EHR REPORT

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 EHR products 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 of issues subsequent to an in-office consultation. Many questions arise, however, when implementing these services, and these issues should be considered before making the huge leap into electronic visits.

Are e-visits secure?

Many physicians and patients are reluctant to embrace health-related electronic communication because they question the security of the medium. Given the ever-looming shadow of the Health Insurance Portability and Accountability Act and frequent reports of personal data being stolen by hackers, this is a reasonable concern. In fact, according to SecureWorks (www.secureworks.com), an Atlanta-based managed security firm, electronic attacks on health care organizations doubled in the fourth quarter of 2009. This underscores the importance of ensuring that the communication medium is 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 and stolen. Such portals also allow communication to be limited to referral requests or lab result notices, which helps prevent unwanted or inappropriate messages from flooding a physician's inbox. Personal e-mail accounts should never be used by physicians or patients who wish to communicate sensitive information. Not only do such accounts lack security, they provide the possibility for patients to take inappropriate advantage of the professional relationship.

What are the legal ramifications?

Unfortunately, every advance in health care provides a new opportunity for litigation. With electronic medical communications, several significant legal pitfalls can arise. E-mails that are typed quickly and casually can be easily misconstrued, and once written, such electronic exchanges provide indelible documentation of every interaction. It is therefore very important to be careful when communicating health-related information electronically.

It's a good idea to set guidelines that limit what and how information is to be communicated. In 2002, the American Medical Association produced well-designed guidelines that are available on its Web site. These guidelines cover not only the technical aspects of electronic communications, but also include a code of ethics that should be followed when using e-mail. For example, the AMA encourages that e-mail be supplemental to office visits, be concise, and only be used once a clear discussion with the patient about privacy issues has occurred.

More recently, several AMA publications have also addressed social networking media, such as Facebook and MySpace. It is strongly encouraged that physicians weigh the implications of involvement in these sites. Although they can present a great 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.

Do e-visits alter the bottom line?

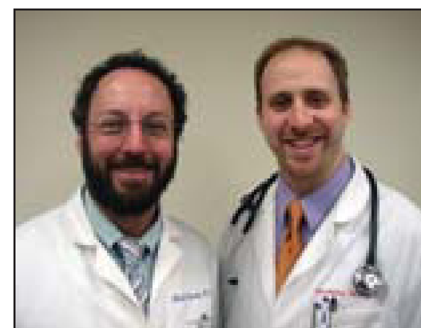
With an increase in virtual availability to patients, it becomes very easy to foresee a future of electronic visits eliminating the need for certain in-office consultations. Depending on an individual physician's payer mix, this can have a dramatic impact on income. It might benefit those with a high 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 Health Information Technology for Economic and Clinical Health Act (HITECH), 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 compensating 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, while 74% of members desire to interact with their physicians in this way.

Hopefully, 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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Physicians Should Be Wary of Medicare RAC Audits

BY MARY ELLEN SCHNEIDER

LAS VEGAS — The federal government is stepping up its audit activities in Medicare, and that could mean greater scrutiny of billing practices.

One development that physicians should keep a close eye on is the recent nationwide rollout of Medicare's Recovery Audit Contractor program, said Edward R. Gaines III, vice president and chief compliance officer at CBIZ Medical Management Professionals Inc. The program, known as the RAC, began as a demonstration project in New York, California, and Florida.

Under the program, private contractors are given contingency fees for identifying improper Medicare payments to health care providers, including over- and underpayments.

But Mr. Gaines said the experience in the demonstration project showed that the contractors concentrated much more on detecting overpayments made to providers.

Now that the RAC program has been rolled out nationwide, four private contractors, each assigned to different regions of the country, will use data mining, outlier analysis, and referrals to root out improper payments. The RACs will earn contingency fees for finding errors, with fees that vary from around 9% to 12%.

Physicians need to be aware of the RAC activities and do their own outlier analyses so they can be ready to defend against an audit, Mr. Gaines advised during a meeting on reimbursement sponsored by the American College of Emergency Physicians.

The RACs will look at evaluation and management services. During the demonstration project, evaluation and management services were exempt from audit—but that is not the case now that the RAC is a permanent program.

Medicare is raising the bar for audits because they are in a financial squeeze, Mr. Gaines said.

Right now, Medicare receives more than 1.2 billion medical claims a year—and that's before the bulk of the baby boomer generation has entered the program. Add to that recent news reports that the Medicare and Medicaid programs are hemorrhaging tens of billions of dollars to fraud, and the federal government is in a position in which it needs to act to contain costs.

During the pilot phase of the program, the RACs collected $1 for every 20 cents spent by the government. "So, if you can get five times the rate of return and you're the federal government, this is a no-brainer," Mr. Gaines said.

One area of specific concern with the RACs is that they have the power, at least in certain limited circumstances, to extrapolate an error rate across a larger number of Medicare claims. For example, if a RAC finds a 10% error rate on 50 medical records, extrapolation would allow the contractor to apply that error rate across all of a physician's Medicare patients over multiple years—potentially dramatically increasing the penalty.

There are restrictions to that power. For example, it can't be applied during the initial audit phase, and officials at the Centers for Medicare and Medicaid Services have stated that it can only be employed in cases where there is a sustained or a high level of payment error, or a failure to correct the error. In addition, penalties cannot be applied to claims before Oct. 1, 2007.

But the ability to perform extrapolation at all is making physicians uneasy. Although there are restrictions on when extrapolation could be applied, Mr. Gaines said, it's unclear how CMS would put it into practice. And the fact that the RACs would earn contingency fees on extrapolated claims seems to increase the likelihood that the method would be used, he said. "That's where the money is," he said.

Physicians who are audited by the RAC and have errors in 1 out of 50 charts would likely be at low risk for extrapolation. he said. However, the risk likely is higher for a physician or group that has been subject to audits in the past or been subject to corrective action. ■