specified in paragraph (d)(2) of this section. Although an eligible professional may attempt to qualify for the electronic prescribing incentive payment using more than one reporting mechanism (as specified in paragraph (d)(2) of this section), the eligible professional will receive only one electronic prescribing incentive payment per TIN/NPI combination for a program year.

(1) *Reporting period.* For purposes of this paragraph, the reporting period with respect to a program year is the entire calendar year.

(2) *Reporting mechanisms.* An eligible professional who wishes to participate in the Electronic Prescribing Incentive

Program must report information on the electronic prescribing measure identified by CMS to—

(i) CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional's Medicare Part B claims for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section;

(ii) A qualified registry (as defined in paragraph (b) of this section) in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected qualified registry will submit information, as required by CMS, for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section to CMS on the eligible professional's behalf; or

(iii) CMS by extracting clinical data using a secure data submission method, as required by CMS, from a qualified electronic health record product (as defined in paragraph (b) of this section) by the deadline specified by CMS for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section. Prior to actual data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing real or dummy clinical quality data extracted from the qualified electronic health record product selected by the eligible professional using a secure data submission method, as required by CMS.

(e) *Requirements for group practices to qualify to receive an incentive payment.*

(1) A group practice (as defined in paragraph (b) of this section) will be treated as a successful electronic prescriber for covered professional services for a reporting period if the group practice meets the criteria for successful electronic prescriber specified by CMS in the form and manner and at the time specified by CMS.

(2) *No double payments.* Payments to a group practice under this paragraph must be in lieu of the payments that would otherwise be made under the Electronic Prescribing Incentive Program to eligible professionals in the

group practice for being a successful electronic prescriber.

(i) If an eligible professional, as identified by an individual NPI, has reassigned his or her Medicare billing rights to a TIN selected to participate in the electronic prescribing group practice reporting option for a program year, then for that program year the eligible professional must participate in the Electronic Prescribing Incentive Program via the group practice reporting option. For any program year in which the TIN is selected to participate in the Electronic Prescribing Incentive Program group practice reporting option, the eligible professional cannot individually qualify for an electronic prescribing incentive payment by meeting the requirements specified in paragraph (d) of this section.

(ii) If, for the program year, the eligible professional participates in the Electronic Prescribing Incentive Program under a TIN that is not selected to participate in the Electronic Prescribing Incentive Program group practice reporting option for that program year, then the eligible professional may individually qualify for an electronic prescribing incentive by meeting the requirements specified in paragraph (d) of this section under that TIN.

(f) *Requirements for individual eligible professionals and group practices for the payment adjustment.* In order to be considered a successful electronic prescriber for the electronic prescribing payment adjustment, an individual eligible professional (or, in the case of a group practice under paragraph (b) of this section, a group practice), as identified by a unique TIN/NPI combination, must meet the criteria for being a successful electronic prescriber specified by CMS, in the form and manner specified in paragraph (f)(2) of this section, and during the reporting period specified in paragraph (f)(1) of this section.

(1) *Reporting periods.* (i) For purposes of this paragraph (f), the reporting period for the 2013 payment adjustment is either of the following:

(A) The 12-month period from January 1, 2011 through December 31, 2011.

(B) The 6-month period from January 1, 2012 through June 30, 2012.

(ii) For purposes of this paragraph (f), the reporting period for the 2014 payment adjustment is either of the following:

(A) The 12-month period from January 1, 2012 through December 31, 2012.

(B) The 6-month period from January 1, 2013 through June 30, 2013.

(2) *Reporting mechanisms.* An eligible professional (or, in the case of a group practice under paragraph (e) of this section, a group practice) who wishes to participate in the Electronic Prescribing Incentive Program must report information on the electronic prescribing measure identified by CMS to one of the following:

(i) For the 6- and 12-month reporting periods under paragraph (f)(1) of this section, CMS, by no later than 2 months after the end of the applicable 12-month reporting period or by no later than 1 month after the end of the applicable 6-month reporting period, on the eligible professional's Medicare Part B claims for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (f)(1) of this section.

(A) If an eligible professional re-submits a Medicare Part B claim for re-processing, the eligible professional may not attach a G-code at that time for reporting on the electronic prescribing measure.

(B) [Reserved]

(ii) For the 12-month reporting period under paragraph (f)(1) of this section, a qualified registry (as defined in paragraph (b) of this section) in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected qualified registry submits information, as required by CMS, for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (f)(1) of this section to CMS on the eligible professional's behalf.

(iii) For the 12-month reporting period under paragraph (f)(1) of this section, CMS by extracting clinical data using a secure data submission method, as required by CMS, from a qualified electronic health record product (as defined in paragraph (b) of this section) by the deadline specified by CMS for

covered professional services furnished by the eligible professional during the reporting period specified in paragraph (f)(1) of this section. Prior to actual data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing dummy clinical quality data extracted from the qualified electronic health record product selected by the eligible professional using a secure data submission method, as required by CMS.

(g) *Informal review.* Eligible professionals (or in the case of reporting under paragraph (e) of this section, group practices) may seek an informal review of the determination that an eligible professional (or in the case of reporting under paragraph (e) of this section, group practices) did not meet the requirements for the 2012 and 2013 incentives or the 2013 and 2014 payment adjustments.

(1) To request an informal review for the 2012 and 2013 incentives, an eligible professional or group practice must submit a request to CMS via email within 90 days of the release of the feedback reports. The request must be submitted in writing and summarize the concern(s) and reasons for requesting an informal review and may also include information to assist in the review.

(2) To request an informal review for the 2013 and 2014 payment adjustments, an eligible professional or group practices must submit a request to CMS via email by February 28 of the year in which the eligible professional is receiving the applicable payment adjustment. The request must be submitted in writing and summarize the concern(s) and reasons for requesting an informal review and may also include information to assist in the review.

(3) CMS will provide a written response of CMS' determination.

(i) All decisions based on the informal review will be final.

(ii) There will be no further review or appeal.

(h) *Public reporting of an eligible professional's or group practice's Electronic Prescribing Incentive Program data.* For each program year, CMS will post on a public Web site, in an easily understandable format, a list of the names of

eligible professionals (or in the case of reporting under paragraph (e) of this section, group practices) who are successful electronic prescribers.

[75 FR 73620, Nov. 29, 2010, as amended at 76 FR 54968, Sept. 6, 2011; 76 FR 73472, Nov. 28, 2011; 77 FR 69368, Nov. 16, 2012; 80 FR 71379, Nov. 16, 2015]

**§ 414.94 Appropriate use criteria for advanced diagnostic imaging services.**

(a) *Basis and scope.* This section implements the following provisions of the Act:

(1) Section 1834(q)—Recognizing Appropriate Use Criteria for Certain Imaging Services.

(2) Section 1834(q)(1)—Program Established.

(3) Section 1834(q)(2)—Establishment of Applicable Appropriate Use Criteria.

(b) *Definitions.* As used in this section unless otherwise indicated—

*Advanced diagnostic imaging service* means an imaging service as defined in section 1834(e)(1)(B) of the Act.

*Applicable imaging service* means an advanced diagnostic imaging service (as defined in section 1834(e)(1)(B) of the Act) for which the Secretary determines—

(i) One or more applicable appropriate use criteria apply;

(ii) There are one or more qualified clinical decision support mechanisms listed; and

(iii) One or more of such mechanisms is available free of charge.

*Applicable payment system* means the following:

(i) The physician fee schedule established under section 1848(b) of the Act;

(ii) The prospective payment system for hospital outpatient department services under section 1833(t) of the Act; and

(iii) The ambulatory surgical center payment systems under section 1833(i) of the Act.

*Applicable setting* means a physician's office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, an independent diagnostic testing facility, and any other provider-led outpatient setting determined appropriate by the Secretary.

*Appropriate use criteria (AUC)* means criteria only developed or endorsed by national professional medical specialty societies or other provider-led entities, to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition for an individual. To the extent feasible, such criteria must be evidence-based. An AUC set is a collection of individual appropriate use criteria. An individual criterion is information presented in a manner that links: a specific clinical condition or presentation; one or more services; and, an assessment of the appropriateness of the service(s).

*Clinical decision support mechanism (CDSM)* means the following: an interactive, electronic tool for use by clinicians that communicates AUC information to the user and assists them in making the most appropriate treatment decision for a patient's specific clinical condition. Tools may be modules within or available through certified EHR technology (as defined in section 1848(o)(4) of the Act or private sector mechanisms independent from certified EHR technology or established by the Secretary.

*Furnishing professional* means a physician (as defined in section 1861(r) of the Act) or a practitioner described in section 1842(b)(18)(C) of the Act who furnishes an applicable imaging service.

*Ordering professional* means a physician (as defined in section 1861(r) of the Act) or a practitioner described in section 1842(b)(18)(C) of the Act who orders an applicable imaging service.

*Priority clinical areas* means clinical conditions, diseases or symptom complexes and associated advanced diagnostic imaging services identified by CMS through annual rulemaking and in consultation with stakeholders which may be used in the determination of outlier ordering professionals.

*Provider-led entity (PLE)* means a national professional medical specialty society or other organization that is comprised primarily of providers or practitioners who, either within the organization or outside of the organization, predominantly provide direct patient care.

*Specified applicable appropriate use criteria* means any individual appropriate