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Part B News
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In this issue

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Practice management

Go the extra mile to onboard new providers and keep them happy

Given current provider shortages, it's important to start your new clinical hires on the right foot. A survey of clinicians and recruiters suggests new provider onboarding in medical practices works best when there's a formal process and early intervention.

The survey, conducted in the first quarter of 2024 and commissioned by the Association for Advancing Physician and Provider Recruitment (AAPPR) in collaboration with Jackson Physician Search and LocumTenens.com, found moderate to high levels of satisfaction with onboarding practices among providers and in-house recruitment specialists.

According to the survey report published in July, 61% of permanent providers rated their onboarding experience as very good or excellent, while 73% of locum tenens providers gave very good or excellent grades to their onboarding. Recruiters were satisfied with their own onboarding processes at rates of 71% (for employed physicians), 68% (employed advanced practice clinicians) and 65% (for locum tenens).

The findings also suggest that the better the onboarding experience, the more satisfied the provider. For example, among providers reporting high job satisfaction, 56% also reported a positive onboarding experience; conversely, only 19% of highly satisfied providers reported an onboarding experience that was negative.

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Make it formal to find success

But what makes onboarding positive? AAPPR finds that not all onboarding is the same, and more formal and involved processes tend to be more successful.

Some of what might be taken for onboarding is actually more like orientation. According to Tara Osseck, regional VP, recruiting at Jackson Physician Search, orientation is more of a "shorter-term new hire process, typically designed to be more task-oriented and built around allowing a provider to successfully navigate the logistics and administrative tasks that come with their new role." This would include "benefits enrollment, obtaining a badge, parking and physician lounge" and so forth.

Onboarding, properly understood, is "a much more comprehensive, longer-term process that helps a physician become fully integrated into their new organization or department or practice," Osseck says. "The tasks tend to be much more heavily relationship-oriented. You might hear, for example, about networking opportunities and relationship-building among clinical and administrative stakeholders within the organization."

Also, while an organization may have some kind of onboarding above and beyond orientation, AAPPR finds the process is often informal — not defined by a protocol and reliant on contingencies of time and availability.

While 72% of recruiters claimed they had a formal onboarding process, only 57% of providers and clinicians said they had received a formal onboarding. That 15-point gap suggests a disconnect in many cases between what providers experience and what recruiters believe they supply.

AAPPR finds this a potential missed opportunity. Osseck finds that "the formal onboarding process tends to drive high job satisfaction because it helps physicians integrate into their new roles so much more smoothly and contributes to better compliance, collaboration across the care team, and quality of patient care."

Start early, go long

Another important aspect of onboarding is that it can go on for much longer than traditional orientation — in fact, the survey shows that 70% of all respondents said theirs goes three to four months, and 14% said theirs can go as long as six months. And more often than not it begins before the new hire walks in the door: 21% say it starts with verbal acceptance of the employment offer, and 61% say it starts when the contract is signed.

"The quicker a new provider becomes familiar with the organization's policies and procedures and adopts the culture, the quicker they feel settled and can start being productive," Osseck says.

Paul D. Werner of the Buttaci, Leardi & Werner law firm in Princeton, N.J., thinks that, ideally, onboarding is an extension of the vetting and interviewing process. "You're not just finding a warm body to fill a spot," he says. "You want somebody who wants to do what you do

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the way you do it. There are a lot of different ways to run a successful medical practice, but [even a good provider] just might not be the right fit for a particular office at a particular time."

The long lead time for formal onboarding helps with this by giving new hires opportunities to not just learn "the ropes" as traditionally understood but also the cultural aspects of their new organization and community. "Physicians, particularly permanent [hires], tell us they're seeking more comprehensive tours and [better] understanding the organization's mission and values," Osseck says, "and they really appreciate prolonged time [spent] getting acclimated with facility protocols. They appreciate more social interaction and mentorship and more focused time on the community."

This can be especially helpful when the provider has relocated and seeks, in addition to housing, to understand the lay of the land.

You still have to teach your new hires simple things like how to use the EHR and where the lockers are. While much of formal onboarding involves soft-skill work like social and cultural acclimation, the parts that are more cut-and-dried should be organized and prepared for convenience. Osseck suggests "building out a master list of all the necessary elements of hiring and ramping up a new provider, and recognizing which of those items — [e.g.,] billing and coding, the medical staff directory — can be easily standardized and scaled. Other elements may need to be much more personalized based on the specific physician."

But making sure the rest of it gets covered should pay dividends down the road. "A formal onboarding process can take what [can be] a nerve-racking and sometimes stressful time for a new physician starting a new role, and make it more welcoming," Osseck says. "And when physicians feel supported and valued from the very beginning, I find that the physician and facility are much more likely to embark on a relationship based on trust and collaboration and communication." — *Roy Edroso* (roy.edroso@decisionhealth.com) ■

RESOURCE

- AAPPR, "Physician and Clinician Onboarding Research Report," July 2024: https://cdn.ymaws.com/member.aappr.org/resource/resmgr/resource_library/reports/2024_AAPPR_Onboarding_Report.pdf

Practice management

Temps need help too: The case for onboarding locums

You may be surprised to see locum tenens providers mentioned in an onboarding story, especially if you think of them as the paratroopers of the medical profession, ready to parachute in at a moment's notice (*see related story, p. 1*).

But many of these temporary assignments, which under Medicare rules can only be billed under the absent provider's NPI for 60 days or less, will blossom into longer-term and even permanent positions. Jenny Binner, associate vice president of emergency medicine, urgent care and occupational medicine services at LocumTenens.com, thinks that's a good reason to provide your locum tenens subs with more than just the basics.

"We've identified different personas of locums providers," Binner says. "One is a 'long-term' locums — somebody who always does locums, it's their career. They don't typically go permanent but then every once in a while they'll find a perfect fit. There's also a 'purpose' locums — somebody who might be waiting on a state license to come through and is picking up locums assignments while they're waiting. Then there are those who are just looking for a good fit [to go permanent]."

So while locums providers are accustomed to "expect the bare minimum from an onboarding standpoint," Binner says smoothing such transitions when they occur may be a good reason to devote the extra resources to give them a fuller treatment. This is especially true in the current era of provider shortages, and may be more salient among certain specialties, such as the emergency medicine sector, where that shortage is especially acute, Binner says.

Binner adds that full onboarding can also make locums providers more effective at your organization no matter how long they stay.

"In my experience, the medical staff office that handles hospital credentialing, for example, is always aware when a locums is coming in," Binner says. "But sometimes ancillary departments like provider enrollment, or revenue integrity — someone to come out and train them on billing expectations and requirements — might not always know. Because facilities do view them as a temporary solution, they don't always think to pull those pieces together at once. That could be frustrating for the associates in those departments as well as for the clinician, who might have five or 10 people reaching out to them for the same information." — *Roy Edroso* (roy.edroso@decisionhealth.com)

Coding

Learn 4 terms that are the key to migraine coding

Whether your practice performs services to diagnose or manage and prevent chronic migraines with conservative therapy or your practice specializes in state-of-the-art migraine treatments, a recent draft local coverage determination serves as a call to review the terminology that drives migraine coding.

Five Medicare administrative contractors (MAC) recently closed their comment periods for a uniform botulinum toxin injections (BTI) local coverage determination (LCD) that includes detailed coverage requirements for chronic migraine treatment.

The draft LCD serves as a reminder of the importance of accuracy in documentation and coding for all practices that treat patients with this condition. The ICD-10-CM code category **G43** (Migraine) contains 50 codes. "And remember this is not only for this particular encounter but for the continuity of care," said Shelley C. Safian, PhD, RHIA, HCISPP, CCS-P, COC, COC-I, AHIMA-approved ICD-10-CM/PCS trainer and president of Safian Communications Services Inc. in Longwood, Fla., during "Chronic Migraines in ICD-10-CM: Coding Without the Headache," a webinar broadcast on Dec. 19, 2023.

Episodic vs. chronic migraine

Many people will experience one or two migraines during their lifetimes. Migraines are distinguished from headaches by several symptoms, including the following:

- Migraine pain is unilateral. This is a key clue for coders, Safian explained. If the patient says the pain encompasses both sides of their head, it is not a migraine.
- Patients will describe the pain as an intense throbbing or pulsing.
- Patients frequently have other symptoms including nausea, vomiting and sensitivity to light, sound or odors.
- The migraine might last up to 72 hours without treatment.
- It interferes with the patient's ability to perform normal activities, such as walking.

When episodic migraine prompts a visit to your practice, you will likely report the encounter as an E/M visit. The treating provider's note may include recommendations for conservative treatments and guidance for preventing another bout, Safian said.

However, coverage for many migraine treatments is restricted to chronic migraines. An existing patient who has episodic migraines might develop chronic migraines or a patient who has chronic migraine might seek treatment at your practice.

Make sure providers and coders know that when migraine is the diagnosis, the definition of chronic goes beyond the standard meaning. In addition, you should report relevant symptoms for at least three months in a row. "With migraines we also need to quantify that patient is suffering more than 15 headache days per month," Safian said.

For example, if the provider documents that a patient has experienced migraine symptoms every month for the past nine months but doesn't include information about the frequency for each month, the coder can't assume the patient's migraines are chronic.

Know 3 more migraine terms

To boost coding accuracy, train your team on three additional terms commonly associated with migraine: aura, intractable and status migrainosus.

Aura in conjunction with migraine means the patient experiences a variety of neurological symptoms up to an hour before the onset of pain. The patient will report visual disturbances, trouble speaking or unilateral muscle weakness among other symptoms. The patient might also experience the aura after the migraine begins.

When the provider describes the patient's migraines as intractable, meaning it is not responsive to treatment, the coder also needs documentation of what medication was tried and for how long and the fact that it didn't work, Safian said.

The term status migrainosus describes a migraine that is intractable and lasts longer than 72 continuous hours. It is not unusual for these patients to be admitted to the hospital, so documentation of the duration of the migraine and the attempted treatments are vital to get an admission covered, Safian said.

(continued on p. 6)

Benchmark of the week

Telehealth by mental health providers surged while other specialties slipped

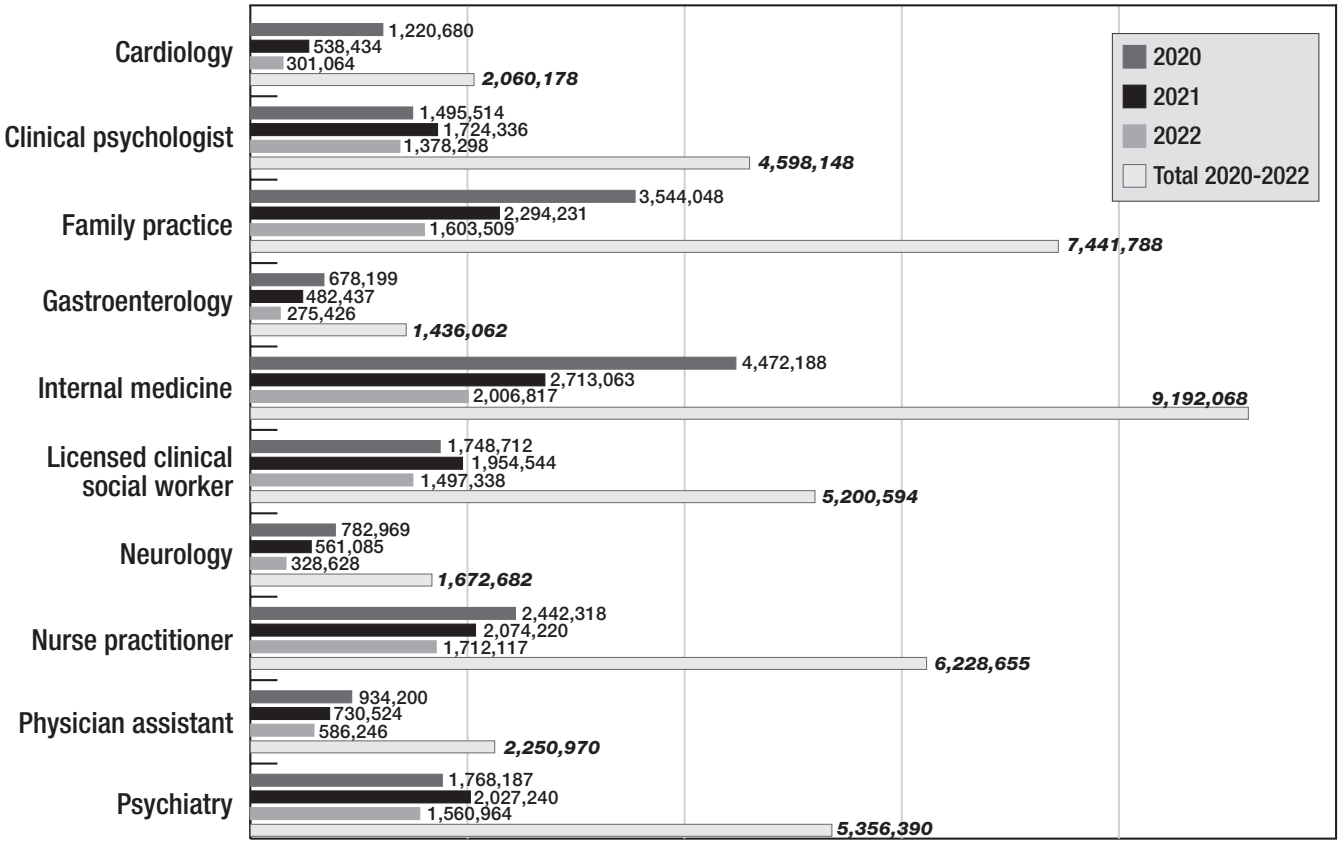
Providers from three specialties broke the trend for Medicare Part B telehealth services, based on claims data submitted by the 10 specialties that reported the highest volume of telehealth services in place of face-to-face encounters in 2020, 2021 and 2022.

Part B News analysis of the top 10 specialties revealed a common pattern: After a surge in 2020, the first and worst year of the COVID-19 public health emergency (PHE), services declined in 2021 and again 2022 even though telehealth waivers remained in place. However, claims by psychiatrists, clinical psychologists and licensed clinical social workers took a step in the opposite direction. Their claims increased during the first year of the PHE and increased again in 2021 before dropping in 2022. These specialties also experienced the smallest dips in telehealth services in 2022 when compared to other specialties that made the top 10.

It is possible that permanent expansion of mental health services via telehealth prompted more Medicare patients to take advantage of the benefit in 2021 and the nature of mental health services means that patients and providers are more comfortable with using telehealth services in lieu of an in-person visit.

The following chart shows the top 10 specialties based on the number of Medicare Part B claims reported with modifier **95** (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) and place of service **11** (Office). In addition to claims submitted each year, the chart shows the total number of qualifying claims submitted during the three-year period. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*)

Telehealth services by top 10 specialties in the office setting, 2020-2022



Source: Part B News *analysis of 2020-2022 Medicare claims data*

(continued from p. 4)

Coding migraines can involve putting several terms together to select the correct code. For example, if the documentation shows the patient had a migraine for six hours and there is no mention of aura or whether the migraine responded to treatment, look to code **G43.001** (Migraine without aura, not intractable, with status migrainosus). If the document supports chronic migraine with aura that did not respond to treatment, but the symptoms resolve after a few hours, look to code **G43.E19** (Chronic migraine with aura, intractable, without status migrainosus), which was introduced Oct 1, 2023. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCE

- Botulinum toxin injections, draft local coverage determination: *www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39856&ver=3&proposedStatus=all&sortBy=title&bc=9*

Ask Part B News

Your patient wants records sent via unsecure email. Are you covered?

Question: *If a patient requests medical records via email and we currently do not use a secure email system, can we send it unencrypted if they agree to it?*

Answer: The general principle of HIPAA security and privacy laws and rules is to protect the patient's protected health information (PHI) from unauthorized disclosure to third parties. In theory, if the patient consents to insecure transmission of their data, you would be able to provide it.

The HHS page "Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.52" directly addresses the issue. HHS says that while "covered entities must implement reasonable safeguards in otherwise carrying out the [email] request, such as taking reasonable steps to verify the identity of the individual making the access request and to enter the correct information into the covered entity's system," an exception arises when "an individual has requested that the PHI be sent to the third party by unencrypted e-mail or in another unsecure manner, which the individual has a right to request. As long as the individual was warned of and accepted the security risks to the PHI associated with the unsecure transmission, the covered entity is not responsible for breach notification or liable for disclosures that occur in transit."

Experts generally read this as permission to send the email, though you should make sure the patient understands their situation as well as their alternatives.

Layna Cook Rush, a shareholder with Baker Donelson in Baton Rouge and a member of the firm's data protection, privacy and cybersecurity team, points to the 2013 HHS Office for Civil Rights (OCR) Omnibus rule, which explicitly states that "covered entities are permitted to send individuals unencrypted emails if they have advised the individual of the risk, and the individual still prefers the unencrypted email." OCR goes on to say that they "expect the covered entity to notify the individual that there may be some level of risk that the information in the email could be read by a third party."

Only in extreme cases may the provider deny the patient's right to their records in whatever form they want if it can be reasonably accommodated. If the provider has a reasonable belief that there is a risk to life or physical safety of the patient or another person, Rush notes, the "preventing harm" exception in the Interoperability Rule allows them to refuse and offer another, more secure approved means of delivery (*see resources, below*). In that case, she adds, "the health care professional would need to document why sending the unencrypted email could cause such a risk."

What if the patient wants email but does not consent to insecure, unencrypted delivery of their information and you don't have secure email capability? You might offer other, more secure means, such as U.S. mail or for the patient to pick up their records from the office with identification, as an alternative. If you use mail, Richard F. Cahill, vice president and associate general counsel of the Doctor's Company in Napa, Calif., recommends you mark the envelope "personal and confidential for review by the addressee only." It's unlikely, however, that a patient who wants email will approve of these slower methods.

You could use encrypted messaging apps such as Signal and Telegram, but "the company offering the app on behalf of the provider's patients must sign a HIPAA business associate agreement [BAA] with the provider and meet HIPAA business associate obligations, such as complying with the HIPAA security rule and notifying the provider in the event of a data breach," says Melissa Soliz, partner with Coppersmith Brockelman PLC in Phoenix.

Given the current state of information technology and the growing threat of cybercrime, it may be that instead of looking for workarounds you should just pick up email encryption service from a vendor that will sign a BAA. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- HHS, "Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.52," last reviewed Jan. 5, 2024: *www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html*
- OCR, "Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Non-discrimination Act; Other Modifications to the HIPAA Rules" (Omnibus Rule), Jan. 25, 2013: *www.govinfo.gov/content/pkg/FR-2013-01-25/pdf/2013-01073.pdf*
- Office of the National Coordinator for Health Information Technology (ONC), "CURES ACT FINAL RULE Information Blocking Exceptions," July 2022: *www.healthit.gov/sites/default/files/2022-07/Information-BlockingExceptions.pdf*

Compliance

HIPAA Q&A: Reproductive care, Change breach, informed consent

Editor's note: *In this issue,* Part B News *welcomes compliance expert Julia Huddleston, CIPP/US, CIPM, CCSFP, principal with Apgar & Associates, to answer a series of questions about HIPAA compliance areas, focusing on reproductive health care policies, data breaches and more. The Q&A session is below.*

Question: *What are the takeaways for HIPAA compliance officers in the HIPAA Privacy Rule to Support Reproductive Health Care Privacy final rule?*

Answer: The HIPAA Privacy Rule to Support Reproductive Health Care Privacy, which took effect June 25, 2024, aims to strengthen HIPAA privacy protections by "prohibiting the disclosure of protected health information (PHI) related to lawful reproductive health care in certain circumstances."

Previously, medical record privacy was at risk, particularly when patients sought legal reproductive health care across state lines. The new level of HIPAA privacy includes the following provisions:

- "Prohibits the use or disclosure of PHI when it is sought to investigate or impose liability on individuals, health care providers, or others who seek, obtain, provide, or facilitate reproductive health care that is lawful under the circumstances in which such health care is provided, or to identify persons for such activities.
- "Requires a regulated health care provider, health plan, clearinghouse, or their business associates, to obtain a signed attestation that certain requests for PHI potentially related to reproductive health care are not for these prohibited purposes.
- "Requires regulated health care providers, health plans, and clearinghouses to modify their Notice of Privacy Practices (NPP) to support reproductive health care privacy."

Compliance with the final rule is required 180 days after the effective date, which means organizations must be compliant by Dec. 23, 2024. The Office for Civil Rights (OCR) is allowing a deferred date for required NPP changes of Feb. 16, 2026, to accommodate other recent regulatory changes that impact NPPs. OCR has also stated that it will make available a model attestation no later than Dec. 23, 2024.

In the meantime (and remembering that December is the height of the holiday season), covered entities (CE) should:

- Review and revise current policies and procedures regarding PHI disclosures, in addition to business associate agreements, to ensure they comply with the final rule.
- Begin updating employee trainings when appropriate to help employees understand the new rule and obtain necessary attestations before disclosing PHI potentially related to reproductive health care.

Question: *HHS created a FAQ about the Change Health care breach. What lessons can providers learn from this breach?*

Answer: After HHS posted its FAQ, the *Wall Street Journal* reported in late April that several issues led to the incident. These included:

- Credentials were compromised for an application that allowed Change staff members to remotely access the network.
- Multifactor authentication (MFA) reportedly wasn't activated on the program.
- The cybercriminals moved "laterally" as they lurked in the network, suggesting they had ample time to steal from the company's massive troves of data.

In other words, basic security controls such as MFA were not in place or were somehow bypassed. This is one of the endpoint protections that HHS points to as an "essential goal" of its voluntary Cybersecurity Performance Goals. Essential goals form a floor of cybersecurity protections, per HHS (e.g., audit logging, monitoring and incident handling).

These requirements have been part of the HIPAA Security Rule since it became effective in 2005 and are basic information security hygiene. They mean (non-technically) that every transaction needs to create a log of who did what when; those logs need to be monitored; and organizations need to be able to detect and respond to security incidents as they occur (e.g., geo-blocking).

An organization of the size and scope of Change shouldn't be ignoring basic information security — and neither should your organization. Even prior to the Change incident, it was clear that OCR had decided that 2024 was the year to enforce the HIPAA Security Rule.

In early May 2024, the OCR director confirmed in an interview that during the next seven months the agency will restart HIPAA audits, focusing on the Security Rule (particularly risk analysis and risk management), and that a Notice of Proposed Rulemaking to update the Security Rule will be released by the end of the year. It's time to make sure that your security house is in order!

Question: *In April, HHS released new guidance to reiterate and clarify hospital requirements for informed consent from patients as it relates to medical professionals performing sensitive examinations, particularly on patients under anesthesia. What's important to know for providers?*

Answer: On April 1, HHS published a memorandum to state survey agency directors and sent a letter about the memorandum to teaching hospitals and medical schools. A few days earlier, OCR had posted a FAQ to clarify hospitals' informed consent and privacy obligations to patients during examinations or procedures conducted for educational and training purposes.

This flurry of guidance is in response to reports of patients under anesthesia who were improperly examined, including pelvic, breast, prostate and rectal examinations, without proper informed consent. These examinations were conducted as part of medical students' courses of training.

In the memorandum, HHS makes clear that permission for sensitive exams is "an essential part of the informed consent process for hospitals, and necessary for compliance with the informed consent requirements in the CMS hospital [Conditions of Participation]."

The new FAQ explains individuals' right under the HIPAA Privacy Rule to request that CEs restrict the use and disclosure of their PHI for treatment, payment or health care operations, and the obligation of CEs to comply with restrictions to which they agree except in emergencies. By way of example, the FAQ notes that an individual concerned about medical trainees observing a pelvic exam without their consent while they are unconscious may request their health care provider not to disclose their PHI to medical trainees.

If the covered health care provider agrees to the request, the provider may not disclose the individual's PHI to medical trainees (even if they are members of the provider's workforce). This means that, in that instance, medical trainees could not be in the room with, observe or provide care to the individual or otherwise access the individual's PHI except in an emergency. And, in the event of an emergency, the CE would be permitted to use or disclose only the portion of the restricted PHI that is needed to provide emergency treatment.

The letter to teaching hospitals and medical schools makes a point to note that OCR investigates complaints alleging that PHI was used or disclosed to medical trainees in violation of HIPAA. The letter also emphasizes that OCR will continue to ensure CEs' policies and practices related to sensitive examinations do not discriminate against patients on any basis protected by federal civil rights laws.

Editor's note: *Huddleston is Apgar and Associates' principal. She holds the designations of Certified Information Privacy Manager, Certified Information Privacy Professional, and Certified (HITRUST) CSF Practitioner. She works with Apgar & Associates' clients on certification readiness, compliance assessments, security risk analysis, and policy and procedure review and implementation.* ■

Have a question? Ask PBN

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