



Snohomish County Medical Society

Update: May 2009

Stimulus Bill includes HITECH Act that affects ALL medical groups.

President Obama signed the 'Stimulus' bill into law on February 17, 2009. (The American Recovery and Reinvestment Act of 2009)

What most clinic managers and administrators may not know, is that the bill also included major provisions known in the act as "Health Information Technology and Clinical Health Act" or HITECH, which changes many provisions of HIPAA that all clinic managers should review.

Managers and Administrators may or may not be aware of their current uninsured exposures for 'cyber-liability' or 1st and 3rd party liabilities for breach of privacy. Current General Liability insurances and Medical Professional Liability policies do not cover this exposure.

What is critical is that as a health care provider, group, clinic or facility; regardless of the proposed implementation of the FTC 'Red Flag' rules; under HITECH, you have a more profound exposure to privacy liability.

The new HITECH law expands the requirements and your liability to civil fines in addition to existing state laws, regarding personal health records, disclosure of breach of security, accounting of disclosures, limitations of disclosures, and enhancement of individual rights. Washington State Law already has distinct requirements for the loss or breach of privacy for both the 1st and 3rd party liabilities.

Not only does the law increase requirements and exposures; it also increases the requirements of your "Business Associates" under HIPAA, as well as taking HIPAA from a reactive complaint-driven system to a much more pro-active system the foundation of which is audits and enforcement activities - funded by civil fines/penalties. No longer will 'Business Associates' be one step removed from HIPAA compliance, and no longer will medical practices be able to rely upon software licensure agreements to protect them if their electronic medical record system results in a breach of protected health information.

Specialty insurance which managers thought to be an elective in the past (given the nature of your stewardship of electronic health records) will now be an essential part of your risk insurance purchases. HITECH rules are now being promulgated by Health and Human Services which will further define your requirements as providers.

Administrators and managers should contact an insurance professional well versed in the specialty coverage of privacy liability to assure that you do not have a critical uncovered financial exposure, both for liability and civil monetary fines which would be significant to your medical practice.

CMS says to expect RAC medical record demand letters to start late May

Recently the Centers for Medicare & Medicaid Services (CMS) announced that medical group practices should expect letters from Recovery Audit Contractor

(RACs) demanding medical records as soon as late May. The purposes of the RACs are to identify overpayments and underpayments by CMS to Medicare providers.

The RAC program evolved from the three-year RAC demonstration project stipulated by the Medicare Modernization Act (MMA) of 2003. The Tax Relief and Health Care Act (TRHCA) of 2006 made the RAC program permanent and authorized CMS to expand it to all 50 states by 2010.

The permanent RAC program limits the medical-record review period to three years and prohibits audits on claims paid before Oct. 1, 2007. The program requires RACs to have a physician medical director and certified coders available to discuss denials with providers. RAC auditors must provide clinical credentials to providers upon request.

CMS also announced the number of medical records RACs may request per National Provider Identifier (NPI) for 2009. CMS will likely adjust these limits each year.

For Part B providers, the 2009 limits are:

- 10 medical records per 45-day period for solo practitioners;
- 20 medical records per 45-day period for two to five provider offices;
- 30 medical records per 45-day period for groups of six to 15 providers; and
- 50 medical records per 45-day period for groups of 16 or more providers.

For Part A claims, the 2009 maximum number of records RACs may demand varies by the hospital's NPI and will equal 10 percent of their average monthly Medicare claims. The RACs cannot request more than 200 records in a 45-day period for both inpatient and outpatient claims combined.

Swine Flu: Interim Guidance for Intensivists, Hospitalists, Pulmonologists, and Infectious Disease Physicians

As of May 10, 2009, the Centers for Disease Control and Prevention reported 2,532 confirmed cases of swine-origin Influenza A virus (SOIV) in the United States. To date, clinical illnesses have been described as mild but there have been sporadic reports of persons requiring mechanical ventilation. Currently, the Washington State Department of Health (DOH) and local health jurisdictions are developing plans for case testing and disease surveillance. A major goal of this surveillance will be to determine if this novel virus becomes more virulent.

DOH is asking intensivists, pulmonologists, hospitalists, and infectious disease practitioners to report cases of severe respiratory illness defined as:

- Hospitalized persons with community-acquired illness (respiratory illness \leq 48 hours of admission) **AND**
- Adult Respiratory Distress Syndrome, Acute Lung Injury, moderate to severe hypoxia, respiratory failure, or pneumonia **AND**
- Presence of fever, hypothermia, or sepsis suggesting an infectious etiology; **AND**
- No other medical explanation for the presentation.

Persons with staphylococcal pneumonia should also be considered in this group.

When these cases are identified, please do the following to identify if influenza virus

is present:

- Confirm that infection control measures are in place. Use standard and contact precautions when collecting the specimens. In addition, wear an N95 respirator when performing a procedure which could result in an infectious aerosol.
- Obtain a nasopharyngeal specimen using a synthetic swab (not cotton or calcium alginate) and place in viral transport medium. This specimen should be refrigerated (not frozen).
- For intubated patients, collect a tracheal specimen and sample the aspirated material using the same type of swab described above. Place in viral transport medium and refrigerate (do not freeze).
- Perform a rapid test for influenza A. If positive, contact your local public health jurisdiction and ship a second swab with a completed virology form (<http://www.doh.wa.gov/EHSPHL/PHL/Forms/SerVirHIV.pdf>) to: Washington State Public Health Laboratories, Attention: Virology Lab, 1610 NE 150th Street, Shoreline, WA 98155. This will be tested for SOIV.
- For rapid test-negative persons, consider performing additional influenza testing if you still suspect influenza. Commonly available tests are direct fluorescent antibody assays, virus culture (using Shell vials or conventional cultures), and polymerase chain reaction. As part of our increased surveillance for SOIV, clinicians may contact their local public health jurisdiction to submit a sample to the state's Public Health Laboratory (PHL) to test for SOIV.
- For intubated patients, PHL will accept broncho-alveolar lavage or deep tracheal suction specimens if packaged and shipped properly. This is an exception to PHL's normal policy. As a result, if the test is positive for SOIV, we will report it. But, if negative for SOIV, because this is a nonstandard sample, we must report the test as inconclusive.
- PHL will test for SOIV only and not any other respiratory pathogens

For more information about SOIV, see: <http://www.doh.wa.gov/swineflu/default.htm> and <http://www.cdc.gov/swineflu/>

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