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Part B News
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In this issue

Practice management

CMS: In AWV, SDOH assessment can occur days before visit; append modifier

A Change Request pertaining to the use of social determinants of health (SDOH) risk assessments during a Medicare annual wellness visit (AWV) stresses provider flexibility as to how they conduct the assessment. That should make it easier to handle the extra steps required.

Change Request (CR) 13486 and a related MLN Matters document revise the Medicare Benefit Policy Manual to specify that, when an SDOH risk assessment is given in conjunction with an AWV, it is to be claimed with the appropriate AWV code (**G0438** for initial, **G0439** for subsequent) and the add-on code **G0136**, plus modifier **33** (Preventive services).

Note that in this situation, the assessment requires neither coinsurance nor deductible on the patient's part. This is different from when it's provided with an E/M office visit or other non-preventive visit. But the provider must remember to add the 33 modifier or the patient will be billed.

Other features of the service and its billing are specified in the Change Request, including that the SDOH risk assessment may be given on a separate occasion, and even a separate day, from the face-to-face or telehealth AWV encounter.

Noting that "for various reasons, elements of the AWV may be initiated and furnished over a period of multiple days," CMS gives an example in which "a patient would provide their input for an SDOH Risk Assessment through an online portal on a Monday and the health professional interprets the patient's SDOH Risk Assessment input and applies that information toward the establishment or update of a personalized prevention plan as part of the remainder of the AWV on a Tuesday," according to the Benefit Policy Manual.

Memorial Day break

Part B News will take its scheduled break next week. Our next edition will be dated June 3, 2024. In the meantime, stay tuned to the *Part B News blog* at https://pbn.decisionhealth.com/Blogs/default.aspx for news and updates. Best wishes for a relaxing and fun-filled holiday from Richard, Roy, Julia and Mike.

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Though the online portal example is the only one that CMS describes, it seems fair to infer than any HIPAA-compliant means of transmission should be acceptable for this step. However, Richard F. Cahill, vice president and associate general counsel of the Doctor's Company in Napa, Calif., cautions that other methods "carry a risk of miscommunication, inadvertent disclosure, or breach of protected health information."

While some providers may not be aware of it, Kaya Holgash, health policy director at McDermott+Consulting in Washington, D.C., notes that CMS also allows the health risk assessment (HRA) associated with the AWV to be administered on a separate day from the patient encounter, so the multiple-days allowance "is not entirely new."

It should be noted that CMS explicitly says in the physician fee schedule final rule that the SDOH risk assessment may be administered in conjunction with the AWV by a broad range of "health professionals," including not only physicians and nurse practitioners but also dietitians and health educators.

Zane Gates, M.D., co-founder and chairman of Gloria Gates Health in Altoona, Pa., suggests that this flexibility can help busy clinicians manage the added work represented by the assessment. "Structured data with templated questions could be sent to the patient through a portal and a health advocate could walk the patient through the questions," Gates says.

"What CMS is trying to say is, 'go ahead and screen so the physician has a heads-up if there are SDOH issues they need to assess during the wellness visit,'" says Jenna K. Godlewski, special counsel and health care attorney with the Maynard Nexsen firm in Charleston, S.C. "If, for example, this person answered 'yes' to a question about homelessness or about drug abuse, the physician knows to dig deeper into those issues when they see them in person."

Also, an explanation of the service during or even immediately before the encounter might be difficult for some patients to comprehend or accomplish on the day of the encounter. The ability to get the assessment done separately and ahead of time may help such patients who have "barriers to completing the information, such as language and cultural barriers," Godlewski says.

CMS specifies that when the SDOH/AWV combo goes past one day, the billing date should be the date on which the entire service is accomplished (presumably the encounter date), and that the multiple performance dates should be noted in the medical records. Also, watch out for other time-based billing issues — for example, the frequency restriction on AWVs that prevent reimbursement when the date of service occurs within a year of a previous claim for the same code — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- Change Request (CR) 13486, "A Social Determinants of Health Risk Assessment in the Annual Wellness Visit Policy Update in the Calendar Year 2024 Physician Fee Schedule Final Rule," May 2, 2024: *www.cms.gov/files/document/r12599bp.pdf*
- MLN Matters, "Annual Wellness Visit: Social Determinants of Health Risk Assessment," May 2, 2024: *www.cms.gov/files/document/mm13486-annual-wellness-visit-social-determinants-health-risk-assessment.pdf*

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Ask Part B News

Must you rehire suspended providers who get their license back? Look to contract.

Question: *I understand that when providers lose their medical licenses they can be fired or removed from a partnership agreement because not having a license prevents them from doing their job, i.e., treating patients and being paid for it. But sometimes these providers get their licenses back. Are there circumstances under which they must be rehired by their former practice?*

Answer: This mainly depends on the contract, and nearly all of them have just-cause clauses that clearly include the inability to practice and get paid as reasons to remove a provider.

"Think of it from the employer's perspective," says Christopher Kutner, a partner in the health services practice group at Rivkin Radler LLP in Uniondale, N.Y. "Loss of license prevents you from being able to see patients and from being able to bill for services. Therefore [the employer] doesn't have an obligation to pay you because you're not able to produce revenue for them."

Kutner worked previously for a managed care company as general counsel "and in our agreements with our network of doctors, there was always a provision that said your participation is terminated upon your loss of license," he says.

In fact, says Kathleen A. Westfall, a health care attorney with the Kerr Russell firm in Detroit, while there have been cases of license-deprived providers doing non-clinical work within their organizations, in some cases they can't even do that. "State laws often require professional entities, including medical practices, be owned and managed by licensed persons," Westfall says. "In Michigan, if a physician is a co-owner of a medical practice and, whether due to license suspension, revocation or otherwise, becomes legally disqualified to practice medicine, Michigan law requires the physician to sever all employment and financial interests in the medical practice within a reasonable time."

It's true that not every license removal is permanent. Richard F. Cahill, vice president and associate general counsel of the Doctor's Company in Napa, Calif., notes that the provider may suffer "temporary suspension for a set term, or probation, with or without conditions such as proctoring or additional supervised training or monetary fines."

Sometimes the provider may be under investigation by a board and their license suspended as a precaution prior to judgment. The provider's license may not even be technically suspended, but rather "encumbered," allowing the provider to fulfill some of their regular duties (*PBN 8/4/20*). But most contracts anticipate that eventuality in their drafting. Kutner says counsel for a provider may attempt to get the board to stay the suspension, which removes their inability to practice — though, again, the contract probably gives the employers or partners the right to remove the provider notwithstanding.

In short, contract terms that commit an organization to rehire a provider once their license issue is resolved are very rare. "Maybe some employment agreements should say, 'if the license is suspended temporarily, there's a duration of time within which the employer would have an obligation to employ,'" Kutner says. "But I've never seen that language."

Despite the lack of legal requirements, it's possible an organization that is invested in a provider may wish to work out a deal to prevent their ouster, Westfall says.

In that case the affected parties should get together to discuss "the nature of the allegations, the plan to defend against the investigation/complaint, and whether the investigation/complaint may impact the provider's ability to provide services, if at all," Westfall says. "Depending on the circumstances, and particularly for more serious allegations, the parties can determine whether a sabbatical or other temporary leave of absence may be necessary or appropriate to avoid termination in the event of adverse action against the provider."

But Cahill brings up another concern: If you rehire or retain a provider who has been sanctioned while in your employ and something goes wrong, it could be trouble for you: "A subsequent adverse event involving that same clinician may lead to another licensing board complaint and investigation and possibly a professional liability claim for malpractice in which the employer may be held vicariously liable for negligent hire or supervision," he says. — *Roy Edroso* (*roy.edroso@decisionhealth.com*). ■

Have a question? Ask PBN

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email *askpbn@decisionhealth.com* with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

Practice management

Manage and engage remote staff with these strategies

Revenue cycle staff are among workers in many industries that are making the shift to remote work. Although there are benefits to working from home, some managers may find themselves struggling to adapt to the changes.

"When managing remote workers, you have to be more deliberate and thoughtful," says Lynn McEneany, MSM, CPC, CPCO, director of revenue integrity at CommonSpirit Health in Chicago, Ill. "You don't have the same level of interaction as you did in the office."

This lack of interaction has a variety of impacts, and it requires managers to face new challenges and find unique solutions. Managers must develop strategies for remote onboarding and training, find different ways to measure productivity, and keep employees engaged.

Onboarding and training

Newcomers to the revenue integrity and medical coding fields might feel overwhelmed by the volume of information thrown their way.

Throughout the onboarding process and beyond, it's important for managers to remind team members that they were hired for a reason, says Jennifer Gardiner, senior director of revenue integrity at the University of Maryland Medical Center in Baltimore, Md. Reassuring these employees that they're on the right track will give them the confidence they need to do their job well, she says.

Many managers have found the onboarding process to be slower for remote workers. However, it can still be effective.

"We recently promoted one of our team members who started during the pandemic," Gardiner says. "Even though it was a slower onboarding process, it clearly worked."

Some organizations keep their revenue integrity staff members on a hybrid schedule, requiring them to work on-site a few days per week. For managers who have hybrid employees, they must prioritize making employees' on-site days intentional and purposeful, according to Gardiner.

"You have to prove the value of coming in," she says. "If your staff is in virtual meetings all day, they might as well be at home."

Gardiner and her management team also coordinate the days that her employees are in the office so that they can attend in-person meetings and training sessions.

For virtual training sessions, managers must do their best to keep employees engaged with material that can be monotonous, according to Aleah Martagon, MBA, RHIA, CRCL, revenue integrity manager at Hennepin Healthcare in Minneapolis, Minn.

"It can be hard to ignore chats and emails that pop up when you're sitting at your usual spot and looking at the same computer," she says.

Management tactics

Along with onboarding and training new hires, measuring productivity and prioritizing employee well-being are critical components of remote team management.

There is a misconception about the productivity of remote workers, says Frank Cantrell, CHRI, corporate director of revenue integrity at Penn Highlands Healthcare in DuBois, Pa.

"I know a lot of people think these employees can get easily distracted at home, but I find that my people are more productive because they are not interrupted as much," he says. In fact, he believes that his staff members are far happier thanks to the freedom of working from home.

Communication is key when it comes to managing a remote revenue integrity team, according to Cantrell. "I don't call everybody every day, but I try to call everybody at least once per week and touch base," he says.

Most managers of remote revenue integrity programs hold regular virtual meetings to review the status of various projects and assignments. Although many remote workers have grown accustomed to audio-only meetings, some managers require their staff to have their cameras on. This decision has many managerial benefits, according to Gardiner.

"I ask them to be on camera so I can judge their body language," she says.

(continued on p. 6)

Benchmark of the week

G0136 joins select group of codes cleared for use with modifier 33

A new billing policy requires that modifier **33** (Preventive services) appear with the social determinants of health (SDOH) assessment add-on code **G0136** on all such claims submitted with annual wellness visits (AWV) (*see story, p. 1*). This will mean a big change in that modifier's utilization, which has mainly been limited to four codes (and overwhelmingly used for just one).

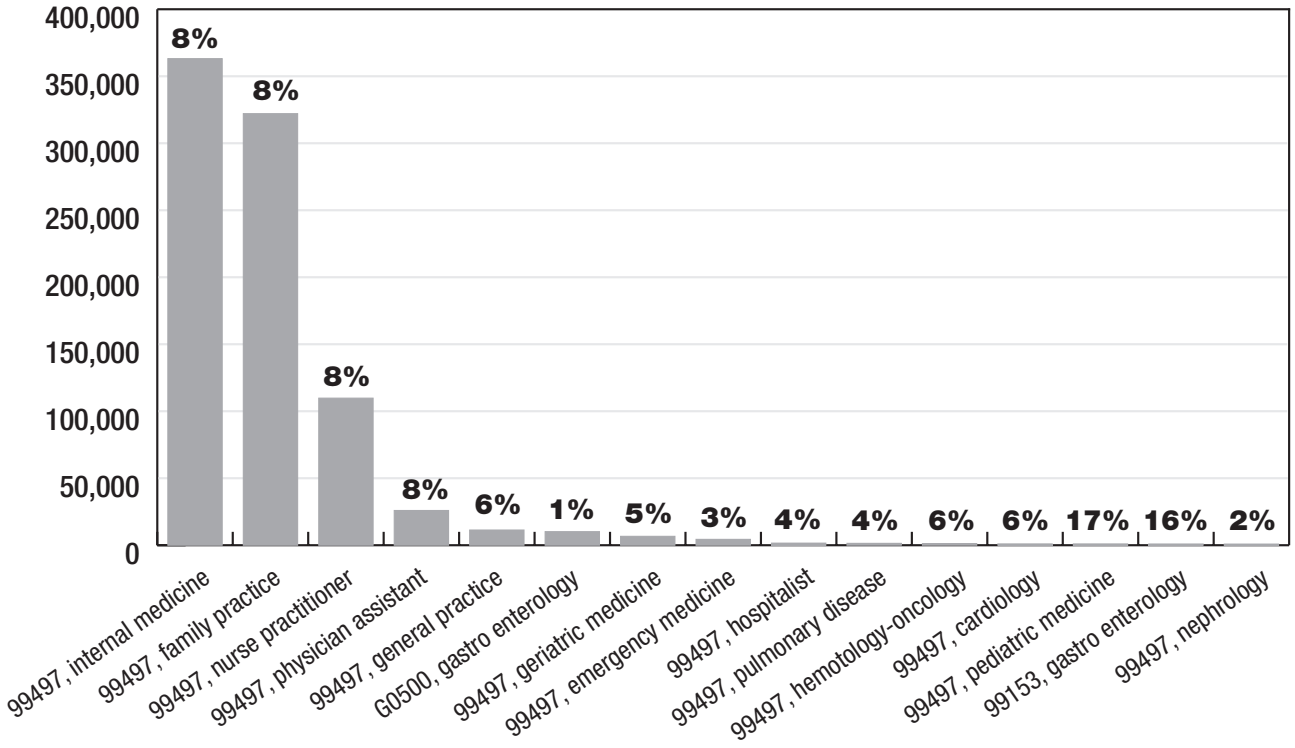
The code most likely to appear with 33 is **99497** (Advance care planning), which earned 855,176 out of 872,385 claims (98%) with 33 in 2022, according to the latest available Medicare claims data. Another advance care planning code, **99498** (… ; for each additional 30 minutes), only got 1,867 claims.

The lion's share of the advance care planning claims were reported by primary-care-related specialties: internal medicine, family practice, nurse practitioner, physician assistant and general practice. The non-PCP specialty with the most substantial showing was geriatric medicine with 6,649 claims. As the chart below shows, denial rates for the leading specialties are not bad; claims with 99498-33, however, have an overall denial rate of 17%.

The only other codes cleared by CMS for use with 33 are two associated with professional fee services for anesthesia in conjunction with screening colonoscopies (*PBN 4/1/24*). The higher code with 33 in this class is **G0500** (Moderate sedation services provided by same physician/QHP, initial 15 mins) with 11,325 claims. Most of the claims (10,131) were reported by gastroenterologists. The remainder of the 33 claims went with **99153** (Moderate sedation services, additional 15 mins).

Some other codes appeared on claims with this modifier, and contractors dealt with them harshly. In 2022, 1,240 claims appeared with 33 and **99401** (Preventive medicine counseling and/or risk factor reduction intervention, 15 mins) and they, in addition to all other codes with 33 besides the abovementioned, were denied 100% of the time. — *Roy Edroso* (roy.edroso@decisionhealth.com)

Top codes by specialty with modifier 33, 2022, with denial rates



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

(continued from p. 4)

Martagon says visual contact improves engagement and gives her the opportunity to see her staff's facial expressions.

"Be comfortable enough with each other to have the same conversations that you would in person," Martagon says.

Convincing employees to turn their cameras on might be easier said than done, she says. One of the benefits of working from home is the ability to dress comfortably, so it's likely that remote team members will not be eager to trade their daily casual clothing for workplace attire.

However, Martagon says she doesn't give appearance too much thought.

"Let's just be vulnerable with each other," she says. "My team and I work together every day, so they can feel free to look however they want — it doesn't matter."

However, other managers don't believe a camera-son policy improves remote team engagement. Recent studies have even shown that camera use during virtual meetings can lower employee engagement and well-being. This phenomenon is known as "virtual meeting fatigue."

Team-building activities

Team-building is another crucial aspect of managing remote workers. For programs with employees on a hybrid schedule, conducting these activities is a little easier, according to Gardiner. Her team has what she calls "work queue Wednesdays," in which they complete items on their Epic dashboards as a group.

"It's a way to put some fun into some mundane tasks," she says.

While it may be more difficult to organize virtual activities for workers who are completely remote, it's still important for managers to ensure these employees are engaged. However, just as remote employees might be reluctant to have their cameras on for virtual meetings, they may not be interested in participating in team-building exercises.

"You're never going to have 100% of people wanting the fluffy stuff, but it's still important to do it," McEneany says.

Many revenue integrity programs have a peer recognition program to boost employee engagement. Gardiner's team has done a "shoutout" program that is not management-driven. Staff highlight their colleagues and show their appreciation for helping with a project or answering questions.

"It's helped them form the team collaboration that went missing during the pandemic," Gardiner says.

Michella Borden, RHIT, revenue integrity department supervisor at St. Charles Health System in Bend, Ore., says that her team takes time to give each other kudos during their meetings, which has helped uplift them as individuals and as a group.

"It's nothing super formal or extravagant," she says. "It can just be a simple 'hey, good job!'"

A popular option for many remote teams is to complete personality tests and discuss their results as a group. Aside from the fun conversation, this activity can provide managers with valuable information, such as staff members' work styles and motivations. It could also prove useful when grouping teams and assigning projects.

"Some people can be more analytical and methodical, while others are more outgoing," McEneany says. "I always find that information very insightful."

A lot of organizations ask new hires to complete personality tests during the onboarding process, but it doesn't have to be a one-and-done activity, according to Borden. "I think that coming back to it once a year or every few years would be really helpful," she says.

Two years ago, Martagon and her team started discussing icebreaker questions weekly. They chat about their favorite kind of ice cream, the shows they are currently watching, and anything else that is of interest to the group.

"It's really amazing how much discussion we get," she says. "Just from that one little question, everyone gets a chance to share something, and it's a really good bonding experience."

Moving forward

There is no single path that all managers of remote teams should take, Gardiner says. Your management style, strategies and approaches should be designed to fit the needs of your team.

"A lot of what we have done has been trial and error," she says. "Certain things worked, and others didn't. But management has to keep trying. Acknowledge when something doesn't work and pivot to something else."

Managers of remote workers should remember that their peers are all in the same boat, according to Martagon.

"Every response I have to questions about managing remote workers ends with 'it's tough,'" she says.

Asking for feedback is a good way to gauge whether your strategies are a good fit for your employees. In addition, managers who treat their staff as people, not just employees, are bound to have more success, according to Gardiner.

"Give a lot of praise and encouragement, and acknowledge when someone is struggling," she says. "We're all human, so let's not forget that."

If managers prioritize employee well-being, staff members are likely to open up more about their lives. This can improve communication, accountability, trust and productivity, says Gardiner.

"I have to assume that my team wanting to share details about their personal lives says that we are doing the right thing as a management team," she says. "We're creating a positive work environment and building relationships." — *HCPro staff* (*pbnfeedback@decisionhealth.com*) ■

Compliance

Alert: NIST publishes Cybersecurity Resource Guide for HIPAA security compliance

The National Institute of Standards and Technology (NIST) published NIST SP 800-66 Rev. 2 in February. You can turn to the publication to gain practical guidance and to safeguard health information and better understand the security concepts discussed in the HIPAA Security Rule.

"The HIPAA Security Rule focuses on safeguarding electronic protected health information (ePHI) held or maintained by regulated entities," NIST officials wrote in the abstract of the guidance. "The ePHI that a regulated entity creates, receives, maintains, or transmits must be protected against reasonably anticipated threats, hazards, and impermissible uses and/or disclosures."

This document supersedes SP 800-66 Rev. 1, published October 23, 2008.

In this issue, *Part B News* delivers a Q&A with ComplyAssistant's Gerry Blass, CEO, and Martin von Grossmann, senior consultant, on the NIST guidance document and other critical HIPAA security matters.

Question: *Can you describe a comprehensive approach to conducting a risk assessment for ePHI that aligns with the NIST SP 800-66 Rev. 2 guidelines?*

Answer: The risk assessment should contain the following elements (they can be conducted sequentially or simultaneously):

- Prepare for the assessment.
- Identify reasonably anticipated threats.
- Identify potential vulnerabilities and predisposing conditions.
- Determine the likelihood that a threat will exploit a vulnerability.
- Determine the impact of a threat exploiting a vulnerability.
- Determine the level of risk.
- Document the risk assessment results.

Question: *How do organizations effectively integrate risk management processes into their daily operations to protect ePHI?*

Answer: Health care organizations need to establish a comprehensive, ongoing periodic process for managing risk, including:

- Periodic risk assessments and analyses based on the HIPAA Security Rule, along with a comprehensive cybersecurity framework such as the recently published NIST CSF 2.0 and/or the Health Industry Cybersecurity Practices Rule. The outcome from each risk assessment and analysis is awareness of potential new vulnerabilities due to change (e.g., network, applications, technologies, mergers and acquisitions).
- Continuous breach detection and response to promptly detect and respond to security incidents. Several companies that provide managed detection and response have begun to utilize artificial

intelligence (AI) to quickly identify network activity anomalies to find and avoid a successful attack.

- Incident response planning, plus workforce training and awareness.
- Third-party vendor/business associate (BA) security risk management.
- Documentation and reporting (compliance and governance).
- Regular review and improvement based on lessons learned from security incidents and audits.

Question: *What are the best practices for implementing technical safeguards to protect ePHI, as recommended in the publication?*

Answer: Technical safeguards are explicitly addressed and defined in the guideline and categorized as follows:

- **Access controls:** "Implement technical policies and procedures for electronic information systems that maintain ePHI to allow access only to those persons or software programs that have been granted access rights as specified in § 164.308(a)(4)."
- **Audit controls:** "Implement hardware, software, and procedural mechanisms that record and examine activity in information systems that contain or use ePHI" [§ 164.312(b)].
- **Integrity:** "Implement policies and procedures to protect ePHI from improper alteration or destruction" [§ 164.312(c)].
- **Person or entity authentication:** "Implement procedures to verify that a person or entity seeking access to ePHI is the one claimed" [§ 164.312(d)].
- **Transmission security:** "Implement technical security measures to guard against unauthorized access to ePHI transmitted over an electronic communications network" [§ 164.312(e)(1)].

Question: *How should organizations approach the documentation of policies, procedures and risk management activities to comply with the HIPAA Security Rule and NIST guidance?*

Answer: Most health care organizations have an inventory of HIPAA Security Rule policies and procedures (P+P). We get requests from startup BAs who request templates they can begin working with.

Once P+Ps are in place, all health care organizations (providers and BAs) need to implement a process for change management, such as updates to regulations and changes in the organization's impact procedures. The changes could be administrative, physical, technical, or organizational. Another example is when applications and data containing PHI/personally identifiable information are moved to a cloud host.

Regarding NIST, organizations should crosswalk their HIPAA Security Rule P+Ps to the NIST CSF 2.0 and determine where they may have gaps that require additional P+Ps.

Changes to P+Ps, security risk assessments (SRA), the Notice of Privacy Practices, and BA agreements about AI, web tracking, and more will be required soon. The ongoing cyberattacks require P+Ps and plans around phishing and the potential for extended downtimes.

In summary, the process for documentation of HIPAA and NIST P+Ps/SRAs never ends and must be included in workforce training. We strongly recommend that all health care organizations adopt the Health Industry Cybersecurity Practices framework. Its website is 405d.hhs.gov, and it contains valuable resources and prescriptive controls that are scoped for small, medium, and large health care organizations.

Question: *In light of the guidance provided in NIST SP 800-66 Rev. 2, what are the most common challenges organizations face when trying to comply with the HIPAA Security Rule, and how can they be overcome?*

Answer: Understanding the changes and how they affect the implementation of compliance within organizations can be confusing at times. Crosswalks between the new NIST changes vis-à-vis HIPAA requirements help identify what those changes are and where they are applicable. — *Dom Nicastro* (pbnfeedback@decisionhealth.com)■

Editor's note: *Stay tuned to the next issue of* Part B News *to discover what the latest report from the National Institute for Standards and Technology means for your HIPAA compliance efforts. You'll find additional Q&A in Part II of the story.*