LEE COUNTY MEDICAL SOCIETY INC.

Bulletin

Physicians Caring for our Community

Editor: Mary C. Blue, MD

Volume 38 Issue 1

January 2014

2014 Meetings & Events

LEE COUNTY MEDICAL SOCIETY

Friday January 17, 2014

6:00 p.m. Social Time
7:00 p.m. Dinner
7:50 p.m. Program:

Installation of 2014 LCMS Officers
Annual Medical Service Awards

Lexington Country Club
16257 Willowcrest Way
Fort Myers, FL 33908

SAVE THE DATE

March 15, 2014 7:05 p.m.

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RSVP to: Lee County Medical Society
13770 Plantation Road, Ste 1
Fort Myers, FL 33912
Tel: 936-1645 • Fax: 936-0533
Email: Valerie@lcmsfl.org

Inserts:
January Meeting Notice
Science & Engineering Fair
Scleroderma Symposium

Inside This Issue:

About the Cover: Dirk Peterson, M.D., PhD
A golaith grouper and a school of grunts cruising the wreck of the Ancient Mariner, Pompano, Florida

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The Lee County Medical Society Bulletin is published monthly with the June and August editions omitted.

The editors welcome contributions from members. Opinions expressed in the Bulletin are those of the individual authors and do not necessarily reflect policies of the Society. Advertisements do not represent sponsorship or endorsement by the Lee County Medical Society nor necessarily implies the accuracy or reliability of any advertisement displayed in this publication.

PRINTERS
The Print Shop

Lee County Medical Society Mission Statement & Disclosure Policy

The purpose of the LCMS is to unite the medical profession of Lee County, FL, into one compact organization; extend medical knowledge and advance medical science; elevate the standards of medical education; strive for the enactment, preservation and enforcement of just medical and public health laws; promote friendly relations among doctors of medicine and guard and foster their legitimate interests; enlighten and alert the public, and merit its respect and confidence.

All LCMS Board of Governors and Committee meeting minutes are available for all members to review.

Membership News

New Phone/Fax Numbers

James Conrad, MD
Robert Grohowski, MD
Steven Lee, MD
Brain Taschner, MD
LPG Cardiology at Bass Road
Tel: 239-343-6410
Fax: 239-343-6411

M. Erick Burton, MD
Richard Chazal, MD
Michael Corbellini, DO
Michael Danzig, MD
Roshan Vatthyam, MD
LPG Cardiology
Tel: 239-343-6350
Fax: 239-343-6358

Resigned

Chris Marino, MD

Relocated

William Figlesthaler, MD
Janet Sperry, MD
Jay Wang, MD
Nicolas Zouain, MD

Subhash Kshetrapal, MD
LPG Cardiology at Bass Road
16261 Bass Road
Fort Myers, FL 33908
Tel: 239-343-6410
Fax: 239-343-6411

Retiring

The LCMS would like to say thank you for your dedicated service to medicine and wishes you a very happy retirement

Bijan Bakhtian, MD
Sam Edwards, MD
Alexander Lozano, MD
Richard Perkins, MD

2014 Membership Dues are due by January 1, 2014. Your membership is a valuable tool for your practice. Please call the LCMS Office if you need to make payment arrangements. We are always happy to work with you.

New Applicants

Alberto R. Figueroa, MD – Dr. Figueroa received his MD degree from Ponce School of Medicine, Ponce, Puerto Rico in 2008. He completed his internship, residency and a fellowship in Neurophysiology at the University of South Florida, Tampa, FL from 2008-2013. Dr. Figueroa was board certified by the American Board of Psychiatry and Neurology in 2012. He is in group practice with Florida Neurology Group, 12670 Whitehall Drive, Fort Myers, FL 33907 Tel: 239-936-3554.

President's Message:

by Peggy Mouracade, MD

"To Thine Ownself Be True"

"To thine ownself be true"-- recently I have heard this quote a few times in different contexts that it has just stayed in my head. It is timeless and with our current situation in medicine have I found it germane. I still believe that medicine is a noble profession.

The very essence of what we do is to care for another--whether it is to diagnosis, to cure, to provide comfort , to give guidance and/or to just give assurance. It should be just that simple but in reality it is not. Unfortunately, there is a realized potential that it will become more difficult and more convoluted as our current culture seems to be centered on regulation, conformity and documentation.

As many of you know, I am a nephrologist by training. One of my duties is to serve as a medical director for one of the larger local dialysis centers. A few years back there was a change in upper management at the corporate level which led to an influx of new ideas and thought processes. Subsequently, one of the new executives with a background in food/beverage industry felt the need to analyze and to offer his suggestions on how to improve our efficiency. My well seasoned facility administrator with over 30 years of dialysis nursing experience wisely invited him to spend a day on the floor. To his credit, he showed up at 5:30 in the morning donned in scrubs and spent the next 12 hours with our staff. At our meeting the next week, there were no further discussions on FTE/patient ratio's or bundling workflow patterns but a simple admission that "this is a different beast--you deal with people, not soda pop bottles."

"I have to go back to the drawing board--what worked in the past may not work here."

What we do requires personalization, yes there is a need for some degree of regulation, conformity and documentation but it must be patient centered. We, as physicians, must promote and protect this vision. Patients want to see their doctor, they want to have human contact and interaction. They look to us to provide advice, recommendations and plans.

Serving as your President, my goal is to help foster and promote this vision within our medical community. We have an incredible collection of physicians with broad experiences, diverse backgrounds and depths of training. I encourage you to take the time to appreciate your fellow physician both as a colleague as well as a fellow human being.

It is with great honor that I look forward to serving you as President this coming year.

Docs Disappointed by Malpractice Ruling

By The Associated Press December 13. 2013

TALLAHASSEE — The Supreme Court refused Thursday to adopt a state rule reflected in a law that creates restrictions on doctors who can testify during medical malpractice trials, agreeing it would have a chilling effect on the ability to find expert witnesses.

The law was a priority for Republican Senate President Don Gaetz and signed by Republican Gov. Rick Scott. It was designed to help doctors defend themselves in malpractice cases. Critics said it would make it more difficult for victims to seek compensation for injuries caused by doctors' mistakes.

In part, the law requires expert witnesses who are called to testify against a defendant doctor to practice the exact same kind of medicine and not just be in similar fields. It also limits judges' ability to use their discretion to qualify or disqualify expert witnesses in malpractice cases.

Like they did before about the law itself, groups representing doctors and lawyers disagreed on the court's opinion.

Jeff Scott, a lawyer for the Florida Medical Association, said the law still stands and the court's opinion was simply declining to accept the law as a procedural rule of the court. But it was not struck down as part of a legal challenge of the law.

"Their action today should have no effect. It's in statute," Scott said. "I don't think the Supreme Court do an end run on that."

Gary Farmer, the immediate past president of the Florida Justice Association, disagreed.

"What they can say and did say is this law is unconstitutional. That's exactly what they said today. The FMA needs to retain some good lawyers to read the opinion for them," Farmer said.

The Florida Bar Board of Governor's voted 34-5 to recommend the court not amend the Florida Evidence Code to reflect the new law, saying that it was unconstitutional. The court agreed.

Gaetz wouldn't comment on the opinion.

MED STATS

Medicare to Deny Payment for Orders, Referrals from Non-enrolled Physicians

If you order supplies for Medicare patients or refer them for services, make sure you are properly enrolled or opted out of Medicare. Otherwise, payment for those services or supplies will be denied starting Jan. 6.

The Centers for Medicare & Medicaid Services (CMS) announced last week that it will begin checking claims for certain imaging, clinical laboratory and home health services as well as durable medical equipment, prosthetics and orthotic supplies to ensure that the ordering or referring physician or other provider is enrolled in Medicare or has validly opted out. Part B drugs generally are excluded from the edit, as are referrals to specialists.

CMS is implementing the denial edits in fulfillment of a statutory requirement. The agency delayed the edits several times over the past few years in response to AMA advocacy, which sought clarification about how the edits would be applied. The delay also allowed adequate time for ordering and referring physicians and other providers to enroll.

Physicians who have a valid opt-out affidavit on file with CMS do not need to enroll in Medicare to fulfill the requirement.

Referring and ordering physicians who do not bill Medicare directly can use a special, shorter enrollment form known as the 855-O.

Visit http://www.elabs10.com/ct.html?ufl=3&rtr=on&s=x8pbgr,1pg18,2ke5,m8qx,8hr5,5ivg,e2vo to read more in an article from CMS.

Serve as a "Doctor of the Day" during the 2014 session

The Florida Office of Legislative Services is seeking volunteer physicians to participate in the annual Doctor of the Day program during the 2014 legislative session (March 4 to May 2, 2014). Physicians who are willing to spend a day in Tallahassee during the legislative session perform an invaluable service by providing health care for members of the Legislature and legislative employees. The program is also a vital component in improving and strengthening physician-legislator relations. The Office of Legislative Services will schedule two physicians for each day of the legislative session: one for the House of Representatives and one for the Senate. If you are interested in serving, please contact Takeshia Stokes at stokes.takeshia@leg.state.fl.us or (850) 717-0301.

Recruit three new members this year and your 2015 dues will be free of charge.

Act Now To Protect Yourself Under The Physician Payment Sunshine Act

Source: American Medical Association

By taking four easy steps now, you can make sure you're prepared when it's time to review your 2013 financial data before it's published online next year.

Under the Physician Payments Sunshine Act, drug and medical device manufacturers started tracking their financial interactions with licensed physicians beginning Aug. 1. Any payments, ownership interests and other "transfers of value" will be reported to the Centers for Medicare & Medicaid Services (CMS) for publication in an online database to be launched in the fall of 2014.

Here are four easy steps you can take now to support the accuracy of this data:

1. Make sure your disclosures are up to date. Financial and conflict-of-interest disclosures required by employers, advisory bodies and entities funding research should be updated regularly so it is consistent with the data that eventually will be publicly reported under the Sunshine Act.

2. Confirm that your National Provider Identifier (NPI) information is current. The information tied to your NPI, including your specialty, must be accurate to help ensure appropriate attribution of payments and other transfers of value that will be listed in CMS's online database.

3. Request ongoing notification from your industry contacts about the data they report to CMS. Ask your representatives at the manufacturers and group purchasing organizations with which you interact to give you an opportunity to review and correct information they intend to submit before they transmit it to CMS. 2013 data is due March 31.

4. Track your payments and financial transfers. Download a free smartphone app to track reportable transfers. Compatible with Apple® and Android platforms, "Open Payments Mobile for Physicians" is available through the Apple Store and Google Play® Store. A number of security features protect the privacy of the data you capture, which will be stored on one device and cannot be backed up to a cloud or other devices. Also urge your industry contacts to use the app so you will be able to capture the information you need to ensure accurate reporting.

The AMA was instrumental in securing a number of reporting exclusions in the law, such as certified and accredited continuing medical education activities funded by manufacturers and product samples intended for patient use. Other improvements made based on the AMA's recommendations include allowing physicians to review their data and seek corrections before it is published, giving physicians an additional two years to pursue corrections and excluding medical residents from the rule.

Visit the AMA Sunshine Act physician toolkit to learn more about the law's timeline, the kinds of financial interactions that must be reported and the process to challenge false, inaccurate or misleading reports. Also watch an archived webinar for additional details.

www.ama-assn.org/go/sunshine

LCMS Mentoring Program Connects Physicians with Fellow Professionals

Left to right, Thomas Jacob, MD Psychiatry & Craig R. Sweet, MD, Specialists in Reproductive Medicine

Lee County Medical Society's mentoring program is a useful tool in assisting new physicians coming to our community by providing an LCMS member in a mentoring role. This will help the new physician acclimate to the community with a fellow professional that is not associated with their specialty practice. A secondary benefit will be to the mentoring physician in establishing new relationships, and to the LCMS for enhancing the benefits of membership.

Dr. Craig R. Sweet, LCMS mentoring physician and new member Dr. Thomas Jacob recently met for lunch and Dr. Sweet discussed what the LCMS is doing for you and offering Dr. Jacob tips to help him become acclimated to the area and to his new medical association.

Report from the AMA Interim Meeting 2013

For details of the Business of the house please visit:
mailto:http://www.ama-assn.org/ams/pub/meeting/reports-resolutions-listing.shtml

There were 109 resolutions and reports discussed at this meeting. Many of these were reaffirmed as policy and many were adopted as amended. Overall, the actions taken by the HOD were more aligned with physician advocacy than in previous meetings. The delegation worked hard reviewing all of the resolutions. In conjunction with FMA staff, each resolution was compared to FMA policy.

The FMA Delegation submitted the following resolutions:
New Rules For Emergency Room Care. This resolution was discussed with numerous states and specialties. It became clear to the delegation that there was inadequate information contained in this resolution and the intent was also unclear as most Emergency physicians have been working on ED Throughput issues for years. In fact, these regulations are supported by the American College of Emergency Physicians. It also became clear that hospitals more than physicians have issues with this particular Medicare policy. It was felt by the delegation that bringing this back to the FMA for clarification and discussion would be the best next step for this topic.

Support Fee For Service As The Most Appropriate Way to Reimburse Physicians. The AMA has clear policy in support of this resolution and it was placed on the reaffirmation consent calendar.

Suspend HCAHPS Rating System. ADOPTED.

Late Resolution submitted by the delegation on SGR repeal. This resolution went through the OMSS where it was slightly modified and sent to the HOD. It was later converted to the following resolution on the SGR as noted below and adopted unanimously.

The most important issue was regarding repeal of the Sustainable Growth Rate. This resolution was originally authored by the Florida Medical Associate delegation and was eventually submitted through another channel. Once in reference committee, the FMA delegation spearheaded organizing many groups to work together to find common ground. It was then presented to the reference committee and passed virtually unanimously. It did the same on the floor of the House of Delegates. It states that the AMA will show integrity and stand on our principles that have been developed by the House of Delegates over the past decade and that as alternative payment models emerge will continue to advocate for private contracting. The reality is that the AMA is one of many voices that Congress hears. Ultimately, the decision is up to Congress with input from many groups.

Thank you to our Sponsors & Speakers of the November General Membership Meeting held November 21, 2013 at the FineMark National Bank & Trust Conference Room

Joseph Rugg, Akerman LLP
Karen Mostellar, Markhan, Norton, Mosteller, Wright, & Company, P.A.
Peter Montalbano CFP, Capital Guardian Wealth Management.

Additional topics reviewed: (for details see link at the top of this report)
Payment Mechanisms for Team Based Care.
The Corporate Practice of Medicine.
Physicians Satisfaction.
Health Insurance Exchange and 90 Day Grace Period (Page 16/27 in Reference Committee J). This should be reviewed by those interested in learning more about health insurance exchange information.

Health Insurance Carriers Canceling Coverage for Hundreds of Thousands of Patients Across the Country. It stated that the AMA support urgent efforts to maintain coverage while facilitating a smooth transition to alternative coverage options which offer meaningful coverage as defined by AMA policy for individuals who have received cancellation notices from their health insurance companies as a result of the Affordable Care Act.

How Government Killed the Medical Profession

As health care gets more bureaucratic, will doctors go Galt?

Author: **Jeffrey A. Singer** from the **May 2013** issue

Submitted by: Brian Kelley

I am a general surgeon with more than three decades in private clinical practice. And I am fed up. Since the late 1970s, I have witnessed remarkable technological revolutions in medicine, from CT scans to robot-assisted surgery. But I have also watched as medicine slowly evolved into the domain of technicians, bookkeepers, and clerks.

Government interventions over the past four decades have yielded a cascade of perverse incentives, bureaucratic diktats, and economic pressures that together are forcing doctors to sacrifice their independent professional medical judgment, and their integrity. The consequence is clear: Many doctors from my generation are exiting the field. Others are seeing their private practices threatened with bankruptcy, or are giving up their autonomy for the life of a shift-working hospital employee. Governments and hospital administrators hold all the power, while doctors—and worse still, patients—hold none.

The Coding Revolution

At first, the decay was subtle. In the 1980s, Medicare imposed price controls upon physicians who treated anyone over 65. Any provider wishing to get compensated was required to use International Statistical Classification of Diseases (ICD) and Current Procedural Terminology (CPT) codes to describe the service when submitting a bill. The designers of these systems believed that standardized classifications would lead to more accurate adjudication of Medicare claims.

What it actually did was force doctors to wedge their patients and their services into predetermined, ill-fitting categories. This approach resembled the command-and-control models used in the Soviet bloc and the People's Republic of China, models that were already failing spectacularly by the end of the 1980s.

Before long, these codes were attached to a fee schedule based upon the amount of time a medical professional had to devote to each patient, a concept perilously close to another Marxist relic: the labor theory of value. Named the Resource-Based Relative Value System (RBRVS), each procedure code was assigned a specific value, by a panel of experts, based supposedly upon the amount of time and labor it required. It didn't matter if an operation was being performed by a renowned surgical expert—perhaps the inventor of the procedure—or by a doctor just out of residency doing the operation for the first time. They both got paid the same.

Hospitals' reimbursements for their Medicare-patient treatments were based on another coding system: the Diagnosis Related Group (DRG). Each diagnostic code is assigned a specific monetary value, and the hospital is paid based on one or a combination of diagnostic codes used to describe the reason for a patient's hospitalization. If, say, the diagnosis is pneumonia, then the hospital is given a flat amount for that diagnosis, regardless of the amount of equipment, staffing, and days used to treat a particular patient.

As a result, the hospital is incentivized to attach as many adjunct diagnostic codes as possible to try to increase the Medicare payday. It is common for hospital coders to contact the attending physicians and try to coax them into adding a few more diagnoses into the hospital record.

Medicare has used these two price-setting systems (RBRVS for doctors, DRG for hospitals) to maintain its price control system for more than 20 years. Doctors and their advocacy associations cooperated, trading their professional latitude for the lure of maintaining monopoly control of the ICD and CPT codes that determine their payday. The goal of setting their own prices has proved elusive, though—every year the industry's biggest trade group, the American Medical Association, squabbles with various medical specialty associations and the Centers for Medicare and Medicaid Services (CMS) over fees.

As goes Medicare, so goes the private insurance industry. Insurers, starting in the late 1980s, began the practice of using the Medicare fee schedule to serve as the basis for negotiation of compensation with the doctors and hospitals on their preferred provider lists. An insurance company might offer a hospital 130 percent of Medicare's reimbursement for a specific procedure code, for instance.

The coding system was supposed to improve the accuracy of adjudicating claims submitted by doctors and hospitals to Medicare, and later to non-Medicare insurance companies. Instead, it gave doctors and hospitals an incentive to find ways of describing procedures and services with the cluster of codes that would yield the biggest payment. Sometimes this required the assistance of consulting firms. A cottage industry of fee-maximizing advisors and seminars bloomed.

I recall more than one occasion when I discovered at such a seminar that I was "undercoding" for procedures I routinely perform; a small tweak meant a bigger check for me. That fact encouraged me to keep one eye on the codes at all times, leaving less attention for my patients. Today, most doctors in private practice employ coding specialists, a relatively new occupation, to oversee their billing departments.

Another goal of the coding system was to provide Medicare, regulatory agencies, research organizations, and insurance companies with a standardized method of collecting epidemiological data—the information medical professionals use to track ailments across different regions and populations. However, the developers of the coding system did not anticipate the unintended consequence of linking the laudable goal of epidemiologic data mining with a system of financial reward.

This coding system leads inevitably to distortions in epidemiological data. Because doctors are required to come up with a diagnostic code on each bill submitted in order to get paid, they pick the code that comes closest to describing the patient's problem while yielding maximum remuneration. The same process plays out when it comes to submitting procedure codes on bills. As a result, the accuracy of the data collected since the advent of compensation coding is suspect.

Command and Control

To view the article in its entirety, please visit:
http://reason.com/archives/2013/04/22/how-government-killed-the-medical-profes

Lee County VA Healthcare Center in Cape Coral Marks 1-Year Anniversary on December 17

Facility sees patient growth and expansion of services

BAY PINES, FL – The Lee County VA Healthcare Center located in Cape Coral, Fla. will mark its first full year of activation on December 17. Operated by the Bay Pines VA Healthcare System (VAHCS), the 220,000 square foot center officially opened to Veterans on Dec. 17, 2012 following a ribbon cutting, or grand opening ceremony, held on Dec. 7 the same year. The facility replaced the VA outpatient clinic previously located in Fort Myers

"The Lee County VA Healthcare Center has had a tremendous first year of activation," said Suzanne M. Klinker, Director, Bay Pines VAHCS. "The new center has greatly expanded our ability to provide primary and specialty health care services to the men and women we have the privilege to serve in southwest Florida."

Since activation, the large multi-specialty outpatient facility has treated about 35,000 Veterans and completed nearly 255,000 medical appointments – a five percent workload increase from 2012. In addition, more than 1,300 new patients have enrolled for care at the facility.

Throughout 2013, the facility expanded and added new services to include magnetic resonance imaging (MRI) and computed tomography (CT); physical therapy and occupational therapy; and expanded outpatient surgery services in ophthalmology, podiatry, and urology. Future surgical program expansions, as well expansions in dentistry, urgent care and women's health are expected in 2014.

The center continues to hire new employees as services expand. Currently, the facility employs about 480 clinical and administrative professionals. Individuals interested employment at the facility can view open positions and apply online at www.usajobs.gov.

To learn more about the Bay Pines VA Healthcare System and the Lee County VA Healthcare Center, please visit www.baypines.va.gov or like us on Facebook at www.facebook.com/VABayPines.

About the Bay Pines VA Healthcare System The Bay Pines VAHCS is one of the nation's leading VA healthcare systems, employing more than 3,500 medical professionals and support staff dedicated to providing the very best care to Veterans residing in southwest Florida. The organization is the fourth busiest VA health care system in the country in terms of patients served and is accredited by The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, and several other nationally recognized accrediting organizations. The Bay Pines VAHCS operates nine facilities to include the main medical center located in Bay Pines and outpatient clinics located in Bradenton, Cape Coral, Naples, Palm Harbor, Port Charlotte, Sarasota, St. Petersburg, and Sebring. Every year the organization treats approximately 103,000 patients while providing a full range of high quality medical, psychiatric, and extended care services in outpatient, inpatient, nursing home, and home care settings.

Alliance Holiday Party Fundraiser, Raffle Winners, Bingo Winner, and Photo

By Mariquita Anderson, Alliance President

The LCMS Alliance raised $1,990 from the Holiday Charity Basket Raffle. Holiday Portraits raised $660 while the Basket Raffle raised $1,330. The proceeds benefit the LCMS Alliance Foundation which produces award-winning programs like the Anti Bullying Train the Trainer Conference and Tdap for 7th Graders. Thank you to all those who contributed to this very important service to our community!

Congratulations to Dr. Rich Lane (spouse of **Renee Lane**) and **Dr. Robert Tomas** (spouse of **Dr. Anne Lord-Tomas**) who each won the Portrait Packages offered in the Holiday Portrait Raffle. The Portrait Packages include a $500 gift certificate towards a portrait sitting and a $500 gift certificate towards purchase of portrait packages. Thank you, **Valarie**, Sarah, and Dr. Eliot **Hoffman** for producing the Holiday Portraits at the party and for donating the proceeds to the LCMS Alliance Foundation!

Congratulations to newcomer Lauren Rehab and veteran **Betty Rubenstein** who each won a basket in the Holiday Charity Basket Raffle! The Holiday Baskets contained all kinds of goodies and wine perfect for the season's holidays. Thank you, **Tami Traiger**, for organizing the Holiday Charity Baskets! Thank you to **Megan Heller**, **Lisa Tritel**, **Mary Macchiaroli**, and **Mariquita Anderson** for selling raffle tickets this year! We'd also like to thank the people who drew our raffle winners: Dr Dave Turkel (spouse of **Gabriela Turkel**), **John Miksa**, **Jeanette Schurman**, and Dr. John Mehalik (spouse of **Traci Mehalik**).

The winner of the Member Profile Bingo card is **Dr. Eleanor Blitzer** who was able to complete all but three squares (duplicates don't count)! We'll be delivering your prize to you soon. Thank you to the Directory Subcommittee of **Leya Neizvest**, **Joann Ellis**, **Brian Kelley**, **Mary Macchiaroli**, and **Mariquita Anderson** for presenting this fun activity. Thank you, too, to everyone who attempted the Bingo card. We realize it wasn't easy.

Lauren Rehab with her Charity Raffle win

Meaningful-Use Deadline Pushed Back One Year

By Joseph Conn

The CMS is giving providers another year to show they've met the Stage 2 critria of the federal government's incentive program to encourage the adoption and meaningful use of electronic health records. That means the start of the next phase will be pushed back a year. Stage 2 will be extended through 2016 and Stage 3 won't begin until at least fiscal year 2017 for hospitals and calendar year 2017 for physicians and other eligible professionals that have by then completed at least two years at Stage 2, the CMS said Friday.

The latest extension parallels what the feds did with Stage 1, which was originally set to last two years but was lengthened by a year when it appeared the industry would be overstretched to build and get acclimated to systems capable of meeting the federal payment program's more stringent Stage 2 criteria.

"The goal of this change is two-fold," according to a CMS statement from Robert Tagalicod, director of the Office for E-Health Standards and Services at the CMS, and Dr. Jacob Reider, acting head of the ONC, the Office of the National Coordinator for Health Information Technology at HHS.

The delay, they said, is intended to allow the CMS and ONC to focus on helping providers meet Stage 2's demands for patient engagement, interoperability and information exchange, as well as use data collected during that phase to inform policy decisions for Stage 3.

The proposed rules are expected to be released in the fall of 2014 for the requirements providers must meet for Stage 3, as well as the 2017 Edition of standards health IT developers must build and test their systems to match.

The start of Stage 2 was Oct. 1 this year for those hospitals that have already met Stage 1 criteria for at least the prior two years. For physicians and other "eligible professionals," the clock starts for Stage 2 on Jan. 1, 2014. A separate rule extending Stage 2 by a year

continued on page 11

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is expected sooner and will be grafted onto another, as yet an unspecified HHS rule already started on the lengthy rule-making process, according to the CMS.

The program, created under the America Recovery and Reinvestment Act of 2009, has paid out about $17 billion since January 2011, according to the latest CMS data.

As the CMS pointed out in its announcement Friday, 85% of hospitals eligible for payments under the program and more than 60% of physicians and other eligible professionals have received money from its Medicare, Medicaid and Medicare Advantage divisions for adopting, implementing, upgrading and or meaningfully using health information technology that's been tested and certified to ONC standards.

Friday's action is not unexpected.

In September, members of Congress called for a delay of Stage 2 and a Modern Healthcare analysis of the federal government's own EHR testing and certification results for Stage 2-ready EHR systems and their components indicated a serious lag in overall health IT industry readiness for the Stage 2 upgrades. Since there is considerable lag time between developers having a system ready and the ability of provider organizations to install and reach maximum utility with even an upgraded EHR, that lag time would impact provider readiness to meet the more stringent meaningful-use targets in Stage 2.

The Health Information and Management Systems Society immediately welcomed the news. "This additional time to attest offers an opportunity for increased feedback and analysis on technology implementation, eClinical Quality Measure reporting, and progress toward interoperability that will enhance the ability of eligible hospitals and eligible professionals to meaningfully use health IT, and thus improve the quality and cost-effectiveness of patient care," the Chicago-based trade group said in a statement.

In another effort to address that lag, the CMS proposed a new, "voluntary" set of health IT system testing and certification criteria to be called the 2015 Edition. The current 2014 Edition of testing and certification criteria will remain "the baseline" for vendors and developers, but the 2015 Edition criteria would "be responsive to stakeholder feedback, address issues found in the 2014 Edition, and would reference updated standards and implementation guides that we expect would continue momentum toward greater interoperability," the statement said. The 2015 Edition would be voluntary in that neither vendors nor providers would be required to create or use the updated technology.

Unmentioned in Friday's announcement was the looming federally mandated nationwide conversion to the International Classification of Diseases 10th Revision of diagnostic and procedural codes.

Reider replaced former ONC chief Dr. Farzad Mostashari, who stepped down Oct. 5. In an interview with Modern Healthcare the day before, Mostashari advised against going slow on Stage 2 and the more function-rich 2014 Edition software that goes with it.

"There should be no hesitation about realizing that we need to, as a country, be using 2014-certified software by the end of 2014—we just need to do that," Mostashari said. Reider said that the federal government isn't backing off.

"We're continuing to move forward aggressively," Reider said. "We're keeping the pedal to the metal, and yet we are recognizing it's going to take additional time to get ready for Stage 3 and we wouldn't have the time to do that if we didn't extend Stage 2."

Follow Joseph Conn on Twitter: @MHJConn

Lee County Medical Society

13770 Plantation Road, Ste 1
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CHANGE SERVICE REQUESTED