AQREVA
Medical Billing & Consulting

"There is nothing permanent except change."
-- Heraclitus

Client Memo August 2019

NEWS Update

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Compliance

Importance of Proper Documentation

Why is proper documentation important to you and your patients? Find out how it affects items/services, claim payments, and medical reviews in the *Provider Minute: The Importance of Proper Documentation* video put out by CMS.

You can either click on the link below if reading this electronically or copy and paste the link to your browser:

https://www.youtube.com/watch?v=10pmw4czf08

Learn about:

- The top five documentation errors;
- How to submit documentation for a Comprehensive Error Rate Testing review; and
- How your Medicare Administrative Contractor can help.

OCR Issues New HIPAA FAQs on Health Information Apps – *National Law Review,* April 24, 2019

On April 18, 2019, the Department of Health & Human Services Office for Civil Rights (OCR) issued five new FAQs addressing the applicability of HIPAA to the use of software applications (apps) by individuals to receive health information from their providers.

The new FAQs are **available here** under the Header "Access Right, Apps and APIs" at the bottom of the screen.

You can also obtain the information by copying and pasting the following into your browser:

https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access-right-health-apps-apis/index.html

The FAQs site contains important information, as well as:

- Emphasizes that an individual's right to access her/his protected health information under HIPAA generally obligates a covered entity to send PHI to a designated app, even if the covered entity is concerned about the app's security or how the app will subsequently use or disclose the PHI;
- Explains that a covered entity would not be liable under HIPAA for an app's subsequent use or disclosure of PHI sent to the app at the direction of an individual, unless the app was "developed for, or provided by or on behalf of the covered entity – and, thus, creates, receives, maintains, or transmits ePHI on behalf of the covered entity"; and
- Notes that a covered entity that transmits ePHI to an app via an unsecure manner or channel – at an individual's direction – would not be responsible for unauthorized access during such transmission, but such an entity may want to counsel the individual regarding the security risks involved in such a transmission.

The FAQs page also address potential liability of a covered entity's EHR system developer under HIPAA following transmission of ePHI to an app on behalf of the covered entity. The OCR similarly counsels that liability could attach under HIPAA where the EHR system developer owns the app or has a business associate relationship with the app developer, and makes the app available to, through or on behalf of the covered entity.

Ultimately, the new FAQs provide important guidance for covered entities, EHR developers and app developers on the intersection of new forms of technology – such as wearables and health tracking apps – with HIPAA and health care providers. The FAQs also provide a reminder regarding the limits on the applicability of HIPAA, and reiterate the importance of HIPAA's right to access for individuals.

The Cost of Not Conducting a Risk Analysis

A recent fine serves as a continued lesson for providers and medical practices to conduct a comprehensive risk analysis, one that can mitigate their risk of penalty from the U.S. Department of Health and Human Services' Health App FAQs, writes Rachel V. Rose, JD, MBA, in the June 20, 2019, issue of *Medical Economics.*

In late May, Medical Informatics Engineering, Inc., an Indiana-based medical records service agreed to pay $100,000 and take corrective action to settle potential violations of the HIPAA Privacy Rule and Security Rule after a cyberattack affected 3.5 million people.

The Office for Civil Rights' investigation revealed that "Medical Informatics Engineering, Inc. did not conduct a comprehensive [enterprise-wide] risk analysis prior to the breach" as required annually under 45 C.F.R. § 164.308(a)(1)(ii)(A).

This particular section of the Security Rule requires an annual risk analysis be done to assess the potential risks and vulnerabilities associated with the confidentiality, integrity and availability of the data.

This breach and the associated legal, compliance and reputational costs could have been avoided through a comprehensive risk assessment.

Here are two lessons that providers should take to heart:

1) if providers read the resolution agreements associated with the imposition of HIPAA penalties as well as class action lawsuits, they will see one of the top areas of non-compliance is not conducting a risk analysis.; and

2) in light of the HHS Health App FAQs, a comprehensive risk analysis and adequate due diligence with an app (or other technology) company can mitigate the wrongful disclosure of protected health information, penalties and legal costs.

Therefore, providers should take this opportunity to learn from Medical Informatics Engineering's fine and consider the implications of not conducting a risk analysis for their own medical practices.

Regulations on Refunds – Amy Tucker, *Healthcare Management Systems*, June 14, 2016

In recent years the regulations have clamped down hard on refunds. In the "old days" we used to hang on to the smaller refunds and just flag the accounts for the patient's next visit, or hold insurance overpayments waiting for the insurance company to request a refund. But no more. The rules as they relate to compliance now require all refunds (regardless of size) be refunded within 60 days. Medicare and Medicaid are the most stringent.

Some of the key points of the regulations are summarized below:

- The OIG published a list of risk factors the OIG identifies as "particularly problematic." Bullet five on this list is **"Inadequate Resolution of Overpayments."** In essence, it says that providers may not keep payments that do not belong to them.
- Processing and returning credit balances, or "overpayments" as the government calls them, is not optional but mandatory
- It's not uncommon for providers to keep such overpayments until specifically asked to return them or until payers have withheld them from subsequent payments. **This is illegal.**
- The rule also addresses the timeliness of refunds and requires Medicare providers to report and return an overpayment to the appropriate patient, intermediary or carrier within 60 days of identifying the overpayment.
- A frequently asked question is, "Must a provider refund all monies?" The answer is yes, for both patients and federal payers, i.e., Medicare and Medicaid.
- For commercial payers, a provider may set a refund threshold, i.e. only credit balances of $10.00 or more shall be refunded. The threshold must be a reasonable amount.

Note: In a discussion dated September 29, 2018, a question was directed to the author about refunds being returned as undeliverable with phone numbers on file being disconnected. Ms. Tucker answered that in California, the refunds are required to be sent to the State as unclaimed property.

Arizona has a similar Unclaimed Property Law: A.R.S. Title 44, Chapter 3 (A.R.S. §§ 44-301 through 44-338).

Every state has their own specific laws on this topic and providers should consult with their local attorney for assistance in their states.

MedPAC Wants To End 'Incident-To' Billing by APRNs, PAs – Kerry Dooley Young, *Medscape Medical News*, June 24, 2019

In an annual report to Congress, released June 14, 2019, the Medicare Payment Advisory Commission (MedPAC) recommended eliminating "incident-to" billing for advanced practice registered nurses (APRNs) and PAs. Instead, APRNs and PAs should consistently bill Medicare directly under their own NPI for the services they provide.

Medicare pays 85% of the amount set in the physician fee schedule when NPs and PAs bill directly for the services they provide to people enrolled in the federal health program. Under certain conditions, though, those services may be billed by supervising physicians as being "incident to" their care, generating reimbursement at 100% of the physician fee schedule rate.

Ending incident-to billing could reduce Medicare spending by $1 billion to $5 billion over the first 5 years following the implementation of this policy change. First-year savings alone could be $50 million to $250 million. In contrast, some medical practices "would experience a decline in revenues" because of the change, MedPAC said.

The AMA described the MedPAC proposal as a step toward more autonomous practice by APRNs and PAs. This "approach would further compartmentalize and fragment health care delivery; while team-based care fosters greater integration and coordination," the AMA added.

The American Association of Nurse Practitioners told *Medscape Medical News* that it "applauds" the MedPAC proposal. "We urge Congress to act on this recommendation as soon as possible."

The American Academy of Physician Assistants said in a statement that Congress should act on MedPAC's recommendation.

MedPAC members and staff have depicted incident-to billing as an outdated policy that adds extra costs and that it muddies the picture of how the nation's seniors get their medical care.

"Incident-to billing is a relic of the Medicare of the late 1960s, where the program was completely passive," MedPAC member Paul Ginsburg, PhD, said at the panel's October 2018 meeting. "We have a different Medicare today," added Ginsburg, who also is a researcher with the nonpartisan Brookings Institution.

Medicare currently covers about 64 million people aged 65 years or older or who have disabilities, according to the nonprofit Kaiser Family Foundation.

Of this population, about 42 million remain in traditional fee-for-service Medicare, for which the proposed elimination of incident-to billing would apply.

MedPAC said its recommendation would not change the coverage of any service or any state supervision or collaboration requirements. It is not intended to alter how healthcare is delivered but to reflect the expanded role of APRNs and PAs.

NPs and PAs are playing an increasingly large role in the care of older Americans, with much of their care billed directly by them to Medicare.

State governments in recent years have steadily increased the scope of practice for NPs and PAs, allowing them increased authority and autonomy.

Lawmakers have no obligation to act on any of MedPAC's recommendations, but members of Congress and the staff of key House and Senate committees pay close attention to the commission's well-regarded reports.

56% of Health Providers Still Rely on Legacy Windows 7 Systems

While most organizations in other sectors have steadily shifted to Windows 10 in recent years, more than half of providers still use legacy platforms that no longer receive security updates, writes Jessica Davis in *Health IT Security*, July 18, 2019.

The researchers from Duo Security, part of Cisco, found that just 44 percent of healthcare has implemented Windows 10, with 56 percent operating legacy Windows 7. The healthcare sector is the "most Windows-dominated industry.

Out-of-date devices are more susceptible to vulnerability and can introduce risk to an organization.

Microsoft will no longer Support Windows 7 on January 14, 2020

After January 14, 2020, if your computer is running Windows 7, it will no longer receive security updates.

2019 Social Determinants of Health ICD 10 Codes -- UnitedHealthcare Network Bulletin, June 2019

Social determinants of health are the conditions in which people are born, grow, live, work and age. They include factors like:

- Access to health care and healthy food
- Education circumstances
- Employment and socioeconomic status
- Physical environment
- Social support networks
- Foster care

If you are providing services to a UnitedHealthcare member and observe a social determinant of health that has an ICD 10 code, please include the code(s) on claims you submit.

ICD-10 Codes to determine Social Determinants of Health include:

Educational Circumstances
Z55.0 Illiteracy and low level literacy
Z55.1 Schooling unavailable and unattainable
Z55.2 Failed school examinations
Z55.3 Underachievement in school
Z55.4 Education maladjustment and discord with teachers and classmates
Z55.8 Other problems related to education and literacy
Z55.9 Problems related to education and literacy, unspec

Effects of Work Environment
Z56.0 Unemployment, unspecified
Z56.1 Change of job
Z56.2 Threat of job loss
Z56.89 Other problems related to employment
Z56.9 Unspec problems related to employment

Foster Care
Z62.822 Parent-foster child conflict
Z62.21 Child in welfare custody

Homelessness/Other Housing Concerns
Z59.0 Homelessness
Z59.1 Inadequate housing
Z60.2 Problems related to living alone

Inadequate Material Resources
Z59.4 Lack of adequate food and safe drinking water
Z59.5 Extreme poverty
Z59.6 Low income
Z59.7 Insufficient social insurance and welfare support
Z59.8 Other problems related to housing and economic circumstances

Other Social Factors
Z60.4 Social exclusion and rejection
Z60.8 Other problems related to social environment
Z60.9 Problems related to social environment, unspec
Z71.3 Dietary counseling and surveillance
Z71.6 Tobacco abuse counseling
Z71.82 Exercise counseling
Z71.89 Other specified counseling
Z71.9 Counseling, unspecified
Z72.0 Tobacco use
Z72.4 Inappropriate diet and eating habits
Z91.82 Personal history of military deployment

Parent/Child/Family
Z62.810 Personal history of physical and sexual abuse in childhood
Z62.820 Parent-biological child conflict
Z63.4 Disappearance and death of family member
Z63.8 Other specified problems related to primary support Group

Why the MIPS Opt-In Policy Could Seriously Boost Your Bottom Line

Beginning in 2019, otherwise-eligible clinicians, groups, and APM entities can elect to opt-in to MIPS if they exceed 1 or 2, but not all, elements of the low-volume threshold. That means that for the first time, these previously ineligible clinicians have the opportunity to participate in the QPP and earn a payment adjustment, explains Mike Lewis for *Healthmonix Advisor*, July 25, 2019.

CMS has not yet finalized operations for opt-in elections. However, they have stated that:

- Clinicians, groups, and MIPS APM entities are required to complete their opt-in election during the submission period before submitting data to CMS.
- Once made, an election to opt-in is final and cannot be reversed.
- When a third-party intermediary is submitting data on behalf of a MIPS eligible clinician, the third-party intermediary must be able to transmit the clinician's opt-in election to CMS.

We've talked to countless clinicians and groups who are not eligible because they see fewer than 200 Medicare patients--but who reach over 200 visits, and/or bill over $90,000 in Part B charges, nonetheless. What many of them don't realize is that if they opt-in and report even just the bare minimum, that revenue will then be multiplied by the MIPS payment adjustment, Mr. Lewis writes.

To find out if you are eligible, enter your NPI number on the QPP Participation Status lookup tool found on the Quality Payment Program website. Sign in to http://www.qpp.cms.govto review eligibility.

Now Available: 2018 MIPS Performance Feedback and Final Score

If you submitted 2018 MIPS data, you can now view your final MIPS performance feedback and score on the Quality Payment Program (QPP) website at www.qpp.cms.gov .

You can access your 2018 MIPS performance feedback and final score by:

1. Visiting cms.gov/login.
2. Logging in using your Health Care Quality Information System (HCQIS) Access Roles and Profile (HARP) system credentials. These are the same credentials that allowed you to submit your 2018 MIPS data.

If you don't have a HARP account, refer to the QPP Access User Guide on the QPP website and start the process now.

For instructions on creating a HARP account and to learn more about performance feedback, please go to the QPP website: www.qpp.cms.gov

FAQs are available and highlight what performance feedback is, who receives the feedback, and how to access it on the QPP website.

MIPS Targeted Review Period Open Until September 30, 2019

If you participated in MIPS in 2018, your performance feedback, which includes your MIPS final score and payment adjustment factor(s), are now available for review on the Quality Payment Program website.

The MIPS payment adjustment you will receive in 2020 is based on your final score. A positive, negative, or neutral payment adjustment will be applied to the Medicare paid amount for covered professional services furnished by a MIPS eligible clinician in 2020.

MIPS eligible clinicians, groups, and virtual groups (along with their designated support staff or authorized third-party intermediary), including APM participants, may request CMS to review the calculation of their 2020 MIPS payment adjustment factor(s) through a process called targeted review.

When to Request a Targeted Review

If you believe an error has been made in your 2020 MIPS payment adjustment factor(s) calculation, you can request a targeted review until September 30, 2019. The following are examples of circumstances in which you may wish to request a targeted review:

- Errors or data quality issues for the measures and activities you submitted
- Eligibility and special status issues (e.g., you fall below the low-volume threshold and should not have received a payment adjustment)
- Being erroneously excluded from the APM participation list and not being scored under the APM scoring standard
- Performance categories were not automatically re-weighted even though you qualify for automatic reweighting due to extreme and uncontrollable circumstances

Note: This is not a comprehensive list of circumstances. CMS encourages you to submit a request form if you believe a targeted review of your MIPS payment adjustment factor (or additional MIPS payment adjustment factor, if applicable) is warranted.

How to Request a Targeted Review

You can request your MIPS final score and performance feedback and request a targeted review by:

- Going to the Quality Payment Program website at www.qpp.cms.gov
- Logging in using your HCQIS Access Roles and Profile System (HARP) credentials; these are the same credentials that allowed you to submit your MIPS data. Please refer to the QPP Access Guide on the QPP website for additional details.

MEDICARE NEWS

On July 29, 2019, CMS issued a proposed rule that includes proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2020.

The proposed rule includes:

- CY 2020 PFS rate setting and conversion factor
  - The proposed CY 2020 PFS conversion factor is $36.09, a slight increase above the CY 2019 PFS conversion factor of $36.04.

- Medicare telehealth services
  - CMS is proposing to add the following codes to the list of telehealth services: HCPCS codes GYYY1, GYYY2, and GYYY3, which describe a bundled episode of care for treatment of opioid use disorders.

- Payment for evaluation and management services
  - The CPT coding changes:
    - ✓ retain 5 levels of coding for established patients,
    - ✓ reduce the number of levels to 4 for office/outpatient E/M visits for new patients, and
    - ✓ revise the code definitions.
  - The CPT changes also revise the times and medical decision making process for all of the codes, and requires performance of history and exam only as medically appropriate.
  - The CPT code changes also allow clinicians to choose the E/M visit level based on either medical decision making or time.

- Physician supervision requirements for physician assistants
  - CMS is proposing to modify regulations on physician supervision of PAs to give PAs greater flexibility to practice more broadly in the current health care system in accordance with state law.
  - In the absence of State law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA's approach to working with physicians in furnishing their services.

- Review and verification of medical record documentation
  - To reduce burden, CMS is proposing broad modifications to the documentation policy so that physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives could review and verify (sign and date), rather than re-documenting, notes made in the medical record by other physicians, residents, nurses, students, or other members of the medical team.

- Care management services
  - Increased payments are proposed for Transitional Care Management.
  - A set of Medicare-developed HCPCS G codes for certain Chronic Care Management (CCM) services is proposed.
  - CMS is proposing to replace a number of the CCM codes with Medicare-specific codes to allow clinicians to bill incrementally to reflect additional time and resources required in certain cases and to better distinguish complexity of illness as measured by time.
  - CMS is also proposing to adjust certain billing requirements and elements of the care planning services.

To see the full text of this excerpted announcement, refer to: Fact Sheet (Issued July 29) or copy and paste the following to your browser:

https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-2

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