Small Practices Exempted

'Noncompliant' Claims *from page 1*

submitting noncompliant claims as of June, CMS said. However, that figure is misleading, according to Rob Tennant, senior policy advisor at the Medical Group Management Association.

"That doesn't mean [all] practices are submitting electronically; they're just getting claims to CMS electronically," he said. "Lots of times providers will utilize a clearinghouse" that takes the providers' paper claims and transfers them into an electronic format for submission.

In addition, the CMS statement mentioned only compliance rates for claim forms, Mr. Tennant noted. Compliance in other electronic transactions, such as remittances and inquiries on claims or eligibility status, is much lower, he said. "These are all very important transactions from providers, and we're hearing from health plans and others that providers aren't there yet."

Several bills in the Senate propose technology initiatives: Sen. Edward Kennedy (D-Mass.), Sen. Hillary Clinton (D-N.Y.), and Senate Majority Leader Bill Frist (R-Tenn.) have introduced legislation that would offer grants to financially needy providers to enhance their use of health IT, as well as financial assistance to establish regional health IT networks. Another bipartisan bill from Sen. Debbie Stabenow (D-Mich.) and Sen. Olympia Snowe (R-Maine) would spur the use of new information technologies to reduce paperwork costs and improve patient care.

Until that legislation is approved, however, another solution might be to tap into existing resources, said Bernard Proy, M.D., Corry, Pa. For example, federal government agencies such as the Department of Veterans Affairs already have an electronic health record in place.

"Individual physicians could tap into that system—which has already been paid for with tax dollars," he said. At press time, CMS was expected to shortly announce just such a program—a way for physicians to install a simplified version of the VA's electronic health records system at a very low cost. ■

Jennifer Silverman, associate editor for Practice Trends, contributed to this story.

Feds to Monitor EHR Gap, Promote Level Playing Field

BY ELAINE ZABLOCKI
Contributing Writer

SAN DIEGO — Government strategies for health information technology will aid physicians by lowering the cost, improving the benefits, and lowering the risks, said David J. Brailer, M.D., Ph.D., national coordinator for health information technology, in a keynote address at the annual meeting of the American Health Lawyers Association.

Information technology "is a tectonic issue for physicians, one that separates old from young, progressive from Luddite, and those who want to be part of a performance-based future from those who want to practice the way they have for years," said Dr. Brailer of the Department of Health and Human Services, Washington. "We're trying to be nonregulatory, to use a market-based approach, and that means we want to work with the willing. Surveys show that many physicians, at least half today, would do this if they could figure out how to do it."

One barrier to adoption of electronic health records (EHRs) is the variety of products on the market. Certifying a basic, minimally featured EHR system will aid physicians in making rational purchasing decisions, Dr. Brailer said.

Another barrier to adoption of EHRs is the current lack of a sound business model. A "pay-as-you-go" financial model is not feasible, and financial incentives will be needed to accelerate the transition, Dr. Brailer said, without specifying any further details.

Large physician groups and hospitals are far ahead of small physician offices in adopting EHRs. According to Jodi Goldstein Daniel, a Department of Health and Human Services senior staff attorney on health information technology issues who also spoke at the meeting, more than 50% of large practices have adopted EHRs, while only 13% of small practices have done so. Dr. Brailer's office plans to monitor the adoption gap annually, to see whether it is closing, whether certified technologies are being used, and whether rural practices and other practices with special needs require some kind of safety net. ■

Medicare's Expansion of Stroke Benefit for Hospitals Praised

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

Medicare's decision to increase payment for stroke patients who receive tissue plasminogen activator likely will result in more stroke centers, but experts are divided over whether it will mean better care for patients.

"It's a great step forward," said William Barsan, M.D., professor and chair of emergency medicine at the University of Michigan, Ann Arbor. "This has been something in the works for a long time. We identified this as an issue that needed to be addressed soon after TPA was released."

Currently, the Centers for Medicare and Medicaid Services pays hospitals the same amount—about $5,700—under its diagnosis-related group (DRG) payment system for treating a stroke patient, regardless of whether TPA is used. But under a proposed regulation issued in August, CMS would develop a new DRG called "acute ischemic stroke with use of thrombolytic agents."

Although TPA costs about $2,000 per dose, the new DRG would pay hospitals about $6,000 more for these patients. That's because patients who receive TPA generally are sicker overall than other stroke patients, and often require more intensive treatment and longer hospital stays, according to a CMS spokeswoman.

That logic is further explained in the proposed regulation. The regulation's authors wrote that when they reviewed average charges for stroke patients, "we noted that the average standardized charges for all patients in DRG 14 ['Intracranial Hemorrhage or Cerebral Infarction'] were $18,997, but that the subset of 2,085 cases in which TPA was used had average standardized charges of $35,128." As a result, "we are changing the structure of stroke DRGs not to award higher payment for a specific drug, but to recognize the need for better overall care for this group of patients."

The new DRG may inspire some hospital administrators to open stroke centers and make sure more candidates for TPA actually receive the drug.

In addition to getting TPA to more patients, this change also will save CMS money if it goes through, said Joseph Broderick, M.D., professor and chair of neurology at the University of Cincinnati.

"If you can keep patients out of rehabilitation and nursing homes because you improve things on the front end, you save Medicare and the health system money," Dr. Broderick said.

But Jerome Hoffman, M.D., professor of medicine and emergency medicine at the University of California, Los Angeles, is not so sure that giving more stroke patients TPA is a good idea. "There is not good evidence that TPA is beneficial in patients with stroke," he said.

"It probably helps a few people and hurts a few people, and the balance is really unclear."

Aside from the issue of which patients should receive TPA, the increased payment will encourage hospitals to put more money into treating stroke patients, according to Dr. Broderick. "A lot of hospitals have not seen a reason why they should put more resources into [treating] strokes when, in essence, these kinds of patients are going to cost them money."

Now that they're being paid more for these patients, "more administrators will say, 'Why don't we have a stroke center? Why don't we have more patients who are treated with TPA?' " he said. "If they are going to get paid almost twice as much money, that's an incentive to see why the system is not working, why someone isn't taking the initiative."

But new financial incentives for hospitals may have little impact on what some experts say is fundamentally a clinical obstacle.

It's not that hospitals don't want to provide patients with proper care, said Dr. Barsan, but it takes a lot of effort to make TPA treatment work efficiently, especially because there is only a 3-hour window for administration once the stroke has occurred. The 3-hour window is a big issue, Dr. Hoffman concurred. "Many people who are having a stroke wake up with symptoms, so it's hard to tell when they were last normal," he said.

"So most people are outside the 3-hour window."

A survey Dr. Barsan and colleagues performed of more than 1,100 emergency physicians found that while 60% of respondents said they were "very likely" or "likely" to use TPA in an ideal setting with an appropriate patient and access to the proper equipment and personnel, another 24% of respondents said they would be unlikely to use the drug, and 16% said they were "uncertain" about the matter (Ann. Emerg. Med. 2005;46:56-60).

Of this combined group, nearly two-thirds said they were concerned about a possible brain hemorrhage, another 23% listed lack of benefit from the drug, and 12% said they would not use it for both reasons.

Then there are the practical issues. "Ideally, you would have a 'door-to-needle' time of 60 minutes," Dr. Barsan said.

This would require first rapidly identifying the patient when he or she arrives in the emergency department, then doing an exam and determining that the patient did have a stroke, and finally sending the patient for a CT scan to make sure it is not a hemorrhagic stroke, he said.

Even in the best of circumstances, all of this takes a while, Dr. Barsan said.

That process can be made even longer if the required specialists are on call but not on site, because it can mean another 30-40 minutes to get them in, he added.

In the end, if the drug is used within strict guidelines, "I don't think it will matter all that much in terms of harm or benefit to patients," Dr. Hoffman added.

"But when you put monetary or legal incentives on people to use it, and they use it a lot more because they think they're supposed to, it could be harmful."

Dr. Broderick noted that the proposed regulation was largely the result of the combined efforts of several medical organizations, including the American Academy of Neurology, the American Stroke Association, and the National Association of EMS Physicians.

"This is a team effort of a lot of organizations who are very passionate about stroke care," he said.

"To CMS's credit, they really listened well and made an informed and well-articulated decision." ■