

Part B News

COLLECT EVERY DOLLAR YOUR PRACTICE DESERVES
partbnews.com

July 9, 2018 | Vol. 32, Issue 27

IN THIS ISSUE

Physician payments 1

MedPAC: Give E/M services a big raise and cut procedure, surgical payments

Chronic Care Management 1

In-house or outboard, check these 7 CCM steps to see whether you can do it

HIPAA 2

Don't let IV bags with protected health information trigger costly penalties

Benchmark of the week 5

Suggested E/M pay hikes would create fee-schedule winners and losers

Ask Part B News 8

Coding a vaper who wants to quit: Don't confuse vaping with smoking

From the Part B News blog 8

Latest crop of Category III codes allow reporting of heart, foot and wound therapies

Clinicians who disagree with their MIPS scores will need documentation to make their cases

Quality out, cost in: MIPS expert says pay attention to spend per beneficiary

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

Physician payments

MedPAC: Give E/M services a big raise and cut procedure, surgical payments

Practices that report a lot of outpatient E/M codes would have a big reason to smile if CMS heeds new advice from the Medicare Payment Advisory Commission (MedPAC). In its latest Report to Congress, the commission calls for a significant payment increase for office-based E/M services — suggesting a 30% pay boost is not out of line.

Citing the “passive devaluation” of E/M codes, such as office-based encounter codes **99201-99205** and home visit codes **99341-99350**, MedPAC says such services “are underpriced in

(see *Physician payments*, p. 3)

Chronic Care Management

In-house or outboard, check these 7 CCM steps to see whether you can do it

Many primary care providers balk at doing chronic care management (CCM) because of perceived difficulties, a recent study notes, but it's both clinically and financially worth the effort to assess your ability to take it on or to farm the job out.

Quest Diagnostics released in May results of a survey of primary care physicians (PCPs) showing that while 86% of PCPs agree “patients with multiple chronic conditions require more time than I am able to spend with them,” 88% haven't gotten on board with the Medicare-payable version of the service (**99490**).

(see *Chronic Care Management*, p. 6)

Capture correct HCCs, improve revenue



Medical practices in all specialties must understand how to connect chronic conditions to accurately report hierarchical condition categories (HCCs). Failure to capture the correct risk via ICD-10 diagnosis codes means you're losing money. Up your game during the webinar **Overcome Top Risk-Adjustment Coding Challenges** on July 11. Learn more: www.codingbooks.com/ympda071118.

HIPAA

Don't let IV bags with protected health information trigger costly penalties

Secure recycling or other waste bins used to dispose of materials with any patient protected health information (PHI) — including medication bottles and intravenous bags — because HHS' inspectors are on the lookout for HIPAA disposal violations.

Improper disposal is one of the enforcement issues “that keeps coming up,” warned Iliana Peters, senior adviser, Compliance and Enforcement, with HHS' Office for Civil Rights (OCR), at a security conference co-hosted by OCR and the National Institute of Standards and Technology.

Use a shredder that can handle not only paper but also pill bottles, compact discs and other nonhazardous materials that may hold or display PHI.

HIPAA allows for options

HIPAA's privacy and security rules require that entities take “reasonable safeguards” when disposing of electronic and nonelectronic materials containing PHI but does not mandate or prohibit any particular disposal method, according to a HHS' frequently asked question (FAQ). Instead, “covered entities must review their own circumstances.”

However, OCR does provide some guidance regarding disposal. For instance, OCR suggests the following disposal methods:

- For PHI in paper records, shred, burn, pulp or pulverize records so that PHI is essentially unreadable, indecipherable or otherwise cannot be reconstructed.
- Place labeled prescription bottles and other PHI in opaque bags in a secure area and use a disposal vendor as a business associate to pick up and shred or otherwise destroy the PHI.

Some methods more effective

These suggestions are not absolute. For instance, some facilities simply take patient labels off pill bottles or put them and other items, such as CDs, into a shredder, says David Zetter, president of Zetter Healthcare Management Consultants in Mechanicsburg, Pa.

“A shredder is not just for paper,” he explains. Other facilities use self-shredding labels that are designed to peel off the PHI, which is then shredded, or simply use a permanent marker where applicable to obfuscate the information.

Note that some methods are more effective than others, warns Michael Zurcher, director and senior counsel for privacy and compliance for the record management and information destruction company Iron Mountain. He recommends, for instance, that papers be shredded. “Burning is not as good a process,” he warns.

Subscriber information

Have questions on a story? Call toll-free 1-855-CALL-DH1

Senior Director of Medical Practice and Post-Acute Products:

Maria Tsigas, x6023
mtsigas@decisionhealth.com

Editor:

Roy Edroso, x6031
redroso@decisionhealth.com

Content manager, medical practices:

Karen Long, x6016
klong@decisionhealth.com

Editor:

Richard Scott, 267-758-2404
rscott@decisionhealth.com

Join our DecisionHealth — Medical Practice & Hospital community!

www.facebook.com/DecisionHealthMP

www.twitter.com/DH_MedPractice

www.linkedin.com/groups/4048762

SUBSCRIPTIONS

Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email: customer@decisionhealth.com

DECISIONHEALTH PLEDGE OF INDEPENDENCE:

Part B News works for only you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. For nearly three decades, we've been independently watching out for the financial health of health care providers and we'll be there for you and your peers for decades to come.

CONNECT WITH US

Visit us online at: www.partbnews.com.

CEUs

Part B News is approved, through Dec. 31, 2018, for AAPC CEUs. Credential holders can earn 0.5 CEUs by passing each five-question quiz, for up to 12 CEUs per year. For instructions on how to access the quizzes, log on to www.partbnews.com/home/ceus_read_more.

ADVERTISING

To inquire about advertising in *Part B News*, call 1-855-CALL-DH1.

COPYRIGHT WARNING

Copyright violations will be prosecuted. *Part B News* shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal photocopying or electronic redistribution. To report violations contact: Brad Forrister at 1-800-727-5257 x8041 or email bforrister@blr.com.

REPRINTS

To request permission to make photocopy reprints of *Part B News* articles, call 1-855-CALL-DH1 or email customer service at customer@decisionhealth.com. Also ask about our copyright waiver, multiple copy and site license programs by calling the same number.

Part B News® is a registered trademark of DecisionHealth. DecisionHealth is a registered trademark of *Part B News* is published 48 times/year by DecisionHealth, 100 Winners Circle, Suite 300, Brentwood, TN 37027. ISSN 0893-8121. pbncustomer@decisionhealth.com Price: \$647/year.

Copyright © 2018 DecisionHealth, all rights reserved. Electronic or print redistribution without prior written permission of DecisionHealth is strictly prohibited by federal copyright law.

Rendering the PHI unusable, unreadable or indecipherable greatly lowers the risk of HIPAA noncompliance for improper disposal but also enables the provider to avoid reporting a breach should the PHI be improperly disposed of because the PHI was considered “secure.” Only insecure PHI that has been exposed or compromised needs to be reported.

OCR has issued guidance outlining how PHI must be destroyed for it to be secure.

Ensure vendor compliance

Disposal can become more problematic when providers use a third-party vendor to handle it. The provider is ultimately responsible for an improper disposal, but now the facility is relying on the vendor to dispose of the PHI properly, notes attorney Elizabeth Litten with Fox Rothschild in Princeton, N.J.

In addition, compliance of business associates with HIPAA has become a front-burner issue for OCR. Several of OCR’s settlement agreements in 2016 involved compromise of PHI in the hands of business associates and of covered entities that had faulty or out-of-date business associate agreements that failed to adequately protect the information.

And it is not just federal law that facilities need to worry about — there’s also state law enforcement. For example, the Indiana attorney general’s office fined a dentist \$12,000 because the disposal company he had hired disposed of his records in a public waste bin.

8 tips to reduce practice risk

- **Make sure that disposal is part of your overall HIPAA compliance plan.** Have policies and procedures that work for your operations and layout, says attorney Michael Kline with Fox Rothschild in Princeton, N.J. “If you have and follow policies and procedures, and something happens, at least you can defend yourself that you took reasonable steps to comply,” he explains.

- **Make sure you know what assets contain PHI,** suggests Zurcher. “In today’s world, a lot can [contain PHI], including etools with memory,” he says. If you haven’t conducted a recent risk analysis to locate PHI and determine vulnerability, that’s an important first step, he says.

- **Use lock boxes or other mechanisms for materials with PHI.** “The mindset is important. Providers are used to biohazards in specially marked containers. So use a ‘HIPAA hazard’ container,” suggests Litten. Third-party vendors that handle disposal of PHI will often provide such containers with padlocks, she adds.

- **Handle disposal on a timely basis.** Don’t let the PHI sit in storage if it’s meant to be destroyed. Maintaining it increases the risk of exposure and compromise, warns Kline.

- **Make sure that staff are trained in the proper disposal of PHI.** That’s a HIPAA requirement.

- **Render devices, records and other items secure.** “If you do so, you will likely avoid breach reporting if disposal is not perfect,” says Zurcher.

- **Have a detailed business associate agreement with third-party vendors if you use them for the disposal of PHI.** The agreement should outline how the vendor will handle the disposal, that you approve the process to be used and how the vendor will provide assurances that the PHI has been destroyed, says Zurcher. Include in the business associate agreement that the business associate will pay for the costs of improper disposal, such as notifying patients and offering free credit monitoring and any ensuing violations of state and federal law. Also determine whether you want the disposal/destruction to be done on site or off site.

- **Don’t forget other applicable laws.** For instance, the Occupational Safety and Health Act (OSHA) also may apply to the disposal of items that have PHI on them. — *Marla Durben Hirsch* (askpbn@decisionhealth.com)

Resources:

- ▶ HS’ FAQ on disposal of PHI: www.hhs.gov/hipaa/for-professionals/faq/575/what-does-hipaa-require-of-covered-entities-when-they-dispose-information/
- ▶ NIST Special Publication 800-88, Revision 1: <http://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-88r1.pdf>
- ▶ OCR guidance on rendering information secure to avoid breach notification: www.hhs.gov/hipaa/for-professionals/breach-notification/guidance/index.html

Physician payments

(continued from p. 1)

the fee schedule for physicians and other health professionals ... relative to other services, such as procedures,” according to the report released in June.

Essentially, MedPAC makes the case that reimbursement for procedure codes and other specialty-focused services has perversely outpaced encounter codes, leaving some providers behind and potentially proving calamitous to patient care. “This mispricing may lead to problems with beneficiary access to these services and, over the

longer term, may even influence the pipeline of physicians in specialties that tend to provide a large share of E/M services,” states the report.

MedPAC recommends an E/M payment boost from anywhere between 5% to 30%, recommending that CMS authorize additional research to determine the sweet spot that would maintain a commensurate level of reimbursement for encounter codes. To offset the E/M pay increase, the commission suggests slashing all other non-E/M services by nearly 4% to attain budget neutrality. The recommendations, if enacted, would create clear winners and losers.

“This would be good for specialties that make most of [their] revenue from E/M codes and bad for specialties that make most of their money from procedures,” says Betsy Nicoletti, president of Medical Practice Consulting in Northampton, Mass.

The report analyzes the specialty groups that would be most affected, stating that endocrinologists, rheumatologists and family practice providers, who frequently report E/M services, would reap the largest percentage gains. Physical therapists, radiologists and emergency medicine providers, conversely, are among those who would see a net decline in payments (*see benchmark, p. 5*).

Surgeons, too, would likely face a loss because the revised payment structure would be “taking the value from the surgical CPT codes to pay for the increase in E/M visit codes,” explains Margie Scalley Vaught, CPC, a consultant based in Chehalis, Wash.

Some experts label the proposed E/M payment revisions a necessary step in leveling the reimbursement landscape. “I think E/M services are underpaid and undervalued,” says Maxine Lewis, president of Medical Coding and Reimbursement in Cincinnati. “This is really the patient’s entry into health care — the gatekeeper, so to speak.”

For the sake of example, MedPAC offers a working suggestion of a 10% E/M pay increase. That would infuse approximately \$2.4 billion into E/M encounters and would necessitate a 3.8% pay cut across all other, non-E/M services to balance it out.

Report targets misvalued services

In addition to the E/M payments, MedPAC takes aim at the broader determination of values assigned to many procedure and testing codes. The commission shares “concerns” about the data that CMS uses to assign value to codes, specifically when it comes to clinician time. As

the report points out, CMS “relies on data from surveys conducted by specialty societies.” Yet MedPAC notes that “the surveys have low response rates and low total number of responses, which raises questions about the representativeness of the results.”

The commission refers to MRI testing as an example: “The time assumption for MRI of the brain was more than twice as high as the actual time spent by physicians on this service, according to a physician survey.” In a review of clinician times associated with common non-E/M services, MedPAC found that 20 of 26 codes have “time assumptions that were higher than” typically reported.

The commission’s report also hones in on global reporting for surgeries, stating that a shift in practice patterns may be contributing to larger-than-necessary global surgical pay rates. The bundled rate for global packages assumes that the same physician who conducted the surgery provides all post-surgical care, including E/M visits. However, reporting that “post-operative care is shifting” and surgeons aren’t as likely to perform post-op visits, MedPAC says that payments for surgical packages may be skewed.

CMS is currently investigating the global surgical package to determine whether payments are in line with the work being performed, and the agency is expected to revalue surgical codes en masse within the next year or two (*PBN 5/15/17*). The MedPAC suggestions may be a direct response to CMS’ ongoing endeavor to update the surgical package, says Terry Fletcher, CPC, president of Terry Fletcher Consulting in Laguna Beach, Calif.

Shifting payment structures spur change

In recent years, CMS has made a concerted effort to pay for services that hew to episodic, not-always-face-to-face care, with the introduction of chronic care management (CCM) codes and non-face-to-face prolonged services. It appears MedPAC is nudging CMS further in this direction.

“One way to view the MedPAC recommendations is to consider them in the context of the emphasis on population health management in a value-based payment system,” says Robert Ramsey, attorney with Buchanan, Ingersoll and Rooney in Pittsburgh. “It can be inferred from the report that MedPAC wants CMS to better align incentives to optimize care coordination and management.”

The big question is: Will it happen? Experts are divided.

“My guess would be that the big guys with the knives and the lasers won’t sit idly by while this happens,” Nicoletti says.

(continued on p. 6)

Benchmark of the week

Suggested E/M pay hikes would create fee-schedule winners and losers

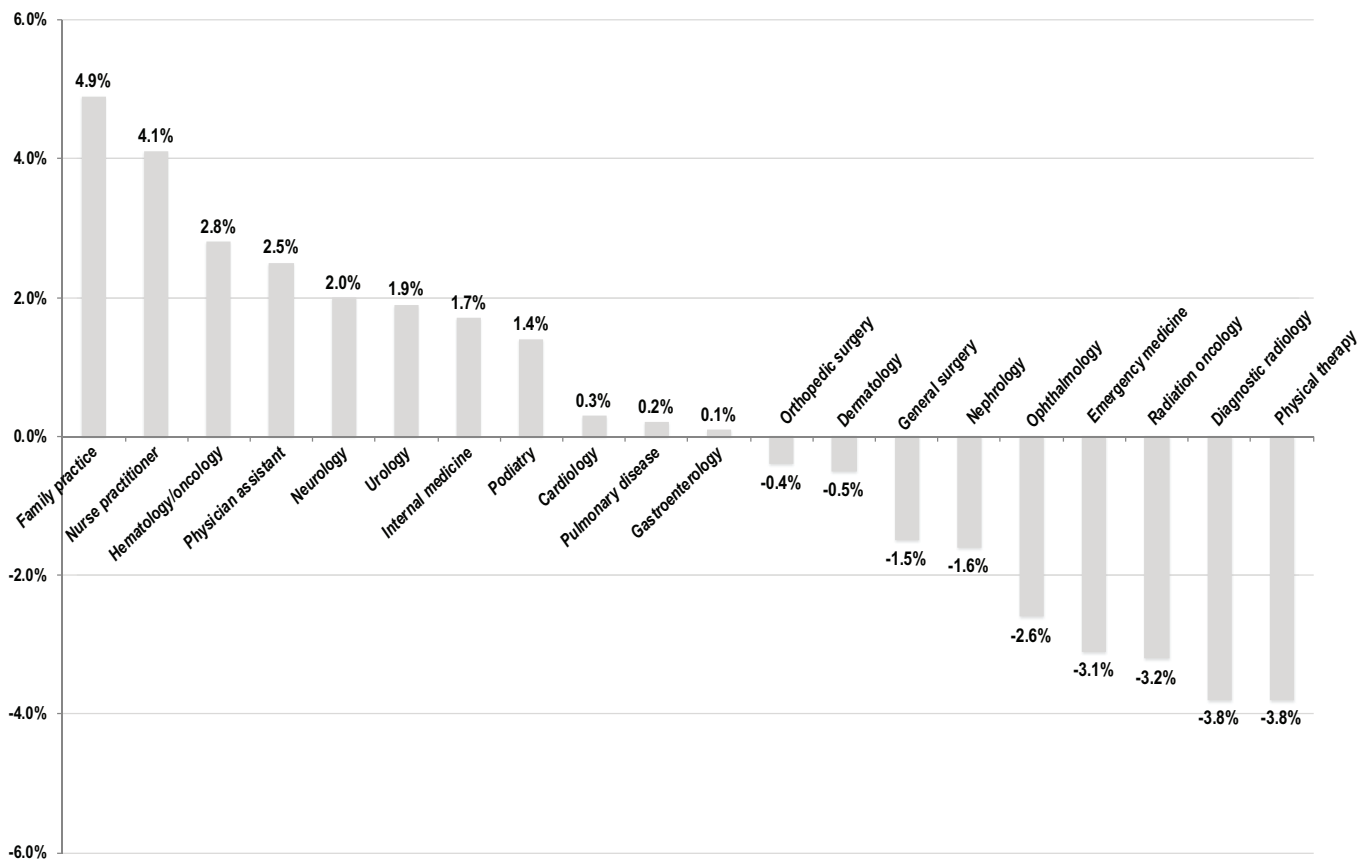
Family practice and internal medicine providers would be big winners under a revamped E/M payment scheme recommended by the Medicare Payment Advisory Commission (MedPAC).

In its latest Report to Congress released in June, MedPAC calls for a significant boost to outpatient E/M payments. The commission suggests that rates could equitably rise by as much as 30%, yet it uses a smaller figure — a 10% increase — for the sake of argument. The chart below details the net change in fee schedule rates that providers in different specialties could expect to see should CMS move ahead with the 10% rate hike. Some providers would see a net decrease because to achieve budget neutrality in the fee schedule rates, other services would take a cut. In the example below, a 3.8% rate cut for non-E/M services would offset the 10% increase.

Under this scenario, family practice providers would take in an additional \$378 million in annual reimbursement, marking a 4.9% net pay increase. Internal medicine providers would see \$435 million in additional revenue, although the percentage increase would be smaller, at 1.7%.

On the reverse side, a number of specialty providers would be subject to a pay cut, including orthopedic surgeons, dermatologists, general surgeons, ophthalmologists and radiologists, among others. On the whole, orthopedic surgeons would see the most dollars missed, at \$93 million in reduced pay, followed by dermatologists at a loss of \$84 million. It remains unclear whether CMS will heed the commission’s advice, though some experts believe coming changes to surgical bundles may be aligned with E/M rate hikes (*see story, p. 1*). — Richard Scott (rscott@decisionhealth.com)

Suggested net change in fee schedule payments by specialty



Source: MedPAC Report to Congress, June 2018

(continued from p. 4)

Lewis is in the same camp. “Surgeons have too big a lobby,” she says.

On the other side, Fletcher can envision a large change taking place, especially if it coincides with a reevaluation of surgical package codes. Should a large-scale surgical code revision occur and counteract the MedPAC recommendations, “physicians won’t feel the reduction in their procedures as much,” Fletcher says. — *Richard Scott* (rscott@decisionhealth.com)

Chronic Care Management

(continued from p. 1)

In fact, 51% of respondents weren’t even aware Medicare was paying for it.

Established in 2015, the chronic care service was claimed more frequently in 2016, its second year and the most recent year for which we have data – going from 1.1 million claims to 2.5 million (*PBN 12/4/17*). Denial rates are low, too, hovering around 4%, and even specialists have been claiming it with success (*PBN 9/25/17*). Polls show that providers who provide the service find it helpful (*PBN 11/1/16*).

Yet, the Quest Diagnostics survey shows many providers still balk at CCM. Among the reasons they cite: complexity of coding (43%), paperwork (37%) and low reimbursement (25%). “Physicians are open to adopting CCM, but it has to be easier to implement and a trusted extension to one’s practice,” says Katherine A. Evans, DNP, FNP-C, GNP-BC, ACHPN, FAANP, immediate

past president, Gerontological Advanced Practice Nurses Association (GAPNA).

“I understand the hesitancy of practices to initiate CCM, especially given the low price point,” says W. Brad Howard, practice advisor, Audit & Education at McKesson Specialty Health. But he thinks they might feel differently “if it can be explained to the providers just how little [actual] additional work is required.” Apart from added elements such as the assignment of the CCM clinical team, the 24-hour contact capability and the development of the electronic plan of care, it’s care you’re probably giving these patients already, he says. “After the initial education period, the practice can easily provide CCM, which truly contributes to a better patient experience.”

When to enlist outside help

If the administrative burden of CCM seems daunting, you can consider using a vendor that can do the job for you, taking a fee that ideally leaves enough profit to make the service worth your while. MassCare LLC in St. Petersburg, Fla., is one of several companies that provide CCM “turnkey solutions,” among other services, to practices under a fee arrangement — in their case, a flat fee per encounter code based on CMS national averages.

MassCare typically opens the service at a practice by sending a registered nurse or medical assistant (MA) and a clinical pharmacist to work on intake. “The nurse or MA is an employee of MassCare,” explains Daniel Miller, the company’s chief operating and financial officer. “The pharmacist, depending on the situation, we either hire on full

Please pass this coupon to a colleague who could benefit from a subscription to *Part B News*.

YES! I want news and guidance to accurately bill and code for physician services so my practice gets the full, correct reimbursement that it’s due. Please enter my one year subscription at \$647.

Name: _____

Org: _____

Address: _____

City/State/ZIP: _____

Phone: _____

Fax: _____

Email: _____

Payment enclosed. Make checks payable to *Simplify Compliance*; (Federal ID#: 26-0753128)

Send me an invoice (PO _____)

Charge my:    

Card #: _____

Exp. Date: _____

Signature: _____

Mail to: **Simplify Compliance**
100 Winners Circle, Suite 300
Brentwood, TN 37027

Toll free: 1-855-CALL-DH1

PAS 2018

www.partbnews.com

time, part time or on contract.” The practice interviews these candidates to make sure they’re a good fit before they set to work there, though they remain employed by MassCare.

“Our program starts with the annual wellness visit (AWV) in the office if the patient is qualified for one,” says Miller. “If it’s Monday and we know Jane Jones is coming in on Wednesday, for example, we can look at chart, ID her as not having had her AWV in the last year, [and that she] is of the right age, has multiple chronic conditions, and therefore [is] qualified [for CCM],” and invite her to her AWV.

When Jane comes in, the nurse/MA performs the exam, and the patient gets a medication review. If she’s on multiple medications, the clinical pharmacist will facilitate a pharmacogenomics (PGx) test, which “allows them to go deeper than drug to drug; they can, by genetics, see if the patient is a bad metabolizer of certain drugs and, if so, make recommendations based on this.”

Jane is then offered the chance to receive CCM, which “isn’t a question,” Miller notes. “You’re not asking, ‘Do you want...’ You’re saying: ‘Your physician wants you to enroll. Here are the benefits, and the result will be healthier life.’ In sales jargon, this is an assumptive close.”

When consent is obtained, the required care plan is produced from the data collected during the AWV, and the service commences. “We work with the office staff,” says Miller, but “our nurse/MA is managing that CCM patient’s whole schedule in the practice.”

MassCare’s arrangement still leaves certain work in the hands of the practice and the provider. For example, facilitating transfers of care required for CCM “is outside the scope of our service and would be referred back to the overseeing physician,” Miller says.

7 tips for potential CCMers

If you’re interested in CCM, review these steps before you choose to take it on or farm it out:

- **Conduct a documentation and coding review.** MassCare has a coding knowledge base that it shares with its clients to make sure code choice reflects both the patient’s eligibility for the service and the provider’s eligibility for payment. Howard recommends clinical documentation improvement (CDI) efforts aimed at backing up those choices. “It’s about understanding what’s required from a reimbursement perspective, as opposed to hoping that if you write 125 pages of notes, you will be covered,” he says.

- **Observe rules of inclusion.** Not everyone who wants CCM should get it, says Howard. Practices should develop a checklist to make sure the patient meets the requirements — particularly the “significant risk of death, acute exacerbation/decompensation or functional decline” one.

- **Have a CCM point person.** This isn’t the care manager in charge, but rather a “thumbs up or thumbs down” person who runs the program day to day. It’s “someone who wears many hats, likely a leadership figure or perhaps a practice administrator,” who can approve or disapprove of individual recommendations for CCM based on the abovementioned metrics, Howard says. This person also should “periodically review the entire process, including claims submissions, to see if claims are getting denied and why, and to follow up on all cost-sharing issues, including whether or not patients’ supplemental insurance is picking this up,” he adds. This person also should use a spreadsheet or dashboard for the program so its profitability may be regularly assessed.

- **Communicate with peer groups.** “When you have a network or opportunities to meet in person for conferences or training, ask them what works for them, what their experience has been, any setbacks or hurdles, etc.,” says Howard. McKesson does this with its own clients and partners such as the U.S. Oncology Network, says Howard.

- **Have a good electronic health record (EHR) — and relationship with the vendor.** Since the plan of care has to be electronic and shareable, make sure your EHR can handle it, says Howard. You also should have “a good relationship with the EHR vendor where you can pick up the phone” if you need help.

- **Don’t sweat the 24-hour requirement.** If it sounds like a big lift, note that in Miller’s experience, such calls are “infrequent,” and if the patient’s issue is medically advanced, the case manager or clinical team who takes the call can explain, “what you’re complaining about is outside our scope,” and refer them to the ER or for follow-up with their physician.

- **Don’t ignore alternative and complementary treatment options.** There are some specific contraindications for CCM coverage — for example, you can’t claim that and transitional care management (TCM) (99495-99496) in the same month. But also remember, in some cases it’s appropriate to add services to CCM — for example, behavioral health integration (BHI) and psychiatric collaborative care management (CoCM) services (*PBN 12/4/17*). Make sure everyone understands the conflicts and the harmonies. — Roy Edroso (redroso@decisionhealth.com)

Ask Part B News

Coding a vaper who wants to quit: Don't confuse vaping with smoking

Question: *How do I bill if a patient comes in and asks for help quitting e-cigarettes — that is, vaping? The patient does not smoke regular cigarettes or any other traditional tobacco products; in fact, he says vaping helped him quit cigarettes.*

Answer: This is a tricky one. “CMS and CPT take some time to catch up on new trends in health care, and vaping is one of them,” says Nancy Enos, FACMPE, CPC-I, CPMA, CEMC, founder of Enos Medical Coding in Warwick, R.I. The Centers for Disease Control and Prevention (CDC) proposed ICD-10 codes for e-cigarettes, aka Electronic Nicotine Delivery Systems (ENDS), in 2017, but there has been no action on that score since (*PBN 3/20/17*).

For this encounter, you wouldn't use **99406** (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or **99407** (...; intensive, greater than 10 minutes), nor the associated G codes because “the codes specify tobacco use and smoking; vaping isn't smoking, and nicotine use isn't tobacco,” says Enos. In the case of e-cigarettes, users inhale a vapor from a superheated liquid source.

But because the patient is using the e-cigarettes to substitute for regular cigarettes, it seems highly likely — pending confirmation from your provider, of course — that the patient's issue is nicotine dependence. Most ICD-10 codes for nicotine dependence are specifically associated with tobacco products, but **F17.200** (Nicotine dependence, unspecified, uncomplicated) will do for the vaper, says Terry Fletcher, CPC, president of Terry Fletcher Consulting in Laguna Beach, Calif., and host of the CodeCast Medical Billing podcast.

As for the counseling, Margie Scalley Vaught, CPC, a consultant based in Chehalis, Wash., recommends whichever of the unspecified preventive counseling codes **99401-99404** applies to the time spent. Vaught says she uses these codes for risk-reduction counseling regarding a wide variety of actions patient wish to pursue more safely — for example, when preparing for a marathon or trying to get pregnant.

It may not be a perfect match — and, though private payers are likely to pay for it, Medicare won't (*PBN 1/9/17*). But it's closer to the mark than the smoking-specific codes — at least until AMA and CDC finally get some ENDS codes going. — Roy Edroso (redroso@decisionhealth.com)

From the *Part B News* blog

Take note of the news that happens between *Part B News* issues by checking out the free *Part B News* blog at <https://pbn.decisionhealth.com/Blogs/default.aspx>. Here's a sampling from this week.

Latest crop of Category III codes allow reporting of heart, foot and wound therapies

A sinus tarsi foot implant designed to correct gait; extracorporeal shockwave wound care treatment; and a wireless cardiac stimulator for biventricular pacing are some of the new CPT Category III codes released by the AMA on July 1 that will be available for reporting in January. Read more: <https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200734>.

Clinicians who disagree with their MIPS scores will need documentation to make their cases

Clinicians who participated in the first year of the merit-based incentive payment system (MIPS) have until Sept. 30 to dispute CMS' calculations. But they should keep two words in mind: supporting documentation. Read more: <https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200735>.

Quality out, cost in: MIPS expert says pay attention to spend per beneficiary

One of the sources in a recent MIPS story has some thoughts about the program in general that didn't quite fit our issue but which we think are worth sharing with readers here. Read more: <https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200731>.

How did you get this email?

It is illegal to forward **Part B News Online** to anyone else.

It is a free benefit only for the individual listed by name as the subscriber. It's illegal to distribute **Part B News Online** to others in your office or other sites affiliated with your organization.

If this email has been forwarded to you and you're not the named subscriber, that is a violation of federal copyright law. However, **only the party who forwards a copyrighted email is at risk**, not you.

Reward: To confidentially report suspected copyright violations, call our copyright attorney Brad Forrister at 1-800-727-5257 x8041 or email him at bforrister@blr.com. Copyright violations will be prosecuted. And **Part B News** shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal electronic forwarding of **Part B News Online** or photocopying of our newsletter.