

Electronic Prescribing: An Update

E-prescribing (eRx) is the electronic transmission 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.¹

The number of e-prescriptions transmitted nationwide nearly tripled to 191 million in 2009 (vs. 68 million in 2008) and now represents about 12 percent of the 1.63 billion original prescriptions. Nearly all chain drug stores and 62 percent of independent pharmacies now accept e-prescriptions. For medical practices, the cost of e-prescribing software, hardware (such as laptops), and training can range from \$1,000 to \$1,750 per provider.²

Benefits of eRx

- **Improves patient safety and quality of care.** E-prescribing can reduce medication errors and the resulting adverse effects that they can cause by: a) eliminating illegible hand-written prescriptions, b) reducing oral communications, c) providing automated clinical warning and alert systems (e.g., drug allergies, drug-drug interactions, FDA safety alerts, etc.), d) alerting prescribers about possible drug diversion of controlled substances, and e) providing access to patient's medical and medication histories.
- **Reduces time spent on phone calls and call-backs to pharmacies.**
- **Reduces time spent faxing prescriptions to pharmacies.**
- **Automates the prescription renewal request and authorization process.**
- **Improves patient convenience and compliance with therapy:** By reducing or eliminating the hassle of dropping off and waiting for prescriptions to be filled at pharmacies, eRx may help reduce the number of unfilled prescriptions. Availability of information on when patient prescriptions are filled can aid clinicians in evaluating and addressing issues of patient compliance.
- **Improves formulary adherence permits lower drug cost substitutions.** By checking with health plan/insurer formularies at the point of care, generic substitutions or lower cost therapeutic equivalent medications can be utilized to lower patient's out-of-pocket expenses.
- **Allows for greater prescriber mobility through the use of mobile devices and wireless networks.**
- **Improves drug surveillance and recall ability.** E-prescribing systems enable providers to request analytical queries and reports, e.g., identifying all patients on a particular medication during a drug recall.¹

Medicare Prescriber Incentive Program

The Centers for Medicare & Medicaid Services' (CMS) five-year eRx incentive program began on January 1, 2009 as part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Physicians who are eligible for the incentive payments but fail to adopt eRx will face penalties beginning in 2012. The program provides incentives in 2010 equal to 2 percent of their total Medicare payments for those "eligible professionals" who are also "successful prescribers." In general, an eligible professional includes nearly all health care providers for

whom office visits, eye exams, psychotherapy, or other services listed in the CMS E-Prescribing Measure Specifications represent at least 10 percent of their Medicare charges. The AMA estimates that nearly all physicians who have an office practice will meet this threshold.³

For 2010, a successful prescriber must report the eRx measure for at least 25 unique electronic prescribing events in which the measure is reportable. The measure can be reported through Part B claims, a qualified registry, or a qualified electronic health record (EHR) system.

There are Part D standards for transmitting prescriptions electronically and certain prescription related information for Medicare Part-D covered drugs. Your system must use the Part D standards in effect at the time of transmission. A qualified eRx system is capable of **all** of the following:

- Generating a complete active medication history
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts
- Provides information related to the availability of lower-cost, therapeutically appropriate alternatives and
- Provides information on formulary or tiered formulary medications, patient eligibility and authorization requirements from the patient's drug plan.³

This incentive may offset the initial setup and operating costs. In addition, financial aid for physicians who purchase eRx may be available from federal, state, and private sources. For more information, review the American Medical Association's [A Clinician's Guide to Electronic Prescribing](#).⁴

CMS eRx Incentive Program		
Calendar Year of eRx	Incentive Amount	Penalty Amount
2010	2.0%	N/A
2011	1.0%	N/A
2012	1.0%	-1.0%
2013	0.5%	-1.0%
2014	N/A	-2.0%

New Rules from the Drug Enforcement Agency (DEA) on eRx of Controlled Substances

One of the most important barriers to widespread adoption of eRx by medical providers has been the inability to prescribe controlled substances. In March 2010, the DEA issued a long-awaited interim final rule with a request for comment. The rule, published in the March 31, 2010 *Federal Register*, became effective on June 1. Changes to the DEA rule are possible based on public comments. A number of states have rules prohibiting eRx of controlled substances, and these rules have not changed with the passage of the DEA rule. Therefore, providers should confirm with their respective state Boards of Pharmacy whether their rules allow eRx of controlled substances.

For those providers who currently use eRx, following is a summary of the steps to take before using eRx for controlled substances:

- The eRx software application will need to comply with DEA requirements. Your vendor must certify that the software is compliant. This is true for both medical providers and pharmacies.

- Medical providers will need to provide two forms of identification (i.e. two-factor authentication) to sign eRx for controlled substances. This two-factor authentication must include two out of three of the following: a) something you have, like a USB key; b) something you know, like a PIN or password; c) a physiologic identifier, like a fingerprint.
- The first time you use your two-factor authentication, two individuals within your practice will need to give you access to the system. One of these must be a DEA registrant, using his or her two-factor authentication.

In addition, the software application must generate a monthly log of controlled substance prescriptions that can be archived for future provider review; ensure that the content is not altered during transmission; and maintain an internal audit trail that records any modifications, annotations, or deletions. Once a prescription is created electronically, all records of the prescription must be retained for two years from the date they were created or received.

An excellent question and answer document is available from the [DEA](#) that contains more specific information about compliance of software, the logistics of issuing and filling e-prescriptions for controlled substances, and record keeping.⁵

Conclusion

According to Surescripts CEO and president Harry Totonis, 2009 was the “tipping point” for eRx. In its report, *2009 National Progress on E-Prescribing*, Surescripts reported significant growth in the services that support the eRx process as well as its adoption by prescribers, payors, and pharmacies. Totonis noted that the top three drivers that have contributed to eRx growth were federal incentives for information technology, rapid adoption by large clinics and health systems, and the support demonstrated by pharmacies. Now that the DEA has issued its long-awaited final rule on the prescribing of controlled substances via electronic systems, the future for eRx in the U.S. looks very promising.⁶

References

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