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Part B News
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In this issue

Health care reform

With WISeR demo, CMS adds prior auth for Medicare services in six states

After earlier reforms that sought to reduce the impact of prior authorization on providers and patients, CMS has created a demonstration model that will add prior authorization for regular Medicare for a select group of regional providers.

CMS' Centers for Medicare and Medicaid Innovation (CMMI) opened an application process for a "Wasteful and Inappropriate Service Reduction (WISeR)" demonstration model on June 27. The application is for companies that would perform the prior auth; the model will automatically apply to providers and suppliers in Medicare administrative contractor (MAC) jurisdictions JH (Oklahoma and Texas), JL (New Jersey), JF (Arizona and Washington), and J15 (Ohio) who submit claims on some services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) picked by CMS.

These providers and suppliers "will have the opportunity to submit a request for prior authorization to either the MAC or the model participant, along with documentation to support Medicare coverage of a selected service included in the model as defined in the statute, regulation, NCD and/or LCD," per a notice HHS published in the Federal Register on July 1.

While submitting for prior authorization is voluntary under the model, providers are notified that if the provider/supplier does not submit a request, their claim "will be subject to prepayment medical review by model participants that

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may involve requests for documentation to support the medical necessity of the targeted item or service."

CMS says that the purpose of the model is to "focus health care spending on services that will improve patient well-being" and "apply commercial payer prior authorization processes that may be faster, easier and more accurate" while "de-incentiviz[ing] and reduc[ing] use of medically unnecessary care."

Model participants chosen by the agency to perform these authorization reviews "will be companies with expertise managing the prior authorization process for other payers using enhanced technology like AI," a related fact sheet says.

The carrot for these participants will be a kind of shared savings bonus: "For each selected service," the fact sheet says, "participants will receive a percentage of the reduction in savings that can be attributed to their reduction of wasteful or inappropriate care."

The notice names 15 diagnoses, services and DMEPOS and their national coverage determinations or, where applicable, local coverage determinations. Among these are electrical nerve stimulators (NCD 160.7), cervical fusion (several LCDs), diagnosis and treatment of impotence (NCD 230.4), and skin and tissue substitutes (several LCDs).

"In general," the notice says, "this model will require the same information and clinical documentation that is already required to support Medicare FFS payment but earlier in the process, namely, prior to the service being furnished."

To educate affected providers and suppliers on the model, the notice says CMS will reach out via "open-door forums, frequently asked questions (FAQs) on our website, other website postings, and educational materials."

A change in direction?

While Medicare Advantage (MA) is rife with prior authorization requirements, traditional Medicare currently requires it only for some DMEPOS and selected medical services, including certain hospital outpatient department (OPD) services and repetitive, scheduled non-emergent ambulance transport (RSNAT), and services within other demonstration models including home health and inpatient rehabilitation facility services.

Recent CMS efforts have sought reduce the negative impact of prior authorization, which has been long decried by providers and patients (*PBN 3/21/22*).

For example, the Interoperability and Prior Authorization Final Rule published in January 2024 seeks to make prior authorization less cumbersome in Medicare Advantage, Medicaid and other gomvernment plans (*PBN 1/29/24*). It requires payers to provide timely and transparent explanations for prior authorization decisions via mandatory application programming interfaces (API).

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The new model also seems contrary to the trend in several states to exempt many procedures from prior authorization under any insurance via "gold card" programs that reward providers who achieve a high success rate in claims acceptance (*PBN 8/14/23*).

CMS does say that they are "exploring implementation" of gold carding, and that it will have an expedited review process for providers whose patients' lives or health would be adversely affected by the resulting prior authorization delays.

But some observers, including Anders Gilberg, senior vice president, government affairs for the Medical Group Management Association (MGMA) in Washington, D.C., think the model is a step in the wrong direction.

"The announcement of this Part B model seems to contradict the administration's recent commitments to ease the burden of prior authorization," Gilberg says. "We look forward to working with CMMI and the administration on efforts to reduce waste and ensure they do not come at the cost of greater administrative burdens and interference with clinical decision-making."

As recently as June 23, portraying his and CMS administrator Mehmet Oz's meeting with health insurance executives on ways "to streamline and improve the prior authorization processes," HHS Secretary Robert F. Kennedy Jr. said that HHS was "actively working with the industry to make it easier to get prior authorization for common services such as diagnostic imaging, physical therapy, and outpatient surgery." Kennedy emphasized that the executives' commitments, including "reduc[ing] the volume of medical services subject to prior authorization by January 1, 2026," would be "voluntary."

The WISeR demo program will run from January 1, 2026, to December 31, 2031. —*Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- CMMI, "WISeR (Wasteful and Inappropriate Service Reduction) Model," June 27, 2025: *www.cms.gov/priorities/innovation/innovation-models/wiser*
- CMS, "Model Overview Factsheet: Wasteful and Inappropriate Service Reduction (WISeR) Model," June 27, 2025: *www.cms.gov/files/document/wiser-fact-sheet.pdf*
- HHS/CMS, "Medicare Program; Implementation of Prior Authorization for Select Services for the Wasteful and Inappropriate Services Reduction (WISeR) Model," notice, July 1, 2025: *https://public-inspection.federalregister.gov/2025-12195.pdf*
- KFF, "Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023," Jan. 28, 2025: *www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/*
- CMS, "Prior Authorization and Pre-Claim Review Initiatives," Jan. 17, 2025: *www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives*
- HHS, "HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System," June 23, 2025: *www.cms.gov/newsroom/press-releases/hhs-secretary-kennedy-cms-administrator-oz-secure-industry-pledge-fix-broken-prior-authorization*

Compliance

HIPAA reproductive care PHI overturned, but law still mostly protects it

Most of a Biden era reproductive health HIPAA policy has been stopped by a federal court decision. Be clear, though, about your remaining duties to safeguard this kind of protected health information (PHI).

The rule, "HIPAA Privacy Rule to Support Reproductive Health Care Privacy," was published on April 26, 2024, and became effective on Dec. 23, though the compliance deadline for the Notices of Privacy Practice (NPP) section — which was not blocked — remains Feb. 16, 2026, meaning many practices will have already put the blocked components of the rule into practice.

The rule prohibited the use or disclosure of PHI for "criminal, civil, or administrative investigation" purposes against "the mere act of seeking, obtaining, providing, or facilitating reproductive health care, where such health care is lawful under the circumstances in which it is provided" (*PBN 8/26/24*). The intention was to prevent prosecutors in jurisdictions that outlaw abortion, gender-affirming care and other reproductive health care from seizing PHI from providers in states where they are legal, a need felt keenly after the U.S. Supreme Court decision in the Dobbs decision removed constitutional protection for abortions in 2022 (*PBN 7/18/22*).

"This [rule] would have limited disclosures of reproductive health information to states such as Texas, looking to investigate their residents who sought

reproductive health care services in other states where those services are legal," says Paul Schmeltzer of the Clark Hill law firm in Los Angeles.

In Purl v. HHS, the plaintiff was a clinic that wished to disclose reproductive health care PHI in the cases of underage women whose pregnancies or surgeries might constitute evidence of a criminal activity, e.g. statutory rape. HHS, now run by Robert F. Kennedy Jr. and unsympathetic to the of the Biden administration's policies on abortion and gender-affirming care, made Purl's and United States District Court Judge Matthew Kacsmaryk's job easier by waiving the "merits arguments" in the case, challenging only "standing and the scope of potential relief."

In his ruling, Kacsmaryk writes that Purl had standing to sue because "it does not matter whether the 2024 Rule does or does not conclusively preclude child-abuse reporting … all that matters is whether the 2024 Rule regulates Plaintiffs to forbid or require 'some action' and whether vacating the 2024 Rule would remedy Plaintiffs' burden."

Also, Kacsmaryk rules Purl has "an 'increased regulatory burden' via compliance costs" that they had to spend to "conduct additional training, update policies, and amend their notice of privacy practices."

Kacsmaryk does speak somewhat to merits: Though he finds the rule does not necessarily prohibit child-abuse reporting, he nevertheless finds that it impermissibly "limits state laws on child-abuse reporting and public-health investigations." He further complains that the terms of the rule "excludes unborn humans and explicitly bars doctors and covered entities from acting on behalf of unborn patients."

Kacsmaryk does allow to stand the small part of the rule that relates to NPP notices related to PHI about substance abuse, which will still be required. (*See resources, below, for the fact sheet.*)

Still not 'fair game'

The effect of Kacsmaryk's vacatur is nationwide. (If you're wondering whether the recent decision in Trump v. CASA, which seems to prohibit nationwide injunctions against laws and executive orders, applies here, Beth Pitman, partner with Holland & Knight in Birmingham, Ala., explains that "an order vacating an agency rule nationwide" — as here — "is treated differently from a nationwide injunction providing individual relief," as in Trump v. CASA.)

While theoretically HHS can challenge the ruling, they are unlikely to do so. If you haven't prepared to change your compliance program to conform with this rule, apart from the NPP section, you can probably ignore it — which, from a strictly administrative point of view, may be a relief.

"The regulatory changes defined 'reproductive health care' very broadly as anything 'that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes,'" says Shannon B. Hartsfield, executive partner in Holland & Knight's Tallahassee office. "Therefore, it applied to a wide swath of medical information that had nothing to do with abortion. For example, it would apply to records about whether a man was infertile, or records of a woman taking birth control pills."

But don't take this ruling to mean your patients' reproductive PHI is now fair game. The vacatur leaves "specific policies and processes already in place for assessing such subpoenas," Pitman says, with parameters determined by legal precedents — for example, how to treat a lawyer's subpoena for PHI, as opposed to a judge's order (*PBN 3/4/24*).

Federal law, specifically 45 CFR 16 4.512 (*see resources, below*), "walks through uses and disclosures of PHI — beyond TPO [Treatment, Payment, and Healthcare Operations] purposes — for which a patient authorization is not required," says Andrea Frey, a partner with Hooper Lundy Bookman in San Francisco and co-chair of the firm's Digital Health and Reproductive Health Practices. "Covered entities still need to go through the analysis and make sure there is a legitimate and valid basis under HIPAA for the disclosure of PHI. For example, a subpoena that is not accompanied by a court order is not in and of itself sufficient to permit covered entity to disclose the requested records."

Also, Pitman notes, "medical practices should also be attentive to the state law in states of operation," which may be more protective of reproductive PHI than the federal HIPAA Privacy Rule.

In fact, Frey says, practices that have begun their compliance with the rule and are in states with more restrictive laws such as California may choose to keep

(continued on p. 6)

Benchmark of the week

PCPs embraced new prolonged service, chronic pain in 2023

Higher-than-average reporting and relatively low denial rates indicate smooth adoption of several new HCPCS G codes that were introduced in 2023. In addition, a few specialties took the lead in using the new codes, according to the latest Medicare Part B claims data.

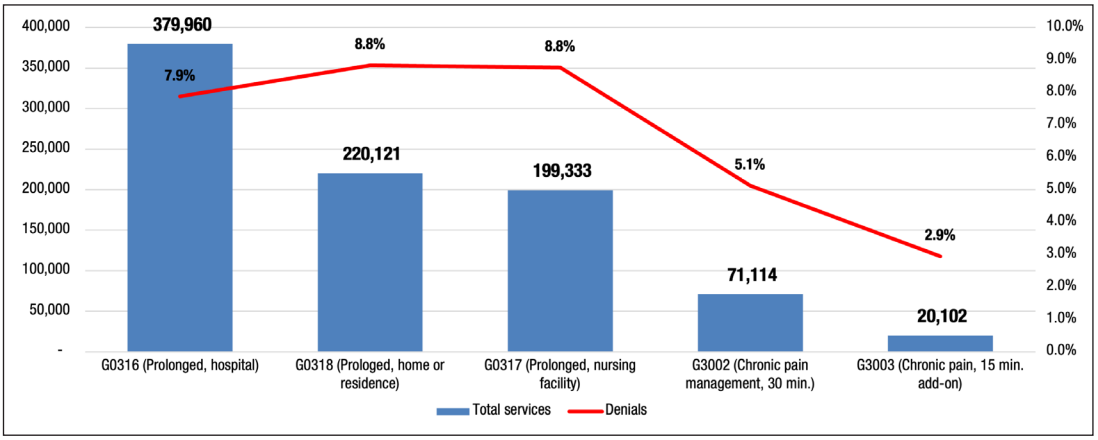
The first chart below shows the total number of Part B claims for the top five G codes that Medicare introduced in 2023, the latest available data from CMS, along with the percentage of denials for each code. The claims data does not include reasons for denials, but practices that report prolonged service codes should make sure the place of service matches the code and remember that each code has a medically unlikely edit of four units per patient, per day.

Providers reported 7,007 services for the remaining five G codes that launched in 2023: **G0323** (Behavioral health care management, 20 min.), home health services via audio/video (**G0320**), audio-only (**G0321**), remote physiologic data transferred to a home health agency (**G0322**), and dental rehab services in a facility that require monitored anesthesia care (**G0330**). The home health and dental services received a 100% denial rate.

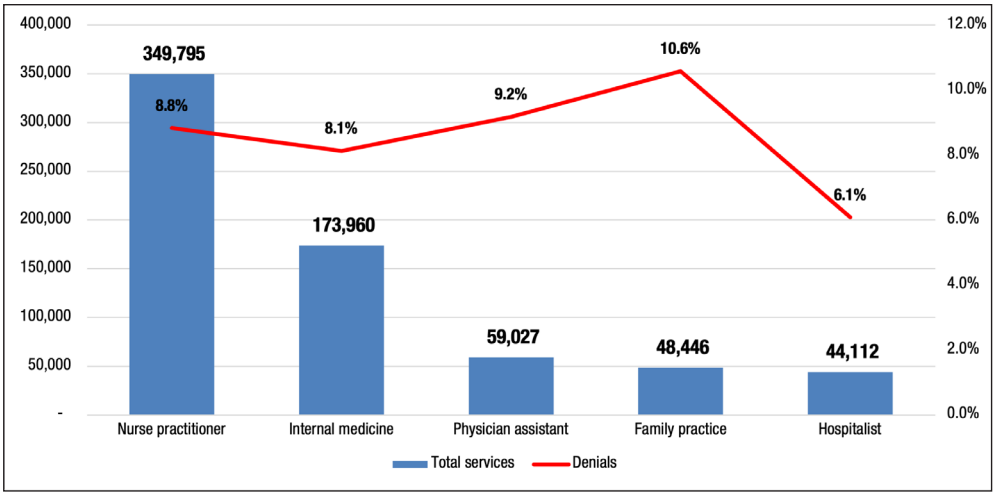
The second chart shows the top five specialties based on their reporting of all new G codes. The chart bears out past reporting by *Part B News* that shows nurse practitioners were the forerunners when it came to using new prolonged care codes and chronic pain management codes (*PBN 12/12/24, 12/9/24*).

However, a closer look at the data shows they were also top reporters of the home health codes, which gave their overall denial rates an unwanted boost. Practices should make sure they understand all the requirements for a code, starting with a review of the complete descriptor, before they submit a claim. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*)

Top 5 new G codes — total services and percentage of denials, 2023



Top 5 specialties, all new G codes and percentage of denials, 2023



Source: Part B News *analysis of 2023 Medicare claims data*

(continued from p. 4)

up its heightened standards for releasing reproductive PHI "as a compliance measure." — *Roy Edroso* (roy.edroso@decisionhealth.com) ■

RESOURCES

- Federal Register, HHS, "HIPAA Privacy Rule To Support Reproductive Health Care Privacy," final rule, April 26, 2024: www.federalregister.gov/documents/2024/04/26/2024-08503/hipaa-privacy-rule-to-support-reproductive-health-care-privacy
- U.S. District Court, Northern District Of Texas decision, Carmen Purl v. HHS, June 18, 2025: https://caselaw.findlaw.com/court/us-dis-crt-n-d-tex-ama-div/117411800.html
- HHS, "Fact Sheet 42 CFR Part 2 Final Rule," Feb. 8, 2024: www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html
- U.S. Supreme Court decision, Trump v. CASA, June 27, 2025: www.supremecourt.gov/opinions/24pdf/24a884_8n59.pdf
- U.S. Code of Federal Regulations, "Uses and disclosures for which an authorization or opportunity to agree or object is not required": www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164/subpart-E/section-164.512

Denials management

Check Aetna policy if you see unexpected ultrasound, injection denials

When Aetna is the patient's insurer take a close look at the ultrasound policy before the practice reports **76942** (Ultrasonic guidance for needle placement [eg, biopsy, aspiration, injection, localization device], imaging supervision and interpretation with treatment for acute or chronic pain), or services that include ultrasound.

The payer added a range of services to its experimental, investigational or unproven list at the end of 2024. The update also added services to the medically necessary column and the complete list is available in policy 0952 Ultrasound Guidance — Selected Indications.

Anesthesia practices should note that the update added ultrasound for placement of a lumbar plexus block to the list of non-covered services.

In the chronic pain management arena, the revised policy blocks payment of ultrasound with services such as botox injections to treat thoracic outlet syndrome, injections of the sacroiliac ligament to treat buttock pain and injections of the foot involving sub-metatarsal spaces, talonavicular joints and tarsometatarsal joints.

The last set of additions means that a claim for **20606** (Arthrocentesis, aspiration and/or injection, intermediate joint or bursa [eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]; with ultrasound guidance, with permanent recording and reporting) combined with an ICD-10-CM code that indicates the foot was treated might trigger a denial even though claims for the treatment of other intermediate joint and bursa injections go through without a problem.

Remember to review the CPT, HCPCS and ICD-10-CM section of the policy for detailed lists of services that are not covered for specific codes.

Ultrasound allowed with DRB

Aetna will cover ultrasound performed with a dorsal ramus block (DRB) according to the revised policy. However, the block must be performed to treat chronic low back or spinal pain, so make sure staff, including your schedulers, are aware of the policy. Treating providers and coders should aim for the highest level of specificity in their diagnosis coding so that everyone can easily determine whether ultrasound is covered for the service. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com) ■

RESOURCE

- 0952 Ultrasound Guidance — Selected Indications: www.aetna.com/cpb/medical/data/900_999/0952.html

Ask Part B News

Written protocol for inappropriate behavior, however mild, can help

Question: *We have a patient who sometimes brings gifts such as flowers or candy to his provider. The provider has shared with us that she finds this awkward and has asked him to stop, but the patient persists. We have a harassment policy, but it seems like overkill to bring it to bear here. What should we do?*

Answer: Not every patient behavior issue needs a legal consult or even management intervention. But if you want to keep it that way, it's best to have some written policy to train and direct staff even in mild situations.

Obviously assault, harassment, disruptive behavior and other actions that would get anyone thrown out of a public place must be anticipated and addressed in clear, legally vetted policy and clear language to protect staff, patients and the institution itself (*PBN 6/24/19*, *7/19/21*, *2/24/25*).

Also, you have to be careful not to brush off behaviors that are aggressive, sexually or otherwise, as "harmless" or "misunderstood." Generally, egregious misbehavior leads quickly to "firing" the patient and, where appropriate, involving law enforcement.

But even some less obviously unacceptable behaviors may be troubling to your staff or other patients and, while many providers have enough training in interpersonal relations to handle it themselves, there are reasons to have something in writing to which they can refer.

Small but still a problem

A personal injury lawyer who has been involved with such cases says he's seen firsthand how these "gray area" incidents "become legal and operational landmines."

"Letting front-line staff improvise on the spot may feel friendly, but it quickly breeds inconsistency and leaves patients wondering if they were treated fairly," the attorney says. He recommends a policy sheet — for example, even "a single page that spells out phone limits, gift customs, and similar touch points" would let staff "redirect trouble quietly and keep the atmosphere consistently respectful."

Some practice consultancies offer templates. In its "Effective Patient Communication: Strategies for Challenging Situations," The Doctors Company in Napa, Calif., talks about covering these situations, first by having patients sign onto a Conditions of Treatment Agreement defining your expectations, then laying out a protocol that may begin by meeting inappropriate behavior with scripted responses (e.g., "let's keep it professional") and proceed to a meeting with the patient in which you "identify the behavior, explain why it is inappropriate, and clarify your expectations," followed by a written warning letter.

Paul Schmeltzer of the Clark Hill law firm in Los Angeles says that while a written protocol for awkward encounters is not legally required, it's still a good idea: "While incidents of abuse toward physicians or staff have serious legal implications," he says, "minor infractions such as excessive visits, inappropriate gifts, or other boundary-crossing behaviors can still disrupt practice operations and affect staff-patient relationships."

A written policy also provides added protection to the practice in case a patient decides to escalate.

"Without a written policy, there's a risk that staff might handle these situations inconsistently, which could lead to patient allegations of wrongful discharge or other complaints," Schmeltzer says. "A clear, written protocol ensures uniformity in how such situations are addressed, helping to maintain professionalism, protect staff and safeguard patient satisfaction."

'Seeking' behaviors, go FAVER

Often an issue arises in which a patient seems to seek by their inappropriate behavior something from the provider different from what care standards require. This may put the provider in the awkward position of wishing, as a professional matter, to meet the patient's needs while knowing that the request — implicit or explicit — is not appropriate.

For staff training purposes, Schmeltzer points to the American Academy of Family Physicians' (AAFP) "FAVER" rubric. A brief version of the guidance features:

- F: Name your feelings about the patient's request.
- A: Analyze your thoughts about the request and what is fueling your feelings (e.g., illegal, dishonest, or against policy).
- V: View the patient in the best possible light.
- E: Explicitly state that the requested action would be [counterproductive].
- R: Reestablish rapport. Use empathy and "I wish …" statements.

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.

This approach "serves as a helpful framework for managing patient behavior, [though] practices should customize it to fit their specific needs and preferences," Schmeltzer says. (*See resources, below, for further explanation at the AAFP link.*)

The policy should be easily accessible to patients, clearly outlining expectations for appropriate behavior within the practice. The FAVER rubric from AAFP serves as a helpful framework for managing patient behavior, but practices should customize it to fit their specific needs and preferences.

If the gifting has an implicitly suggestive character, then it's time to activate your harassment protocol. — *Roy Edroso* (roy.edroso@decisionhealth.com) ■

RESOURCES

- The Doctors Company, "Effective Patient Communication: Strategies for Challenging Situations," December 2024: https://cdn.intelligencebank.com/us/share/a7ZkMl/kVJ0Z/6rlrn/original/Effective+Patient+Communication+Guide
- Debra Kane Hill and Richard F. Cahill, The Doctors Company, "Set Expectations for New Patients With a Conditions of Treatment Agreement," December 2023: www.thedoctors.com/articles/set-expectations-for-new-patients-with-a-conditions-of-treatment-agreement
- AAFP, FPM, "Getting to No: How to Respond to Inappropriate Patient Requests" (includes FAVER): www.aafp.org/pubs/fpm/issues/2018/0100/p25.html

Ask Part B News

The doc's practice did the imaging test. Can we still count it toward MDM?

Question: *How would you count the following tests toward medical decision-making (MDM) in the following two scenarios?*

1. *The physician orders an MRI at today's visit for the patient's right ankle. His practice performs the MRI three days later and bills the professional and technical component.*
2. *The physician orders a CT scan at today's visit for the patient's right ankle and the CT is performed on the same date by the physician's practice, which then bills the professional and technical component for the scan.*

In each case, we are wondering:

- *Can we count the imaging test toward the E/M visit MDM?*
- *Can we count the imaging interpretation (if they perform one) at the follow-up visit?*
- *Does it make a difference whether the test is done the same day or on a subsequent date?*
- *Would it be considered double dipping to count these tests toward the MDM, since the physician's own practice also performed and billed for the tests' professional interpretation?*

Answer: In both cases, you are correct that it would not be appropriate to count the test toward the MDM calculation for the E/M visit. The key, according to the AMA, is whether the physician or his practice billed separately for the diagnostic imaging.

The AMA states: "The ordering and actual performance and/or interpretation of diagnostic tests or studies during a patient encounter are not included in determining the levels of MDM when the professional interpretation of those tests or studies are reported separately by the physician or other QHP reporting the E/M service." (CPT Assistant, Feb. 2022)

In such cases, you can't count the ordering of the test, nor can you count it toward "independent interpretation," because you or someone at your practice did the interpretation of record.

When the test is performed has no bearing on whether it's counted in these cases. If they are billing separately for it, they can't count it for the MDM.

Note that the above rule applies to diagnostic tests with professional and technical components. If the provider orders a test that does not require a separate interpretation (such as a clinical lab test), they can count either ordering or reviewing the test toward the MDM (not both) — even if the practice itself performs the test. — *Laura Evans, CPC* (laura.evans@decisionhealth.com) ■