Communiqué
VOLUME 17, ISSUE 2
SPRING 2012
ANESTHESIA BUSINESS CONSULTANTS

Proposed Meaningful Use Stage 2 – What it Means to the Anesthesia and Pain Communities

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On March 7, 2012, the Centers for Medicare and Medicaid Services (CMS) published its Notice of Proposed Rule Making (NPRM, or proposed rule) for Stage 2 user requirements for the Medicare/Medicaid Electronic Health Record (EHR) Incentive Program ("meaningful use," or MU) in the *Federal Register.* 77 FR 13698.[1] There is a three pronged focus to the Stage 2 criteria: standardizing data formats to dramatically simplify how information is both captured and shared across disparate IT systems in order to be better able to coordinate care with other physicians; ensuring that patients be able to access and easily download their healthcare records and images for their own use; and expanding the scope of tracked quality metrics to include specialists and

to reflect and improve specific patient outcomes as well as care coordination.

Although subsequent to the final rule establishing Stage 1 MU criteria CMS repeatedly assured the medical

Continued on page 4

➤ INSIDE THIS ISSUE:

Proposed Meaningful Use Stage 2 – What it Means to the Anesthesia and Pain Communities 1
Helpful and Not So Helpful Implementations of Health Information Technology 2
The AQI: Present and Future 3
Planning for Payor Negotiations 14
Anesthesiologists Should Beware of HIPAA Audits 16
Knowledge is Power: Why Anesthesiologists Need to Capture, Analyze and Use Data 18
Event Calendar 20

PROPOSED MEANINGFUL USE STAGE 2 – WHAT IT MEANS TO THE ANESTHESIA AND PAIN COMMUNITIES

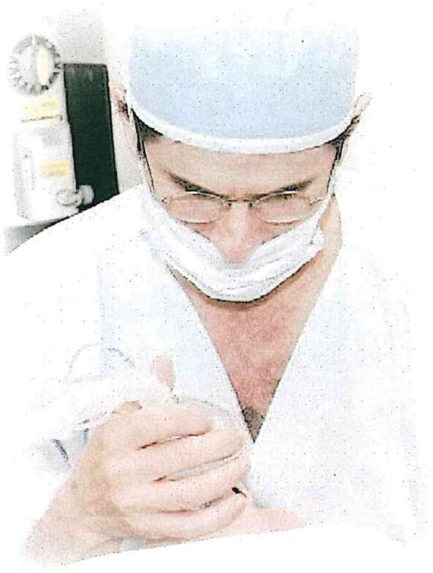
Continued from page 1

community that the needs of specialists would be addressed in the Stage 2 requirements, the Stage 2 proposed rule still falls short for certain specialists including anesthesiologists. Indeed, although CMS itself boasts that the Stage 2 criteria have greater applicability to many specialty providers with the addition of objectives with respect to:

- Imaging results and information accessible through certified EHR technology;
- Capability to identify and report cancer cases to a State cancer registry; and
- Capability to identify and report specific cases to a specialized registry (other than a cancer registry),

these objectives are not generally applicable to anesthesiologists or pain specialists.

The proposed Stage 2 criteria establish that anesthesiologists and pain physicians are still stuck in the unenviable position of being required to demonstrate they are meaningful users of Certified EHR Technology – a difficult, if not impossible proposition for most – or face Medicare or Medicaid payment adjustments starting in 2015. As such, this article attempts to boil down the voluminous 455 page NPRM, highlight the changes that have been made to Stage 1 criteria and identify the similarities and differences between Stage 1 and 2 Meaningful Use. On the basis of the majority of this reading audience, the focus is exclusively on the



proposed changes to the Medicare version of the EHR Incentive Program for eligible professionals (EPs)[2].

BACKGROUND

On July 13, 2010, CMS issued the final rule defining the meaningful use of EHR that specified the Stage 1 criteria EPs, eligible hospitals and critical access hospitals must meet in order to qualify for an incentive payment, calculation of the incentive payment amounts, and other program participation requirements. The final rules implemented the EHR incentive program requirements under the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), the health care information technology provisions enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA). Under the EHR incentive program, Medicare and Medicaid incentive payments totaling as much as $27 billion from 2011 to 2021 will be available for payment to EPs and eligible hospitals for the "meaningful use of certified EHR technology." The HITECH Act provisions are designed to serve the dual goals of improving health care through increased efficiencies and improved care decisions, while also stimulating economic recovery.

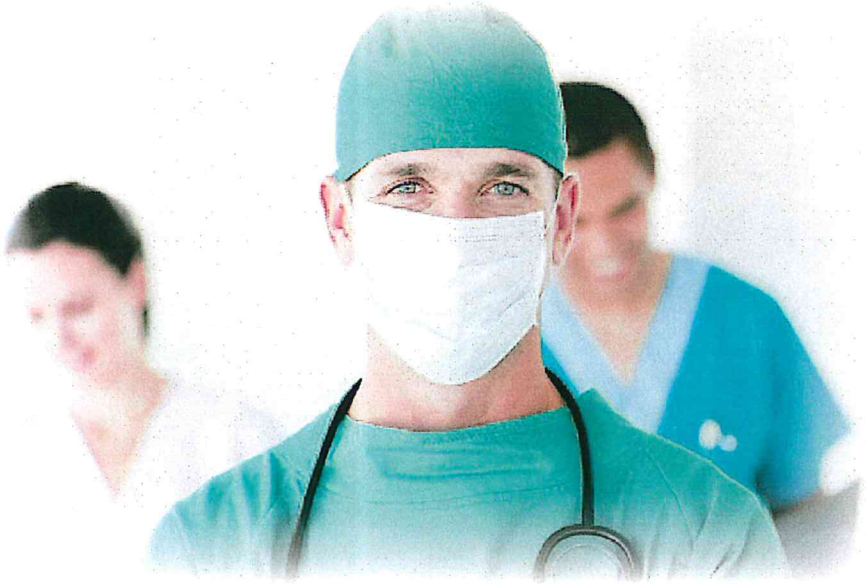
EPs who qualify for Medicare incentives can receive up to $44,000 per EP over a five-year period, while EPs who meet Medicaid patient volume requirements and qualify for Medicaid incentives can receive incentives of up to $63,750 per EP over six years. (EPs who qualify for both incentive programs must choose one.)

In the Stage 1 final rule, CMS indicated that the Medicare and Medicaid EHR Incentive Programs would consist of 3 different stages of meaningful use requirements, with each stage requiring increasing use of EHRs and electronic information exchange. The three stages are:

- **Stage 1 (which began in 2011 and remains the starting point for all providers):** "meaningful use" consists of transferring data to EHRs and being able to share information, including electronic copies and visit summaries for patients.
- **Stage 2 (to be implemented in 2014 under the proposed**

[1] The HHS Office of the National Coordinator for HIT (ONC) issued a companion rule identifying updates to the standards and criteria for the certification of EHR technology. Whereas CMS has regulatory purview over implementation of the EHR Incentive Program, including requirements for participants, incentives, etc., ONC has regulatory authority over the HIT certification program, including the certification criteria, standards, and implementation specifications for products used by program participants.

[2] Eligible professionals under the Medicare EHR Incentive Program include: (1) a doctor of medicine or osteopathy; (2) a doctor of dental surgery or dental medicine; (3) a doctor of podiatry; (4) a doctor of optometry; and (5) a chiropractor. Hospital-based eligible professionals are not eligible for incentive payments. An eligible professional is considered hospital-based if 90% or more of his or her services are performed in a hospital inpatient (Place Of Service code 21) or emergency room (Place Of Service code 23) setting. Only a small minority of anesthesiologists provide 90% or more of their services on an inpatient basis. Outpatient procedures performed in the hospital or in an ambulatory surgery center are excluded from the 90%.



rule): "meaningful use" focuses on advanced clinical processes, including standards such as online access for patients to their health information and electronic health information exchange between providers.

- **Stage 3 (expected to be implemented in 2016):** "meaningful use" focuses on demonstrating that the quality of health care has been improved.

Stage 2 – Anesthesiologists and Pain Physicians Must Still Comply

In the Stage 2 NPRM, there were no proposed changes to the hospital based eligible professional definition, and thus most anesthesiologists will continue to fall within the definition of an EP. Notably, however, CMS does ask for comment on situations where EPs who are classified as hospital-based and working in specialized hospital units have independently procured and utilized EHR technology that is completely distinct from that of the hospital. The focus of the comments should be on whether specialized hospital units are using stand-alone EHR technology as opposed to using the facilities and equipment of the hospital. This situation could be applicable to anesthesia groups, especially those that include pain specialists who have their own pain clinics where they are using stand-alone certified EHR technology.

Transitioning From Stage 1 to Stage 2 Meaningful Use

In the NPRM, CMS proposes a continuation of the existing paradigm in which an EP enters the program at Stage 1, regardless of the year of entry, and spends two years in each stage before proceeding to the next. Importantly, however, CMS proposes an extension of Stage 1, ***giving providers an additional year for implementation of Stage 2 criteria.*** Thus, those EPs who successfully participated in 2011 will have until 2014 to move into Stage 2. The reasoning behind this extension is to allow the needed time for vendors to develop and providers to implement certified EHR technology that can meet the new Stage 2 requirements. The additional time to achieve Stage 2 objectives is critical given the higher performance thresholds of Stage 2. With proposed regulations coming out now and final regulations expected this summer, it would have been nearly impossible for EPs to start Stage 2 by January 1, 2013. Certainly, this additional time will give providers the opportunity to emphasize quality over quantity in meeting meaningful use objectives.

In Stage 1, EPs are required to meet, or qualify for an exclusion to, all of the 15 core objectives and 5 out of the 10 menu measures for a total of 20 objectives. In the proposed rule, CMS proposes to maintain the same core and menu measures structure of meeting or qualifying for an exclusion of a total of 20 objectives but increases the number of core objectives to 17 and requires that EPs meet 3 of the 5 menu objectives. CMS is also proposing that, beginning in 2014, meeting exclusions from individual menu set measures will not reduce the total number of menu set measures that need to be reported. In other words, EPs will need to report on 5 of 10 menu set measures, regardless of whether they qualify for exclusions. However, those EPs qualifying for more than 5 exclusions will need to report on all of the menu set measures that are possible to report as well as the remaining exclusions.

Almost all of the Stage 1 core and menu objectives have been retained for Stage 2. However, multiple Stage 1 objectives have been combined into more unified Stage 2 objectives, with a subsequent rise in the measure threshold that providers must achieve for each objective that has been retained from Stage 1. According to CMS, this eliminates unnecessary accounting and reporting burden for providers by recognizing that, for providers who have been Stage 1 meaningful users already, recording these data in structured form has become a normal part of their delivery of health care. Stage 2 follows most of the existing Stage 1 core and menu objectives while adding new objectives for patient access to health information and increasing expectations for health

Continued on page 6

PROPOSED MEANINGFUL USE STAGE 2 – WHAT IT MEANS TO THE ANESTHESIA AND PAIN COMMUNITIES

Continued from page 5

information exchange and data transfer, among other changes. Certain areas and elements in the Stage 2 rule may benefit EPs aiming for, and currently on the way to, meaningful use, whereas others may represent challenges.

CHANGES TO STAGE 1

There have been five (5) specific changes to existing Stage 1 objectives and measures including computerized provider order entry (CPOE); vital signs; test of health information exchange; e-copy and online access; and public health objectives. Some of the proposed changes are optional for EPs beginning in 2013 and mandatory in 2014 and beyond. The following chart describes the changes and their effective dates:

Stage 1 Objective	Proposed Change(s)	Effective
Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record Per State, local and professional guidelines	**Change to denominator:** More Than 30% of medication orders created by the EP during the EHR reporting period are recorded using CPOE	2013 optional (can use new measure as an alternative) 2014+ required
Record and chart changes in vital signs	**Change to age limitations:** More than 50% of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data **Change to, and splitting up of, exclusions – 4 total:** (1) sees no patients 3 years or older is excluded from recording blood pressure; (2) believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; (3) believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (4) believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.	2013 optional (can use new measure as an alternative) 2014+ required
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically	**Deleted**	2013+
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4 business days of the information being available to the EP	**Replace with the Stage 2 objective and measure:** Objective: Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP Measure: More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information	2014+
Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice	**Added clarification:** Addition of "except where prohibited" to the objective regulation text	2013+

PROPOSED STAGE 2 MU OBJECTIVES AND MEASURES

The following table shows the proposed 17 mandatory objectives, measures and exclusions (where available). Changes from Stage 1 or new provisions are highlighted. This table is followed by a table containing the five menu set objectives.

Stage 2 Objective	Measure(s)	Exclusion(s)
Use CPOE for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local, and professional guidelines to create the first record of the order.	More than 60% of medication, laboratory, and radiology orders created by the EP during the EHR reporting period are recorded using CPOE.	Any EP who writes fewer than 100 medication, laboratory, and radiology orders during the EHR reporting period.
Generate and transmit permissible prescriptions electronically (eRx).	More than 65% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period or does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 25 miles of the EP's practice location at the start of his or her EHR reporting period.
Record all of the following demographics: (A) Preferred language (B) Gender (C) Race (D) Ethnicity (E) Date of Birth	More than 80% of all unique patients seen by the EP during the EHR reporting period have demographics recorded as structured data.	N/A
Record and chart changes in the following vital signs: (A) Height/Length (B) Weight (C) Blood pressure (ages 3 and over) (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for patients 0-20 years, including BMI	More than 80% of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data	Any EP who: (A) Sees no patient 3 years or older is excluded from recording blood pressure (B) Believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them (C) Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (D) Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded form recording height/length and weight
Record smoking status for patients 13 years old or older	More than 80% of all unique patients 13 years old or older seen by the EP during the EHR reporting period have smoking status recorded as structured data	Any EP who sees no patients 13 years old or older
Use clinical decision support to improve performance on high priority health conditions	(A) Implement 5 clinical decision support interventions related to 5 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period; and, (B) The EP has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period	N/A

Continued on page 8

PROPOSED MEANINGFUL USE STAGE 2 – WHAT IT MEANS TO THE ANESTHESIA AND PAIN COMMUNITIES

Continued from page 7

Stage 2 Objective	Measure(s)	Exclusion(s)
Incorporate clinical lab-test results into Certified EHR Technology as structured data	More than **55%** of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data	Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one report listing patients of the EP with a specific condition	N/A
Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care	More than 10% of all unique patients who have had an office visit with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference	Any EP who has had no office visits in the 24 months before the beginning of the EHR reporting period
Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP	(A) More than 50% of all unique patients seen buy the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) **online access** to their health information subject to the EP's discretion to withhold certain information; and, **(B) More than 10% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their health information**	Any EP who neither orders nor creates any of the information listed for inclusion as part of this measure is excluded from both (A) and (B) measures Any EP that conducts the majority (50%) or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period is excluded from (B)only
Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients within **24 hours** for more than 50% of office visits	Any EP who has no office visits during the EHR reporting period
Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient	Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10% of all office visits by the EP	Any EP who has no office visits during the EHR reporting period
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP performs medication reconciliation for more than **65%** of transitions of care in which the patient is transitioned into the care of the EP	Any EP who was not the recipient of any transitions of care during the EHR reporting period
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care of referral	The EP that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than **65%** of transitions of care and referrals **with 10% sent electronically**	Any EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period

Stage 2 Objective	Measure(s)	Exclusion(s)
Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice	**Successful ongoing** submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period	Any EP that meets one or more of the following criteria: (A) The EP does not administer any of the immunizations to any of the populations for which data is collected by the jurisdiction's immunization registry or immunization information system during the EHR reporting period (B) The EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of receiving electronic immunization data in the specific standards required for Certified EHR Technology at the start of their EHR reporting period (C) The EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the version of the standard that the EP's Certified EHR Technology can send at the start of their EHR reporting period
Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process	N/A
Use secure electronic messaging to communicate with patients on relevant health information	**A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10% of unique patients seen by the EP during the HER reporting period**	Any EP who has no office visits during the EHR reporting period

MENU SET OBJECTIVES:

Stage 2 Objective	Measure(s)	Exclusion(s)
Imaging results and information are accessible through Certified EHR Technology	**More than 40% of all scans and tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through Certified EHR Technology**	Any EP who does not perform diagnostic interpretation of scans or tests whose result is an image during the EHR reporting period
Record patient family health history as structured data	**More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives**	Any EP who has no office visits during the EHR reporting period

Continued on page 10

PROPOSED MEANINGFUL USE STAGE 2 – WHAT IT MEANS TO THE ANESTHESIA AND PAIN COMMUNITIES

Continued from page 9

Stage 2 Objective	Measure(s)	Exclusion(s)
Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice	**Successful ongoing** submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period	Any EP that meets one or more of the following criteria: (A) The EP is not in a category of providers who collect ambulatory syndromic surveillance information on their patients during the EHR reporting period (B) The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required for Certified EHR Technology at the start of their EHR reporting period (C) The EP operates in a jurisdiction for which no public health agency is capable of accepting the version of the standard that the EP's Certified EHR Technology can send at the start of their EHR reporting period
Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice	**Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period**	Any EP who: (A) Does not diagnose or directly treat cancer; or (B) Operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for Certified EHR Technology at the start of their EHR reporting period
Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice	**Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period**	Any EP who: (A) Does not diagnose or directly treat any disease associated with a specialized registry; or (B) Operates in a jurisdiction for which no registry is capable of receiving electronic specific case information in the specific standards required under Stage 2 at the beginning of their EHR reporting period

CLINICAL QUALITY MEASURES

Just as in Stage 1, CMS proposes that EPs be required to report on 12 specified clinical quality measures (CQM) in order to qualify for incentive payments. CMS proposes, however, to eliminate CQMs as a meaningful use core objective and instead make reporting CQMs an inherent component of the definition of "meaningful EHR user." The end result is that CQMs must still be reported in order for the EP to qualify as a meaningful EHR user.

For EPs, Stage 2 proposes a set of clinical quality measures beginning in 2014 that align with the existing quality programs such as measures for the Physician Quality Reporting System (PQRS) and the CMS Shared Savings Program. A major burden for providers to date has been the checkerboard of clinical quality measures that HHS programs ask providers to report. Hopefully, private payors will also adopt these measures for their quality programs since they will be already incorporated into certified electronic health records. If this occurs, it would radically reduce the complexity and burden of quality reporting for providers, and thereby increase clinicians' focus on improvement.

The Stage 2 changes for clinical quality measures include an enhanced objective and associated measure to use clinical decision support to improve performance on high-priority conditions. This is a move from a requirement to use one decision support "rule" relevant to a specialty or

a high clinical priority to the use of five clinical support "interventions" associated with high-priority health conditions. There is also a specific requirement to link each decision support intervention to one or more of the clinical quality measures reported on by a provider. Additionally, the objective to "exchange key clinical information" from Stage 1 was enhanced to provide a summary of care when a patient transitions from, or is referred to, a healthcare professional. These changes are intended to enhance the value of the clinical decision support and data exchange objectives.

The proposed rule also outlines a process by which EPs would submit CQM data electronically after their first year of Stage 1 participation, which, according to CMS, is aimed at the goal of reducing the associated burden of reporting on quality measures for providers. CMS has proposed two different approaches of CQM reporting: aggregate-level electronic reporting as a group or through existing quality reporting systems and is soliciting comments on these approaches.

Payment Adjustments

Medicare payment adjustments are required by statute to take effect in 2015. CMS proposes that any Medicare EP or hospital that demonstrates meaningful use in 2013 would avoid payment adjustment in 2015. Also, any EP that first demonstrates meaningful use in 2014 would avoid the penalty if they meet the attestation requirement by October 1, 2014. This means that the EP must begin the 90 day EHR reporting period no later than July 2, 2014.

Notably, CMS is proposing new exceptions to these payment adjustments. This proposed rule outlines three categories of exceptions based on:

- Availability of internet access or barriers to obtaining IT infrastructure;
- A time-limited exception for newly practicing EPs who would not otherwise be able to avoid payment adjustments;
- Unforeseen circumstances such as natural disasters that would be handled on a case-by-case basis.

EPs would be required to submit an application to CMS for an exclusion to apply. The applications would need to be submitted not later than July 1 of the year before the payment adjustment year.

CMS is also soliciting comments on additional criteria for exceptions. Most important to specialists such as anesthesiologists, CMS specifically discussed the possibility that the combination of three barriers that are common to the specialties could constitute a significant hardship. The three barriers include:

- Lack of direct interaction with patients;
- Lack of need for follow-up care for patients; and
- Lack of control over the availability of Certified EHR Technology.

CMS made it a point that they do not believe that any one of these barriers taken independently constitutes a significant hardship but considered whether any specialty may nearly uniformly face all three barriers. Clearly, this is an excellent opportunity for the anesthesia community to convince CMS during the comment period that this exclusion should apply, in large part, to anesthesiologists.

Conclusion

Pursuant to the Stage 1 final rule and the proposed Stage 2 rule, the majority of anesthesiologists and pain physicians will fall within the definition of an EP and, as such, must either demonstrate they are a meaningful user of Certified EHR Technology or face Medicare payment adjustments starting in 2015. In the Stage 2 NPRM, CMS did open the door, ever so slightly, for specialists to make their case that they should not be included in the Medicare and Medicaid EHR Incentive Programs or be subject to the payment adjustments.

There is a 60-day public comment period, until May 7, 2012, which the Anesthesia Community would be well served to aggressively continue in its efforts to convince CMS that they should be excluded from the meaningful use requirements and payment adjustments. Comments can be made at www.regulations.gov. ABC will be submitting a letter. The importance of the comment period cannot be stressed enough as the general consensus is that the final rule, expected to be released this summer, is likely to mirror, in large part, the proposed rule.

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