CCH Health Care Compliance LETTER

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Wolters Kluwer Law & Business

CMS issues surety bond requirement for DME suppliers

CMS issued a final surety bond regulation, as required by the Balanced Budget Act of 1997, that requires certain suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to post a $50,000 surety bond in an effort to combat Medicare waste, fraud, and abuse. Existing suppliers have until October 2, 2009, to comply, while newly enrolling suppliers must meet this requirement by May 4, 2009. The surety bond requirement was promulgated because of the large number of improper and potentially fraudulent payments made to DME suppliers for furnishing medical equipment and devices to Medicare beneficiaries. The 2007 Medicare error rate report found approximately $1 billion in improper payments for medical equipment and supplies.

Bond requirements. The surety bond requirement is designed to limit the Medicare program risk from fraudulent DME suppliers and ensure that only those suppliers that remain in the program furnish items to Medicare beneficiaries that are considered reasonable and necessary. Suppliers that have had adverse legal actions imposed against them in the past will be required to post a higher bond amount. All newly enrolling suppliers that meet the requirements of the rule will be required to have a surety bond before they can participate in the Medicare program. While the regulation requires most suppliers to obtain a surety bond, some companies or organizations that supply these items are exempt, including certain physicians and nonphysician practitioners, physical and occupational therapists, state-licensed orthotic and prosthetic personnel, and government-owned suppliers.

Privileges revoked. In conjunction with the new regulation, CMS revoked the billing privileges of more than 1,100 DME suppliers in south Florida and southern California in an effort combat Medicare waste, fraud, and abuse as part of the DMEPOS High-Risk Suppliers Demonstration that began in October 2007. "We know the majority of medical equipment suppliers and health care providers want to improve the health of Medicare beneficiaries, but we also know there are those who look for any opportunity to take advantage of beneficiaries and Medicare," said CMS Acting Administrator Kerry Weems. These suppliers were paid a combined total of $265 million between calendar years 2005 and 2007.

In addition to suspending payments to these DME suppliers, CMS:

- implemented extensive pre- and post-payment review of claims submitted by ordering or referring physicians;
- validated claims submitted by physicians ordering a high number of items or services by sending follow-up letters to these physicians;
- verified the relationship between physicians and beneficiaries for these services; and
- identified and visited high risk beneficiaries to ensure appropriate services were received. ■

CMS Press Release, Dec. 29, 2008

OIG: Gainsharing arrangement includes sufficient safeguards

An arrangement under which a hospital would share with several physician groups a portion of the hospital's cost savings attributable to the physicians' implementation of certain cost reduction measures would not result in the imposition of sanctions or civil monetary penalties. Although the arrangement raises possible implications under the Social Security Act and the anti-kickback statute, the hospital has implemented safeguards to ensure compliance with federal regulations and reduce the risk of fraud and abuse, the Office of Inspector General (OIG) concluded.

Arrangement. Under the arrangement, the hospital, an acute-care facility, entered into separate contracts with four cardiology groups and one radiology group. Collectively, those groups perform nearly all of the cardiac catheterization services at the hospital.

The hospital agreed to pay each group a share of cost savings arising directly from specific changes in that group's cardiac catheterization practices over two years. The cost-saving opportunities were identified by a program administrator after a study of the historical practices of the physician groups. The administrator's recommendations are largely aimed at standardizing the physicians' use of medical devices and supplies and curbing the inappropriate use or waste of devices and supplies.

Safeguards. A number of safeguards reduce the risk of fraud or abuse within the arrangement, including: (1) a transparent process that clearly identifies and separates cost-saving actions and resulting savings; (2) credible support for the position that such cost-saving measures do not adversely affect patient care; (3) thresholds beyond which no savings accrue to the physician groups; (4) protections to ensure that individual physicians continue to have available the same selection of devices and supplies; and (5) written disclosures of the arrangement provided to patients.

Based on the information provided about the arrangement, the OIG would not pursue sanctions or civil monetary penalties against any of the parties. ■

OIG Advisory Opinion, No. 08-21, Nov. 25, 2008, Health Care Compliance Reporter, ¶500,201

Exception allows cost-sharing waiver for EMS

A proposed arrangement under which a county would not bill bona fide residents who receive emergency medical service (EMS) transportation to hospitals for copayments, deductibles, and other applicable cost-sharing amounts would not generate prohibited remuneration under the anti-kickback statute. Under the arrangement, the county, which provides EMS transportation through its fire department, would accept full payment from the insurers of bona fide residents and would treat revenues from taxes as payment of the cost-sharing amounts.

Although waivers of Medicare cost-sharing amounts can constitute prohibited remuneration, there is a special exception for health care providers and suppliers that are owned and operated by a state or a subdivision of a state, such as a municipality or fire department. CMS confirmed that this provision would apply to waivers of cost-sharing amounts by a state or municipal ambulance company that is a Medicare Part B supplier. Such exception, however, would not apply to contracts with outside ambulance suppliers. Because the proposed arrangement would not generate prohibited remuneration, no sanctions would be imposed. ■

OIG Advisory Opinion, No. 08-23, Dec. 12, 2008, Health Care Compliance Reporter, ¶500,203

Arrangement with physician employees is permissible

An arrangement between a corporation and physicians that would be employed on a part-time basis to perform services on the corporation's premises while continuing to practice medicine elsewhere would not violate the anti-kickback statute.

The corporation certified that the physicians would be bona fide employees as established in 26 U.S.C. § 3121(d)(2) and Internal Revenue Service (IRS) regulations. The applicable safe-harbor provisions of the anti-kickback statute provides that a prohibited remuneration does not include "any amount paid by an employer to an employee who has a bona fide employment relationship with the employer for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare or a State health care program."

Whether an employee is a bona fide employee is outside the scope of the anti-

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kickback statute and is properly addressed by the IRS; the Office of Inspector General (OIG) must rely upon the employer's certification that the employees qualify as bona fide employees. Accordingly, the proposed compensation arrangement would not constitute a prohibited remuneration under the anti-kickback statute, and the OIG would not impose administrative sanctions. ■

OIG Advisory Opinion, No. 08-22, Dec. 15, 2008, Health Care Compliance Reporter, ¶500,202

Organization, documentation keys to Stark compliance

Although the Stark Act is known for being broad, confusing and generally disliked by health care providers, remaining in compliance with the physician self-referral prohibition statute often boils down to paperwork, according to health care attorney Robert A. Wade. "It's process, process, process," said Wade, a partner with Baker & Daniels who has represented large health systems, hospitals and other health care clients.

During a fall 2008 teleconference sponsored by the Health Care Compliance Association, Wade advised hospitals and other entities subject to Stark regulations to develop a clear compliance program, stick to it, monitor it, and document everything in writing. "A lot of it is a paper chase, but if you can get your ducks in a row early, you're better off," Wade explained. "It's better to do it now than having a regulator at your door."

Put it in writing. To "operationalize" Stark, Wade recommended that hospitals keep their policies simple. Guidelines should be in place to determine who within the organization (1) initiates financial arrangements, (2) documents fair market value, and (3) monitors those financial arrangements while they are ongoing. The hospital's policy also should keep clear records on when financial terms were developed, when financial arrangements were approved, and the process by which fair market value was determined.

"My approach is to constantly be thinking, 'How would I defend this arrangement if was called into court?'" Wade explained. "What kind of documentation could I present? What kind of paper trail do I have to show how and why this financial arrangement came about?" Without clear and convincing documentation of fair market value, an organization may not be able to defend a financial relationship against claims of an alleged Stark violation, Wade warned. Moreover, compiling such documentation after such a violation has been alleged can prove much more costly and time-consuming.

Strict adherence. Because of the language of the physician self-referral law, even an inadvertent violation can result in penalties for an organization. Wade said Stark is a strict liability statute, "so arguably, intent is not an issue."

Moreover, one provision – 42 U.S.C. § 1320a-7b(a)(3) – operates as a catch-all, imposing liability on anyone who fails to disclose the occurrence of an event affecting his or her right to benefits or payment.

Generally, the Stark law prohibits physicians from referring Medicare patients to an entity for the provision of designated health services if the physician has a direct or indirect financial relationship with the entity unless the law provides a specific statutory exception. The term "financial relationship" has been construed broadly, encompassing many different forms of compensation. During his presentation, Wade highlighted a number of operational issues for which Stark exceptions may be applicable.

Office space and equipment. If a physician is leasing office space from the entity to which he is referring patients, both parties must be able to justify the provisions of the lease. Parties should consider the size of the space, the length of the lease term, the amount of rent payments, and the amount of any improvements provided for the tenant. Generally, percentage-based leasing arrangements will not be permitted, nor will "per-click" rentals for referrals from the tenant.

"I advise my clients to review these office space leases at least once every three years," Wade noted. He also suggested that organizations "get a real estate appraisal and validate that what [it is] charging in rent is appropriate."

Many of the same principles apply to the leasing of equipment. Wade advised seeking out a fair market value determination from an independent third party with no interest in the relationship. He also suggested monitoring equipment usage to ensure that it complies, in practice, with the terms of the lease.

Employment arrangements. If a referring physician is employed in some way by the entity receiving those referrals, any compensation must be aligned with the productivity of the physician, Wade stressed. "If someone is performing at the 25th percentile and their compensation is at the 90th percentile, that is going to raise red flags, unless there are exceptional circumstances," he added.

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POA Coding Requirements Create a Chilling Effect for Hospitals

by Kathy Johnson, RHIA

The chill felt throughout Inpatient Prospective Payment System (IPPS) hospitals has little to do with the change of season. As of October 1, 2008, IPPS hospitals became at risk to have Medicare payments reduced or denied as a consequence of CMS instituted present on admission (POA) guidelines.

The bottom-line impact of POA coding has stirred organization-wide discussions to bring administrators, physicians, clinicians, and compliance professionals in line with guidelines.

Background

POA indicators were developed as part of the Deficit Reduction Act of 2005 to differentiate between conditions POA and those acquired during an inpatient admission.

On the surface, the change may simply seem to be a data reporting or billing issue. Yet, the potential loss of Medicare dollars along with additional compliance demands has left health care providers with a collective headache.

On October 1, 2007, CMS mandated IPPS hospitals to begin reporting POA for all inpatient admissions. The POA guidelines identify eight hospital-acquired conditions that will not receive reimbursement, including:

- serious preventable events such as an object left in surgery, air embolism, and blood incompatibility;
- difficult to control conditions such as catheter-associated urinary tract infections, pressure ulcers, vascular catheter-associated infection, surgical site infection (mediastinitis after coronary artery bypass graft (CABG) surgery);
- hospital-acquired injuries—fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes.

Reduced reimbursement in the form of a lower-paying diagnosis-related group (DRG) for one of the selected hospital-acquired conditions will occur only when the selected conditions are the only major complications and comorbidities (MCCs) or complications and comorbidities (CCs) present on the claim. If the patient has other secondary diagnoses that are an MCC or CC, the case will continue to be assigned to the higher-paying MCC or CC DRG and there will be no savings to Medicare from that case.

Of the eight conditions, those resulting from hospital negligence, such as serious preventable events and hospital-acquired injuries won't earn the provider reimbursement. Others such as catheter-associated urinary tract infections and pressure ulcers are more difficult to assess and may not always be the liability of the provider. For these conditions, accurate POA reporting becomes crucial to ensure appropriate payment. Physicians and other clinicians need to be attentive in identifying these conditions as POA and communicating to coders.

Documentation Concerns

What happens if a coder doesn't know if a condition was POA? Resolving this confusion is critical for accuracy and proper reimbursement. The CMS guidelines provide the following reporting definitions including the designation of "U" for all unknown conditions.

- Y = present at the time of inpatient admission;
- N = not present at the time of inpatient admission;
- U = documentation is insufficient to determine whether the condition is POA; and
- W = provider is unable to clinically determine whether the condition was POA.

Add to this list another option—if the condition is on the list of diagnoses exempt from reporting, then the field for reporting POA indicators is to be left blank.

Examples of documentation that might be used to determine POA assignment include emergency department notes, history and physical examination, and progress and admitting notes. Other documentation that can be helpful includes:

- conditions present and diagnosed prior to admission;
- conditions diagnosed as existing during the admission process and, therefore, present before admission;
- any suspected, possible, probable or to-be-ruled-out conditions;
- differential diagnoses;
- underlying causes of any sign or symptoms present on admission;
- specific identification of acute or chronic status of any condition; and
- external causes (the "how" and "where") of any injury or poisoning in the physician's notes.

An Organization-Wide Approach

POA creates numerous pitfalls. Successful compliance requires organization-wide communication, training, and physician commitment.

Communication

POA compliance elevates the need for legal and compliance professionals to initiate organization-wide discussions with hospital administrators, coders, auditors, nurses and other clinicians, and physicians. Separately, these groups seem to speak different languages; collectively they share the same organizational goals of quality patient care and a fiscally healthy organization.

Hospitals should look for natural opportunities to bring these groups together, such as medical and nursing staff meetings, the hospital's physician newsletter and one-on-one education through the ongoing query process. Bringing these key stakeholders together for regular POA discussions improves overall compliance and forges better work relationships.

Training

Training is one area in which organizational leadership can directly impact POA compliance. Adequate training and guidance is crucial for success in the new POA coding environment. At the same time, coders must be diligent to keep current on coding changes and improve their skill sets.

POA compliance training opportunities can range from informal lunch-and-learns to more structured in-service and other formal trainings. In addition, coders should:

- become proactive in spotting and addressing potential coding issues later;
- read the notices published by participating insurance companies and stay aware of the flags they provide regarding code changes or documentation requirements;
- regularly review trade journals;
- visit the Medicare Web site; and
- participate in available internal and external training (many are offered by coding and compliance associations).

Physician Commitment

Physician documentation is the most efficient and most reliable source for accurate POA information. Therefore, it is crucial compliance staff provides the appropriate oversight to guarantee physicians recognize their reporting expectations.

Start by educating physicians on POA nuance that often lead to improper coding. For example, responsibilities for coders and physicians differ between Medicare severity-adjusted diagnosis related group (MSDRG) and POA documentation. While MSDRGs don't allow coders to look at diagnostics (lab results, for example) and draw logical conclusions (the physician must be the one to list diagnoses in the medical chart), POA allows coders to connect those dots and indicate the condition.

Simply making physicians aware of this difference can prevent compliance and related reimbursement headaches for hospitals and health networks. Other suggestions include inviting physicians to monthly coding workshops to review new clinical topics and discuss the coding involved, assigning an education liaison with each medical staff department for coder education, and placing articles in the hospital's physician newsletter.

Queries as Opportunities

Most physicians have established habits for documenting their notes on patient encounters. But, POA reporting is new to physicians and to ensure compliance, physicians need to adjust their reporting habits. Compliance can take the lead by providing physicians with necessary education to assign correct POA indicators.

When coding professionals discover inconsistent, missing, conflicting or unclear documentation, they must query the provider. Physicians then must resolve the data deficiency themselves.

Querying is an important part of the learning process for physicians. It provides physicians with opportunities to better understand their role, as well as the coder's, in POA compliance. Queries also can serve to build stronger relationships between physicians and coders.

To make documentation a more joint effort, hospitals have instituted clinical documentation improvement programs and the use of documentation specialists to review documentation concurrently during the course of care being delivered. These efforts allow for effective feedback to the provider and supports timely documentation. In addition, concurrent queries are received better by the providers rather than a retrospective query.

Hospitals can further enhance this relationship by encouraging physicians to be available to coders and analysts to regularly review POA documentation. A concerted effort to involve physicians in the POA process will lead to improved physician and coder relationships, decrease queries over time, and ultimately achieve better POA compliance and proper Medicare reimbursement. Without physician involvement, organizations can expect ongoing POA compliance issues.

Risks

The risk of fraud exists whenever reimbursement is involved. Although hospitals place numerous safeguards against fraudulent practices, they can and do occur.

Potential areas of concern are altering or under documenting POA reports. Besides internal quality and risk assurance programs, organization-wide efforts to communicate and train staff serve as a natural safeguard against POA fraud.

Hospitals further reduce their vulnerability to fraud by conducting a self-audit. Self-audits spot reporting problems or discrepancies and allow staff to quickly address and correct any discrepancies identified. It also identifies what areas of POA reporting are being done well. Used appropriately,

a self-audit serves as a valuable educational tool and provides greater business transparency.

The HIM Role

In successful organizations, Health Information Management (HIM) teams play a significant role in assisting the organization to maintain POA compliance. Hospital legal and compliance teams need to take the lead to maintain POA awareness and help HIM teams serve as change leaders within the organization.

The following are actionable examples HIM professionals can positively affect POA compliance:

- continue to increase familiarity with POA indicator assignment;
- monitor medical record documentation practices;
- assess the impact of the new indicator;
- educate data users (e.g., case management, quality, data analysis);
- conduct internal reviews to determine appropriate selection of POA indicators based on documentation and guidelines
- train new staff and contract coders on the POA requirements, including the collection of the POA within the system;
- work with the facility finance area to evaluate potential future reimbursement impact;
- work with the quality department to understand the data being collected;
- continue to monitor operational impact and potential areas for improvement within the HIM and coding processes; and
- continue to work with physicians on accurate and complete documentation.

Keeping key organizational stakeholders aware of POA issues, including updates and regular and successful reimbursement documentation, will ensure ongoing POA compliance and proper reimbursements.

Challenges Post POA

The original year-long grace period for IPPS hospitals to implement new POA reporting requirements has ended. How well hospitals have prepared their coding staff and physicians will soon be reflected in their bottom lines.

Failure to accurately document POA could result in hospitals receiving lower Medicare reimbursements. Yet, many confusing and gray areas exist within the POA guidelines that demand a continued focus on POA education to maintain compliance and ensure proper reimbursements.

Hospitals and HIM professionals need to offer ongoing POA training opportunities for both coding professionals and providers. This effort requires support from legal and compliance experts to make POA training a priority. A commitment to POA training will provide organizations with appropriate reimbursements, reduced queries, and improved physician/coder relationships, far outweighing any training costs incurred.

In addition to adjusting to the new requirements, hospitals will be further challenged by a continuing shortage of qualified and experienced professional coders. Therefore, it is crucial for administrators to handle these requirements smoothly and proactively and continue to monitor and track the impact of POA documentation reports, as well as the operational impact to ensure compliance. ■

Kathy M. Johnson, RHIA, Director of Coding Services for Care Communications, has held health information management director and various coding positions for more than 25 years. Johnson manages the Care Communications, Inc. Coding Consulting Services division and conducts Coding Quality Reviews and Education Programs. She works closely with health care executives to streamline and improve revenue cycles, claims processing and other critical hospital functions.

Anti-kickback/ Physician self-referral (cont.)

Productivity bonuses also must be limited to services performed personally by the physician.

Personal service compensation. For a physician who is compensated for personal service – under a medical directorship, for example – Wade recommended using a tracking device akin to a timesheet. Although timesheets may be unpopular, Wade explained that they serve as a reliable way to determine that physicians actually work the hours for which they receive payment. ■

CCH Chicago Bureau, Oct. 31, 2008

Trends

Final rule allows providers to object to performing services

Under a controversial final rule issued by HHS in the final weeks of the Bush administration, federally funded health care providers may refuse to participate in services to which they object, such as abortion and sterilization, without facing negative consequences from federal, state or local governments.

The rule requires hospitals and other recipients of certain HHS funds to certify their compliance with laws protecting the rights of health care providers to refuse to perform services to which they object for religious, moral, ethical or other reasons. The rule was published in the Federal Register on December 19, 2008, and will take effect after 30 days.

Provider conscience protections. The "provider conscience" rule affirms existing laws that allow providers to decline to perform certain procedures without losing federal funding. According to HHS Secretary Mike Leavitt, the rule will increase awareness of, and compliance with, provider conscience laws and prevent discrimination against those with moral objections to procedures like abortion.

The final rule:

- clarifies that nondiscrimination protections apply to institutional health care providers as well as individual employees working for recipients of certain HHS funds;
- requires recipients of certain HHS funds to certify compliance with laws protecting provider conscience rights; and
- designates the HHS Office for Civil Rights as the entity to receive com-

plaints of discrimination addressed by the existing statutes and the regulation.

Far-reaching rule. The new rule is far-reaching in that it applies, not just to physicians and nurses, but to any employee who plays a role in the health care delivery process, including pharmacists, technicians, psychologists, counselors, volunteers and trainees.

Leavitt said the rule's broad scope is necessary to prevent doctors and other health care providers from being "forced to choose between good professional standing and violating their conscience."

The American Hospital Association (AHA) opposed the rule. Executive Vice President Rick Pollack said in a statement that "The AHA is concerned that access to services for patients may be significantly hampered by the current definitions in this rule. The rule could also adversely impact important federal health care funds at a time when patients most need help."

Opponents of the rule have indicated that they will attempt to have it reversed under the Obama administration. ■

CCH Chicago Bureau, Dec. 23, 2008, Health Care Compliance Reporter, ¶700,098

Industry faces financial, performance, coding challenges in 2009

The health industry will face many challenges in 2009, including how to deal with more underinsured, document performance and adapt to new coding and payment methods, according to research published on December 11, 2008, by the Health Research Institute at PricewaterhouseCoopers (PwC), New York, New York.

"The coming year will be a watershed for health care in the United States," said David Chin, PwC Health Research Institute leader. "President-elect [Barack] Obama has called for significant reform for health care and will have a Democratic Congress supporting him."

Issues in 2009. According to PricewaterhouseCoopers' Health Research Institute, in 2009:

- Hospitals and other providers will experience an increase in bad debt and a drop in elective procedures as the payer mix continues to shift away from relatively lucrative commercial insurers.
- The number of underinsured will continue to rise. An estimated 25 million adults qualify as underinsured, an increase of 60 percent since 2003.
- Health care providers will be penalized for underperformance. CMS has proposed adding a new index, the total performance score, as part of Medicare's move to value-based purchasing. If Congress approves, CMS would replace the current quality reporting system with one in which Medicare withholds between 2 percent and 5 percent of its reimbursements to hospitals.
- Health care organizations will begin the conversion to a new International Classification of Disease code sets, known as ICD-10. The federal government has proposed an accelerated timetable for increasing the number of code sets used for billing and clinical classifications from 17,000 to 150,000. In addition to clinical process changes, the entire health care system from quality of care to medical records, incentive salary systems, and reimbursement will have to be adapted.

A copy of PricewaterhouseCoopers' Health Research Institute's "Top Nine Health Industry Issues in 2009" is available at http://www.pwc.com/hri/top9. ■

CCH Washington Bureau, Dec. 29, 2008

HIPAA

HHS outlines health information privacy toolkit and principles

In an effort to foster the privacy of health care information while enhancing technology, HHS Secretary Michael Leavitt has unveiled a framework that emphasizes principles such as transparency and limits on disclosure. Consumers should be provided with a simple and timely means to access and obtain their personal health information in a readable format, Leavitt said during a keynote address to the Nationwide Health Information Network Forum in Washington, D.C. on December 15, 2008.

Key features. Leavitt noted that consumers should (1) be provided a timely means to dispute the accuracy or integrity of their personal identifiable health information; (2) have erroneous information corrected or, if their request to correct information is denied, have the dispute documented; and (3) be able to add to and amend information in products controlled by them such as personal health records.

Leavitt also outlined the following principles:

- Consumers should have information about the policies and practices related to the collection, use, and disclosure of their personal information in an easy-to-read, standard notice.
- Consumers should decide to whom, when, and how their personal health information is shared.
- The collection, use, and disclosure of personal health information should be limited to the extent necessary to accomplish a specified purpose.
- Those who hold records must take reasonable steps to ensure that information is accurate and up-to-date and has not been altered or destroyed in an unauthorized manner. This principle should be applied even when the information is not covered by the Health Insurance Portability and Accountability Act, Leavitt added.
- Personal identifiable health information should be protected with reasonable administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure.
- Those who break the rules and put consumers' personal health information at risk must be held accountable.

In addition, Leavitt announced tools to help, including the "Leavitt Label," modeled after the nutritional labels on food packaging, to allow consumers to quickly compare personal health record products. ■

CCH Washington Bureau, Dec. 15, 2008

Health IT

E-prescribing systems with updated data boost costs savings

Electronic prescribing (e-prescribing) systems that incorporate updated drug formulary data can save possibly $845,000 per 100,000 patients a year, according to a recently published study by the HHS Agency for Healthcare Research and Quality (AHRQ). The study, titled "Effect of Electronic Prescribing with Formulary Decision Support on Medication Use and Cost," examined data collected over 18 months from two major Massachusetts health insurers covering 1.5 million patients and predicted that a complete transition to e-prescribing systems could potentially boost the savings up to $3.9 million per 100,000 patients per year. As these e-prescribing systems become widely available, the likelihood physicians will encounter and use these systems will increase. Using e-prescribing systems has the potential to improve drug safety by avoiding drug-drug interactions and other safety issues.

Formulary data. The price of drugs has led many insurers, policymakers, and patients to examine ways in which to control the fast-rising costs; many insurers have taken to listing approved prescription drugs known as formularies to inform both physicians and patients prices charged. As a result, patients are charged prices for medications in tiers, with the lowest copayment for generic medications (tier 1), higher copayments for preferred brand names (tier 2), and the highest copayments for nonpreferred brand names (tier 3).

A major obstacle to adoption of tiered systems and e-prescribing in general is the lack of updated drug formularies at the time of prescribing. E-prescribing systems incorporating updated formularies resulted in physicians increasing use of generic prescriptions by 3.3 percent; the increase usage was above and beyond the increasing use of generics trending in Massachusetts. The study noted that the doctors who wrote e-prescriptions were slightly younger and more likely to be female than those who did not. Internists, pediatricians, and family physicians made up nearly three quarters of those who used e-prescribing. ■

AHRQ Press Release, Dec. 9, 2008

In the News

Health care reform will take months to develop

Despite a public push for Congress to pass wide-ranging health care reforms in 2009, a key player in the House, Rep. Pete Stark (D-Calif.) said the legislation could take a year to complete. During a conference call with reporters on December 17, 2008, Stark, chairman of the Ways and Means Health Subcommittee, also noted that Congress will need the backing of the American Medical Association, the American Hospital Association, and the Pharmaceutical Research and Manufacturers of America to pass an effective health reform bill. Discussing legislative options with those groups will take time, Stark explained. "You're not going to do that in the first 100 days," he said, predicting that proposals will be formed by the end of 2009 and ready for a vote in early 2010. Such legislation may never receive the backing of the insurance industry, which opposes key elements of President-elect Barack Obama's reform plan.

CCH Washington Bureau, Dec. 17, 2008.

IRS releases final Form 990

The Internal Revenue Service announced that it has released the final versions of the 2008 Form 990 (Return of Organization Exempt From Income Tax), Form 990-EZ (Short Form Return), schedules and instructions. Form 990-EZ generally was not changed, although schedules from the Form 990 redesign must be used with the Form 990-EZ. The redesigned Form 990 must be filed in 2009 for the 2008 tax year. Form 990 must be filed by May 15 for a calendar year taxpayer. An automatic three-month extension is available, and another three month extension may be requested. Form 990 must be filed by all tax-exempt organizations that exceed the filing threshold for Form 990-EZ. For 2008, the thresholds for using Form 990-EZ are gross receipts under $1 million and total assets under $2.5 million. Form 990 had not been substantially redesigned in 30 years. The new form has an 11-page, 11-part core form that must be completed by all organizations, and 16 schedules to be filed by organizations satisfying the schedule's requirements. The revised instructions are 75 pages long.

CCH Washington Bureau, Dec. 24, 2008

IT can lower health care costs

A new report by the Healthcare Information and Management Systems Society (HIMSS) makes the case that expanding and improving health information technology (IT) can lower health care costs and help avoid medical errors. The report, entitled "A Call for Action: Enabling Healthcare Reform Using Information Technology," also outlines recommendations for Congress and President-elect Barack Obama. HIMSS recommends that Congress and the administration: (1) invest a minimum of $25 billion in health IT to help nongovernmental hospitals and physician practices adopt electronic medical records; (2) apply recognized standards and certified health IT products among all federally funded health programs; and (3) expand Stark exemptions and anti-kickback safe harbors for electronic medical records to cover additional health care software and related devices. The HIMSS report is available at http://www.himss.org/ASP/ContentRedirector.asp?ContentId=68724&=HIMSSNewsItem.

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