Flu Shot Coding for 2017-2018

What's new this flu season?

- The recommendation to **not** use the nasal spray flu vaccine (LAIV) was renewed for the 2017-2018 season. Only injectable flu shots are recommended for use again this season. CDC recommends use of the flu shot (inactivated influenza vaccine or IIV) or the recombinant influenza vaccine (RIV).
- Flu vaccines have been updated to better match circulating viruses (the influenza A(H1N1) component was updated).
- Pregnant women may receive any licensed, recommended, and age-appropriate flu vaccine. (NOTE: there is some concern about administration of the flu shot during the first trimester – **NPR news story today 9/25/17**)
- Two new quadrivalent (four-component) flu vaccines have been licensed: one inactivated influenza vaccine ("Afluria Quadrivalent" IIV) and one recombinant

influenza vaccine ("Flublok Quadrivalent" RIV).
- The age recommendation for "Flulaval Quadrivalent" has been changed from 3 years old and older to 6 months and older to be consistent with FDA-approved labeling.
- The trivalent formulation of Afluria is recommended for people 5 years and older (from 9 years and older) in order to match the Food and Drug Administration package insert.

Cell-based Flu Vaccines

A candidate vaccine virus (CVV) is an influenza (flu) virus that has been prepared by CDC or its public health partners for use by vaccine manufacturers to mass produce a flu vaccine. During the 2017-2018 season, for the first time, a true cell-based CVV has been approved for use in flu vaccine production for the Northern Hemisphere. Traditionally, CVVs have been produced using fertilized chicken eggs. The cell-based CVV has been used to produce the influenza A (H3N2) component of cell-based flu vaccines for the Northern Hemisphere in 2017-2018. Recombinant flu vaccines also are based on genetic sequences of recommended vaccine viruses that have not been propagated in eggs. Cell-based flu vaccines that use cell-based CVVs or genetic sequences have the potential to offer better protection than traditional, egg-based flu vaccines as a result of being more similar to flu viruses in circulation. For more information, see CDC's Cell-Based Flu Vaccines webpage.

Options this season include:

- Standard dose flu shots. Most are given into the muscle (usually with a needle, but one can be given to some people with a jet injector). One is given into the skin.
- High-dose shots for older people.
- Shots made with adjuvant for older people.
- Shots made with virus grown in cell culture.

- Shots made using a vaccine production technology (recombinant vaccine) that does not require the use of flu virus.

Medicare Reimbursement for the Flu Shot

The Part B deductible and coinsurance amounts do not apply to influenza vaccines or vaccine administration. All physicians, nonphysician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination **must take assignment** on the claim for the vaccine.

The following Medicare Part B payment allowances for HCPCS and CPT codes apply to 8/1/2017-7/31/2018:

- 90630 $20.343
- 90653 $50.217
- 90654 Pending
- 90655 Pending
- 90656 $19.247
- 90657 Pending
- 90661 Pending
- 90662 $49.025
- 90672 Pending
- 90673 $40.613
- 90674 $24.047
- 90682 $46.313
- **(New code) 90685 $21.198**
- 90686 $19.032
- 90687 $9.403
- 90688 $17.835
- Q2035 $17.685
- Q2036 Pending
- Q2037 $17.685
- Q2038 Pending
- Q2039/90756 $22.793 **Until CPT code 90756 is implemented**

on 1/1/2018, Q2039 will be used for products described by the following language: influenza virus vaccine, quadrivalent (ccllV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use. Providers and MACs will use HCPCS Q2039 for dates of service from 8/1/2017- 12/31/2017. HCPCS Q2039 Flu Vaccine Adult – Not Otherwise Classified.

Flu Shot Administration Codes

Don't forget to code the vaccine administration as well as the vaccine itself!

Administered by a Physician, NP, PA, RN, LPN, Medical Assistant (etc) WITHOUT COUNSELING:

- **90471** –percutaneous, intradermal, subcutaneous, or intramuscular injections: one vaccine (single or combination vaccine/toxoid)
- **90473** – intranasal or oral: one vaccine (single or combination vaccine/toxoid)

Administered by a Physician, NP, PA (etc) WITH COUNSELING:

- **90460** – Immunization administration through 18 years of age via any route of administration, w/ counseling by physician or other qualified healthcare professional; first vaccine/toxoid component

Here's that **invaluable flu shot chart** from the Immunization Action Coalition with flu vaccine manufacturer, trade name, how supplied, age group, and CPT/HCPCS codes for Medicare and non-Medicare plans.

2017 Medicare Deductibles and Premiums

2017 Medicare Parts A & B Premiums and Deductibles Announced

The Centers for Medicare & Medicaid Services (CMS) announced the 2017 premiums for the Medicare inpatient hospital (Part A) and physician and outpatient hospital services (Part B) programs.

Medicare Part B Premiums/Deductibles

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and other items.

On October 18, 2016, the Social Security Administration announced that the cost-of-living adjustment (COLA) for Social Security benefits will be 0.3 percent for 2017. Because of the low Social Security COLA, a statutory "hold harmless" provision designed to protect seniors, will largely prevent Part B premiums from increasing for about 70 percent of beneficiaries. Among this group, the average 2017 premium will be about **$109.00,** compared to $104.90 for the past four years.

For the remaining roughly 30 percent of beneficiaries, the standard monthly premium for Medicare Part B will be **$134.00** for 2017, a 10 percent increase from the 2016 premium of $121.80. Because of the "hold harmless" provision covering the other 70 percent of beneficiaries, premiums for the remaining 30 percent must cover most of the increase in Medicare costs for 2017 for all beneficiaries. This year, as in the past, the Secretary has exercised her statutory authority to mitigate projected premium increases for these beneficiaries, while continuing to maintain a prudent level of reserves to protect against unexpected costs. The Department of Health and Human Services (HHS) will work with Congress as it explores budget-neutral solutions to challenges created by the "hold harmless" provision.

"Medicare's top priority is to ensure that beneficiaries have affordable access to the care they need," said CMS Acting Administrator Andy Slavitt. "We will continue our efforts to improve affordability, access, and quality in Medicare."

Medicare Part B beneficiaries not subject to the "hold harmless" provision include beneficiaries who do not receive Social Security benefits, those who enroll in Part B for the first time in 2017, those who are directly billed for their Part B premium, those who are dually eligible for Medicaid and have their premium paid by state Medicaid agencies, and those who pay an income-related premium. These groups represent approximately 30 percent of total Part B beneficiaries.

CMS also announced that the annual deductible for all Medicare Part B beneficiaries will be $183 in 2017 (compared to $166 in 2016).

Medicare Part A Premiums/Deductibles

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. **About 99 percent of Medicare beneficiaries do not have a Part A premium** since they have at least 40 quarters of Medicare-covered employment.

The Medicare Part A **inpatient hospital deductible that beneficiaries pay when admitted to the hospital will be $1,316 per benefit period in 2017**, an increase of $28 from $1,288 in 2016. The Part A deductible covers beneficiaries' share of costs for the first 60 days of Medicare-covered inpatient hospital care in a benefit period. Beneficiaries must pay a coinsurance amount of $329 per day for the 61st through 90th day of hospitalization ($322 in 2016) in a benefit period and $658 per day for lifetime reserve days ($644 in in 2016). For beneficiaries in skilled nursing facilities, the daily coinsurance for days 21 through 100 of extended care services in a benefit period will be $164.50 in 2017 ($161 in 2016).

Enrollees age 65 and over who have fewer than 40 quarters of coverage and certain persons with disabilities pay a monthly premium in order to receive coverage under Medicare Part A. Individuals who had at least 30 quarters of coverage or were married to someone with at least 30 quarters of coverage may buy into Part A at a reduced monthly premium rate, which will be **$227** in 2017, a $1 increase from 2016. Uninsured aged and certain individuals with disabilities who have exhausted other entitlement and who have less than 30 quarters of coverage will pay the full premium, which will be **$413** a month, a $2 increase from 2016.

It’s Not Too Late to Launch CCOF on January 1st

High Deductible Plans and CCOF Are Becoming Mainstream

When we first starting teaching practices how to implement credit card on file (CCOF) in their practices in 2010, only a few practices had ever heard of it. Today, we get calls weekly from practices who need help collecting patient balances, especially from patients with high-deductible plans, many whom do not understand how their plan works. Note that almost 25% of persons covered by employer health plans are enrolled in

high-deductible plans, and almost 90% of enrollees in the healthcare exchange (Affordable Care Act Marketplaces) have a high-deductible plan!

The time-honored tradition of sending patients monthly statements and allowing them to pay on their own timetable has increasingly become untenable for medical practices, especially small practices that have limited financial resources to wait out patient payments. Physicians are paying their staff, medical supplies, utilities and rent monthly while waiting for insurance plans to pay in 30 to 45 days and patients to pay anywhere from 60 to 120 days or more past the date of service.

Having the Talk With Patients

Credit card on file opens the patient payment dialogue by changing the conversation from ***"We'll send you a bill when insurance pays their portion"*** to ***"Once we receive the insurance Explanation of Benefits (EOB), we'll charge your card for the patient-responsible balance. If the balance is over $____, we'll call you to discuss your payment."***

On January 1st, the deductible starts afresh for most plans, and any practice not using credit card on file to collect those deductibles is in for a particularly tough quarter – what I've always called "The Black Months". With the size of deductibles however, many practices are in for another tough year. Contrary to plans of the past that applied the deductibles only to very high-priced services or hospital events, many deductibles apply to office visits, medications, labs – essentially every healthcare service one can have. Some patients will never meet their deductible and will be paying your practice out of their pocket for every service all year long.

Is 2017 the year you streamline and improve patient collections?

It’s not too late to get it together to launch your program now to be ready for the new year. Here are the steps:

1. **Integrate software** that allows you to keep patient credit cards on file on an offsite, secure, third-party server as an add-on to your current merchant services (credit card processing). Call your current credit card processor to see if they have CCOF, but be careful – there is a lot of confusing language around the CCOF part and CC processing charges. My recommendation for **CCOF software is here.**
2. **Educate patients** on the change. Inform and educate patients about your new policy between now and when you launch.
3. **Rewrite your financial policy** to include CCOF. If no one ever reads your financial policy, now is the time to make it simpler and clearer.
4. **Educate the staff.** Explain why you’re making the change, how it works and how to communicate with patients that might have questions.
5. **Change your patient scripts** to include CCOF language when you schedule and confirm appointments.
6. **Get rid of patient statements.** Decide how you will handle current patient statements to clear those balances. You eliminate statements when you implement CCOF.
7. **Determine your philosophy.** How are going to deal with patients who say they don’t have a credit or debit card, or refuse to give you their card to place on file? Most practices will lose a few patients, but it is always less than you expect. Most patients who refuse are patients who never intended to pay you anyway!

I ask physicians this question:

> *If you collected the same amount of money each month whether you saw 500 patients who paid you part of what they owed, or 350 patients who paid you everything they owed, which would you prefer?*

Of course, every physician would love to see less patients, having more quality time with each patient! What's wrong with having a practice full of patients who agree to pay you what they owe? FYI, CCOF does not mean you cannot also serve patients who need help with medical expenses – that's a different conversation!

For more information and help, see our **CCOF page here**, or watch this 30-minute **YouTube video here.**

NOTE: I use the term "credit card" in this article, but you can accept, if you so choose, debit cards, health savings account cards, flexible spending account cards – even gift cards.

Flu Shot Information: 2016 – 2017

CDC Updates Flu Shot Recommendations for 2016-2017 Flu Season

A few things are new this season:

- Only injectable flu shots are recommended for use this season.
- Flu vaccines have been updated to better match circulating viruses.
- There will be some new vaccines on the market this season.
- Live attenuated influenza vaccine (LAIV) – or the nasal

spray vaccine – is **not** recommended for use during the 2016-2017 season because of concerns about its effectiveness.
- CPT code 90674 is a new code for 2017, and some code descriptions are revised for 2017 to indicate dosage as opposed to age.
- The recommendations for vaccination of people with egg allergies have changed.

The recommendations for people with egg allergies have been updated for this season:

- People who have experienced only hives after exposure to egg can get any licensed flu vaccine that is otherwise appropriate for their age and health.
- People who have symptoms other than hives after exposure to eggs, such as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who have needed epinephrine or another emergency medical intervention, also can get any licensed flu vaccine that is otherwise appropriate for their age and health, but the vaccine should be given in a medical setting and be supervised by a health care provider who is able to recognize and manage severe allergic conditions. (Settings include hospitals, clinics, health departments, and physician offices). People with egg allergies no longer have to wait 30 minutes after receiving their vaccine.

Options this season include:

- Standard dose flu shots. Most are given into the muscle (usually with a needle, but one can be given to some people with a jet injector). One is given into the skin.
- A high-dose shot for older people.
- A shot made with adjuvant for older people.
- A shot made with virus grown in cell culture.
- A shot made using a vaccine production technology

(recombinant vaccine) that does not require the use of flu virus.

Medicare and the Flu Shot

The Medicare Part B payment allowance limits for seasonal influenza and pneumococcal vaccines are 95% of the Average Wholesale Price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. When the vaccine is furnished in the hospital outpatient department, payment for the vaccine is based on reasonable cost.

Providers should note that:

- All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- The annual Part B deductible and coinsurance amounts do not apply.

Medicare Payment Allowances and Effective Dates for the 2016-2017 Flu Season

Effective Dates 8/1/2016 – 7/31/2017

- CPT 90630 Payment allowance is $20.343.
- CPT 90653 Payment allowance is $37.383.
- CPT 90656 Payment allowance is $17.717.
- CPT 90657 Payment allowance is pending.
- CPT 90661 Payment allowance is pending.
- CPT 90662 Payment allowance is $42.722.
- CPT 90672 Payment allowance is $26.876.

- CPT 90673 Payment allowance is $40.613.
- CPT 90674 Payment allowance is $22.936.
- CPT 90685 Payment allowance is $26.268.
- CPT 90686 Payment allowance is $19.032.
- CPT 90687 Payment allowance is $9.403.
- CPT 90688 Payment allowance is $17.835.
- HCPCS Q2035 Payment allowance is $16.284.
- HCPCS Q2037 Payment allowance is $16.284.
- HCPCS Q2039 Flu Vaccine Adult – Not Otherwise Classified payment allowance is to be determined by the local claims processing contractor with effective dates of 8/1/2016-7/31/2017.

Click here for a handy flu shot chart with CPT codes and manufacturers.

Creating Facebook and Blog Content for Your Medical Practice – Free Webinar!

Ever wish you felt more confident about social media, particularly Facebook and blogs?

If you are ready to start using Facebook and posting blog content for marketing, you've come to the right place.

If you're not 100% sold on the time and effort you and your staff have been putting into social media, **you are not alone**.

Managers, physicians and other healthcare providers tell me they are stressed out over what they should be doing for social media and blog content. They have questions like:

- **How much time I should focus on Facebook?**
- **Why is no one engaging with my Facebook posts?**
- **I have no followers/fans – what am I doing wrong?**
- **Are Facebook Ads really worth it?**
- **Should our practice have a blog?**
- **How do we get started?**
- **How do we create a doable plan for posting?**
- **What on earth should we be blogging about, anyway?**

Because I think this is so important to medical practices, I've asked my good friends, Janet Kennedy and Carol Bush with Get Social Health if they would introduce this topic to my readers and they've agreed to share their best social media secrets for healthcare practices – for free!

Janet and Carol will be addressing the questions above and answering your specific questions in the web clinic: "Creating Engaging Content for Your Blog and Facebook". Click here to reserve your spot for "Creating Engaging Content for Your Blog and Facebook"

They will be sharing with you (and me) the latest information on how to create engaging Facebook and Blog posts.

Can't wait to see you there!

Mary Pat

P.S. The web clinic will last about an hour because I asked Janet and Carol to devote at least 10-minutes to full-on Q&A. That means you can ASK THEM ANYTHING about your business, their business, social media, or whatever you can think of. So start jotting down your questions now, and **don't forget to sign up by clicking here**.

P.S.S. They'll be giving away some freebies – but you can only get them if you're on the Web Clinic LIVE! So register now and mark your calendar for **Thursday, August 25th at 12:00pm EST.**

What's Driving Your Medical Practice to Change?

We've heard from many small independent practices of their desire to evaluate/change their practice model due to:

- Ongoing Medicare quality program and commercial insurance fee reductions.
- Increasing administrative expense related to pre-authorizations, denials, and patient collections due to high-deductible health plans.
- Desire for more time with patients without sacrificing income.

Now you can weigh in on the discussion by participating in **Kareo's** and the **American Academy of Private Physicians' (AAPP)** annual survey which asks independent physicians for their perceptions of different practice models such as traditional fee-for-service, cash fee-for-service,

concierge/retainer plans, telemedicine and more.

This description of the survey is posted on Kareo's blog:

> *"Industry research has shown that many independent physicians are concerned about whether or not they can be adequately prepared from the growing shift to value-based reimbursement. As a result, they are testing or fully transitioning to other options like concierge, direct-pay, and virtual models. For the second year, Kareo has partnered with AAPP to investigate this trend more broadly, seeking to understand the challenges and benefits of each payment structure. Furthermore, this survey seeks to determine if a hybrid practice model, which takes into account various payment models, could solve issues of contention that physicians have with their current practice model."*

Healthcare providers and those who manage their practices can access the survey for a chance to win an Apple Watch, an iPad, or a one year AAPP membership. The survey is here: **Private Practice Model Perspective 2016**.

Want to learn more about different practice models. See my slide deck below "Twelve Practice Models for 2016"

12 Practice Models for 2016 from **Manage My Practice**

Heart Failure Patient

Innovation Leads to New Service Line

Setting up new practices and healthcare businesses gives me the opportunity to meet some very creative and dedicated people. An exceptional case in point – Elizabeth Blanchard-Hills, the founder of CareConnext. She and I met several years ago while she was piloting a Transitional Care Management program for Heart Failure patients and she wanted a business model to match the care model.

Fast forward several years,and Elizabeth has taken her experience and her success and made it available to organizations who are looking for a proven way to improve care to patients, reduce healthcare costs by preventing hospital readmissions, and improve patient satisfaction.

Elizabeth agreed to an interview to update me on CareConnext.

Mary Pat: What is CareConnext?

Elizabeth: CareConnext is a care transition service giving heart failure patients renewed hope and a sense of personal control over their emotional well-being and physical health. Patients meet weekly for one month in a small group; they are coached by a multidisciplinary team and encouraged by their peers.

Mary Pat: Why would CareConnext be of interest to hospitals, physician practices or home health agencies?

Elizabeth: Hospitals interested in lowering their heart failure readmissions and improving their HCAHPS scores would benefit from CareConnext. Nurse practitioners and doctors who want to increase revenue by saving time would also benefit from CareConnext, as Medicare and private insurers will pay for this model of care. Home health agencies tell us CareConnext offers them a unique marketing edge over their competitors.

Mary Pat: What is the science behind CareConnext?

Elizabeth: CareConnext is the result of a randomized clinical trial (then called SMAC-HF) which followed more than 200 patients for five years. The results were recently published in Circulation, an American Heart Association journal for cardiologists.

Mary Pat: What is the business rationale for CareConnext?

Elizabeth: My company currently has the privilege of "transitioning" the results of the randomized clinical trial into practice. We have been conducting an on-going pilot project with The University of Kansas Hospital since November

2013, and our results are corroborating the results of the randomized clinical trial. Happily, we also discovered that Medicare and private insurers are willing to pay us for the work we do. This is an important benefit when attempting to persuade executive leadership to implement CareConnext.

There are dozens of very good interventions for heart failure, such as software solutions or post-discharge case management tools. Very few are able to pay for themselves; fewer still have the rigor of a randomized clinical trial behind their results.

Mary Pat: What are the main findings of the study?

Elizabeth: That we could, in fact, significantly lower hospital readmissions among heart failure patients.

Mary Pat: What was most surprising about the results?

Elizabeth: We have found several surprises:

- The importance of **managing emotions** when managing a chronic disease such as heart failure;
- The randomized clinical trial showed **depression puts heart failure patients at risk for readmission;** this mirrors what we are now finding in the literature; helping patients feel emotionally and spiritually better is now a signature piece of CareConnext. We screen for depression using the PHQ9, and watch our patients rebuild hope by regaining a sense of control. We do so by talking frankly and directly about sensitive issues that are often time-consuming to address: end-of-life planning, the loss of independence, or asking family members to participate in a change of diet.
- The **value of peer-to- peer coaching**; because of the time

constraints we as health care professionals face, we too often resort to “lecturing” our patients, leaving us little time to validate our patients’ understanding, or their ability to take positive action. For example, it is easy to “tell” someone to limit their sodium intake to 2 grams a day. But does the patient even understand how to read a food label? If not, would he or she feel comfortable revealing that? CareConnext provides a safe environment for patients to recognize and overcome knowledge gaps, as they rely on one another for real-life strategies and emotional support. Our providers are mostly on “standby,” available to address specific questions or misconceptions that specifically require the expertise of an advanced practice nurse or physician.

- Our **data holds across varying patient populations**; patients who struggle with literacy or language benefit from our intervention as do patients who are affluent, well-educated and compliant. Only the “sickest of the sick” (Heart Failure Class III and IV) were included in the randomized clinical trial.
- Our **physicians and nurse practitioners enjoy the CareConnext model,** too. Our team is quite talented, and therefore much in demand at The University of Kansas Hospital. They are often recruited for interesting projects always in play at a large academic medical center. They tell us CareConnext is professionally rewarding, and a welcome change from the standard, one-on- one office visit.

Mary Pat: What should clinicians and patients take away from your report?

Elizabeth: This particular patient population will remain engaged if they find something of value. Being “noncompliant” is a convenient label we often misuse with our patients. Heart Failure patients have logical reasons for being

skeptical of what they perceive as “yet another doctor’s appointment,” such as a lack of energy.

We have been quite strategic in attempting to meet our patients’ emotional needs. The “clinical stuff” (monitoring fluid volume, especially overload) we offer as part of CareConnext are the ‘greens fees’ we pay so we can address and change patient behavior. By making patients feel emotionally and spiritually empowered, we help them change the feelings they have and the choices they make.

Mary Pat: How does a reader get more information?

Elizabeth: Many organizations have approached us over the past couple of years about implementing CareConnext within their own institutions, using their own staff. We now have the experience, “lessons learned” and tools to help them be successful. Readers can email me directly to start the conversation at **ehills@careconnext.org** and can also visit our website: **www.careconnext.org**

Mary Pat: Anything else you’d like to say about CareConnext?

Elizabeth: Yes, I’d like to give you a special shout-out, Mary Pat. I first approached you with what I saw as an insurmountable problem several years ago: We had a unique care model that delivered outstanding outcomes for patients with Heart Failure, but no way to get paid for it. Using both common sense and a “roll up your shirt sleeves” approach, you helped us figure it out. Now I am excited to help others do the same, and I am grateful for your belief in me, my team and CareConnext.

Mary Pat: Thank you for the kind words, Elizabeth!

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New Rules for Charging Patients for Their Medical Records

Just when you thought you understood how to charge for medical records!

New clarifications have just been released that give specific direction to medical practices and other healthcare providers on charging patients for medical records. I have extracted the most salient pieces for you below, followed by FAQs from the published clarifications.

1. Covered entities must inform the individual in advance of the approximate/exact fee that may be charged for the copy.
2. A covered entity can develop a schedule of costs for labor based on average labor costs to fulfill standard types of access requests (e.g. paper records, electronic records, mailed records, etc.)
3. **A covered entity may charge individuals a flat fee for**

all standard requests for <u>electronic</u> copies of PHI maintained electronically, provided the fee does not exceed $6.50, inclusive of all labor, supplies, and any applicable postage. While the Privacy Rule permits the limited fee as described, covered entities should provide individuals who request access to their information with copies of their PHI free of charge.

4. The fee limits apply when an individual directs a covered entity to send the PHI to a third party (and it doesn't matter who the third party is) HOWEVER, where the third party is initiating a request for PHI on its own behalf, with the individual's HIPAA authorization (or pursuant to another permissible disclosure provision in the Privacy Rule), the access fee limitations do not apply.
5. Administrative and other costs associated with outsourcing the function of responding to individual requests for access cannot be the basis for any fees charged to individuals for providing that access.
6. A covered health care provider cannot charge an individual a fee when it fulfills an individual's HIPAA access request using the View, Download, and Transmit functionality of the provider's CEHRT.
7. HIPAA does not override those State laws that provide individuals with greater rights of access to their health information than the HIPAA Privacy Rule does
8. A covered entity may not charge an individual who, while inspecting her PHI, takes notes, uses a smart phone or other device to take pictures of the PHI, or uses other personal resources to capture the information, however, a covered entity is not required to allow the individual to connect a personal device to the covered entity's systems.
9. A covered entity may not withhold or deny an individual access to his PHI on the grounds that the individual has not paid the bill for health care services.

May a covered entity charge individuals a fee for providing the individuals with a copy of their PHI?

Yes, but only within specific limits. The Privacy Rule permits a covered entity to impose a reasonable, cost-based fee to provide the individual (or the individual's personal representative) with a copy of the individual's PHI, or to direct the copy to a designated third party. The fee may include only the cost of certain labor, supplies, and postage:

1. **Labor for copying the PHI requested by the individual, whether in paper or electronic form.** Labor for copying includes only labor for creating and delivering the electronic or paper copy in the form and format requested or agreed upon by the individual, once the PHI that is responsive to the request has been identified, retrieved or collected, compiled and/or collated, and is ready to be copied. Labor for copying does not include costs associated with reviewing the request for access; or searching for and retrieving the PHI, which includes locating and reviewing the PHI in the medical or other record, and segregating or otherwise preparing the PHI that is responsive to the request for copying.While it has always been prohibited to pass on to an individual labor costs related to search and retrieval, our experience in administering and enforcing the HIPAA Privacy Rule has shown there is confusion about what constitutes a prohibited search and retrieval cost and this guidance further clarifies this issue. This clarification is important to ensure that the fees charged reflect only what the Department considers "copying" for purposes of applying 45 CFR 164.524(c)(4)(i) and do not impede individuals' ability to receive a copy of their records.
2. **Supplies for creating the paper copy (e.g., paper, toner) or electronic media (e.g., CD or USB drive)if**

the individual requests that the electronic copy be provided on portable media. However, a covered entity may not require an individual to purchase portable media; individuals have the right to have their PHI e-mailed or mailed to them upon request.

3. Labor to prepare an explanation or summary of the PHI, if the individual in advance both chooses to receive an explanation or summary and agrees to the fee that may be charged.
4. **Postage,** when the individual requests that the copy, or the summary or explanation, be mailed.

Thus, costs associated with updates to or maintenance of systems and data, capital for data storage and maintenance, labor associated with ensuring compliance with HIPAA (and other applicable law) in fulfilling the access request (e.g., verification, ensuring only information about the correct individual is included, etc.) and other costs not included above, even if authorized by State law, are not permitted for purposes of calculating the fees that can be charged to individuals. See 45 CFR 164.524(c)(4).

Further, while the Privacy Rule permits the limited fee described above, covered entities should provide individuals who request access to their information with copies of their PHI free of charge. While covered entities should forgo fees for all individuals, not charging fees for access is particularly vital in cases where the financial situation of an individual requesting access would make it difficult or impossible for the individual to afford the fee. Providing individuals with access to their health information is a necessary component of delivering and paying for health care. We will continue to monitor whether the fees that are being charged to individuals are creating barriers to this access, will take enforcement action where necessary, and will reassess as necessary the provisions in the Privacy Rule that permit these fees to be charged.

What labor costs may a covered entity include in the fee that may be charged to individuals to provide them with a copy of their PHI?

A covered entity may include reasonable labor costs associated only with the: (1) labor for copying the PHI requested by the individual, whether in paper or electronic form; and (2) labor to prepare an explanation or summary of the PHI, if the individual in advance both chooses to receive an explanation or summary and agrees to the fee that may be charged.

Labor for copying includes only labor for creating and delivering the electronic or paper copy in the form and format requested or agreed upon by the individual, once the PHI that is responsive to the request has been identified, retrieved or collected, compiled and/or collated, and is ready to be copied. For example, labor for copying may include labor associated with the following, as necessary to copy and deliver the PHI in the form and format and manner requested or agreed to by the individual:

- Photocopying paper PHI.
- Scanning paper PHI into an electronic format.
- Converting electronic information in one format to the format requested by or agreed to by the individual.
- Transferring (e.g., uploading, downloading, attaching, burning) electronic PHI from a covered entity's system to a web-based portal (where the PHI is not already maintained in or accessible through the portal), portable media, e-mail, app, personal health record, or other manner of delivery of the PHI.
- Creating and executing a mailing or e-mail with the responsive PHI.

While we allow labor costs for these limited activities, we note that as technology evolves and processes for converting and transferring files and formats become more automated, we expect labor costs to disappear or at least diminish in many

cases.

In contrast, labor for copying does not include labor costs associated with:

- Reviewing the request for access.
- Searching for, retrieving, and otherwise preparing the responsive information for copying. This includes labor to locate the appropriate designated record sets about the individual, to review the records to identify the PHI that is responsive to the request and to ensure the information relates to the correct individual, and to segregate, collect, compile, and otherwise prepare the responsive information for copying.

May a covered health care provider charge a fee under HIPAA for individuals to access the PHI that is available through the provider's EHR technology that has been certified as being capable of making the PHI accessible?

No. The HIPAA Privacy Rule at 45 CFR 164.524(c)(4) permits a covered entity to charge a reasonable, cost-based fee that covers only certain limited labor, supply, and postage costs that may apply in providing an individual with a copy of PHI in the form and format requested or agreed to by the individual. Where an individual requests or agrees to access her PHI available through the View, Download, and Transmit functionality of the CEHRT, we believe there are no labor costs and no costs for supplies to enable such access. Thus, a covered health care provider cannot charge an individual a fee when it fulfills an individual's HIPAA access request using the View, Download, and Transmit functionality of the provider's CEHRT.

May a covered entity that uses a business

associate to act on individual requests for access pass on the costs of outsourcing this function to individuals when they request copies of their PHI?

No. A covered entity may charge individuals a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary or explanation of the PHI if the individual requests a summary or explanation, and postage, if the PHI is to be mailed. See 45 CFR 164.524(c)(4). Administrative and other costs associated with outsourcing the function of responding to individual requests for access cannot be the basis for any fees charged to individuals for providing that access.

Must a covered entity inform individuals in advance of any fees that may be charged when the individuals request a copy of their PHI?

Yes. When an individual requests access to her PHI and the covered entity intends to charge the individual the limited fee permitted by the HIPAA Privacy Rule for providing the individual with a copy of her PHI, **the covered entity must inform the individual in advance of the approximate fee that may be charged for the copy.** An individual has a right to receive a copy of her PHI in the form and format and manner requested, if readily producible in that way, or as otherwise agreed to by the individual. Since the fee a covered entity is permitted to charge will vary based on the form and format and manner of access requested or agreed to by the individual, covered entities must, at the time such details are being negotiated or arranged, inform the individual of any associated fees that may impact the form and format and manner in which the individual requests or agrees to receive a copy of her PHI. The failure to provide advance notice is an unreasonable measure that may serve as a barrier to the right of access. Thus, this requirement is necessary for the right of access to operate consistent with the HIPAA Privacy Rule.

Further, covered entities should post on their web sites or otherwise make available to individuals an approximate fee schedule for regular types of access requests. In addition, if an individual requests, covered entities should provide the individual with a breakdown of the charges for labor, supplies, and postage, if applicable, that make up the total fee charged. We note that this information would likely be requested in any action taken by OCR in enforcing the individual right of access, so entities will benefit from having this information readily available.

How can covered entities calculate the limited fee that can be charged to individuals to provide them with a copy of their PHI?

The HIPAA Privacy Rule permits a covered entity to charge a reasonable, cost-based fee for individuals (or their personal representatives) to receive (or direct to a third party) a copy of the individuals' PHI. In addition to being reasonable, the fee may include only certain labor, supply, and postage costs that may apply in providing the individual with the copy in the form and format and manner requested or agreed to by the individual. A covered entity may calculate this fee in three ways.

- Actual costs. A covered entity may calculate actual labor costs to fulfill the request, as long as the labor included is only for copying (and/or creating a summary or explanation if the individual chooses to receive a summary or explanation) and the labor rates used are reasonable for such activity. The covered entity may add to the actual labor costs any applicable supply (e.g., paper, or CD or USB drive) or postage costs. Covered entities that charge individuals actual costs based on each individual access request still must be prepared to inform individuals in advance of the approximate fee that may be charged for providing the individual with a copy of her PHI. An example of an

actual labor cost calculation would be to time how long it takes for the workforce member of the covered entity (or business associate) to make and send the copy in the form and format and manner requested or agreed to by the individual and multiply the time by the reasonable hourly rate of the person copying and sending the PHI. What is reasonable for purposes of an hourly rate will vary depending on the level of skill needed to create and transmit the copy in the manner requested or agreed to by the individual (e.g., administrative level labor to make and mail a paper copy versus more technical skill needed to convert and transmit the PHI in a particular electronic format).

- Average costs. In lieu of calculating labor costs individually for each request, **a covered entity can develop a schedule of costs for labor based on average labor costs to fulfill standard types of access requests**, as long as the types of labor costs included are the ones which the Privacy Rule permits to be included in a fee (e.g., labor costs for copying but not for search and retrieval) and are reasonable. Covered entities may add to that amount any applicable supply (e.g., paper, or CD or USB drive) or postage costs.
    - This standard rate can be calculated and charged as a per page fee only in cases where the PHI requested is maintained in paper form and the individual requests a paper copy of the PHI or asks that the paper PHI be scanned into an electronic format. Per page fees are not permitted for paper or electronic copies of PHI maintained electronically. OCR is aware that per page fees in many cases have become a proxy for fees charged for all types of access requests – whether electronic or paper – and that many states with authorized fee structures have not updated their laws to account for efficiencies that exist

when generating copies of information maintained electronically. This practice has resulted in fees being charged to individuals for copies of their PHI that do not appropriately reflect the permitted labor costs associated with generating copies from information maintained in electronic form. Therefore, OCR does not consider per page fees for copies of PHI maintained electronically to be reasonable for purposes of 45 CFR 164.524(c)(4).

- Flat fee for electronic copies of PHI maintained electronically. A covered entity may charge individuals a flat fee for all standard requests for electronic copies of PHI maintained electronically, provided the fee does not exceed $6.50, inclusive of all labor, supplies, and any applicable postage.

Are costs authorized by State fee schedules permitted to be charged to individuals when providing them with a copy of their PHI under the HIPAA Privacy Rule?

No, except in cases where the State authorized costs are the same types of costs permitted under 45 CFR 164.524(c)(4) of the HIPAA Privacy Rule, and are reasonable. **The bottom line is that the costs authorized by the State must be those that are permitted by the HIPAA Privacy Rule and must be reasonable.** The HIPAA Privacy Rule at 45 CFR 164.524(c)(4) permits a covered entity to charge a reasonable, cost-based fee that covers only certain limited labor, supply, and postage costs that may apply in providing an individual with a copy of PHI in the form and format requested or agreed to by the individual. Thus, labor (e.g., for search and retrieval) or other costs not permitted by the Privacy Rule may not be charged to individuals even if authorized by State law. Further, a covered entity's fee for providing an individual with a copy of her PHI must be reasonable in addition to cost-

based, and there may be circumstances where a State authorized fee is not reasonable, even if the State authorized fee covers only permitted labor, supply, and postage costs. For example, a State-authorized fee may be higher than the covered entity's cost to provide the copy of PHI. In addition, many States with authorized fee structures have not updated their laws to account for efficiencies that exist when generating copies of information maintained electronically. Therefore, these State authorized fees for copies of PHI maintained electronically may not be reasonable for purposes of 45 CFR 164.524(c)(4).

A State law requires that a health care provider give individuals one free copy of their medical records but HIPAA permits the provider to charge a fee. Does HIPAA override the State law?

No, so the health care provider must comply with the State law and provide the one free copy. In contrast to State laws that authorize higher or different fees than are permitted under HIPAA, **HIPAA does not override those State laws that provide individuals with greater rights of access to their health information than the HIPAA Privacy Rule does**. See 45 CFR 160.202 and 160.203. This includes State laws that: (1) prohibit fees to be charged to provide individuals with copies of their PHI; or (2) allow only lesser fees than what the Privacy Rule would allow to be charged for copies.

When do the HIPAA Privacy Rule limitations on fees that can be charged for individuals to access copies of their PHI apply to disclosures of the individual's PHI to a third party?

The fee limits apply when an individual directs a covered entity to send the PHI to the third party. Under the HIPAA Privacy Rule, a covered entity is prohibited from charging an individual who has requested a copy of her PHI more than a reasonable, cost-based fee for the copy that covers only certain labor, supply, and postage costs that may apply in

fulfilling the request. See 45 CFR 164.524(c)(4). This limitation applies regardless of whether the individual has requested that the copy of PHI be sent to herself, or has directed that the covered entity send the copy directly to a third party designated by the individual (and it doesn't matter who the third party is). To direct a copy to a third party, the individual's access request must be in writing, signed by the individual, and clearly identify the designated person or entity and where to send the PHI. See 45 CFR 164.524(c)(3)(ii). Thus, written access requests by individuals to have a copy of their PHI sent to a third party that include these minimal elements are subject to the same fee limitations in the Privacy Rule that apply to requests by individuals to have a copy of their PHI sent to themselves. This is true regardless of whether the access request was submitted to the covered entity by the individual directly or forwarded to the covered entity by a third party on behalf and at the direction of the individual (such as by an app being used by the individual). Further, these same limitations apply when the individual's personal representative, rather than the individual herself, has made the request to send a copy of the individual's PHI to a third party.

In contrast, third parties often will directly request PHI from a covered entity and submit a written HIPAA authorization from the individual (or rely on another permission in the Privacy Rule) for that disclosure. Where the third party is initiating a request for PHI on its own behalf, with the individual's HIPAA authorization (or pursuant to another permissible disclosure provision in the Privacy Rule), the access fee limitations do not apply. However, as described above, where the third party is forwarding – on behalf and at the direction of the individual – the individual's access request for a covered entity to direct a copy of the individual's PHI to the third party, the fee limitations apply.

We note that a covered entity (or a business associate) may not circumvent the access fee limitations by treating individual requests for access like other HIPAA disclosures – such as by having an individual fill out a HIPAA authorization when the individual requests access to her PHI (including to direct a copy of the PHI to a third party). As explained elsewhere in the guidance, a HIPAA authorization is not required for individuals to request access to their PHI, including to direct a copy to a third party – and because a HIPAA authorization requests more information than is necessary or that may not be relevant for individuals to exercise their access rights, requiring execution of a HIPAA authorization may create impermissible obstacles to the exercise of this right. Where it is unclear to a covered entity, based on the form of a request sent by a third party, whether the request is an access request initiated by the individual or merely a HIPAA authorization by the individual to disclose PHI to the third party, the entity may clarify with the individual whether the request was a direction from the individual or a request from the third party. OCR is open to engaging with the community on ways that technology could easily convey this information.

Finally, we note that disclosures to a third party made outside of the right of access under other provisions of the Privacy Rule still may be subject to the prohibition against sales of PHI (i.e., the prohibition against receiving remuneration for a disclosure of PHI at 45 CFR 164.502(a)(5)(ii)). Where the prohibition applies, a covered entity may charge only a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI or a fee otherwise expressly permitted by other law or must have received a HIPAA authorization from the individual that states that the disclosure will involve remuneration to the covered entity.

May a health care provider withhold a copy of an

individual's PHI from the individual who requested it because the covered entity used the individual's payment of the allowable fee for the copy to instead pay an outstanding bill for health care services provided to the individual?

No. Just as a covered entity may not withhold or deny an individual access to his PHI on the grounds that the individual has not paid the bill for health care services the covered entity provided to the individual, a covered entity may not withhold or deny access on the grounds that the covered entity used the individual's payment of the fee for a copy of his PHI to offset or pay the individual's outstanding bill for health care services.

Can an individual be charged a fee if the individual requests only to inspect her PHI at the covered entity (i.e., does not request that the covered entity produce a copy of the PHI)?

No. The fees that can be charged to individuals exercising their right of access to their PHI apply only in cases where the individual is to receive a copy of the PHI, versus merely being provided the opportunity to view and inspect the PHI. The HIPAA Privacy Rule provides individuals with the right to inspect their PHI held in a designated record set, either in addition to obtaining copies or in lieu thereof, and requires covered entities to arrange with the individual for a convenient time and place to inspect the PHI. See 45 CFR 164.524(c)(1) and (c)(2). Consequently, covered entities should have in place reasonable procedures to enable individuals to inspect their PHI, and requests for inspection should trigger minimal additional effort by the entity, particularly where the PHI requested is of the type easily accessed onsite by the entity itself in the ordinary course of business. For example, covered entities could use the capabilities of Certified EHR Technology (CEHRT) to enable

individuals to inspect their PHI, if the individuals agree to the use of this functionality.

Further, a covered entity may not charge an individual who, while inspecting her PHI, takes notes, uses a smart phone or other device to take pictures of the PHI, or uses other personal resources to capture the information. If the individual is making the copies of PHI using her own resources, the covered entity may not charge a fee for those copies, as the copying is being done by the individual and not the entity. A covered entity may establish reasonable policies and safeguards regarding an individual's use of her own camera or other device for copying PHI to assure that equipment or technology used by the individual is not disruptive to the entity's operations and is used in a way that enables the individual to copy or otherwise memorialize only the records to which she is entitled. Further, a covered entity is not required to allow the individual to connect a personal device to the covered entity's systems.

More information is available **here.**

Solo and Small Medical Practices Benefit from New Manage My Practice and The Billing Department Partnership

Durham, NorthCarolina and Falmouth, Maine: Today, Manage My Practice, LLC, a full-service consulting firm specializing in services to solo and small medical practices and The Billing Department, Inc., a company that provides revenue cycle management services to healthcare providers, announced a partnership to offer practice consulting, coding, medical billing and a range of other services to physicians and other healthcare providers nationally.

Of the decision to form a partnership to jointly provide high-quality coding and billing services, Mary Pat Whaley, founder and president of Manage My Practice said “I’ve been recommending The Billing Department to my clients for several years and they report back to me that The Billing Department’s services are always exceptional. It seemed a natural step that The Billing Department and Manage My Practice collaborate to offer a wider range of services together.”

Vanessa Higgins, founder and president of The Billing Department stated " Manage My Practice is well-established as the premier consulting company specializing in solo and small medical practices in the United States today. It is a thrill to be able to partner with such a well-respected company to serve an often-overlooked market such as solo physicians and other small practice healthcare providers."

Among the services the new partnership will offer are:

- New Practice Start-up
- End-to-end Revenue Cycle Management including Credit Card on File implementation
- Consulting on medical practice organizational and operational issues
- Professional Coding and Clinical Documentation Improvement for primary care and other specialties

About Manage My Practice: Mary Pat Whaley, FACMPE, CPC, founder and president of Manage My Practice, LLC, has 30+ years managing physician practices of all sizes and specialties in the private and public sectors In addition to her Board Certification in Medical Practice Management, she is also a Certified Professional Coder and a Fellow in the American College of Medical Practice Executives. Her company, Manage My Practice, LLC, a full-service practice management consulting firm, has assisted practices nationally and internationally since 2008.

About the Billing Department: Established in 1999, The Billing Department, Inc. has steadily grown. Providing practice and revenue cycle management services for healthcare providers nationwide, The Billing Department offers a fully-integrated, end-to-end solution which simplifies every step of the revenue cycle management process – from the initial scheduling of an appointment to the cumbersome billing process following each patient visit. The company's ultimate goal is to reduce the expenses and increase the income of their clients.

Mary Pat Whaley, FACMPE, CPC

Manage My Practice

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(919) 370-0504

Vanessa Higgins

The Billing Department

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10 Books Every New Medical Practice Manager Should Read

Daniel Pink recently published a list of 10 books every new manager should read. I'd like to spin his list into my own 10 books that I recommend for all new healthcare managers.

Dan's pick #1: 'Drive' by Daniel H. Pink

I agree with his description:

> *In this best-selling business book, Pink explains why, contrary to popular belief, extrinsic incentives like money aren't the best way to motivate high performance. Instead, employers should focus on cultivating in their workers a sense of autonomy, mastery, and purpose in order to help them succeed.*

I have always felt that as a manager, my job is to make sure employees succeed, not look for the ways in which they fail.

Dan's Pick #2: 'The One Thing You Need to Know' by Marcus Buckingham

I've not read this book, but I would replace it with my all-time recommendation **'The One Minute Manager' by Ken Blanchard.** I have given this book to scores of people that I've worked with over the years and I recommend it because it introduces you to the seminal concept of

> *"Praise immediately in public, critique later in private."*

I do agree on capitalizing on individual's greatest strengths, but especially in small offices, one does not have the ability to craft jobs or tasks that play to one's individual strengths. You can certainly search for those strengths during the recruiting phase, understanding what qualities often are reflected in those that are good at the front desk, in the exam room, etc.

Dan's Pick #3: 'Thinking, Fast and Slow' by Daniel Kahneman

I had never heard of this book, but now I am anxious to read it. It sounds like it covers things I had to learn along the way, the hard way. Pink says:

> *Kahneman, a psychologist who won the Nobel Prize in economics, breaks down all of human thought into two systems: the fast and intuitive "System 1" and the slow and deliberate "System 2." Using this framework, he lays out a number of cognitive biases that affect our everyday behavior, from the halo effect to the planning fallacy.*

Dan's Pick #4: 'Act Like a Leader, Think Like a Leader' by Herminia Ibarra

Right away I have to say that I was turned off by the notion that you can be too authentic at work,. Authenticity can be much more of a problem for women than for men. Dan says:

> *For example, Ibarra, a professor at business school INSEAD, suggests leaders act first and then think, so that they learn from experimentation and direct experience. There's even an entire chapter devoted to the dangers of being too authentic at work.*

Being authentic doesn't mean wearing your emotions on your sleeve, or making all employees best friends. It does mean being the same person at work that you are at home. See my blog post **"Should (Female Leaders Cry at Work?"**

Try **'Lean In: Women, Work and the Will to Lead' by Sheryl Sandberg.** Even if you're a man.

Dan's Pick #5: 'How to Win Friends and Influence People' by Dale Carnegie

Couldn't agree more! This is a classic and there's a reason it's a classic – it is a book that not just all healthcare managers should read, it's a book that all humans should read. In case you can't find the time or justification to read HTWF&IP, my mother-in-law's homespun synopsis of the book is "You enter a room and say hello to everybody." Got it?

Dan's Pick #6: 'Mindset' by Carol Dweck

This is another book that had not crossed my path before, but one that sounds similar to #2, only applied to oneself. I would substitute **'Blink: The Power of Thinking Without Thinking' by Malcolm Gladwell** for a slightly different take on listening to oneself to bolster confidence and self-learning. Actually, I recommend every one of Malcolm Gladwell's books for a good read with powerful insights.

Dan's Pick #7: 'Meditations' by Marcus Aurelius and Gregory Hays

To bring things into the 21st century, I suggest **'Good Boss, Bad Boss: How to Be the Best…and Learn from the Worst'**. Author Bob Sutton is a hero of mine, if only because he had the chutzpah to write **'The No Asshole Rule'**, which I live by in my business. One of the foundations of my consulting firm is that I don't work with mean people. I've had to fire a few (clients) along the way, but not many.

Dan's Pick #8: 'Things Fall Apart' by Chinua Achebe

If you didn't cover this book in graduate school, or didn't go to graduate school, pick up **'Crossing the Quality Chasm: A New Health System for the 21st Century'**. It's the book that changed the way we all look at healthcare and it's good background reading for where we are today.

Dan's Pick #9: 'Now, Discover Your

Strengths’ by Marcus Buckingham and Donald O. Clifton

Seems similar to Pick #2.

Dan’s Pick #10: ‘Good to Great’ by Jim Collins

Yes, and yes.

READERS: What books would you recommend to a new manager in healthcare?