14 ISSUE – April 2021
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The HIM Times Newsletter

MARSI MEDICAL AUDIT RESOURCE SERVICES INC.

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ALS (AMYOTROPHIC LATERAL SCLEROSIS)

(LOU GEHRIG'S DISEASE)

Author: Julie Scarborough CCS, RHIT, HCC/Auditor

HCC 73 (G12.21)

ALS, Amyotrophic Lateral Sclerosis, also known as Lou Gehrig's disease, is a progressive nervous system disease that affects nerve cells in the brain and spinal cord, causing loss of muscle control. As of right now, there is no cure for ALS. Various treatments are used to treat symptoms and help support life functions as this fatal disease slowly takes over the body.

ALS is a rare disease that is part of a larger group of motor neuron disorders. The motor neurons of both the upper (brain) and lower (nuclei of brain) degenerate or die and stop sending messages to the muscles. Once these neurons weaken and are unable to function, the muscles start to weaken which leads to muscle twitches (called fasciculations), and lastly waste away, ceasing to work at all. At this point, the brain has lost its connection to the rest of the body and death occurs.

WHO IS AFFECTED?

- Age – ALS can strike at any age but mostly affects people between the ages of 55 and 75
- Gender – the disease affects men more than women, but as we age the difference between men and women disappears
- Race and ethnicity – ALS most likely affects Caucasians and non-Hispanic

CAUSES

Aside from genetics, the cause of ALS is not well understood. Some factors that scientists think might contribute to ALS include:

- Free radical damage
- An immune response that targets motor neurons
- Imbalances in the chemical messenger glutamate
- A buildup of abnormal proteins inside nerve cells

Also, the Mayo Clinic has identified smoking, lead exposure, and military service as possible risk factors for this condition.[1]

TYPES OF ALS

- Sporadic ALS – The majority of cases (90% or more) are classified as Sporadic. This is when ALS occurs at random, with no clearly associated risk factors and with no family history of the disease.
- Familial (Genetic) ALS - Five to 10% of all ALS cases are familial, meaning the disease was inherited from his or her parents.

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ALS (AMYOTROPHIC LATERAL SCLEROSIS) CONT'D

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DIAGNOSIS

- Electromyography (EMG) – a special recording technique that detects electrical activity of muscle fibers
- Laboratory tests on blood and urine to rule out the possibility of another disease are affected
- Nerve conduction studies to test your nerve function
- An MRI that shows which parts of your nervous system are affected
- Genetic testing for people with a family history of ALS

TREATMENT

- Medication
- Physical and Speech Therapy
- Nutritional support
- Breathing support (NIV—noninvasive ventilation)

PROGNOSIS

Although there is no cure for ALS and death usually occurs 3-5 years from onset of symptoms, some people with ALS can survive 10 years or more.

FOR HCC

This is a chronic condition and should be documented and coded at least once a year. If you see this condition in a Past Medical History or on a Problem List but not addressed in any chart notes, the best practice would be to query the provider and ask if the patient has this condition. If the provider agrees that the patient has this condition, then they would need to document and code it in a face-to-face visit.

SOURCES

1. https://www.healthline.com/health/amyotrophic-lateral-sclerosis#causes
2. https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Amyotrophic-Lateral-Sclerosis-ALS-Fact-Sheet

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CLARIFICATIONS ON E/M GUIDELINES

Author: Marsha S. Diamond, CPC, COC, CCS, CPMA, AAPC Fellow

The new Evaluation and Management guidelines for Office/ Outpatient services were effective January 1, 2021. Hopefully, your practice/facility has been successful in implementing these rules per CPT guidelines.

CPT and the AMA have offered some additional clarifications, posted March 9, 2021 on their website on some of the areas to help simplify some areas of ambiguity or where further explanation has frequently been requested. Changes, additions or additional interpretations have been marked in bold.

Time

When utilizing time as the determining factor for selecting E/M level, the services may include the following:

- Preparing to see the patient (e.g. review of test) **when performed on the day of the encounter**
- Obtaining and/or reviewing separately obtained history **when performed on the day of the encounter**
- Performing a medically appropriate examination and /or evaluation
- Counseling and education the patient, family and/or caregiver
- Ordering medications, tests or procedures **(includes analysis)**
- Referring and communicating with other health care professionals **(when not separately reported)**
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient, family, caregiver
- Care coordination (not separately reported)

The following do NOT count as time

- **The performance of any services that are reported separately**
- **Resident time cannot be utilized**
- **Teaching that is general and not limited to discussion required for management of the specific patient**

Additional clarification of the recording of time has also been provided as follows:

According to the AMA, total time should be listed as well as a description of the activities that were performed.

An example would be as follows:

A total of 35 minutes was spent caring for this patient on this date, including reviewing labs, examination of the patient, documenting in the electronic medical record and arranging for additional studies to be performed.

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CLARIFICATIONS ON E/M GUIDELINES CONT'D

Author: Marsha S. Diamond, CPC, COC, CCS, CPMA, AAPC Fellow

Medical Decision Making

Additional clarification for tests ordered and interpreted under the "data" element:

- The ordering and actual performance and/or interpretation of diagnostic tests during patient encounters is not included in the determination of E/M levels since it is separately reportable.
- **Tests that do not require separate interpretation, such as tests that are results only, do not count as an independent interpretation, however, may be counted as ordered or reviewed tests.**
- **Tests ordered are presumed to be analyzed when the results are reported.** Therefore, when they are ordered during an encounter, they are counted in that encounter. Therefore, you cannot count the date of the encounter they were ordered and also count in another encounter when the same test results are reviewed.

  Per CPT Assistant, November 5, "It is assumed that the physician or other QHP would review the results of the test ordered; therefore, the physician or other QHP would not receive dual credit toward MDM for service-level selection for both ordering and reviewing the test."
- **Tests ordered by any member of the physician group, however, reviewed by another member of group are considered to be a single physician.** Credit cannot be given for independent interpretation or interpretation of lab results in these instances.
- **Pulse oximetry is not considered a test.**
- Discussion of results or with another provider requires an interactive exchange that **must be direct** and not through any intermediaries.
- Credit for independent historian may be counted even if not performed in person, but, **must be obtained directly** from the person or historian providing the information.
- Parents and other individuals count as an independent historian **only when the patient is unable to provide a complete and reliable history** for reasons such as developmental stage, dementia, psychosis or when confirmatory history is determined to be necessary.
- The term "pose a threat to life or bodily function" applies to conditions that **"pose a threat to life or bodily function in the near term without treatment."**

As of this date, CPT/AMA is expected to move forward with further implementation of similar guidelines for other Evaluation and Management services for calendar year 2022. as originally planned.

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HIPAA COMPLIANCE IN THE MIDST OF COVID-19

Author: Tammy Adkins , RHIA, CHP

On March 13, 2020, President Donald J. Trump declared the COVID-19 outbreak in the United States a national emergency, beginning March 1, 2020. This declaration gave authority to the Secretary of the Department of Health and Human Services (HHS) to temporarily waive or modify certain requirements of the Medicare, Medicaid, and State Children's Health Insurance programs and of the HIPAA Privacy Rule throughout the duration of the public health emergency declared in response to the COVID-19 outbreak.[1]

In February of 2020, the Office of Civil Rights (OCR) at HHS posted a bulletin, "HIPAA Privacy and Novel Coronavirus". This bulletin was provided to ensure that HIPAA covered entities and their business associates are aware of the ways that patient information may be shared under the HIPAA Privacy Rule in an outbreak of infectious disease or other emergency situation, and to serve as a reminder that the protections of the Privacy Rule are not set aside during an emergency as it applies to their workforce, safeguarding electronic patient information by applying the administrative, physical, and technical safeguards, and other disclosures such as for treatment, to prevent a serious and imminent threat and to the media or others not involved in the care of the patient..[2]

Then, former Secretary of Health and Human Services (HHS), Alex M. Azar, had exercised the authority to a limited waiver of HIPAA sanctions and penalties against covered entities and business associates and only to specific provisions of the HIPAA Rule issued on March 15, 2020.[3] The affected provisions entailed patient rights to obtain authorization to convey information to family or friends involved in the care, opt-out of facility directory, distribution of notice of privacy practices (NOPP), privacy restrictions, and confidential communications.

Since that time, the Office of Civil Rights (OCR) has posted additional news releases, notices of enforcement discretion, guidance, bulletins, and resources concerning HIPAA during the COVID-19 pandemic. This information can be found on the HHS HIPAA newsroom website for professionals, special topics page titled "HIPAA and COVID-19".[4]

Documents and material posted include:

- Waiver of penalties for good faith provision of telehealth to serve patients through popular non-public facing applications with a frequently asked questions (FAQs) format guidance.
- Waiver of penalties for violations of the HIPAA Rules associated with good faith participation in the operation of community-based testing sites. This was issued to promote mobile testing sites.

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HIPAA COMPLIANCE IN THE MIDST OF COVID-19 CONT'D

Author: Tammy Adkins , RHIA, CHP

- "How-to" examples of disclosing minimum necessary protected health information on a need-to-know basis of individuals exposed to COVID-19 to first responders, law enforcement, paramedics, and public health authorities.
- A bulletin to ensure covered entities do not unlawfully discriminate against people with disabilities when making decisions about their treatment during the COVID-19 health care emergency.
- Notification to allow uses and disclosures of protected health information by business associates for public health and health oversight activities.
- Guidance to remind covered health care providers to obtain a valid HIPAA authorization from each patient before giving access to the media; noting covering or distorting faces is not acceptable during filming.
- Health care providers and health plans guidance in contacting COVID-19 patients about blood and plasma donation.
- Guidance on HIPAA, health information exchanges, and disclosures of PHI for public health purposes.
- Waiver of penalty for use of online or web-based scheduling applications to schedule COVID-19 vaccination appointments.

On April 24, 2020, the OCR posted a webinar to the HHS HIPAA website: "OCR Update on HIPAA and COVID-19"[5] presented by Marissa Gordon-Nguyen, Senior Advisor, Health Information Privacy policy, Office for Civil Rights and Timothy Noonan, Deputy Director, Health Information Privacy, Office for Civil Rights. A slide presentation is included and available in PDF format.[6]

Organizations should review the material in their entirety, recognize the time restraints and other limitations, maintain detailed documentation of your organization's decisive actions to incorporate an allowed waiver, apply as necessary to policy and procedures, and train the workforce where appropriate.

As we educate our workforce on COVID-19, please remember to incorporate this information into your HIPAA training . Train staff to not succumb to social media or cybercriminals and utilize reliable sources of information.

Sources:

1 https://trumpwhitehouse.archives.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/

2 https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf

3 https://www.hhs.gov/sites/default/files/hipaa-and-covid-19-limited-hipaa-waiver-bulletin-508.pdf

4 https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html

5 https://youtu.be/2C6iOdS_FR0

6 https://go.usa.gov/xvExS

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A NOTE FROM DR. HUSTY

"Value-based reimbursement is going to save the practice of Medicine."

I have made that wild statement to hundreds of Physicians. I warn them that I may sound like a heretic, but I then promise them I will prove that that is true.

We all know the problems of modern-day medicine in the United States. If we think about it, we can boil it down to some root causes...yes, malpractice concerns guide physicians to order some unnecessary tests in order to cover their assets...and there are other influences, but none as big as the driving force of reimbursement. Yes, reimbursement has a major impact on the practice of Medicine.

When Medicare started, Physicians were allowed to set their own fees and balance bill. That caused some skyrocketing of medical costs so Medicare reigned it in by setting usual and customary Fee-for-Service medicine. Fee-for-Service medicine means that, in order to make more money, you have to see more patients. Plain and simple. And hidden in that very simple relationship is a decrease in time spent with patients, lower quality care, physician dissatisfaction and burnout, and a lack of attention to detail that does costs more in unnecessary procedures, testing, consults, and admissions. They say that money is the root of all evil. I don't know if that is true but it certainly is a major cause of the problems of modern American Healthcare.

As a very wise physician that I know, Jeff Lowenkron, states;

"If you pay for volume what do you get? More volume. If you pay for Quality what do you get? More quality."

Value-based reimbursement means paying for the quality treatment of diseases. It is **not** paying for every office visit where the more patients a physician can fit into the daily schedule, the more money they generate. Who came up with that?

And interestingly, it places primary care physicians back in the captain's chair, for better or worse. Somebody has to be the captain of the ship and most primary care physicians welcome that recognition and responsibility. Unfortunately, it also means that they have that responsibility and that includes documenting everything that their patients have and being clear about how they're being monitored, managed, evaluated, assessed, and/or treated. It seems that being Captain is a double edged sword.

For those who have accomplished the transformation such as the Villages Health Care in West Central Florida, they have seen amazing results. They partnered with MARSI to do a complete transformation process. That meant training Coder/Auditors, training physicians and retraining physicians through a process of chart audits and continuous queries. It was, at first, painful. But what has come from that is physicians spending a half an hour to an hour on each patient, increased satisfaction of the physicians and of the staff, and most importantly of the patients. The secret sauce for Quality Healthcare is "every patient gets enough time". They have seen the medical costs go down and the revenue increase. They have also become extremely compliant in their documentation and coding. They are experiencing quality growth on an individual patient level but also on a organizational level.

We have seen identical results in other organizations who have embraced the transformation to value-based reimbursement. When physicians are incentivized to find all of their patients' diseases, take really good care of them and keep them out of the hospital, we return medicine to our roots...it saves the practice of Medicine.