Part B News

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

HIPAA

8 tips to handle patient requests for records without violating HIPAA

Prepare for more patients and their families to ask for copies of their medical records. HHS' Office for Civil Rights (OCR) recently issued guidance reminding consumers they're entitled to the documentation.

In addition, practices should understand that OCR is going to be more likely to punish those who don't comply. OCR's guidance should serve as a road map for handling medical

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

Preventive services

Specialists can perform lung cancer screening, despite guidance to the contrary

Specialty providers can order a certain lung cancer screening for their patients and get reimbursed for the newly covered preventive service, despite language issued in MLN Matters 9246 stating otherwise.

Confusion cropped up about which providers are eligible to report code **G0296** (Counseling visit to discuss need for lung cancer screening [ldct] using low dose ct scan [service

*(see **Lung cancer**, p. 7)*

Prevent a 6% Medicare pay cut

Under the value-based modifier (VBM) program, an intensified version of PQRS, your practice will face up to a 6% pay cut in 2018 or a 4% payment boost dependent upon your 2016 PQRS reporting and a slew of specific cost measures Medicare will analyze. Perform well and you'll gain the incentive. Underperform and you'll be penalized. Get an action plan during **Master the Value-based Modifier: Report successfully to gain — not lose — a 4% Medicare pay boost** on Apr. 6. For more information, visit *www.decisionhealth.com/conferences/a2660/index.html*.

Quality reporting

Look to registry reporting now; be ready when CMS releases the 2016 list

Practices need to weigh the cost of alternative quality reporting methods against the risk of flubbing quality reporting in 2016. This year, any group that employs at least one physician could face a combination of cuts totaling 6%, based on quality reporting.

Currently the majority of providers who participate in the physician quality reporting system (PQRS) program use claims-based reporting, according to the 2016 Medicare physician fee schedule. The key advantage of claims-based reporting is it's free, says Jennifer Searfoss, president and CEO of SCG Health, Ashburn, Va.

However, PQRS and the stakes of reporting have rapidly evolved: What was once a program that gave providers the chance to receive a bonus if they reported three measures became a program that penalized providers who failed to report at least one measure. Now, providers who treat Medicare patients must report nine measures, including one cross-cutting measure, across three national quality domains — noted with shorthand 9(1), 3 — to avoid a 2% penalty on payments.

In addition, the value-based modifier (VBM) applies to most group practices and is based on the PQRS performance of at least half of the providers under the same tax identification number. The VBM could cut up to another 4% from the group's payments based on quality reporting.

Registry reporting, particularly for larger practices, can relieve staff of the effort and time required to make sure the measures codes are appended to each appropriate claim. However, registries aren't free. A practice will need to select and enroll with a registry, enter into an agreement that allows the registry to access the practice's data and comply with the registry's requirements.

Understand the 2 types of registries

You may hear people refer to qualified registries and qualified clinical data registries (QCDR). They aren't the same thing, although an organization may offer both kinds of registries. Here is an overview of the two types:

Qualified registry. These registries report CMS-approved PQRS measures. A provider may report individual measures as he would claims-based measures: 9(1), 3 for at least 50% of all eligible Medicare patients. Expect to pay $300 to $500 per provider, said Jeanne Chamberlin, FACMPE, director, MSOC Health, during DecisionHealth's **2016 PQRS Action Plan** webinar.

However, you'll find there are more registry-based measures as CMS continues its shift away from claims-based reporting. For example, the new opioid therapy management measures are registry-only.

You can find information on registry measures on CMS' measures code website (*PBN 1/18/16*).

In addition, this form of registry reporting is the only way to report measures groups, and providers who

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choose that method have to report on only 20 patients, so long as at least 11 are Medicare patients, Searfoss notes.

Qualified clinical data registry. Think of this as registry plus. Providers must report nine measures across three domains, but QCDRs may report PQRS and non-PQRS measures. There is no cross-cutting measure for QCDR, but providers must report outcome measures — measures that show the result of the patient's treatment:

- Two outcome measures.
- One outcome measure and one of the following types of measures:
  - Resource use.
  - Patient experience.
  - Efficiency appropriate use.
  - Patient safety.

In 2016, providers must successfully report quality measures for 50% of eligible Medicare and non-Medicare patients and the cost can range from free to $10,000 per provider, Chamberlin noted.

Think about registries now

Each year, registries must apply for CMS approval, and the federal agency releases a list of registries in the middle of the current reporting year. There's no guarantee that a vendor that was approved for 2015 will be approved for 2016.

That gives practices time to think about whether registry reporting is a good fit and to review the measures that can be reported via registry. Contact a few registries that were approved in 2015 to determine whether they have applied to participate in 2016 and investigate them, so you have a smaller list of organizations to consider when CMS releases the final list. — *Julia Kyles, CPC (jkyles@decisionhealth.com)*

Resources:

- CMS measures codes *www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html*
- Registry reporting *www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Registry-Reporting.html*
- Qualified clinical data registry reporting *www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Qualified-Clinical-Data-Registry-Reporting.html*

Editor's note: *Get on-demand access to DecisionHealth's webinar* ***2016 PQRS Action Plan: Avoid penalties, gain revenue, ease reporting*** *by visiting www.decisionhealth.com/conferences/a2653/register.html.*

Patient encounters

Avoid turning off LGBTQ patients, prevent lawsuits with 'cultural competency'

A pending law in the District of Columbia underlines your obligation to proactively guard against discrimination against lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) patients — or risk alienating patients or even legal trouble.

On Feb. 2, the D.C. Council passed the LGBTQ Cultural Competency Continuing Education Amendment Act of 2015, requiring health care professionals licensed in the district to acquire two continuing education credits "on cultural competency or specialized clinical training focusing on patients who identify as lesbian, gay, bisexual, transgender, gender nonconforming, queer or questioning their sexual orientation or gender identity and expression ('LGBTQ')."

The Act, which at press time awaits Congressional approval, includes a waiver for providers with only limited patient engagement and authorization for the District to arrange funding for cultural competency training vendors.

The legislation is a sign that competency in the special needs of LGBTQ patients is increasingly expected of providers.

While "there is not a [federal] legislative mandate that addresses this specifically, many providers are being sued because of a lack of cultural competence and appropriateness," says Venessa Marie Perry, president/CEO of Health Resources Solutions LLC in Washington, D.C. Some cases, such as *Taylor v. Lystila* involving a transgender patient whose provider refused to give her hormone replacement therapy, have explicitly referenced the Affordable Care Act (ACA).

How HHS weighs in on LGBTQ rights

Section 1557 of the ACA prohibits discrimination in federal health care programs against groups covered by various anti-discrimination laws, such as the Civil Rights Act. Subsequent HHS regulations indicate the department considers these laws apply to LGBTQ federal beneficiaries as well, and the language in a proposed

HHS rule issued on Sept. 8, 2015, suggests that a final rule will make this explicit: "We believe that discrimination on the basis of sex further includes discrimination on the basis of gender identity."

Regulation affecting health care providers increasingly refers to LGBTQ needs. For example, the most recent meaningful use final rule includes a requirement that certified electronic health record (EHR) technology be used to "record a patient's sexual orientation and gender identity (SO/GI) in a structured way with standardized data" as "a crucial step forward to improving care for LGBT communities."

The language of "cultural competency" is well-established in HHS sub-departments, says Perry, as shown by tools like the 2012 MLN Matters, "Cultural Competency: A National Health Concern," and the Office of Minority Health's "Think Cultural Health" page. "The number of increasing health disparities in minority and disadvantaged communities has indicated that there is a need for providers who understand and are able to relate to the sensitive needs of the population," she explains. Given this trend, it behooves providers to make sure they're equipped to provide a welcoming environment to LGBTQ patients.

4 tips to promote cultural competency

1. Explain the need. "Professionals in the field are not empty vessels; many have carefully figured out over time how they want to talk to patients," says Liz Margolies, founder and executive director of the National LGBT Cancer Network in New York City. "The challenge is to convince them that the way they've been doing it isn't working well for a whole population of people and to ask them to change without shaming them; making them defensive will only lead them to shut down."

"Many providers proudly say, 'I treat everyone the same,' — they think this shows that they don't discriminate," Margolies adds. "But not every patient needs the same thing." Explain the difference as one between "treating people how I want to be treated" and "treating people the way *they* want to be treated," she suggests.

2. Don't neglect non-clinical staff. A welcoming environment begins at intake. Think about your answers to these questions, says Lillian Rivera, director of advocacy & capacity building at The Center for LGBTQ Youth Advocacy and Capacity Building of the Hetrick-Martin Institute in New York City: "When they go to the physical space … do they see images that are reflective of their experiences? Are reading materials reflective of their experiences? Are they referred to by the names that they choose and affirm or by names that have been assigned to them? Do you have gendered restrooms?"

Margolies' training film, *Vanessa Goes to the Doctor*, suggests intake forms that include variant names or pronouns, for example. She also recommends making sure receptionists understand how to address a transgender woman whose legal name is different from her preferred one, for example.

3. Address community-specific health issues. Providers are encouraged to proactively address care concerns of special importance to these patients. For example, "I would include some information about HIV, specifically with young African-American and Latino gay men" — populations for whom HIV rates are high, says Rivera.

4. Work with professionals. "I strongly recommend hiring an individual or organization that has a solid history of training health care providers" in cultural competency, says Margolies. She recommends exploring the National LGBT Health Education Center of The Fenway Institute, part of Fenway Health in Boston; the Healthcare Equality Index benchmarking tool of the Human Rights Campaign, Washington, D.C.; and her own Cultural Competency Toolkit.
— *Roy Edroso (redroso@decisionhealth.com)*

Resources:

- D.C. Council Act: *http://lims.dccouncil.us/Download/33671/B21-0168-Introduction.pdf*
- Cultural Competency: A National Health Concern: *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0621.pdf*
- Think Cultural Health: *www.thinkculturalhealth.org*/
- Vanessa Goes to the Doctor: *www.youtube.com/watch?v=S3eDKf3PFRo*
- Healthcare Equality Index benchmarking tool of the Human Rights Campaign: *www.hrc.org/campaigns/healthcare-equality-index*
- Margolies' Cultural Competency Toolkit: *www.lgbtcultcomp.org*/

HIPAA

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records requests — and excuses for failing to follow that guidance will not be tolerated, says attorney Elizabeth Litten with Fox Rothschild in Princeton, N.J.

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Benchmark of the week

Watch for high-denial surgery, post-op modifiers on E/M claims

While modifier **25** (Significant, separately identifiable E/M services) is often the cause of denied E/M claims, other common modifiers have been known to crash and burn such claims.

The data below show the most-denied modifier-E/M combinations billed at least 10,000 times in 2014, the most recent year for which Medicare data are available. Few modifiers were combined that often. For example, **99201** has a top-two list instead of top three because **GY** (Item or service statutorily excluded) and 25 were the only modifier combos that were billed that often for that code in 2014.

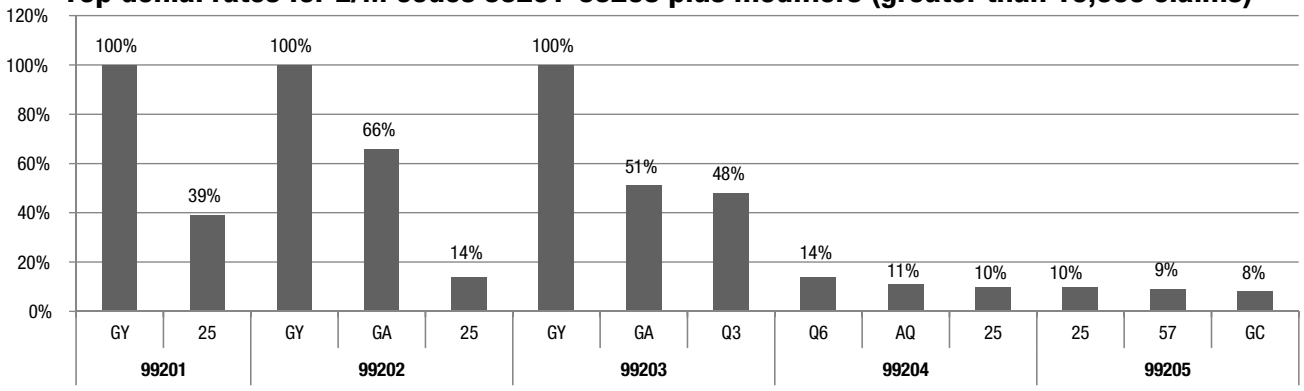
But when codes were billed that often, they were frequently denied. Modifier 25 comes up frequently in highly denied E/M-modifier combos, especially on level 1 where it gets a whopping 39% rate (*PBN 1/4/16*). And it's no surprise to see high denials with GY and **GA** (Waiver of liability statement issued) modifiers — the former is used when you know you won't get paid, the latter when you give the patient an advance beneficiary notice because you expect not to get paid (*PBN 9/1/14*).

Other modifiers that came up frequently were **57** (Decision for surgery), **24** (Unrelated evaluation and management service by the same physician during a postoperative period) and **59** (Distinct procedural service), especially among the established-patient E/M codes.

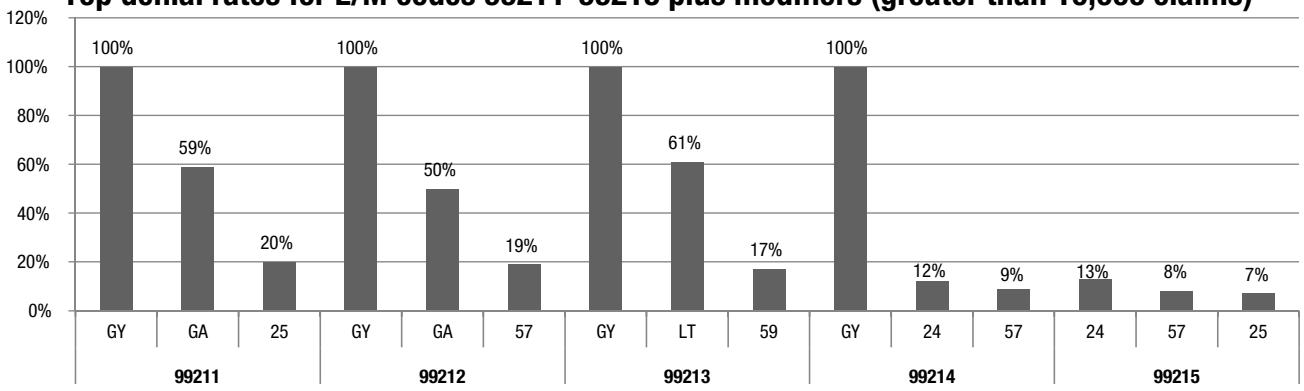
Modifier 24 is "the No. 1 RAC audit modifier issue" and will always get looked at, says Terry Fletcher, CPC, president of Terry Fletcher Consulting in Laguna Beach, Calif. Modifier 57 often gets an E/M claim dinged "because the procedure that follows the E/M does not have a 90-day global attached," she adds, and that's a condition of the modifier (*PBN 1/9/16*). Modifier 59 is not supposed to be used with E/M codes at all.

Q6 (Locum tenens) was an issue with **99204** (14% denial rate) — and though it wasn't billed enough to make our chart, the rate is high across the other nine office visit codes too, especially **99215** (23%). Q6, says Fletcher, will get claims kicked out when it's used for a covering provider when there was no established leave of absence by the primary physician (*PBN 9/28/15*). — *Roy Edroso (redroso@decisionhealth.com)*

Top denial rates for E/M codes 99201-99205 plus modifiers (greater than 10,000 claims)



Top denial rates for E/M codes 99211-99215 plus modifiers (greater than 10,000 claims)



Source: Part B News *analysis of Medicare claims data*

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Practices that don't comply could face financial penalties. The penalties vary based on the extent of the violation and the intent.

For many years, rather than punishing providers who refused to give medical records to patients who sought them, OCR offered education.

But now that OCR has issued the new guidance, providers have no excuse for errors.

They "need to be primed for this," warns attorney Michael Kline, also with Fox Rothschild. Providers that don't comply will be "set up for enforcement actions."

HIPAA gave patients the right to access their health records when the law was first enacted in 1996. However, many providers have refused to honor these requests, much to OCR's frustration. The office notes that this is one of the five top complaints it receives, according to Deven McGraw, deputy director of OCR's health information privacy division.

Much of the problem stems from providers' reluctance to share information that could be used against them in court and/or fear of violating HIPAA by sharing too much, Litten says.

Major components of OCR's road map

OCR had been trying to get the word out to patients and providers by creating YouTube videos, according to McGraw. But guidance released Jan. 7 is more detailed and reiterates the major components of the rights to access under HIPAA. These include:

- Patients and their personal representatives (such as a legally appointed guardian or executor of a patient's estate) are entitled access to almost all of their records in a practice's possession, such as medical, billing and payment information, also called a "designated record set."

They're not entitled some data, such as psychotherapy notes or information compiled by the practice for anticipation or use in a civil, criminal or administrative proceeding. A request can be denied in limited situations.

- Practices need to take reasonable steps to verify the identity of the person requesting access but not steps so onerous that it would make it difficult for the person to obtain the records.

Examples of what would be unreasonable: Requiring requests only via a portal because not all patients have Internet service or requiring a response by mail because patients may want their information sooner.

- The record needs to be provided in the form and format requested, if readily producible that way. If not, it needs to be produced in an alternative, agreed-to form and format. A summary or explanation is acceptable, so long as the patient chooses to receive the summary or explanation and agrees to pay any fees for it.

- The practice can charge only the reasonable costs for the labor to make the copy, supplies for creating it, postage if it's being mailed and preparation for any summary or explanation.

- The patient must receive the record within 30 days of the request. If the practice can't meet the deadline, it's entitled to a one-time 30-day extension so long as it notifies the patient why it can't make the initial deadline.
- The patient can direct the practice to send the record to a third party, so long as that request is in writing, signed by the patient and identifies where the record is to be sent.

Take these steps to comply with HIPAA

1. Make sure you keep only appropriate information in a patient's file. For instance, if your practice reasonably anticipates being sued and has begun to compile documents to defend itself, those records should not be in the record that the patient can request, Litten says.

2. Identify the locations where patient information may be kept. Some records may be in paper form and others in electronic form; older records may be stored off-site.

3. Have policies and procedures to honor requests for access to records. To reduce confusion and ensure that the deadlines are met, designate one person at the practice to handle these requests.

4. Make sure any business associate holding patient records on your behalf is familiar with the rules. The right to access extends not only to practices and other covered entities but also to their business associates, such as a billing or storage company.

5. Consider requiring requests to be in writing, which is allowed but not required under HIPAA. "As a matter of good bookkeeping, you want to document that you gave the patient what he asked for," Kline says. Some providers have simple forms for patients to complete.

Note: If you're going to require requests in writing, you need to notify patients in advance. One easy way to accomplish that is to include it in the Notices of Privacy Practices provided to all patients; this informs them of your and their HIPAA rights and obligations.

6. Tread carefully if you want to ask patients why they want their records. You're not supposed to ask that, and you can't penalize patients by withholding their records if, say, you're concerned that they'll be used against you in a lawsuit, Kline says. If you do want to ask that, make sure that patients understand that such information is to be provided voluntarily.

7. Use caution when calculating costs for copies. While HIPAA limits the costs that can be charged for records, states' laws set those fees, and they vary significantly, Litten says. HIPAA and state requirements need to be taken into account and reconciled (*PBN 3/10/14*).

8. Don't assume that all requests from attorneys are subject to these requirements. HIPAA's rules regarding access to records apply to requests from patients or their "personal representatives."

Just because an attorney is acting on a patient's behalf and is her legal representative does not mean that the attorney is a "personal representative" as defined by HIPAA's privacy rule. If an attorney is not a personal representative, HIPAA's 30-day deadline and restriction on fees charged for records do not apply, and the records do not need to be sent directly to the attorney.

At least one OCR regional office (region 3 in Philadelphia) has confirmed this distinction. So if you receive a request from an attorney and you're unsure whether it falls under HIPAA's rules, check with your OCR regional office.
— *Marla Durben Hirsch (pbnfeedback@decisionhealth.com)*

Resources:

- View OCR guidance at *http://1.usa.gov/1K0jEkj*
- Read an OCR letter explaining status of attorney requests at *http://bit.ly/21lHWyY*
- Find information about OCR headquarters and regional offices at *http://1.usa.gov/1qYWMHA*

Editor's note: *Get updated HIPAA guidance in the 2016 HIPAA Answers book. Learn more at www.codingbooks.com/topic/compliance/2016-hipaa-answers.html.*

Lung cancer

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is for eligibility determination and shared decison-making]) after CMS issued guidance in a November MLN Matters article that contradicted the national coverage determination (NCD) for the lung cancer screening that CMS issued in March 2015.

The MLN Matters article states: "For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services."

While this sowed confusion among specialty groups, you can simply disregard that part of the MLN Matters article, experts told *Part B News*. CMS clarified its mixed messages in a February email exchange with the American Thoracic Society, the American College of Radiology and other organizations involved in cancer care and screening, according to a source at the American Thoracic Society.

"Based on the NCD and applicable regulations, the physician or non-physician practitioner who furnishes the shared-decision making visit and orders the LDCT must be treating the beneficiary and use the results in the management of the beneficiary's specific medical problem to ensure improved health outcomes," stated CMS in the email exchange, according to sources.

This means that reporting code G0296 is not relegated to primary care providers. Instead, you should heed the "treating physician" guidance in the NCD and in CMS' clarification, which allows specialty physicians, as well as primary care physicians, to bill the service.

It remains unknown whether or when CMS will update MLN Matters 9246. At press time, CMS had not responded to *Part B News*' inquiries on the matter.

3 tips to bill lung cancer screening

Here's how to streamline the service to fulfill specific requirements, such as counseling and shared decision-making, and make sure you get paid (*PBN 3/9/15*):

1. Find a reliable shared decision-making tool. You won't get reimbursed for G0296 without performing shared decision-making with the patient, "including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate and total radiation exposure," according to the coverage guidelines.

CMS doesn't stipulate that you use a specific test. "Eligible practitioners may select from various available decision aids designed for this purpose and recognized by national professional medical organizations," states the NCD.

You can save time by adopting a go-to tool for the task. The American College of Radiology recommends the decision-making tool found at *www.shouldiscreen.com*, developed at the University of Michigan. Another decision-making resource is available from the National Cancer Institute (*www.cancer.gov/newscenter/qa/2002/NLSTstudyGuidePatientsPhysicians*), which contains "take home" messages for the patient.

2. Bill G0296 with same-day services, provided you have medical necessity. CMS ironed out the same-day billing policy in the 2016 Medicare final physician fee schedule: "As long as the NCD requirements for the counseling and shared decision-making visit are met, the counseling visit may be billed on the same day as a medically necessary E/M visit," states the fee schedule.

Be sure to attach modifier **25** (Significant, separately identifiable E/M service), points out Margie Scalley Vaught, CPC, a consultant based in Chehalis, Wash. While providers typically attach 25 to an E/M code, in this case the language in the fee schedule suggests otherwise — and specialty organizations have taken note. "Modifier 25 … would be required on code G0296," states an article on coding guidance from the Association of Community Cancer Centers.

"Offices might want to double check with their carrier," advises Vaught.

You're also eligible to bill the lung cancer screening visit the same day as an annual wellness visit (AWV), according to CMS guidance in the 2016 fee schedule. Again, you'll be required to attach modifier 25 to ensure payment; make sure you adequately document the separate service to get paid (*PBN 1/12/15*).

"Providers should also note that since the shared decision-making visit is a preventive service benefit, there is no patient copay," adds Katina Nicolacakis, M.D., chair of the American Thoracic Society's clinical practice committee, New York, N.Y.

3. Standardize the patient order form to streamline referrals. You must provide a written order form as part of the code's billing requirements. The order form must include pertinent patient information as well as a statement authenticating that shared decision-making occurred. Consider the sample order forms provided at the following link from the American College of Radiology: *http://bit.ly/1LEAOoc*. You'll find examples of paper forms and automated forms for the electronic health record (EHR). — *Richard Scott (rscott@decisionhealth.com)*

Resource:

- MLN Matters 9246: *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9246.pdf*

Clarification

The article, "Gain an MU hardship exception because of CMS' delayed final rule," published in the Feb. 15 issue, stated that providers who filed a hardship exception for the 2015 reporting period would forfeit incentive payments for the same reporting year. CMS released updated guidance Feb. 18 stating that providers can file a hardship exception and also be eligible for incentive payments. See the official FAQ at *https://questions.cms.gov/faq.php?faqId=14357&id=5005.*

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