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Part B News
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In this issue

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Practice management

Soothe 'great resignation' squeeze on staff with a supportive workplace

The story is unfolding day to day, but America's normally robust health care employment environment appears to be getting squeezed by the exodus of workers across the country, a phenomenon being called the "great resignation." Practice employers should acknowledge that this is probably not a transitory trend, and now is the time to take steps to improve retention and avoid costly hiring waves.

In August, 4.3 million of employed Americans, or 2.9%, left their jobs, the U.S. Bureau of Labor Statistics (BLS) confirmed in its October 12 Job Openings and Labor Turnover (JOLT) Survey. That marks a substantial change from a year earlier, when the departing number was 2%. BLS further reported that in August employee "quits" in the health care and social assistance industries totaled 534,000; in August 2020, there had been 404,000.

Other BLS numbers indicate that physician practice employment volume has been steady since the start of the public health emergency (PHE). The Bureau projects total physician practice employment in August at 2.7 million, which is slightly ahead of the August 2020 number of 2.6 million and less than 1% behind February 2020. But taken with the JOLT numbers, this suggests that while the volume of workers in practices remains similar, an unusual number of those roles are being filled with new employees — meaning greater-than-usual turnover expenses.

Some observers attribute the exodus to a cresting wave of general worker dissatisfaction, particularly among less-well-compensated workers. Others think it may be just a blip caused by factors such as the summer emergence of the Delta COVID variant.

Get ready for 2022 E/M updates

CMS is unleashing big changes to E/M coding, billing and documentation policy starting Jan. 1, 2022. From revisions for split/shared billing policy to a wide-ranging update on critical care services, a flurry of new policies will hit medical practices in the new year. Prepare for the updates during the Nov. 23 webinar E/M for 2022: Brace for Revised Medicare Policies, Code Updates. Learn more: https://codingbooks.com/ympda112321.

A long resignation?

But medical practice experts say it would be a mistake to discount the trend.

"Many ambulatory care practices Greenway works with have actually reported difficulty maintaining and recruiting new staff," reports Michael Blackman, M.D., chief medical officer at Greenway Health, a health information technology services provider, in Tampa, Fla. "Maintaining staff has been one of the most common issues raised by practices at our regional user meetings. Hourly staff are most impacted as difficulty in other industries has opened other opportunities which can offer higher monetary compensation."

Burnout, heightened by the pandemic, may be playing a leading role too. "Health care employees have been in the trenches for years dealing with life-and-death matters, and a lot of them are ready to look for a different job or take a step back," says Brett Holubeck, a labor and employment lawyer in Houston, Texas, and proprietor of the Texas Labor Law Blog (*texaslaborlawblog.com*).

Also, physician practices may soon see a labor disruption, notes Robert L. Kilroy, partner with Mirick O'Connell in Westborough, Mass., and member of the firm's management committee. "I definitely see an uptick in the hospital-based environment in terms of tightening of the labor market, whether it's sub-clinical employees or even nurses, CNAs and so on," Kilroy says. "It's becoming very difficult to staff, and I would suspect that will reverberate into physician group practices as well."

No end in sight

While Andrew Colbert, senior managing director with the Ziegler investment firm in New York City, says labor shortages haven't impacted his work in health care transactions, they "could become a discussion topic in deals with buyers and investors, who are obviously concerned about labor cost and any increase in challenges with recruiting. Companies are forecasting financials for the next 12 months. They're probably having to factor in incremental wage growth at maybe a higher rate than they have historically."

Kareem Malek, co-founder & COO of Within Health in New York City, says health care leaders are aware of the challenge presented by a newly changeable workforce, particularly in organizations with a large support staff, such as outpatient radiology clinics that comprise some of Within Health's client base. "In some instances, these outpatient radiology practices have call centers with ... 50, 60 schedulers, and their churn rates are incredibly high," he says.

4 ways to support employees

If you're not sure your human relations approach is strong enough to withstand the flood, it's a good time to shore it up. Money's always appreciated, but if your budget's tight, focus on some other hiring solutions:

- **Don't bully**. Don't bully. People are more likely to quit a job because their boss makes them miserable than they would to gain a slight salary increase, Holubeck says. Make sure managers aren't driving employees away.

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- **Listen**. "It's time for employers to go back to some basic things to improve their retention — for example, meetings where you're taking feedback," Holubeck suggests. You may not be able to have giant meetings in the COVID era, but small ones may be even more helpful.

Giving workers ways to get grievances off their chest is good way to relieve pressure. But workers may be shy about telling their supervisor they're having a problem — especially if the supervisor is the problem, Holubeck says. "Have you really thought out your complaint process?" he asks. "It's very important that the employee handbook has a procedure." You might also bring back the old-school suggestion box.

Follow through is important. "Where there are issues, you try to find something you can do to fix," Holubeck says. "And if you can't fix it, at least make the employees aware that you're doing your best to try to correct the problems."

- **Be flexible**. "It seems a key strategy is to strive to enhance job satisfaction through such measures as altered work arrangements, flexible scheduling and the like," Kilroy says.

While there are barriers to work-from-home arrangements for clinical workers, you might see if your staff would be open to scheduling innovations that leave work covered while reducing the burden on individual employees, according to Kilroy. Maybe in the old days workers took pride in how much overwork they could tolerate, but "the younger generations don't see the need to necessarily work the same incredible hours" as prior generations, he says.

"Because we've seen so many people being burnt out and moving on from health care, the health care industry is going to have to become more flexible and accommodating so as to continue to creatively meet their patient care and operational needs," Kilroy says. "This will require emphasis on programs aimed at retaining talent, programs designed to attract new hires and efforts to combat burnout, possibly through job sharing [or] reduction of demands."

Kilroy also sees an employer advantage in the expected collapse of the paid family leave legislation in Congress: Offering "some degree of paid family leave as a benefit that might incentivize employees to continue in their employment as opposed to seeking job opportunities elsewhere," he says.

- **Recognize your staff**. "Practices should work to ensure that the entire staff feels appreciated. Set goals and celebrate successes," Blackman says. "Most people want to do a good job, and ongoing communication will help everyone know how the entire team is doing and what should be done to improve. That communication, however, must be bi-directional. Listen to the team and empower them to look for better ways to get to the desired goals, and incorporate their ideas when possible." — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCE

- Bureau of Labor Statistics Job Openings and Labor Turnover (JOLT) Survey, August 2021: www.bls.gov/news.release/jltst.nr0.htm

Billing

Navigate billing differences for coming principal care management codes

Principal care management (PCM) may be more attractive to practices than traditional care management in 2022. The transition from temporary HCPCS codes to permanent CPT codes (**99424-99427**) includes new add-on codes that will allow practices to increase the revenue they receive for this service (*PBN 11/1/21*).

But before you add PCM to your suite of chronic care management (CCM) services, make sure you understand what sets it apart from the other codes in the family.

"The primary difference between PCM and CCM is that PCM involves management of only one chronic condition while CCM involves management of at least two chronic conditions," says Kaitlyn O'Connor, Esq., senior counsel with Nixon Gwilt Law in Richmond, Va.

The provider who performs the service is another departure. "PCM is often provided by specialists (though this is not a requirement) while CCM is typically offered by a primary care provider," O'Connor says.

More than one provider may deliver PCM to the same patient during the same period, but practices should be prepared to demonstrate the medical necessity of their services.

Medicare's intent for the service could be another key difference. When CMS created the G-codes (**G2064-G2065**), PCM was "intended for a specialist to stabilize a specific condition, not provide the ongoing care for all the patient's conditions," says Kim Huey, MJ, CHC, CPC, CCS-P, PCS, CPCO, COC, president of KGG Coding and Reimbursement Consulting in Alabaster, Ala.

CMS indicated the service would be "billed for three months or so, then the patient would be returned to the physician who manages all their care," Huey adds.

In addition, "PCM will typically be triggered by a recent exacerbation [such as an emergency room visit] and continue until the condition at issue is stabilized and care is returned to the primary care provider," O'Connor says. "CCM, on the other hand, is for ongoing management of a patient's care that may continue for several years."

CMS intends to cover the CPT codes but it remains to be seen whether the agency will adopt CPT guidelines without modification or stick to its model for PCM.
— Julia Kyles, CPC (jkyles@decisionhealth.com) ■

Coding

Audit, monitor, train: Stay compliant as OIG spotlights modifier 25

Pay attention to your billing of E/M services and a minor procedure at the same encounter, because federal auditors are taking notice. In April, the Office of Inspector General (OIG) added a new item to its Work Plan titled "Dermatologist Claims for Evaluation and Management (E/M) Services on the Same Day as a Minor Surgical Procedure" (*PBN 6/14/21*).

Despite the title, the application and overall concern about this concept is much broader than dermatology. Practices reporting an E/M service separately from a minor procedure should take notice of this item.

Defining minor procedures

Generally, E/M services provided on the same day as a minor surgical procedure are included as part of the procedure. You are eligible to report an E/M code on the same day when the E/M service is significant and separately identifiable from the surgery.

While the focus of the OIG item is on E/M with minor procedures, take note that any time an E/M code is reported with another procedure or service, the E/M service must be separately identifiable from that procedure or service.

Minor procedures are procedures with a zero- or 10-day post-operative period. CMS has been collecting data for select procedure codes in nine states tracking post-operative visits. The agency is seeking to determine whether to end the use of global package days and change code pricing to no longer include these post-operative days. Ultimately, this could change how a "minor procedure" is defined in the future.

Correct use of modifier 25

It is critical to understand what significant and separately identifiable means. Modifier 25 is used to report a service on the same day as a procedure when that service was a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative care associated with the procedure — and the documentation must support the criteria to report an E/M code.

Generally, a procedure includes three components: pre-service; intra-service; and post-service work. The E/M code is reported when services are provided beyond the usual work associated with the procedure. Reporting an E/M code with a procedure does not require a separate ICD-10-CM code. The documentation for the separate E/M code must support medical necessity and the services provided that were above and beyond the components included in the procedure code reported.

Incorrect use of modifier 25

The use of modifier 25 is narrow. It should not be used with a CPT code reporting a service that is inclusive of the procedure. E/M codes do not need to be reported any time another procedure or service is performed. For example, a provider may have the patient return for a follow-up visit for continued treatment following a particular procedure. A provider may be freezing a wart and may instruct the patient to return in a month for evaluation and possible refreezing. The patient returns and the wart is present and requires another freezing. Because nothing the provider

(*continued on p. 6*)

Benchmark of the week

Monitor revised CPT codes that take changing descriptors in 2022

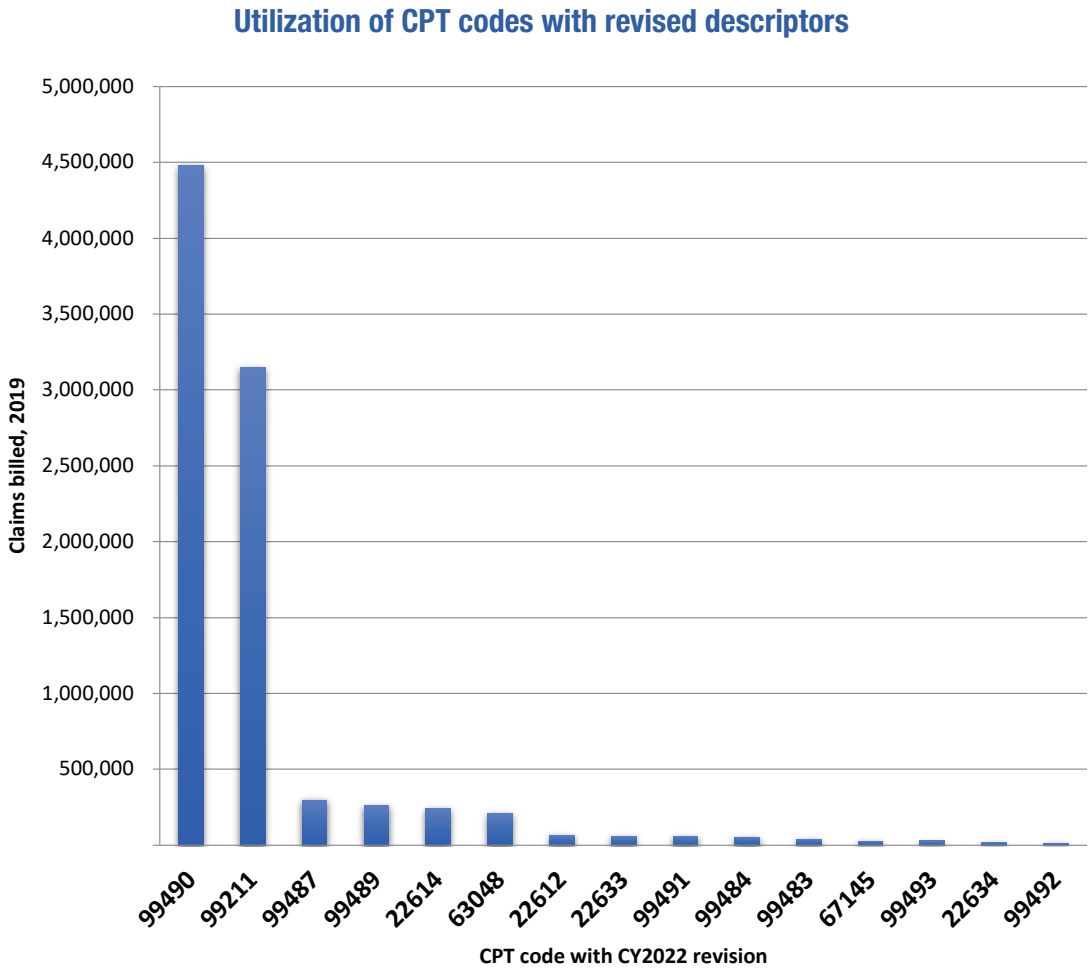
Get ready to sharpen your claims billing when the calendar flips to 2022 by adapting to a slate of CPT code revisions. Of the hundreds of CPT code changes taking effect Jan. 1, you'll find 93 revised codes, many of which are impacting oft-reported services.

The chart below details the most frequently reported CPT codes, based on the latest available Medicare claims data, that will see a revised code descriptor in 2022. Topping the list is chronic care management (CCM) service **99490**, which practices reported nearly 4.5 million times in 2019, the latest year of available data. That's followed by E/M office visit code **99211**, with 3.2 million claims in 2019.

Some of the revisions to the code set are minor in the coming year. For instance, the AMA, which maintains the code set, deleted the phrase "Usually, the presenting problem(s) are minimal" from the code descriptor for code 99211.

The revisions to CCM code 99490 arrive along with changes to the code descriptors of complex CCM codes **99487** and **99489**, as well as the physician-directed CCM code 99491. The most significant revision among the batch of CCM services impacts **99491**, which now includes the phrase "first 30 minutes provided personally by a physician or other qualified health care professional" in place of "at least 30 minutes of physician or other qualified health care professional time." The change will allow practices to tap into a CCM add-on code, **99437**, which is new in CY2022.

Among the other code revisions, you'll find a key update to surgical service 22614, which will pertain to "each additional interspace" rather than "each additional vertebral segment." Use the chart below to ascertain which codes that get reported most often are in need of review before you begin billing your services in the new year. – *Richard Scott* (rscott@decisionhealth.com)



Source: *Part B News analysis of the 2022 CPT code update and 2019 Medicare claims data*

(*continued from p. 4*)

did went beyond freezing the wart, no additional E/M service would be supported in this scenario.

A key way to determine what would be included in a procedure code would be to access the AMA's RVS Update Committee (RUC) web-based lookup tool. The RUC is composed of a group of physicians who determine what is included within each category for a specific code. RUC information for each procedure describes the type of professional involvement and work that is inclusive of the procedure. Access to the subscription is the only way to know the exact components that are included in the pre-, intra- and post-service work for any procedure.

Prevention is key

Your auditing and monitoring process should include constant monitoring of the OIG Work Plan, which is updated each month. For the April item on modifier 25, the issue identified by the OIG can apply to all E/M codes reported with modifier 25. As a result, practices should internally audit for correct application of modifier 25 and whether the documentation supports the use of the E/M code in addition to the other procedure or service provided.

You can perform an internal audit before or after claim payment, and you can find benefits to both. Performing an audit before submitting a claim allows for any findings to be corrected without having the claim hit an edit or denial first and then having to submit a corrected claim.

Looking at claims post-payment provides a view of exactly what may have gone wrong when the claim was submitted to the payer. The codes reported on a claim may not be the codes that actually remain on the claim once it is submitted to the payer, as claims have many touch points before they are transmitted to the payer. Each touch point, work queue or bridge routine creates a potential risk in which the claim may be modified incorrectly.

For example, a claim may hit an edit requiring a modifier, a staff member may not fully understand which modifier to append, and the staff member may misapply modifier 25. Additionally, a code may be hard-coded with modifier 25. A post-payment review may identify whether a claim was altered incorrectly before it got to the payer.

Tap into authoritative documents

When auditing modifier 25 to determine whether it is reported for a service that is truly significant and separately identifiable from the procedure, it is critical to reference documents that have authority over the claim. Source authorities, definitions and modifier rules may vary among payers. Traditional Medicare source authorities include the Medicare manuals and Medicare administrative contractor (MAC) policies.

For commercial payers, authoritative documents include the contract, the provider manual published by the payer and any other communications including coding and payment policies.

Reimbursement check

The review process of modifier 25 should include a reimbursement review. For example, some payers only pay for one E/M service with a procedure regardless of the number of times a patient returns for a follow-up. It is critical to ensure payment policies and contract terms are properly carried out by the payer. A practice may determine financial risks by profiling denial data and third-party requests associated with claims with modifier 25.

From a denial and audit standpoint, looking at claims data may help with payer negotiations. The data collected can be used to help limit the number of audits performed on an annual basis. Denial information can also provide leverage in negotiating contracted rates on a fee schedule or move certain types of services that were denied to a carve-out provision. Disconnects may occur on the payer side between contracting and claims. Once a contract is negotiated and executed, monitor claims processing to ensure claims are properly adjudicated and are not being underpaid.

While it is sometimes appropriate to report modifier 25 with an E/M code and a separate procedure code, the requirements must be met: the E/M service must be one that is above and beyond what is included in the procedure and must meet medical necessity. Internal auditing, monitoring and continued training are essential components to ensure compliance and proper reimbursement. — *Joe Rivet, Esq., CCS-P, CPC, CEMC, CPMA, CICA, CHRC, CHPC, CHEP, CHC, CICA, CAC, CACO* (*pbnfeedback@decisionhealth.com*) ■

Editor's note: This article first appeared in Medicare Insider. Rivet is founder of Rivet Health Law PLC in Grand Haven, Mich., and Medicare Boot Camp instructor with HCPro.

RESOURCES

- OIG Work Plan item: https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000577.asp
- Global surgical period report: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Global-Surgery-Data-Collection-

Ask Part B News

Patients asking for vaccine exemptions? Stick to medical facts

Question: *We have had some patients calling for an appointment to "get a COVID vaccine exemption." They seem to have jobs that mandate their vaccination. Do we need to tell our doctors anything? Should we prepare some kind of form?*

Answer: If you're working with a self-produced form, you should take any necessary steps to protect yourself from liability.

"If a physician practice is considering using a written form to provide to patients or prospective patients who were seeking a medical exemption for the COVID vaccine, I recommend the practice have the form first reviewed by their legal counsel," says Robert L. Kilroy, partner with Mirick O'Connell in Westborough, Mass. "Their legal counsel can ensure the wording is accurate so as not to open the practice to some sort of legal claim later."

But patients are more likely to bring a form from their job to you. Businesses that mandate COVID vaccinations often supply employees with a form that states what they consider acceptable reasons to bypass a vaccine on medical grounds. That may be happening in anticipation of a U.S. Equal Employment Opportunity Commission (EEOC) or Americans with Disabilities Act (ADA) challenge.

The employer's form would be helpful for providers if the patient is unclear as to what specifically they want the provider to attest, suggests Brett Holubeck, a labor and employment lawyer in Houston, Texas, and proprietor of the Texas Labor Law Blog (texaslaborlawblog.com).

For example, Teachers' College at Columbia University in New York City has a form specifying the medical grounds it will consider, and asking the provider to "certify below the medical reason that your patient should not be vaccinated for COVID-19 by completing this form and attaching avail-able supporting documentation."

The Teachers' College form lists allergic reactions to any COVID vaccines as possible contraindications, and asks for confirmation that "the physical condition of the patient or medical circumstances relating to the individual are such that vaccination is not considered safe." Further, the request seeks "sufficient detail for independent medical review."

In general, your providers will be bound by their medical board's standards. Most if not all such boards have made statements regarding the provision of exemptions. For example, Kilroy notes, the Massachusetts Board of Registration in Medicine states:

"Physicians who grant vaccination or mask exemptions must have a physician-patient relationship with the person who is the subject of the exemption and a legitimate medical reason supporting an exemption. A physician who grants an exemption outside the acceptable standard of care may be subject to discipline. The standard of care applicable is the same whether the patient is seen in person or through telemedicine."

Some doctors have already gotten in trouble for flouting board requirements. On Sept. 24, the Connecticut Medical Examining Board suspended the license of Sue McIntosh, M.D. "until a full hearing on the merits can be held." The state Board of Health had received a complaint that McIntosh "provided through the mail signed forms absent a patient name providing exemptions from COVID-19 masks, COVID-19 vaccines, general vaccines and COVID testing without examining, identifying or evaluating the patient."

This would seem to be a good argument for the practice to *not* supply its own forms. — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCES

- "Request for Medical Exemption from COVID-19 Vaccine Form for Employees and TC Housing Affiliates," Teachers College, Columbia University: *www.tc.columbia.edu/media/administration/preparedness/Request_for_Medical_Exemption_from_COVID-19_Vaccination_Form_Employees_6-10-21.pdf*
- Agenda, Connecticut Medical Examining Board, Sept. 24, 2021: *https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/phho/Medical_Board/Agenda/2021/CMEB-Agenda---September-24-2021.pdf*

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Billing

It's official: New epidural policies will go live before the year ends

Practices that perform intralaminar and transforaminal epidural injections to manage chronic pain should add "Implement the new local coverage determination (LCD)" to their to-do list.

At press time, the following Medicare administrative contractors (MAC) had posted final versions of the LCD and related billing and coding articles, according to Amy Turner, RN, BSN, MMHC, CPC, CHC, CHIAP, director of advisory solutions for abeo. The LCDs and articles from the following MACs have a Dec. 5, 2021, effective date:

- CGS.
- First Coast Service Options.
- National Government Services.
- Noridian.
- Novitas.
- Palmetto GBA.
- WPS.

Turner has been keeping a close eye on the proposed uniform LCD and article that MACs collaborated on and released earlier this year (*PBN 7/5/21*). According to Turner, the MACs made some clarifications and tweaks in response to comments, but they did not make radical changes to the proposed policies. Practices should start preparing now so they don't end the year with a mound of denials.

Here are four quick hits from the final policy:

1. Modifier **KX** (Requirements specified in the medical policy have been met) will be required for diagnostic blocks.
2. The language on drugs and dosage levels has been clarified.
3. The policies will not apply to lumbar epidurals performed as part of a pain pump trial.
4. There will be more restrictions on the use of deeper levels of sedation in conjunction with epidurals. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

Editor's note: You can get more details and earn CEUs by accessing the on-demand webinar, *Epidural Update: Prepare for the Uniform Policy for Translaminar, Transforaminal, and Caudal Epidurals*. Learn more: *https://codingbooks.com/ympda102121*.