Advisory Panel Aims to Ease EHR Requirements

BY JOYCE FRIEDEN

WASHINGTON — A Health and Human Services Department advisory committee is moving to make it easier for physicians to meet federal requirements for adopting electronic health records.

The Health IT Policy Committee has recommended that providers who adopt EHRs after 2011 or 2012—the first years that federal stimulus money for adoption will be available—have to meet only 2011/2012 requirements for "meaningful use" of EHRs in their first year of adoption. They will then need to meet additional requirements each year in order to continue getting the money, although they will receive less than they would have if they had adopted EHRs earlier.

"A rising tide floats all boats, but if you're not in the water, it just doesn't help," said Dr. Paul Tang, cochair of the committee's meaningful use working group. "So we're just trying to find a way to get people to deal with it, even if it's a little bit late."

Under the Recovery Act (formally known as the American Recovery and Reinvestment Act of 2009), $19 billion in stimulus money has been set aside to encourage adoption of health information technology, including EHRs. The money includes up to $44,000 in financial incentives for each physician who purchases a certified EHR system and who makes "meaningful use" of it.

To put the law into effect, the government has to define "meaningful use" and set standards for system certification and health information exchange. The HIT Policy Committee, chaired by Dr. David Blumenthal, national coordinator for health information technology at HHS, will make recommendations; the actual regulations will be written by staff members at the Centers for Medicare and Medicaid Services (CMS).

The working group will try to make sure that specialists' needs are addressed when the committee finalizes its recommendations, not all of which would apply to all specialties.

At a recent HIT Policy Committee meeting, committee member Gayle Harrell, a former Florida state legislator, expressed concern that some of the meaningful use requirements were aimed more at primary care physicians and would not be appropriate for specialists. Dr. Tang agreed that the working group would try to make sure that specialists' needs were addressed when the recommendations were finalized, and noted that not all measures would apply to all specialties. The committee agreed to accept the meaningful use working group's recommendations.

Ms. Harrell also raised the question of whether specialists would now be liable for information presented in the EHR that falls outside of their purview. "Would an ophthalmologist have to verify whether or not I had a mammogram?" she asked.

Dr. Blumenthal said he didn't think the liability issue was within the committee's scope. "I think we have to stay focused on what we think appropriate good care should be, and we can't sort out the medical liability system here."

The standards and certification subcommittee also presented the following five recommendations to the committee:

- ► Focus certification on meaningful use.
- ► Leverage the certification process to improve progress on security, privacy, and interoperability.
- ► Improve the objectivity and transparency of the certification process.
- ► Expand certification to include a range of software sources, such as open-source and self-developed systems.
- ► Develop a short-term transition plan for certification.

Dr. Neil Calman, a family physician and CEO of the Institute for Family Health in New York, said he was concerned that the last recommendation would send the wrong message to providers who were already certified by the Certification Commission for Health Information Technology (CCHIT), currently the government's only approved certifying body. "It basically makes it sound like CCHIT is temporary," he said.

But working group cochair Paul Egerman said that was not the message the group meant to convey. "That was not at all what was intended," he replied. "I would be very surprised if … CCHIT wasn't equally involved with this [process] going forward. Basically, they're the ones that know how to do it."

The committee agreed to adopt the working group's main recommendations but to let working group members rework some of the specifics. ■

CMS Reminds Physicians of HIPAA 5010 Format Deadline

BY MARY ELLEN SCHNEIDER

Physicians have a little more than 2 years to complete their transition to new HIPAA X12 standards for submitting administrative transactions electronically, according to Medicare officials.

As of Jan. 1, 2012, physicians and all other entities covered under HIPAA (Health Insurance Portability and Accountability Act) will be required to use the HIPAA X12 version 5010 format when submitting claims, receiving remittances, and sending claim status or eligibility inquiries electronically. The new standard replaces the version 4010A1 currently in use. The change will affect dealings not only with Medicare, but also with all private payers.

The Medicare fee-for-service program will begin its own system testing next year and will begin accepting administrative transactions using the 5010 version as of Jan. 1, 2011. Throughout 2011, the Centers for Medicare and Medicaid Services will accept both the 5010 and 4010A1 versions. However, beginning on Jan. 1, 2012, only transactions submitted using the 5010 version will be accepted.

During a recent conference call to update providers, officials at the Centers for Medicare and Medicaid Services urged physicians not to wait until the last minute to make the transition to the new format.

"There's no room to delay. We cannot possibly convert all of the Medicare trading partners at the 11th hour," said Christine Stahlecker, director of the Division of Medicare Billing Procedures in the CMS Office of Information Services.

The switch is necessary, according to the CMS, because the 4010A1 version is outdated. For example, the industry currently relies heavily on companion guides to implement the standards, which limits their value. The new version includes some new functions aimed at improving claims processing, such as resolving ambiguities in the situational rules and providing more consistency across transactions.

But Medicare officials urged physicians to analyze the new version carefully prior to implementation. Billing software will need to be updated, and business processes may need to be changed as well. "There are real changes in these formats," Ms. Stahlecker said.

A comparison of the current and new formats can be viewed online at www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp.

Another reason that physicians should pay attention to the 5010 transition is that it paves the way for the move from the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) code sets now used to the significantly expanded ICD-10 code sets on Oct. 1, 2013.

Ms. Stahlecker advised physicians to contact their system vendors as soon as possible to find out if their licensing agreement includes regulatory updates and to get the vendor's timeline for upgrading its systems. ■