

Akamai Practice Management



NEWSLETTER

Summer 2010

Government Actions: What You Need to Know



What the heck is the government doing to us now?

In recent months there have been a number of federal pronouncements that will ultimately alter the way Hawaii's medical practices must function. With all the other demands of running an office, how is anyone supposed to keep track of what's coming down the road?

Well Akamai is here to the rescue with this summer newsletter

providing brief synopses of upcoming rules and regulations that every practice in Hawaii needs to be aware of.

EMR regulations? Meaningful Use? Red Flag rules? Medicare reimbursement changes? ICD-10?

See inside for quick updates.

Federal EMR Initiatives: Fact versus Fiction

For better or for worse, the federal government is convinced that increased EMR use will improve the quality and decrease the cost of our nation's healthcare. Although some may debate the validity of this opinion, the fact remains that considerable legislation has already been enacted related to EMR use and this will likely impact your practice.

There is a lot of misconception about what has actually transpired. Let's try to separate some of the facts from fiction.

Mandated EMR Use: First off, there is nothing in any legislation that would force Hawaii's physicians to use an electronic medical record. There are many very good reasons to use EMRs and we think that most physician practices will eventually adopt one. However, there is no legislative mandate that would require an individual office to undertake this change if it is unwanted.

What the feds have done is adopt a "carrot and stick" approach to encouraging more rapid EMR adoption.

Generous Incentives: On the "carrot-side" special funding is

potentially available to practices that appropriately use an EMR (see Stimulus Funding on page two). There is also funding for "Regional Extension Centers" to assist physicians in choosing appropriate EMR technology as well as encouraging the creation of Healthcare Information Exchanges (HIEs). HIEs are meant to provide a way for different provider organizations to share information about patients.

On the "stick-side" the government has said that if a practice isn't using appropriate EMR technology by 2015, Medicare reimbursements will be reduced by 1% with an additional 2% reduction by 2017.

So how juicy a carrot and how big a stick are we talking about? Well it sounds significant; a max incentive of \$44,000 for most practices and the specter of those reduced reimbursements.

However, if you allow for the fact that incentives are spread over five years, it really means less than \$170 per week. If the promise of increased productivity doesn't come to pass and the doctor ends up seeing as little as

one and a half fewer patients per week, the practice could be losing more in income than they would be receiving through the incentives.

Punative Reimbursement Reductions: And the reduced reimbursements? Well many insiders don't believe that Congress will actually penalize physicians, many of whom may be unable to qualify under the proposed strict qualification criteria (see Meaningful Use on page two).

Keep in mind that if reimbursement rates are reduced, it's only for Medicare patients. Even in a practice bringing in a million dollars a year with 25% Medicare patients, each 1% of reimbursement reduction means income loss of less than \$50 per week.

In Short: We think EMRs have tremendous potential to benefit offices and healthcare in general. However, for a given office, the overall cost of implementation dwarfs any federal funding. A practice's EMR decision should be driven by their individual needs and not short-term, unclear incentives.

Highlights

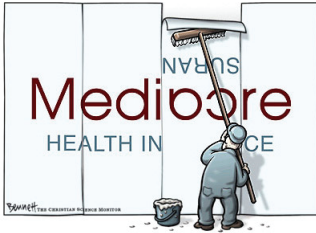
- DESPITE ALL THE HOOPLA, EMR INCENTIVE RULES HAVE NOT BEEN FINALIZED
- CONGRESS CONTINUES TO WAFFLE ON PHYSICIAN REIMBURSEMENT REFORM
- ARE THE FEDERAL EMR INCENTIVES SIGNIFICANT FOR MOST PRACTICES?
- AKAMAI PM EMERGES AS MOST HIGHLY DESIRED PRACTICE MANAGEMENT SYSTEM IN HAWAII

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Akamai Practice Management

What's with those Medicare Fee Schedule Changes?



In 1998 Congress devised a formula which determined how much money would be paid to physicians each year under the Medicare program. Based on expected utilization, this formula is then used to determine the reimbursement level for each CPT code.

Almost immediately it was obvious that the formula was unworkable. But rather than modify bad legislation, Congress has elected to take the politically expedient

option of passing annual overrides to the legislation. Unfortunately, the problem gets bigger each year.

As we all have heard, if Congress took no action this year, the formula would have resulted in a 21% decrease in physician reimbursements.

So, three times in the last seven months, Congress has put a last minute band-aid on the problem. The latest bandage was applied about in mid-June (which grate-

fully includes a 2.2% increase). However, it only is applicable through November 30th.

What this means is that unless Congress addresses the overall problem, we must hope for yet another short-term solution in the fall. The alternative? If Congress fails to act, reimbursements will decline by 23% in December and further drop to 30% in January.

Congress definitely needs to address the big problem. But we aren't holding our breath.

ICD-10 and 5010

In October 2013, the US will be joining much of the rest of the world in the use of version 10 of the International Classification of Diseases (ICD-10). The current system simply doesn't have the capacity to accommodate the changes in medicine that have occurred in the more than thirty years since ICD-9 was adopted.

ICD-10 is a complete re-write of the classification system and it will radically change how every diagnosis is reported. It is far more specific (about 68,000 codes instead of version ICD-9's 14,000). This is going to have a profound impact on both provider offices (who will need to learn to re-code) and payers (who need to completely revamp their reimbursement systems). The good news is that this change is still over three years away and there is time to learn more and plan for

its implementation.

In order to be prepared for the 2013 ICD-10 deadline, all of the claim forms and electronic claim formats need to be revised. Therefore, there is a new set of electronic transactions (claims, remittances, eligibility, etc.), labeled version "5010". These become the required format for all HIPAA covered transactions on January 1, 2012. This deadline provides 21 months to get all the wrinkles out of these 5010 transactions before the ICD-10 mandate takes place in the following year.

Many older billing systems will not be made 5010 compliant and if you are in doubt about the status of yours, it's paramount that you contact your vendor. Keep in mind that after the drop-dead date of 12/31/2011,

electronic claims in the present format will not be accepted by payers. So, for example, a practice who is banned from submitting paper claims to Medicare would be unable to submit claims to this payer starting 1/1/2012 unless their billing system was capable of supporting 5010.

Akamai is recommending that no charges be entered after July 1, 2011 into billing systems that will not be made 5010 compliant. This lead time will provide the practice ample opportunity to follow-up, file secondary claims and generally clear-out balances on the old system before the end of the year.

We are working closely with HMSA and are scheduled for early verification of our 5010 compliance late in 2010, more than a full year ahead of time.

FOR MANY PRACTICES, THE FIRST DEADLINE WILL BE JANUARY 1, 2012 WHEN THEIR CURRENT BILLING SYSTEMS CEASE TO WORK



Red Flag Rules were initially targeted at financial institutions to reduce the risk of identity theft

Red Flag Rules

The federal government's notorious "Red Flag" rules are a series of regulations intended to reduce identity theft. They were designed for financial institutions. Unfortunately, through some quirk of bureaucratic excess, it was decided that it should apply to physician offices as well. Although

well meaning, if enforced, they would require offices to adopt written policies, appoint personnel to be in charge of the program and be subject to audit for compliance.

The good news? Three times now, Congress has delayed the implementation date (of course always

at the very last minute) and the general consensus is that they will move by fall to amend the law to clarify that physician offices are not the intended target.

We are betting that this legislation never sees the light of day in your office.

Stimulus Funding – Payment Amounts and Qualification

There has been a lot of attention given to the funding that is going to be available for EMR use. Here are some key facts for every Hawaii practice to know.

First and most importantly, as of early July, the regulations regarding which physicians will be eligible, what they will need to do to qualify and what each EMR system must be capable of, have not been finalized. Preliminary regulations have been circulated for public comment, but to date, final rules have not been issued.

This is far from a trivial point. Generally comments from physician organizations on the proposed rules were highly critical. Common complaints were that the rules disqualified too many doctors, that the qualifying requirements were unduly burdensome

and that deadlines for achieving certain required benchmarks were unreasonably optimistic.

What we do know is that funding will come from either Medicare or Medicaid and will be paid out over a number of years (five to six depending on the funding agency). If you see few Medicare or Medicaid patients, don't count on getting a windfall. Medicare funding is generally limited to \$44,000 and Medicaid funding to \$63,750. In both cases there are limitations based on how much you are already being reimbursed by these agencies. In the case of Medicaid a minimum percentage of your patients (30% has been proposed, 20% for pediatricians) must be covered through that program.

To qualify, you will need to use a

“certified” EMR product in a “meaningful” way. It is virtually certain that the requirements for both the product and how it is used will escalate in two additional “stages” in subsequent years and each physician will have to escalate their utilization in order to continue to qualify.

In the case of both Medicare and Medicaid funding, qualifying in either 2011 (the earliest possible time frame) or 2012 can result in the same overall incentive funding. In the case of Medicare, maximum funding is reduced by \$5,000 should a practice elect to wait until 2013. In the case of Medicaid, full incentives are still available for practices waiting until 2013 to qualify.

ALTHOUGH FINAL RULES HAVE YET TO BE FINALIZED, SOME KEY ASPECTS OF THE STIMULUS FUNDING ARE KNOWN.

Meaningful Use - The Key Phrase

The term “meaningful use” has been at the epicenter of EMR discussions for nearly a year. Although the medical community is eagerly waiting for a final definition of what this actually means, it's important to know what has been proposed and where things are likely to go.

To begin with, “Meaningful Use” refers to how a provider must utilize a qualified EMR product in order to receive funding under the Federal stimulus program. Please remember that the meaningful use rules are in addition to other regulations which define which types of providers may qualify and how results need to be reported.

In the initial proposal by the Department of Health & Human Services, a provider must meet and report on twenty five criteria to achieve meaningful use for the first stage of compliance. As indicated earlier in this newsletter,

there are two later stages and each will have increasingly rigorous requirements.

A near universal criticism is that as the regulations now stand, all twenty five criteria must be met to receive any funding in a given year.

This means that a practice can spend a protracted period of time gathering information, reporting to the government, applying for funding, only to have reimbursement denied because one of the relatively arcane requirements was deemed insufficient.

Many medical groups such as AMA and MGMA have lobbied for a change to this “all or nothing” approach. Instead, they suggest that partial funding for meeting less than all twenty five criteria would provide greater incentive for providers to participate.

Another criticism is that many criteria may be nearly impossible for many segments of the medical community to achieve. Obviously, restricting which physicians even have the potential for achieving meaningful use will again work against the goal of wide-scale EMR adoption.

Akamai believes that even users of “certified” EMR software should take the time to evaluate whether they have a reasonable chance of meeting the final meaningful use requirements and the effort it will take to achieve compliance.

Final meaningful use regulations are predicted to be released within the next few weeks. We strongly encourage interested parties to monitor the official CMS website:

www.cms.gov/EHRIncentivePrograms/

IN THE PROPOSED LEGISLATION, ALL TWENTY FIVE MEANINGFUL USE MEASURES MUST BE ACHIEVED TO RECEIVE ANY FUNDING. MANY OBSERVERS FEEL THIS WILL BE UNATTAINABLE FOR MANY PROVIDERS.

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Akamai PM A New Vision for Physician Software in Hawaii



We are proud of the fact that Akamai PM has been the best selling practice management system in Hawaii for the last four years. There are a variety of reasons for this success. They include:

Cost: Akamai PM is cost effective to use and our hosted or “over-the-Internet” option minimizes up front expenses. All costs are clearly stated and easy to understand.

EMR Diversity: Akamai PM works with a wide variety of EMR systems. This allows practices to select the EMR that is the best fit and still have the benefit of the finest practice management system

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