American Academy of Sleep Medicine

June 30, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3248-P
PO Box 8013
Baltimore, MD 21244-8013

To Whom It May Concern,

Thank you for providing stakeholders with the opportunity to comment on the proposed rule **42 CFR Part 414 Medicare Program; Proposed Changes to the Electronic Prescribing (eRx) Incentive Program**. On behalf of our membership, comprised of over 9000 individuals, the American Academy of Sleep Medicine (AASM) would like to comment on the difficulty sleep specialists will have in meeting the requirements of the proposed 2012 eRx program.

Having reviewed the proposed rule, as well as the many resources available on the eRx section of the CMS website, the AASM has concerns about the changes to practice patterns that may result from sleep specialists attempting to comply with eRx requirements. Physicians who practice sleep medicine full time have a limited number of prescriptions they typically write. Prescriptions may be written for restless leg syndrome (RLS), though patients with this diagnosis make up only a small percentage of the individuals with sleep disorders. For a much greater percentage of sleep disorders patients, prescriptions are written to treat insomnia and hypersomnia disorders. Sleep specialists will write prescriptions for stimulant (Schedule II) medications to treat hypersomnia disorders and hypnotic (Schedule IV) medications for the treatment of insomnia. They also prescribe continuous positive airway pressure (CPAP) therapy for obstructive sleep apnea. Sleep specialists are encountering issues when trying to obtain incentives for these prescription types.

Hypnotics prescribed for the treatment of insomnia are typically prescribed during an evaluation and management visit. The codes used for evaluation and management visits fall within the denominator of the eRx measure. However, as CMS has noted in the proposed rule, some states do not allow for the electronic transmission of prescriptions for hypnotics (Schedule IV) or stimulants (Schedule II) significantly limiting the ability of sleep specialists in those states from successful participation in the eRx program. Since the ability to prescribe these medications electronically is limited by state, an unnecessary burden is placed on only some physicians to meet the eRx program requirements with other prescriptions.

CMS has clarified that DME, prescribed electronically, can be counted toward the eRx measure. However, most DME supplier locations are not set up to accept electronic prescriptions from the physicians' office. Sleep physicians located in areas with only a few DME locations may be very limited in the amount of electronic prescriptions they write. Additionally, since the beneficiary is entitled to select his or her own DME supplier, the physician cannot encourage the beneficiary to use an eRx-ready DME supplier for the sole purpose of avoiding the proposed penalties. Additionally, in certain cases, some sleep specialists prescribe CPAP without seeing the patient in consultation. In these scenarios, the prescriptions are not associated with services in the denominator of the 2011 eRx program. For these physicians, the program is encouraging them to schedule potentially unnecessary evaluation and management visits so they can avoid proposed eRx penalties.

The AASM also has concerns that the design of the eRx program may encourage medically unnecessary prescriptions. The program does not account for the range in number of prescriptions written across different fields. A typical family practice physician or internist may write multiple prescriptions for Federal health care beneficiaries on a daily basis. This may not be the case for other specialties. Sleep physicians may get the impression that they are being encouraged to look for new prescription opportunities to avoid the proposed penalties.

CMS recently approved a specialty designation for sleep. Once sleep medicine specialists have the ability to designate sleep medicine as their primary specialty, the AASM will contact its members and ask them to do so. Due to the limited electronic prescribing options available for sleep specialists, the AASM recommends an automatic exemption from the eRx payment adjustment of 2012 for physicians who enroll with a primary specialty of sleep. If such an automatic exemption is not possible, the AASM urges CMS to seriously consider any exemption requests sent in by physicians with a primary specialty of sleep. If necessary, the AASM will work with its members to meet the October 1, 2011 deadline for submission of exemption requests to CMS as outlined in the proposed rule.

Thank you again for your consideration of our comments.

Sincerely,

Nancy Collop, MD
President