'Red Flags' Rule Delayed Through End of 2010

Physicians contend they're not creditors, and they already safeguard information through HIPAA.

BY MARY ELLEN SCHNEIDER

The Federal Trade Commission has again postponed enforcement of the "Red Flags" rule, giving physicians until the end of 2010 before they must implement identity-theft prevention programs in their practices.

Enforcement of the rule had been scheduled to begin on June 1.

In a statement issued on May 28, the FTC said it was delaying enforcement to give Congress time to consider pending legislation that would exclude some small physician practices and small businesses from the rule.

Last year, the House passed a bill (H.R. 3763) that would have exempted physician practices that have 20 or fewer employees from having to comply with the Red Flags rule, but that legislation has failed to gain traction in the Senate.

FTC officials urged lawmakers to act quickly to clarify what groups should be covered by the regulation. "As an agency we're charged with enforcing the law, and endless extensions delay enforcement," FTC chairman Jon Leibowitz said in a statement.

The Red Flags rule was written to implement provisions of the Fair and Accurate Credit Transactions Act, which calls on creditors and financial institutions to address the risk of identity theft.

The rule requires creditors to develop formal identity-theft prevention programs that would allow an organization to identify, detect, and respond to any suspicious practices, or "red flags," that could indicate identity theft.

The rule became effective on Jan. 1, 2008, with an original enforcement deadline of Nov. 1, 2008.

However, the FTC has delayed enforcement of the rule several times, first to give organizations more time to get familiar with the requirements, and later to comply with requests from members of Congress.

The rule has been controversial in the medical community because many physicians believe their practices don't fit into the definition of a "creditor."

However, the FTC has continued to insist that physicians are in fact "creditors" because they allow their patients to defer payments over time.

The agency also has tried to assure physicians that the requirements should not be a burden and that small practices can come into compliance by implementing simple steps. For example, in low-risk settings, practice staff can ask patients for photo identification when they come in for an appointment.

The American Medical Association and other physician groups have been lobbying to get physicians excluded completely from the requirements. On May 21, the AMA joined the American Osteopathic Association and the Medical Society of the District Columbia in a federal lawsuit that seeks to prevent the FTC from applying the Red Flags rule to physicians.

The groups contend that not only are physicians not creditors, but that the rules would be burdensome and duplicate requirements already in place under the Health Insurance Portability and Accountability Act.

"Physicians are already ethically and legally responsible for ensuring the confidentiality and security of patients' medical information," said Dr. Peter E. Lavine, president of the Medical Society of the District of Columbia, said in a statement. "It is unnecessary to add to the existing web of federal security regulations physicians must follow." ■

Incentives Available for Early Adopters of E-Prescribing

BY SHERRY BOSCHERT

FROM THE ANNUAL MEETING OF THE AMERICAN MEDICAL DIRECTORS ASSOCIATION

LONG BEACH, CALIF. — The inability to prescribe controlled substances electronically is slowing the adoption of electronic prescribing, but financial incentives could make it worthwhile for physicians who see patients covered by Medicare to start "e-prescribing" now if they can, a consultant said.

In 2009, the Centers for Medicare and Medicaid Services began offering to Medicare physicians, nurse practitioners, and physician assistants a 2% bonus in payments for participation in its electronic prescribing incentives program for 2009-2010. The bonus for early adopters of e-prescribing will drop to 1% in 2011-2012 and to 0.5% in 2013, Rachelle F. Spiro said.

The early e-prescriber incentives were extended to long-term care settings this year. The incentives are not yet available for non-Medicare e-prescribers.

"Here's the hard part," she added: Physicians who do not successfully adopt e-prescribing by 2012 will see a 1% reduction in Medicare payments for that year, a 1.5% drop for 2013, and a 2% reduction for 2014 and each subsequent year. The Department of Health and Human Services may exempt physicians with hardships, but on a case-by-case basis only.

The Drug Enforcement Agency (DEA) does not allow controlled substances to be electronically prescribed, however, which "has hindered the adoption of electronic prescribing," said Ms. Spiro, a pharmacist and consultant based in Las Vegas.

"We've been told that CMS will be working with the DEA to put out final rules for electronic prescribing" of controlled substances, she said.

Only a few days after she spoke, the agency published a proposed rule to that effect.

A pilot program for e-prescribing of controlled substances was conducted in Massachusetts, but not in long-term care settings.

To promote participation, CMS will reduce Medicare payments to MDs not successfully e-prescribing by 2012 by 1% that year, by 1.5% in 2013, and by 2% in 2014 and each subsequent year.

Physicians do not need to preregister for the CMS e-prescribing incentive program and do not need to participate in the Physician Quality Reporting Initiative to participate, Ms. Spiro said.

Instructions and examples of how to submit claims under the e-prescribing incentive program are available on the CMS Web site at www.cms.hhs.gov/ERxIncentive. Assistance also is available through the CMS QualityNet help desk at qnetsupport@sdps.org or 866-288-8912.

Physicians can use their facility's electronic health records (EHR) system to send a prescription and to document it in the medical record, then bill for the incentive in much the same way they already handle billing.

Or physicians can turn to certified practice management systems that have an e-prescribing component, or to standalone e-prescribing systems if they come from an entity on the CMS list of qualified EHR vendors, she advised.

She warned that prescriptions from these two types of systems generally go directly to the pharmacy and not necessarily to the nursing home, "so you're going to have to work out some other mechanism to get that communication to the facility."

To file claims in the e-prescribing incentives program, report the e-prescribing numerator G-code G8553 to denote that at least one prescription was created during the patient encounter that was transmitted using a qualified e-prescribing system. Report the G-code on the same claim as the denominator billing code for the same beneficiary and the same date of service. Submit the e-prescribing G-code with a line-item charge of zero dollars ($0.00).

Denominator billing codes for e-prescribing include codes for services in nursing facilities (99304-99310 and 99315-99316), home visits (99341-99350), and others including domiciliary codes (99324-99328, 99334-99337, and 99346).

As of 2011, Medicare will be offering incentives for physicians in hospitals and ambulatory settings to switch all of their records to EHR, but these incentives won't be available to long-term and post–acute care settings until 2013, Ms. Spiro said.

Physicians must choose between the Medicare e-prescribing incentives and complete EHR incentives programs, and cannot participate in both (because presumably the EHR would include an e-prescribing component).

However, the same HITECH (Health Information Technology for Economic and Clinical Health) Act that established the EHR incentives included a provision for state Medicaid programs to incentivize early adoption of e-prescribing.

"Actually, those incentives are a lot better" than Medicare incentives, she said.

Physicians who work in long-term care settings and who see patients covered by Medicare and Medicaid may want to participate in both e-prescribing early-adopter programs rather than wait for the 2013 EHR incentives under Medicare.

For the long-term care setting, that's "probably a better value," said Ms. Spiro. ■

Disclosures: Ms. Spiro reported having no relevant conflicts of interest.

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