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#### *Compliance*

# Warning: How EHRs can increase your medical malpractice liability

Review how your electronic health record (EHR) docu- ments patient care. Some of the features providers rely on to save time and enhance documentation may create errors in the record and cause or contribute to patient harm.

EHRs also may not support the physician’s testimony, and in a medical malpractice case, that can hurt the doctor’s cred- ibility and give the appearance that she’s liable.

About 70% of physicians have adopted EHRs. However,

EHRs also are increasingly the cause of or a contributing

*(see* ***EHRs****, p. 5)*

#### *Coding*

**CCI update: Don’t overbill for obesity behavioral counseling, E/M visits**

Pay attention to the time requirement and shore up your documentation when you perform group behavioral therapy for obesity, which is now bundled with a batch of E/M and psych codes in the latest National Correct Coding Initiative (CCI) edits.

Effective July 1, CCI version 21.2 edits stipulate that you can bill code **G0473** (Face to face behavioral counseling for obesity, group [2-10], 30 minutes) with E/M service codes

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

COLLECT EVERY DOLLAR YOUR PRACTICE DESERVES

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

**File meaningful use hardship exception by July 1**

Discover which meaningful use hardship exception might be appropriate for your practice and gain step-by-step instructions on how to apply by the deadline — and by the rules — to avoid a negative payment adjustment for your

practice with the webinar on CD **Meaningful use hardship exception: Take advantage before July 1 to avoid penalties.** Learn more: [*www.decisionhealth.com/conferences/A2602/index.html*](http://www.decisionhealth.com/conferences/A2602/index.html).

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to track 1 to sustain the growth we have been seeing and am concerned that large numbers of current ACOs are not ready to take on the higher risks of track 2, 3 or

CMMI’s [upcoming] Next Generation ACO program,” said NAACOS CEO Clif Gaus in a statement. — *Roy Edroso* (*redroso@decisionhealth.com*)

### Resource:

` Final rule, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations: [*www.federalregister.gov/arti-*](https://www.federalregister.gov/articles/2015/06/09/2015-14005/medicare-program-medicare-shared-savings-program-accountable-care-organizations)[*cles/2015/06/09/2015-14005/medicare-program-medicare-shared-*](https://www.federalregister.gov/articles/2015/06/09/2015-14005/medicare-program-medicare-shared-savings-program-accountable-care-organizations)[*savings-program-accountable-care-organizations*](https://www.federalregister.gov/articles/2015/06/09/2015-14005/medicare-program-medicare-shared-savings-program-accountable-care-organizations)

#### *HIPAA*

**Improve usability but mind HIPAA if using personal mobile devices for work**

Let physicians and other staff use their own mobile devices for transmission of protected health informa- tion (PHI) — once you’ve optimized the technology for security and usability.

Practice communications are increasingly mobile com- munications. About 83% of health care workers reported that their physicians use mobile technology to provide patient care; 71% said their nurses did as well, according to the most recent Mobile Technology Survey from the Healthcare Information and Management Systems Society (HIMSS). But the devices have to be managed to keep from creating an undue HIPAA security risk.

*Accountable care organizations*

**Pioneer ACO test results inconclusive after two years, GAO report implies**

While inconclusive, a recent Government Accountability Office (GAO) report found some evidence that the Pioneer accountable care organization (ACO) model may not be sustainable over the long run.

Some of the 23 ACOs participating in the Pioneer program have earned significant bonus dollars. But as the report notes, other ACOs actually increased Medicare spending.

The demonstration, now in its final year of a three-year contract, is testing rewarding providers with quality-weighted bonus pay- ments when they save Medicare money and holding them liable for some of the extra cost when they don’t.

But as the GAO cited, 13 original Pioneer participants withdrew from the program.

The report — requested by the House Ways and Means Com- mittee — also cites allegations by critics of the Pioneer program that some participating ACOs were limiting beneficiary access to necessary but expensive services “or avoiding beneficiaries with greater health care needs altogether.”

Of the 23 ACOs that participated in 2013, 11 averaged about $11 million each in shared savings while six of the 23 produced about

$23 million in total shared losses. The remaining six ACOs didn’t produce shared savings or shared losses. *— Burt Schorr (**burt.**schorr@verizon.net**)*

Resources:

` GAO report Results from the First Two Years of the Pioneer Accountable Care Organization Model: [*www.gao.gov/products/*](http://www.gao.gov/products/GAO-15-401)[*GAO-15-401*](http://www.gao.gov/products/GAO-15-401)

Some practices, like corporations in other fields, give their employees work devices that remain under the control of the company so they can institute their own security modifications, including the ability to remotely wipe the unit. But because mobile devices are ubiqui- tous, some practice administrators are adopting a “bring your own device” or BYOD policy, whereby health care providers use their own phones and tablets to handle work, including patients’ PHI ([*PBN 2/9/15*](http://pbn.decisionhealth.com/Articles/Detail.aspx?id=519361)). But that’s only after letting the practice’s IT people outfit the phone with HIPAA-compliant software, such as virtual private network (VPN) capability, that allows more secure com- munication with PHI.

Experts caution that users must be on board with the security features or they simply won’t use them — and may just go rogue and start handling PHI outside your security parameters. To encourage effective use, over- come “historic barriers of poor usability, arduous secu- rity and a lack of mobile integration,” says David Parpart, executive consultant at NavisHealth in Santa Clara, Calif.

## ‘Containerize’ files

One issue that may make users balk at BYOD is the “nuclear” option — that is, the chance the phone will have to be remotely wiped if it’s lost. Even when using work-issued devices, “people use it for personal and busi- ness purposes, so if it’s lost, all their stuff gets wiped too,” says Jennifer Searfoss, CEO of SCG Health, Ashburn, Va.

**Solution: Use technology that separates work from personal files.** Brad Rostolsky of law firm Reed Smith says his firm uses the third-party app Good, “a fully

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encrypted uber-secure email app that sits within its own partition of the phone.” The business files are “container- ized” from the user’s personal files and when the com- pany is forced to wipe it, only the work part gets wiped.

Whatever software you use, remember “it also requires the individual who lost or had their device stolen to report the incident, which can be a gap in the process,” Rostolsky says. That will be easier for them to do if they don’t have to worry about losing their vacation photos as well.

## Hard for thieves but easy for users

Whether it’s a loaner or personally owned, a mobile device should be difficult for outsiders to access but simple for the user. One way to make it harder for thieves is double authentication — two ways to identify yourself to the device — rather than simple password access. But it shouldn’t be cumbersome.

**Solution: Make your two-part authentication easy.** “There are three ways to validate a user: by who you are (e.g., a fingerprint), by something you have with you (the phone’s UDID [unique device identifier]) or

by something you know (a PIN number),” says Parpart. Using two of those three features as authenticators would be simple for the user, he says.

## 5 more mobile must-dos

* **Turn mobile communication into a practice initiative and enlist key people as leaders.** Don’t just put software on phones and hand them back, says Harry Nelson, a partner with Nelson Hardiman in Los Angeles.

“Since this is an ongoing culture change, it is valuable to enlist doctors in leadership positions and doctors who are more sensitive to legal compliance to be testing and adopting solutions,” says Nelson. Managers also should find incentives to encourage adoption, measure progress and set goals for organizational compliance, he adds.

* **Enforce your policies.** Part of the “risk mitiga- tion” required by HIPAA rules involves policies and procedures that show a good-faith effort at regulating employee behavior with PHI ([*PBN 7/21/14*](http://pbn.decisionhealth.com/Articles/Detail.aspx?id=518330)). It helps to track access via IT logs for authorized use, says Matthew
1. Fisher, an associate with the Mirick O’Connell law firm in Worcester, Mass. Logs can tell what user and what kind of device has accessed your files.

“Have real policies that make sense, train on them and make clear that you’ll take immediate action on

violations — maybe a warning written in the file, maybe the loss of a vacation day — something that forces the employee to take notice,” says Rostolsky. “Termination should also be on the table depending on the facts and circumstances of the issue. The government responds to that because the provider is supposed to be proactive.”

* + **Use encryption.** Make mobile devices more secure with modifications to ensure the messages are encrypted, such as text-messaging apps with a HIPAA compliance angle ([*PBN 6/24/13*](http://pbn.decisionhealth.com/Articles/Detail.aspx?id=516018)). E-mail programs should be able to assure that the message can’t be read until it has been transmitted to your device.
	+ **Get the business associate agreement (BAA).** Companies, even some email giants, will sign the BAA required for your third-party vendors in the HIPAA mega- rule, says Searfoss. Microsoft, for example, will enter

into that contract with health care providers who use its Office 365 software, which allows mobile mail access.

* + **Educate users on security gaps.** “You could have a secure browser, the most secure software and then connect over a coffee-shop Wi-Fi that’s not secure,” says Searfoss. Train users on how to use their equipment properly. — *Roy Edroso (redroso@decisionhealth.com)*

***Part B News* briefs**

* + **Senate Finance Committee approved a bill to tackle the appeals backlog at the administrative law judge (ALJ) level.** Nearly 900,000 Medicare claims now await ALJ hearings. The legislation offered by Finance Chairman Orin Hatch, R-Utah, would increase fiscal 2016 funding for the Office of Medicare Hearings and Appeals (OMHA) by $127 million and by $2 million for the HHS Departmental Appeals Board, the last stop for administrative appeals.

As voted out on June 3, the bill also would authorize OMHA to augment its ALJs with a new category of hear- ing officer, the Medicare “magistrate.” Beginning Jan. 1, 2017, magistrates would be responsible for the smallest claims, currently those between $150 and $1,460.

In addition, the bill would direct HHS to establish a process to allow ALJs and magistrates to issue decisions.

* + **ICD-10 update: New bill seeks two-year “grace period” for providers.** The bill introduced June 4 by Rep. Gary Palmer, R-Ala., H.R. 2652 (Protecting Patients and Physicians Against Coding Act of 2015), has gained

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