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October 19, 2015 | Vol. 29, Issue 40

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Meaningful use

Discover eased reporting, navigate vendor issues for stage 2 MU

You'll find the final rules governing meaningful use reporting in 2015 to be a tad less laborious than previous versions, even if the seven-month wait for the late-breaking regulations left you a bit weary.

In the final rule released Oct. 6, CMS confirmed that it would ease several meaningful use requirements that had given providers trouble in the past, such as secure electronic messaging and the transmittal of a patient's health information, in an apparent effort to make the electronic health record (EHR) program less taxing on the physician community.

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

Compliance

As health care hacking evolves, take these 4 steps to protect your practice

The recent discovery of new hacking threats to medical devices and systems is a reminder that you should go beyond the four walls of your offices when you perform your security risk analysis under HIPAA.

A new order of threats to your data is brewing in cyberspace. The heath care IT "threatscape" gets more active each year. Health care organizations have been spooked by major hacks such as the Heartbleed virus, and this year a home health

*(see **Hacking**, p. 7)*

Meaningful use

Patient engagement requirements make meaningful use stage 3 tough going

Providers will have large loads to lift to transition to meaningful use stage 3 by 2018 — the last year before the merit-based incentive payment system (MIPS) replaces the current electronic health record (EHR) programs.

CMS on Oct. 6 released its 752-page final rule that included stage 3 and modified stage 2 requirements *(PBN 10/12/15)*. Providers can voluntarily start stage 3 in 2017 but must move to stage 3 in 2018.

CMS is going for a "simpler structure" but also "increased responsibility" for providers with the stage 3 requirements, says Theresa Hush, CEO and founder of iClops, a qualified clinical data registry in Chicago. She also thinks this trend will continue up to the MIPS debut, where the combination of technical, reporting and performance requirements will push many providers into value-based operational models such as accountable care organizations (ACOs).

In fact, CMS indicates in the rule that the comment period will be used to inform the federal agency's transition from meaningful use to MIPS.

Where stage 3 will challenge providers

- **The jump in the "view online, transmit and download" requirements** of the "patient electronic access to health information" objective, notes David Kibbe, president and CEO of DirectTrust, a network of health information service providers in Washington, D.C., and senior advisor to the American Academy of Family Physicians' Alliance for eHealth Innovation. Under the old stage 2 requirements, eligible providers (EPs) had to attest that 50% of their patients have been provided timely online access to their health information. Under the new rule, stage 3 attesters will have to do the same for 80% of their patients. *(For more on stage 2 modifications, see story, p. 1.)*

Also, the percentage of patients for whom attesters must "use clinically relevant information from CEHRT [certified electronic health records technology] to identify patient-specific educational resources and provide electronic access to those materials" jumps in stage 3 from 10% to 35%.

- **The application programming interface (API) option for collecting patient data** via devices such as Fitbits, which was first mentioned in the proposed rule *(PBN 4/6/15)*. In the final rule, this is an optional measure, but it might not remain optional forever. At present, "it borders on the unreasonable. … It depends on ONC providing us with a certified API standard, and I have real doubts in my mind whether they can do that in a manner that's acceptable to the vendors," Kibbe says.

"The transmission will be up to the patient — but it's the reception that's the issue [for providers]," says Matthew R. Fisher, an associate with the Mirick O'Connell law firm in Worcester, Mass. "Assuming you can get the

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data in, will it be clinically meaningful? … I worry that they're trying to force the issue before they're ready to deliver data that will actually improve and advance care."

- **The "public health and clinical data registry reporting" objective for which EPs will have attest to two of five measures.** EPs must report via any of three options: completed registration to submit data, testing, and validation and production. Providers have multiple grounds for exclusion from these measures that relate to technical readiness, but providers will be less likely to qualify for these as vendors bring their systems into alignment with CMS standards.

"It'll take a lot of work" to meet these measures, says David Cooling, accountable care director at Quirk Healthcare in Delray Beach, Fla. "First, you have to find registries. If the registries won't work, that still leaves you in a situation where you have to pick from the other measures [syndromic surveillance, etc.], which may be more difficult. And you have to have good knowledge of all the registries available to you, then reach out to them."

Tip: Keep records. If the registries you approach can't work with you, keep the correspondence to prove to CMS why you couldn't submit for that measure.

- **Steep requirements for measure 2 of stage 3's "coordination of care through patient engagement" objective.** The rule lifts the secure messaging requirement for stage 3 to 25% whereas stage 2 attesters have to attest to messaging with just a single patient, Cooling says. As for the "patient generated health data or data from a nonclinical setting" in measure 3, "providers don't have much history with this," says Cooling. "They'll have to incorporate some kind of tech that captures this, and I don't think many of them know much about it."
- **"Old" objectives that haven't relented.** Daunting as these objectives are, don't lose focus on the ones that haven't changed much. For example, the security risk analysis requirement in the "protect patient health information" objective is among the top reasons providers fail meaningful use audits. "It's an old-hat issue, and it's one people speed by without really doing it," he says.

Send your comments before Dec. 15

On balance, though, providers have "a lot to like" in the final rule, Kibbe finds. He appreciates the scaled-back number of objectives, "a significant recognition on the part of CMS that they had gone too far with too many objectives and metrics."

Also, the new comment period announced for this rule suggests flexibility. "This way, they can still make changes and soften the blow," says Kibbe. He and other experts suggest you make your voice heard — or get your medical specialty or professional group to get theirs heard.

"There will be some actual change [from the comment period], I think," says Fisher. "I don't think they're just trying to appease people. Given how vocal providers have been about the whole program, getting comments and doing nothing with them would create a lot of backlash." You can send your comments to via *www.regulations.gov*. — *Roy Edroso (redroso@decisionhealth.com)*

Transitional care management

Make the transition work: 4 core billing strategies for TCM services

You can join the tide of providers who are getting paid for transitional care management (TCM) services by sticking to tried-and-true claims submission strategies, such as filing the claim with the correct date of service and holding to a contingency plan if the patient is readmitted.

Overall, the TCM success rate has improved significantly: In 2014, the second year providers could bill TCM codes **99495** and **99496**, more claims were paid and far fewer denials were handed out. In 2014, the denial rate of 99495 for family practice providers hovered around 5%, down from 35% the previous year, according to the latest available Medicare claims data (*PBN 11/3/14*).

Specialists are finding success too. While the bulk of TCM services are offered in the primary care setting, cardiologists and pulmonologists — two specialties that bill TCM codes with modest frequency — are seeing just a 6% denial rate for each code (*see benchmark, p. 5*).

Follow these tips from successful practices

1. Date the claim to read 30 days after discharge, advises Penny Sue, practice administrator with Century City Primary Care in Century City, Calif. "Our billers struggled in the beginning," recalls Sue. That's because the practice would see a denial when the billing staff submitted a TCM claim with a date of service that reflected the date the patient was seen in the office.

Remember, TCM codes require a face-to-face visit within 14 days of hospital discharge for 99495 or seven days for 99496. But don't list the visit date as the date of service on the claim. After a series of denials, Century City Primary Care's billing department revised its tactics and learned that it had to use a date of service 30 days after the discharge date. "They learned that this was the only way [Medicare] can accept and pay on the claim," advises Sue, whose team now sees "zero denials for either code."

Example: A 67-year-old patient with chronic obstructive pulmonary disease (COPD) is released from the hospital on Aug. 30. The office staff makes contact with the patient via telephone within three days, and the patient visits the office on Sept. 2 for follow-up care. The date of service on the TCM claim must reflect 30 days after discharge, or Sept. 30. Don't forget to hold the claim too, advises Sue. "The claim can only be sent to [Medicare] on or after Sept. 30."

2. Line up a contingency plan if the patient returns to the hospital. You'll still get paid for the services you provide within the 30-day post-discharge period, but you may need to resubmit a claim that reflects an E/M visit rather than a TCM code, says Karyn Cardenas-Foray, CPC, CPMA, CEMC, CIMC, government reimbursement analyst with Sharp HealthCare, San Diego.

"We get a recoupment of the funds from Medicare" for the TCM payment when the patient returns to the hospital within 30 days, says Cardenas-Foray. When that happens, "bill out a regular office visit [for] the day that the patient was actually seen." After you submit a replacement E/M service, you can pick up the TCM protocol following the patient's subsequent discharge and go after that process again.

3. Bill any additional E/M services you provide after the required TCM visit, reminds Beth Aldridge, CPC, coding manager with Northern California Medical Associates in Santa Rosa, Calif. Don't leave revenue on the table, advises Aldridge. TCM billing requirements make it clear that they cover the initial face-to-face visit — all other office visits during the 30-day period should take the appropriate E/M or other service code.

4. Wait for the final discharge to bill because that might not be from a hospital. In some cases, a patient might get discharged from a hospital and then go to skilled nursing, and you can't bill a TCM code until the patient is discharged from the skilled nursing facility, advises Sue. In that case, mark the date of service as the date 30 days past the discharge from skilled nursing, not from the initial hospital discharge.

Tip: Don't bill a TCM code following an emergency department visit, warns Betsy Nicoletti, president, Medical Practice Consulting, Northampton, Mass. Medicare policy explicitly states that an ED visit does not count for TCM coding. — *Richard Scott (rscott@decisionhealth.com)*

Part B News briefs

- **CMS allows provider initials on paper documents.** The age-old provider practice of initialing changes to the medical record instead of adding a full signature has been sanctioned by CMS. Change Request 9332, issued Oct. 2, adds explicit directions to accompany changes CMS had made to documentation requirements in the Medicare Program Integrity Manual in 2013. Those changes allowed providers to make changes to the record so long as they "clearly indicate the date and author of any amendment, correction or delayed entry," but also said that, on paper records, providers must sign the change. The new request clarifies that "amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider's initials with their name." Electronic records are unaffected, and providers are still directed to "provide a reliable means to clearly identify the original content, the modified content and the date and authorship of each modification of the record." The new request implementation date is Nov. 2. For more, see *www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R615PI.pdf.* — *Roy Edroso (redroso@decisionhealth.com)*

MU

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"It's a great thing for providers, other than that the information was released so late," notes Elizabeth Woodcock, MBA, FACMPE, CPC, principal, Woodcock and Associates, Atlanta. Much of the "[reporting] criteria has been vastly simplified," she adds.

Though the Feb. 29 attestation deadline means you'll still need to get a move on wrapping up the final slate of reporting requirements, you should have an easier time getting to stage 2 given the updates in the final rule.

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Benchmark of the week

Specialists join primary care in providing transitional care services

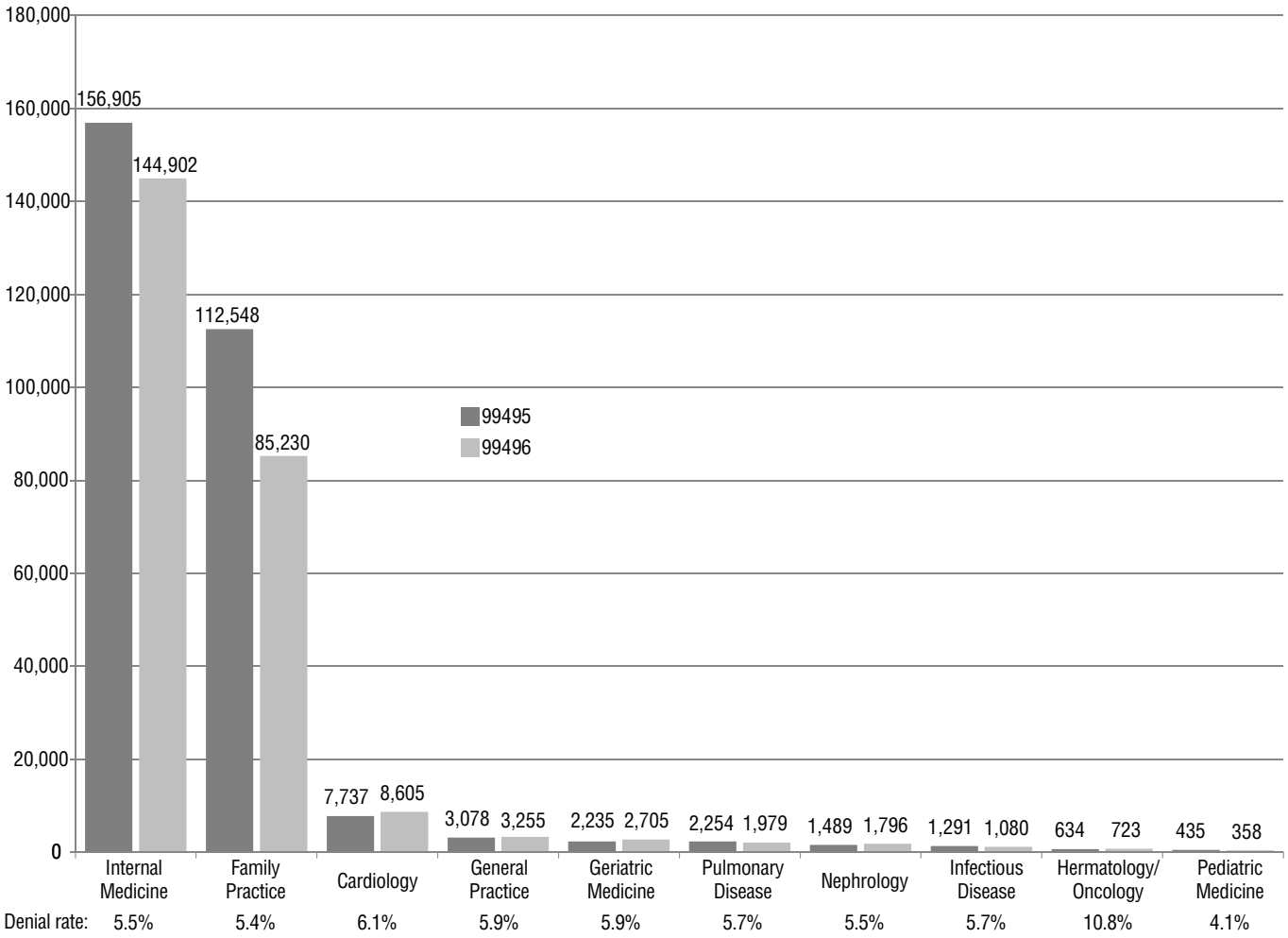
More than a dozen specialty providers billed transitional care management (TCM) services in 2014, with internal medicine setting the bar for highest utilization among physician groups and about average denial rates.

In 2014, the second year of availability for TCM codes **99495** and **99496**, denial rates for either code ranged from 3% on the low end (pediatrics) to 12% on the high end (hematology/oncology) among the 10 specialties that billed the codes most often. Denial rates dropped significantly between 2013 and the 2014 for most providers (*see story, p. 3*).

The two big utilizers, internal medicine and family practice, accounted for more than 90% of all TCM services, or about 500,000 claims, in 2014. But other specialists got into the game as well. Cardiology submitted about 16,000 claims total, with about 1,000 more high-level claims (99496) than moderate level claims (99495). Geriatric medicine delivered about 6,300 services, and pulmonology about 4,200.

Most specialties ultimately got paid for their work, though hematology/oncology had the most trouble with a combined 10.8% denial rate for its 1,300 claims for the two codes. Pediatric medicine, while it submitted only 793 claims total, saw an equally low 4.1% combined denial rate. Nephrology also provided TCM services in 2014, billing about 1,800 high-level codes and nearly 1,500 lower level ones. *—Richard Scott (rscott@decisionhealth.com)*

Total services and denial rates by specialty for TCM codes 99495 and 99496



Source: Part B News *analysis of 2014 Medicare claims data, the latest available*

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"While not perfect, they remove the biggest stumbling blocks for providers in attaining [meaningful use stage 2]," notes Jeanne Chamberlin, practice management consultant with MSOC Health in Chapel Hill, N.C.

(For more on stage 3 requirements in the rule, see story, p. 2.)

3 changes make stage 2 reporting easier

Instead of needing 5% of your patients to view, transmit or download their health information to a third party, the final rule confirms that you need only one patient to do so during the reporting period to meet the eighth meaningful use objective (patient electronic access). "Literally one," says Woodcock. The one-patient rule for the eighth objective is good for 2015 and 2016 reporting periods.

Also scaled back is the ninth objective (secure electronic messaging), for which you'll need to show that the electronic messaging capability was "fully enabled" during the 2015 reporting period. "Fully enabled means the function is fully installed, any security measures are fully enabled and the function is readily available for patient use," notes the final rule.

In 2016, the secure electronic messaging objective follows the lead of the view, transmit or download requirement and must be fulfilled by one patient.

"I believe we will see many more providers able to meet these revised rules as compared to the original ones," predicts Chamberlin. In 2017, the requirements for objectives eight and nine will revert to a 5% threshold for stage 2 reporting, according to the final rule.

All providers are eligible for a 90-day reporting period in 2015 (*PBN 10/12/15*). The last period you can report this year starts Oct. 3 and ends Dec. 31. But practices that have been gearing up for stage 2 all year "might go back and say, 'We had this a long time ago, no worries,'" says Woodcock.

The 90-day reporting period helps relieve the frustration expressed by many medical groups about the late release of this rule (*PBN 9/14/15*). Providers can pick the 90-day periods in 2015 that they believe are most likely to meet program requirements.

Also, those who decide to start with the final 90 days of 2015 to attest have only missed the first week or two and can arguably meet their numerators by stepping up their compliance in their remaining patient encounters, says Matthew R. Fisher, an associate with the Mirick O'Connell law firm in Worcester, Mass.

Make sure your dashboard is up to speed

Although the objectives have been stripped down, that doesn't mean it's all smooth sailing for would-be 2015 attesters. That's because the rule's delayed release might mean your vendors don't have their software quite up to date.

"You may have an existing stage 2 dashboard" within your EHR and that's going to have to be updated to reflect the revisions to stage 2 that are now finalized, notes Woodcock. "Ask the vendor: 'How do I interpret the dashboard?' and 'Are you going to get me a new dashboard?'"

However, a dashboard that needs an update will affect only your reporting mechanism — not the actual function of collecting the data you need — so you can

continue to meet your data collection even if you have to wait for a dashboard, adds Woodcock.

Investigate your public health reporting needs

One of the areas you'll want to address immediately is public health reporting, advises Chamberlin. "CMS doesn't have a list of registries that meet their definition and can accept electronic feeds from 2014 certified EHR systems," she warns.

That means you'll have to conduct some legwork to fulfill the public health reporting objective (objective 10), which requires eligible professionals to be "in active engagement" with at least two public health agencies to report patient data. Reporting options include:

- Immunization registry reporting.
- Syndromic surveillance reporting.
- Specialized registry reporting.

Do your due diligence for objective 10 because registry reporting might cost you out-of-pocket expenses — "sometimes thousands of dollars," notes Chamberlin. Also, understand that "active engagement" is a malleable term. At a minimum, it means that you've registered to submit data to a public health agency; you've completed registration no later than 60 days after the start of your reporting period; and you're prepared to begin testing and validation.

"There's no denominator and numerator to report," notes Chamberlin. "It's just an attestation that you are reporting on an ongoing basis."

2 more tips for public health reporting

- Complete registration by Dec. 1, which marks the 60th day of the year's final reporting period.
- Check with the following associations to identify a registry that will meet your needs: state public health department; your specialty association; the certification board for your specialty; the Qualified Clinical Data Registry List that's attached to the physician quality reporting system (PQRS) requirements (*see www.cms.gov/pqrs*); and the National Quality Registry Network inventory (*see www.nqrn.org*).

Note that providers can report to two specialized registries to fulfill the two-agency requirement for stage 2 meaningful use. However, providers are not eligible to report to more than one immunization registry or one syndromic surveillance agency in a given reporting period to fulfill the stage 2 public health objective. Note that providers attesting to stage 1 in 2015 are required to report to only one public health agency.

Don't miss the deadlines

The attestation period opens Jan. 1 and the deadline for attestation is Feb. 29, although CMS indicated in the final rule that the attestation deadline might be pushed back until March to allow providers more time. — *Richard Scott (rscott@decisionhealth.com)*

Hacking

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agency was snared by a ransomware attack (*PBN 5/4/15, 5/5/14*). But hacks to insurers such as Anthem and Premera Blue Cross have made 2015 into what *The Washington Post* calls "the year of the health-care hack."

"It's interesting what people predicted a couple years ago is actually happening," says David Kibbe, president and CEO of DirectTrust, a network of health information service providers in Washington, D.C., and senior advisor to the American Academy of Family Physicians' Alliance for eHealth Innovation. "In years past, we had a spate of well-covered hacks at Target and places like that, and people said, 'where are the health care hacks?' Some of us said they will come because the larger industries will harden their systems, and the hackers will look for something that isn't hardened. And we saw with Anthem and Premera Blue Cross and others that we were right. I think there will be a lot more."

How to stay updated about threats

If you're not sure what the latest threats are, educate yourself. "You can't protect yourself against threats you don't know about," says Asaf Cidon, co-founder and chief technology officer of Sookasa in San Mateo, Calif. Some security officers may think paying attention to what's inside the four walls of the office covers the job, but in an increasingly interconnected world, that's not the case.

"Monitoring the outside environment would be a part of conducting an annual risk analysis in addition to general good practice to be aware of changes," says Matthew R. Fisher, an associate with the Mirick O'Connell law firm in Worcester, Mass. "An organization cannot afford to be unaware of the changing nature of threats."

- **Use Google alerts or some similar technology to stay current.** "From my perspective, if you're a security professional and you aren't subscribed to Google alerts and tracking IT security media on a constant, almost neurotic, basis, then you're frankly negligent," says Jeff Mongelli, CEO of Acentec Inc. in Irvine, Calif.
- **Make sure your compliance officer follows key Twitter feeds.** Advise your compliance officer to follow the Twitter accounts of the equipment vendors they use and other Internet security vendors, says Hoala Greevy, founder and CEO of Paubox in San Francisco. He recommends WhiteHat Security (@whitehatsec), Security Affairs (@securityaffairs) and Eric Vanderburg (@evanderburg) for starters.
- **Check the white papers at the National Institutes of Standards and Technology (NIST).**"It arms you with information when you deal with vendors" because the vendors read those papers, says Lee Barrett, executive director of the credentialing organization Electronic Healthcare Network Accreditation Commission (EHNAC). That's in addition to the regulatory agency reading you should already be doing — the latest news and reports from the Office for Civil Rights, the Workgroup for Electronic Data Interchange (WEDI) and CMS, for example.

Get tough with vendors

Remember that you're in the driver's seat when you hire a technology vendor; don't give them the opportunity to shirk on security. "Medical groups have been penalized by CMS because of HIPAA violations caused by unqualified IT providers," says Joyce Tang, president and chief customer happiness officer of AgilisIT in San Diego.

"You don't want to rely on a vendor to tell you what you should be looking for because a vendor will always say they're compliant," Barrett says. EHNAC and WEDI created an accreditation program to vet project management software vendors at the request of the Medical Group Management Association (MGMA) and others called the Practice Management System Accreditation Program (PMSAP). "We're getting the message out so providers can say to their vendors: You need to go through this accreditation or you don't make our shortlist," says Barrett.

Research vendors you consider doing business with, then put them to the test, says Rebecca E. Gwilt of the Nixon Law Group in Vienna, Va. "You should ask them directly about their privacy and security policies and protocols and request to review their incident logs," she says. "If they are unwilling to share this information with you or you determine their security posture is not sufficient, move on. There are plenty of vendors out there to choose from."

Be tough on contracts too. In addition to the HIPAA-required breach notification, require that vendors inform you of any actual or suspected security incidents. "If the covered entity would like more detailed reporting than required by HIPAA or if the covered entity would like notification by the business associate for any unauthorized use or disclosure, even if it doesn't result in a breach, then that expectation should be defined in the business associate agreement," says Gwilt.

2 more tips to protect your practice:

- **Recognize changes in your vulnerability.** As technology evolves, so does your vulnerability. Any time a new piece of technology enters your workflow — whether it's installed by your practice or owned and used by your clinical staff, such as mobile devices — find out what the risks are and take steps to meet them. For example, "companies should understand that PHI and corporate data is never safe by default on mobile devices — and that vulnerability is one of the top causes of data breaches," says Cidon. Also, if you use cloud services, you should use cloud software that encrypts PHI at the file level.
- **Disseminate information about threats to your organization.** "If you have a HIPAA committee, that's a good place to be talking about these issues," says Fisher. "A committee can be a central repository of knowledge about changes and awareness of threats, including big things as they come out. Another good avenue is to include changes in the annual HIPAA training." — *Roy Edroso (redroso@decisionhealth.com)*

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