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HIPAA

To avoid penalties, go beyond HHS' HIPAA security risk analysis tool

Plan on following up with more serious compliance efforts if you use HHS' new HIPAA security risk analysis (SRA) tool, which experts say has serious drawbacks.

Practices are likely to re-invest their attention on HIPAA compliance — with 65% of respondents listing it as "a key initiative" in *Part B News*' recent survey of almost 1,100 respondents — after Congress delayed ICD-10 for at least a year (*PBN 4/14/14*).

(*see* ***HIPAA****, p. 4*)

Billing

5 tips to help your critical care services claims withstand audits

Don't assume that a patient in intensive care is eligible for a critical care service (**99291-99292**).

In reality, a patient does not have to be in intensive care to qualify for critical care, nor does the patient's presence in intensive care justify a critical care service, says Maxine Lewis, consultant with Medical Coding and Reimbursement in Cincinnati.

Lewis has seen critical care services rendered in a driveway that were medically supported.

(*see* ***critical care****, p. 7*)

Ensure proper use of modifiers 59, 76

Guidelines and policies for some of your most commonly used modifiers – including **59** (Distinct procedural service) and **76** (Repeat service) – have changed, which could lead to denials if your practice doesn't know the new requirements. Buy the webinar on CD **2014 Modifier Maze: Master your use of modifiers 59, 76 and more to minimize Medicare denials** to train your staff. For more information, visit *https://store.decisionhealth.com/Product.aspx?ProductCode=TA2488CD*.

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All Medicare fees are par, office, national unless otherwise noted.

Meaningful use

Sleeping on meaningful use? 4 ways to reboot your compliance

ICD-10 may be delayed, but meaningful use standards won't be, say experts — and if, like some providers, you've been slacking on your compliance, now's the time to get back on track to avoid an up to 2% payment penalty in 2015.

Practices tell *Part B News* they will focus more on compliance with meaningful use requirements in the wake of the recent ICD-10 delay. Meaningful use was the second-most-cited "key initiative" in the survey mentioned by 53% of the almost 1,100 respondents (*PBN 4/14/14*). (*HIPAA was first with 65% — see related story, p. 1.*)

No pullback on meaningful use

CMS has shown some flexibility in recent months by pushing back the stage 3 timeline and by allowing a new hardship exception category for providers with vendor problems (*PBN 3/10/14*). And it's understandable that people would think, if ICD-10 can be set back after repeated official insistences that it would not be, they could do the same with meaningful use.

"If anything, they'll be even more likely to make sure people stick to the task," says Dr. Michele C. Reed, a family medicine physician in Queens, N.Y., and 2014 Office of the National Coordinator for Health IT Fellow, because they know providers have more time for it now.

"Recent extensions and delays to government-mandated health care programs have more to do with political influence and legislative timing than with deliberative policy changes," says Ben Quirk, CEO of Quirk Healthcare Solutions in Delray Beach, Fla. Though medical organizations still push for meaningful use relief, the ICD-10 delay came from an act of Congress, not from CMS – which at this writing has not issued a formal response to the delay, though some contractors have issued guidance saying that their ICD-10 testing plans for July have been put on hold.

Quirk "highly doubts" anything like what happened to ICD-10 will happen to meaningful use this year, since there won't be anything like the "doc fix" bill to slip it into.

4 ways to reboot

Because you're not likely to get relief from your current requirements, take these steps to comply with meaningful use:

- **Update your system for stage 2.** "So many of our colleagues haven't done it," says Reed. Even if you're on stage 1 now, upgrade to be prepared for the upcoming requirements. Reed recognizes some practices have had vendor issues but if you aren't claiming the new hardship exception for vendors who have not certified their software for stage 2, then you have to make the necessary adjustments to attest (*PBN 3/10/14*).

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• **Focus on documentation.** "I advise [providers] to keep and retain all documentation necessary to demonstrate satisfaction of the meaningful use objectives and quality measures," says Rick Rifenbark, a partner at Foley & Lardner in Los Angeles and a member of its Health Care Industry Team. He cites the document support for the security risk analysis measure – which enough providers got tripped up on that CMS issued a tipsheet about it, says Rifenbark. He also reminds you that the analysis has to be performed during the meaningful use reporting period – not before or after.

That requires extra attention "because not all EHR systems may capture documentation related to the yes/no meaningful use measures," says Rifenbark. Providers may need to keep external documentation and screenshots to support compliance with those measures. Examples include objectives related to drug formulary checks, drug-drug/drug-allergy interaction checks and clinical decision support. "All of these materials will be very important in the event of a CMS audit," says Rifenbark.

• **Use the CMS resources.** CMS recently issued the stage 2 version of the calculator it had created for stage 1 attestation last year. Our experts are mixed on its usefulness but suggest the calculator is a good first step if you haven't done any work on stage 2, aren't sure how much coverage your EHR is giving you on it and need to see where you stand.

Also check out the stage 1 and stage 2 tipsheets at the CMS website, recommends Todd Searls, director of Wide River LLC in Lincoln, Neb.; there are several of them, including a "Meaningful Use for Specialists" tipsheet. If you've been away from meaningful use or are new to it, they will bring you up to date on what you missed, he says.

• **Get help from local health departments and medical associations.** Reed has had a relatively smooth time of her meaningful use transitions because she got involved with New York City Department of Health and Mental Hygiene's Primary Care Information Project (PCIP), which gave her training on achieving meaningful use. "They've been helpful from day one," she says. "If there were any glitches, I didn't feel them. They had classes for all the different training aspects, from reception through billing." *— Roy Edroso (redroso@decisionhealth.com)*

Resources:

- Stage 1 calculator: *www.cms.gov/apps/stage-1-meaningful-use-attestation-calculator/*
- Stage 2 calculator: *www.cms.gov/apps/stage-2-meaningful-use-attestation-calculator/*
- Security Risk Analysis tipsheet: *www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAssessment_FactSheet_Updated20131122.pdf*

Coding

Review your EOBs to watch for payer trends on modifier reimbursements

Don't let rumors about payers' acceptance of certain modifiers prevent you from appending modifiers and capturing your appropriate reimbursements.

For example, a revenue cycle management company in Tinley Park, Ill., was told that the **51** modifier (Multiple procedures) is not accepted by Medicare. Thus the organization uses modifier **59** (Distinct procedural service) instead.

"This is incorrect as a general rule," notes Terry Fletcher, CPC, a health care coding and reimbursement consultant based in Laguna Beach, Calif.

Some Medicare administrative contractors (MACs) will add the modifier 51 on their own for price reduction internally. The 51 modifier is a CPT modifier that some payers recognize and some don't.

"We recommend you keep an eye out for trends in your explanation of benefits (EOBs)," Fletcher adds. Fletcher was the speaker for *Part B News*' webinar **2014 Modifier Maze: Master your use of modifiers 59, 76 and more to minimize Medicare denials** and answered a variety of modifier coding questions.

Below are some of the questions posed by attendees about how to properly use modifiers to ensure you're capturing all of the reimbursements you deserve.

Question: *What is the difference between the* ***GV*** *and* ***GW*** *modifiers? And when are they used?*

Answer: The GV modifier (Attending physician not employed or paid under agreement by the patient's hospice provider) is typically used for long-term nursing facility or skilled nursing facility (SNF) patients. The GW

modifier (Service unrelated to terminal condition) is for physicians treating hospice patients when the patients are seen in the outpatient office setting for visits unrelated to their Medicare Part A SNF/hospice stays.

Question: *When we have* ***99223*** *(Initial hospital care) and* ***99291*** *(Critical care E/M) occur on the same day, some payers allow the* ***25*** *modifier (Significant, separately identifiable E/M service by the same physician or qualified health care professional on the same day of the procedure) on each and some don't. Is this a payer-specific decision or is there a better way to try and get both codes paid?*

Answer: The critical care code (99291) is not subject to a 25 modifier use. You will need clear documentation to reflect different encounters to report both codes on the same day.

Question: *We have pulmonary function tests performed on the same day as hospital visits. Should a 25 modifier be appended to the hospital code?*

Answer: Only if you see denials when they are billed together.

Question: *I thought Medicare states that the* ***76*** *modifier (Repeat procedure or service by same physician or other qualified health care professional) cannot be used on surgical codes. Am I wrong?*

Answer: Medicare gives recommendations about when to use the 76 modifier; it is not a rule. For CMS and some payers, they can be unclear on using the code for other procedures. It is allowed when appropriate on codes throughout the CPT book.

Question: *Is the* ***KX*** *modifier (Requirements specified in the medical policy have been met) used only for physical therapy and occupational therapy or can it be used for other specialties that have a lot of local coverage determinations (LCDs) such as chronic wound care in the outpatient setting?*

Answer: The KX modifier is used on different procedural codes, and you have to search the LCDs to know when it is needed. For example, Medicare's recent pacemaker billing transmittals R161NCD and R2872CP for an updated national coverage determination (NCD) instruct physicians to use the KX modifier.

Question: *If we report* ***64713*** *(Neuroplasty; brachial plexus) four times on one claim, can we use a 76 modifier with the same diagnosis?*

Answer: You can try, but because you have to specify multiple brachial plexus nerves, you may be better served using the 59 modifier or coding units.

Question: *Can different areas of debridement be bundled and does it need a modifier?*

Answer: Debridement is based on area and total centimeters. You would have to reflect different extremities or body parts and then yes, the 59 modifier would be appropriate.

Question: *Can you clarify the use of modifier 59 and 51 with codes* ***45385*** *(Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor, polyp or other lesion by snare technique),* ***45381*** *(With directed submucosal injection),* ***43239*** *(Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple) and* ***43450*** *(Dilation of esophagus, by unguided sound or bougie, single or multiple passes) all done in one session?*

Answer: You would need to clarify different sites, different polyps and techniques to use the 59 modifier. The upper GI endoscopy biopsy does not need a modifier when billed with a colonoscopy. The 43450 needs a 51 modifier when reported with the 43239 procedure.
— Jennifer Clampet (jclampet@decisionhealth.com)

Editor's note: *To purchase the CD for the April 8 webinar* ***2014 Modifier Maze: Master your use of modifiers 59, 76 and more to minimize Medicare denials****, visit* https://store.decisionhealth.com/Product.aspx?ProductCode=TA2488CD&PromotionCode *or call 1-877-602-3835 and refer to product code TA2488CD.*

HIPAA

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Right on time for that shift in attention, HHS released its tool that was designed by the Office of the National Coordinator for Health Information Technology (ONC) and Office for Civil Rights (OCR). The tool will guide practices with 10 or fewer physicians in conducting risk assessments of their organizations.

According to HIPAA Security Rule, covered entities are required to "conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of electronic protected health information held by the covered entity," and then take steps to plug the leaks.

A security risk analysis also is part of providers' meaningful use requirements, so you could be putting your meaningful use bonuses at risk if auditors find you haven't done it (*PBN 6/4/12*).

(continued on p. 6)

Benchmark of the week

Some specialties see denial rates rise for 99291; others see fewer denials

Internal medicine, critical care and family practice saw jumps in denials for **99291** (Critical care, E/M of the critically ill or critically injured patient; first 30-74 minutes) in 2012 from previous years.

Denials for 99291 for family practice had dipped from 2010 to 2011 (from 6.9% to 6.7%) but then jumped to 9.0% in 2012.

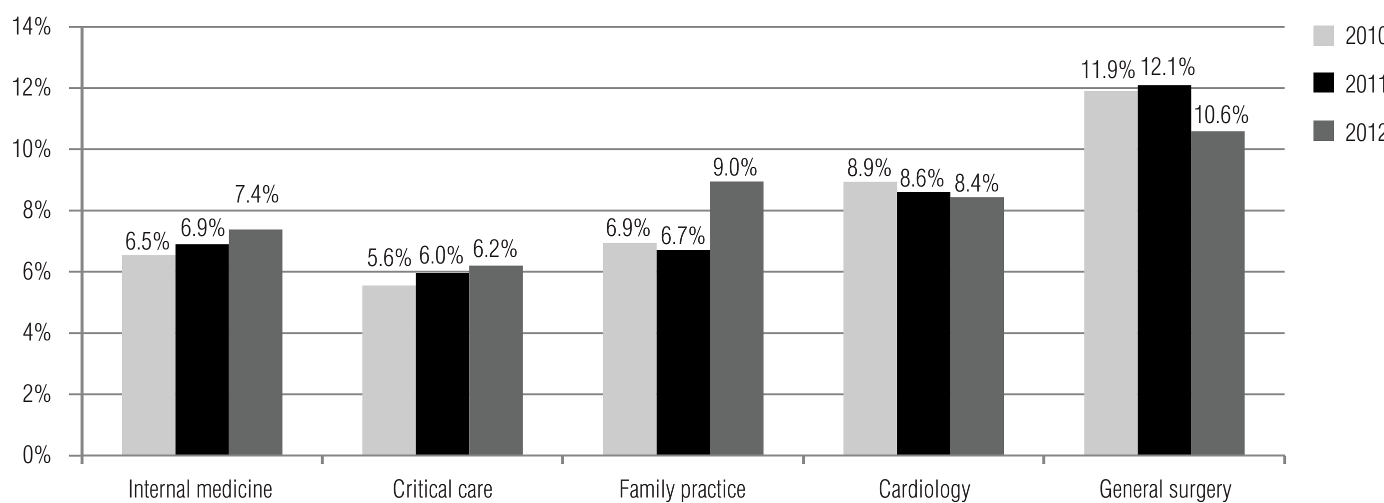
Cardiology and general surgery – which like the three specialties above were among five of the 10 specialties billing critical care services most often in 2012 — saw denials decrease in 2012, according to the latest Medicare billing data available.

For add-on code **99292** (Critical care ... each additional 30 minutes), critical care saw a steep rise in denials from 14.1% in 2010 to 15.7% in 2011 to 19.8% in 2012. Meanwhile, internal medicine saw a steep decline in denials to 18.3% in 2012 from 23.9% in 2011.

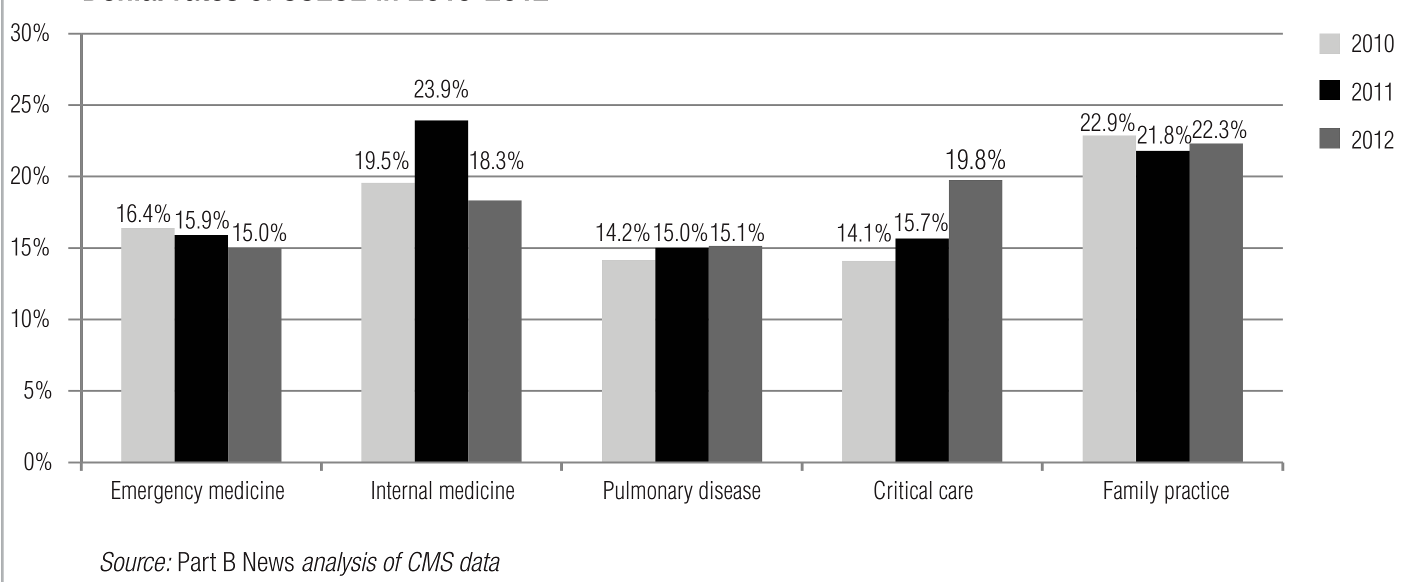
The chart for denial rates of 99292 also shows data for five of the 10 specialties that billed the code most often in 2012.

(For tips to bill critical care services correctly, see story, p. 1.)

Denial rates of 99291 in 2010-2012



Denial rates of 99292 in 2010-2012



Source: Part B News *analysis of CMS data*

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What HHS' tool misses

The tool – which comes in paper, desktop computer and iPad versions – runs users through 155 questions about their handling of protected health information (PHI). The consensus from five *Part B News* experts is that going through the tool does not take care of your SRA responsibilities, though it could make a good start.

"I don't think it's that bad, especially given the truly onerous NIST [National Institute of Standards and Technology] tool that is also out there," says Todd Searls, director of Wide River LLC in Lincoln, Neb.

The tool also outlines security rule issues OCR will find important, says Rick Hindmand, attorney with McDonald Hopkins in Chicago. "It also shows lofty expectations for thorough risk analysis and consideration of possible safeguards."

But the tool doesn't clarify the requirements of the rule in language providers can understand, says Carolyn Hartley, CEO at Physicians EHR Inc., a Cary, N.C.-based firm that helps practices implement EHRs. Take Question T44: "Does your practice have policies and procedures for encrypting ePHI when deemed reasonable and appropriate?" The tool doesn't make clear that in addition to requiring data to be encrypted in transmission, OCR requires data to also be encrypted when at rest to avoid penalties in the Breach Notification Rule. "What physician knows to look this up?" she asks.

Tip: Check regional extension centers (RECs) for more useful tools, Hartley suggests. RECs such as HIT in Arkansas, HealthPOINT in South Dakota and Stratis Health in Minnesota have developed SRA materials – and "generally the RECs freely shared their tools with each other and ONC," she says. If you're in one of their areas, she advises that you ask them about it.

But the biggest issue with HHS' tool is a lack of context, says Paul Calatayud, chief information security office for health information company SureScripts. "It only reports scores based on the objective you input," he says. "It doesn't evaluate your responses." If you say 'no' to a question, for example, it doesn't tell you how much risk that represents — you have to figure that out yourself.

Also, "it's doing risk-analysis on every single question without putting it into context," says Calatayud, creating a forest-through-the-trees situation where practices might not see the relationship between one security risk and another.

"What if you missed something because the tool doesn't understand your business?" agrees Tatiana Melnik, health care and technology attorney at Melnik Legal in Tampa, Fla. "When I work with organizations, for example, I say, 'You have mobile devices here, fine, what are your policies and procedures on using those technologies? If you get texts from patients, is that information being added into their medical records?' This tool is not going into that level of detail."

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PAS 2014

Tip: Inventory all of your PHI on-site and off to ascertain how your PHI is being handled, says Calatayud. "From this, you can get a more holistic risk assessment. Identify your relationships with vendors and partners who are handling [your PHI]." Then make sure you have complete, appropriate business associate agreements (BAAs) with all of them (*PBN 9/2/13*).

Overall, says Hindmand, the tool is a good starting point for practices that are not experienced in this kind of analysis — even practices that are larger than 10 physicians. But "keep in mind that risk analysis as well as HIPAA practices, policies and procedures need to be customized for the environment of each covered entity or business associate."

If you analyze, also realize

Remember, too, that getting the analysis done is just the first step – you have to follow through on whatever you prescribe to put yourself in compliance.

"Your policy may be your organization audits the EHR logs monthly to confirm appropriate access," says Melnik. "But the logs demonstrate that the organization actually audits access every two months or, worse yet, maybe the organization has never undertaken an audit. The mismatch between the policy and actual practice is problematic — especially if you have an incident and it turns out complying with your own plan could have avoided it."

If you use the tool, consider these immediate follow-through steps:

- **Start mitigating whatever's at risk.** Remedy any deficiencies the tool turns up. "Start with the biggest red flags," says Melnik. One example is any potential exposure of medical records data, particularly if they include Social Security numbers, which exposes your patients to identity theft.
- **Do more research.** HHS, CMS and OCR have plenty of materials, as do the RECs and health IT journals. Make sure you're using your time wisely, though: "A lot of practice managers or owners will think, 'Is it cost effective for me to be doing this?' and get a third party to walk them through the process," says Melnik.
- **Send your report to a consultant.** This is like filling out a tax organizer for your accountant — it saves time, effort and money. "I love when clients do that," says Melnik. "I see that they're engaged in the process and at least thinking about what to do. It can be significantly more expensive to implement a compliance program from ground zero." — *Roy Edroso (redroso@decisionhealth.com)*

critical care

(continued from p. 1)

On the other hand, a good example of a non-critical care service for a patient in intensive care is when a dermatologist is called in to see a patient for a rash that is not related to the patient's need for intensive care, says Janae Ballard, a senior consultant for Altegra Health based in Tacoma, Wash.

CPT defines a critical care service as one that "involves high complexity decision-making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and to present further life-threatening deterioration of the patient's condition." Critical care typically requires interpretation of multiple physiologic parameters or application of advanced technology, but those elements are not required if the patient's life is in danger.

Use these five tips to get critical care services billing right:

- **Look for a patient who has a severely acute condition or an acute exacerbation of a chronic condition**, Ballard points out. Those patients are usually at risk of dying or going into single or multiple organ failure. A patient can be in intensive care and severely ill but not require the level of personal attendance and complex decision-making needed for a critical care service, she adds.
- **Count time spent away from the patient toward the total critical care minutes, as long as the provider is on the floor or unit where the patient is located**, even if the provider is not at the patient's side, according to the CPT guidelines for critical care services. Time spent working on the patient's case outside of the unit or floor, such as a phone call taken at home about the case, will not support critical care.
- **Bill only for time the provider spends exclusively on the critical care patient**, Lewis says. If any services are being provided to other patients at the same time, a critical care service may not be billed.

4 ground rules for billing critical care

Critical care services are billed with time-based codes intended to pay providers appropriately for furnishing lengthy, complex services to patients with potentially life-threatening conditions. But they also come with complex documentation requirements that have the potential to imperil your payments.

The two CPT codes used to bill critical care are **99291** and the add-on code **99292**. Here are some ground rules for those codes:

- Critical care services of fewer than 30 minutes cannot be reported with critical care codes. Use the appropriate E/M code instead.
- 99291 is used for critical care services that last between 30 and 74 minutes. 99292 is billed for each additional 30-minute block of time after 74 minutes. In other words, 30 additional minutes of critical care would result in billing one unit of 99292, while anywhere from 31 to 60 minutes of additional critical care time beyond 74 minutes would result in two units of 99292.
- They may not be billed as split/shared services under Medicare policy. Medicare will allow a non-physician practitioner (NPP) to furnish and bill critical care if it is within the NPP's state scope of practice and license.
- Inpatient critical care provided to patients who are 28 days old or younger are reported with **99468-99469**, which use the same time parameters as 99291-99292. Inpatient critical care to patients aged 29 days through 71 months is billed with 99471-99476, which are initial and subsequent codes based on the patient's specific age. — *Scott Kraft (pbnfeedback@decisionhealth.com)*

- **Have providers document which orders they made and actions they took as part of critical care services** and instruct them to make clear that they were done as part of critical care, Ballard advises. Often, a hospital inpatient note has documentation from multiple providers across multiple days and needs to be clear that the provider's actions supported critical care, she adds.
- **Don't count a resident's time toward the minutes used to justify critical care being billed by the attending physician**, Ballard says. Only the attending physician's minutes can be counted, she adds.

Order of E/M, critical care a factor

One important distinction that determines whether a critical care and other E/M service may be billed on the same date of service is the order in which the services occur, according to Pub. 100-04, Sec. 30.6.12 of Medicare's Internet Only Manual.

When an E/M service is rendered to the patient earlier on the same day prior to the need for the critical care service, both the E/M and critical care services may be reported on the same date of service, the manual states. An E/M service cannot be separately billed if it takes place after medically necessary critical care is given to the patient, Lewis adds. — *Scott Kraft (pbnfeedback@decisionhealth.com)*

Part B News briefs

- **LabMD sues Federal Trade Commission (FTC) after breach investigation.** Medical testing facility LabMD is seeking legal relief from the FTC's actions against the provider following a security breach of patient information. LabMD, which announced in January that the FTC's investigation was forcing it to wind down its operations, claims in its lawsuit that the FTC lacks the authority to regulate patient protected health information and/or cybersecurity and lacks the expertise to do so. LabMD also claims that the FTC's actions are an abuse of power. Learn more at *http://docs.ismgcorp.com/files/external/20140320_DKT001_Verified_Complaint_for_Declaratory_and_Injunctive_Relief.pdf.*
- **Sequestration pay cuts to continue.** Physicians and other providers have no break from sequestration, which imposes a 2% reduction in Medicare fee-for-service payments on claims on or after April 1, 2013, CMS announced April 3. The cuts will continue at least through March 31, 2015. Although beneficiary payments for deductibles and coinsurance are not subject to the 2% reduction, payments to beneficiaries for unassigned claims are subject to the 2% reduction. CMS encourages providers who bill on an unassigned basis to bill appropriately and address the impact of sequestration on reimbursement. Questions should be directed to a physician's Medicare administrative contractor (MAC).

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