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Compliance

As PHE nears end, know when audio-only care becomes ePHI — and stay compliant

HIPAA compliance for telehealth services applies to audio-only services, including telephone E/M codes (**99441-99443**). To protect your practice and patients from breaches, make sure staff understand the security requirements for phone-based care that the HHS Office for Civil Rights (OCR) outlined in a guide on audio-only services.

Doing so will help you prepare for the end of the OCR's enforcement discretion that allows covered entities, including medical practices, to provide telehealth services that don't meet all of HIPAA's stringent requirements during the COVID-19 public health emergency (PHE). The OCR recently announced that it would extend the enforcement discretion until Aug. 9 (*PBN blog 4/13/23*).

"The [OCR] released guidance to help health care providers bound by HIPAA understand how they can use remote communication technologies for audio-only telehealth," explains Laura Dillon, senior manager, Washington Council, Ernst & Young.

The guidance "addresses questions that HHS has received about whether, and in what circumstances, audio-only telehealth is permissible under the HIPAA rules," according to the OCR's release, "Guidance on how the HIPAA rules permit covered health care providers and health plans to use remote communication technologies for audio-only telehealth."

For example, the guidance states that the security rules apply to electronic protected health information (ePHI) and audio-only services provided through a traditional telephone landline aren't subject to HIPAA's security rules. However, when a practice connects with the patient through electronic

communication systems, such as a voice over internet protocol (VoIP), that constitutes the transmission of ePHI. "Covered entities using telephone systems that transmit ePHI need to apply the HIPAA security rule safeguards to those technologies," the OCR states.

"According to the OCR guidance, while a HIPAA-covered entity does not need to apply security rule safeguards to telehealth services that they provide using traditional landlines, it does apply when they are using electronic communication technologies that transmit ePHI," Dillon explains. Electronic communication systems include a communication app on a smartphone, programs that support voice calls using a broadband internet connection and other systems that transmit ePHI, Dillon says.

Is the ePHI just passing through?

There's more to figuring out your HIPAA security obligations than knowing whether the practice uses a landline or VoIP system, observes Sara Shanti, partner with Sheppard Mullin in Chicago. The security rule only applies when the practice or a third party retains the ePHI. Therefore, you must know what happens to ePHI that comes to your practice.

"This is based on whether the phone service is considered a conduit … whether the service is only transmitting the communication through the phone line, with only transient access to the flowing information," Shanti explains. "If the service involves electronically creating, using or otherwise storing patient information for or on behalf of the provider, the HIPAA security rule would apply."

If your providers perform audio-only services through a system that can capture ePHI, such as a teleconferencing platform with a recording option, make sure they don't hit the "record" button for patient calls. Doing so could create additional security obligations and risks for the practice.

Review HIPAA requirements for audio-only care

While everyone is paying attention to the end of the PHE, make sure providers understand the steps they should take to comply with HIPAA's privacy and security rules now and after Aug. 9. Some steps will be familiar because they're the same for in-person visits, Shanti notes. "For example, limit any third parties from overhearing [the call] and [ensure] the equipment and any software used is not accessible to unauthorized individuals," she advises.

That includes providing the audio-only service in a private setting and not using a speakerphone. When the provider works from home they shouldn't conduct phone calls on a shared phone line because that would allow family members or housemates to see the call history, Shanti adds.

"The OCR guidance does not make an explicit distinction between sites of care; however, OCR expects covered telehealth providers to provide services in private settings to the extent feasible and implement appropriate safeguards when that is not possible," Dillon explains. She points to additional tips from the OCR, such as conducting "a robust inventory and asset management process along with accompanying risk assessments to ensure organizational compliance with HIPAA's administrative, physical and technical safeguards."

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Practices should expect more guidance from the OCR as the new discretion enforcement end date approaches. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

RESOURCES

- HHS Office for Civil Rights announces the expiration of COVID-19 public health emergency HIPAA notifications of enforcement discretion: www.hhs.gov/about/news/2023/04/11/hhs-office-for-civil-rights-announces-expiration-covid-19-public-health-emergency-hipaa-notifications-enforcement-discretion.html
- Guidance on how the HIPAA rules permit covered health care providers and health plans to use remote communication technologies for audio-only telehealth: www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-audio-telehealth/index.html#footnote8_ygxoimz
- Notification of enforcement discretion for telehealth remote communications during the COVID–19 nationwide public health emergency: www.govinfo.gov/content/pkg/FR-2020-04-21/pdf/2020-08416.pdf

Public health emergency

For providers: An at-a-glance guide for PHE end on May 11

Help your busy providers prepare for the end of the COVID-19 public health emergency (PHE) with this summary of key waiver activities that will and will not be allowed after May 11 (*PBN 3/20/23*). For example, providers can continue to perform telephone E/M services after May 11, but they cannot perform virtual check-ins for new patients.

Remember, your practice must use HIPAA-compliant systems for its telehealth and telephone services after May 11. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

Is this allowed after May 11?	Yes	No
Audio-only telehealth services	●	
Designated telehealth services	●	
Billing for in-home COVID-19 vaccinations	●	
Direct supervision through an audio/visual connection	●	
Patients in any location can receive telehealth	●	
Provider performs telehealth at home, bills with office address	●	
Remote physiologic monitoring for new patients		●
Remote physiologic monitoring for less than 16 days		●
Telehealth through systems that aren't HIPAA-compliant	●	
Telephone E/M visits	●	
Virtual check-ins for new patients		●

Sources:

- www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf
- www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf
- oig.hhs.gov/coronavirus/covid-flex-expiration.asp
- www.cms.gov/files/document/covid-19-blanket-waivers-section-1877g.pdf

Coding

Examine documentation improvement strategies for 2023 CPT updates

Editor's note: *In this issue,* Part B News *welcomes guest author Aimee L. Wilcox, CPMA, CCS-P, CST, MA, MT, a clinical development analyst at 3M, to examine 2023-effective CPT code changes and how you can best capture documentation to keep your claims secure.*

The January 2023 update to the CPT manual introduced 225 new and 93 revised codes, while 75 codes were deleted, with almost every chapter undergoing some form of change. As expected, the spotlight fell on facility-based E/M services, with changes to codes, descriptions, guidelines, definitions and the medical decision-making (MDM) table.

This article will delve deep into some of the major changes to E/M coding and considerations for documentation integrity. It will also break down important code updates in the other chapters of the CPT manual for 2023.

Major changes to E/M services

While many changes were made to the facility-based E/M services, the following are a few noteworthy changes:

- Except for emergency department services, facility-based E/M will now be scored by either MDM or time.
- Provider time spent performing patient services both directly and indirectly may be counted toward the total time of the service.
- Inpatient and observation E/M services are now combined and reported with the same codes.

- Many prolonged service codes were deleted and replaced with add-on code **99418**. For Medicare beneficiaries, replace 99418 with one of the CMS-approved HCPCS codes: **G0316** (prolonged hospital inpatient or observation), **G0317** (prolonged nursing facility) or **G0318** (prolonged home or residence).
- Almost every E/M definition has been revised, so be sure to review the new definitions.
- The way Medicare and CPT calculate time for prolonged services varies widely and should be carefully reviewed before assigning prolonged service codes.

Remember that CMS announced an error in the 2023 Medicare physician fee schedule (MPFS) final rule (*PBN 3/20/23*). When reporting HCPCS code G0316 with inpatient and observation E/M visit claims (**99223**, **99233** and **99236**), the number of minutes to be met or exceeded to use these codes was incorrect by 15 minutes.

Minor documentation changes can be impactful

While it is often difficult to affect provider documentation and template changes, once the changes are explained, providers often become more amenable to making them.

A few simple documentation changes may be beneficial to consider:

- **Document a medically appropriate history and exam for each patient**. Documenting the patient's history can provide clarity on the status of the patient's problems being addressed and support medical necessity for ordered or planned treatments.
- **Document the status of each problem addressed during the encounter**. When providers document the status of a patient problem that is being assessed during the encounter, it provides clarity for scoring the first element of the MDM, which is the number and complexity of problems addressed during the encounter. These details will prevent coders from assigning a lower level of severity for lack of clarity.

A simple statement such as, "insulin-dependent diabetes type 2, not currently at goal" or "severe, persistent asthma with acute exacerbation indicated by …" will allow proper scoring of the first column in the MDM table for problems addressed during the encounter.

- **Identify and document the source of any data ordered or analyzed**. Scoring the second element of MDM, the amount and/or complexity of data analyzed, can be a complicated process. If providers do not clearly document where tests were performed, who provided additional patient history, the providers they spoke with, or other required details, scoring could easily be incorrect.

To prevent an issue with this, consider scoring the MDM level on the first and third elements of MDM and only rely on the second element (data analyzed) when one of the others are severely lacking or nonexistent.

- **Document the risks of the recommended treatment specific to the patient**. According to the CPT definition of risk, the third element of MDM, it is assessed based on the "consequences of the problem(s) addressed at the encounter when appropriately treated."

Many treatment options have an element of risk associated with them, such as side effects of prescription drugs or risk of injury due to surgery. Assessing patient risk from the planned treatment (or failure to treat) is a provider responsibility that ensures accurate E/M level scoring.

- **Clarify the total provider time spent on the date of the encounter**. Time spent performing services by clinical/nursing staff should not be combined with provider time. Consider a section header just for this statement and remember that scoring a service based on time no longer requires a statement that 50% or more of the time spent was on counseling or coordinating patient care. Consider instead, a statement such as, "Total provider time: I spent a total of 78 minutes providing patient care today."

Major updates to surgery and other chapters

While E/M may have stolen the annual update spotlight, several other major changes occurred that will require documentation updates to ensure accurate coding.

When performing and reporting services from the surgery chapters, carefully review the code descriptions to identify key details that should be included in the documentation to support the code being reported. Failure to document these details often leads to an increase in provider queries, reduced coding, and poor reimbursement.

Vaccine supply and administration updates

New COVID-19 vaccine supply and administration codes were added based on the manufacturer and which shots the patient received. Additionally, new vaccine codes were added for respiratory syncytial virus (RSV) and dengue, a mosquito-borne disease.

(continued on p. 6)

Benchmark of the week

Primary care won CCM, but other specialties rose up for PCM codes

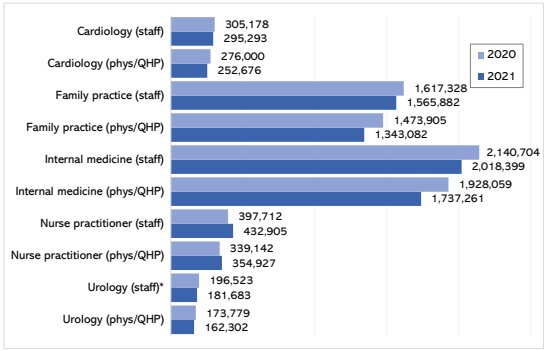
Primary care providers dominated the top five slots in total reporting of traditional chronic care management (CCM) involving at least two chronic conditions. However, a wide range of specialties rose to the top when CMS introduced two codes for the management of one complex chronic condition, also known as principal care management (PCM).

Cardiologists, interventional cardiologists, intensivists and pulmonologists were the top reporters of PCM by supervised clinical staff, according to a review of the latest available Medicare Part B data.

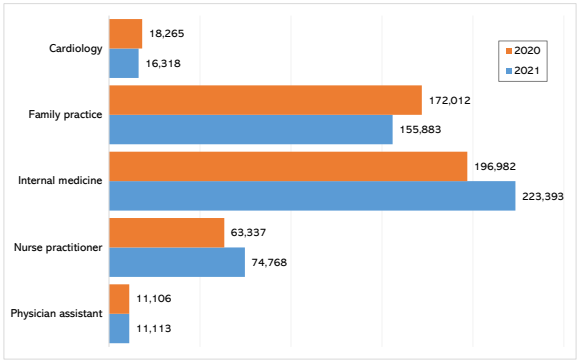
The first chart below shows the top five specialties that reported CCM performed by supervised clinical staff – tied to code **99490** and add-on codes **G2058** in 2020 and **99439** in 2021 – and CCM performed by a physician or qualified health care professional (QHP), linked to code **99491**. The second chart shows data for complex CCM performed by a physician or QHP (**99487** and add-on code **99489**). The final charts reveal the top specialist for PCM performed by a physician or QHP (**G2064**) and supervised clinical staff (**G2065**). (*See the chart on p. 6 for consumer-friendly and short descriptors for these codes.*)

Note: An asterisk (*****) beside a specialty indicates that it was in the top five in 2020 but fell out of the top rankings in 2021. – *Julia Kyles, CPC* (*jkyles@decisionhealth.com*)

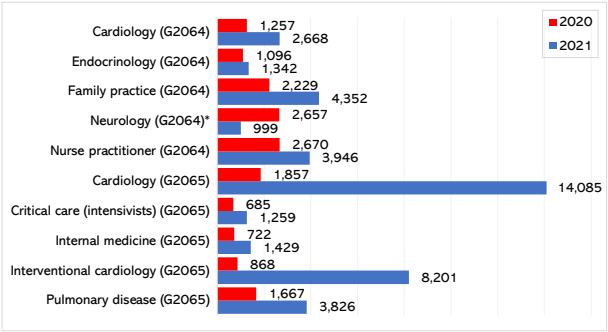
Chronic care management claims by specialty, 2020-2021



Complex CCM claims by specialty, 2020-2021



Principal care management claims by specialty, 2020-2021



Sources: Part B News *analysis of 2020-2021 Medicare claims data*

(continued from p. 4)

Documentation that includes the product name, National Drug Code, strength, dose and how it was administered (e.g., intramuscular deltoid) help to ensure proper code selection. Additional details related to the COVID-19 vaccines are available in Appendix Q.

Add-on codes included in the update

Add-on codes begin with a plus (+) symbol in the CPT manual, indicating that a primary procedure code must be reported first. Refer to the coding guidelines and Appendix D when assigning add-on codes. Here are some of the newest add-on codes for 2023:

- **15853** (Removal of sutures or staples not requiring anesthesia).
- **15854** (Removal of sutures and staples not requiring anesthesia).
- **22860** (Total disc arthroplasty [artificial disc], anterior approach, including discectomy to prepare interspace [other than for decompression]; second interspace, lumbar).
- **33904** (Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections).
- **49623** (Removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach [i.e., open, laparoscopic, robotic]).

Add-on codes 15853 and 15854 may only be reported with a primary E/M service code. Add-on code 22860 must be reported with primary service (**22857**), describing the same procedure performed at the first interspace. Add-on code 33904 is reportable only with a primary code from **33900-33903**. Add-on code **49623** is reported in conjunction with a primary code from **49591-49622**.

Cardiovascular system updates

Five new codes (33900-33904) for reporting endovascular repair of congenital heart and vascular defects require documentation of specific details such as the artery, approach, number of vessels stented, laterality and whether the connections were normal or abnormal native.

Digestive system updates

The AMA's Relative Value Scale Update Committee noted these hernia repairs are performed less than 50% of the time in the inpatient setting and required review and updates to align them with current clinical practices. These updates resulted in the deletion of 12 codes and replaced them with 15 new codes describing hernia repair surgeries, which will require documentation of the following specific details:

- Hernia type (anterior or parastomal).
- Episode (initial or recurrent).
- Size (less than 3 cm, 3-10 cm, or greater than 10 cm).
- Status (reducible, incarcerated or strangulated).

Coding

Chronic care management codes – 2020-2021

The following list provides the codes, consumer-friendly CPT descriptors and abbreviated HCPCS descriptors for the chronic care management services featured in the benchmark of the week (*see benchmark, p. 5*).

Code	CPT descriptor
99490	(Chronic care management services, first 20 minutes of clinical staff time per calendar month)
G2058	(Chronic care management services, each additional 20 minutes of clinical staff time) Effective 1/1/20-12/31/20
99439	(Chronic care management services, each additional 20 minutes of clinical staff time per calendar month) Effective 1/1/21
99491	(Chronic care management services by qualified health care professional, 30 minutes or more per calendar month)
99487	(Complex chronic care management services, first 60 minutes clinical staff time per calendar month)
99489	(Complex chronic care management services, each additional 60 minutes clinical staff time per calendar month)
G2064	(Principal care management, at least 30 minutes of physician or other qualified health care professional time, per calendar month) Effective 1/1/2020-12/31/21
G2065	(Principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month) Effective 1/1/2020-12/31/21

Source: 2021 CPT consumer-friendly descriptors

Nervous system updates

Changes to these codes (**64415**-**64417**, **64445**-**64448**) now bundle imaging guidance, which will impact the procedures commonly performed in interventional radiology and pain management.

Auditory system updates

New and revised codes describe osseointegrated implants for treating hearing loss, often associated with middle ear and mastoid disorders. Documentation should include the vital details to support whether the implant was being implanted, replaced or removed; if the implant is percutaneous or magnetic transcutaneous; and the size of the defect, if applicable.

Apply annual update strategies

While this is not an all-inclusive report on the annual updates, it does cover many of the major changes for 2023 and if shared with providers, may provide insight into documentation strategies that support medical necessity and code assignment. A few additional approaches to improved documentation specific to your organization include:

- Identifying updates that specifically impact your organization.
- Creating a document for providers and coders that outlines the changes and new documentation requirements for the updates identified above.
- Holding a meeting or training session where questions can be asked and answered regarding the updates, including changes to documentation, coding, billing and preauthorization, where applicable.
- Scheduling a review of the updated codes, documentation and coding outcomes to determine how providers and staff have implemented the changes and to determine how payers are responding to the changes.

Every year, coding teams should review updates to the CPT guidelines, definitions and code descriptions to ensure correct practices and identify any additional changes or staff education that may be needed. — *Aimee L. Wilcox, CPMA, CCS-P, CST, MA, MT* ■

Editor's note: *Aimee L. Wilcox, CPMA, CCS-P, CST, MA, MT, is a clinical development analyst at 3M. Opinions expressed do not necessarily reflect those of DecisionHealth, HCPro or any of its subsidiaries.*

Coding

When drugs are partially discarded: Clarify use of modifier JW

Modifier **JW** (Drug amount discarded/not administered to any patient) is used to describe drug amounts that are discarded and not administered to any patient. It does not reduce the payment for the drugs so it is an informational modifier; however, but you're required to use it on Medicare claims for drug wastage. Wrap in the following guidance and tips to ensure your claims are accurate.

Application of modifier JW

- The modifier shall only be used for drugs in single-dose or single-use packaging.
- Medicare will also pay for the amount of drug that has been discarded, up to the amount that is indicated on the vial or package label.
- The discarded amount is the amount of a single use that remains after administering a dose/quantity of the drug to a Medicare beneficiary and cannot be used otherwise (hence, single use).
- This applies to all separately payable Part B drugs that are designated as single use or single dose on the Food and Drug Administration (FDA)-approved label or package insert.
- Modifier JW is not to be used for drugs that are from multiple-dose vials or packages (FDA, 2018).
- The modifier is not required if no discarded drug is being billed to any payer.
- Modifier JW is not used:
  - For drugs not separately payable, such as packaged OPPS drugs or drugs administered in the federally qualified health center (FQHC) or rural health clinic (RHC) setting.
  - For drugs paid under the Part B drug Competitive Acquisition Program (CAP).
  - To report overfill wastage as overfill cannot be billed at all.
- When the actual dose of the drug administered is less than the HCPCS billing unit, the drug discarded amount should be billed on a separate line with modifier JW.
- Units of service should reflect the amount of drug discarded.

- The medical records (medical administration and dispensing) should support:
  - Single-use packaging.
  - Amount administered.
  - Amount discarded.
- Eligible and participating 340B providers are not exempt from reporting modifier JW.
- Modifier JW does not apply to drugs assigned SI N (items and services packaged into ambulatory payment classification [APC] rates).

Modifier JW coding tips

Practices may submit modifier JW to indicate drug wastage of a single-dose vial/packaged drug or biological (this is a required modifier). **Note**: CMS released modifier **JZ** (Zero drug amount discarded/not administered to any patient), effective Jan. 1, 2023, due to low usage rates of JW (*PBN 3/13/23*).

- Modifier JW would be appended to the HCPCS code if an unused portion of the drug is appropriately discarded.
- Bill on a separate line from the used portion of the drug.
- Payment will be made for the used and discarded amounts.

Consider the following billing example:

- Aria — single-dose vial, 50 mg, HCPCS **J1602** (Injection, golimumab, 1 mg, for intravenous use).
- Patient is administered 40 mg, and 10 mg is discarded.

Billing should be:

- First line item: J1602 x 40 units.
- Second line item: J1602-JW x 10 units.

Example: Provider has a single-use vial that is labeled to contain 100 units of a drug, and 75 units out of the 100-unit vial are administered to the patient:

- The 75-unit dose is billed on one line.
- 25 units out of the 100-unit vial is discarded.
- The discarded five units may be billed on another line using HCPCS modifier JW.

To submit a claim for drug waste reimbursement, providers must report two claim lines per wasted drug as outlined in the following example:

- Line 1:
  - HCPCS code for drug administered.
  - No modifier.
  - Number of units administered to the patient.
  - Calculate submitted price for only the amount of drug given.
- Line 2:
  - HCPCS code for the drug discarded.
  - HCPCS modifier JW to indicate wastage.
  - Number of units discarded.
  - Calculate submitted price for only the amount of drug discarded.
  - A provider may decline reimbursement for the discarded drug amount by only submitting a claim for only the drug amount administered to the patient.

Note: When the billing units are equal to or greater than the total actual dose and the amount discarded, HCPCS modifier JW may not be submitted. Example: One billing unit for a drug is equal to 100 mg of the drug in a single-use vial:

- A 70-mg dose is administered to a patient.
- 30 mg of the remaining drug is discarded.

The 70-mg dose is billed using one billing unit that represents 100 mg on a single line item. The single line item of one unit would be processed for payment of the total 100 mg of drug administered and discarded.

Billing another unit on a separate line item with HCPCS modifier JW for the discarded 30 mg of drug is incorrect, as it would result in an overpayment.

The following is a billing example for which it would be inappropriate to report modifier JW:

- Remicade — single-dose vial of 100 mg.
- HCPCS code **J1745** (Injection, infliximab, 10 mg).
- Patient is administered 95 mg, and 5 mg are discarded.

Billing should be:

- First line item: J1745 x 10 units.
- There is no additional line item to bill since the 10 units includes the discarded amount. — *Savannah Schmidt* (*pbnfeedback@decisionhealth.com*) ■

***Editor's note**: This article was excerpted from JustCoding Guide to Modifiers: Hospital Outpatient Edition, 3rd Edition. Learn more: https://hcmarketplace.com/justcodings-guide-to-modifiers-third-edition.*