MDs Are Untrained in Fraud

Red Flags Rule *from page 1*

ministrative burden. The Mayo Clinic may have the resources for dealing with these challenges, but most clinical medical practices remain a cottage industry and do not, she said.

The rule requires creditors to establish formal identify theft prevention programs to protect consumers. Aimed primarily at the financial industry, the regulation was originally scheduled to go into effect on Nov. 1, 2008. However, to give small businesses more time to prepare for compliance, the Federal Trade Commission (FTC) delayed enforcement until May 1, and then until Aug. 1, and most recently until Nov. 1.

By no stretch of the imagination can rheumatologists be considered to be creditors, given how small the outstanding bills tend to be. Patients leave 'Cosco owing more than they leave my office owing.'

Dr. Kolba noted that if the rule goes into effect, "rheumatologists will be liable for things we are not trained to do. How can I train my staff to look for forged documents? Where would I send them for training? How would I know whether a Social Security number is valid? And if we do find that a patient is using invalid identity papers, what do we do about it? Call the FBI? Notify the district attorney?"

Earlier this year, the AMA and physician specialty societies argued that physicians are not creditors because they bill insurance companies, not individual consumers, Ms. King said. "But the patient does get billed for copays, deductibles, and excluded services, so unless all those charges are collected up front, the health care provider is billing and possibly deferring payment for the cost of services."

Dr. Kolba disagreed that the size of most patients' outstanding bills is big enough to qualify rheumatologists as creditors. "People come out of Costco owing more than they leave my office owing," said Dr. Kolba, who practices in Santa Maria, Calif. These same issues apply to other cognitive specialties, such as endocrinology and most of primary care. The few cases of medical identity theft have involved hospitals, she said.

To address health care providers' concerns, the FTC has published guidance and developed a template for an identity theft prevention program for low-risk creditors. (The information is available at www.ftc.gov/bcp/edu/pubs/articles/art11.shtm.)

Low-risk providers who see the same patients regularly can adopt a simple identity theft program, she said, adding that personnel involved with front desk, medical records, and patient account functions should be involved in the program.

Physicians need to identify which patient accounts—such as those for patients who need to make repeat payments—will be covered by the rule, and then develop appropriate policies and procedures, Ms. King said. "The final [Red Flags Rule] had 26 examples of identity theft. Look through them and see which ones are most applicable to you."

Providers also need to look at what information they collect when patients register. "Many of us need to rethink our standard registration procedures and beef them up," said Ms. King. One example might be to ask for a photo ID.

Dr. Kolba noted that it is already standard practice in her office to ask all patients for photo ID and to make a photocopy of it. In addition, all patients have their photo taken in the office and that becomes part of their medical record.

Ms. King noted that procedures for guarding against identity theft need to be approved by the organization's board of directors and overseen by senior management, according to the rule, "because this is intended to be a high-priority program, not something that's delegated to a lower-level manager."

Typical "red flags" that practices should watch for include the following:

- ► Insurance information that cannot be verified.
- ► No identification.
- ► A photo ID that doesn't match the patient.
- ► Documents that appear to be altered or forged.
- ► Information given that is different from information already on file.
- ► An invalid Social Security number.
- ► A patient who receives a bill or an explanation of benefits for services he or she didn't receive.
- ► A patient who finds inaccurate information on their credit report or on a medical record.
- ► A payer that says its patient information does not match that supplied by the provider.

When a particular patient raises one or more red flags, the practice has two options, according to Ms. King. It could refuse to provide service, although this might raise a problem under the Emergency Medical Treatment and Active Labor Act (EMTALA), a law that prohibits providers from not treating persons with questionable identification who require emergency care.

Or the practice could provide the service, but ask the patient to bring in the correct information to his or her next visit. Ms. King cautioned providers about freely providing medical records to a patient suspected of identity theft, because it could lead to more identity theft.

Patients also will have to be educated about the new rule, Ms. King said. "Providers are going to run into problems with patient expectations. Patients have gotten used to coming to their doctor … with either no identifying documents or only their insurance card. They will need some education in advance by being informed when they call on the phone to schedule an appointment, or by signs in the waiting room [indicating] that you really need to have identifying documents with you."

Providers also should note that compliance with the Health Insurance Portability and Accountability Act (HIPAA) does not shield them from complying with the Red Flags Rule.

"One of the questions we get is, 'I already comply with HIPAA; aren't I done?' The answer is, 'Probably not,' " said Naomi Lefkowitz of the division of privacy and identity protection at the Federal Trade Commission.

"The Red Flags Rule is really about fraud protection, and HIPAA is more about data security. There is certainly some overlap, and to the extent that, for example, someone is checking photo IDs … to make sure that the person [has access only to his or her own] medical record, that's a policy that might do double duty under the client's identity theft program as far as verifying ID [is concerned]. … But merely having the HIPAA program is probably not going to make [providers] compliant with Red Flags." ■

Mary Ellen Schneider and Sally Koch Kubetin contributed to this story.

In-School Vaccination to Be Part of Federal H1N1 Plan

BY DOUG BRUNK

While clinical results of some 2009 pandemic influenza A(H1N1) vaccine trials won't be known until late September at the earliest, planning a vaccination program for the virus is well underway.

Officials from the National Vaccine Advisory Committee provided a wide-ranging update on activities related to 2009-H1N1 vaccine development and implementation planning during a recent teleconference.

Dr. Anne Schuchat, director of the National Center for Immunization and Respiratory Diseases at the Centers for Disease Control and Prevention, noted that there have been "disruptive clusters and outbreaks" of H1N1 influenza at summer camps in the United States with "remarkable heterogeneity," with some people disproportionately affected. "We are continuing to see illness here in the U.S. at a lower frequency than in the spring, but a very high frequency compared to a usual summer."

Robin Robinson, Ph.D., director of BARDA (Biomedical Advanced Research and Development Authority), an agency of the Health and Human Services department, noted that the HHS has contracted with five manufacturers to develop 2009 H1N1 vaccine: Four are producing an inactivated form of the vaccine, which will be available in prefilled syringes and multidose vials, and one is producing a live attenuated form. Clinical vaccine trials will be carried out in adults first, and then proceed to pediatric populations. Dr. Robinson estimated that about 20% of the entire clinical trial population will include children. Results from the first clinical trials—which began in mid-July—are expected by late September or early October.

The CDC's H1N1 Vaccine Task Force recommends that vaccine administration planning should take into account certain at-risk groups, including children and staff in day care centers and in schools serving grades K-12; pregnant women; young children; persons with household contact of children younger than 6 months of age; persons with underlying medical conditions; health care workers; and then—when enough vaccine is available—everyone else. Dr. Jay C. Butler, director of the task force, noted that uncertainties about a vaccine roll-out persist, including the amount of vaccine required and when it will be available; its formulation; specific recommendations for use; and demand for the vaccine.

Dr. Marie McCormick, a member of NVAC who is also a professor of maternal and child health at Harvard School of Public Health, presented draft recommendations of the H1N1 Vaccine Safety Subgroup. It calls for a federal plan to monitor 2009 H1N1 influenza vaccine safety, "both for proper planning purposes and to provide information to the public and stakeholders (including states) about important vaccine activities."

One key recommendation says that the need "to actively monitor vaccine recipients for vaccine adverse events is critical given that the vaccine candidates will all contain a new antigen and may be combined with adjuvants that are not part of licensed vaccines in the United States." Another recommendation calls for "transparent and independent review of vaccine safety data as it accumulates."

The NVAC voted to adopt these recommendations, which will be passed along to National Vaccine Program Director Dr. Bruce G. Gellin for consideration.

Dr. Anne Bailowitz, medical director of environmental health and emergency programs for the National Association of County and City Health Officials, expressed concern about the implementation of a 2009 H1N1 vaccine program in light of financial challenges faced by many local health departments. In 2008, she said, 27% of local health departments had budget cuts and 53% had layoffs. This year, she said, 44% of local departments have had budget cuts and 32% have had layoffs. Establishing local partnerships, such as encouraging large business to immunize their own employees, will be key to successful implementation, she said. Volunteer H1N1 vaccination providers could also include student nurses, medical school students, dental students, veterinarians, EMTs, and pharmacy chain personnel. ■