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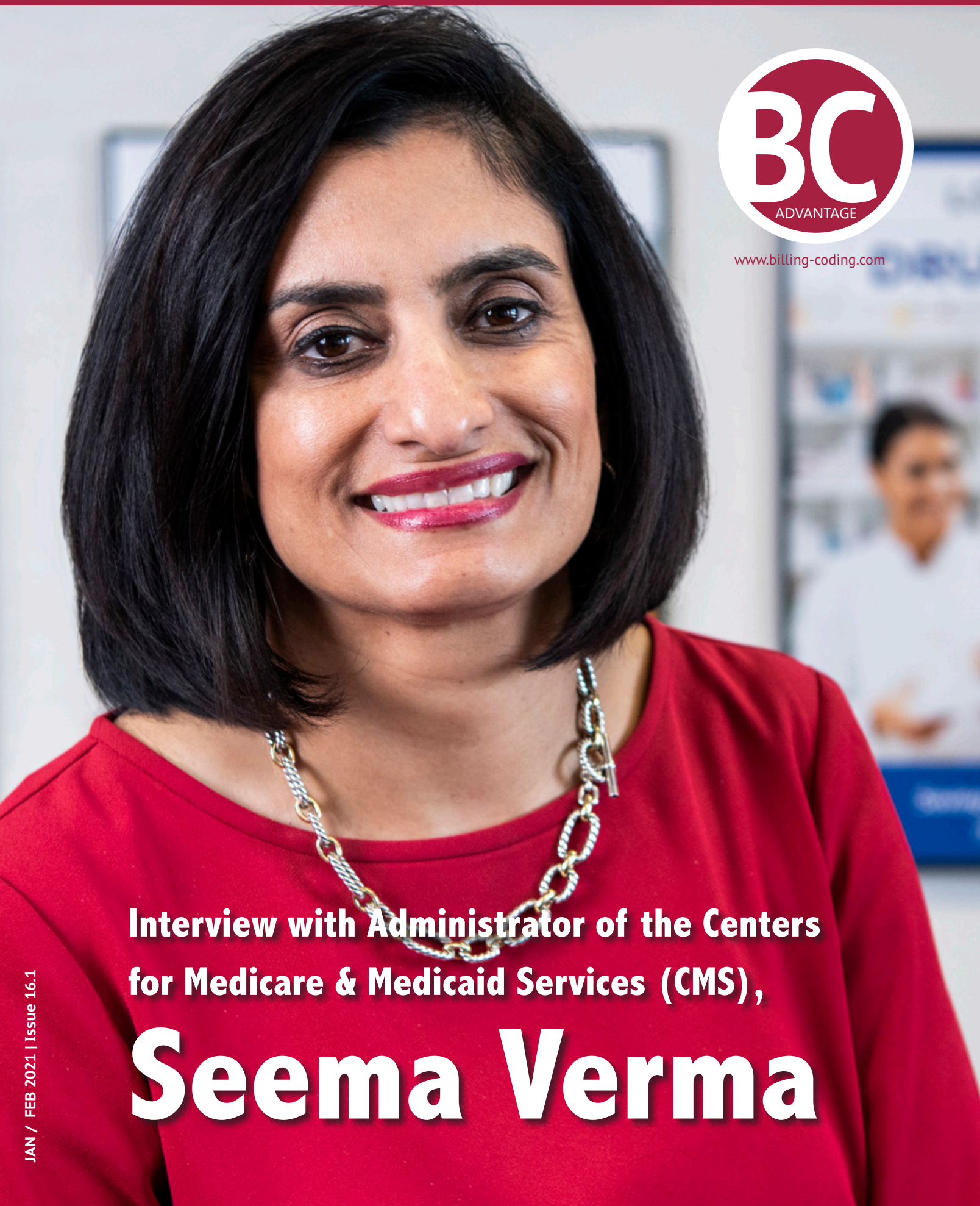

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Interview with Administrator of the Centers for Medicare & Medicaid Services (CMS),

Seema Verma

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CEO Letter

Well, we made it! 2020 is in the rear-view mirror and we're barreling into 2021 at high speed! Is it time to set cruise control and relax yet? Not even close! At the time of writing, the vaccines have been delivered and have started being administered, which is an amazing accomplishment in and of itself. I understand that politics has infiltrated much of our daily lives and that the vaccine itself is polarizing, but again, we cannot diminish this amazing accomplishment and the effect it will have for our front-line staff and those who are vulnerable in our community. People are hurting in our community in many different ways and helping them should be a major priority for all of us.

As we move into 2021, we've got some exciting things happening! In this issue, we're so pleased to welcome CMS Administrator, Seema Verma, in an interview conducted by Sean Weiss, Scott Kraft, and Grant Huang from DoctorsManagement. We're thrilled with the article and hope you enjoy reading it too. In addition to that, we have updates to the E/M coding in Tim McNamara from AcumenMD's article; a great article by Betty Hovey on the new regulatory changes that may help expand telehealth usage moving forward; Amy Wagner has written about using CPT code 97002 to capture practice expense factors; the PAHCOM National Board has continued their Back to Basics series with this one focusing on problem resolution; and of course, we welcome Rachel Rose, J.D., MBA, with her article on the final rules on the false claim cases—among many more. David Jakielo writes about things never being the same again and provides some great insight into the future, post-COVID-19, and we spend 5 minutes with Scott Kraft from DoctorsManagement.

Also, I wanted to let you all know that we listened to those of you who took the time to call us about the CEU certificate printing issues. We have now fixed it so that all certificates come in a PDF format so you can save and/or print easier to submit to your associations for proof of completion. We hope that helps.

BTW – We need to issue a correction for the article, "2021 E/M Changes: Are You Ready?" in issue 15.6-November/December 2020. On page 12 and 13, under the Coding by Medical Decision Making section, the codes in the New Patient and Established Patient were reversed. We apologize for any inconvenience this has caused our subscribers and the author, Betty Hovey, CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I.

So, let's all wave goodbye to 2020 and move into 2021 with a positive outlook. And if you can't, fake it until you make it!

Until next time, always choose kindness. Storm Kulhan

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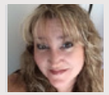
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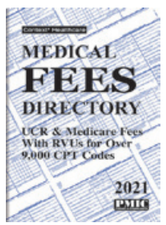

FEATURES

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Practice Management

The Impact of the November 2020 Stark Law and AKS Final Rules on False Claims Act Cases

In tandem on November 20, 2020, the Centers for Medicare and Medicaid Services (CMS) issued a Final Rule related to the Medicare Physician Self-Referral Law (Stark Law), while the Office of the Inspector General, Department of Health and Human Services (HHS-OIG), released a Final Rule, which amends various safe harbors to the Federal Anti-Kickback Statute (AKS).

The primary purpose of the Final Rules is the shift toward value-based healthcare delivery and payment systems, which emphasize the coordination of care among physicians and other healthcare providers across both the government and private sectors.

As HHS-OIG has stated, "The five most important Federal fraud and abuse laws that apply to physicians are the False Claims Act (FCA), the Anti-Kickback Statute (AKS), the Physician Self-Referral Law (Stark law), the Exclusion Authorities, and the Civil Monetary Penalties Law (CMPL)." These laws do not only apply to physicians, but to other healthcare industry participants, as well. For years, pharmaceutical companies and medical device manufacturers have led the headlines for providing improper remuneration, also known as a "kickback" to providers, who are usually physicians, to induce them to use a certain product or service. The primary vehicle for bringing this type of fraudulent conduct to the attention of the Federal Government, as well as State Governments, is the FCA.

In light of the new Final Rules, healthcare industry participants should be aware of two key items. First, just as in the past, the AKS safe harbors are not identical to the Stark Law exclusions. Second, the FCA remains a viable option for combatting fraud under the AKS and Stark Law, even in light of the changes. The purpose of this article is to highlight value-based enterprise participants (VBEs) and the impact on FCA cases.

Analysis

With a lot of wheels in motion, it's important to step back and appreciate the fundamentals before delving into the recent changes expressed in the Final Rules.

AKS and Stark Law

While the AKS, 42 USC § 1320a-7b(b) and the Stark Law, 42 USC §1395nn, are similar in that a payment is made in exchange for referrals for goods or services, there are some distinct differences. HHS-OIG compiled a chart, of which portions of it are reproduced in Table A (see next page).

The primary purpose of both the AKS and the Stark law is to protect patients and federal healthcare programs from fraud and abuse. While the payment systems and payment models have shifted over the past decade to utilizing value-based care, which is based on patient outcomes, including reductions in hospital admissions and infection rates, the fundamental purposes of both the AKS and the Stark Law remain unchanged.

Final Rules and VBE Participants

Value-based enterprise (VBE), VBE participants, and the related elements to meet exceptions/safe harbors are critical to understanding the Final Rules. Importantly, there are differences between the Stark Law Final Rule and the AKS Final Rule.

Here are the relevant VBE-related definitions under the Stark Law:

- A Value-based enterprise (VBE) means two or more VBE participants: (1) Collaborating to achieve at least one value-based purpose; (2) Each of which is a party to value-based arrangement with the other or at least one

Table A

	AKS	Stark Law
Prohibition	Prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals or general Federal healthcare program business	• Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies • Prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral
Referrals	Referrals from anyone	Referrals from a physician
Items/Services	Any items or services	Designated health services
Intent	Intent must be proven (knowing and willful).	• No intent standard for overpayment (strict liability) • Intent required for civil monetary penalties for *knowing* violations
Penalties	Criminal and/or Civil	Civil Only
Exceptions	*Voluntary* safe harbors	*Mandatory* exceptions
Federal Health Care Programs	All	Medicare/Medicaid

other VBE participant in the value-based enterprise; (3) That have an accountable body or person responsible for the financial and operational oversight of the value-based enterprise; and (4) That have a governing document that describes the value-based enterprise and how VBE participants intend to achieve its value-based purpose(s).

- A VBE participant is defined as "a person or entity that engages in at least one value-based activity as part of a value-based enterprise."
- A Value-based purpose means any of the following: (1) Coordinating and managing the care of a target patient population; (2) Improving the quality of care for a target patient population; (3) Appropriately reducing the costs to or growth in expenditures of payors without reducing the quality of care for a target patient population; or (4) Transitioning from healthcare delivery and payment mechanisms based on the volume of items and services provided to mechanisms based on the quality of care and control of costs of care for a target patient population.

For Stark Law purposes, CMS stated the following:
In addition, due to our (and our law enforcement partners') ongoing program integrity concerns with certain other participants in the health care system and to maintain consistency with policies proposed by OIG, we stated that we were also considering whether to exclude the following providers, suppliers, and other persons from the definition of "VBE participant": pharmaceutical manufacturers; manufacturers and distributors of DMEPOS; pharmacy benefit managers (PBMs); wholesalers; and distributors. At final §411.351, "VBE participant" is defined to mean a person or entity that engages in at least one value-based activity as part of a value-based enterprise. The definition of "VBE participant" finalized here does not exclude any specific persons, entities, or organizations from qualifying as a VBE participant" (emphasis added).

By way of contrast, HHS-OIG stated that the following entities do not qualify for value-based safe harbors known as the "ineligible entity list":

(i) Pharmaceutical manufacturers, distributors, and wholesalers (referred to generally throughout this preamble as "pharmaceutical companies");
(ii) PBMs;
(iii) Laboratory companies;
(iv) Pharmacies that primarily compound drugs or primarily dispense compounded drugs (sometimes referred to generally in this rule as "compounding pharmacies");
(v) Manufacturers of devices or medical supplies;
(vi) Entities or individuals that sell DMEPOS, other than a pharmacy or a physician, provider, or other entity that primarily furnishes services, all of which remain eligible (referred to generally throughout this preamble as "DMEPOS companies");
(vii) Medical device distributors or wholesalers that are not otherwise manufacturers of devices or medical supplies (for example, some physician-owned distributors).

Healthcare industry participants should heed the distinctions between the Stark Law exclusions and the AKS safe harbors, including how VBE participants are impacted. Not all the changes can be viewed as negative. For example, "Entities or individuals that sell DMEPOS, other than a pharmacy or a physician, provider, or other entity that primarily furnishes services, all of which remain eligible." Those readers who have undergone surgery will appreciate that it is both easier and reassuring to have a brace fitted post-operatively by a member of an orthopedic surgeon's ancillary office team than being asked to go to a medical supply company that sells a variety of different items for different specialties.

The critical items that providers need to be aware of include the following: (1) documenting value-based purpose as part of its policies and procedures; (2) making sure that "one purpose" of the referral is to induce or compensate a referral or payment funded by a federal health care program; and (3) that the referral is not based on the volume of patients referred. Failing to do these items may lead to a viable FCA case.

The Interplay Between the False Claims Act and the VBE Participants in the Final Rules
Known as "the Lincoln Law," the FCA, 31 USC §§ 3729-3733 was "enacted by a Congress concerned that suppliers of goods to the Union Army during the Civil War were defrauding the Army." A FCA case may be brought by the United States Government on its own or by an individual known as a qui tam relator. In exchange for a relator bringing fraud against the Federal Government to the attention of the United States Department of Justice (DOJ), a relator shares in a portion of a settlement, when it is reached between the government and the defendant(s).

The AKS and Stark Law have long been utilized as the basis for successful FCA causes of action. For example, on September 23, 2020, pharmaceutical company Gilead Sciences, Inc. settled claims for $97 million that it violated both the AKS and the FCA by using a foundation to pay for Medicare patients' copays. And, on November 20, 2020, Doctor's Choice Home Care, Inc., along with its former executives, agreed to pay $5.15 million to resolve allegations that the home health agency provided improper financial inducements to referring physicians utilizing sham medical director agreements and bonuses to physicians' spouses in violation of the Stark Law and AKS.

Considering these recent settlements, a fundamental question to ask is, "Would the outcomes have been different under the new Final Rules as VBE participants?" The answer is no, because sham medical directorships do not fall under the protection of the VBE parameters and pay for Medicare patients' copays on a large-scale basis (there is an exception which allows providers to waive a copay on a case-by-case basis after financial need has been established). Additionally, there is nothing in other parts of the Final Rules that provide new exceptions to waiving copays or overpaying/creating sham scenarios for medical directorships. In sum, despite the AKS and Stark Law Final Rules, the FCA may still be a viable option, as the government did not give VBE participants carte blanche to engage in any activity they wish in order to increase revenues under the guise of improving patient outcomes.

Conclusion
"The more things change, the more they stay the same" is a phrase with which most of us are familiar. In relation to the AKS and the Stark Law, despite the new Final Rules, the VBE participants still need to do the following: (1) meet the exception/safe harbor in each law; (2) read the laws in pari materia with each other in order to glean the full meaning; (3) meet all of the elements of the VBE participant purpose; and (4) ensure that one purpose of the referrals is not to base compensation on the volume or revenue of the referrals. Failing to do these items could lead to a viable FCA case.

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New Regulatory Changes May Help Expand Telehealth Usage

The COVID pandemic has changed the way that healthcare delivery is viewed. Telehealth services, although used prior to the pandemic, really increased when states had stay at home orders and restrictions. People still needed to get medical care, and telehealth stepped up.

One of the driving issues behind lower usage of telehealth in the past has been the CMS restrictions on the ability to bill for these services.

Prior to the COVID-19 outbreak, Medicare had specific guidelines on what it considered a payable telehealth service that included where the patient was located. The physician would not be paid by Medicare if they provided the telehealth service to the patient in his/her own home. When the public emergency was declared, CMS relaxed some of the restrictions so more patients could obtain medical care from home and physicians could get paid for providing that care. CMS will keep these relaxed guidelines in place until the public emergency has ended. So, what happens then?

There are also federal regulations, such as the Stark Law and Anti-Kickback Statute, that made providing telehealth services more difficult for some practices. But there have been some things that have come into the picture that may change that. One is a Final Rule, and another is a new proposed law.

Final Rule

A Final Rule for Medicare and State Health Care Programs, 42 CFR Parts 1001 and 1003, will take effect January 19, 2021. The Final Rule has introduced new safe harbors and modified some existing ones. The Stark Law was enacted by Congress in 1989 as part of the Ethics in Patient Referrals Act, with an intent of disallowing physicians from referring Medicare patients to labs that the physician had a financial stake (ownership, partnership, etc.). For example, a physician could not become a partner in an MRI center and then refer his patients to that center only for MRIs.

The Anti-Kickback Statute was part of the Social Security Amendment in 1972. The intent was to prohibit offering, soliciting, or accepting any type of gift or remuneration for patient referrals. There are exceptions, or "safe harbors" that include payment and/or business practices that are not treated as offenses under the Anti-Kickback Statute (OIG.hhs.gov). The Safe Harbor Exceptions list the safe harbor, and then list the standards necessary to meet the safe harbor.

For example, space rental is not considered remuneration (a violation under the Statute) if:

1. The lease agreement is in writing and signed by both parties.
2. The lease states the terms for the lease and the premises covered.
3. The lease states the schedule of access to premises if not on a full-time basis.
4. The lease term is not less than one year.
5. The rental charge must be at fair market value.
6. The leased space does not exceed what is reasonably necessary for accomplishing its purpose of the rental.

Due to the move toward value-based care, the new rules were created to update the laws to keep up with the new arrangements for delivery and payment of healthcare services today, accounting for the movement from fee-for-service payments to value-based care systems. The Final Rule creates new safe harbors and modifies other existing ones. This will allow practices to enter into business arrangements with other companies that are currently prohibited. For instance, a remote glucose monitoring company could enter into a value-based payment arrangement with a practice and offer to provide a staff member to help set up and monitor patients at no charge.

The new safe harbors are as follows:

- Value-based arrangements with substantial financial risk: protects both in-kind and monetary remuneration among participants that share a substantial financial risk;
- Value-based arrangements with full financial risk: allows for more flexibility for in-kind and monetary remuneration than the safe harbor above for substantial financial risk;
- Care coordination: protects in-kind remuneration among participants for care coordination and management (includes digital health technology);
- Patient engagement: focuses on patient engagement and support tools provided by a participant in a target population;
- Safe harbor for CMS-sponsored models: focuses on payment and delivery models sponsored by CMS;
- Cybersecurity technology and services: focuses on improved cybersecurity in healthcare;
- Telehealth technologies for in-home dialysis: allows for certain telehealth technologies to be provided to beneficiaries with end-stage renal disease that are receiving in-home dialysis.
- The revised safe harbors are as follows:
- Local transportation: allows for expansion of transportation for residents in rural areas, and removes the 25-mile limit on transportation of a patient to his/her home upon hospital discharge;
- Personal services, management contracts, and outcomes-based payment arrangements: eases the existing

Anti-Kickback Statute for personal services arrangements;
- Warranties: redefines warranty and includes protections for warranties;
- ACO beneficiary incentive program: allows for remuneration.

New Bill

The Interstate Medical Licensure Compact is an agreement made between participating U.S. states to work together to streamline the process for licensing physicians that want to practice in multiple states, including by telehealth. The IMLC includes 29 states, the District of Columbia, and Guam. This issue is causing one of the biggest barriers to telehealth expansion; some states still restrict or prevent physicians from using telehealth to treat patients in other states. But that is another thing that lawmakers are trying to change.

There has also been a new bill introduced in Congress in October of 2020 regarding the Interstate Medical Licensure Compact (IMLC). The bill (HR 8723) would block states from receiving funding from the Bureau of Health Workforce if they do not join the IMLC. In addition, the bill would prevent state licensing boards from getting certain federal grants unless they've joined the compact within the next three years.

When the pandemic hit, about half of the states enacted emergency measures that allow for license portability, which enabled them to use telehealth across state lines.

There have also been two other bills put before Congress; one that would allow physicians in any state to treat a patient via telehealth in any other state, and another that would enable physicians in good standing to use connected health to treat patients during the pandemic.

Conclusion

While telehealth cannot replace every type of office visit, it can be beneficial to home bound or disabled patients that could benefit from not travelling to an office. And, with the pandemic, there are times when no one may be able to travel to their physician's office. No one knows where telehealth will land after the pandemic. Congress and the new Federal Rule have taken steps to broaden accessibility to patients to any physician from any state. We'll all have to keep watch to see what happens. To keep up with the progress of the Bills, they can be tracked on the govtrack.us website. The three mentioned in this article are Bill HR 8723, The Equal Access to Care Act, and the Temporary Reciprocity to Ensure Access to Treatment Act. The new Final Rule discussed can be found on the Federal Register website at the following link: https://public-inspection.federalregister.gov/2020-26072.pdf.

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E/M 2021:

A New Year Brings Some Big Changes

After a year filled with new regulations, new rules, new financial models, new viruses, and new ways of interacting remotely with patients, New Year's Day brings one final present: a package of new guidelines for E/M coding. So, let's welcome in 2021 with a quick review of the new E/M coding system that CMS has planned for office practices.

Since the 1990s, U.S. physicians have been billing for Evaluation and Management Services based on three-and-a-half key items: history, exam, medical decision making (MDM), and sometimes, in selected situations, time (for example, when counseling and coordination of care constitute more than 50% of the encounter, but only for face-to-face time with the patient). (Our sisters and brothers in other developed countries have looked on and said, "WHAT?!?! You've got to be kidding!") Recognizing this burden, in 2018, CMS launched the "Patients Over Paperwork" initiative to "cut the red tape." And three years later, at the stroke of midnight on January 1, 2021, the baby will be born.

The fundamental difference between E/M 2021 and the iterations it replaces is that time and MDM are now the drivers for coding. Performance and documentation of history and exam are only required as medically appropriate. What this means is that the complex rules for counting the elements in an HPI, the number of systems reviewed in the ROS, and the number of body areas/organ systems examined go away. Instead, providers are given a choice on any individual office encounter to code based either on time spent or MDM.

One big caution: The new E/M 2021 changes only apply to office/outpatient encounters. E/M services provided in hospital, ED, nursing facility, etc. are not affected.

For E/M 2021, CMS retains the familiar "new patient" and "established patient" codes (with one exception…99201 "New Patient—Problem Focused" is being retired). With a little help from its friends at the AMA (the trademark holder for CPT Codes), CMS has re-defined the remaining office codes 99202-99205 and 99211-99215.

First, Let's Take A Close Look at Time

If you choose to code based on time, here are the 2021 definitions:

Code	Total Time Spent on Date of Service
New Patient	
99201	[This code is retired as of 1/1/2021.]
99202	15-29 minutes
99203	30-40 minutes
99204	45-59 minutes
99205	60-74 minutes
Established Patient	
99211	The new definition removes reference to time.*
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

*99211 is newly defined as "Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually the presenting problem(s) are minimal."

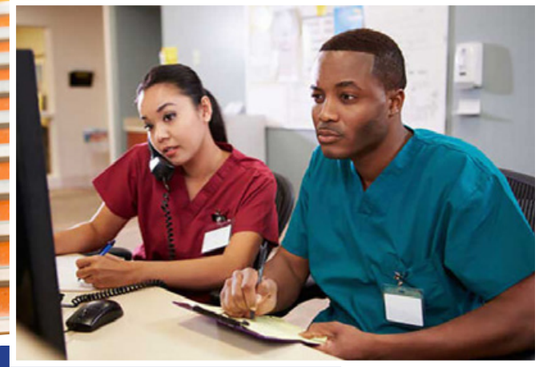
A big change with E/M 2021 is that the total time spent by the provider includes both face-to-face and non-face-to-face time spent on the date of service. And time-based coding can be used whether or not counseling and/or coordination of care dominate the service.

Specifically, the new time-based coding may include time for the following activities:

- Preparing to see the patient (i.e. reviewing the chart or tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Referrals or discussion with other providers
- Documenting the clinical encounter
- Placing orders
- Writing prescriptions
- Reviewing results (on the same day of service)
- Care coordination that is not separately reported

A few important caveats regarding time-based coding:

- Clinic staff time (like the time to check in the patient and collect vitals) may not be included.
- If two qualified healthcare professionals (i.e. a physician and nurse practitioner) see the same patient together, only one can bill for the overlapped time.
- The "midpoint" and "threshold" times used in previous E/M guidelines go away. The new 2021 definitions give exact time ranges.
- For prolonged services (beyond the limits of 99205 and 99215) a new code temporarily called +99XXX will be available. Providers will be able to use +99XXX once for each 15 minutes beyond the primary service time (only for activities provided on the day of service).
- Currently, there are conflicts between AMA (who creates CPT codes) and CMS regarding codes 99358 and 99359 (intend-



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Please visit www.billing-coding.com/group for more information.

ed by AMA to cover prolonged services on a day other than the day of service). CMS has indicated that these codes will not be payable in association with E/M coding in 2021. Look for ongoing changes and evolution on this topic.

Now, Let's Examine MDM

For MDM, AMA has closely examined the CMS "Table of Risk" and supplemented it with additional information from contractor guidelines and its own definitions and examples to create a single one-page (very small print) table that you should absolutely download and print. You can find the table at: www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Effectively, the level of MDM is broken into 4 categories:

- Straightforward (99202 and 99212)
- Low (99203 and 99213)
- Moderate (99204 and 99214)
- High (99205 and 99215)

(AMA provides an additional code—99211 described above—where MDM is not applicable.)

And, AMA associates each level with three Elements of Medical Decision Making (the three major columns in the table):

- Number and Complexity of Problems Addressed
- Amount and/or Complexity of Data to be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management

To determine a code for a given encounter, find a row where at least two of the three elements are met.

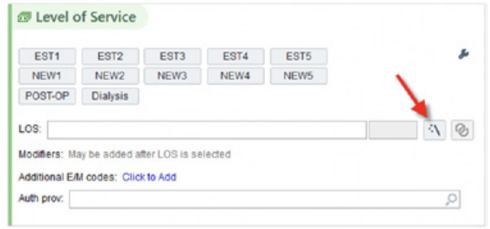
In addition to reviewing the table, it is critical to understand the AMA's definitions of the terms that appear in the table. The AMA has published a detailed document outlining the 2021 changes to office E/M coding. That document can be found at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. Three pages of definitions start on page 3.

So Happy New Year and Happy Coding! Break out the champagne and the Hoppin' John. And let's hope that Uncle Sam's plan to decrease administrative burden and paperwork for office visits brings some welcome relief in 2021!

Timothy McNamara, MD, MPH, is Sr. Director of Clinical Health IT in FMCNA Medical Office and serves as Acumen's Medical Director. Dr. McNamara is a physician with an extensive health informatics background. He brings 26 years of experience in healthcare IT from work in both corporate and academic environments. www.acumenmd.com

HOW IS ACUMEN 2.0 RESPONDING TO THESE CHANGES?

Early in January 2021, Acumen will be pushing out an update to 2.0 that incorporates the new E/M definitions. This update will affect relevant SmartSets and the Wrap-Up activity. It will also provide a new "Level of Service" calculating tool accessible from the wand icon below.



The new calculating tool will automatically suggest an E/M code for medical decision making based on chart documentation (including things like diagnoses and orders) and display the criteria that contribute to each level of service. Of course, users can change these suggestions as needed. It will also allow users to enter the total time they spent on the visit and it will then calculate the relevant service code.

For E/M coding for the first few days of 2021, providers can continue to select the same buttons as 2020, but the new definitions described above should determine which code providers select. Note "NEW1"—99201—should not be selected after December 31, 2020.

COVID Vaccine Codes Announced

On November 10, 2020, the American Medical Association (AMA) announced the addition of two new codes which will be used for the new COVID-19 vaccines, along with four new administration codes to be used when reporting the administration of these vaccines.

Please keep in mind that, at this time, these vaccines are currently in the trial phase. In preparation for their approval, a new coding structure has been created. According to a special edition of the AMA's CPT Assistant:

"This new structure differs substantially from that used for extant vaccines. This is due in part to the rapid development of these vaccines, the request to track the administration of each individual vaccine, and the need for a long-term viable solution that will enable the Panel to add codes as new vaccines become available without affecting other subsections of the code set. Instead, instructional parenthetical notes will be added throughout the code set, directing users to the appropriate subsection for COVID-19 vaccine codes."

The new vaccines must be administered in two doses, so the new administration codes (0001A-0012A) specify which dose is being administered and include risk/benefit counseling when performed. Having two separate codes for dosage administration will help to identify patients who may still need to get a second dose, as well as when they received the second dose.

The new vaccine codes are the following:

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free:

- 91300 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use
- 91301 100 mcg/0.5mL dosage, for intramuscular use

In addition to these codes, a new Appendix (Appendix Q) has been added to be part of the CPT codebook. This appendix includes the manufacturer, vaccine name, NDC product ID, and dosing interval information. This information is essential to ensure that you are reporting the correct codes for the vaccine being administered.

Alert: Although these codes have been released, they are not effective until they have been granted either Emergency Use Authorization or approval from the Food and Drug Administration.

These codes and their guidelines have been added to FindACode.com and can be viewed immediately. However, do not use them until they are officially effective.

Wyn Staheli, is the Director of Research for Find-A-Code. www.findacode.com

References:
COVID-19 CPT vaccine and immunization codes AMA page
Appendix Q: Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) Vaccines

Get Ready: 1135 Waivers, Licensing Extensions Ending Soon

HHS recently extended the Public Health Emergency (PHE) into January 2021, keeping the 1135 waivers — including licensing requirements — in place, for now.

While there is no definitive expiration date for the waivers, the one thing that is certain is that these waivers will end, and if you are not prepared, you could lose your license.

1135 Waivers
By granting a PHE, HHS can temporarily waive or modify certain Medicare, Medicaid, Children's Health Insurance Program (CHIP), and HIPAA requirements in an emergency area during the emergency period.

The 1135 waivers have benefited you many ways, enabling you to be more easily reimbursed for services and exempted from sanctions.

These waivers include:
- Conditions of participation or other certification requirements and program participation and similar requirements
- Preapproval requirements
- Requirements that you are licensed in the state in which you are providing services, so long as you have equivalent licensing in another state (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-federal provider is authorized to provide services in the state without state licensure)
- Emergency Medical Treatment and Labor Act (EMTALA)
- Stark self-referral sanctions
- Performance deadlines and timetables may be adjusted (but not waived)
- Limitations on payment for items and services you provide to Medicare Advantage enrollees when you are out-of-network

The national emergency and PHE together keep the waivers in place, along with each individual state mandate. The big issue is that there isn't a one-size-fits-all approach to ending the waivers.

Any of these scenarios could signal the waivers' expiration:
- An end to the national emergency
- An end to the PHE
- Any end or change to the 1135 waivers

It is unclear when any of the items including the pandemic and the PHE are ending. There is nothing definitive, except that the termination depends on each state.

States Mandate Overall Licensing Requirements
Do not take the extended PHE as an invitation to hold off fulfilling your state licensing requirements! A PHE declaration does not waive or preempt state licensing requirements. Your state has the final say in whether you are authorized to provide services without a license.

The Federation of State Medical Boards (FSMB) has released a rundown of how each state and territory is handling licensing and continuing medical education waivers and requirements.

You should pay close attention to what your state is doing and the projected deadlines that affect you in your home state and other states you practice in:
- **Licensing waivers:** Many states extended temporary emergency licenses to physicians who held licenses in other states, to come and assist during the pandemic. Some states, including Colorado, also allowed physicians with an expired license to operate within a certain time frame without being fined.
- **Retired/inactive physicians:** With the healthcare system overwhelmed at the start of the pandemic, many states were calling retired and inactive physicians back into service, expediting licenses. Louisiana called on medical students to serve as volunteers.
- **Telehealth providers:** Many states expanded their telehealth services, allowed an expansion of professions to provide telehealth, and granted temporary licenses to if you provided telehealth visits to patients in a different state where you did not have a license. Connecticut, for example, expanded the type of healthcare professionals that can provide telehealth services to dentists, genetic counselors, and occupational or physical therapist assistants, among others. They also allowed audio-only telemedicine modalities, and prohibited insurers from reducing reimbursement for telemedicine services.
- **Continuing medical education (CME):** With a nation on lockdown, acquiring CME credits during the pandemic has been difficult to say the least. Many states have extended the credit requirements for license renewals, while other states like Massachusetts suspended CME for physicians whose license expired between April 2, 2020 and Dec 31, 2020.

Get Ready for Licensing Waiver Expirations
If you aren't ready to move forward with your licensing updates, you need to be. Neglecting to go through the process now will cost you reimbursements for services you already provided.

Sign up for an upcoming training, "Licensing Waivers Expire Jan. 1: Comply or Risk Losing Your License," for step-by-step practical advice on keeping up with licensing requirements so you can keep your license and your patients!

Jennifer Godreau, CPC, CPMA, CPEDC, COPC, has almost 20 years of experience in billing, coding, compliance, and practice management. She develops the content and programs for Healthcare Training Leader, a practice-specific online training company offering step-by-step advice on increasing reimbursement and avoiding compliance violations. Jennifer has a Bachelor of Arts from Wittenberg University in Springfield, Ohio. She holds certificates in coding, auditing, pediatric coding, and ophthalmology billing and coding, and is AAPC Vice President of the Naples, FL chapter. Please reach out to Jennifer for step-by-step guidance at editorial@hctrainingleader.com

Solid Commandments for A/R Management

In a recent survey of physician practices, physician reimbursement and management of the accounts receivable (A/R) were among the top important topics affecting physician practices today.

A/R management has many methods which, combined and implemented, can reduce the cash flow and staff workflow. I have curried some of my favorite focus areas and come up with a few solid commandments for A/R management.

Front Desk Responsibilities and Accountability

This first item is where the preaching gets to the thumping mode! I swear that a strong front desk, with strong intake policies and procedures, will fix your A/R problems before they occur. Usually the front desk personnel are the least paid, least experienced, and busiest people in the practice. Those octopi up front are dealing with hundreds of different items at the same time. However, oftentimes, their mistaken belief is that getting the patient in their face at that moment out of their face as quick as possible is their primary goal. Wrong!

That failure to develop a strong front desk is the root cause of so many A/R issues. How many rejections are the result of missing or incorrect demographic information? Who checked to make sure the visit is eligible before the services were performed? How many times has the patient tried to run out without paying their copayment, or told you they did not know they had a balance, because no one let them know? How often do you hear, "I left my checkbook at home"? Come on! Does anyone leave home these days without some cash or debit/credit card in their possession? What is in those purses and wallets anyway?

Remember, it is our job to ask for the money and the patient's job to pay for their services. Starbucks has it right! Pay for your coffee before you get served! Today's technology makes it easy to go online to all the payers and verify coverage and obtain coinsurance information before the patient is even escorted back. Build a strong front end and avoid chasing the money later!

Remind Patients of Copayments and Past Due Balances When Appointments are Scheduled

One of our training sessions for our clients is how to utilize each patient contact as a means to control your A/R. I remind people that A/Rs are created by failure to collect the money at the time of service.

I have seen A/R improvement with the electronic appointment schedulers that ties into the patient practice management billing information. Brilliant, I say. This is also called a fully integrated system! While on the telephone when the appointment is being made, click another screen that brings up the demographics and advance to the outstanding balance screen. It is the perfect time to remind the patient to bring their balance due of $X with them.

The person doing the appointment confirmation (hopefully you do call and remind!) is usually working off the patient schedule printed for the next day. Over 95% of the time, missing from that sheet is the outstanding balance or copayment amount required at the time of service. Adding this information, and including it in the appointment confirmation script, will inform the patient and provide them the preparation time necessary to meet their financial responsibility. We treat the medical condition, and they pay for the treatment! Brilliant!

Collect or Reaffirm Accurate Patient Demographics and Insurance Information Before the Visit

Another important part of that appointment confirmation script, or information to have played on the telephone during a patient hold, is to remind patients to bring their insurance card in order to update their demographic information. It is also advisable to capture a copy of a government issued picture ID to reduce insurance fraud and identity theft.

This eliminates those common A/R issues such as:

- Patient no longer has coverage
- Patient has changed jobs
- Employer has changed insurance companies
- Patient is retired
- Patient has started Medicare
- Patient has moved

With mobile phones so prevalent these days, make sure you ask the patient for their cellular number as the main point of contact.

I also want to speak to my techno-geek doctors or as I call my new doctors, my baby docs, out there! I have not helped set up a practice in the last four years that did not involve EMR and development of their own websites. Web-based patient registration is another brilliant idea! I personally am happy for the ability to make an appointment or register for a visit in the comfort of my home, after hours, instead of hanging on to the phone for many minutes waiting for a live person to take my information. I personally find myself too busy to stay on hold for long periods of time. Using your technology for online registration assists the technology-savvy patients in helping themselves and relieves some of the load from your overworked front office staff.

Failure to Move Insurance Responsibility to Patient Responsibility in a Timely Manner

The science of electronic filings and prompt payment initiatives has made it possible for us to know within a few days the number of days a clean insurance claim will take from submission to payment. We are addressing how to assure that the claims are clean when they are sent, so now we need to use our technology to tighten up those days in the system. Most billing software has the ability to define your management prompts, such as the number of days to be notified when a claim is overdue, or when to transfer from insurance to patient. Set up your insurance responsibility to patient responsibility transfer prompts to less than 30 days. Additionally, strong A/R management advisors recommend that if you haven't collected the copayment up front, then the patient should be second invoiced within five days from the visit.

Strong collectors, when working the A/R, will tend to look at the big money and work down. Or, they will work on the aged and work forward. Additionally, most activity is either patient balance centered, or insurance balance centered, but not both at the same time. As a result, these methodologies usually translate into working the insurance claims first and then going after patient balances last. We have already addressed how to nip the patient A/R in the bud before it happens; however, while you are in that transitional period of implementing your new strategies, the current patient balances are still there and need to be cleared up. Invoicing the patients within five days cuts your timeline down significantly and puts that account into a more aggressive activity mode.

Review the Physician Coding Before Submitting Claims

Do I need to explain this one? It's common sense.

Establish Collection Goals and Targets and Reward Staff for Meeting Those Goals

It is not just the collectors who should be incentivized in your practice; establish practice-wide goals and enroll active participants into the process of resolving them. From patient registration to charge entry processing, claim submission to posting of payments and handling of denials and resubmission, these individuals need to split the rewards, as well as the failures of the A/R. Goal setting should be realistic and measurable. Then dollar amounts, or other types of rewards, should be determined and distributed.

Finally, I've listed a few other hints on how to control and manage your A/R below:

- Electronic remittance and fund transfers
- Use credit card and debit card services (check verification)
- Periodically review accuracy of intake to make sure the most common procedure codes and diagnosis codes are updated to the fifth digit
- Use encounter forms or EMR correctly to capture all services performed and require sign off by persons providing the services

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Interview with Administrator of the Centers for Medicare & Medicaid Services (CMS),

Seema Verma

Welcome to 2021 and the start of what I can only hope and pray will be a better year for all. I am humbled and privileged to again be asked by BC Advantage to interview one the industry's most recognized and influential leaders. Seema Verma was nominated by President Trump to be the Administrator of the Centers for Medicare and Medicaid Services (CMS) and was confirmed by the United States Senate on March 13, 2017. The U.S. Department of Health and Human Services reports of Ms. Verma that:

"As Administrator of CMS, she oversees one of the largest federal agencies that administers vital healthcare programs to over 100 million Americans. Before becoming CMS Administrator, she was the President, CEO, and founder of SVC, Inc., a national health policy consulting company. For over 20 years, Ms. Verma has worked extensively on a variety of policy and strategic projects involving Medicaid, insurance, and public health, working with Governor's offices, State Medicaid agencies, State Health Departments, State Departments of Insurance, as well as the federal government, private companies, and foundations… Ms. Verma received her Master's degree in Public Health with concentration in health policy and management from Johns Hopkins University and her Bachelor's degree in Life Sciences from the University of Maryland" (Seema Verma | HHS.gov).

This interview was focused on the most significant policy changes and those critical questions left unanswered in 2020 that our industry is desperate for answers to in 2021. Ms. Verma provided an outstanding, in-depth, and candid interview. She did not shy away from the tough questions! I would like to thank Scott Kraft, Senior Compliance Consultant, and Grant Huang, Director of Content of DoctorsManagement, LLC, for their help to ensure we thought through each and every question and phrased it so that we were able to solicit answers from Ms. Verma that provided the most direct and complete answers to help you, the reader, strategically position your company with what is coming down the pike!

On behalf of BC Advantage, we would like to thank Ms. Verma for her time and willingness to engage in this interview and for sharing critical information that we as healthcare professionals desperately require to ensure we are compliant and prepared for the challenges that lie ahead in the New Year!

BC Advantage (BCA): This most recent Physician Fee Schedule (PFS) final rule implemented the biggest cut to the Medicare conversion factor (-10%) since 2011. CMS stated that this is needed to comply with the budget neutrality provision because the PFS increases payment for E/M services in 2021. Specialties that primarily report E/M services will benefit, but specialties that don't (e.g., surgical specialties, anesthesia, radiology, etc.) will see a sharp reduction in Part B payment. Is this intended to help E/M-based specialties like primary care? Does this represent a long-term rebalancing of how Part B reimbursement is allocated?

Seema Verma (SV): The PFS final rule continued CMS's historic efforts to reduce burden and compensate providers for the important work of managing their patients' complex conditions. Last year, CMS increased payment rates for evaluation and management visits, reflecting the most significant revision in payment to the E/M codes since they were instituted.

Over 10,000 beneficiaries join the Medicare program every day, and alongside this growth in enrollment, beneficiaries' healthcare needs are also increasingly complex, with over two-thirds of Medicare beneficiaries having two or more chronic conditions. These payment increases, informed by recommendations from the American Medical Association (AMA), support clinicians who provide crucial care for patients, such as managing ongoing care of patients with chronic disease. And these changes bring Medicare payment in line with the great value common office visits render to the patient and the broader healthcare system.

The rule addresses decades in underinvestment in primary and preventative care that has led to the costly system of sick care we have in this country. Ultimately, a reimbursement system needs to reward providers for keeping patients healthy.

The increase in payments for E/M visits are long overdue and will now better reflect the additional resources, complexity, and time involved in routine patient visits. These services comprise 20% of PFS spending, but their valuation hasn't been comprehensively updated since the early 90s. The increase in payment for E/M codes, as with any changes in payment for specific services, are implemented in accordance with statutorily mandated budget neutrality requirements. As we increase payment in certain places to drive value in healthcare, especially for chronic care management and preventive care, we also must decrease payment for other services. These adjustments are required by law, and are similar to adjustments clinicians see every year, both up and down. Physicians that see a higher proportion of patients' visits will see increases in payments compared to physicians that do fewer visits or do more procedures.

The payment changes build on our efforts to modernize and simplify Medicare's E/M documentation and coding guidelines, and will give clinicians greater discretion to choose the E/M visit level for billing Medicare based on either guidelines for medical decision-making or time dedicated to patients, and they go hand-in-hand with the payment changes.

BCA: There are numerous aspects of the new 2021 E/M guidelines that could be interpreted in different and conflicting ways. Will CMS address these via sub-regulatory guidance in 2021? Will CMS's program integrity efforts, such as E/M audits, account for the strong possibility that new rules with gray areas could result in apparent overcoding?

SV: We are planning to release additional provider communications on the E/M changes from last year and note that the American Medical Association began educating the medical community on the new guidelines (which we adopted) last year. We are always eager to hear concerns and questions that arise once the codes start being used.

Additionally, we are currently working on subregulatory guidance that we believe will help address some of your concerns. We anticipate that if this topic is subject to Medicare Administrative Contractor review, the contractors will conduct individualized discussions with providers to help ensure uniformity in application and consistent understanding. This type of targeted probe (claim audit) and education (including discussion) facilitates provider/contractor communications and helps ensure a consistent interpretation.

BCA: Revenue Integrity: MAC & RAC Audits. MAC & RACs have admitted that they sometimes have significant errors in their assessments when claiming physicians were improperly paid. This creates administrative burdens for providers. Why doesn't CMS implement a reimbursement policy where those subcontracted auditors have to reimburse providers if their audit findings are revealed to have been erroneous and resulted in improper recoupments?

SV: In 2017, we launched our Patients over Paperwork initiative with the clear goal of reducing provider burden to put patients first. Since then, we have eliminated unnecessary regulations, reformed coding and documentation policies, and updated the Stark Law. Most recently, we issued a proposed rule to address prior authorization and further reduce burden on patients and providers. This important rule would improve the electronic exchange of healthcare data among payers, providers, and patients, and streamline processes related to prior authorization, ultimately giving providers more time to focus on their patients and provide better quality care.

Specific to the RACs, several enhancements to the Program have led to better oversight, reduced provider burden and appeals, and increased program transparency. RAC accuracy is independently monitored by a RAC Validation Contractor (RVC). The RACs are required to maintain an accuracy rate of 95% or greater, and for each percentage point above 95%, RACs earn a .2% contingency fee increase. Failure to maintain an accuracy rate of 95% may result in CMS actions, such as progressive reductions in additional documentation request limits, modification/termination of the contract, Corrective Action Plan, CMS's decision to not exercise the next option period of the contract, etc. RACs will not receive a contingency fee until after the second level of appeal is exhausted. Previously, RACs were paid immediately upon denial and recoupment of the claim. This delay in payment can assure providers that the RAC's decision was correct before they are paid. Additionally, the institution of the 30-day discussion period, on all RAC reviews, after an improper payment is identified, means that providers do not have to choose between initiating a discussion and filing an appeal. Finally, CMS regularly seeks public comment on all newly proposed RAC areas for review, before the reviews begin, allowing providers to better prepare for RAC reviews before they begin and to voice any concerns in regard to unclear policies.

CMS will continue to build on our efforts to reduce burden on providers to ensure they can continue to focus on caring for their patients.

BCA: Incident-to Billing has long been a thorn in CMS's side and painful for providers who may have misinterpreted the guidelines, which resulted in significant overpayment demands and/or civil/criminal cases being filed against these providers. There has been speculation of CMS doing away with Incident-to Billing completely; can you speak to where CMS stands on the issue?

SV: In the recent Physician Fee Schedule rules, CMS has not indicated any intention to eliminate billing services under Incident-to. We've continued to make clarifications on our Incident-to policies. In the most recent Physician Fee Schedule Final rule, we clarified that pharmacists may fall within the regulatory definition of auxiliary personnel under our "incident to" regulations. As such, pharmacists may provide services as part of the professional services of a practitioner who bills Medicare, in accordance with the pharmacist's state scope of practice and applicable state law. These clarifications are especially important to help providers respond to the COVID-19 public health emergency.

BCA: CMS is undertaking a huge change starting January 1, 2021 with the Evaluation and Management Service Codes (99202 – 99215). Is CMS considering similar changes to other Evaluation and Management Service Codes? If so, which would be the next code range affected and what would be a potential implementation date?

SV: The revisions to the E/M codes that go into effect on January 1, 2021 represent 20% of Medicare spending under the Physician Fee Schedule, so the documentation and payment changes will have a substantial impact on clinicians across the country.

CMS has sought comment on potential changes to other E/M codes, and notes that the AMA CPT Editorial Panel has indicated potential review of the codes. Any changes would be subject to notice and comment rulemaking prior to taking effect.

The agency is committed to reducing provider burden so that providers can spend more time with patients, and we continue to welcome input from the front lines on what else we can do to help providers. CMS must constantly be vigilant and continue to consider changes as technology, innovation, and physician practices evolve.

BCA: In keeping with the question above, will CMS be moving to more clinicians performing audits of provider medical records since the changes to the Evaluation and Management Codes essentially remove the quantification aspect of the code and put more emphasis on the clinical judgement (qualification) and "Medical Necessity" of the service? If so, will CMS require UPICs, RACs, etc. to comply with the requirement for audits to be performed by clinicians and not certified coders? Again, this would be only for the codes 99202-99215 at this point.

SV: Audit strategies are determined based upon data mining and aberrancies that demonstrate the potential for vulnerabilities. Should these E/M codes be subject to review, the contractor review scope would be determinant of the type of personnel assigned to conduct the review.

BCA: Given the fact that the country remains in a Public Health Emergency (PHE), will CMS remain as aggressive in their auditing of providers as they have been since the "ramp-up" that started again in August 2020? If so, outside of Telehealth Services, which are a significant audit target, what other services are a top priority for CMS to audit?

SV: We have continued to action to strengthen Medicare and protect it to better serve the interests of patients. Our program integrity efforts are aimed at holding the entire healthcare system accountable, protecting beneficiaries from harm, and safe-

guarding taxpayer dollars to empower patients while minimizing unnecessary provider burden.

Earlier this year, Medicare Administrative Contractors (MACs) resumed fee-for-service medical review activities. Beginning August 17, the MACs resumed post-payment reviews of items/services provided before March 1, 2020. The Targeted Probe and Educate program (intensive education to assess provider compliance through up to three rounds of review) will restart later. The MACs will continue to offer detailed review decisions and education as appropriate.

CMS has worked to balance MAC and RAC auditing activities with both the demands on providers during the PHE and our responsibilities to protect the Medicare Trust Funds. We have been careful to consider audit scope relative to the amount of funds at stake to evaluate provider burden. Providers are encouraged to reach out to their contractor if they are experiencing difficulty complying with an audit request in a timely fashion. Any future audits will continue to be mindful of identified claims vulnerabilities and provider impacts. Audit strategies are jurisdictionally determined, based on contractor claims data and analysis.

CMS is continuing to be vigilant in protecting the trust fund while balancing provider burden during the public health emergency. After careful analysis, CMS is continuing prior authorization for certain hospital outpatient department services. In July 2020, we began the prior authorization process for five types of cosmetic surgical procedures. In July 2021, we will require prior authorization for two additional categories of procedures—cervical fusion with disc removal and implanted spinal neurostimulators.

CMS is creating demonstrations to give providers review options to alleviate burden while conducting necessary monitoring. CMS is continuing the Home Health Review Choice Demonstration (HH RCD), which assists in developing improved procedures to identify and prevent fraud, protect beneficiaries from harm, and safeguard taxpayer dollars for home health services. The demonstration establishes a review choice process to help ensure that the right payments are made at the right time for home health services. The demonstration is currently operational in IL, OH, TX, NC, and FL.

CMS is also beginning the Paperwork Reduction Act approval process for a new Review Choice Demonstration for Inpatient Rehabilitation Facilities (IRF) services. This demonstration will mirror the RCD for home health services and will begin in FY2021.

CMS will continue to identify and investigate fraud, waste, and abuse in the Medicare program.

BCA: With the PHE expected to last through fall 2021, what additional waivers do you think CMS will issue to ensure providers can continue to offer care to the most vulnerable patients?

SV: Since the beginning of the pandemic, CMS has crafted unprecedented regulatory relief to support providers and issued four Interim Final Rules with Comment Period. These waivers have been instrumental in ensuring the American healthcare system was prepared, and we hope CMS continues to ensure greater hospital capacity and coverage of the COVID-19 vaccine, especially as it becomes more widely available to patients.

Early on during the pandemic, CMS issued a sweeping array of new rules and waivers to increase hospital capacity. Through our Hospital without Walls initiative, we are allowing hospitals and healthcare systems to create new treatment sites outside of their facilities. This will allow them to coordinate care, expand capacity, and safely separate patients with COVID-19 from those who don't have the virus.

Most recently, we expanded that effort by creating an innovative Acute Hospital Care At Home program, providing eligible hospitals with unprecedented regulatory flexibilities to treat eligible patients in their homes.

In anticipation of COVID-19 vaccines becoming available and new treatments for COVID-19 coming to the market, we laid the groundwork to ensure that these were accessible to patients. We announced that the COVID-19 vaccine would be covered by Medicare at no cost to patients, as well as released new Medicare payment rates for COVID-19 vaccine administration, recognizing the costs involved in administering the vaccine, including the additional resources involved with required public health reporting, conducting important outreach and patient education, and spending additional time with patients answering any questions they may have about the vaccine. We also recently announced that Medicare beneficiaries can receive coverage of monoclonal antibodies to treat COVID-19 with no cost-sharing during the public health emergency, as well as created new additional Medicare hospital payment to support Medicare patients' access to these potentially lifesaving COVID-19 therapies.

CMS continues to conduct stakeholder outreach to ensure we are hearing from those on the frontlines. At the end of the day, if there are additional waivers needed, we will work to ensure the healthcare system continues to have the resources it needs to combat the pandemic.

BCA: Telehealth has shown to be an effective alternative to delivering care to significant segments of the population who either cannot or will not come to a provider's office. How does CMS see integrating these services into a permanent service offering and what changes to published guidance during the PHE via the 1135 waivers do you foresee CMS making?

SV: Telehealth has long been a priority for the Trump Administration, even before the COVID-19 pandemic hit. We understood its potential for increasing access in rural areas where providers are often in short supply and provided a convenient option for beneficiaries across the country, whether using it for mental health services or who have trouble finding adequate transportation over long distances or difficulty accessing specialty care. Starting in 2019, we allowed for short virtual check-ins between doctors and their patients in their home and expanded the number of services that could be provided via telehealth.

The national emergency declaration allowed us to waive various restrictive regulations, including those that prevented telehealth from being furnished in certain care settings such as people's homes. We also expanded the types of providers that can provide telehealth and removed face-to-face requirements for certain types of care. Finally, we added services that Medicare would pay for when done by telehealth, such as emergency department visits, mental healthcare, and eye exams.

The speed and effectiveness with which the American healthcare system has adapted to telehealth is astounding given where we were just one year ago and has made clear its usefulness extends beyond rural areas. Before the COVID-19 public health emergency (PHE), only 15,000 beneficiaries each week received a Medicare telemedicine service. But between mid-March and mid-October 2020, early data show that over 24 million Medicare beneficiaries have used telehealth.

This explosion represents nothing less than a seismic shift in healthcare delivery. President Trump recently signed an executive order that directed CMS to make many of these flexibilities permanent. During the public health emergency, we added 144 services that could be paid when delivered by telehealth. In the recent Physician Fee Schedule final rule, we announced that we would make nine of them, including group psychotherapy and certain types of visits for patients with cognitive impairments, a permanent part of the Medicare telehealth benefit. Another 59 services, including emergency department visits, physical and occupational therapy services, and critical care services, will be extended temporarily after the end of the public health emergency, so we can continue to evaluate their impact on quality of care and health outcomes. These additions allow beneficiaries in rural areas who are in a medical facility to continue to have access to a range of telehealth services that we know work for them.

It's important to understand that CMS does not have the statutory authority to cover telehealth for beneficiaries living outside of rural areas or generally allow beneficiaries to receive telehealth

from their home unless there is Congressional action. Without a change to the statute, telehealth will revert to a merely rural benefit, albeit with a significantly expanded menu of services. Congress has the opportunity to make telehealth available to beneficiaries across the country and allow them to get telehealth services from the convenience of their home.

Finally, we are commissioning a study to evaluate telehealth as a whole, and in particular, as remote patient monitoring and virtual physician supervision flexibilities added during the pandemic, to assess the impact of telehealth on quality, safety, and other aspects, including reimbursement, as well as, and potential for, fraud and abuse. This study should help inform future efforts of the agency.

BCA: With some states likely to adopt a $15 per hour minimum wage, which is more than many front desk jobs pay at physician practices, do you foresee Medicare adjusting allowable amounts upward?

SV: CMS's authority in calculating payment rates under the Physician Fee Schedule is limited to estimating the relative resource costs among the services. Overall payment increases would require legislative changes. But in the 2021 Physician Fee Schedule rule, CMS sought comment on approaches to updating practice expense costs, including labor costs, for making these estimates. Using updated data to calculate the payment rates would be subject to notice and comment rulemaking prior to implementation.

BCA: What are some of your most important accomplishments thus far as CMS administrator, and what advice would you give to your successor?

SV: In 2017, we began a four-year mission to transform the American healthcare system by empowering patients and doctors, ushering in a new era of state flexibility and local leadership, fostering innovation, and improving the CMS customer experience through the creation of 16 strategic initiatives. In addition to our revisions on E/M codes previously discussed, there are a few noteworthy accomplishments directly benefiting physicians.

Early on, we conducted a nationwide listening tour and directly engaged providers, beneficiaries, family members, caretakers, and healthcare professionals. This helped inform our thinking around cutting the red tape of government in order to direct clinician focus on patient care, forming the foundation of our Patients over Paperwork initiative. CMS burden reduction efforts under this initiative are estimated to save the medical community $6.6 billion and 42 million burden hours in administrative burden through 2021, with additional savings expected as additional burden reduction measures are finalized.

We are also addressing physician burnout by untangling the government's web of quality measures through our Meaningful Measures Initiative and our historic reforms of the MIPS program. Through Meaningful Measures, CMS rolled back nearly 20% of measures that were either "topped out," duplicative, or simply overly burdensome to report for little gain, eliminating 79 measures across CMS's quality reporting and value-based payment programs. Through our new MIPS Value Pathways, physicians will be able to pick a set of measures that clearly relates to their specialty or the type of patients they see. We're cutting measures that aren't relevant or are difficult to report, and we're focusing on measures that assess outcomes, not process minutiae.

In addition, CMS ended the era of hidden prices, requiring hospitals and plans to make their pricing information public. In addition to price transparency, we ensured data transparency by giving patients access to their medical information, allowing them to be empowered to share data directly with their doctor with the click of a button, and enjoy the coordinated, high-quality care that will result.

Our reforms have produced two consecutive years of premium declines in Obamacare's individual insurance market after years of double-digit price increases. Medicare is a stronger program across the board: premiums in Medicare Advantage and Part D are at historic lows. In traditional Medicare, seniors pay less out-of-pocket for a range of procedures and drugs, including insulin, and enjoy more options when seeking care.

Crucially, these successes proved a strong foundation upon which CMS crafted unprecedented regulatory relief during the Coronavirus pandemic to support providers. But no regulatory flexibility was as consequential as the expansion of telemedicine, which proved a lifeline for patients amid lockdown orders.

It's incumbent of whomever leads the agency next that they continue to build upon these transformational patient-centered reforms. Many of our accomplishments won't be going into effect right away, so my successor will be in charge of implementing many of them. It's critical that he or she put the interests of patients first by continuing to implement these reforms.

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Back to Basics
A Series Presented by Your PAHCOM National Advisory Board

Part IV - Back to Basics:

Problem Resolution

Problem resolution is the cornerstone of business management. All business managers, including medical office managers, have a wide variety of skills which may include revenue and finance management.

Others may be stronger with technology and data and reporting clinical performance. Most have tremendous human resources and practice marketing skills. The skill set that separates outstanding managers from the rest, however, is the ability to resolve issues. The best functioning practice with the most educated leadership may have challenges. Successful practices resolve issues in a timely manner that does not disturb the revenue or reputation of the practice.

While business management gurus will tell you that there are many ways to resolve issues that make everyone feel like they are walking away with a "win," this is not always the case and should not be a determining factor in how you proceed to resolve an issue plaguing your practice. The key issue of resolution is understanding the core of the problem. There are many techniques that have been developed to assist business professionals to drill down and discover the root of an issue. My tried and true favorite is the "Five Whys" method. I use this method in my office because it affords me the opportunity to resolve issues quickly while allowing my staff to be introspective about their part in the issue.

Courtney Seiter at Buffer.com shared that Taiichi Ohno, the architect of the Toyota Production System in the 1950s, described the Five Whys method in his book, Toyota Production System: Beyond Large-Scale Production as "the basis of Toyota's scientific approach . . . by repeating why five times, the nature of the problem as well as its solution becomes clear." In today's business management lingo, the Five Whys is akin to drilling down until you find your solution. Two major differences are the level of participation of the staff members directly involved in the issue and the time it takes to get to the heart of the problem.

Here are the steps to using the Five Whys method effectively:

1. Gather staff involved
2. Define the problem
3. Ask the first Why
4. Ask Why four more times
5. State the core issue
6. Fix it
7. Monitor for success

The Five Whys approach is a time saver since it focuses on issue resolution, not the feelings of the parties involved. By prompting you to push past assigning blame to an individual, it requires that you take a closer look at your process. This method is information driven and demands a level of introspection that forces people involved to think critically about the cause and effect of an issue. The answers to each question "Why?" must be factual. Each answer forms the reasoning for the next question. You know you have reached conclusion when the core issue is apparent.

As an example, let us look at the following scenario that occurred in my office and could possibly happen in yours as well: Mr. Jones, a longtime patient of Dr. Smith, is displeased with the length of time he has been waiting for a scheduled appointment. He has been waiting 15 minutes. The receptionist asks Mr. Jones to wait patiently. Another individual is taken to the back office before Mr. Jones. Mr. Jones becomes furious and yells at the staff. The staff defends themselves by telling him, "We have more than one provider." Mr. Jones continues to escalate and eventually storms out of the office without receiving a reasonable explanation or another appointment. How did we get here? Better yet, how do we fix it? By applying the Five Whys method, we gain clarity. After asking the receptionist and the medical assistant for Dr. Smith to join me for a problem-solving session, we all concluded the problem stems from waiting times for Dr. Smith.

Here are our Five Whys:

1. **Why was this patient kept waiting while others were called for services?** Mr. Jones's provider was running behind, but the other providers were not.
2. **Why wasn't Mr. Jones told that his provider was running behind?** It was just a few minutes. I asked him to be patient. He was next for Dr. Smith. I need him to work with us. Dr. Smith runs behind. Sometimes that is just how it works. Patients expect to wait at a doctor's office.
3. **Why is his time less valuable to you than Dr. Smith's time?** Dr. Smith is a busy physician. Mr. Jones has the rest of the day to do whatever he has to do. Anyway, all of Dr. Smith's patients know that they must wait, he is always behind. Mr. Jones should expect it. It is not new.
4. **Why is Dr. Smith always behind?** He spends time catching up with the patients; then it takes him longer to document his work. They say he is worth the wait, but they all know they must wait.
5. **Why haven't we adjusted the schedule for Dr. Smith to reflect the extra time he takes with his patients?** We did not want to embarrass Dr. Smith in front of the other providers. Changing his schedule would look like he cannot keep up with the pace of other providers.

In this scenario, this manager discovered several issues that need to be addressed: most importantly, the root of the issue with Dr. Smith's extended waiting times.

Here are our fixes:

- We immediately adapted Dr. Smith's schedule to add five minutes to each appointment slot and strongly encouraged him to use a scribe to assist him with his documentation.
- The manager crafted a policy and held an all staff training session regarding the appropriate techniques for communicating extended provider waiting times to our patients. Staff members should explain any extended waiting times immediately to patients as they are checking into the office. This allows patients to decide whether their schedule will allow for the wait or if they want to reschedule.
- During the training, we also held a roundtable discussion about the real value of the patients to our practice. There is more than a dollar value associated with each patient. Our reputation is at stake. It is always easier to build a great reputation than it is to fix a bad one.

Ultimately, we were able to resolve the scheduling issue and convince Mr. Jones to give us another opportunity to show him that we indeed value his time and his standing as a patient with our practice.

Using the Five Whys method can help you resolve small to moderate issues or, at a minimum, be a great starting point for larger issues that need to be dissected into smaller, more workable portions. These easy to follow steps have worked for Fortune 500 companies and small medical practices. Edward Hodnett, author of The Art of Problem Solving: How to Improve Your Methods stated, "If you don't ask the right questions, you don't get the right answers. A question asked in the right way often points to its own answer. Asking questions is the ABC of diagnosis. Only the inquiring mind solves problems."

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Look for more "Back to Basics" from PAHCOM in upcoming issues!

Surviving Your Shift:

Seven Things Healthcare Workers Can Do to Make It Through the Workday During COVID

Mark Goulston, MD, and Diana Hendel, PharmD, share simple strategies and hacks to help frontline workers manage traumatic stress and stay calm and centered at work.

COVID-19 has raged on for the better part of a year and it has taken a serious toll on healthcare professionals. They are stressed, worried, anxious, and exhausted. Nonetheless, they keep showing up to for work despite the risks and challenges because they are essential and because, well, that's what healthcare workers *do*.

But working amid grim circumstances *doesn't* mean healthcare workers have no control over their state of mind, say Mark Goulston, MD, and Diana Hendel, PharmD. There's plenty they can do to meet the workday with greater resilience and strength.

"As gritty and self-determined as healthcare employees are, they need to give themselves extra support and self-care throughout the day," says Dr. Goulston, coauthor along with Dr. Hendel of *Why Cope When You Can Heal?: How Healthcare Heroes of COVID-19 Can Recover from PTSD.* This is especially true during a pandemic when traumatic stress is at an all-time high.

"There are plenty of small routines and tools that can help you get through these tough days," adds Dr. Hendel, who became an expert in organizational trauma after leading a major medical center through a deadly workplace shooting over a decade ago. "Not only can they provide immediate relief in the short term, they can help you build the coping skills to stay physically and emotionally healthy long term."

Why Cope When You Can Heal? shares therapeutic approaches that are currently used to effectively treat traumatic stress and introduces powerful exercises to help you move through the trauma and further your healing. Here are some strategies to keep you calm and as stress free as possible (given the extraordinarily stressful circumstances) at work each day.

Keep something nearby that makes you laugh. Humor is a great way to alleviate stress. Tape a clip of a funny cartoon to your work area or carry a small notebook with jokes that make you laugh every time you read them.

Use calming affirmations to give you strength and peace. Written positive statements can give you a lift when you feel yourself sinking. If self-talk is not for you, imagine a supportive other saying these to you in your mind's eye.

A few examples:

- *I am great at my job, and my training and skills are empowering.*
- *I feel energized and ready for anything the day has in store for me.*
- *I accept myself as I am. I am enough.*
- *I am safe in this moment.*

Reach for an anchor. Carry a small reminder of what you love about your life and focus on it if you feel triggered and need to center yourself. It might be a photo of your kids or pet, a small rock you picked up on a scenic nature hike, or a special necklace. Think of the gratitude you feel for your life whenever you look at this token.

Take a few minutes to get grounded. Grounding is a great way to reduce anxiety and arrive in the here and now. Use it any time you feel carried away by anxious thoughts or feelings or triggered by upsetting memories and flashbacks.

- Find a comfortable place to sit (or stand). If sitting, rest your hands on your legs. Feel the fabric of your clothing. Notice its color and texture.
- Next, bring your awareness to your body. Stretch your neck from side to side. Relax your shoulders. Tense and relax your calves. Stomp your feet.
- Look around and notice the sights, sounds, and scents around you for a few moments.
- Name fifteen to twenty things you can see. For example, the floor, a light, a desk, a sink.
- As you keep looking around, remind yourself that "The flashback or emotion I felt is in the past. Right now, in this moment, I'm safe."

Take a quick walk. Try to find time to take a walk outside every day—even if only for five minutes. Breathe in the fresh air and appreciate the gifts of nature around you, such as a busy squirrel, a cluster of trees, or drifting clouds. If you absolutely can't get outdoors for a few minutes, do a few stretches in between visiting patients.

Nourish and energize yourself with healthy food and drinks. If you aren't already eating a healthy diet, start swapping in better choices that will give your body the fuel it needs to make it through the workday. Pack healthy homemade lunches instead of opting for pizza in the cafeteria each day. Fill up on veggie-filled salads topped with healthy proteins such as grilled chicken or salmon. Replace your daily snack of potato chips with a piece of fruit. Instead of reaching for a soda, sip water flavored with citrus or cucumber slices.

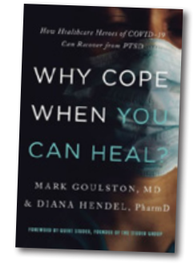
Check in with your support group (a.k.a. your "fire team"). If your organization has not already formed a support group for its employees, consider starting an informal meeting so you and your coworkers can get together and talk about what you are going through. This group is your "fire team"—the colleagues fighting by your side in the battle against COVID-19. You can meet with them for a few minutes every day or set up a longer weekly meeting. This gives you a community to share about your mental and emotional struggles, and yes, your triumphs too!

"While it's important to reach out and get professional help if you need it, it's also crucial to remember to help yourself during stressful, discouraging moments at work," concludes Goulston. "These tools help you maintain a sense of calm during chaos and will help you form healthy habits to support healing from traumatic stress over time."

Mark Goulston, MD, FAPA, is the coauthor of Why Cope When You Can Heal?: How Healthcare Heroes of COVID-19 Can Recover from PTSD (Harper Horizon, December 2020) and Trauma to Triumph: A Roadmap for Leading Through Disruption and Thriving on the Other Side (HarperCollins Leadership, Spring 2021).

Dr. Diana Hendel is the coauthor of Why Cope When You Can Heal?: How Healthcare Heroes of COVID-19 Can Recover from PTSD (Harper Horizon, December 2020) and Trauma to Triumph: A Roadmap for Leading Through Disruption and Thriving on the Other Side (HarperCollins Leadership, Spring 2021).

About the Book:
Why Cope When You Can Heal?: How Healthcare Heroes of COVID-19 Can Recover from PTSD (Harper Horizon, December 2020, ISBN: 978-0-7852-4462-2, $17.99) is available in bookstores nationwide and from major online booksellers.
To learn more, please visit https://whycopewhenyoucanheal.com/



Incident To

Just about any large clinic you visit will have non-physician practitioners, or NPPs. These will include physician assistants, nurse practitioners, and clinical nurses, for example. Practices and clinics can bill under the NPPs if they are credentialed with the payer, but the reimbursement is only 85% of the fee schedule.

There is one rule that allows the NPP to treat and bill with 100% reimbursement, called "incident to," under Medicare rules. The billing requirements are in the Medicare Benefit Policy Manual, Chapter 15, Section 60. Read this section if you are doing any "incident to" services.

One of the most important aspects of "incident to" services is that the services must be performed under the direct supervision of the physician. This does not mean that the physician must be present in the exam room. However, the physician must be present in the office and immediately available to provide assistance and direction throughout the time the service is being performed. The physician is also not agreeing with the NPP's treatment but is supervising the NPP. Therefore, agreeing with the NPP's signed notes or stating that the physician was present does not meet the criteria to be covered as "incident to."

In order to be covered as "incident to" the physician's service, the following criteria must be met of the service:

- Be an integral, although incidental, part of the physician's professional service;
- Commonly rendered without charge or included in the physician's bill;
- A type that is commonly furnished in physicians' offices or clinics; and
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision.

OPPS and CAH Outpatient

According to "incident to" clarification for OPPS and CAH Outpatient (A55214), "incident to" does not pertain to the inpatient setting, such as a hospital or skilled nursing. It is only applicable in the outpatient hospital setting.

Medicare may reimburse the costs of services provided either:

1. Delivered personally by eligible practitioners, e.g., MD, NP, PA; or
2. Delivered by hospital personnel working "incident to" the eligible practitioner's care.

When a hospital personnel provides services, the following payment requirements must be met.

Services delivered incident to the services of an eligible practitioner must:

- Be an integral, although incidental, part of a physician's/non-physician practitioner's (NPP's) professional service(s) and, hence, must always occur after an initial patient care service is provided by an eligible practitioner;
- Be delivered in accordance with a valid and signed order, i.e., written by "a practitioner who is authorized to write orders by hospital policy and in accordance with state law…" 42 CFR§482.12(c);
- Be delivered under the supervision of a physician who is an employee or has another contractual relationship with the hospital and is immediately available to provide assistance to the personnel delivering the service; and
- "Immediately available" in the outpatient hospital setting means that the physician must be available in the same timeframe as the personnel designated to manage cardiac arrests (codes) in the hospital.

The supervisor does not need to be in the same department as the ordering physician/NPP or in the same department in which the services are rendered, but must be on the physical premises where and when the patient receives services.

The physician/NPP that provides the oversight may not bill for the services of hospital employees. Only the hospital may bill for the services of hospital employees.

All service providers must work in accordance with their skills, license, and/or other hospital and other Medicare requirements.

Christine Woolstenhulme, QCC, QMCS, CPC, CMRS
Find-A-Code is a product of innoviHealth Systems, Inc. FindACode.com is an online database of medical billing codes and information. People use Find-A-Code to assign codes to medical diagnosis and procedures in order to be reimbursed by insurance companies and Medicare. FindACode.com is a quick and easy system that uses a simple search to return accurate information. Rather than searching through 10 or more books, Find-A-Code has combined the information into one simple search.

Complete Guide to Building HIPAA Compliant Health Apps

The laws that relate to health information privacy (HIPAA Compliance) must be adhered to when developing healthcare mobile apps.

Violation of the HIPAA guidelines can land you directly on the breach portal of the office of civil rights and the name of your healthcare practice or organization gets permanently inked on their wall of shame.

While the tarnishing of reputation and bad press has negative ramifications, the monetary impact of these violations is also huge.

In October 2019, OCR imposed a $2.15 million civil money penalty against Jackson Health system for HIPAA violations.

Touchstone Medical Imaging agreed to pay $3 million to the Office for Civil Rights at HHS to settle allegations that the medical imaging provider violated the HIPAA security rules.

These penalty figures are scary but important to note.

Health Insurance Portability and Accountability Act (HIPAA) works as a regulator for this business. The law which was introduced in the year 1996 seeks to limit access to individually identifiable healthcare information to those that "need to know."

The health information protected by HIPAA is called "protected health information" (PHI).

Different apps will require different levels of HIPAA compliance, depending on the kind of data they hold and share. However, not all apps need to be HIPAA compliant.

These four questions will help you know if HIPAA Compliance applies to your app or not.

1. Who needs HIPAA Compliance?

Many apps collect users' information, but not all apps share that information with an internal and external party. You should know if you are dealing with protected health information (PHI) or consumer health information.

The simple rule to know whether you need HIPAA compliance or not is to differentiate between collecting information and sharing information.

If your app currently shares or will share the user's personal health data held in the app with any entity, such as a doctor, then you are dealing with protected health information and need HIPAA compliant backend.

But if your app collects the user's personal health information (PHI) and does not share it with anyone at any point in time, then you do not need to be HIPAA compliant.

What comes under PHI?

Protected health information (PHI) is defined as "any information held by a covered entity which concerns health status, the provision of healthcare, or payment for healthcare that can be linked to an individual."

HIPAA lists eighteen personal identifiers that fall under PHI:

- Names
- All geographical data smaller than a state
- Dates (other than year) directly related to an individual
- Telephone numbers
- Fax numbers
- Email addresses
- Social Security numbers
- Medical record numbers
- Health insurance plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers including license plates
- Device identifiers and serial numbers
- Web URLs
- Internet protocol (IP) addresses
- Biometric identifiers (i.e. retinal scan, fingerprints, etc.)
- Full face photos and comparable images
- Any unique identifying number, characteristic, or code

Take for example the My Breast Cancer Journey app. This app acts as a support system for cancer patients, their families, and friends. During this process, the users share their medical history and records, which can be shared with the patient's family members and friends.

Since the information is collected and shared, the app had to comply with the HIPAA law.

2. When do you need HIPAA Compliance?

You need HIPAA compliance when your app is in the development stage. Delaying the process can result in penalties, fines, and black listings. Not only that, but the additional costs and timelines of redoing the app for compliance can significantly set you back.

Two important rules will help you further understand HIPAA compliance: HIPAA's Privacy rule and HIPAA's security rule.

HIPPA's Privacy rule focuses on the right of an individual to control the use of his or her personal information. If your app asks for any kind of health-related information from the user, it should also give the power to let the user decide if that information can be shared or not.

The user is also authorized to control who can access their information and under what circumstances this information may be accessed, used, and/or disclosed to third parties in all formats, including electronic, paper, and oral.

It needs to be at the discretion of the user (patient) whether they

want to share the assessment reports with anyone. This feature takes care of the privacy rule of HIPAA Compliance.

The HIPAA Privacy Rule applies to PHI in any form. This includes computer and paper files, x-rays, physician appointment schedules, medical bills, dictated notes, conversations, and information entered into patient portals.

HIPAA's Security Rule focusses specifically on electronic PHI (ePHI). Security is the ability to control access and protect information from accidental or intentional disclosures to unauthorized persons. Anyone can file a complaint to the Office for Civil Rights if they believe a HIPAA Compliance violation has occurred.

3. What are the requirements of the HIPAA law?

In order to meet HIPAA compliance software requirements, you need to meet four main requirements of the HIPAA law:

- You must put safeguards in place to protect patient's health information (PHI). These safeguards can be administrative, technical, and physical. The safeguards can be policies for staff that come in contact with PHI, encryption and decryption, audit controls, emergency access procedures, and platforms used for security of data.
- Reasonably limit use and sharing of protected health information to the minimum necessary to accomplish your intended purpose.
- Have agreements in place with service providers that perform covered functions. These agreements, called Business Associate Agreements (BAAs) ensure that service providers (Business Associates) use, safeguard, and disclose patient information properly.
- Procedures to limit who can access patient health information, and training programs about how to protect patient health information.

4. How do you become HIPAA compliant?

Becoming a HIPAA compliant app means storing the PHI in a HIPAA approved server. The standard safeguards, like app logins and auto-logouts, can be built using hosting servers as a part of core infrastructure of the app.

But others which require more technical and physical safeguard can be outsourced to HIPAA compliant cloud storage. Amazon AWS and Microsoft Azure are two popular platforms for this service.

Authorization procedures need to be in place to prevent unauthorized access to protected patient information. Prior to any use or disclosure of an individual's protected health information that is not permitted by the HIPAA Privacy Rule, authorization must be obtained from the individual. Encryption and de-identification of PHI collected, stored, and transmitted by the healthcare app is an absolute must-do when building a HIPAA compliant mobile application.

The technical, physical, and administrative safeguards outlined under the HIPAA security rule need to be adhered to, to ensure that your app stays compliant with the HIPAA guidelines.

However, you need not build all app features with the HIPAA compliance hosting servers. In the case of My Breast Cancer Journey app, we built only the in-app messaging feature, the feature to share documents, and the feature to share images using HIPAA compliant servers, since all these features carry PHI.

Make sure you discuss compliances while you're discussing the overall project concept with a healthcare software development company like Arkenea.

Disclaimer: To fully understand HIPAA compliance for your app, consult a healthcare attorney.

Rahul Varshneya is the co-founder of Arkenea, a custom healthcare software development and consulting firm for fast-growing healthcare organizations.

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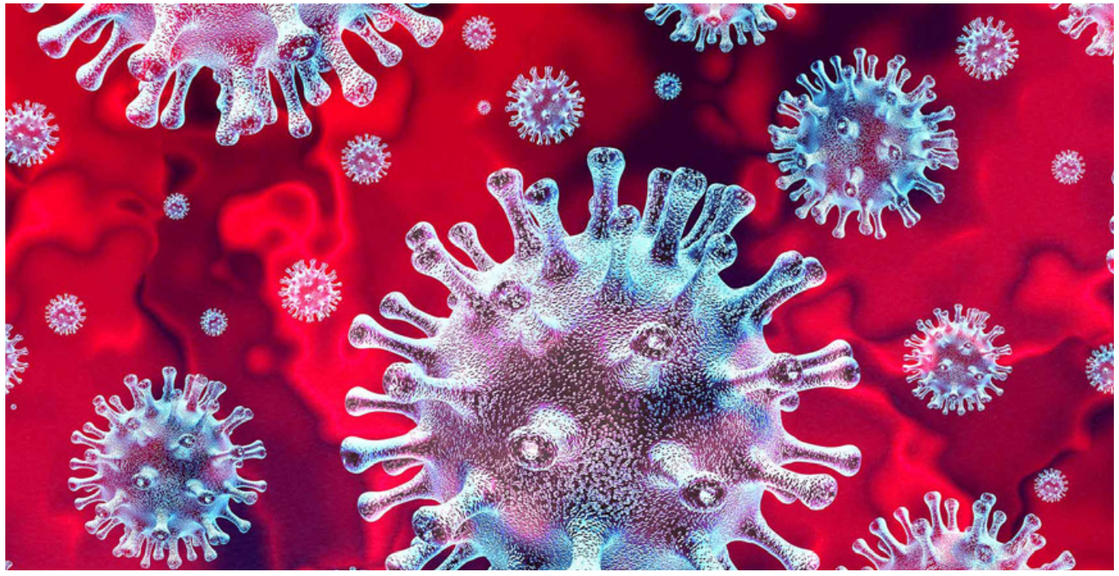


Things Will Never Be the Same

The world will never be the same. The coronavirus has disrupted everything, including the entire Medical Billing Industry, and I don't think anyone could have predicted the damage. While we try to get back to some kind of normal, here are my predictions attending how companies and practices will look going forward. stepped up.

Many of my clients have been embracing work from home for their team members for a few years now and have had a portion of their staff performing some functions from home. However, with the "stay at home" orders, we realize that nearly every function can be handled remotely.

There is an upside to this new finding:

1. Many employees are more productive at home. (Yet, there are some who cannot stand the isolation and miss the opportunity to cause havoc in the office. These are the folks who waste not only their time, but they also bother others, and you lose double the productivity. It's ironic how these are the same folks who complain about the temperature in the office, dislike the radio station that is playing in the background, and chew gum like it's the last thing they will ever put in their mouth.)
2. Every employee who agrees to work from home gets an automatic raise. No commuting costs, savings on clothing expenses, and cheaper lunches at home.
3. You can downsize or eliminate your office square footage, saving a ton of money since rent is usually your second largest expense after salaries and benefits. Most billing companies' clients do not ever visit your office, so a lack of an office will not affect your clients. Cha Ching! Eliminate your office and you just substantially increased your bottom line.
4. You and your teammates will probably find ways to improve many of your current procedures. When people have time to think, which occurs because you are not interrupted every 15 minutes, they will come up with how to do things faster and cheaper, plus come to the realization that some procedures and steps can be eliminated altogether.

Some other things that will change:

1. An estimated 10 to 20 percent of billing companies will go out of business before the end of 2021 because there will be fewer independent office-based practices. Some doctors will decide to retire; others will finally bite the bullet and become employees of larger health systems.
2. There has been a decrease in services by at least 50 percent in most practices and hospitals due to people's fear of catching the virus. I don't think we will see a huge uptick in elective procedures until there is a vaccine to prevent or minimize the effects of COVID-19.
3. Telehealth has increased dramatically. If practices do not embrace and implement telemedicine as a tool in their practice, it is going to be hard for them to stay in business.
4. Long established medical billing companies will be looking to exit the industry either by selling their companies or merging into another established company to ensure that their clients do not suffer any financial harm. Either way, it may not be too soon to think about your exit strategy.
5. Management fees will continue to spiral downward, and if you do not embrace and implement Robotic Process Automation and Artificial Intelligence tools, your chances for remaining profitable are slim to none.
6. Healthcare debt has never been at the top of the pile when it comes to paying bills, but now with so many who were unemployed for most of March, April, May, and June, when money does start rolling in, it will first be used to catch up on house and car payments. I expect we will see a decrease in self pay payments.

Medical billing companies will not totally disappear because your services will be needed more than ever to help practices collect as much money as they can. The need for expert coding, denial management, and A/R follow-up will be paramount to a practice's future success.

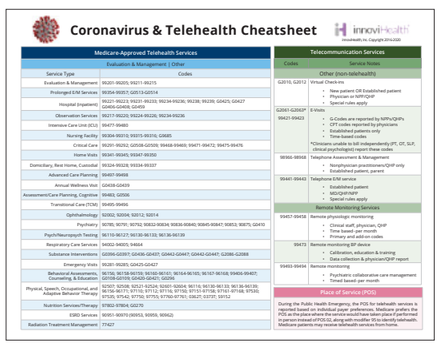
If you have enough money in reserve or have access to a strong line of credit, you will survive and can come out of these unusual times stronger than ever.

Stay healthy and hope for an effective vaccine.

Dave Jakielo is an International Speaker, Consultant dedicated to the Medical Billing Industry, Executive Coach, and Author, and is President of Seminars & Consulting. Dave is a Founder and past President of Healthcare Business and Management Association and the National Speakers Association, Pittsburgh. Sign up for his FREE weekly Success Tips at www.Davespeaks.com. Dave can be reached via email Dave@Davespeaks.com; phone 412-921-0976.

Download the latest Coronavirus & Telehealth Cheatsheet

https://www.billing-coding.com/telehealth-2020-cheatsheet.cfm



Coronavirus & Telehealth Cheatsheet

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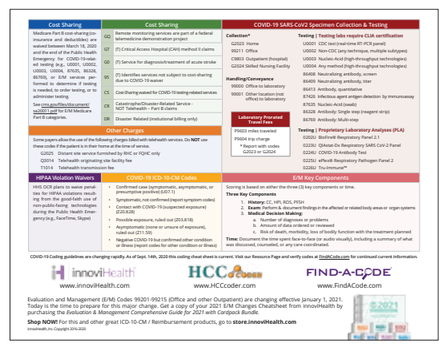
Medicare-Approved Telehealth Services

Evaluation & Management | Other	
Service Type	Codes
Evaluation & Management	99201-99205, 99211-99215
Prolonged E/M Services	99354-99357, G2013-G2014
Hospital (Inpatient)	99221-99223, 99231-99233, 99234-99236, 99238, 99239, G0425-G0427 G0459-G0498, G0498
Observation Services	99217-99220, 99224-99226, 99234-99236
Intensive Care Unit (ICU)	99477-99480
Nursing Facility	99304-99310, 99315-99316, G0685
Critical Care	99291-99292, G0508-G0509, 99468-99469, 99471-99472, 99475-99476
Home Visits	99341-99345, 99347-99350
Domiciliary, Rest Home, Custodial	99324-99328, 99334-99337
Advanced Care Planning	99497-99498
Annual Wellness Visit	G0438-G0439
Assessment/Care Planning, Cognitive	99483, G0506
Transitional Care (TCM)	99495-99496
Ophthalmology	92002, 92004, 92012, 92014
Psychiatry	90785, 90791, 90792, 90832-90834, 90836-90840, 90845-90847, 90853, 90875, G0410
Psych/Neuropsych Testing	96116-96127, 96130-96133, 96136-96139
Respiratory Care Services	94002-94005, 94664
Substance Interventions	G0396-G0397, G0406-G0407, G0442-G0447, G0442-G0447, G2086-G2088
Emergency Visits	99281-99285, G0425-G0427
Behavioral Assessments, Counseling, & Education	96150, 96158-96159, 96160-96161, 96164-96165, 96167-96168, 99406-99407, G0398-G0399, G0406-G0411, G0396
Physical, Speech, Occupational, and Adaptive Behavior Therapy	92507, 92508, 92521-92526, 92601-92604, 96110, 96130-96133, 96136-96139, 96156-96159, 96164-96167, 97110, 97112, 97116, 97150, 97151-97158, 97161-97168, 97530, 97535, 97542, 97750, 97755, 97760-97761, 0362T, 0373T, 0591T-0593T
Nutrition Services/Therapy	97802-97804, G0270
ESRD Services	90951-90970 (90953, 90959, 90962)
Radiation Treatment Management	77427

Telecommunication Services

Codes	Service Notes
	Other (non-telehealth)
G2010, G2012	Virtual Check-ins • New patient OR Established patient • Physician or NPP/QHP • Special rules apply
G2061-G2063*	E-Visits
99421-99423	• G-Codes are reported by NPPs/QHPs • CPT codes reported by physicians • Established patients only • Time-based codes *Clinicians unable to bill independently (PT, OT, SLP, clinical psychologist) report these codes
98966-98968	Telephone Assessment & Management • Nonphysician practitioners/QHP only • Established patient, parent
99441-99442	Telephone E/M service • Established patient • MD/QHP/NPP • Special rules apply
	Remote Monitoring Services
99457-99458	Remote physiologic monitoring • Clinical staff, physician, QHP • Time based: per month • Primary and add-on codes
99473	Remote monitoring BP device • Calibration, education & training • Data collection & physician/QHP report
99453-99454	Remote monitoring • Psychiatric collaborative care management • Timed based per month
	Place of Service (POS)

During the Public Health Emergency, the POS for telehealth services is reported based on individual payer preferences. Medicare prefers the POS as the place where the service would have taken place if performed in-person instead of POS 02, along with modifier 95 to identify telehealth. Medicare patients may receive telehealth services from home.



Cost Sharing	Cost Sharing	COVID-19 SARS-CoV2 Specimen Collection & Testing
Medicare Part B cost-sharing (coinsurance and deductibles) are waived between March 18, 2020 and the end of the emergency period for COVID-19-related testing (e.g., U0001, U0002, U0003, U0004, 87635, 86328, 86769), or E/M services performed to determine if testing is needed, in order testing, or to administer testing. See www.innovitHealth.com/covid19.pdf for full Medicare Part B categories.	G0 Remote monitoring services are part of a federal telemedicine demonstration project G7 (f) Critical Access Hospital (CAH) method II claims G8 (f) Service for diagnosis/treatment of acute stroke 95 (f) Identifies services not subject to cost-sharing due to COVID-19 waiver CS Cost-Sharing waived for COVID-19 testing-related services CR Catastrophe/Disaster-Related Service - NOT Telehealth – Part B claims DR Disaster Related (institutional billing only)	**Collection*** G2023 Home; 99211 Office; C9803 Outpatient (hospital); G2024 Skilled Nursing Facility **Handling/Conveyance** 99000 Office to laboratory; 99001 Other location (not office) to laboratory **Laboratory Prorated Travel Fees** P9603 miles traveled; P9604 trip charge * Report with codes G2023 or G2024 **Testing | Testing labs require CLIA certification** U0001 CDC test/real-time RT-PCR panel; U0002 Non-CDC (any technique, multiple subtypes); U0003 Nucleic Acid (high-throughput technologies); U0004 Any method (high-throughput technologies); 86408 Neutralizing antibody, screen; 86409 Neutralizing antibody, titer; 86413 Antibody, quantitative; 87635 Infectious agent antigen detection by immunoassay; 87635 Nucleic Acid (swab); 86328 Antibody, Single step (reagent strip); 86769 Antibody, Multi-step **Testing | Proprietary Laboratory Analyses (PLA)** 0202U BioFire® Respiratory Panel 2.1; 0223U QIAstat-Dx Respiratory SARS-CoV-2 Panel; 0224U COVID-19 Antibody Test; 0225U xMap® Respiratory Pathogen Panel 2; 0226U Tru-Immune™
Other Charges		
Some payers allow the use of the following charges billed with telehealth services. Do **NOT** use these codes if the patient is in their home at the time of service. G2025 Distant site service furnished by RHC or FQHC only G2014 Telehealth originating site facility fee T1014 Telehealth transmission fee		
HIPAA Violation Waivers	**COVID-19 ICD-10-CM Codes**	**E/M Key Components**
HHS OCR plans to waive penalties for HIPAA violations resulting from the good-faith use of telehealth technologies during the Public Health Emergency (e.g., FaceTime, Skype)	• Confirmed case (symptomatic, asymptomatic, or presumptive positive) (U07.1) • Symptomatic, not confirmed (report symptom codes) • Exposure to COVID-19 (suspected exposure) (Z20.828) • Possible exposure, ruled out (Z03.818) • Asymptomatic (none or unsure of exposure), ruled out (Z11.59) • Negative COVID-19 but confirmed other condition or illness (report codes for other condition or illness)	Scoring is based on either the three (3) key components or time. **Three Key Components** 1. **History:** CC, HPI, ROS, PFSH 2. **Exam:** Perform & document findings in the affected or related body area or organ systems 3. **Medical Decision Making:** a. Number of diagnoses or problems b. Amount of data ordered or reviewed c. Risk of death, morbidity, loss of bodily function with the treatment planned **Time:** Document the time spent face-to-face (or audio-visual), including a summary of what was discussed, counseled, or any care coordinated.

COVID-19 Coding guidelines are changing rapidly. As of Sept. 14th, 2020 this coding cheat sheet is current. Visit our Resource Page and verify codes at FindACode.com for continued current information.

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Evaluation and Management (E/M) Codes 99201-99215 (Office and other Outpatient) are changing effective January 1, 2021. Today is the time to prepare for this major change. Get a copy of your 2021 E/M Changes Cheatsheet from innovitHealth by purchasing the *Evaluation & Management Comprehensive Guide for 2021 with Cardpack Bundle.*

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5 Minutes with...

Scott Kraft,

CPMA, CPC, Auditing Specialist

BC Advantage (BCA): Tell us about yourself, your training, and how you became an expert healthcare auditor.

Scott Kraft (SK): I'm currently a senior compliance consultant and auditor with DoctorsManagement. I audit charts, review and create compliance plans and structure, provide education on coding and billing rules, and focus on best practices for our clients. I have a journalism degree and a writing background, so I came to this role in a non-traditional way. I worked for 11 years as an editor for DecisionHealth covering and developing products around Medicare Part B, learning as much as I could about billing and coding from that perspective.

At that point I met Sean Weiss, who was building our consulting division. He left DecisionHealth shortly before I did to join DoctorsManagement. He convinced me that based on my training and knowledge, I could be successful supporting DoctorsManagement clients as a consultant—taking my knowledge from covering the industry to being part of it. We started on a trial basis and, seven years later, I'm thrilled to be part of DoctorsManagement.

Throughout the last 18 years, I've been incredibly fortunate to speak with and work with people who have been incredibly generous in sharing their knowledge and experience with me and I certainly try to pay that forward.

BCA: Can you describe a typical workday for you?

SK: I am not sure we have typical workdays! If I'm not on-site with a client (and I look forward to that again after the pandemic), I start by answering client questions from the previous day and catching up on industry news. After that, I'm usually auditing charts or doing provider education sessions with physicians and other medical practice or healthcare system staff. I'm also usually putting together at least one webinar or live conference session and touching base with clients through the day as questions come up related to either our audit work or helping them to interpret or respond to something they've received from one of their payers. There is a lot of variety to my average workday, which is great. I try to squeeze in a workout most mornings before I start.

BCA: How do you stay on top of the ever-changing rules, regulations, and news that our industry faces?

SK: I'm fortunate to be part of a really strong team at DoctorsManagement and NAMAS. Everyone here is so engaged in every aspect of healthcare operations that we're always discussing changes that we think are coming or are taking place and what they'll mean to our clients, as well as all physician practices. Beyond that, I regularly look at the CMS website and contractor websites, as well as industry resources, such as BC Advantage and list-serv resources. LinkedIn can be an invaluable resource for networking and hearing the perspectives of experts and thought leaders throughout our industry.

BCA: What has been the most reoccurring question from your clients in 2020?

SK: It's probably been a tie between being asked to explain the 2021 E/M documentation guidelines for office services and being asked some variant of how to bill for or document telehealth services during the COVID-19 public health emergency.

BCA: What do you believe to be the most challenging topic facing the industry in 2021?

SK: Changes to E/M documentation guidelines and their implementation. I think there is a broad expectation that these changes to office and outpatient code guidelines are the first of possibly a series of changes. There is definitely more latitude to the documentation of the rendering provider, but the reality is that these new guidelines will change the code selections for many services—good and bad, from a bottom line perspective—and I think it will be a challenge to change documentation habits and still produce good documentation.

BCA: What topic do you feel many practices do not spend enough time or resources on and how would you direct your clients moving forward?

SK: Building consistency throughout their organizations on navigating the grey areas of coding, billing, and auditing. There will always be legitimate debates within our industry on how to interpret policies related to documentation requirements, but individual organizations should take a consistent approach to their own requirements and how they're implemented, from physician documentation through the auditing process. Most of us exist to support good provider documentation and it tends to be inconsistency that frustrates the provider most.

BCA: Do you have 2 or 3 questions you always like to ask a new practice that can really give you a quick insight into their potential needs? And why those questions?

SK: My first question is to ask them to explain their code selection and billing process from start to finish. These details help me figure out who is responsible for selecting codes and how the practice vets codes before the claim is filed. I also like to ask for all of their current written policies, procedures, and job titles and descriptions.

My goal when I work with a practice isn't to start from scratch, but to figure out how to build on and improve current processes in a way that is achievable for the practice in its current configuration and has broad organizational buy-in. Asking these questions helps me identify risks and pain points in the practice as it currently operates and help the practice build a compliant program using as much of their current framework as possible. I'm always leery of trying to change so many things that people lose sight of good results

amidst the process. So I try to stick within their process for the things that work and build a compliant culture within that process. If they need or want a total process rebuild to ensure the best results, we can certainly do that as well.

BCA: With COVID-19 restrictions in 2020, how has it changed the way you deal with clients for the good and bad?

SK: I'm not spending as much time on-site with clients. Despite the advances in virtual meetings, it can be hard to substitute the experience of being on-site to work collaboratively with the client to improve documentation, coding, and billing. It usually ties in the entire operation. That's the bad part. The good part is my clients have been very engaged this year between COVID-19 changes and 2021 documentation changes. It has been easier to reach out and connect to more clients for remote training thanks to schedules being more open.

BCA: Moving forward into 2021, what's the one thing you would like to see practices concentrate on the most?

SK: Making sure documented examinations for telehealth visits don't include things impossible to examine over a video connection. More seriously, focus on good office note documentation with clinically appropriate history, exam, and assessment that tells the story of the visit without a lot of the extra documentation that the previous documentation guidelines compelled providers to create.

BCA: With extensive experience in more than 30 specialties, how do you stay ahead of all the regulations and changes for each?

SK: I stay on top of CPT/HCPCS and ICD-10 changes. The AMA's CPT changes process is incredibly insightful into the mindset behind the coding rules for various specialties and how those specialists see the codes. Specialty society guidance is also critical, as are established experts within specific specialties. I am a vacuum when it comes to information, because I think the more guidance I can read, the more perspectives I can get—including from physician leaders within specialties—the better positioned I am to navigate policies and give the best guidance I can. My DoctorsManagement colleagues are invaluable.

BCA: When educating both the physician and their staff, are there any regular issues you face? For example, a physician wanting to code XXX, while the staff wants to use another code. And if so, how would you confront this issue?

SK: A disconnect on code selection between the physician and the staff is quite common. I try to work backward and figure out why each party sees the patient's case the way they see it and that often provides the roadmap to the solution. For example, the provider may be coming at it from a clinical perspective, but the coder has the right technical knowledge of the rules for the codes. Or the provider may have some clinical knowledge of the case that could have been expressed better in the documentation. I think we all hold the views we hold for a reason, and I try to get all of the reasons on the table so that the solution is what is most compliant and also best for the ultimate goal, which is to produce the best documentation and bill the encounter correctly based on that documentation.

BCA: Outside of the office, what do you enjoy in your free time to relax and take the stress off work?

SK: I'm a runner, and so health permitting, I try to get out for a run most mornings or some sort of workout to just clear my mind for the day. I'm also a pretty voracious reader and I do my share of binge-watching of good shows or movies.

BCA: Before we go, do you want to give our readers any tips or personal thoughts for moving into 2021?

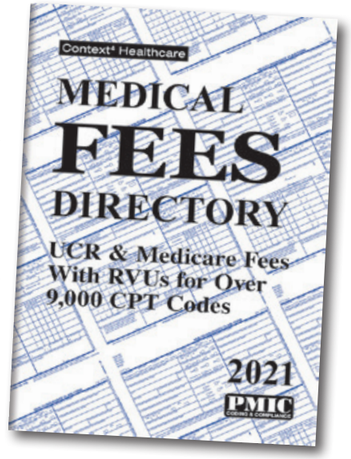
SK: Do your best to be optimistic. 2020 has challenged us all in ways that we didn't anticipate. But we're moving into 2021 and it feels like good news and better times are on the horizon. My tip would be, for the 2021 E/M documentation guidelines, build office policies around clinically appropriate history and exam to give the rendering providers some framework of what they're expected to document.

New product discounts and Reviews

Title: Medical Fees Directory 2021

Price: $149.95

From: https://pmiconline.stores.yahoo.net/otcore20.html



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Title: Collections Made Easy!

Price: $54.95

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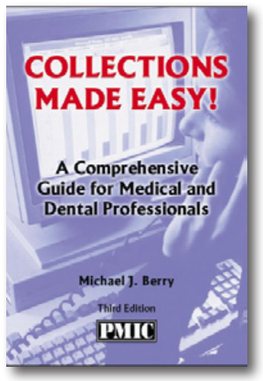

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