SwipeIT Pushes for Machine-Readable ID Cards

BY ERIK L. GOLDMAN

DENVER — Incorrect patient identification information is still the leading reason for rejected insurance claims, and the majority of these errors—which cost the nation an estimated $2.2 billion in administrative waste—reflect the failure of the health care industry to embrace standardized, machine-readable magnetic ID cards.

The Medical Group Management Association (MGMA) is hoping to change that. Last year, it launched Project SwipeIT, a national, multistakeholder effort to push for full implementation of magnetic insurance ID cards in all public and private health insurance plans.

In its first year, Project SwipeIT garnered pledges of support from more than 1,000 physicians' organizations, insurance companies, and health information technology vendors who vow to issue, support, or accept machine-readable ID cards.

Standards for magnetic insurance ID cards were first developed in 1997. Yet today, health care transactions are still almost entirely dependent on paper or plastic ID cards. Each insurance company has its own card design and format, some of which can be difficult to read or copy. Stapling a photocopy of a patient's ID card into the medical chart or manually key-stroking information into the patient's record is still the norm in nearly all medical practices.

Reliance on paper-to-paper transfer of identifying information leaves a lot of room for error.

Numerals are easily mistaken, names misspelled, benefits changed, and expiration dates unnoted. The MGMA estimates that 98% of all claims generated by physicians' offices are not electronic, and approximately 5% of those claims are rejected because of incorrect ID information, leading to long and costly delays in physician reimbursement.

On average, it takes roughly 15 minutes of staff time to manually correct and resubmit an erroneous claim once the error has been identified.

The MGMA estimates that outpatient physicians nationwide could save as much as $290 million per year if all insurers used swipe cards in compliance with standards developed by the Workgroup for Electronic Data Interchange.

American College of Physicians, American College of Surgeons, American Medical Association, and the American Academy of Family Physicians have endorsed Project SwipeIT.

Dr. Lori Heim, AAFP president, attributed the failure to adopt swipeable ID cards to "procedural inertia." Though standards for creation of cards have been in place for more than a decade, it has taken more time to develop standards for reader devices, interfaces between card readers and electronic health record systems, and platforms for interoperability.

"It is reflective of the broader problems we've seen regarding the adoption of health care [information technology] in general," she said in an interview.

Without strong consensus and commitment from all major insurers—or an unequivocal federal mandate—individual plans have been unwilling to take the first steps and implement their own swipe cards. And if the plans weren't going there, neither would physicians, even though both parties stand to gain.

Creating standards for transfer of ID card data into electronic health records will be critical for general success, she said. "In order to realize the savings potential, we need the patient ID information to transfer smoothly from the card reader to the right places in the EHR."

Like any other technological innovation, implementation of swipe cards will carry some upfront costs for purchase and installation of card readers and production of the cards themselves. The question of who should bear those costs is an open one at this point.

According to the MGMA, card readers cost around $200 per clinic, and the software upgrades needed to interface card readers with electronic practice management systems are minimal.

Some have suggested implementation costs should be borne by insurers, who have much to gain by digitizing transactions and reducing errors. Dr. Heim said that she will not be surprised if the insurance industry tries to put all or some of that cost on the shoulders of physicians and hospitals. "We will definitely push back on that," she promised.

In 2010, the MGMA and its partners plan to become more active in pushing the Project SwipeIT agenda. According to the group's Web site, the second phase of the project involves publicly recognizing payers that have met their pledges and issued standardized, machine-readable health ID cards, while publicly identifying those that have not. ■

EXPERT OPINION

EHRs Enhance Virtual Patient Encounters

BY CHRIS NOTTE, M.D., AND NEIL SKOLNIK, M.D.

One of the greatest proposed advantages of electronic health record systems is enhanced physician-patient interaction. Most of the recommended EHRs available today are robust and include a Web-based portal that facilitates communication, allowing for the sharing of lab results, medication refill requests, and follow-up after an in-office consultation. Many questions arise, though, in the implementing of these services, and they should be considered before making the leap into electronic visits.

Security of E-Visits

Many physicians and patients are reluctant to embrace health-related electronic communication because they question its security. Given the Health Insurance Portability and Accountability Act and reports of personal data being stolen by hackers, this is a reasonable concern. According to Atlanta-based SecureWorks, electronic attacks on health care organizations doubled in the fourth quarter of 2009 (www.secureworks.com). Your communication medium must be designed to prevent sensitive data from falling into the wrong hands.

Most EHR products that include an interactive portal require that both the physician and the patient log in to the same encrypted Web site to ensure that the data stay on a single server and are not mailed through cyberspace, where they can be intercepted. Such portals also allow communication to be limited to referral requests or lab result notices, which keeps irrelevant messages from flooding a physician's in-box. Personal e-mail accounts should never be used to communicate sensitive information. Not only do they lack security, they also allow patients to take inappropriate advantage of the professional relationship.

Legal Ramifications of E-Visits

Unfortunately, every advance in health care provides an opportunity for litigation. With electronic medical communications, several significant legal pitfalls can arise. Quick, casual e-mails can be easily misconstrued, and once written, such exchanges provide indelible documentation of every interaction.

Set guidelines that limit what and how information is communicated. The American Medical Association produced well-designed guidelines that not only cover the technical aspects of electronic communications, but also include a code of ethics. For example, the AMA encourages e-mail to be concise, supplemental to office visits, and used only after a discussion with the patient about privacy issues.

More recently, several AMA publications have also addressed social networking media such as Facebook and MySpace. Physicians are strongly encuoraged to weigh the implications of involvement in these sites. Although they can provide an opportunity for marketing and sharing general practice information, they also may jeopardize the physician-patient relationship by blurring the line between personal and professional communication.

E-Visits and the Bottom Line

With an increase in virtual availability to patients, it's easy to foresee a future of electronic visits eliminating the need for certain in-office consultations. Depending on an individual physician's payer mix, this can have a dramatic impact on income.

It might benefit those with a high percentage of Medicaid or capitated patients, but it could be greatly detrimental to a practice with a larger share of fee-for-service patients. At this point, it's not clear if and when insurers will begin reimbursement for electronic visits.

Currently, the Centers for Medicare and Medicaid Services limits reimbursement for electronic patient encounters only to regions where there is limited access to health care, known as Health Professional Shortage Areas (HPSAs).

In light of the HITECH (Health Information Technology for Economic and Clinical Health) Act, several proposals are being considered that would expand payment opportunities to all areas of the country.

In the meantime, it is important to note that a few private insurers have begun to compensate physicians for e-visits. BlueCross BlueShield of North Carolina recently started to offer reimbursement under e-visit–specific CPT codes, provided certain reasonable criteria are met. So far, the insurer reports that only 31% of participating providers are using electronic patient communications, whereas 74% of members desire to interact with their physicians in this way.

One hopes that, as more practices adopt EHR systems and insurers expand reimbursement for virtual office encounters, an increasing number of physicians will find e-visits to be both clinically and financially beneficial.

As we've said before, the true mark of success will be better health care outcomes and improved satisfaction for both physicians and patients. ■

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