Health Law Webinar

The Annual FAQ Session

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What If Our Physician Note Is Crummy?

- Fix it!
- Addendum to notes are always allowed.
- Be transparent about it.

Shared Visits: 42 CFR § 415.140

- Replaces guidance with a regulation.
- Applies where “incident to” billing is prohibited.
- Use “FS” modifier on the claim.
- Only the professional doing the “substantive portion” may bill.

42 CFR 415.140

- *Facility setting* for purposes of this section means institutional settings in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under § 410.26(b)(1) of this subchapter.
- *Split (or shared) visit* means an evaluation and management (E/M) visit in the facility setting that is performed in part by both a physician and a nonphysician practitioner who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or nonphysician practitioner if furnished independently by only one of them.

42 CFR 415.140

- *Substantive portion* means more than half of the total time spent by the physician and nonphysician practitioner performing the split (or shared) visit, except as otherwise provided in this paragraph. For visits other than critical care visits furnished in calendar year 2022, *substantive portion* means one of the three key components (history, exam or medical decision-making) or more than half of the total time spent by the physician and nonphysician practitioner performing the split (or shared) visit.

42 CFR 415.140

- (b) *Conditions of payment.* For purposes of this section, the following conditions of payment apply:
- (1) *Substantive portion of split (or shared) visit.* In general, payment is made to the physician or nonphysician practitioner who performs the substantive portion of the split (or shared) visit.
- (2) *Medical record documentation.* Documentation in the medical record must identify the physician and nonphysician practitioner who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.
- (3) *Claim modifier.* The designated modifier must be included on the claim to identify that the service was a split (or shared) visit.

Shared Visits: Substantive Portion

- 2022 more flexible than 2023 for all but Critical Care.
- In 2022, “substantive portion” of the visit means the professional performed any one of the three key components (history, exam or medical decision-making) or more than 50 percent of the time.
- In 2023, whoever does the most time. (CMS has indicated informally that if both professionals are there, they may decide which gets the time.)

Shared Visits: General Principles

- A physician and an NPP in the same group. Can they be leased?
- New medical record documentation requirements including identifying both the physician and NPP, and signature and date from the professional performing the substantive portion.
- Historically signatures have NOT been a condition of payment. Is that changing?

Be Careful What You Wish For: 42 CFR 410.20(e)

Medical record documentation. The physician may review and verify (sign/date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team including, as applicable, notes documenting the physician's presence and participation in the services.

Shared Visits

1. When MD and NPP both have substantive portion documented equally for split/shared visit, who do you give the credit to?
2. When billing by time (per new guidelines), if EM elements support a higher level code and the typical time of that EM supports lower level code, would it be appropriate to level the code with EM elements or should it (code level) be only with the typical time of that specific EM?
3. What sort of attestation should we use?

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Shared Visits

4. When split/shared visit is billed by time, if one of the providers does not document time, but documents all or some of the elements in detail, how and under who would you bill that visit?
5. For split/shared billing, if an MD is explaining and providing the complete treatment guidance on a patient in conversation to NPP but not rendering, does that MD get any credit or only the NPP because he or she is the actual rendering and should be the billing as well?
6. Do you have recommendation of any efficient workflow/process ideas for this care delivery model of new split/shared guidelines?

Incident To

- Clinic can bill for “incident to” services only if:
  - Clinic pays for the expenses of the ancillary person.
  - Clinic is the sole provider of medical direction.
  - The physician initiates the course of diagnosis or treatment. The first visit should be with the physician (later visits may be with the non-physician provider). Note the “new problem” myth.

(b) Medicare Part B pays for services and supplies incident to the service of a physician (or other practitioner).

(1) Services and supplies must be furnished in a noninstitutional setting to noninstitutional patients.

(2) Services and supplies must be an integral, though incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness.

(3) Services and supplies must be commonly furnished without charge or included in the bill of a physician (or other practitioner).

Incident To

- The service is something typically done in an office.
- The service is not in a hospital or nursing home (may be a “shared visit”).
- A clinic physician must be in the “office suite.”
- The services should be billed under the supervising physician.

What Did Stark Do To Compensation Formulas This Year?

- Allows “profit shares” and “productivity bonuses.”
- Profit shares are now MUCH more restrictive:
  - Subgroups must have at least five physicians.
  - The same allocation methodology must be used for **all** DHS.
  - This now applies to non-Medicare DHS revenue.
- Stark does NOT require equal division of DHS.

The Problem

- Ortho (7), rheumatology (2) and internal medicine (4).
- Want to split MRI evenly, give PT to the Ortho, lab to rheum and IM.
- That doesn't work!
- Can split into ortho and rheum/IM, but then all of ortho's DHS must stay with ortho, and rhem/IM with rheum/IM.

Productivity Bonuses In Group Practice*

- Can credit for services personally performed or incident to if not directly related to volume on the value of referrals (may directly relate for incident to).
- Deemed not to relate to the volume or value if:
  - Personally performed by the physician,
  - Not DHS and not considered DHS if payable by Medicare, or
  - Revenues from DHS are less than 5% of total revenue and each physician's compensation.

* You need to be sure you are a group practice!!!!

Options For DHS Under The Compensation Formula

- Productivity (RVUs, visits etc.).
- Choose an allocation and stick with it.
- Equal division.
- Seniority.
- Any combo of above, provided it is used consistently for all DHS within the group/subgroup of 5.
- Anything else unrelated to creating the plan of care.
- Don’t forget state law!

Special Stark Savior

- If less than 5% of all revenue of the group, and less than 5% of each physician's comp is from DHS, you may not need to worry about the comp formula.

Who Is Next Of Kin For ROI Purposes? Does It Automatically Become The Oldest Sibling?

- Maybe it should, but that is not the law.
- Under HIPAA, only a patient's designated personal representative or the legal executor of his or her estate has a right under law to access the records.
- But if the patient died without naming a representative or executor, look to state law.

What Do We Do With Credits For Defective Medical Devices?

- 42 CFR § § 412.89 (DRG) and 419.45(APC) require reductions in Medicare payments for the replacement of implanted devices that are due to recalls or failures.

Credits For Defective Medical Devices, The DRG Edition

- The reduction occurs when:
  - A device is replaced without cost to the hospital;
  - The provider received full credit for the cost of a device; or
  - The provider receives a credit equal to 50 percent or more of the cost of the device.
- ***"Amount of reduction:***
  - For a device provided to the hospital without cost, the cost of the device is subtracted from the DRG payment."
- Did anyone proofread that??

Can We Do PT/Imaging Offsite?

- Yes! Stark provides two options. The "same building" where you do services unrelated to DHS ***OR*** a centralized building.
- The centralized location often gets lost.

Centralized Building: 411.351

- All or part of a building, including, for purposes of this subpart only, a mobile vehicle, van, or trailer that is owned or leased on a full-time basis (that is, 24 hours per day, 7 days per week, for a term of not less than 6 months) by a group practice and that is used exclusively by the group practice. Space in a building or a mobile vehicle, van, or trailer that is shared by more than one group practice, by a group practice and one or more solo practitioners, or by a group practice and another provider or supplier (for example, a diagnostic imaging facility) is not a centralized building for purposes of this subpart. This provision does not preclude a group practice from providing services to other providers or suppliers (for example, purchased diagnostic tests) in the group practice's centralized building. A group practice may have more than one centralized building.

What Is The NSA?

- Limits balance billing for services provided in “Facilities,” air ambulance, hospital (including CAH) ambulatory surgical center, or freestanding emergency room.
  - All emergency services (facility and professional).
  - Non-emergency services by out-of-network professionals at an in-network facility.
  - Does NOT apply to services at a free-standing clinic, though must give a notice about the rule to patients going to a facility.
- Good Faith Estimates: Much Broader.

Lifenet, Inc. v. HHS

IDR Process for Air Ambulance Services:

45 CFR 149.520(b)(2)

(1) ***In general.*** Except as provided in paragraphs (b)(2) and (3) of this section, in determining the out-of-network rate to be paid by group health plans and health insurance issuers offering group or individual health insurance coverage for out-of-network air ambulance services, plans and issuers must comply with the requirements of § 149.510, except that references in § 149.510 to the additional circumstances in § 149.510(c)(4)(iii)(C) shall be understood to refer to paragraph (b)(2) of this section.

(2) ***Additional information.*** Additional information submitted by a party, provided the information is credible, relates to the circumstances described in paragraphs (b)(2)(i) through (vi) of this section, with respect to a qualified IDR service of a nonparticipating provider of air ambulance services or health insurance issuer of group or individual health insurance coverage that is the subject of a payment determination. This information must also clearly demonstrate that the qualifying payment amount is materially different from the appropriate out-of-network rate.

What's To Come In 2023?

- Insured patient provisions?
  - ETA unknown
- Guidance on penalties?
  - ETA unknown
- Convenor v. co-convenor requirements?
  - January 1, 2023 (AMA requested an extension)

Who Gets A GFE?

2022	2023
Uninsured (self-pay) patients when the patient asks for one or when the patient schedules an item or service 3+ business days out.	Same.*

**This presentation is limited to GFEs for uninsured (self-pay) patients. It does not include the future requirements to provide GFEs for insured patients. The timing of those requirements is unknown.*

Who Gives The Patient The GFE?

2022

- The convenor.
- Any professional or facility that a patient asks to provide a GFE.

2023

- Same*

**If the patient separately schedules or requests a GFE, the co-convenor is considered a convenor.*

What Must The GFE *Include*?

2022	2023
Itemized list with specific details and expected charges for items and services related to the patient's care provided by the *convenor*.	Itemized list with specific details and expected charges for items and services related to the patient's care provided by the *convenor AND co-convenor*.

Do We Need AG Approval For A Merger/Acquisition Among Nonprofits?

- Depends on applicable state law.
- May also depend on exempt status under the Internal Revenue Code.

AG Approval For Nonprofit M&A?

- New York: Approval of AG or court always required for charitable corporations (N-PCL Article 9).
- Delaware: No approvals required.
- Ohio: Court approval or AG notice required if nonprofit is a public benefit corporation and survivor is not; different rules for certain nonprofit healthcare entities (ORC 1702.41, 109.34).

New Developments In CPMD?

- Corporate Practice of Medicine Doctrine (CPMD): Only licensed physicians may practice medicine, and general business entities cannot employ or otherwise engage physicians to practice medicine.
- Varies from state to state
  - Some states have no CPMD (Alaska, Missouri, Florida).
  - Some strictly and actively enforce it (California, Illinois, Texas, New York).
- When it comes up as an issue, it is often from:
  - Insurers seeking to avoid paying for certain medical services.
  - Competitors.
  - Former (disgruntled) employees or business partners.

New Developments In CPMD?

- 2022 case in a CPMD State: MRI facility cannot be owned by a lay person.
  - Allstate Indemnity Co. v. Twin Cities Diagnostic Ctr., LLC (Minn. App. May 23, 2022).
  - To be accredited, MRI facility must have a physician medical director.
  - As a matter of law “medical directors of MRI facilities are engaged in the practice of healing”.
  - MRI practice can’t be bifurcated into a technical component and a professional component, so laypersons can’t own/operate technical component per CPMD.

New developments in CPMD?

- Contrast with 2014 federal district court case in same state: MRI facility owned by layperson was not in violation of the CPMD.
  - State Farm Mutual Automobile Insurance Company v. Mobile Diagnostic Imaging, Inc, 7 F.Supp.3d 934 (D. Minn. 2014).
  - The technical and professional components of MRI practices are separable.
  - State's statute contemplates lay ownership of diagnostic-imaging facilities.
- Take away: CPMD is still out there, still evolving, and still an important issue to consider when structuring health care ventures.

What Is The Current Status Of Telehealth?

Telehealth During PHE

- Patient location: telehealth available to patients located in their homes and outside of designated rural areas.
- Types of telehealth services: significantly expanded list of services can be provided by telehealth.
- Technology: some services can be audio only; visits can be conducted using a phone.
- Providers/licensure: any provider eligible to bill Medicare for professional services can bill for telehealth, even across state lines.

What If No Legislation Is Passed?

- Medicare will require that the originating site of care be a health care facility in a rural area.
- Both audio and video coverage will be required for coverage.

Any Congressional Efforts?

- Consolidated Appropriations Act, 2021
  - Permanently eliminated geographic and originating site requirements for **mental health services** delivered via telehealth (requires at least one in-person visit every six months, then every 12 months; the in-person visits are currently waived for 151 days after the end of the PHE).

Any Congressional Efforts?

- Consolidated Appropriations Act, 2022
  - Modifies the definition of “originating site”.
  - Extends coverage for 151 days after the PHE.
  - Includes Medicare coverage for audio-only telehealth for 151 days after the PHE.

CONNECT For Health Act (Proposed)

- Title I- Removing Barriers to Telehealth Coverage
  - Removes geographic restriction for telehealth permanently;
  - Expands originating sites to include the home and other appropriate sites;
  - Removes restrictions for emergency medical care services;
  - Requires CMS' process to add telehealth services to better consider how telehealth can improve access to care.
- Title II – Program Integrity
  - Clarifies that the provision of technologies to a Medicare beneficiary for the purpose of telehealth services is not considered "remuneration" under fraud and abuse laws.
  - Provides additional resources for the OIG for telehealth oversight activities.
  - Requires additional provider and beneficiary education on telehealth, including to support underserved and high-risk populations in utilizing telehealth services.
  - Requires a study of telehealth utilization during the pandemic.

Telehealth Expansion and Evaluation Act (Proposed)

- Permanently removes geographic requirements and expands originating sites.
- Two-year extension of COVID-19 telehealth waivers.
- Broadens authority for CMS to authorize telehealth during future emergencies.

What Does CMS Think?

- Post March 2022 legislation, CMS seems focused on a temporary expansion, with an emphasis on more time to study telehealth before adopting a permanent policy and also possibly returning to some prior policies (i.e., at least some in-person connection). Becerra comments in April 2022:
  - "During the COVID-19 public health emergency, telehealth has been a reliable resource for providers to reach patients directly in their homes to ensure access to care and continuity of services. The Administration is committed to supporting a temporary extension of broader telehealth coverage under Medicare beyond the declared COVID-19 Public Health Emergency to study its impact on utilization of services and access to care. "

What About Controlled Substances?

- Drug Enforcement Administration (DEA)
  - Controlled substance prescribing license/registration.
  - Registration required in each state where a practitioner prescribes a controlled substance via telemedicine.
    - Waived for the PHE.
- Ryan Haight Act of 2008
  - In-person exam requirement
    - waived for PHE.
  - Exceptions & special registration.
- No knowledge of current extensions

HIPAA: Can We Send Texts To Patients?

- "A covered health care provider must permit individuals to request and must accommodate reasonable requests by individuals to receive communications of protected health information from the covered health care provider by alternative means or at alternative locations."
  45 CFR 164.522(b)
- OCR guidance permits covered entities to send individuals unencrypted emails if
  - they have advised the individual of the risk, and
  - the individual still prefers the unencrypted email (78 FR 5566, 5634).

HIPAA: Can We Send Texts to Patients?

- As with all disclosures of PHI, a covered entity still must use reasonable safeguards when sending unencrypted email or text.
- Suggested Practices:
  - Get written consent from the patient if they wish to communicate by text.
  - If written consent is not feasible, document how consent was provided.
  - Additional safeguards.

HIPAA: Can We Send Texts To Patients?

- Strong password protection on all devices.
- Settings that don't allow messages to be viewed on a locked device screen.
- Limits on the type of patient information that can be exchanged (e.g., no sensitive information).
- A process to promptly transfer patient information to secure systems.
- Encryption on devices.
- Security safeguards that allow remote locking of the device if it is lost or stolen.
- Restrictions on the use of personal devices for work purposes.

Implications of *Dobbs v. Jackson Women's Health Organization*

- Executive Order - directive to HHS to consider actions on:
  - Medicare patients who travel out of state.
  - Comply with federal non-discrimination laws.
    - E.g. guidance to retail pharmacies.
- FTC:
  - Guidance on sharing of "sensitive" data.

What Are The EMTALA Implications?

The term “emergency medical condition” means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in— (A) placing the patient’s health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part.

42 USC § 1396b(v)(3)

What Are The EMTALA Implications?

- HHS guidance:
  - Federal preempts state restricting access to abortion in emergency situations.
- U.S. v. The State of Idaho
  - Filed August 2, 2022.
  - Enjoin “restrictive” abortion law.

What Are The Telehealth Implications?

- FDA permanently lifted the in-person requirement to obtain medical abortion.
- BUT:
  - 32 states still require medication abortions to be administered by a physician.
  - 19 require the physician to be physically present.

What Are The HIPAA Implications?

1. Disclosures required by law.
2. Disclosures for law enforcement purpose.
3. Disclosures to avert a serious threat to health or safety.

https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/phi-reproductive-health/index.html

What are my Entity's Non-Discrimination Obligations?

- OCR enforces nondiscrimination regulations that apply to programs, services, and activities receiving HHS Federal financial assistance. These regulations apply to "Covered Entities."
- What is a covered entity?
  - Entity that receives federal funding from HHS or is covered under Title II of the ADA.
- Conscious Rule.

What Type Of Interpreter Services Should I Provide?

- All recipients of federal financial assistance from HHS are required to provide meaningful access to LEP persons.
- Up to providers to decide what is reasonable and necessary.
- Up to providers to cover the cost.

What Type Of Interpreter Services Should I Provide?

- Requirements for LEPs under Section 1157.
- Requirements for individuals with disabilities.
- Update to non-discrimination notices.
- Look to state law.

What Is The State Of Co-Location Of Clinics And Hospitals?

- Great news here. The “draft” memo was materially changed.
- If each entity satisfies the applicable rules, the “co-location” issue is largely dead.

Can We Send Outside Records?

- What is the record?
- If you HAVE it, it is part of the record, even if you didn't CREATE it.
- If the care team used it, you need to send it.

Can Coders Go To Jail?

- Unless they are making money from a scam, they won’t.
- They will worry.
- Explain indemnification:
  - Best interest of corporation.
  - Good Faith.
  - Believe conduct is legal.

Our Physician Certification Is Not Timely, Help?!

- Common question, but not entirely generalizable.
- Need to determine if it is a condition of payment.
- It often is not.
- Even it is, you may be able to bill for services post-certification.

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