CMS to Shorten 2015 Attestation Reporting Period

The Centers for Medicare & Medicaid Services ("CMS") has announced it intends to give providers a "reprieve" by issuing a new rule which would "update" the Medicare and Medicaid Electronic Health Records ("EHR") incentive programs, and shorten the attestation period in 2015 from 365 to 90 days, in order to help "accommodate" those changes.

In a late January blog post (http://ow.ly/ISBdz), the deputy administrator for innovation and quality and the Chief Medical Officer ("CMO") for CMS, Patrick Conway, M.D., stated that CMS is following "multiple tracks" to realign the Meaningful Use program "to reflect the progress toward program goals and be responsive to stakeholder input." This new rule would be separate from the proposed rule implementing Stage 3 of the Meaningful Use program, which has already been submitted to the Office of Management and Budget for review.

It was generally acknowledged, even by CMS, that the 365 day attestation period presented problems, so the proposed changes should be welcome. In addition to shortening the attestation period, CMS is also considering proposals to modify other aspects of the program in order to match long-term goals, reduce complexity and lessen providers' reporting burdens, as well as shortening the EMR reporting period in 2015 to 90 days in order to accommodate these changes.

ABIM Suspends Part of Controversial Recertification Process

The American Board of Internal Medicine ("ABIM") has suspended controversial aspects of its maintenance-of-certification ("MOC") program, specifically the "Practice Assessment," "Patient Voice" and "Patient Safety" requirements, for at least two years, and apologized for these provisions.

At a recent AMA meeting, physicians pointed out that board-certification is becoming a frequent requirement for credentialing by hospitals, health systems and health insurance plans. Proposals advanced included asking the AMA to pass resolutions opposing discrimination on the basis of board certification by hospitals, employers, state licensing boards, insurers and government programs which could restrict a physician's right to practice medicine without interference, and asking the AMA to oppose any mandated MOC unless research shows a link between certification and improved patient outcomes.

The ABIM, along with the other twenty-three members of the American Board of Medical Specialties, recently changed its recertification process from one that required an examination every ten years to one requiring continuous education and self-assessment. Dr. Richard Baron, President of the ABIM, said, in a letter posted on the Board's website, http://ow.ly/IPzkt that "ABIM clearly got it wrong. We launched programs that weren't ready and we didn't deliver an MOC program that physicians found meaningful." The ABIM now will not revoke an internist's board certification for non-completion of the program's suspended aspects.

Board Increasing Scrutiny of CDS Prescriptions

The New Jersey State Board of Medical Examiners (the "Board") has been giving increased scrutiny to providers who treat patients with chronic, intractable pain by prescribing Controlled Dangerous Substances ("CDS"). This scrutiny has spread beyond those few instances of "pill mills" or providers diverting narcotics to the streets, to encompass virtually every physician who prescribes CDS to treat chronic pain. It is essential for physicians to maintain full and complete records, showing physical examinations and diagnoses to support the type and quantity of CDS prescribed, keep current on the latest medical literature on the subject, and take advantage of Continuing Medical Education ("CME") courses. A physician should also make use of the New Jersey Prescription Monitoring program, to ensure the patient is not also receiving CDS from other sources. For general practitioners, specialists should be consulted and, should the circumstances warrant, consideration given to referral to a narcotics addiction treatment or rehabilitation facility.

Deadline for Notifying the HHS of any Breaches of Protected Health Information is March 1, 2015

Question:When is the deadline for notifying the United States Department of Health and Human Services ("HHS") of any breaches of protected health information? If I need to give notice, how do I submit a notice of breach?

Answer:The Health Insurance Portability and Accountability Act ("HIPAA") requires covered entities to report to HHS any breaches of protected health information pursuant to 45 C.F.R. § 164.408. In cases where fewer than 500 individuals' protected health information was breached in the prior calendar year, a covered entity must notify the Secretary of the breach within sixty (60) days of the end of the calendar year in which the breach was discovered (March 1, 2015). In cases where breaches affected 500 or more individuals, a covered entity must notify the Secretary of the breach "without unreasonable delay" and in no case later than sixty (60) calendar days from the discovery of the breach.

If the number of individuals affected by a breach is uncertain at the time of submission, the covered entity should provide an estimate, and, if it discovers additional information, submit updates. If only one option is available in a particular submission category, the covered entity should pick the best option, and may provide additional details in the free text portion of the submission.

Should you have any questions, please feel free to call me. Thank you.

Best,

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