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In February, President Obama signed the American Recovery and Reinvestment Act of 2009. The bill has designated \$30 billion for health care initiatives, including research for chronic disease, community health centers, information technology and training for primary care physicians. The bill designates \$19 billion for health information technology. Physicians will be incentivized to move to electronic medical records (EMR) through \$17 billion of incentive payments tied to implementation of information technology.

The bill aims to accomplish four major goals: 1) improve health information technology infrastructure, 2) complete standards and health information certification organization by 2010, 3) save the government health programs \$12 billion, and 4) strengthen federal privacy and security law. The federal government is finally providing funding through increased payments to physicians to assist in the capital investment necessary to implement new technology. While the final rules and measurements continue to develop, now is the time to begin to study your options, contact vendors and begin to reevaluate how you approach Medicare as well as incorporate EMR, e-prescribing and the Physician Quality Reporting Initiative (PQRI) into your business plan for 2009. That's why, in this issue of *VitalSigns*, we discuss these very topics, as well as changes to the Fair and Accurate Credit Transactions Act of 2003 (FACTA) that you should be aware of.

## Review your Medicare ABCs to stay competitive in 2009



**The current economic climate has added more variables to an already challenging equation for physicians and other ancillary providers trying to stabilize their declining incomes. High unemployment is certain to increase the number of uninsured and underinsured patients, while those still employed face significant job insecurity. Increased deductibles and copays levied by employers will place pressure on families — even insured ones — to make decisions about services that they consider routine or elective.**



Even those who still choose to receive their services will have more difficulty paying for them. Finally, third-party and government payors will likely continue their trend of keeping payments stable, at best, or making further reductions. What is a provider to do?

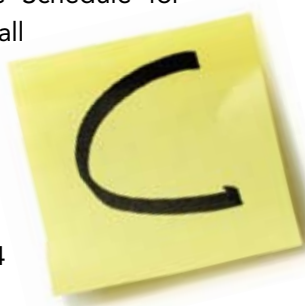
Remember the old adage "Everything you need to know you learn in kindergarten"? In 2009, when it comes to Medicare and staying competitive, that old adage may be truer than ever. Chances are you may know what e-Rx is; however, do you know what MIPPA is? How about MIEA-TRHCA or PQRI? If these abbreviations are wholly or even partly unfamiliar to you, it's time to review your Medicare ABCs.

### MIPPA

As a result of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) – not to be confused with HIPAA – payment rates for physician fee schedule services will be increased by 1.1% in 2009, rather than being reduced by 5.4% as previously expected.

Additionally, through MIPPA, providers participating in Medicare may qualify to participate in a new incentive program if they e-prescribe. Eligible providers include those authorized by their respective state practice laws to prescribe. Depending on the state, this group may include physicians, physical or occupational therapists, qualified speech-language pathologists, nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dietitians, nutritional professionals, and qualified audiologists.

Successfully implemented, the e-prescribing program offers a 2% incentive payment on total Medicare charges for covered professional services paid under the Medicare Physician Fee Schedule for 2009, in addition to the aforementioned 1.1% overall increase. The rate is expected to remain at 2% for 2010, moving to 1% for 2011 and 2012, and then dropping to 0.5% for 2013. Also notable is the future plan to implement penalties for providers not utilizing e-prescribing. In 2012 and 2013 the penalty will be 1% and will increase to 2% for 2014 and beyond.



### E-prescribing

Electronic prescribing (e-prescribing or e-Rx) is a program many providers are currently using and is reasonably simple to implement for those currently not involved. Many third-party and government payors see utilization of e-prescribing as a step toward higher quality and efficiency when ordering drugs for patients.

With e-prescribing, both new prescriptions and responses to renewal requests can be transmitted without having to write, call or fax the information. According to the Centers for Medicare and Medicaid Services (CMS), e-prescribing will help to reduce the number of patients who are injured by drug errors, currently 1.5 million Americans every year. (For a more in-depth look at e-Rx, see "E-mailing ... E-banking ... E-prescribing?" on page 2.)

### PQRI

The Physician Quality Reporting Initiative (PQRI) is a quality reporting incentive program established through the Medicare Improvements and Extension Act of 2006 and the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA). The PQRI program has been available on a voluntary basis since 2006 with an anticipation of becoming mandatory at some future point.

In the past, e-prescribing was one of the PQRI measures but has been removed to enable a separate and additional incentive as noted above. Those providers participating in the PQRI program during 2009 will receive a 2% incentive payment for total Medicare charges for covered professional services paid under the Medicare Physician Fee Schedule for 2009. The noncompensated benefit involves the opportunity to become familiar with and proficient in reporting these measures before it becomes mandatory. (For a more in-depth look at PQRI, see "Understanding the nuances of PQRI" on page 3.)

### Simple math

OK, back to kindergarten:  $2 + 2 = 4$ , right? Well, you really can increase your Medicare reimbursement by 4% by successfully using e-prescribing and participating in PQRI. With the addition of the 1.1% overall increase you could achieve 5.1% more. Where else can you get such a deal in today's economy? Think about it.

# E-mailing, E-banking ... E-prescribing?

## Medicare offers incentives for going electronic

The electronic world, love it or hate it, is here to stay. Succinctly defined, e-prescribing (sometimes called e-Rx) is the transmission of prescription or prescription-related information through electronic media. Medicare is actually providing an incentive to those providers who are willing to e-prescribe, or who have already entered this brave new world. How does 2% of total Medicare charges for covered professional services paid under the Medicare Physician Fee Schedule sound?

Providers don't need to register to participate in this incentive program. The incentive will be paid for services provided from Jan. 1, 2009, through Dec. 31, 2009. Claims for the reporting period must be submitted no later than Feb. 28, 2010.

There is also an incentive to assist with startup costs. The Centers for Medicare and Medicaid Services (CMS) and Office of Inspector General established rules creating exceptions to the Physician Self-Referral (Stark) Law and new safe harbors to the Anti-Kickback Statute. These new exceptions and safe harbors provide rules for allowable donations of e-prescription and electronic health record technology.

Additional relief appeared in a May 11, 2007, IRS memorandum focused on physicians with staff privileges at tax-exempt hospitals. The IRS directive said that technology subsidies provided to staff physicians aren't impermissible private benefits or inurements, provided the HHS regulations are followed by the 501(c)(3) hospital and all recipients. For more information, visit the AMA's Web site ([ama-assn.org](http://ama-assn.org)) and search for "hitdonate."

### Specific criteria

Several specific criteria need to be met for participation. First, a qualified e-prescribing system must be used. The guidelines are available at the CMS Web site ([cms.gov](http://cms.gov); search for "e-prescribing"). Software vendors can also provide documentation of compliance for you.

The second criterion involves certain applicable volume targets. Medicare-allowed charges for all covered professional codes to which the e-prescribing incentive applies must be at least 10% of the total allowed charges under Medicare Part B for physician-provided services. If you're unsure about your volumes, CMS encourages reporting in the event your volumes of the codes below reach the 10% threshold. The following CPT or HCPCS G-codes are included in the denominator of the measure:

- 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, and
- G0101, G0108, G0109.

If you haven't billed one of the codes listed above, no action is necessary. But if you have, you must submit via e-prescription at least 50% of the time. (Typically, if you report one of the codes each time, this criterion will be met.) Also, when billing these codes, you should report one of the following codes for the same visit:

- G8443 (All prescriptions generated for this visit were sent via e-prescription.)
- G8445 (No prescriptions were generated for the patient during this visit.)
- G8446 (Some or all of the prescriptions for this visit were printed or phoned in as required by state or federal law or regulations because of patient request or the pharmacy system being unable to receive electronic transmissions, or because they were for narcotics or other controlled substances.)

### 6 steps to getting started

Six immediate action steps to implementing an e-prescription system should include:

1. Identifying eligible providers in the practice,
2. Reviewing the system in use to determine whether it meets necessary qualifications,
3. Choosing and vetting vendors to buy an initial or updated system (if necessary),
4. Evaluating your Medicare case mix, per specified codes, for the 10% volume target,



5. Training billing staff regarding reporting with new G-codes, and
6. Ensuring the measure is reported on at least 50% of eligible prescriptions.

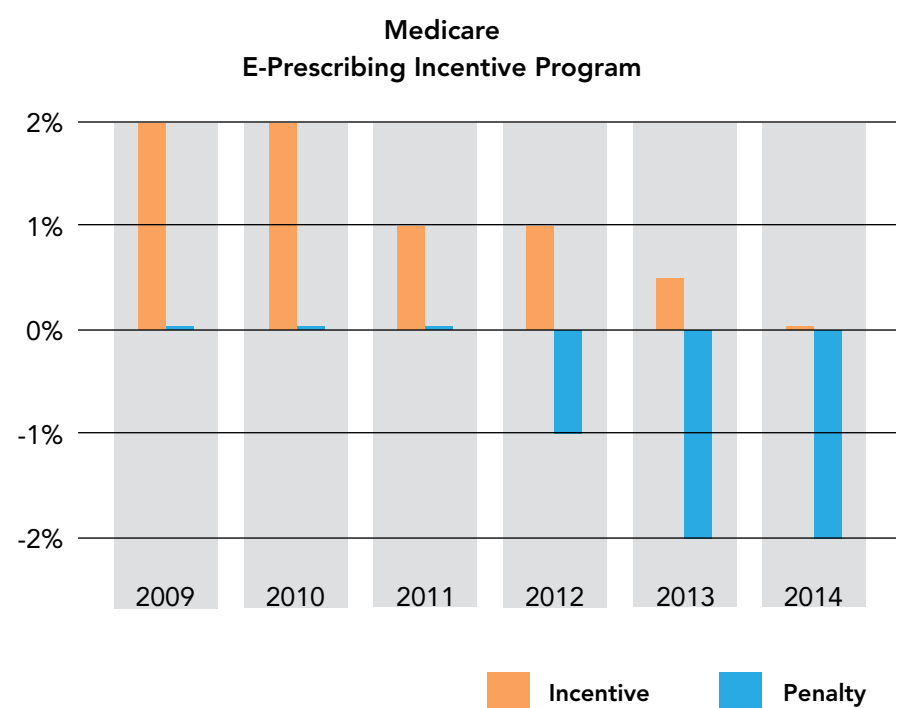
E-prescription systems connect to the pharmacy through the Pharmacy Health Information Exchange™ using a standardized Prescriber/Pharmacist interface. Systems are certified through SureScripts as using National Council for Prescription Drug Programs (NCPDP) compliant technology to connect to the Pharmacy Health Information Exchange.™

A list of SureScripts-authorized vendors with a link to a Buyer's Guide is available at [surescripts.com](http://surescripts.com). All vendors listed meet 2009 Part D standards for the functions they provide. Included on the list are six SureScripts "Gold Rx™" Certified Solutions Providers. Programs receiving this distinction include E-Prescribe, E-Refills, Rx History, Eligibility and Formulary functions.

Bear in mind that you're not required to have implemented electronic medical record (EMR) software to participate in e-prescribing. There are a number of standalone systems that will meet the CMS criteria for participation.

### The time is now

Starting in 2012, nonparticipating providers will actually be *penalized* by Medicare, so the time is now to make the leap and earn some additional revenue in the process. For a helpful guide to getting started with e-Rx, pick up *A Clinician's Guide to Electronic Prescribing* at [ehealthinitiative.org](http://ehealthinitiative.org).



# Understanding the nuances of PQRI

The Physician Quality Reporting Initiative (PQRI) is a program designed to improve the quality of care provided to Medicare beneficiaries. In general, the quality measures consist of “a unique denominator (eligible case) and numerator (clinical action) that permit the calculation of the percentage of a defined population that receive a particular process of care or achieve a particular outcome,” according to the *CMS 2009 PQRI Implementation Guide*.

The program was legislatively established through the Tax Relief and Health Care Act of 2006 (TRHCA). It was built on a foundation established through the Physician Voluntary Reporting Program (PVRP) developed in 2005; however, unlike PVRP, incentive payments are linked to the reporting of quality data through PQRI.

## A cap removed

During the initial rollout of PQRI (July 1, 2007, through Dec. 31, 2007), there was a cap on incentive payments. This changed in 2008 when the incentive cap was removed. Each year has brought changes in the implementation of the program.

For 2009, providers who successfully participate in the PQRI program will earn an incentive payment of 2% of their total Medicare charges for covered professional services paid under the Medicare Physician Fee Schedule. Eligible professionals paid under the Medicare Physician Fee Schedule include Medicare physicians (MD, DO, DPM, OD, DDS, DMD, DC), practitioners (PA, NP, CNS, CRNA, CNM, CSW, PsyD, RD, AuD), and therapists (PT, OT, SLP).

The PQRI Incentive Program is similar to the E-Prescribing Incentive Program in that eligible providers don't need to register to participate. Submission of quality data codes (QDCs) for eligible measures, through claims



or a qualified registry, will signal a provider's desire to participate. The incentive will be paid for services provided from Jan. 1, 2009 through Dec. 31, 2009. Data for the reporting period must be submitted no later than Feb. 28, 2010.

## A variety of options

The PQRI program provides nine different options for reporting data that represent claims-based or registry options, full or half year options, and overall percentage of patients or a defined number of consecutive patients. There are 153 quality measures and seven measures groups to select from for 2009 PQRI reporting. Of these, 131 quality measures and six measures groups can be submitted through claims-based reporting.

Measures groups contain at least four individual measures and are applicable to specified chronic conditions. Potential measures cover a variety of different treatment aspects including prevention, chronic and acute care management, procedure-related care, resource utilization, and care coordination. A comprehensive list is located at the CMS Web site ([cms.hhs.gov](http://cms.hhs.gov)).

## Help is available

PQRI measures are one of the more complex aspects of Medicare. Fortunately, many specialty associations and professional organizations, such as the American Medical Association ([ama-assn.org](http://ama-assn.org)), have information and tools available to assist physicians with successful reporting.

## Another “red flag” on the regulatory front

### New FACTA rules seek to curb medical identity theft

In November 2007, the Federal Trade Commission (FTC) issued regulations known as “Red Flag Rules” as part of the Fair and Accurate Credit Transactions Act of 2003 (FACTA). The purpose of the Red Flag Rules is to address the growing incidence of identity theft, including financial and medical identity theft.

While financial identity theft is fairly clear and may include staff from within the office stealing patient demographic and credit card information, the concept of medical identity theft requires further clarification. Medical identity theft occurs when a patient impersonates another person in order to obtain medical services without appropriate payment. It can get complicated, however, when certain situations arise, such as when necessary treatment or legitimate hospital care is denied because insurance benefits have been depleted or a lifetime cap has been reached despite the patient not receiving those services.

In addition to the obvious financial consequences of medical identity theft, the medical records of the legitimate patient may reflect inaccurate clinical data (such as diagnoses, allergies or blood type) leading to treatment errors. Once discovered, efforts must be undertaken to correct the records both within the practice and with any medical insurers involved.

## Red Flag regs

The Red Flag Rules originally required financial institutions and creditors to have implemented identity theft prevention programs by Nov. 1, 2008. A number of organizations, most notably the American Medical Association and the Medical Group Management Association (MGMA), communicated directly with the Chairman of the FTC in September 2008, requesting that physicians receive exemption from the Red Flag Rules — especially in light of the extensive privacy and security measures already in place to protect patients through HIPAA.

Despite the best efforts of these organizations, the FTC has determined that most physicians will be defined as creditors. Per the *MGMA Washington Connexion*, Oct. 1, 2008:

The FTC regulation defines a creditor as an entity that regularly extends, renews, or continues credit or arranges for the extension of credit. The FTC would include a medical provider in this definition if the provider does

not regularly demand payment in full for services or supplies at the time of service, which, according to the FTC, would be considered extending credit. The FTC attorney said there is no “bright line” rule for determining whether a practice meets this definition; rather it is determined on a case-by-case basis.

However, the efforts of these organizations contributed to securing an extension of the implementation deadline until May 1, 2009. What needs to be done by that date? Simply put, every practice needs to establish a Red Flag Rules compliance program. (The FTC is expected to develop templates but, as of this writing, none have been produced.) Bear in mind that a simple program will be most economical and can be just as effective as a complicated one. The program should be written, include succinct policies and procedures, and be approved by the governance structure established for your practice.

Continued on page 4



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#### **Elements for compliance**

There are four elements that compose a compliant Red Flag Rules Identity Theft Prevention Program: 1) identify, 2) detect, 3) respond, and 4) update.

Each "creditor" must *identify* a list of Red Flag threats applicable to their business. A few for physician offices might include a patient who attempts to use a fake ID or altered insurance card; a patient with frequent address changes or addresses that don't match; or clinical conditions that are inconsistent with a patient's age or sex.

A plan to *detect* these Red Flags must be developed and staff must be educated. For example, one mechanism of detection could be observation by front desk staff through diligent attention to detail when patients present for registration. Another detection mechanism could be through a patient who receives a bill for services and notifies you that he or she was never at your office that day. An incident report should be available to record all pertinent data and follow-up responses.

To *respond*, internal records may need to be reviewed; you may need to advise the patient along with law enforcement and medical insurance companies; and records, both clinical and financial, may need to be corrected.

Finally, leadership must *update* the program annually to identify trends and revise policies and procedures to include new potential threats.

#### **Developing a program**

Key individuals to involve in the development of your program would be your office manager, current HIPAA compliance officer, or billing supervisor, along with a representative from the front desk staff.

Some of the policies, procedures, and documents from your HIPAA program may be easily amended to fit the needs of a Red Flag Rules Identity Theft Program.

For example, a HIPAA incident report template could be tweaked to include the necessary questions for Red Flags. A few key policies to develop would include:

- Requesting all patients to provide a photo ID that will be copied and kept in their chart,
- Establishing the use of passwords and restricting access to patient records on a need-to-know basis in your office,
- Setting up a process for initiating an investigation and following it up when an incident occurs, and
- Identifying who will approve/handle any necessary billing or medical records corrections and notification to appropriate individuals.

It is recommended that program policies be kept with your current HIPAA manual. Once the policies, procedures and documents are complete, staff must be educated. Emphasis should be placed on the need to notify leadership if a situation seems unusual. Once the program is reviewed and updated each year, staff should have a brief annual refresher.

#### **Stay updated**

As mentioned, the implementation deadline for the new FACTA rules is May 1, 2009. So it's important to stay updated with the latest developments in these Red Flag Rules and to be sure that your practice is compliant.