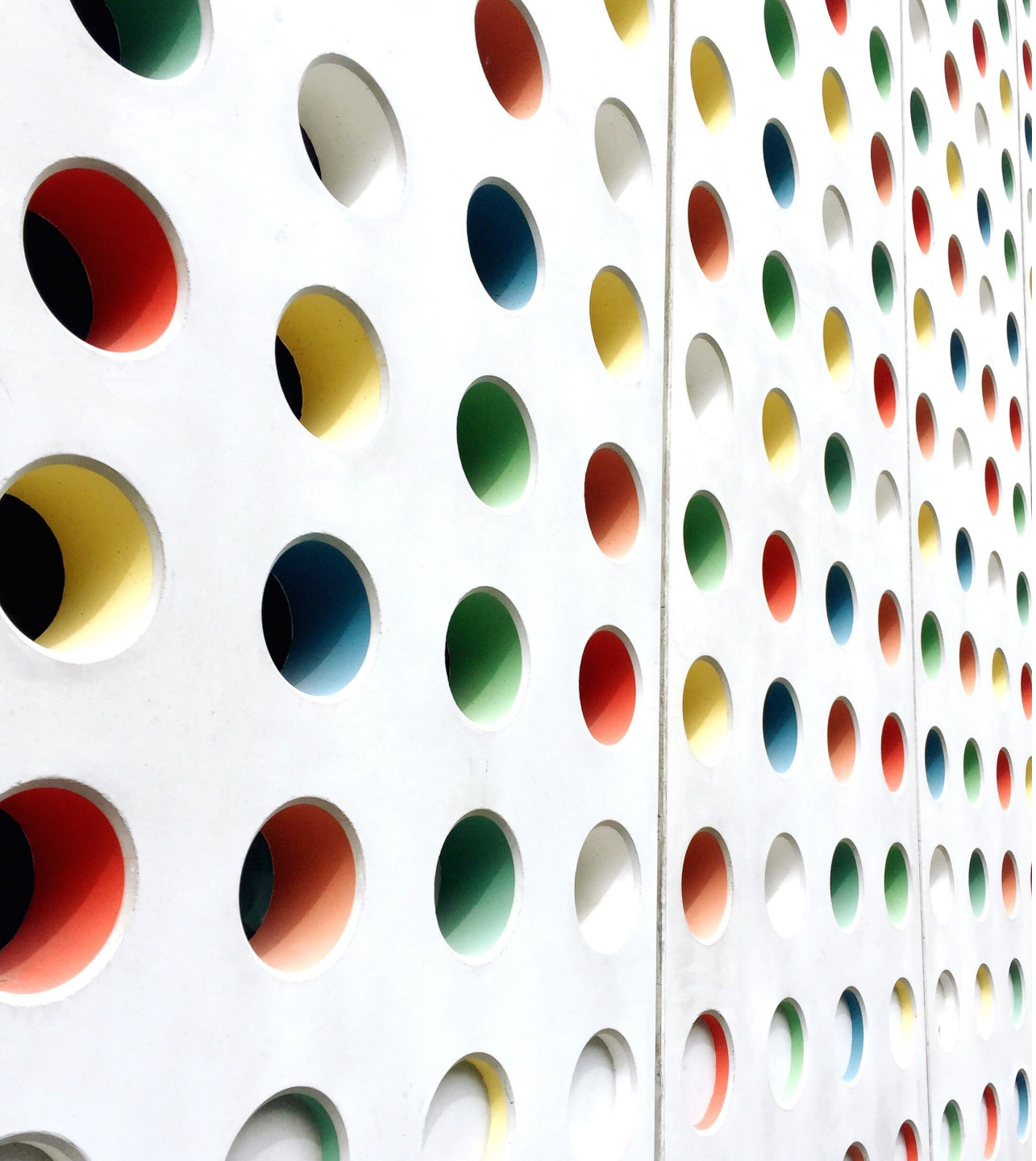

Calculating a New Route

A TIME OUT TO REVIEW CURRENT CODING AND LEGAL TRENDS AFFECTING 2022

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Disclaimer

The information presented in today's program is intended to serve as a general guide only. It is not intended to be a substitute for legal counsel on any subject matter and does not constitute an opinion of Brouse McDowell LPA or any member of the firm. It is also not intended to serve as any specific billing or coding guidance opinion of KraftCPAs or any of its affiliates. No participant should act or refrain from acting on the basis of any information presented in today's program without seeking the appropriate legal or other professional advice on the particular facts and circumstances at issue from a lawyer licensed in the recipient's state, country or other appropriate licensing jurisdiction or a consultant engaged under appropriate arrangements with full knowledge and facts of a particular situation. No attorney-client relationship is created or implied by the information provided during the program.

Where Are We Exactly?

HEALTH CARE INDUSTRY ROUTINE ANNUAL UPDATES (THINK MEDICARE FEE SCHEDULE CHANGES)

OVERLAY THE LAST 20+ MONTHS OF PANDEMIC SPECIAL RULES

PLUS, SUBSTANTIAL CHANGES TO E&M CODING ASSIGNMENT, STARK AND MORE…

This is not your ordinary year!

TRIP OVERVIEW

Where have we been, and where are we going?

- Part I Coding: Evaluation & Management Coding Lookback
- Part II Compliance: Specific impacts on compliance resulting from changes in E&M code selection and related financial impact to practice AND physician comp
- Part III Legal: Stark law changes affecting physician compensation, other Medicare Physician Fee Schedule highlights, and the Surprise Billing Act

Part I: Evaluation & Management Lookback

STACEY STUHRENBERG, KRAFT CPAS

Evaluation & Management

Applying 2021 E&M guidelines are not as easy as counting elements.

The feedback received from providers, auditors, coders, and billers, is that we are not all on the same page. We were teaching providers and staff, while learning the guidelines ourselves.

There is a difference in opinion when interpreting the guidelines. We must remember the guidelines were written by doctors for doctors. This can cause gray areas.

Evaluation & Management

- Changes to the E&M office/outpatient codes represented the biggest guideline change in over 20 years!
- E&M code changes were applicable to all specialties unlike the coding updates received each year. You only use what you need for your specialty. Depending on the edits released, this could represent a minor change or a major change.
- Providers and coders had become accustomed to using the 1995 and 1997 guidelines which required asking the same questions and utilizing the same processes. Providers and coders had become comfortable with counting elements. The biggest difference between 1995 and 1997 guidelines were in the examination documentation section. Providers could use either one of the documentation guidelines.

Evaluation & Management

- Industry professionals were focused on learning the new guidelines, as well teaching them. This was happening in real time in most instances. We didn't focus on the effect the change of guidelines would have operationally–EMR's, processes, etc.
- When implementing ICD-10-CM, we prepared for months on the appropriate use and how software systems would potentially be affected.
- A significant number of EMR's use a calculator that counted elements to level visits. Was this updated? Have templates been updated? Are exams and HPI only being utilized when medically appropriate? The new E&M guidelines do not require 50% face to face counseling. Has the EMR system been updated appropriately?

Evaluation & Management

Interpretation of guidelines can differ from provider to provider. This can cause inconsistency and gray areas to exist within the same practice or specialty.

What processes are in place to ensure your practice is interpreting and complying with the guidelines in the same manner?

- Self-limited versus Acute, uncomplicated.
  - Should your specialty ever have self-limited or acute, uncomplicated (i.e. cardiology, oncology)
  - Are the providers in your practice on the same page? Do they agree on the interpretation of the definitions? Is the use consistent within the practice? For example, one provider may consider a condition as self-limiting while another provider considers the condition more severe which could change the level of the visit.
- What constitutes a problem addressed?

Now more than ever the documentation drives the level of the visit.

Rest Stop: Education and Process

- Identify providers and staff who need additional training
  - Identify any potential issues relating to providers assigning different severity levels when utilizing the same diagnosis
  - Make sure providers understand how the electronic health record process for assigning the level of visit
  - Establish a policy for providers to know when time should be used a level versus medical decision making.
  - Ensure physicians understand that they will follow two sets of guidelines depending on where their services are rendered.
- Identify gray areas within your practice
  - Establish policy/procedures to ensure consistency with interpretation and compliant use of the guidelines
- Work with practice management system to understand how the system is assigning visit levels based on 2021 changes. Verify that your system been updated appropriately.
  - For example, is your system counting over the counter drugs listed in the assessment and plan even though there is no order in the system for them.

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Part II: Compliance Updates

NICOLE THORN, BROUSE MCDOWELL

Why Do CPT (and Dx) Code Selections Matter?

- Not all patients are created equal; thus, not all CPT levels should be selected equally
- Many providers develop habits, even unintentionally, of choosing the same E&M codes
- Payors are watching and targeting probe audits and other policies based on a provider's coding trends
  - Watch Managed Care Contract Language
    - "Medically Necessary"… a health service is payable when it is appropriate and consistent with the diagnosis or symptoms….
    - "Claim" … complete and accurate billing of the Covered Services in a format that complies with standard coding guidelines as supplemented in the Provider Manual

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What is Leveling?

- Payor policy called "Leveling"
  - Payor uses the dx code(s) on the claim to determine whether on its face the E&M code selected is justifiable
  - Legal/contractual implications for this practice
  - Payor agreement terms
    - Clean claims
    - Provider Manual terms
    - Provider Clinical/Policy Bulletins
  - Advocacy (MGMA, OSMA)

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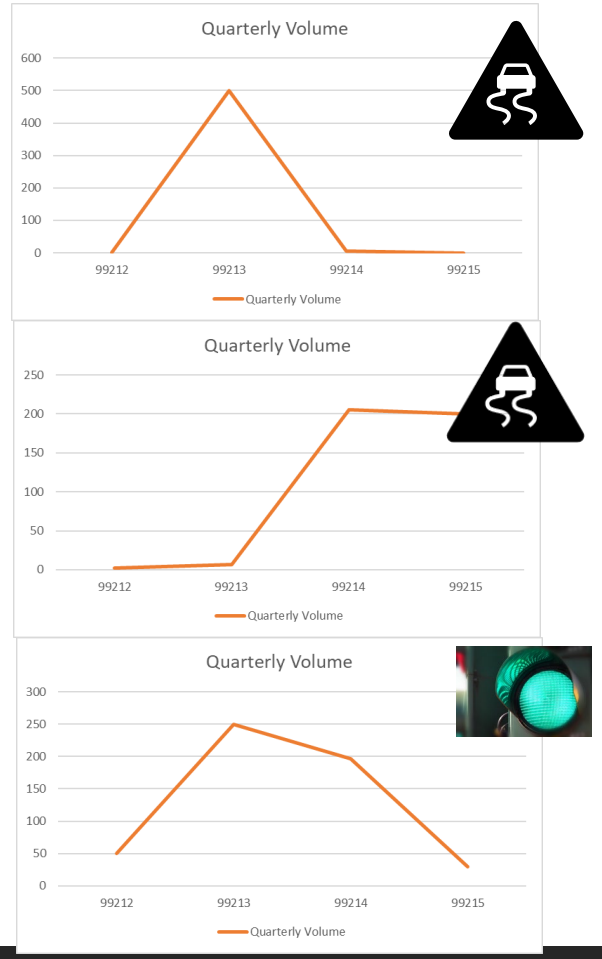
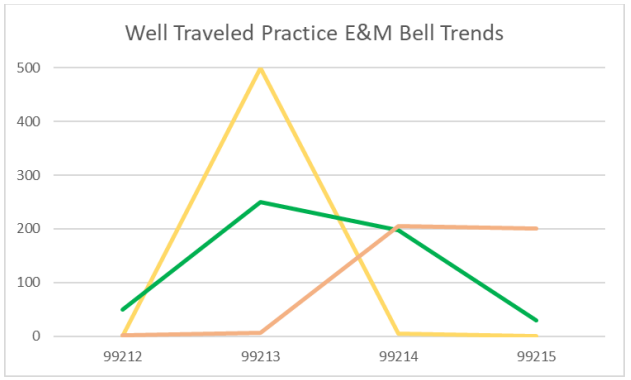
How Do You Reduce Risk for Targeted Audits?

TO GET WHERE YOU'RE GOING, YOU NEED TO KNOW WHERE YOU'RE AT.

	Q1 2021	Q2 2021
Dr. A		
99202	25	48
99203	250	155
99204	201	118
99205	33	42
99211	0	37
99212	16	237
99213	760	199
99214	298	88
99215	105	4
Dr. B		
99202	0	5
99203	415	375
99204	0	1
99205	0	1
99211	0	3
99212	0	1
99213	1069	951
99214	0	4
99215	0	0





Rest Stop: Compliance Check

- ✓Litmus Test: Conduct an internal review of your providers' coding trends
  - ✓ Start by running a report from your practice management system
    - ✓ (E&M CPT code frequency by provider for the last two quarters)
  - ✓ Graph them to see a bell curve for each provider
  - ✓ Look for trends

Rest Stop: Coding Check

- ✓Look for trends in the curve; it should be a true curve
  - Conduct an analysis on each providers' coding trends and document, even if briefly your findings. If you don't have a formal compliance or quality committee, select one or two clinical and billing individuals to review these results.
    - Are there strange "curves"?
    - How do similar specialty practitioners compare?
    - Some of these "trends" may not be bad; they have to be justified.

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Rest Stop: Documentation Check

Get into the habit of routine audits, establish baseline, incorporate deficiencies into practice "work plan".

- Meet and review your coding results from the previous step.
- Identify an independent coding expert to spot check your providers' documentation at least annually.
  - Consider E&M codes and also procedures if applicable.
  - Use the frequency report discussed earlier to drive your attention. Most payors target providers whose claims are outside the standard deviation (bell curve) of other providers in the same specialty.
- Review those audit results with your providers.
  - Was the CPT code selection accurate?
  - Did the documentation reflect the level or was there more they could have said to support the code that was billed?
  - Were the correct dx code selected and billed?
- Continue to review and monitor these results with your providers. In some instances, provider compensation and bonuses can be tied to documentation compliance.
- Armed with these details in advance of audit or payer practice is helpful to defend such practices.

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Part III: Legal Updates

Checkpoint: Physician Compensation

- 2021 CMS Changes to the "Group Practice" definition in Stark law to go into effect January 1, 2022. We're here.
  - Back to the beginning… Stark prohibits a physician from referring any patient for designated health services (DHS) to an entity with which the physician has a financial relationship and for which the entity accepts Medicare/Medicaid payments unless an exception applies
  - Common Exceptions
    - In-Office Ancillary Services
      - Used by many physician practices that provide/bill for in-house lab, therapy, imaging, DME, inpatient and outpatient hospital services and more.
      - Requires practice to meet the Group Practice definition
    - Employment
      - Used by most health systems, hospitals, including physician practice affiliates
      - Requires FMV, commercial reasonableness and volume or value elements

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Impacts of Stark Law Changes

Group Practice DEFINITION – PROFIT DISTRIBUTION*

- Changes/Clarifications
  - No more "split-pooling" (i.e. service line separation)
  - Practice profits resulting from DHS can be distributed to physicians so long as they are not based on the volume or value of the referrals of that individual physician to "the pot".
  - "Overall profits" means a group's entire profits derived from ***all*** the designated health services of any component of the group that **consists of at least five physicians**. (Think practice distribution vs. individual pod or specialty-specific distributions.)
  - Amounts can include "incident-to"services
  - Overall profits means the group's entire profits derived from DHS payable by Medicare or Medicaid or the profits derived from DHS payable by Medicare or Medicaid of any component of the group practice that consists of at least five physicians.

  Distribution Options:

  - Based on shares of ownership in practice
  - As a percent of profits that are **not** DHS
  - De minimus exception (DHS revenues are <5% of overall practice revenues and <5% of a physician's total practice compensation)

- Whatever methodology is used must be applied to all physicians in the component

- Profits are Revenue – Expenses, not revenue alone.

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*42 C.F.R. Section 411.352

"Siri, what is FMV, Commercial Reasonableness, and Volume or Value?"

For groups leaning on the employment exception under Stark, the 2022 changes involve the following concepts:

- ❑Fair market value – "arm's length transaction, consistent with the general market value"
  - ❑Changes remove the "volume or value" condition
  - ❑Consider all factors (i.e. not just salary surveys, but recruiting efforts, specialty, payor mix, cost of living, location, nearest alternative, etc.)
- ❑Commercial Reasonableness – "furthers a legitimate business purpose of the parties to the arrangement and is ***sensible***, ***considering the characteristics of the parties, including their size, type, scope, and specialty***"
  - ❑Lack of profitability for the arrangement does not alone deem the arrangement non-compliant
- ❑Volume or Value - formula takes into account volume or value if compensation ***positively or negatively*** correlates with the number or value of the physician's referrals to the entity

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Medicare Physician Fee Schedule 2022: Detour Please?

- A primer on wRVU changes
  - The *2021* Medicare Physician Fee Schedule (MPFS) substantially increased the wRVUs associated with many E&M codes (up 46% in some cases)
  - While wRVUs increased, the Medicare payment for same did not increase by the same percentage.
  - Some health care organizations who pay and/or otherwise compensate providers based on wRVUs held off on any increases resulting from those changes because of the pandemic and for other reasons
- No wRVU changes to the *2022* Medicare PFS, but have you reconciled your provider compensation with the actual reimbursement?
- Consider that provider compensation may have increased by substantially more than wRVU's without any additional effort/change in volume

	2020	2021	% Change from 2020	2022	% Change from 2021
99202	$73.96	$70.93	-3.0%	$70.98	0.0%
99203	$105.04	$109.66	4.6%	$109.83	0.2%
99204	$161.41	$164.49	3.1%	$164.15	-0.3%
99205	$204.26	$217.43	13.2%	$217.28	-0.2%
99211	$22.06	$21.64	-0.4%	$22.09	0.4%
99212	$43.98	$54.37	10.4%	$54.99	0.6%
99213	$73.04	$89.00	16.0%	$88.58	-0.4%
99214	$106.18	$126.50	20.3%	$125.02	-1.5%
99215	$142.92	$177.08	34.2%	$176.89	-0.2%

	2020 wRVU	2021 wRVU	% Change from 2020	2022 wRVU	% Change from 2021
99202	0.93	0.93	0.0%	0.93	0%
99203	1.42	1.6	18.0%	1.6	0%
99204	2.43	2.6	17.0%	2.6	0%
99205	3.17	3.5	33.0%	3.5	0%
99211	0.18	0.18	0.0%	0.18	0%
99212	0.48	0.7	22.0%	0.7	0%
99213	0.97	1.3	33.0%	1.3	0%
99214	1.5	1.92	42.0%	1.92	0%
99215	2.11	2.8	69.0%	2.8	0%

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Rest Stop:
Review Physician Compensation Methodologies

1. Analyze whether your practice bills for DHS and you rely on the In-Office Ancillary Services exception under Stark
2. Analyze whether your entity relies on the Employment exception
3. Ensure that your 2022 methodology accounts for 2022 Stark law changes
   a. Review historical practice distribution methodology
   b. Be able to justify any compensation methodologies by reviewing *and documenting* all factors weighing into the numbers
   c. Discuss this calculation with your accountant and health care attorney

Speaking of 2022 MPFS and Revenue Shifts…

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Medicare Physician Fee Schedule: Split/Shared Billing[1]

- Split billing: Performed in hospital inpatient/outpatient settings when an E/M visit where the physician and a qualified non-physician provider each personally perform a substantive portion of an evaluation and management (E/M) visit face-to-face with the same patient on the same date of service.
  - A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision-making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer."
- Was billed under the physician's provider numbers and reimbursement based on physician fee schedule
- Not to be confused with incident-to billing, the sister of split billing non-hospital settings

[1] This is a Medicare concept however some other payors permit this practice. Check your own payor contracts, and provider manuals for their specific billing rules.

What is Changing?

- The provider who bills is the one who spent the more substantial time on the patient (i.e. > 50% of the visit)
  - Documentation must support both providers and the one who performed the substantial portion signs and dates the note
  - Think role of APP's and potential reimbursement impacts if they will now become the billing provider (e.g. 85% of fee schedule)
- Like other E&M codes in 2021, medical-decision making or time-based methodologies may be instances when split/shared billing requirements are met
- In 2023, all split billing must be based only on the time-based methodology.
  - Again, plan now for potential revenue impacts if this changes your coding bell curve.
- Split/shared billing may now be performed in critical care and SNF[1] settings
- May not be done at all in office anymore; note, this was only ever permitted if incident-to guidelines were met.

[1] Excludes visits that expressly require only a physician perform

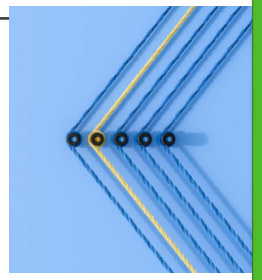
Rest Stop…

- If your practice bills split/shared visits, analyze your volume, coding and payment (See previous slides for analysis)
- Consider what portion of your visits is performed by an APP as a portion of the visit
- Review your charge entry process for choosing a billing provider to ensure the correct practitioner's name makes it on the claim

Map Overview: Other MPFS Highlights

- Provides a 3% increase to fee schedule which offsets the loss of the 3.75% reduction which was set to expire.
- 2% sequestration paused until April, 2022; only 1% for the next three months.
- Pay-as-you-go (PAYGO) sequestration 4% decrease delayed another year
- Extended certain Category 3 telehealth services through 2023[1]
  - Modified the definition of "interactive telecommunication system" to including not only two-way audio-visual capabilities but adds that audio-only is acceptable for mental health visits to established patients when provider can meet the two-way requirement, but patient is either unable or unwilling to participate in two-way communication. Must be billed with a modifier.
- Changes to therapy billing for OTAs and PTAs to allow payment at 85% of the fee schedule when properly supervised; also note certain conditions for *de minimus* standard and calculation of time under the 8-minute rule
- Creates ability for physician assistants to bill independently now; (note: state supervisory requirements still in effect)
- Electronic prescribing of controlled substances (EPCS) now required with limited exceptions, but enforcement delayed until 2023.
- Payment penalty phase of the Acceptable Use Criteria (AUC) postponed to the later of 2023 or January 1 of the year following the end of the PHE.
- Clinical Laboratory Fee Schedule rate reductions are postponed until 2023
- Radiation Oncology Model postponed until 2023 (required episodic payment model)

[1] See next slide for details.



Surprise! Last Minute Aversions…Déjà vu: SGR flashbacks anyone?

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Medicare Category 3 Telehealth Services Extended through 2023	
Domiciliary, rest home, or custodial care services, established patients (99336-99337)	Nursing facilities discharge day management (99315-99316)
Hospital discharge day management (99238-99239)	Critical care services (99291-99292)
Home visits, established patient (99349-99350)	Psychological and neuropsychological testing (96130-96133; 96136-96139)
Inpatient neonatal and pediatric critical care, subsequent (99469, 99472, 99476)	End-Stage Renal Disease monthly capitation payment codes (90952, 90953, 90956, 90959, 90962)
Emergency department visits, levels 1-5 (99281-99285)	Therapy services, physical and occupational therapy, all levels (97161-97168; 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
Continuing neonatal intensive care services (99478-99480)	Subsequent observation and observation discharge day management (99217; 99224-99226)

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Surprises in 2022

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No Surprises Act: Does this apply to your practice?

- Applies to health care facilities: 1) a hospital; (2) a hospital outpatient department; (3) a critical access hospital; or (4) an ambulatory surgical center.
- Applies to stand-alone physician practices (i.e. not hospital or system affiliated)–the Good Faith Estimate obligations
- Provides protections against balance billing and out-of-network cost sharing with respect to emergency, nonemergency services furnished by nonparticipating providers at certain participating health care facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services
  - Think especially, pathology, anesthesia, radiology practices that contract with hospitals

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Recalculating New Route…

HHS to conduct 200 random or targeted investigations per month in 2022; Expect state agency involvement (i.e. Attorney General's Office)

Requirements

- Provide advance notice of the out-of-network status and estimate of difference in out-of-network balance and obtain the patient's consent (72 hours in advance or if same day, 3 hours before appointment)
- Note: Notice and Consent is **impermissible** for:
  - Emergency services
  - Unforeseen urgent medical needs arising when non-emergent care is furnished
  - Ancillary services, including items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology
  - Items and services provided by assistant surgeons, hospitalists, and intensivists
  - Diagnostic services including radiology and lab services
  - Items and services provided by an out-of-network provider if there is not another in-network provider who can provide that service in that facility
- Good Faith Estimates (GFE) required for out-of-network or self-pay services
  - See CMS documentation samples: https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf
- Publicly post the requirements and prohibitions under the Public Health Service Act Section 2799B-1 and 2799B-2 and their implementing regulations
- Follow state law regarding balance billing
  - Ohio law is like the federal law except it includes labs performed during the emergency or unanticipated care, also includes ground ambulance services, but only covers fully-insured patients (federal law also includes self-insured plans). Effective January 12, 2022.

Keys For Medical Practices

- Determine and educate your staff on what constitutes a request for an estimate
- Do your due diligence on eligibility checking in advance of patient appointments/services
- Review your website and other patient-facing disclosures about obtaining "estimates" for care, including your Financial Policies
- Establish a contact in your practice to deal with billing disputes to ensure compliance under this regulation
- Create a notice and consent document

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Q & A

THANK YOU FOR JOINING US TODAY.

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