New Guidelines for Insurance Payments Benefit Physicians

VCC may sound like new college basketball conference, but it's actually a term that could be adversely affecting your practice's revenue without your knowledge. Moreover, there's now something you can do about it.

First, let's define the term. The acronym, VCC, stands for "virtual credit card." Essentially payment cards, virtual credit cards are temporary, typically single-use, time-bound, computer-generated cards. The "card" is not a physical document per se, it's a series of data -- each has its own unique card number, expiration date, and CVV number. They are increasingly used for financial transactions, as they avoid the natural fraud and abuse that occurs when a physical card gets into the wrong hands.

Although VCCs have merit for payment transactions, they have created a significant issue for medical practices. Financial technology companies – fintech, for short – sell the cards to health insurance companies who use them to generate payments. Instead of the insurance company having to manage the financial transactions, the payment processing is passed onto the fintech company. And guess who pays for the security and convenience of

the new financial transaction? You do. The fee is passed on to the *payee*, and most often, you agreed to it when you accepted electronic funds transfer in your participation agreement with the insurer. Although the fees typically range from 1 to 3%, they can have an impact on your bottom line.

An equally challenging impact is the fact that a third-party now involved – the fintech company being paid to process the payments. It's not uncommon for the payment to be separated from the information about the payment, which is necessary to associate the payment with the correct guarantor. This so-called "reassociation" is crucial for effective and efficient revenue cycle management. When payments and associated information get out of sync, havoc in the business office reigns.

After years of suffering from these largely unknown fees, physicians finally received good news from the Centers for Medicare & Medicaid Services (CMS) in March. CMS issued guidance that an insurer cannot require physicians to receive EFT payments or reassociation services from its selected fintech vendor. However, the onus is on the medical practice to communicate with the insurance company.

A practice may request a health plan to comply with national standards for electronic payment transactions. This includes the required one-to-one matching of funds to transaction information.

The health plan may not force practices to use their business associate (the so-called fintech company that is processing payments) in order to receive payments.

The new guidelines extend the requirements to all health plans, whether you are a participating provider – or not.

CMS has issued a complaint portal should you find that your health plans are not in compliance.

A good place to start may be reviewing the guidance from CMS. Then, set up a meeting with your biller or business office team; ask them about the remittance process regarding insurance payments. Do they have trouble matching associated payments with patients' services? (A warning sign may be a high number of credits, as those often indicate that there were payments – but problems applying them.) Are fees being taken out by your health plans for payment processing? (Look at your remittances, as they are often poorly marked – no one wants you to see that fees are being applied.)

The new CMS guidelines take some time to review, but avoiding these fees pays off in the long run.

Tracking Referrals & Consultations

A frequently asked question when referrals are made is, *"What is my duty as the referring physician to ensure that the patient keeps his/her appointment with the consultant?"* Many physicians do a good job of tracking labs and diagnostic tests, but they do not think about tracking appointment cancellations, no-shows, consultations, or referrals. **Tracking the receipt of lab and diagnostic tests is not enough.** If a test result indicates the need for further follow up with a specialist, you should have a tracking system in place to alert you if the patient fails to keep a scheduled or recommend referral or consultation. A physician's duty to a patient may not be discharged just by referring the patient or making an appointment. Although patients are expected to take responsibility for managing their healthcare, physicians are expected to play a part in ensuring that patients get appropriate care; your medical training gives you a better understanding of the consequences of various treatment options as well as the consequences of delaying treatment. It is important that you have an informed consent discussion with the patient outlining the significance of the findings, why you are referring the patient, and the possible consequences of not following up. Be sure to inform the patient of the risks, benefits, and alternatives if the referral is for a particular test or procedure. Always document your

rationale for the referral and document your conversations with the patient.

A standardized form of communication, such as a referral request form, will help consultants provide appropriate care for your patients and keep you in the loop, making the process run smoothly for everyone. Including your patient in the process is another safety net in the event one of the other systems fail. SVMIC has a sample Request For Consultation form that may be useful to your practice when requesting a consultation from a specialist. Your request should include the following information:

- patient's name
- date of birth
- reason for consultation
- the degree of urgency
- pertinent history
- any specific requests
- whether you wish to transfer the patient's care

It's important to select a specialist with the appropriate skills and training to care for your patient's condition. Always inform the specialist of any special circumstances involving the patient and send the appropriate medical records. In all instances, clarify the role of each physician in the patient's care. If the referral is urgent or the condition is serious, a phone call to the physician is indicated. Have your office staff schedule the appointment before the patient leaves your office, which will dramatically increase the likelihood of patient compliance.

Once a referral is made, it should be tracked utilizing the same system you use to track a lab or diagnostic test result. If you learn the patient has not kept the appointment, have your office call or send a letter noting your concern and emphasizing the importance of the consult. Depending on the severity of the issue, a certified letter may be necessary to document your attempt. On the other hand, if you determine the consult is no longer necessary, document your reasons for the change in opinion. Finally, train all staff not to file any reports, including consultation reports or letters, without the physician's review and signature.

Clarifying Communication

“The single biggest problem with communication is the illusion that it has taken place.”
– George Bernard Shaw

A recurring theme in SVMIC newsletters, seminars, etc. is the importance of effective communication. The emphasis is often centered around communicating with patients, but there are other situations in which the importance of communication should be emphasized – these are when healthcare providers are communicating with each other. The following closed case is an example in which more detailed communications would have better served the patient.

A 76-year-old male patient presented to the hospital to undergo right ankle fusion surgery. The patient’s medical history was significant for a stroke with right-sided weakness, peripheral vascular disease with stents to the common iliac and peroneal arteries, and an injury to his ankle while playing college basketball. He had difficulty walking over the years and used a brace on his right ankle. The patient also had a history of prostate cancer, nerve damage from prostate surgery, and urinary incontinence. A robotic urinary control system had been implanted four years earlier to address his urinary incontinence.

The patient was discharged from the hospital to a rehabilitation center a few days after the ankle surgery. The discharge instructions included, “Non weight bearing to right lower extremity. Foley catheter should stay in place until he is able to stand on left leg to use robotic bladder device.” (You will recall that the patient’s surgery was on his right ankle.) The rehabilitation center’s chart contained a telephone nursing note regarding the patient’s admission that was slightly different. The note said, “Robotic urinary device must be weight bearing before F/C comes out.” A note made by another nurse at the rehabilitation center said, “Res has indwelling robotic urinary device that will be utilized when res can stand and bear weight.” The chart included an apparent verbal order a few days later from a nurse practitioner to an LPN stating, “FC to stay in place until res is wt. bearing. Res has urinary control system in place.” The patient was discharged from the rehabilitation center about a month after admission. A discharge order from a physician included the entry, “SN may take out Foley cath with next visit.” A home health nurse visited the patient 5 days later and attempted to remove the Foley catheter but was unsuccessful. A cystourethroscopy was performed, and it showed the patient had a complete erosion of the artificial urinary sphincter cuff into the distal urethra bladder. The artificial urinary sphincter was removed, and the erosion site was repaired. Another artificial urinary sphincter was placed a few weeks later.

A lawsuit was filed by the patient against the rehabilitation center, the nurse practitioner who gave the verbal order to the LPN, and the nurse practitioner’s supervising physician. The patient alleged the defendants failed to properly read and interpret the order from the physician who discharged the patient from the hospital to the rehabilitation center. The lawsuit asserted that the discharge order specifically stated that the Foley catheter should stay in place until the patient was able to stand on his left leg to use the robotic bladder device. The lawsuit further stated that the patient was able to stand on his left leg and use the robotic device for urine control purposes at or soon after his admission to the rehabilitation center. The lawsuit alleged that the nurse practitioner improperly interpreted this order to mean that the Foley catheter was to stay in place until the patient was weight bearing on his surgically repaired right leg, which he was not able to do until his discharge from the rehabilitation center about a month after the ankle surgery. As a result, the Foley catheter remained in place for an extended period of time and resulted in calcification and increased pressure inside the urethra, causing a urethral erosion, which then caused his robotic bladder device to fail.

The rehabilitation center settled out of the case, and the supervising physician was voluntarily dismissed by the patient, leaving the nurse practitioner as the only defendant to go to trial. Although the nurse practitioner had expert witnesses who were supportive of her care, the defense of the case was difficult based on the difference in the language used in the discharge instruction and the nurses’ notes regarding the Foley catheter. To repeat, the discharge instruction stated, “Foley Catheter should stay in place until he is able to stand on left leg to use robotic bladder device,” while one nurse’s note said, “FC to stay until res is weight bearing res has a urinary control system in place,” and the other nurse’s note said, “Res has indwelling robotic urinary device that will be utilized when res can stand & bear weight.” It is apparent that at some point, the understanding of the order was

changed from taking the catheter out when the patient could bear weight on his left (non-operative) leg to taking the catheter out when he could bear weight on both legs. Better communication, or clarification, between the healthcare providers in this case would have likely led to an earlier removal of the Foley catheter with a better outcome for the patient. The litigation may have been avoided completely if the discharge instructions from the hospital had been clarified by a subsequent provider.

This case was tried over four days, and the jury returned an unusual, but not unheard of, verdict. The jury found that the nurse practitioner had deviated from the standard of care in her treatment of the patient, but also found that the treatment was not a substantial factor in causing an injury to the patient. There was competing expert testimony regarding when the urethral erosion likely occurred. In a medical malpractice case, it is not enough for the patient to prove that the defendant deviated from the standard of care, but the patient must also prove that the defendant's treatment was a substantial factor in causing an injury to the patient. It isn't very often that a defendant is found to have deviated from the standard of care and still wins the case, but it does happen from time to time, and that is what happened in this case. The jury determined the patient was not entitled to any damages, and the case was dismissed without any payment being made to the patient.

The lesson learned from this case is to ask for clarification. If something about an order seems odd or amiss, it is incumbent upon the healthcare provider to seek clarification from the physician or practitioner who issued the order. In this case, simply seeking clarification would have avoided the patient's injuries and the subsequent lawsuit.

Intersections of the ONC Information Blocking Rule and the HIPAA Privacy Rule May Create Overlapping Obligations

Health Information Accessibility, Interoperability, and Information Blocking

While there were likely earlier efforts, the policy of increasing health information exchangeability and system interoperability was stated over 25 years ago in the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among the stated goals of the legislation was the implementation of standards to enable the efficient electronic exchange of health information, "consistent with the goals of improving the operation of the health care system and reducing administrative cost."[1] While these expressed goals were oriented more toward the financial aspects of the health care system, namely health insurance claim processing and health plan administration, the HIPAA legislation also specifically directed the Secretary of the United States Department

of Health and Human Services (HHS) to "study the issues related to the adoption of uniform data standards for patient medical record information and the electronic exchange of such information."[2]

Twenty years following the enactment of HIPAA, the 21st Century Cures Act was passed in 2016. The concepts set forth in the legislation concerning information exchanges and interoperability were not new. In many ways, the legislation was the next step toward increasing health information accessibility for patients and health care providers. Accordingly, the legislation provides for penalties for unreasonable impediments to information access, specifically, if operational practices are "likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information." [3] This impediment to information access, use and exchange is known as "information blocking." The law directed appropriate HHS agencies to "identify reasonable and necessary activities that do not constitute information blocking."[4]

On May 1, 2020, the HHS Office of the National Coordinator for Health Information Technology (ONC) issued its final rule on information blocking (the "Information Blocking Rule"). The American Medical Association's informational material on the regulation summarizes the definition of information blocking as:

> "[B]usiness, technical, and organizational practices that prevent or materially discourage the access, exchange or use of **electronic health information** (EHI) when an **Actor knows**, or (for some Actors like EHR vendors) **should know**, that these practices are **likely** to interfere with **access, exchange, or use** of **EHI**. If conducted by a health care provider, there must also be **knowledge that such practice is unreasonable** and likely to interfere with, prevent, or materially discourage access, exchange, or use of EHI."[5]

Among other individuals and entities, an "actor" under the Information Blocking Rule specifically includes "a health care provider."[6]

The AMA guidance material provides examples of specific circumstances when information blocking may occur: "Physicians can experience [information] blocking when trying to access patient records from other providers . . . [and] [p]atients can also experience [information] blocking when trying to access their medical records or when sending their records to another provider."[7] While there are many other aspects of the ONC's Information Blocking Rule, these two scenarios are the focus of the discussion below. The Information Blocking Rule specifically incorporates aspects of the HIPAA Privacy Rule, and as a result, an understanding of relevant provisions of the two regulations is required for effectuating compliance with both.

The Patient's Right to Access and Disclosures of PHI for Treatment Purposes under HIPAA

With relatively few exceptions, under the HIPAA Privacy Rule, patients or their proper personal representative, such as a parent of a minor patient, have a legally enforceable right to see and receive protected health information (PHI) in their "designated record set."[8] A HIPAA covered entity, such as a medical practice, may require a patient to make a request for access in writing, including on the group's own form, so long as patients are informed, perhaps in the group's notice of privacy practices, of the requirement for a written request. Relatedly, while covered entities must take reasonable steps to verify the identity of an individual making a request for access to PHI, the verification process cannot create barriers or unreasonable delays in obtaining access to PHI. If an access request is required to be made in writing, the form itself, or the process—including identity verification— for submitting the form, cannot impose unreasonable barriers on patients requesting access to their PHI. HHS has provided examples of what it deems to constitute unreasonable requirements. A medical practice may not require a patient, or their personal representative:

- Who wants a copy of her medical record mailed to her home address to physically come to the doctor's office to request access and provide proof of identity in person.
- To use a web portal for requesting access, as not all individuals will have ready access to the portal.
- To mail an access request, as this would unreasonably delay the covered entity's receipt of the request and thus, the individual's access." **[9]**

While, in many cases, a patient may request access to their information to provide records to another provider themselves, no authorization is required for a provider to send a patient's PHI directly to another healthcare provider for the purposes of providing treatment.[10] One example provided by HHS of a disclosure for treatment purposes is a "primary care provider may send a copy of an individual's medical record to a specialist who needs the information to treat the individual."[11] Provided such a disclosure is made for the purpose of providing treatment to an individual, such a disclosure may be made without obtaining authorization[12] from the patient.

The Intersection of HIPAA and the Information Blocking Rule

The Information Blocking Rule specifically incorporates the HIPAA Privacy Rule in many aspects, including its scope of applicability. As an initial matter, the Information Blocking Rule regulates electronic health information (EHI). The Information Blocking Rule states, "EHI is defined as the electronic protected health information (ePHI) in a designated record set (as defined in the Health Insurance Portability and Accountability Act (HIPAA) regulations) regardless of whether the records are used or maintained by or for a covered entity."[13] Like the HIPAA Privacy Rule, there are numerous exceptions to the provision of access under the Information Blocking Rule including preventing harm to a patient or another person and privacy protection.[14] Unlike the HIPAA Privacy Rule, however, which generally prohibits the disclosure of PHI unless permitted otherwise, the Information Blocking Rule requires the provision of unimpeded access to EHI unless an exception applies. In general, if a patient is entitled to access of PHI under HIPAA, the patient is

likely entitled to unimpeded access to EHI under the Information Blocking Rule. Similarly, if PHI may be used or disclosed for treatment purposes without patient authorization under the Privacy Rule, the same EHI is likely subject to the Information Blocking Rule as to other providers who need access to the information.

Considering the regulatory overlap of the HIPAA Privacy Rule and the ONC Information Blocking Rule, while certain regulatory defenses may be available in the future to health care provider actors that are not available to other entities covered by the Information Blocking Rule, a covered actor may violate both the HIPAA Privacy Rule provisions pertaining to patient access and the ONC rule pertaining to information blocking.

An everyday scenario that may implicate both the Privacy Rule and Information Blocking Rule is the provision of PHI/EHI to other providers for treatment purposes. Many medical groups request new patients sign or initial a document, which is typically in the form of a consent, expressly providing an acknowledgement of patient's permission to disclose PHI for treatment purposes. As addressed above, the HIPAA Privacy Rule specifically states that a covered entity "may obtain consent of the individual to use or disclose protected health information to carry out treatment," medical groups should make the distinction between consent and a disclosure authorization. The distinction becomes significant if a medical practice's procedure for requiring patient involvement for permissible disclosures for treatment purposes results in conduct a provider knows "is unreasonable and is likely to interfere with access, exchange, or use of electronic health information."[15] For example, it is unnecessary for a practice to require a patient to complete, sign, and return a disclosure authorization prior to every disclosure for treatment purposes. Such a practice could constitute impermissible EHI blocking under the Information Blocking Rule, and perhaps, if the patient had also requested the information, an unreasonable barrier to patient access to their PHI. While obtaining a patient's written consent for disclosure of PHI for treatment (and payment) purposes on new patient registration forms may help confirm patient understanding of permissible disclosures, medical practices should re-evaluate their procedures for requiring additional patient involvement for disclosures for treatment purposes or when patients have requested access to their own records.

Health information technology has been rapidly evolving in physician practices for well over a decade. After many years of inaction, federal regulations are catching up toward the goal of facilitating information exchangeability and system interoperability. It is important that physician practices understand their obligations under these regulations as they pertain to the use of their electronic health record systems. Practices should review existing procedures, and, as necessary, implement new or revised proper procedures to avoid problems such as the scenario above.[16] While enforcement of the Information Blocking Rule as to health care providers has yet to begin, as patients increasingly have and expect immediate access to their health information, especially in electronic form, providers are at an increased risk of patient complaints and related risks.

[1]. Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, § 262, 110 Stat. 1936, 2025.

[2]. Id. § 263 at 2032.

[3]. 21st Century Cures Act, Pub. L. No. 114-255, § 4004 (2016) (codified as 42 U.S.C § 300jj-52 (a)(1)).

[4]. Id. (codified as 42 U.S.C § 300jj-52 (a)(3)).

[5]. American Medical Association, "What is information blocking?" at 1, https://www.ama-assn.org/system/files/2021-01/information-blocking-part-1.pdf

[6]. 45 C.F.R. § 171.102.

[7]. "What is information blocking?" at 1.

[8]. The definition of a "designated record set" is stated in the HIPAA Privacy Rule. 45 C.F.R. § 164.501.

[9]. HHS, Individuals' Right under HIPAA to Access their Health Information 45 C.F.R. § 164.524, https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html.

[10]. A patient's request for a provider to send a copy of the patient's PHI to a third party is likely to be deemed an access request. While these requests are required to be in writing, signed by the individual, and clearly identify the designated person or entity and location where the PHI is to be sent, similar considerations apply to minimizing barriers for honoring these requests. This is situation different, however, from a third party requesting the PHI using a HIPAA compliant disclosure authorization signed by the patient.

[11]. HHS, Uses and Disclosures for Treatment, Payment, and Health Care Operations, https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html.

[12]. Of note, there is a legal distinction between a patient's consent, which may, but is not required to be, obtained and a valid HIPAA disclosure authorization. As stated by HHS, "A 'consent' document is ***not*** a valid permission to use or disclose protected health information for a purpose that requires an 'authorization' under the Privacy Rule . . ., or where other requirements or conditions exist under the [Privacy] Rule for the use or disclosure of protected health information" Id. (emphasis added). Relatedly, providers must be aware whether a patient has requested, and the practice has agreed, to place restrictions on disclosure of PHI, which would prevent disclosures, even for treatment purposes, except in the case of an emergency.

[13]. 45 C.F.R. § 171.103(a)(3).

[14]. A summary discussion of the exemptions is provided by ONC. https://www.healthit.gov/curesrule/final-rule-policy/information-blocking.

[15]. 45 C.F.R. § 171.103(a)(3).

[16]. The Information Blocking Rule contains specific provisions which contemplate the existence of relevant written policicies and procedures. See 45 C.F.R. § 171.202(b).
