

DOCTOR PERSPECTIVES



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Spring 2009

THE NEW FTC RED FLAG RULES:

Physicians and physician offices face countless rules, guidelines, and regulations from many different sources in today's healthcare environment. Extensive effort has already been placed on compliance with HIPAA and the protection of patient information. With the alarming increase in identity theft in recent years, it has become imperative that all businesses and organizations with access to protected information scrutinize their policies and procedures. It is important that they continue to improve the methods in place to address any security breaches as well as proactively attempt to prevent the theft of protected information. The new Red Flag Rules hope to address this issue.

A requirement of the Fair Credit Reporting Act (FCRA) as amended in 2003 calls for the issuance of regulations and guidelines relating to the detection, prevention, and mitigation of identity theft. The Federal Trade Commission and bank regulatory agencies are responsible for these issuances. They were published in final form on November 9, 2007. The compliance deadline was originally set at November 1, 2008, but the enforcement of compliance was delayed until May 1, 2009.

To determine if you must comply with the Rule, two questions need to be answered:

1. Is your business a "creditor"?
2. Do you have "covered accounts"?

A business, or in this case a physician practice, is considered a creditor if it extends, renews, or con-

tinues credit on a regular basis. By deferring payment (billing after the completion of services) and accepting deferred payments for the provision of services, credit is established. Physicians who bill patients after the completion of services, or who bill insurance carriers with the understanding that the patient is ultimately responsible for the charges are considered creditors. Physicians who require all payments in full and up front (cash or credit card payment prior to the rendering of service) are not considered creditors and would not fall under this rule. Clearly, the vast majority of physician practices will be considered creditors under this definition.

If you are a creditor, you must then determine if you have "covered accounts". There are two types of covered accounts. The first one is an account involving multiple payments or transactions that are used mostly for personal or family (household) purposes. The ongoing relationship between a patient and a physician for the provision of medical services would be considered this type of account. The other type of covered account is one for which the possibility of identity theft exists (i.e. credit card accounts). The risks associated with such accounts include how the accounts are opened and accessed and what type of information is needed to maintain them.

Creditors with covered accounts are now required to have a written program in place that will identify and address potential red flags that may be signs of identity theft. The Red Flag Rules do not specifically tell you what your program must look like. As long as the requirements

of the Rules are met, the design of the program is up to each individual practice. This allows for the flexibility of a tailored program that is well suited to meet the needs of each practice in detecting and preventing identity theft.

The World Privacy Forum has compiled a list of Red Flags relating to medical identity theft. The full report as well as other resources can be found at www.worldprivacyforum.org/medicalidentitytheft.html. Red Flags include, but are not limited to, the following:

- ◆ A patient's receipt of a bill for another individual or an EOB for a service that they did not receive.
- ◆ An inquiry from a patient regarding the receipt of a collection notice.
- ◆ Claim denial due to depletion of benefits or reaching a lifetime cap.
- ◆ An inquiry from a patient regarding information added to a credit report by a health care provider or insurer.
- ◆ Inconsistencies between treatment detailed in a medical record and the medical history reported by a patient.
- ◆ A patient presents documents that appear to have been altered or forged.
- ◆ Lack of consistency with personal identifying information when compared to external sources.

If a practice becomes aware of the existence of a Red Flag, appropriate responses must be in place to mitigate the potential for theft. This extends beyond the requirements of HIPAA.

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Responses include, but are not limited to, additional questioning and verification of both internal and external sources and notification of the findings to the appropriate parties involved. Closing the account and opening a new one, halting collection efforts, and notifying law enforcement are also appropriate responses. Findings from these experiences must then be incorporated into the written program, as it is periodically reviewed, updated, and approved.

A practice's written program should clearly define the types of accounts offered, how the accounts are opened (including what information is needed), and who has access to the accounts. Any previous experience with identity theft needs to be documented.

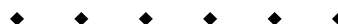
An analysis should be performed to determine where and how the protected information exchange is taking place and identifying areas that may be vulnerable to identity theft. Methods of identifying Red Flags (like the ones previously listed) need to be described in addition to the responses that would occur should a Red Flag be detected.

The written program must be approved by the Board or Owner(s), whichever is applicable. The program must be updated periodically to reflect changes in the risks associated with identity theft. Any changes in service provider arrangements (i.e. billing company, credit card vendor, shredding company, etc.) must also be documented. A designated oversight officer should be named (similar to a HIPAA compliance officer) and staff should be

appropriately trained. All training should be documented.

In reviewing arrangements with service providers, it is important to make certain to include in any contract you have with them the requirement that they have policies and procedures in place to detect, mitigate, and prevent identity theft. They should also notify you should they discover any Red Flags related to a covered account. Make sure an oversight function is in place to address continued compliance from service providers.

Refer to www.ftc.gov/os/fedreg/2007/november/071109redflags.pdf (pages 63773-63774) for a full description of the guidelines.



STIMULUS FUNDING TO SUPPORT EMR

The American Recovery and Reinvestment Act, commonly called the Stimulus Package, included \$17 Billion in incentives for physician practices and hospitals that adopt electronic healthcare records (EHR). Practices that implement a full featured EHR, and ARE USING the EHR in a meaningful way can receive up to \$44,000 per doctor for Medicare/Medicaid participants. The incentive will be paid over a five year period AFTER you have met the utilization and implementation requirements. Unfortunately, this is not an open ended offer. You have to complete the implementation of an EHR by the end of 2014 to receive any money. If you want to receive the full amount, you must implement the EHR by 2012. You can start receiving money in 2011 for EHRs in place by the end of 2010.

How long can you wait?

The key problem for your practice is that the implementation of your EHR achieving "meaningful" use is a process that may take some time. For example:

- ◆ Choosing an EHR product typically takes 4 to 6 months. How

ever, some practices may take much longer.

- ◆ In many cases practices will have to replace old legacy practice management systems that are too old to interface or support an EHR. Mid-size practices that have to replace a practice management system are looking at a four to six month period to implement a PMS followed by a period for the billing process to stabilize before undertaking an EHR implementation.
- ◆ An EHR implementation may take 5 to 8 months, but unlike a PMS, an EHR implementation typically requires a transition period before your practice is using the EHR in a meaningful way. A key factor is that the move from the paper record to an EHR could necessitate a complete makeover of every aspect of your clinical operation. From the way you schedule appointments to triage, and from the start of a patient visit to recording the treatment plan, every process and activity will have to be adjusted to account for the use of the EHR. These changes must be made while your office is still operating and therefore have to be deployed at a pace that will not disrupt operations and this will take some time. Larger practices with several offices will

need additional time to roll out the EHR to the various doctors and locations.

- ◆ The actual move of a practice to an EHR also requires a transition from the historic paper chart to the EHR. The initial effort to start using the EHR for your patients will be based on your typical recall cycle which can range from four to six months for the typical primary care practice while the initial transition for specialists can take from 6 to 12 months. At the end of the transition period, the practice should be fully utilizing the EHR for all of the patients in the practice.

Based on these estimates, many practices are looking at a two year timeline to fully implement and transition over to the EHR. Looking ahead at the 2010 deadline to get the first payments in 2011, and the 2012 deadline to get the maximum incentive payment, the window of opportunity is limited depending on the size of your practice and ability to make these changes in a timeframe that will work for your practice

EMR STIMULUS INCENTIVE FACTS

Your practice can start receiving EHR Stimulus funds as early as 2011, if you have an approved system installed and in use by the end of 2010. As noted in the previous article, to receive the maximum incentive, systems must be in place by 2012 and meet all government standards. Unfortunately, the standards are not complete at this time. To receive any Stimulus money you must have EHR by 2014, after that, the opportunity is passed. HHS, via the Office of the National Coordinator of Health Information Technology, must complete and announce the final government standards no later than December 31, 2009. In addition, they must announce which systems qualify and what constitutes the ability to use the records in a "meaningful" way.

Each individual provider could qualify for up to \$44,000 in stimulus funds, in total. This payout would be made over a five year period. The payout schedule is as follows:

Year 1 - up to \$18,000
Year 2 - up to \$12,000
Year 3 - up to \$ 8,000
Year 4 - up to \$ 4,000
Year 5 - up to \$ 2,000

While the program is voluntary, there also will be penalties for practices that do not comply by 2015. The penalty will take the form of reduced Medicare reimbursement for providers that are not compliant. That schedule is as follows:

2015 - 1% Reduction
2016 - 2% Reduction
2017 - 3% Reduction (The final 3% reduction will then continue each year.)

Eligible providers may qualify either under the Medicare or Medicaid program, but only under one of them. To be eligible under the Medicare program, physicians must accept Medicare patients and bill Medicare for the services provided.

To qualify under the Medicaid program, 30% of the physician's practice must be Medicaid patients, with the exception of Pediatricians, where only 20% of their practice would need to consist of Medicaid patients.

Hospital based physicians; (pathologists, anesthesiologists, Emergency Room physicians and hospitalists) will not be eligible.

OIG 2009 WORK PLAN

As in previous years, the primary focus of the OIG's 2009 Work Plan will continue to be reviews and investigations of the Medicare and Medicaid programs. Every attempt is made to detect and prevent waste, fraud, and abuse within these programs and to hold accountable those found to be in violation.

Some target areas that might be of particular interest to physicians include the following:

Place of service errors (coding for ASCs vs. hospital outpatient departments)
Number of E&M services provided during a global surgery period
Payments for colonoscopy services
Services performed by non-physician providers
Billings with the modifier GY
Medical identity theft

Additional information can be found on the OIG website at: <http://www.oig.hhs.gov/publications/workplan.asp>

NATIONAL NEWS

IVR & CSR Access Requirements

Starting April 6, 2009, you will be required to furnish your National Provider Identifier (NPI), Provider Transaction Access Number (PTAN) and the last five digits of your tax identification number (TIN) when calling the IVR (Interactive Voice Response) or when speaking to a CSR (Customer Service Representative).

For written inquiries, these three pieces of identification are also required unless the inquiry is written on letterhead that includes the provider's name and address. Keep in mind that the provider name and practice location on the letterhead must match

CMS's files exactly, including matching the information associated with the NPI, PTAN and TIN #. For details go to: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6139.pdf>

Monetary Levels For Appeals

The 2009 amount-in-controversy (AIC) level for administrative law judge appeals (ALJ) stays the same as 2008 which is \$120 to request a hearing. However, the level for Federal court appeals has increased to \$1,220 as of January 1, 2009.

Retrospective Billing Rule

CMS has changed the retroactive effective date for new providers to whichever date is later is based on the following:

- ◆ The date the enrollment application is received by CMS
- ◆ The date the physician first starts to practice at the location.

For all the details, including exceptions go to: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6310.pdf>

OTHER NEWS

DOL Opinion on Overtime

Non-exempt employees are entitled to overtime if they work more than 40 hours during a work week. A work week is set by the employer and can be different for different groups of employees. It must be 168 hours in length and cannot be changed regularly in attempts to avoid paying overtime. However, the DOL recently released an opinion that may give your practice some flexibility.

The opinion was based on a practice that had its staff working 9 hour days, Monday through Thursday, eight hour days on Friday, with every other Friday off. If the standard work week definition was followed (running from 8:00 a.m. Monday to 7:59 a.m. the following Monday), this resulted in staff working 36 hours one week, and 44 hours the second week. Each staff person would therefore receive 4 hours of overtime every other week.

What the practice did was set two work weeks, one that ran from 11:31 a.m. Friday to 11:30 a.m. the following Friday, and the second work week ran from 12:31 p.m. Friday to 12:30 p.m. the following Friday. Each work week contained a Friday shift that either started at 7:30 a.m. or 8:30 a.m. Staff was grouped into the two work weeks. The result was the Friday shift was split between two different work weeks, with 4 hours in each week. Thus, the staff only worked 40 hours every work week, and no overtime was due.

This was a win-win situation, be-

cause the practice had 9 hours of coverage daily and the staff also benefited by having 3 day weekends, every other week. You may want to consider this for your practice if applicable.

UNITED HEALTHCARE

In March 2009, UHC released a Network Bulletin. In this issue UHC addresses the process to follow if you believe your claim was processed incorrectly. It allows you to complete and submit a "Claim Reconsideration" form on-line. In addition, if you have 20 or more denied or incorrectly paid claims, you can send these claims together by completing a "Claim Research Project" on-line form and have them all researched and reviewed at one time. Also included is what UHC requires to prove timely filing for both electronic and paper claims.

Providers can also find useful information concerning:

- ◆ Reimbursement Policies
- ◆ Medical Policies
- ◆ Pharmacy Updates
- ◆ Protocol Updates
- ◆ E-Business updates

To obtain a copy of the bulletin go to the link below, click on Tools & Resources, and go to News.

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The key issue is to ensure that you leave your practice enough time to pick the right product, and ensure that you are using the EHR in a meaningful way which requires supporting electronic exchanges with other healthcare organizations, electronic prescriptions and reporting through your EHR throughout the five year incentive period. Meeting this standard to qualify for the continuing payments will require a level of commitment and sophistication that will take the average practice more than a few months to master.



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