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Health IT

Medicare MOVEit breach a warning of persistent cyber-danger; watch impact

A data breach at a Medicare subcontractor is bad news for affected beneficiaries — and a warning to practices that downstream providers may also be putting their files in danger.

A July 28 press release from HHS and CMS announced that they had "responded" to a "May 2023 data breach Progress Software's MOVEit Transfer software on the corporate network of Maximus Federal Services, Inc. (Maximus), a contractor to the Medicare program, that involved Medicare beneficiaries' personally identifiable information (PII) and/or protected health information (PHI)."

This Maximus incident is only part of a massive breach suffered by file transfer producer MOVEit, consequences of which are still rolling out. Some of the victims are health care entities, such as Colorado's Medicaid administration, whose breach potentially exposed the data of 4 million beneficiaries; some are education entities such as the New York City Department of Education and UCLA; other are corporations such as Siemens.

Avery A. Dial, chair of the Data Privacy & Cybersecurity Practice Group at Kaufman Dolowich LLP in Fort Lauderdale, Fla., notes one ominous aspect of the MOVEit breach: while its total market share isn't huge, "it does have almost 100% of federal civilian agencies and U.S. military agencies."

Maximus is a qualified independent contractor (QIC), a type of contractor that usually handles Medicare appeals at the reconsideration or second level. HHS believes the breach has affected 612,000 current Medicare beneficiaries.

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HHS has sent a letter to affected beneficiaries offering "free-of-charge credit monitoring services for 24 months" and a free credit report, and, since their Medicare Beneficiary Identifier number may have been impacted, a new Medicare card with a new number.

Brace for downstream effects

It would be bad enough if this only affected the beneficiaries HHS identified, but modern cybercrime can reach backward and forward within systems if security is lax — and affected parties may not learn they've been hacked until months later (*PBN 1/23/23*).

Data security expert Robert Siciliano, co-founder and head of training for security firm Protect Now in Boston, stresses that you can't be sure whether the breach extended further than admitted; sometimes cybercriminals take months to pull the trigger on such exploits.

"If the only data at risk was that which was appealed, then no, patients whose records were not involved in appeals would not be involved," Siciliano says. "However, it all boils down to how the QIC managed and stored records on their server."

"It's highly unlikely that the initial number [612,000] is accurate," says Dan Kraciun, chief marketing officer, VP operations for Trust.med in Cleveland. "In many cases, it's not until months, even years later that we can fully understand the system impacts and the amount of compromised data [in a breach]."

Dial says the Maximus breach, and the other MOVEit breaches, are well known enough that most IT departments have made patches that should fix the vulnerability. Experts say that if you haven't, or haven't done testing to see whether you've been breached, you should do that right away.

How to stay compliant

You should be practicing advanced cybersecurity regardless, and you also need to make sure that the MOVEit breach isn't affecting you from other venues.

Alisa Chestler, chair of the Data Protection, Privacy and Cybersecurity Team at Baker Donelson in Nashville, encourages vendors "to ask questions affirmatively of their own vendors rather than just waiting to hear if one of their vendors had the problem." If a provider doesn't use MOVEit, she says, "maybe their billing company uses it to move files. And how do they get files to the HIEs — the health information exchanges? They need to be thinking about the larger picture."

You could write a letter to these vendors, Chestler says, but the main thing is to make sure you keep a record of your efforts. "If they have a person who is assigned security responsibility, having that person identify at least the highly likely places to be looking [for a breach interface] — say, a revenue cycle manager — they should be asking, whether via email or phone call … for assurances that MOVEit was not used [on their files] or, if it was used, why they feel that it was not a problem. Then they just document that."

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What to tell patients

Some panic-stricken patients may come to you for advice, given the widespread news coverage this breach has received. (One such headline, from WSB-TV in Georgia: "No — this is not a scam! GA Medicare beneficiaries are receiving letters about info breach.")

If they do, Siciliano advises that you direct patients to the CMS press release, which he says "spells out what the physician should communicate as well."

Siciliano suggests having a pre-printed copy of the release available to any patient who asks, as this "would negate the physician's responsibility or liability, and put the onus of responsibility on the patient who's affected. Specifically, the 'What Can You Do?' section is really what the physician should recommend."

"Until people receive more information, it would be premature for them to be guessing" as to what advice to give patients, Chestler says. "You don't want to misrepresent it. You don't want to say, 'don't worry, you're not affected,' only to find out later they might be."

Kraciun, however, thinks you might give them a little help at least with a "concise bullet-point summary."

"It's not safe to assume the [beneficiary letter] is sufficient," Kraciun says. "The audience impacted is older and the notification can be hard for them to interpret. Also caregivers have a closer relationship with patients [than CMS] and the ability to communicate with them at a deeper level."

Kraciun also suggests that you warn patients whose records are among those affected and who plan to apply for a new Medicare number that the public announcement "opens the door for bad actors looking — as they would be during tax season — for [mail containing] these [cards with new] identifiers because they know they'll be going out."

As for providers, they might think about whether the constant fight against cybercriminals is something they can continue to handle alone.

"I think this is one reason that a lot of the provider practices are rolling up [to private equity and other owners]," Chestler says (*PBN 6/14/21*). "It's very expensive and outside of their area of expertise to do all these security controls. When you're asking practices to basically do the same thing as a large hospital system in terms of securing information, that's hard — it's hard enough for the hospitals!" — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCES

- CMS press release, "CMS Responding to Data Breach at Contractor," July 28, 2023: *www.cms.gov/newsroom/press-releases/cms-responding-data-breach-contractor*
- WSB-TV, "No — this is not a scam! GA Medicare beneficiaries are receiving letters about info breach," Aug. 7, 2023: www.wsbtv.com/news/local/henry-county/ga-medicare-beneficiaries-are-receiving-letters-about-info-breach-no-this-is-not-scam/5OBAJ4IQW5H5TC4P5Z32HR3ULI/

Compliance

DEA prescribers should start MATE prep before their next renewal date

Make sure clinicians who prescribe controlled substances complete the eight hours of training required by the Medication Access and Training Expansion (MATE) Act. Effective June 27, all prescribing clinicians who are registered with the Drug Enforcement Administration (DEA) must attest that they completed the training when they renew their registration or apply for the first time.

While providers may not welcome the idea of another training requirement, there is some good news. They only have to train and attest once, they might have already completed the training and, if they haven't, there are a variety of ways to get the task done.

Here's how MATE emerged

The MATE Act was included in the Consolidated Appropriations Act of 2023 (CAA 2023) and is designed to increase the number of providers who can screen, diagnose and treat patients who have substance use disorders (SUD), such as opioid use disorder (OUD).

A spokesperson for the American Society of Addiction Medicine cited a passage from the RAND Corporation to explain why this will benefit patients. In the synopsis for the study State Policies Requiring Education for Buprenorphine Prescribers Boosts Use of Opioid Use Disorder Treatment, Bradley Stein, the study's lead author and a physician scientist at RAND noted that "our findings suggest that requiring education for buprenorphine prescribers and training in substance use disorder treatment for medical providers

are actionable proposals for increasing buprenorphine utilization and ultimately serving more patients."

"What the MATE Act did was eliminate the need for a special DEA waiver in the form of an X Number, which was added to your existing DEA registration, and which then enabled practitioners to prescribe certain approved FDA medications to treat OUD," says Ron Friedman, an attorney who specializes in DEA matters, Karr Tuttle Campbell, Seattle.

Friedman went on to explain that providers had to receive eight hours of training to get the X-number, and there were limits on the number of patients a provider could treat. The MATE Act eliminated the special waiver, which was called a Data waiver or an X waiver, and the patient limits. "But you still had to complete or have already completed an eight-hour training requirement, which can be satisfied in a number of ways," Friedman says.

The training will expand "the number of practitioners eligible to treat opioid use disorder across this country to nearly two million," said DEA Administrator Anne Milgram in an undated press release about the rule.

However, you can assure providers that the rule does not create a requirement to treat patients. In fact, Friedman does not expect a significant change in the number of providers who are actively treating SUD. Eight hours of training wouldn't be enough for a provider who wants to treat SUD. In addition, many providers don't want to treat SUD patients, according to Friedman. "The truth is most practitioners simply do not want to treat these people. It is the stigma associated with having drug addicts in your office mainly," he says.

And managing SUD requires a lot of work, Friedman adds. "To do it right requires a lot of attention, which is why most practitioners (including internal medicine docs and family practice docs) shy away from this practice entirely, and patients are then seen by the few medical practices which cater to and indeed specialize in such treatment," he says.

Determine who needs training

Your first step should be to determine how the provider will satisfy the training requirement. Providers who don't have the Data or X waiver have three ways to do so, said Yngvild Olsen, M.D., M.P.H., director of the Center for Substance Abuse Treatment for the HHS Substance Abuse and Mental Health Services Administration (SAMHSA), during a joint SAMHSA DEA webinar on June 14. The following three scenarios would meet the training requirement for your providers:

1. **Have a current, eligible board certification**. Providers who are board certified for addiction medicine or addiction psychiatry have met the requirement. "So, for example, I hold a board certification from the American Board of Preventive Medicine for addiction medicine that that would satisfy [the requirement]," Olsen explained.
2. **Received training during medical school**. "All practitioners that graduated in good standing from a medical, dental, physician assistant, or advanced practice nursing school in the United States within five years of June 27, 2023, and successfully completed a comprehensive curriculum that included at least eight hours of training on: Past trainings on the treatment and management of patients with opioid or other substance use disorders can count towards a practitioner meeting this requirement," according to the DEA Q&A on the MATE Act.
3. **Completed eight hours of training from a certified organization**. Congress listed the organizations that can provide the training (*see sidebar, p. 6*) and gave providers flexibility in the way they complete the training. For example, they could take an online course that allows them to train at their own pace or take part in training offered at a medical society's conference. But beware of imitators. The training won't count unless it was conducted by an organization described in the law.

Know when to submit the attestation

Prescribers will attest to their training during the process to renew their DEA registration or receive a new one, explained Matthew Strait, deputy assistant administrator for the DEA's Diversion Control Division, in a brief video about the process.

During the June 14 webinar, Strait emphasized that providers don't need to attest until they are ready to register or renew their registration. "We are not making all 1.9 million registrants go to our website on June the 27 and attest to this training requirement. This will actually occur at the time of your normally scheduled renewal," Strait said.

(continued on p. 6)

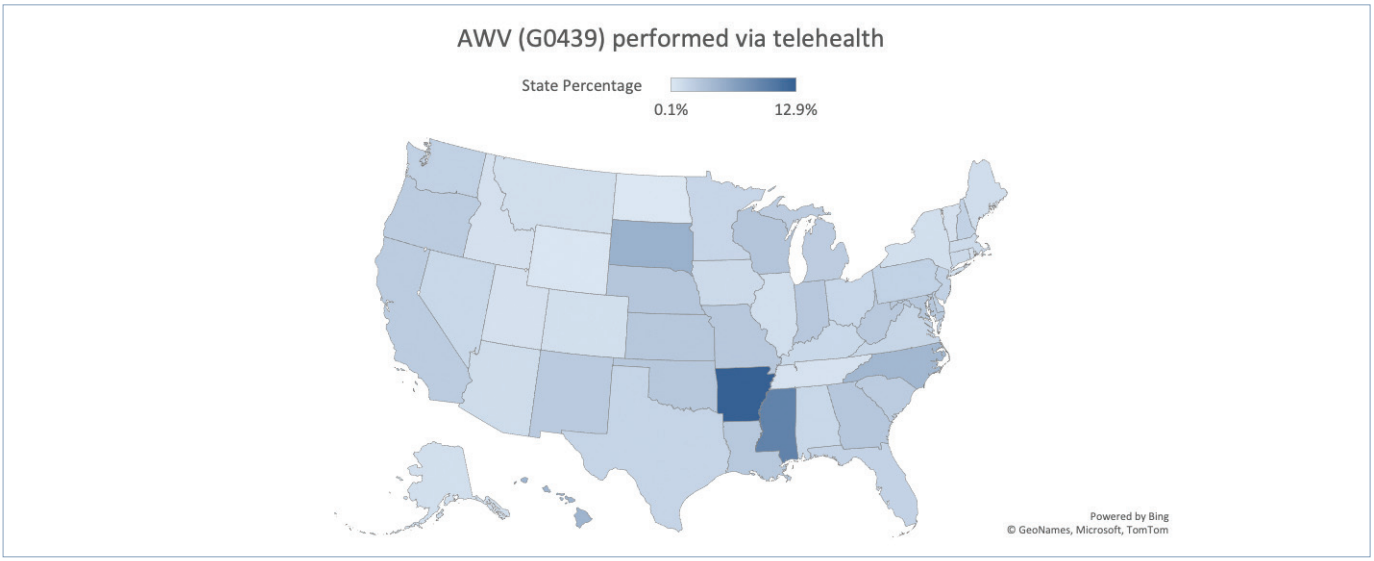
Benchmark of the week

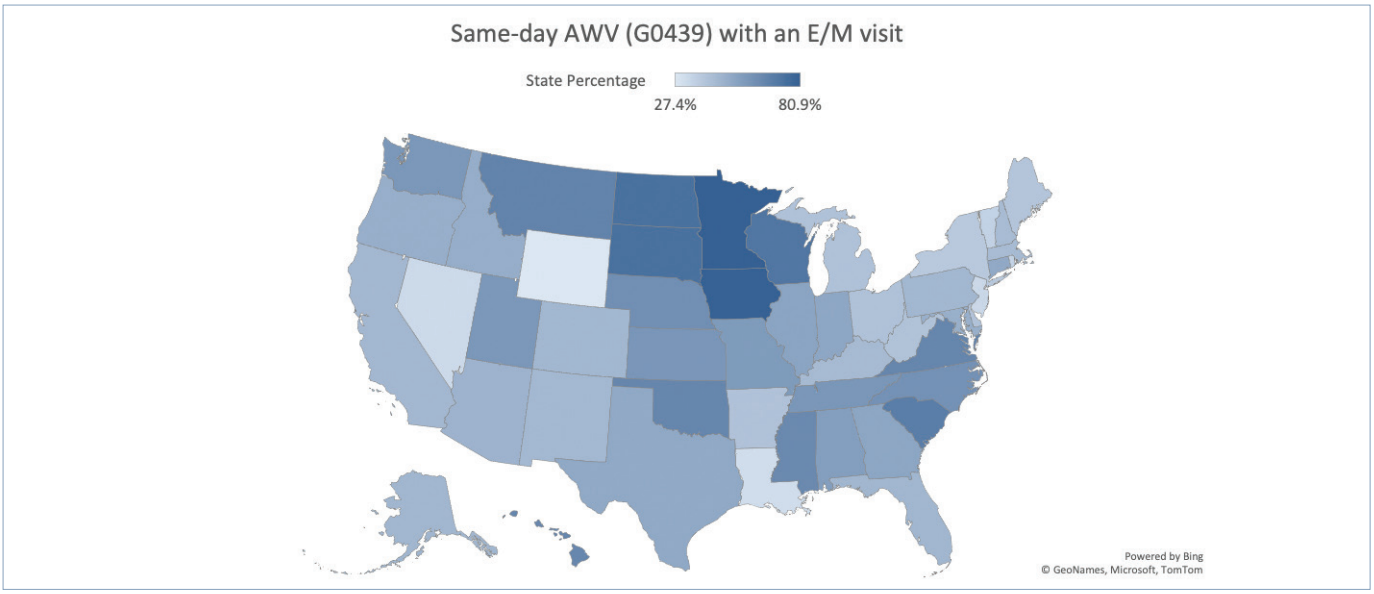
Map out state-level data for AWVs to see where your practice stands

Check your claims for subsequent annual wellness visits (AWV) (**G0439**) against state level data. You can mine the information to provide a more nuanced picture of your billing data, capture a peek into the services your competitors provide and alert you to coding patterns that warrant a closer look.

The following maps draw on data from Comparative Billing Report (CBR) 202307 Subsequent Annual Wellness Visits. CBR "used detailed information for that data during the CBR summary year of March 1, 2022, through February 28, 2023," to create the reports, explained Annie Barnaby, RELI Group Inc., during the webinar on the report. RELI Group is the CBR contractor for CMS.

The first map shows the percentage of providers who reported a separate E/M visit on the same day as the AWV. The national average is 50.6%, but at the state level the figure ranges from 27.4% in Wyoming to 80.9% in Minnesota. The second map shows data for AWV performed via telehealth. The national average is 2.2%, but practices in Arkansas boosted that number with a hefty 12.9% of telehealth visits. North Dakota practices were on the opposite end of the scale with .08% visits reported via telehealth. — *Julia Kyles, CPC (jkyles@decisionhealth.com)*





Sources: CBR 202307 Subsequent Annual Wellness Visits: www.youtube.com/watch?v=HiwxR2EbfXs&t=4s; CBR 202307 Subsequent Annual Wellness Visits National/state data: https://cbr.cbrpepper.org/LinkClick.aspx?fileticket=DPVcN3GQzZ0%3d&tabid=85&portalid=0&mid=501

(continued from p. 4)

In other words, if a provider completed their DEA license renewal on June 25, they will attest when they renew their DEA license in three years. On the other hand, if a prescriber is up for renewal on Sept. 1, they'll need to complete their training before they can renew.

In either case, once the prescriber attests that they have completed their training, they're done. They are not required to take the training again or maintain continuing medical education credits.

Don't submit records, but maintain them

Attestation involves clicking on a box. You don't need to submit a certificate or other proof of training to the DEA, Strait explained during the June 14 webinar. He gave participants a walkthrough of the process using screenshots (*see resources, below*).

But it would be a good idea to make sure the provider has proof they completed the training, he said. "We believe it's a best practice for you to maintain a record of that," Strait advised. "But please know that you're not obligated at the time of submitting this application to submit."

Friedman thinks it would be "reckless" not to maintain proof of training, even though the DEA isn't asking for it. "On the form, in order to get the DEA registration, you will just check a box saying 'done that.' But if you haven't, and it were discovered, you may well lose your DEA registration entirely and could not prescribe controlled substances for anything," Friedman says. He doubts anyone would knowingly lie on their application but thinks there could be "honest confusion about whether a certain prior training qualified, but that is about it," he adds. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

RESOURCES

- DEA MATE Act FAQ: *www.deadiversion.usdoj.gov/faq/MATE_Act_faq.htm*
- DEA MATE Act training requirement (video): www.youtube.com/watch?v=1skwKtXscbk
- SAMHSA MATE Act resources: *www.samhsa.gov/medications-substance-use-disorders/training-requirements-mate-act-resources*
- SAMHSA DEA joint webinar, registration walk-through (video): *https://youtu.be/Yhhuzy5625Q?t=1192*
- RAND Corporation: State Policies Requiring Education for Buprenorphine Prescribers Boosts Use of Opioid Use Disorder Treatment: *www.rand.org/news/press/2023/05/26.html*

Compliance

Make sure SUD training meets MATE's requirements

Whether your prescribers think they've met the MATE Act's training requirements or they're looking for a way to meet the training requirement before they renew their DEA license, make sure the substance use disorder (SUD) training is offered by a properly accredited group (*see related story, p. 4*). The official list includes 10 named organizations but leaves room for additional organizations that are accepted by certain accredited organizations or the Assistant Secretary for Mental Health and Substance Use.

If the organization offering SUD training is not specifically named on this list or doesn't fall under the broader categories outlined below, it won't qualify for your training requirements.

1. The American Society of Addiction Medicine.
2. The American Academy of Addiction Psychiatry.
3. The American Medical Association.
4. The American Osteopathic Association.
5. The American Dental Association.
6. The American Association of Oral and Maxillofacial Surgeons.
7. The American Psychiatric Association.
8. The American Nurses Credentialing Center.
9. The American Association of Nurse Practitioners.
10. The American Academy of Physician Associates.
11. Any other organization accredited by the Accreditation Council for Continuing Medical Education (ACCME) or the Commission.
12. Any organization accredited by a State medical society accreditor that is recognized by the ACCME or the CCEPR.
13. Any organization accredited by the American Osteopathic Association to provide continuing medical education.
14. Any organization approved by the ACCME or the CCEPR.

— *Julia Kyles, CPC* (*jkyles@decisionhealth.com*)

Source: Substance Abuse and Mental Health Services Administration

Have a question? Ask PBN

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email *askpbn@decisionhealth.com* with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

Coding

CMS makes a push to activate, pay for 'caregiver training services'

You may find fresh billing opportunities when your providers enlist the help of caregivers in a patient's treatment plan, according to the proposed 2024 Medicare physician fee schedule released July 13. CMS seeks to make active a suite of behavioral management and functional improvement training codes in 2024.

You'll find five caregiver training services (CTS) codes under CMS' watch, two of which are currently bundled and three of which would be new in 2024. The two codes that are currently bundled involve "group behavior management/modification training" and would allow providers to train caregivers — and get paid for doing so.

Check out the full code descriptors:

- **96202** (Multiple family group behavior management/modification training for parent[s]/guardian[s]/caregiver[s] of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional [without the patient present], face-to-face with multiple sets of parent[s]/guardian[s]/caregiver[s]; initial 60 minutes)
- **96203** (Multiple family group behavior management/modification training for parent[s]/guardian[s]/caregiver[s] of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional [without the patient present], face-to-face with multiple sets of parent[s]/guardian[s]/caregiver[s]; each additional 15 minutes [List separately in addition to code for primary service]] that describe group caregiver training services for patient behavior management/modification [without the patient in attendance).

CMS floated the two training codes during the 2023 rulemaking period after the CPT Editorial Panel created the codes in 2021.

"The two codes are to be used to report the total duration of face-to-face time spent by the physician or other qualified health professional providing group behavior management/modification training to guardians or caregivers of patients," CMS states in the rule. "Although the patient does not attend the group trainings, the goals and outcomes of the sessions focus on interventions aimed at effectuating the practitioner's treatment plan through addressing challenging behaviors and other behaviors that may pose a risk to the person, and/or others."

CMS is proposing a work relative value unit (RVU) of 0.43 for primary code 96202, which was the value suggested by the AMA's valuation committee.

In October 2022, the CPT Editorial Panel created three additional codes, not yet published, for CTS pertaining to functional performance. Below you will find the placeholder codes along with the full code descriptors:

- **9X015** (Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community [e.g., activities of daily living (ADLs), instrumental ADLs (IADLs), transfers, mobility, communication, swallowing, feeding, problem solving, safety practices] [without the patient present], face-to-face; initial 30 minutes).
- **9X016** (… ; each additional 15 minutes [List separately in addition to code for primary service] [Use 9X016 in conjunction with 9X015]).
- **9X017** (Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community [eg, activities of daily living (ADLs), instrumental ADLs (IADLs), transfers, mobility, communication, swallowing, feeding, problem solving, safety practices] [without the patient present], face-to-face with multiple sets of caregivers).

Similar to the behavior management training codes, the functional performance services would be used to report the total face-to-face time spent by the provider delivering individual or group training. The patient does not need to be present.

"During the face-to-face service time, caregivers are taught by the treating practitioner how to facilitate the patient's activities of daily living, transfers, mobility, communication and problem-solving to reduce the negative impacts of the patient's diagnosis on the patient's daily life and assist the patient in carrying out a treatment plan," the agency states in the rule. CMS is proposing a work RVU of 1.00 for primary code 9X015.

Defining a 'caregiver'

In the proposed rule, CMS offers a definition of who counts as a caregiver. The agency says a caregiver "is an individual who is assisting or acting as a proxy for a patient with an illness or condition of short or long-term duration (not necessarily chronic or disabling); involved on an episodic, daily, or occasional basis in managing a patient's complex health care and assistive technology activities at home; and helping to navigate the patient's transitions between care settings. For purposes of CTS, we also are including a guardian in this definition when warranted."

When it comes to billing, check out other pieces of fine print that CMS proposes:

- Because the CTS services are delivered without the patient's presence, the providers must obtain consent, from either the patient or the patient's representative, to receive the services.
- The patient's or representative's consent must be documented in the medical record.

CMS seeks public comment on all CTS proposals it put forth in the proposed rule. Comments are due by 5:00 p.m. (ET), Monday, Sept. 11. — *Richard Scott* (*rscott@decisionhealth.com*) ■

Coding

Accurately report JW, JZ modifiers before Oct. 1 enforcement

By now, most practices should be aware of the **JW** and **JZ** modifiers, which you are to append to codes for single-dose drug containers that you bill to Medicare Part B.

Report modifier JW when part of the drug is discarded and not administered to a patient. Use JZ to attest when there were no discarded amounts. When JW is appended, remember to report the discarded amount on the claim.

Medicare began requiring you to use the modifiers as appropriate last month, and starting Oct. 1, single-dose drug codes that don't have a JW or JZ appended will be returned as unprocessable.

CMS recently expanded its FAQs on JW/JZ to specify, among other things, settings where the modifiers should be reported. For example, "the JW and JZ modifiers are mostly reported on claims from the physician's office and hospital outpatient settings for beneficiaries who receive drugs incident to physicians' services," CMS states.

Other settings and stipulations:

- Critical access hospitals (CAH) should plan to use them "since drugs are separately payable in the CAH," according to the CMS Q&A document.
- Pharmacies only need to use JW and JZ for cases when drugs are actually administered, not merely dispensed.
- End-stage renal disease (ESRD) facilities should append the modifiers only for drugs in single-dose containers that are not renal dialysis service drugs or biological products provided for the treatment of ESRD, CMS states.
- Rural health clinics (RHC) or federally qualified health centers (FQHC) should not use the modifiers because "drugs administered in RHCs and FQHCs are generally not separately payable under Part B.
- Hospital inpatient claims billed under the Inpatient Prospective Payment System — don't use the JW or JZ.
- In outpatient hospitals and ambulatory surgery centers, only separately payable drugs administered via single-dose vials require the modifiers, CMS notes.

In addition, providers don't have to worry about appending the modifiers to vaccines described under section 1861(s)(10) of the Social Security Act, including influenza, pneumococcal and Covid-19 vaccines. These injections "are often roster billed by mass immunizers, and roster billing cannot accommodate modifiers," the agency notes.

Practices can find additional details, such as the specifics of how the modifiers should appear on the claim and documentation requirements in the CMS FAQ (see resource, below). — *Laura Evans, CPC* (*levans@decisionhealth.com*) ■

RESOURCE

- CMS FAQs on JW/JZ modifier: *www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf*