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ICD-10

Hospital proposed rule: New ICD-10 implementation date is Oct. 1, 2015

Providers can mark Oct. 1, 2015, on their calendars as the date they'll switch to ICD-10, according to a hospital inpatient proposed rule posted April 30.

After Oct. 1, 2015, "we will collect nonelectronic health record-based quality measure data coded only in ICD-10-CM/PCS," the Hospital Inpatient Prospective Payment Systems rule states.

"This allows them to essentially put in a new date, sort of ride the coattails of an existing regulation," says Robert Tennant, senior policy adviser for the Medical Group Management Association (MGMA) in Washington, D.C.

Tennant notes that the references in the rule to ICD-10 and 2015 — such as one on page 1,065 — are more direct than CMS' usual language. "Will officially' is not 'we propose,'" he says. "That's not common in regulatory language. So I don't know whether that means it's not up for public comment."

The "doc fix" bill had delayed ICD-10 implementation at least a year (*PBN 4/7/14*).

Also the proposed rule made no revisions to the ICD-9-CM diagnosis or procedure codes.

Read the rule at http://ofr.gov/OFRUpload/OFRData/2014-10067_PI.pdf. — Josh Poltilove (jpoltilove@decisionhealth.com) and Roy Edroso (redroso@decisionhealth.com)

Meaningful use

Do meaningful use hardship exception forms right or lose 1% of payments

Increase your chance of earning a meaningful use exception by submitting proper documentation, picking the right categories and providing a smart "narrative" with the CMS application form due July 1.

CMS recently unveiled its 2015 Hardship Exception Application for Eligible Professionals (EPs) who are new or returning to the electronic health records (EHR) incentive

(see *meaningful use*, p. 7)

HIPAA

After Heartbleed, step up security to stay in HIPAA compliance

You may not need to follow breach-notification rules in the wake of the Heartbleed Internet security crisis, but you do need to take steps to inform patients and ensure their data are safe.

Everyone who uses the Internet was alarmed by the recent revelation that OpenSSL, the widely used code library behind a huge percentage of Web security — including the “https” protocol of commercial sites — has had an undetected bug in it for two years.

Dubbed Heartbleed, the bug theoretically makes it possible for a hacker to make Web servers give up valuable information such as passwords and credit card numbers. Perhaps the most frightening thing about the bug is that, while it affects millions of Web servers, it's not known how much sensitive information was removed with it because a Heartbleed-based attack leaves no evidence in server logs.

“So far, I've only heard of two data hacks attributed to Heartbleed,” says David Harlow, principal of The Harlow Group LLC health care law consultancy and proprietor of the HealthBlawg blog.

How HIPAA and Heartbleed intersect

For health care providers, the fear is compounded by the need to observe HIPAA regulations regarding

breaches of patients' protected health information (PHI). The massive spread of the Heartbleed bug raises a question: Should all covered entities just assume they've suffered a reportable breach?

The consensus among experts *Part B News* spoke to is that, absent direct evidence of misused PHI, the threat is too vague to constitute a reportable breach.

“If you look at the questions on the HHS Breach Notification form, a number of specific details need to be included,” says Jay Hodes, president, Colington Security Consulting, Washington, D.C. “In my opinion, providers may have a difficult task in being able to provide specific details. ... For one thing, I'm not sure a provider would be able to make an accurate determination as to how many records could have been compromised.”

Under the four-part assessment HHS' Office for Civil Rights (OCR) advises providers to take to determine the risk level of a breach, most providers' Heartbleed exposure would be judged low-risk, Harlow adds.

The way Heartbleed works, an intruder would have to “pick your service or application as a needle in the haystack then actively listen for data that might be of interest to them and then exploit that data,” says Dr. Michael G. Mathews, president, COO and co-founder of CynergisTek, Inc.

3 things to do now

Notwithstanding the slim chance of trouble, you can't just ignore Heartbleed. For one thing, you've heard of it —

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even if only by reading this — and that means you have to respond if you want to protect yourself in the event of a future exploit.

“Providers should also make sure to document their processes and responses as necessary in case something does go wrong so that they can demonstrate they were taking commercially reasonable efforts to protect PHI,” says Tatiana Melnik, health care and technology attorney at Melnik Legal in Tampa, Fla.

Experts recommend responding in these three ways:

- **Notify patients about Heartbleed.** Notify patients “whose data you store or process, much as non-health care organizations did in the wake of Heartbleed,” recommends Travis Good, M.D., co-founder and CEO of Catalyze Inc. in Madison, Wis. This isn’t a breach notification — just a heads-up about Heartbleed to assure your patients that you’re aware of the problem. Inform patients “of the potential risk of a breach or that the risk had been mitigated and the vulnerability patched,” says Good.

- **Check for problems and fix them.** Several sources offer specific Heartbleed advice, including Codenomicon’s heartbleed.com site. The first step is to check for vulnerabilities. Mathews notes that several free tests online will do that check; some, such as security experts McAfee’s, may be more reliable than others.

If the tests show your system is vulnerable, it should be patched or taken out of production until a patch is supplied by the vendor, says Good. Mathews advises looking at new tech to shield your applications from direct access by the public — for example, “thin-client” solutions that allow secure remote connections. You also could install an application layer (proxy) firewall and unified threat management (UTM) solutions for “a safe handoff of traffic between the public network and the local area network for the SSL protocol,” he adds.

Sound a little technical for you? Then:

- **Give more responsibility to your IT vendor.** This crisis provides “encouragement for practices to move away from the break-fix relationship with their IT vendor into a managed service relationship,” says Jeff Mongelli, CEO of Acentec in Irvine, Calif.

Given this increasing pressure, smaller offices that have been trying to handle their own IT security or who use IT professionals occasionally may want to reconsider those plans. — Roy Edroso (redroso@decisionhealth.com)

Billing

Make sure your documentation supports medical necessity of allergy skin tests

It’s the time of year for patients to present at your practice for issues related to seasonal allergies. Make sure your providers document carefully because billing allergy skin tests carries a significant risk of denials for the tests and accompanying E/M services.

Allergy skin tests are billed with codes in the **95004-95071** range, based on the nature of the allergy test and the reason. For example, the most highly billed code, 95004, is a percutaneous test with an allergenic extract that was denied 11.3% of the time in 2012, the most recent year available. The intracutaneous tests billed with **95024** and **95027** also had high utilization (*see benchmark, p. 7*).

Here are three things to look out for when your practice bills allergy skin tests to avoid denials:

- **Same day E/M service:** Most payers, including Medicare, are cracking down on billing for a separate E/M service on the same day as allergy testing, says Janae Ballard, senior consultant for Allegra Health based in Tacoma, Wash.

A few years ago, the allergy testing codes were revised to include interpretation and report along with the test, so a separate E/M service is not routinely appropriate, says Teresa Thompson, consultant for TM Consulting based in Sequim, Wash., and an expert in allergy coding. To support the separate E/M billed with modifier **25**, the documentation needs to show that the patient was treated for at least one separate condition, she points out.

The condition may be a precursor to doing allergy testing, such as a sore throat or runny nose; but the documentation must clearly reflect the decision to do allergy tests arose from that encounter rather than being known when the patient arrived.

Example: A chief complaint of allergy testing in an E/M service will draw scrutiny because it appears the patient presented just for the testing with no reason for the E/M service, Thompson says. When allergy testing is ordered in the assessment and plan of a separate E/M service, both are easier to support, she adds.

Even so, expect payers to push back and be prepared to appeal, Ballard says. You also can separately support an E/M service for medical decision-making based on the test results. If the patient has a confirmed allergy,

evidenced by the treatment and report, a decision to prescribe medication would be separately supported, Ballard believes.

Your best approach would be to have separate documentation for the allergy tests that shows which allergies were tested for and why, Thompson believes.

One thing that can trip up your practice is when consult services are billed along with allergy skin tests on the same encounter, Thompson says. These denials are caused by CCI edits that involve the consultation codes. While they are irrelevant for Medicare patients because consults are not covered, private payers who pay for consults but follow the edits often haven't made the distinction, she notes.

- **Medical necessity of the allergy tests:** Payers also are concerned that patients are being over-tested for allergies, says Denise Walsh, a senior consultant with SCG Health in Vienna, Va. While the patient would probably prefer to get all of the allergy testing out of the way in one visit, medical necessity requires a justification for each test done, she adds.

The provider must document the medical necessity for testing certain allergies based on interviewing the patient and determining the timing and nature of the allergic reaction, Thompson points out. For example, at this time of year, it is more likely for environmental allergies to be a factor for a patient with a new allergic reaction, and they would be part of the decision-making process for which allergens to use to test the patient, she adds.

Payers are looking to providers to start small when it comes to allergy tests, based on the patient's symptoms up to the point of the visit, Walsh believes. When allergy causes are eliminated but the patient continues to have allergy symptoms, additional tests may be done.

- **Frequency limits:** Limits for how often an allergy test can be done are another tool in the payer's arsenal to prevent overutilization of allergy testing codes, Thompson says. This is also a big cause of denials for providers because a patient can be tested for potentially dozens of allergies.

Most local coverage determinations (LCDs) for 95004, for example, suggest it is not clinically appropriate for a patient to get more than 20 tests done in a calendar year. CPT codes 95024 and 95027 can be billed up to 40 times each per year, per patient, before triggering a frequency edit, according to a *Part B News* review of a sampling of LCDs.

Watch coding changes

The rules for allergy tests changed slightly before 2013 when newly created CPT codes **95017** and **95018** replaced **95010** and **95015**.

The impetus behind the change was to base the codes on the nature of the allergy, rather than the type of testing done, Thompson says. Now, 95017 is used for any combination of percutaneous or intracutaneous testing when venoms are involved, while 95018 is for any type of testing when drugs or biologics are involved.

Previously, the codes were based on whether the testing was percutaneous or intracutaneous, regardless of whether it used venoms or drugs or biologics, she adds.
— Scott Kraft (pbnfeedback@decisionhealth.com)

Front desk matters

Strategies to treat patients under old, new Medicaid without breaking the bank

Take steps to determine which Medicaid plan your patients have before treating them to avoid providing care that isn't covered and eating the bill.

About 3 million newly enrolled Medicaid patients are spread among the 25 states that expanded their Medicaid program. Those patients will receive the 10 mandatory "essential health benefits" — such as mental health care and free preventive services that private exchange plans must offer.

Those who had Medicaid prior to the implementation of the Affordable Care Act (ACA) are not eligible for the same benefits, though the old Medicaid plans may offer more "robust" benefits than the new ones, a CMS official points out. Because of that, you need to know which Medicaid plan your patients have before treating them.

Your state's Medicaid office may administer the coverage, but more likely, a managed care organization (MCO) will provide the Medicaid benefits, says David Zetter, lead consultant at Zetter HealthCare Management Consultants in Mechanicsburg, Pa. For example, Maryland has seven MCOs administering its Medicaid benefits. You need to figure out who covers each patient — Medicaid or an MCO — and call them to see what's covered. If the Medicaid patient is covered by an MCO, his Medicaid card will have the MCO's name on the front; the back will have a number for your staff to call. (*For a list of states that expanded Medicaid and their contact information, see sidebar, p. 7*)

Benchmark of the week

Denial rates for less frequently used allergy tests soar from 2011 to 2012

Practices billed **95071** (Inhalation bronchial challenge testing [not including necessary pulmonary function tests]; with antigens or gases, specify) just 16 times in 2012 but 11 of those claims were denied for a 68.8% denial rate.

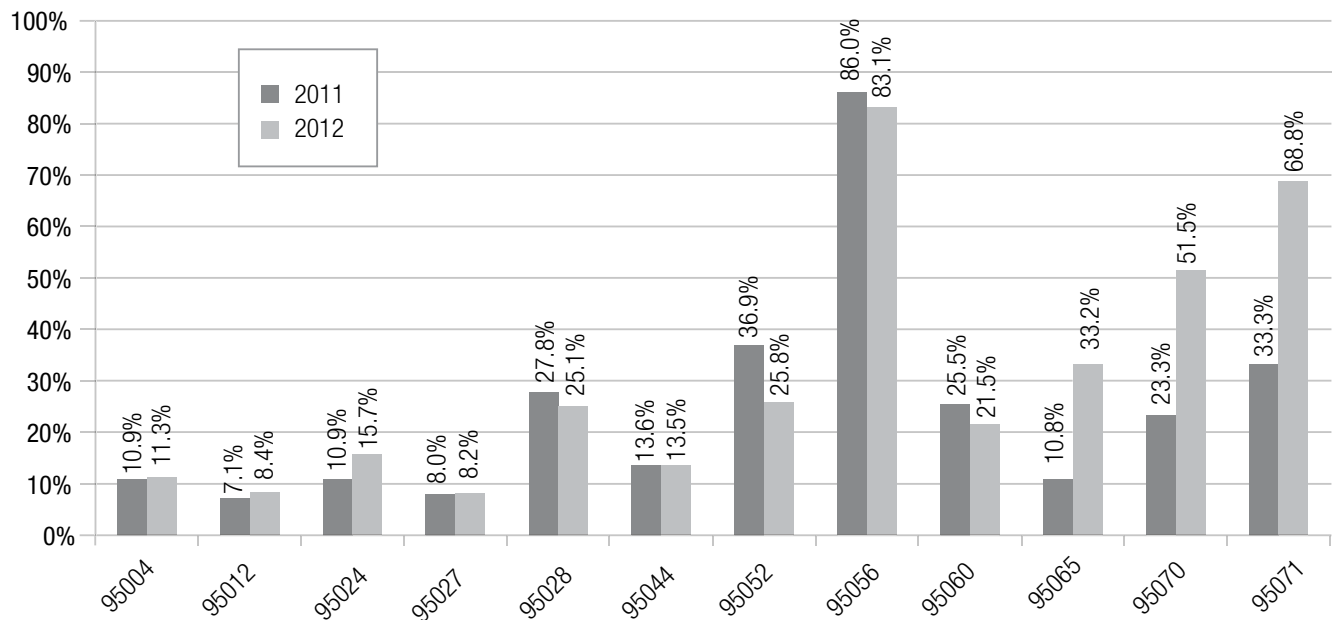
That's up from 2011 when the code was billed just 18 times but six claims were denied for a 33.3% denial rate, according to a *Part B News* analysis of the most recent Medicare data available.

Practices billed **95070** (Inhalation bronchial challenge testing [not including necessary pulmonary function tests]; with histamine, methacholine, or similar compounds) more often — 7,349 times in 2012, up from 5,454 in 2011 — but denial rates for that code jumped as well from 23.3% to 51.5%.

But even more commonly billed codes had higher denial rates in 2012 than in 2011, the data show. For **95004** (Percutaneous tests [scratch, puncture, prick] with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests), which was billed more than 8.8 million times in 2012, the denial rate inched up to 11.3% from 10.9% in 2011. And **95024** (Intracutaneous [intradermal] tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests), which was billed 2.3 million times in 2012 was denied 15.7% of the time in 2012 compared with 10.9% in 2011.

(For more on proper billing of allergy tests, see story, p. 2)

Denial rates for 95004-95071 from 2011 to 2012



Source: Part B News analysis of Medicare data

“A practice needs to do their normal due diligence on any patient that walks through the door, whether it’s a pre- or post-Medicaid patient or whether it’s a commercial insurance plan off the insurance exchange,” says Zetter. “Understanding which services are supposed to be provided to the patient and which aren’t is incumbent on the practice to figure out.” If you don’t, your practice will bill the patient directly and, if they don’t pay, deal with collections.

Even though benefits are different for patients with old or new Medicaid plans, the fee schedule is the same for both, including the reimbursement increase for certain primary care services (*PBN 5/21/12*).

“Aside from this primary care service benefit, there are no other [Medicaid] fee schedule adjustments,” says Jennifer Searfoss, CEO of Searfoss Consulting Group, Annapolis, Md. “I think there is this huge misnomer. My doctors [clients] keep calling me asking me, ‘where are

my new Obamacare contracts?’ There is no Obamacare contract. There is nothing happening to you except you are getting more patients. That’s it!”

So if you live in a state that expanded Medicaid, you need to decide how to deal with the new patients when they request appointments knowing that Medicaid typically pays rates lower than Medicare.

“In a large institution, we can do it because we take a loss in some clinics and make it up in others,” says Dr. Robert Pallay, a family medicine physician and director of the family medicine residency program at Mercer Medical School in Savannah, Ga. “If I’m in private practice, ... I can’t treat a lot of people with Medicaid because of the low reimbursement.”

How to take Medicaid, stay solvent

If you are in a small or medium-sized private practice, it’s probably not in your financial interest to take new Medicaid patients. But if, for ethical reasons, you want to see these patients, consider these options:

- **Stop accepting new Medicaid patients if you currently take them.** “Under ACA, you can absolutely close your panel to any plan,” says Searfoss. This is a strategy for practices that want to treat their current Medicaid patients but can’t afford take any more. You’ll need to know how often your current Medicaid patients come in and for what problems, which will help you budget for the revenue loss.

- **Limit the number of Medicaid patients you will accept.** “You [can] go to an HMO, which covers

Medicaid patients, and say, ‘I want to limit my panel to 75 patients.’ They’ll allow you to do that,” says Zetter. You would use this strategy if you need more patients but don’t want them all to have Medicaid.

- **Block off a time period to see Medicaid patients.** For example, see them between 9 and 11 a.m. every day but at no other time. You take this approach to limit revenue losses and have adequate staff and resources to treat these patients. You can discriminate by insurance, but you cannot discriminate by race, gender, age or another protected class, says Searfoss.

When to stop taking Medicaid patients

You can stop participating in Medicaid and discharge all your Medicaid patients. Along with low reimbursements, many providers won’t take Medicaid because of “problems with higher utilization, patients that don’t show up, patients that are late and the fact that most state Medicaid programs tell patients they don’t have to pay the copays and deductibles,” says Zetter. In those cases, practices are left holding the bill and don’t get paid. In addition, they lose an appointment slot that another patient could have filled.

If you decide to discharge your Medicaid patients, most states require you give patients at least 30 days advance notice, Zetter says. During that 30-day period, you must continue to provide care. — Ben Hartman (bhartman@decisionhealth.com)

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PAS 2014

*Front desk matters***Save time verifying enrollment of Medicaid patients with websites, phone numbers**

Below is a list of the states that expanded their Medicaid programs. You'll need to know what type of Medicaid your patient has for appropriate payments (*see story, p. 3*). The websites and phone numbers take you straight to the relevant sources.

- ▶ Arizona: <https://azweb.statemedicaid.us/Home.asp>, (602) 417-4451
- ▶ Arkansas: <https://www.medicaid.state.ar.us/InternetSolution/default.aspx>, (800) 457-4454
- ▶ California: http://files.medi-cal.ca.gov/pubsdoco/county_contacts.pdf, (916) 636-1200
- ▶ Colorado: <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542696399>, 1-800-237 0757
- ▶ Connecticut: http://www.huskyhealthct.org/providers/providers_login.html, 1-800-842-8440
- ▶ Delaware: <https://www.dmap.state.de.us/secure/providerInquiry.do>, 1-800-999-3371
- ▶ District of Columbia: <http://doh.dc.gov>, (202) 442-5955
- ▶ Hawaii: <http://www.med-quest.us/contactus.html>
- ▶ Illinois: <http://www2.illinois.gov/hfs/MedicalProvider/rev/Pages/default.aspx>, hfs.webmaster@illinois.gov
- ▶ Iowa: <http://www.ime.state.ia.us/Providers>, 1-800-338-7909
- ▶ Kentucky: <http://www.chfs.ky.gov/dms/provider.htm>, 1-800-807-1232
- ▶ Maryland: <https://encrypt.emdhealthchoice.org/emedicaid>, 1-866-710-1447
- ▶ Massachusetts: <http://www.mass.gov/eohhs/provider/insurance/masshealth/claims/eligibility-verification/access/Status>, 1-800-841-2900
- ▶ Michigan: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-145006--,00.html#Accessing_the_CHAMPS_system, 1-800-292-2550
- ▶ Minnesota: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008922#P131_12644, 1-800-366-5411
- ▶ Nevada: <https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx>, (877) 638-3472
- ▶ New Hampshire: <https://nhmmis.nh.gov/portals/wps/portal/ProviderLogin>, (866) 291-1674
- ▶ New Jersey: <http://www.state.nj.us/humanservices/dmahs/info/resources/care>, 1-800-776-6334
- ▶ New Mexico: <https://nmmedicaid.acs-inc.com/static/providerlogin.htm>, (505)-246-2056
- ▶ New York: http://www.health.ny.gov/health_care/medicaid/program/contact.htm, 1-800-343-9000
- ▶ North Dakota: <http://www.nd.gov/dhs/services/medicalserv/medicaid/provider.html>, (701)-328-2321
- ▶ Ohio: <http://medicaid.ohio.gov/PROVIDERS/andSupport/ProviderAssistance.aspx>, 1-800-686-1516
- ▶ Oregon: http://www.oregon.gov/oha/healthplan/Pages/tools_prov/electron.aspx, 1-800-422-5047
- ▶ Rhode Island: <https://www.eohhs.ri.gov/secure/logon.do>, (401) 462-5274
- ▶ Vermont: <https://www.vtmedicaid.com/secure/logon.do>, 1-800-925-1706
- ▶ Washington: <http://www.hca.wa.gov/medicaid/provider/pages/factsheets.aspx>, 1-800-562-3022
- ▶ West Virginia: <http://www.dhhr.wv.gov/bms/mwportal/Pages/default.aspx>, 888-483-0793

meaningful use

(continued from p. 1)

program and believe they will not be able to attest to their relevant stages of meaningful use by Oct. 1.

If your exception application is rejected and you can't attest, your providers stand to be docked a 1% adjustment on their Medicare payments in 2015. Even getting a hardship exception could have a financial downside: "It will also eliminate the incentive payment you might have received" for the reporting period, says Kathy McCoy, director of content marketing for EHR firm HealthFusion.

The hardship exception decision cannot be appealed, so it's especially important to get it right the first time, points out Clinton Mikel, partner with The Health Law Partners firm in Southfield, Mich., and chair of the American Bar Association's eHealth, Privacy and Security Interest Group.

Don't wait; document

CMS says you can attach files to your application and provides clear instructions for their formatting in the instructions section of the form. If you have documentation that supports your case, send it with your application rather than wait to be asked, Mikel suggests.

“It’s worth putting the time in,” he says. “There are big dollars involved here.” He suggests providing as much documentation to support your case as you can find. “The point is to make it seem unreasonable for them to deny you,” he says.

Here are three tips for your documentation:

- **Give the files “highly descriptive names”** so CMS reviewers understand quickly what they are, says Mikel. For example, label a file “FloodedServerRoom.jpg” rather than “1.jpg.”

- **Write a clear and succinct narrative** that explains why you think you should get an exception. “They don’t want to see 10 pages of rambling,” Mikel says. Add references in the text to the documentation — for example, when you come to mention a flooded server room, add a notation like “[see attachment, FloodedServerRoom.jpg].”

- **Put claims into multiple categories** in your application. Mikel says he favors a “shotgun approach” — if you can justify putting your Internet issue into two categories, such as lack of infrastructure and unforeseen circumstances, do it.

How to handle hard cases

The application form is at CMS’ website. Responses are divided into categories of hardship. The form and can be filled out online and must sent by email to ehrhardship@provider-resources.com or faxed to 814-464-0147 by July 1.

While many hardship claims are straightforward, experts see some categories in which your claim may require some extra explanation:

- **Internet issues.** In the lack of infrastructure category, the form asks for your “minimum bandwidth available at the practice location.” The problem is that your minimum may be difficult to determine. You may be getting speeds well below what your contract promises or service may be patchy, making it difficult to receive send and receive large files or offer patients consistent portal access.

Mikel recommends that you use online speed tests such as www.speakeasy.net, screen-capture the results and submit those as evidence. If reliability is the problem, attach your email exchanges with the Internet service provider to the submission. “You can even file Better Business Bureau complaints,” says Mikel.

- **Disasters.** The exception application form has a subsection for you to list disasters. “This is not keyed

to FEMA certification of a disaster zone,” says Mikel, so you can qualify for the exception if the downstream effects of the disaster have impacted your infrastructure. Documentation could include clips from your local newspaper that note the impact, insurance claims and damage photos taken with your smartphone. Be sure not to include images of patients or patient information in your photos or risk a HIPAA violation, Mikel warns.

- **Vendor issues.** CMS recently added vendors’ failure to certify their EHRs for 2014 as grounds for a hardship exception (*PBN 3/17/14*). The agency anticipates some gray areas in the application by adding variations such as “2014 product is installed but not yet fully implemented” among your choices.

That may be relevant because providers may have issues owing to a dispute with their vendor — the equipment may be certified, but the vendor may be uncooperative about doing a build-out, especially if a contract dispute is involved.

McCoy recommends you back up your case with “any communication from the vendor around their inability to support meaningful use attestation: emails, notices on the vendor website, posts by other practices on forums, etc.”

But be careful, says Mikel: “Some vendors have draconian confidentiality clauses” that may prevent you from citing contract terms in communications to other parties, he says. Just to be safe, describe the issue to CMS and add that your confidentiality agreement prevents you from quoting the contract.

Also remember CMS has said several times that not being able to pay for meaningful-use services is not grounds for exception, and if your argument is based on higher-than-anticipated costs, Christopher A. Parrella of the Health Law Offices of Anthony C. Vitale in Miami, thinks CMS “could possibly just tell the EP ‘buyer beware.’” He also thinks contract issues might be appropriate for the “unforeseen circumstances” category because you could argue that “explosive back-end costs ... were not disclosed when you purchased the platform.” — *Roy Edroso* (redroso@decisionhealth.com)

Resource:

- 2015 Hardship Exception Application for Eligible Professionals (EPs): http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipException_EP_Application.pdf

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