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Medical Practice Compliance Alert

News, tools and best practices to assess risk and protect physicians

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Predictions

COVID-19 will drive compliance in 2021

By Marla Durben Hirsch

Your practice will face several compliance challenges this year, experts warn. For example, COVID-19 issues will feature prominently. In addition, a new president in the White House adds an element of uncertainty to the level of compliance risk. Here are six predictions of what you can expect in 2021.

Prediction 1: There will be confusion and compliance issues with Paycheck Protection Program (PPP) loan forgiveness.

Many physician practices obtained loans through the PPP loan program — the federal stimulus program created by the CARES Act in March 2020 to help businesses weather the COVID-19 pandemic *(MPCA 5/2020)*. The lender can forgive part or all of the loan if the borrower meets certain requirements, such as being able to show that the funds were used correctly, says David Zetter, president of Zetter Healthcare Management Consultants in Mechanicsburg, Pa. However, there is little clarity regarding how the loan forgiveness works. For instance, some but not all borrowers need to complete a loan forgiveness application; only some banks will accept the application form recommended by the Small Business Administration. "It's literally a cluster," he says. As a result, some borrowers will make mistakes and end up having to repay the loan.

Prediction 2: ONC's new interoperability rule will cause compliance headaches.

Providers will need to respond quickly to requests for medical records or risk running afoul of the prohibition on information blocking, warns attorney Elizabeth Litten, with Fox Rothschild in Princeton, N.J. There are eight exceptions where refusing to share this data is acceptable, but it will be difficult to meet some of the exceptions' requirements.

Prediction 3: Practices will struggle to transmit electronic health information to patients.

Patients will be sending more of their data to their physicians electronically via remote physiologic monitoring and self-reporting. And more patients will ask providers to send their electronic medical records to their phones and other mobile devices, as contemplated by ONC's interoperability rule. These activities will create compliance glitches. For instance, this data may

be subject to loss, hacking, and problems capturing information into the medical record, says attorney Michael Kline, also with Fox Rothschild in Princeton.

Prediction 4: Telehealth challenges will linger.

While telehealth has increased, in large part due to COVID-19, the compliance issues involving telehealth will continue to haunt practices. For instance, payers have different policies regarding coverage and reimbursement, and their policies keep on changing. The rules will morph again once the pandemic is over. "There will be missteps," says Zetter. There may also be cybersecurity issues with telehealth, says attorney William Maruca, with Fox Rothschild in Pittsburgh.

Prediction 5: There will be ongoing compliance issues with COVID-19.

The national health emergency caused CMS and other agencies to waive billing, enrollment, and other requirements to reduce provider burden during the pandemic. It is not yet known which of these rules will be reinstated and to what extent, which will create confusion regarding compliance. In addition, physicians will need to deal with the allocation of resources for the rollout of a vaccine for COVID-19, says Litten.

Prediction 6: The Department of Justice will take a more proactive role in False Claims Act lawsuits.

The past four years marked a decline in the government's involvement in whistleblower lawsuits because of other priorities, according to Maruca. Since the return on investment for the government in these *qui tam* suits is significant, there may be an uptick in government intervention and enforcement. "This [use of resources] pays for itself," he says. ■

RESOURCES:

The ONC Final Rule: www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-07419.pdf

Predictions

MPCA's expert sources earn perfect score on their 2020 predictions

By Marla Durben Hirsch

For the third year in a row, the experts who shared their predictions with *MPCA* hit each of their predictions. (*MPCA 1/2020*). Here's a review of their predictions for 2020, and how they played out:

Prediction: Telehealth will attract more providers, and compliance problems.

True. Physicians embraced telehealth, which soared in large part due to the COVID-19 pandemic. However, the increased use of telehealth has increased the risk of violating HIPAA as well as malpractice risks *(MPCA 10/2020, 5/2020)*. The HHS Office of Inspector General (OIG) has ramped up its scrutiny of telehealth, adding several new telehealth investigations to its work plan in 2020. The Department of Justice (DOJ) announced the biggest health care takedown in its history, in September 2020. The charges included more than $4.5 billion in fraudulent billing connected to telemedicine.

Prediction: Ransomware problems will not abate.

True. Ransomware attacks have doubled since last year, according to a report from Security Boulevard. The health care industry continues to be particularly hard hit, says attorney Michael Kline, with Fox Rothschild in Princeton, N.J. HHS, the FBI, and the Cybersecurity and Infrastructure Security Agency (CISA) issued an alert in October 2020 that ransomware was specifically targeting hospitals and other health care providers.

Prediction: Value-based pay models will bring new compliance risks.

True. Physicians moving from fee-for-service into value-based payment programs have had to deal with more complex rules. "It's a challenge to know what the rules are, and some physicians are stumbling," says David Zetter, president of Zetter Healthcare Management Consultants in Mechanicsburg, Pa. The recent government enforcement actions by the government against health IT developers for falsifying the certification of their EHRs' ability to track and report data has also put providers at increased risk that they will be accused of false attestation in these value-based programs, says attorney Elizabeth Litten, with Fox Rothschild in Princeton, N.J. *(MPCA 3/2020, 2/2020)*. CMS' Center for Program Integrity announced that one of its priority areas in 2020 was to look at how to implement new approaches against fraud that work for value-based payment programs.

Prediction: Ownership transfers will increase scrutiny of practices.

True. The DOJ targeted several providers who had sold their businesses to private equity investors. Some practices closed due to the pandemic, others closed and then reopened, both actions creating new legal risks *(MPCA 7/2020, 6/2020, 5/2020)*.

Prediction: Enrollment will create more challenges for doctors.

True. CMS has started to make sure that physician enrollment is accurate under the expanded CMS enrollment program integrity rules that went into effect November 2019, and the Medicare Administrative Contractors are de-activating billing privileges, says Zetter. Private payers have also increased their review of physician board certifications, malpractice complaints, and reports to the National Practitioner Data Bank when assessing who should be allowed in their networks. "Payers have gotten smarter," he says.

Prediction: The focus on interoperability of patient records will increase.

True. ONC and CMS issued final rules in May 2020 implementing the data sharing requirements of the 21st Century Cures Act and prohibiting "information blocking" activities. These rules greatly increase providers' compliance obligations regarding responding to requests from patients and others for electronic health records *(MPCA 11/2020, 9/2020)*. ■

RESOURCES:

Security Boulevard report: https://securityboulevard.com/2020/09/top-5-ransomware-attacks-to-watch-out-for-in-2020-2021/

OIG work plan: https://oig.hhs.gov/reports-and-publications/workplan/index.asp

DOJ fraud takedown: www.justice.gov/opa/pr/national-health-care-fraud-and-opioid-takedown-results-charges-against-345-defendants

Ransomware alert: https://us-cert.cisa.gov/ncas/alerts/aa20-302a

The ONC final rule: www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-07419.pdf

Center for Program Integrity Announcement: www.cms.gov/About-CMS/Components/CPI

CMS

10% CF cut offsets E/M gains, with wild fluctuations on the horizon

By Richard Scott

You'll find a steep cut to the Medicare Part B conversion factor (CF) in 2021, in one part of a systemwide redistribution of the more than $100 billion in annual Part B provider payments. The CF falls 10.2% to a rate of $32.41 in 2021, down from $36.10 in 2020.

The double-digit decrease to the CF, which is slightly better than the 11% cut floated in the proposed rule in August that, at the time, led to outcry among many provider organizations, comes in response to large pay gains awarded to an oft-reported basket of E/M services: the series of office visit codes **99202-99215.**

Calculation of the CY 2021 PFS conversion factor

CY 2021 conversion factor (before adjustments)	$36.0896
Statutory update factor	0%
CY 2021 RVU budget neutrality adjustment	-10.20%
Final CY 2021 conversion factor	$32.4085
Source: Final 2021 Medicare physician fee schedule, released Dec. 1	

As confirmed in the final 2021 Medicare physician fee schedule that CMS released Dec. 1, the agency has accepted the revised relative value units (RVU) for the E/M office visit codes that the AMA approved under a recent revaluation process. **Example:** The total non-facility RVUs for code 99214, the most frequently reported office service, go from 3.06 in 2020 to 3.81 in 2021, a 25% gain. The RVU increases for 99212 (31%), 99213 (27%) and 99215 (30%) are also significant.

Yet the slashed CF is dampening the effects of the revalued RVUs, and it is expected to result in fee cuts for dozens of specialties. Consider the outlook of 99214 allowable charges in 2021: While the RVUs went up 25%, the actual fee per service rises just 10.6%.

Yet to better align the RVU expectations and allowable charges, CMS also finalized a primary care add-on code, **G2211,** which is projected to pay roughly $16 per claim. The agency assumes the vast majority around 90%, CMS says of E/M encounters will be eligible for the G2211 add-on code. Padding the E/M office visit fees with an extra $16 per encounter pushes the allowable charges into the territory of the RVU valuations.

"I have to say, this is what they said they wanted to do, and they're doing it," says Betsy Nicoletti, CPC, president of Medical Practice Consulting in Northampton, Mass., about CMS' focused attention on increasing fees for primary care services. "They're putting their money where their mouth is. I think it's important for the health of our country that we pay more for this type of care."

Some rise, others fall

The money that's getting redirected to primary care services will have broad repercussions on the remainder of the Part B pool of allowable charges. Nearly two dozen specialties are expected to see a net pay cut of at least 5% in 2021, with radiology, nurse anesthesia/anesthesia assistant

and chiropractor on pace for a 10% reduction in allowable charges.

Others, including endocrinology (+16%) and family practice (+13%), are scheduled for big pay gains. Perhaps not surprisingly, the public comments that CMS fielded in the weeks leading up to the release of the final rule were largely flavored by the 2021 fee projections.

"In general, commenters from physician specialties who saw projected increases related to our previously finalized revaluation of the office/outpatient E/M code set, our implementation of code G2211, and our revaluations of services analogous to office/outpatient E/Ms were supportive," CMS relays in the final rule, "while those commenters from physician specialties who projected decreases objected."

Numerous groups and associations urged CMS to take action under the COVID-19 public health emergency (PHE) and waive the budget neutrality requirement that mandates similar year-to-year fee projections. But CMS balked, indicating that Congress would have to intervene to allow for a spending increase.

"The statutory waiver authorities available to the Secretary following a public health emergency declaration É do not include waiver authority that would allow for implementation of changes to the PFS outside of the budget neutrality requirements in statute," the agency says in the final rule.

The CY 2021 anesthesia conversion factor

CY 2021 conversion factor (before adjustments)	$22.2016
Statutory update factor	0%
CY 2021 RVU budget neutrality adjustment	-10.20%
CY 2021 practice expense and malpractice adjustment	0.59%
Final CY 2021 anesthesia conversion factor	$20.0547
Source: Final 2021 Medicare physician fee schedule, released Dec. 1	

Finalized: 2021 E/M documentation changes

The old regime of E/M documentation guidelines is fading away, as a new paradigm comes into play for E/M office visit codes on Jan. 1.

The changes, developed in collaboration with the AMA, will eschew the 1995 and 1997 documentation guidelines and the rigorous history, exam and medical decision-making elements that defined code level selection.

"Under this new CPT coding framework, history and exam will no longer be used to select the level of code for [office/outpatient] E/M visits," CMS states. "Instead, an [office/outpatient] E/M visit will include a medically appropriate history and exam, when performed. The clinically outdated system for number of body systems/areas reviewed and examined under history and exam will no longer apply, and the history and exam components will only be performed when, and to the extent, reasonable and necessary and clinically appropriate."

All updates to the E/M documentation guidelines that CMS and the AMA have touted for more than a year are coming into play, with almost no surprises, Nicoletti says. The only curveball is the new prolonged services code (**G2212**) that CMS debuted in the final rule. ■

CMS

Stark boosts opportunities for value-based collaboration

By Marla Durben Hirsch

CMS' new rule updating the Stark physician self-referral law brings some welcome relief for physicians who want to participate in value-based initiatives but were afraid of violating the law's strict referral ban *(MPCA 12/2020)*. The rule creates three new exceptions that enable physicians to partner with providers in a value-based enterprise to provide value-based care:

1. **Full financial risk:** The enterprise takes on full risk, such as capitation, for all patient services and items for a target patient population.
2. **Meaningful financial risk:** The physician is at downside risk to repay or forgo no less than 10% of the value of the remuneration she receives under the value-based arrangement for failure to achieve the value-based purpose.
3. **No financial risk:** A value-based arrangement without financial risk, which CMS sees as critical to transitioning to value-based arrangements.

The exceptions were designed to remove regulatory barriers to innovation, create flexibility for coordinated and cost-effective care, and move to more outcomes-based care, according to CMS. They are effective Jan. 19, 2021, and apply to any value-based program, not just ones involving Medicare.

As with other Stark exceptions, the parties must meet each requirement for a value-based exception, or they'll be in violation of the rule's prohibition against Medicare referrals for certain services to an organization with which the physician — or an immediate family member — has a financial relationship.

Here's a deeper dive into some of the provisions of these exceptions that pertain the most to physicians.

Focus on new value-based definitions

The exceptions contain new definitions that detail how the value-based care needs to be performed.

"You need to meet the definitions. Then see if you meet an exception," said Matthew Edgar, health insurance specialist with CMS in Baltimore and one of the rule's authors. Edgar made his remarks during the American Bar Association's Health Law Summit, Dec. 9.

For example, the participants must be in a value-based enterprise and collaborate to achieve at least one value-based purpose, with a governing body or person who is accountable for oversight, and a governing document that describes the enterprise and how the participants plan to achieve a value-based purpose.

The value-based purpose must be to coordinate and manage care, improve quality, reduce costs without reducing quality, and/or transition from volume to value. A value-based activity is designed to achieve at least one value-based purpose.

"That's what you want protection for," explained attorney Kristin Carter, with Baker Donelson, Baltimore during a webinar titled Physician Self-Referral (Stark) Law and Anti-Kickback Final Sprint Rules: Understanding the Impact, Dec. 3.

There is no value-based purpose just to maintain quality of care alone or reduce costs alone, said attorney Darby Allen, with Davis Wright Tremaine, Seattle during the Done Sprinting but Are We There Yet? The Value Based Stark Exceptions and AKS Safe Harbors webinar, Dec. 7.

However, there is some flexibility in the definitions. For example, a value-based enterprise can be informal, and as small as two participants, so two solo physician practices could form one, Edgar pointed out. It could also be a more traditional partnership, such as an independent practice association, a hospital and its physicians, a patient-centered medical home, or a payer's program.

Compliance risk rises as financial risk falls

All three exceptions share some elements. For instance:

- The remuneration needs to be for or result from value-based activities in the target patient population.
- There can't be inducement to reduce or limit medically necessary services.
- Remuneration can't be conditioned on referrals of patients who are not part of the target patient population or business not covered by the value-based arrangement, a practice known as swapping.

However, the three exceptions contain additional requirements based on the amount of financial risk the participants are taking. The "full financial risk" exception, which is the least likely to run afoul of the law, has only five additional elements.

The exception for arrangements with no financial risk, which will apply to many more physicians, allows physicians to receive either monetary or nonmonetary remuneration for participating, but requires 10 conditions to fit within the exception, including that the arrangement be monitored and commercially reasonable.

Documentation is key

A value-based activity can be the provision of a service or item, taking an action or refraining from taking an action. While a referral alone can't be a value-based activity, providing nonmedical support personnel to a physician, data analytics, or coordinating care would probably qualify.

But since the activity must be designed to achieve at least one value-based purpose, you need evidence that the participants had a good faith belief that the activity will lead to a value-based purpose, said attorney Adam Romney, Davis Wright Tremaine, during the firm's Dec. 7 webinar. For example, language in the contract for the arrangement that outlines the program's purpose.

"This is where the rubber will meet the road," he said. ■

RESOURCES:

Stark update fact sheet: www.cms.gov/newsroom/fact-sheets/modernizing-and-clarifying-physician-self-referral-regulations-final-rule-cms-1720-f

Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations public inspection version: www.federalregister.gov/public-inspection/2020-26140/medicare-program-modernizing-and-clarifying-the-physician-self-referral-regulations

Workplace compliance

4 tips for employment issues related to race, color and national origin

By Marla Durben Hirsch

The CMS bulletin that addresses discrimination against patients on the basis of race, color or national origin

during the COVID-19 pandemic reminds practices to take a hard look at their workplace through the same lens in order to avoid employment discrimination claims (*MPCA 10/2020*). Consider these four tips:

1. **Review your practice's criteria for employment decisions including hiring and promotions.** "Make sure that the criteria are in writing and objective, and that policies are applied in a consistent, even-handed manner," says attorney Stephen Fleury, Jr., with Saxton & Stump, Malvern, Pa.
2. **Be prepared to address employee claims of discrimination or harassment.** The health disparities occurring during the pandemic and the Black Lives Matter movement have highlighted the issue of racial inequality. Make sure you have systems in place to deal with and investigate complaints, says attorney Jonathan Hyman, with Meyers, Roman, Friedberg & Lewis in Cleveland.
3. **Take steps to increase diversity of job applicants and employees.** This could include outreach and recruiting to underrepresented groups, such as targeted advertising and job fairs, says Fleury. Some practices engage in philanthropic activities, such as sponsoring scholarships. "It shows a nondiscrimination bias," he says.
4. **Don't implement hiring restrictions to force diversity.** It's just as wrong to insist on, for example, looking at only job candidates of a desired minority. "Unless the employer is under court-ordered affirmative action to address a market disparity, preferring or avoiding job applicants based on a protected category is unlawful," says attorney Audrey Mross, with Munck Wilson Mandala, LLP in Dallas. ■

Billing & coding compliance

Solidify staff knowledge on the rules for advance directive discussions

By Julia Kyles, CPC

Medicare auditors have identified failure to document time as a key flaw in claims for advance care planning (ACP) and the HHS Office of Inspector General (OIG) plans to conduct an audit of the services (*MCPA 11/2020).*

Remind staff: Documentation about advance directive conversations (**99497-99498**) will not survive an audit if the charts don't include how much time the treating physician or qualified health care professional spent on the time-based service. CMS provided three examples of documentation that failed Comprehensive Error Testing Rate review and the problem with the documentation in the January 2018 edition of the Medicare Quarterly Provider Compliance Newsletter:

Example 1

- A complete annual wellness visit note for the date of service that included an end-of-life planning discussion with the patient.
- Other office visit notes.
- Diagnostic reports.

Problem: Missing clinical documentation of the time spent discussing the ACP.

Example 2

- An annual wellness visit questionnaire dated prior to the date of service.
- An office visit note that documented "…does not have a health care power of attorney or living will, these were discussed in paperwork given today."

Problem: Missing clinical documentation of the time spent discussing the ACP.

Example 3

- A progress note that documented a patient with chest pain and acute coronary syndrome after a four-day hospitalization with diagnosis of polymyalgia rheumatic and a history of pernicious anemia.
- A procedure note for vitamin B12 injection.
- A hospital discharge note.
- A hospital admission note.
- An unsigned cardiolyte stress test.
- Emergency room medical records.
- An order invoice showing an order for ACP first 30 minutes.

Problem: Missing clinical documentation of the face-to-face ACP service and missing clinical documentation of the time spent discussing the ACP.

Review the basic rules

Make sure staff understand the three Ds of ACPs: Descriptors, definitions and diagnosis

- **Descriptors:** Start with the full descriptors for the primary and add-on code when you train staff and emphasize how much time is required to bill the service cand that time must be documented for time-based codes.

99497: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.

99498: …; each additional 30 minutes (List separately in addition to code for primary procedure).

Your practice can decide if practitioners will document minutes or start and stop time, but it should be consistent and located on the same place in the chart. In the event of an audit make sure the time is included in the documentation you send to the auditor.

- **Definitions:** Next, share the definition of advance care planning and advance directives. According to CMS 100-02, chapter 15, §280.5.1, ACP is a face-to-face service between a physician or other qualified health care professional "and the patient discussing advance directives, with or without completing relevant legal forms."

An advance directive "is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time." The CPT manual lists examples of advance directives including a living will, durable power of attorney for health care and medical orders for life-sustaining treatment (MOLST).

The patient does not have to complete an advance directive or agree to complete an advance directive during the visit.

- **Diagnosis:** You don't need a specific ICD-10-CM code to report the service, CMS notes in the MedLearn fact sheet for ACP. Report the condition the provider counseled the patient about or use a diagnosis code for an administrative examination, or a well exam diagnosis when it is performed as part of a Medicare Wellness Visit (MWV), that is, the Welcome to Medicare visit (**G0438**) or the annual wellness visit (**G0439**).

Delve into the details

- **Consent is crucial.** The practitioner must ask for and receive the patient's go-ahead to discuss advance directives each time the conversation takes place. Make sure this is documented in the chart.
- **Frequency is flexible.** Medicare assigned a medically unlikely edit (MUE) of '1' to the primary code and an MUE of '3' to the add-on code. Beyond the daily limit "there's no limit on the number of times you can report ACP for a patient," CMS says in the fact sheet. However, if the practitioner performs the service more than once for the same patient, the practitioner should note "the change in the patient's health status and/or wishes about their end-of-life care."
- **Other visits are OK.** You may report the service in conjunction with several E/M visits that occur in a variety of settings. In most instances you will not use a modifier to report both services. You may also perform and report an ACP in conjunction with a wellness visit, but make sure to append modifier **33** (Preventive service) to the ACP code and do not collect a co-pay or deductible from the patient. "Waiver of the deductible and coinsurance for ACP is limited to once per year. Payment for an AWV is limited to once per year. If the AWV billed with ACP is denied for exceeding the once per year limit, the deductible and coinsurance will be applied to the ACP," according to CMS 100-04, chapter 18, §140.8.

Be aware of PHE changes

ACP is a permanent telehealth service and during the COVID-19 public health emergency (PHE) CMS allows ACP performed via an audio-only visit — AKA a telephone call. The phone call exception will end when the PHE expires. The current expiration date is Jan. 21, 2021. It remains to be seen whether the new administration will continue the PHE. ■

RESOURCES:

CMS 100-02, chapter 15, §280.5.1: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf#page=261

CMS 100-04, 18, §140.8: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf#page=180

Advance care planning fact sheet www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCare-Planning.pdf

Medicare Quarterly Provider Compliance Newsletter: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN904144.pdf

Billing & coding compliance

Beware 3 types of E/M update compliance challenges

By Julia Kyles, CPC

The transition to the 2021 E/M office visit paradigm will require practices to remain vigilant against risks, such as incomplete documentation. The E/M revisions also introduce a series of new risks, such as staff who may try to make the practice's new coding patterns

match the old patterns. You can't assume that what is coded today will always transition to a specific level under the new system.

In addition, there are no crosswalks between MDM- and time-based codes. For example, you can't assume that a visit that is coded as a 99213 under MDM will always translate to 99213 under the time-based system.

The high-stakes — and high-dollar — nature of the update is also likely to spur increased external audit activity. You can protect your practice by understanding the new risks that the update will bring and how to resolve them. Incorporate this guidance into your compliance plan to make sure they stay on your risk radar.

General risks

The following risks could impact E/M office visit claims coded with the time-based and MDM methods.

- **Incomplete education.** Staff will need to take in, retain and use a great deal of new information. In addition, Medicare and private payers may have specific requirements. A forgotten detail could create documentation that doesn't stand up to scrutiny or claims that create improper payments. **Resolution:** Start training early and don't treat it as a one-and-done process. Plan to keep teaching after the new system goes live. Regularly ask staff if they have questions and share the questions and answers with everyone in the practice.
- **Updates that cause upcoding.** Problems with your updated software may range from improperly applied rules to prompts that encourage upcoding. **Resolution:** Work with your software vendors to make sure the update doesn't push staff toward improper coding. Double check systems before and after they're deployed and alert vendors to any bugs in the system.
- **Right code, wrong coding guidelines.** When the practice's clinicians see patients in a variety of settings, staff may apply the wrong coding guidelines to a chart. **Resolution:** Tell coders to work on charts in batches that are based on where the encounter took place. Keep a close eye on charts and claims until staff get used to juggling the two systems.
- **Double-counting overpayments.** Coders may count separately reportable services, such as a consultation with a practitioner from another practice, toward an office visit and report the consultation as a separate service. **Resolution:** Don't rely on coding edits to stop this mistake. Remind coders they must pick one — counting it toward the visit or reporting it separately when it meets the requirements for a standalone code. Practices can create a rule that states the service is always included in the E/M or always reported separately. But it may make sense to give coders the flexibility to decide on a case-by-case basis.

MDM-based coding

- **Dozens of definitions.** The new guidelines add new terms and definitions for terms that have been previously open to various interpretations. However, confusion about the new definitions could cause improper coding. For example, clinicians can get credit when they talk to an independent historian, such as a family member or informal caregiver. But that person must provide additional information that the patient cannot provide. A person who brings the patient to the visit and sits in the exam room or serves as a translator is not considered an independent historian. **Resolution:** Drill staff on definitions but customize training to their duties. Coders need an in-depth understanding of the definitions, but physicians need to know how to capture the information that coders need. For example, a statement that the physician spoke to the patient's wife about the patient's condition doesn't count as a discussion with an independent historian. The provider must indicate why the discussion was medically necessary and include the information that the spouse provided that the patient could not.
- **Forgotten histories and physical exams.** Clinicians may become overly lax with the new guidance regarding the history and examination. **Resolution:** Remind clinical staff that the new guidelines state that office visits "include a medically appropriate history and/or physical examination, when performed." If they do it, they should document it.

Time-based coding

- **Definition of a day.** Practices may count a clinician's work that takes place in the 24-hour period that starts when the face-to-face encounter begins. **Resolution:** Emphasize that time-based encounters are based on the calendar date of the face-to-face encounter and require clinicians to note the time

and date they started prep work for a visit, such as reviewing a patient's labs.

- **Split or shared double-time.** When a physician and another qualified health care professional both see the patient on the same day and work together for part of the encounter, coders may count the time each provider spent during that period, rather than counting it once. **Resolution:** Make sure clinicians document how much time they spend working together and remind coders that when the clinicians are together, their time is counted as though they are one person.
- **Average time and cloned time.** Clinicians may be in the habit of performing a task, such as chart review, for several patients at once. If they do it for time-based coding, they may be tempted to average out the total time. They may also document that they always spend the same amount of time for other activities or the entire visit. For example, they may report 10 minutes for every physical exam, or 49 minutes for every new patient visit. Averaging time or reporting the same amount of time for the same activities is considered improper coding because it doesn't accurately reflect the clinician's work and could lead to claims issues. **Resolution:** Scan claims for red flags, such as a practitioner who spends three minutes reporting labs for every patient, no matter how many labs she reviews. Remind clinicians that their time documentation must accurately reflect the work they did and require them to document the actual time they spent on each activity.

Editor's note: This article is an excerpt from DecisionHealth's **2021 E/M Office Visit Reference Guide,** which is available for order now at www.codingbooks.com/topic/e-m/2021-em-office-visit. To order by phone: 1-855-CALL-DH1. ■

COVID-19

2021 begins with a PHE countdown

By Julia Kyles, CPC

Practices that are using the COVID-19 public health emergency (PHE) exceptions should note that the current declaration will last into January 2021, but the current expiration date may spell a permanent end to the PHE and the dozens of waivers and flexibilities implemented by CMS and other federal agencies, including the popular telehealth expansion that reimburses telephone encounters at a rate that is comparable to an in-person office visit.

The current PHE expires on Jan. 21, 2021, the day after Inauguration Day. It remains to be seen whether the Biden administration will renew the PHE declaration. However, HHS Secretary Alex Azar might renew the PHE at any time before it expires. With this level of uncertainty practices should start planning now for an end to the PHE. For example, warn staff that the flexibilities might end soon and don't schedule telephone visits for the day the PHE will end. Note that if it is renewed, it will last for minimum of 90 days. ■

RESOURCE:

Public health emergency declarations: www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx

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Audit adviser

Providers again clear $1B in revenue for critical care services

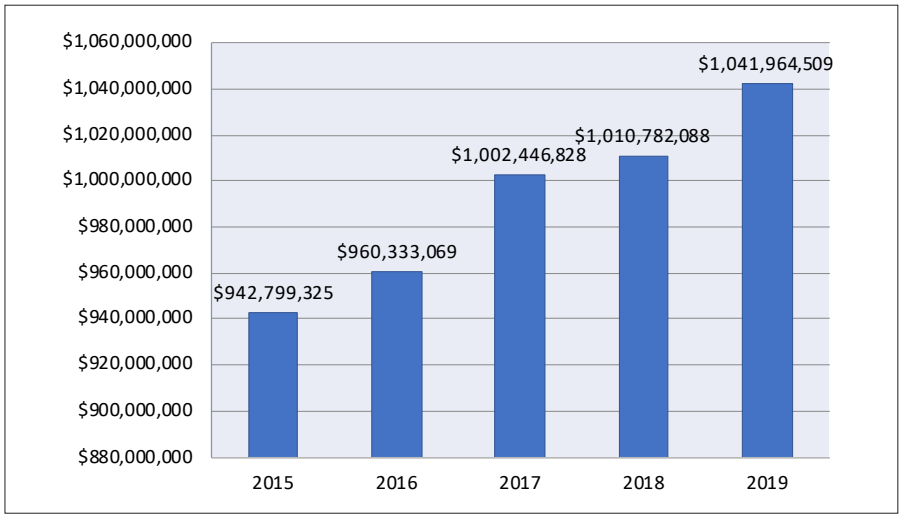
By Richard Scott

The critical care code set may be small, consisting of two CPT codes (**99291, 99292**), but it packs a wallop when it comes to provider revenue. In 2019, practices surpassed the $1 billion mark in payments tied to the two codes.

That makes it three years in a row that providers netted more than $1 billion in revenue, and the steady growth shows no signs of abating, according to the latest available Medicare claims data. In the five years from 2015 to 2019, practices increased the amount of 99291 claims that they reported from 5.7 million to 6.2 million. Claims for add-on code 99292 edged up from 563,000 to 630,000 over the same time period. That claims growth has resulted in a gain of $99 million over the five-year stretch, with total payments nearing $1.1 billion in 2019, up from about $980 million in 2015.

Specialties that frequently provide critical care services, including emergency medicine, pulmonary disease and internal medicine, achieved the lowest denial rates across the five-year period in 2019. That year, the cumulative denial rate of 99291 fell to 5%, down from 6.7% in 2015. And the rate on 99292 dropped to 11.2%, a decrease from 15.7% four years earlier. ■

Payments for 99291, 2015-2019



Payments for 99292, 2015-2019