2022 New Compliance Trends for Compliance Officers

Georgia Hospital Association
Compliance Officers Roundtable Meeting

September 7, 2022

Introductions

Lori Foley
CMA, CHC, PHR, SHRM-CP
Principal, Healthcare Consulting
lfoley@pyapc.com

Tynan Kugler
MBA, MPH, CVA
Principal, Healthcare Consulting
tkugler@pyapc.com

PYA

pyapc.com
800.270.9629

ATLANTA | KANSAS CITY | KNOXVILLE | NASHVILLE | TAMPA

Agenda

- Price Transparency
  - No Surprises Act
  - Good Faith Estimates
- Real Estate Compliance
- Proposed E/M Changes
- Advanced Practice Provider Considerations
- Physician Arrangements
  - Recruitment Agreements
  - Benchmarking
- Cybersecurity
- Preparing for the end of the PHE

Price Transparency

No Surprises Act

- **Two Purposes:**

Prohibit “surprise” billing and replace with new payment methodology

- Patients through no fault of their own receive services from out-of-network (OON) provider

Provide self-pay patients with good faith estimates of charges

Surprise Billing

Application

Healthcare Entities

- Facilities - hospitals, CAHs, freestanding EDs, ASCs
- Providers that furnish services to patients in facilities (including clinics operated as hospital outpatient departments)
  - Does NOT apply to physicians not providing services at facilities

Health insurance issuers and health plans

- *Group coverage* - insured and self-insured plans, ERISA plans, non-federal government plans, church plans, traditional indemnity plans
- *Individual coverage* - exchange and non-exchange plans, student health insurance coverage
- DOES NOT include Medicare Advantage, managed Medicaid, health reimbursement arrangements, health-sharing ministries, short-term limited-duration insurance, retiree-only plans

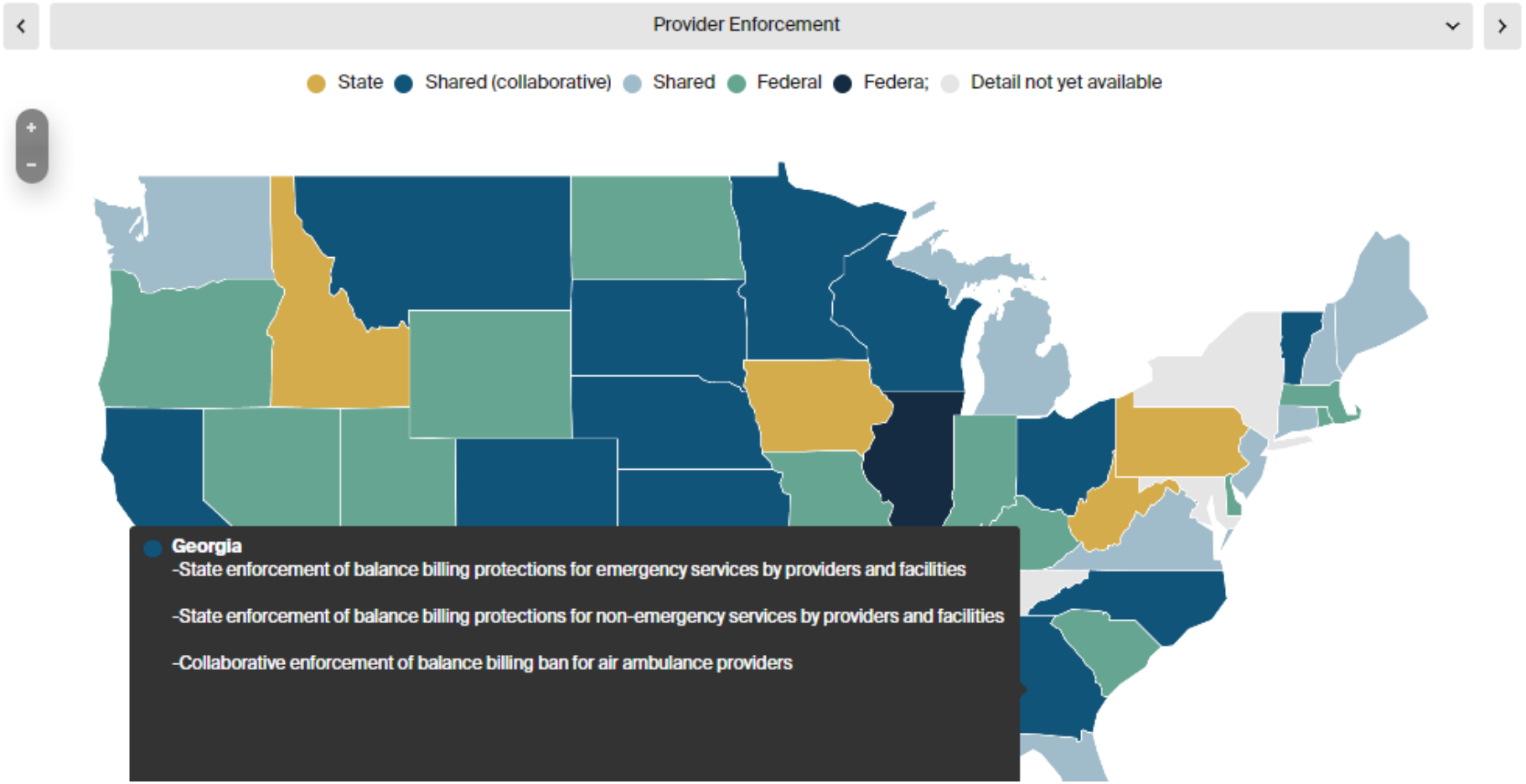
Application

- Provider cannot balance bill out-of-network patient for-
  - Emergency services furnished at hospital or ASC
    - Includes post-stabilization services
  - Non-emergency services furnished at *in-network* hospital or ASC
    - Opportunity for patient to consent to balance billing only if patient selects provider in advance

Georgia Surprise Billing Consumer Protection Act

- Signed into law by Governor Kemp June 16, 2020
- Defines “provider” as “any physician, other individual, or facility other than a hospital licensed or otherwise authorized in this state to furnish healthcare services.”
- Defines a “balance bill” as “the amount that a nonparticipating provider charges for services provided to a covered person”
- Defines a “surprise bill” as “a bill resulting from an occurrence in which charges arise from a covered person receiving healthcare services from an out-of-network provider at an in-network facility.”
- Specifically prohibits both a “nonparticipating provider” and a “nonparticipating facility” from balance billing a patient for emergency medical services.

Georgia Enforcement



https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act.

Good Faith Estimates for Self-Pay Patients

Application

Convening Provider

- Provider responsible for scheduling primary item or service
- Includes office visits, diagnostic testing, procedures, etc.

- **Beginning in 2023**, items and services to be billed by 'co-provider' (i.e., furnishes care in conjunction with the primary item or services)
  - Convening provider must request and co-provider must furnish within 1 business day information required to complete GFE

GFE Must Include

- Items and services to be billed by convening provider
  - Hospital includes professional fees for which it bills

- **Numerous disclaimers:**
  - Additional services may be recommended
  - Information provided is an estimate only of items/services reasonably expected to be furnished at the time the GFE is issued

Compliance Check List - Micro

Surprise Billing

- Compliance with notice requirements
  - Written agreement with facilities at which provide services
- Process to identify services subject to Surprise Billing
  - OON emergency services
  - OON non-emergency services furnished at in-network facility
- Some providers are electing to NOT bill patient – creates additional compliance concerns!

Good Faith Estimates

- Process to identify self-pay patients (inquiries and scheduling)
- Compliance with notice requirements (website, physical location, inquiries and scheduling)
- Assigned responsibility for completing and sending GFEs in timely manner

Compliance Check List - Macro

Compliance Program

- Update your compliance program to address NSA and GFE
- Include steps entity takes to ensure Surprise Bills are not sent and Good Faith Estimates are provided
  - Employee training
  - Monitoring
- Include steps taken if an issue is identified
- Integrate into the entities “Culture of Compliance” similar to HIPAA

Real Estate Compliance

Lease Arrangements

- Ensure FMV support for lease transactions
- Supporting real estate valuation is aligned with the lease arrangement itself
- Additional tenant benefits are considered (tenant improvement allowances, renewal options, provided services, etc.)
- Incorrect lease structure categorization (triple net versus full-service gross)
- Inaccurately interpreting and calculating square footage (rentable versus usable square footage)
- Improperly relying on dissimilar comparison properties

E/M and Coding Changes

E/M Services – 2023 General

CMS Adopts CPT Policy	CMS Policy	CMS Valuation
• Adopting new CPT guideline for E/M coding: • "…a continuous service that spans the transition of two calendar dates is a single service and it reported on one date, which is the date the encounter begins. If the service is continuous before and through midnight, all the time may be applied to the reported date of the service." • Definition of initial service for CPT includes subspecialty.	• CMS does not acknowledge subspecialties, so initial service should be limited to different specialties.	• wRVU adjustments on Other E/M codes range from -48% (99281) to +32% (99316, 99231) • Considering the -4.4% adjustment to the CF, overall impact estimated to range from -4% for Interventional Radiology to 5% for Infectious Disease

E/M Services – Hospital Inpatient

CMS Adopts CPT Policy

- CMS proposes to adopt the 2023 E/M guidelines to include:
  - New descriptor times
  - Medical decision making (MDM)
  - Certain time guidelines
  - Choice of MDM or time in the level selection
  - Elimination of history and exam requirements
- CPT revised the inpatient visit codes to include observation services:
  - Allows for the billing of an outpatient E/M and an inpatient/observation service on the same date

CMS Policy

- Bundling an outpatient E/M into inpatient E/M on same date:
  - CMS will allow the obs/inpatient to be billed on the following day, even if less than 24 hours from the office visit
- Swing beds, hospital or nursing facility, are billed based on place of service.
- A transition from observation status to inpatient status does not constitute a new stay.
- Only the provider responsible for discharge can bill a discharge code 99238-99239, others should bill subsequent hospital visit codes 99231-99233.

CMS Valuation

99221	Initial hospital care	-15%
99222	Initial hospital care	0%
99223	Initial hospital care	-9%
99231	Subsequent hospital care	32%
99232	Subsequent hospital care	14%
99233	Subsequent hospital care	20%

No change

Negative adjustment

Positive adjustment

E/M Services – Observation

CMS Adopts CPT Policy	CMS Policy	CMS Valuation

• CMS proposes to adopt the 2023 E/M guidelines to include:
  • New descriptor times
  • MDM
  • Certain time guidelines
  • Choice of MDM or time in the level selection
  • Elimination of history and exam requirements
• CPT deleted observation section and included it in the inpatient visit section:
  • Allows for the billing of an outpatient E/M and an inpatient/observation service on the same date
	• Bundling an outpatient E/M into observation E/M on same date:
	  • CMS will allow the obs/inpatient to be billed on the following day even if less than 24 hours from the office visit
	• CMS will maintain the 8 – 24-hour rule for observation care:
	  • **< 8 hours:** Initial hospital service 99221-99223
	  • **8 – 24 hours:** Same day admission and discharge 99234-99236
	  • **24 hours+:** Initial hospital for date of admission 99221-99223, and hospital discharge 99238-99239 on subsequent date
		• wRVU values of initial and observation codes were fairly similar depending on the code.
		• Now, overall, the valuation is lower for the initial level 1 and 3 codes, but effectively the same for level 2 (99222).
		• However, there is a 14-32% increase in wRVU value for the subsequent codes when compared to prior year, similar to the adjustment for inpatient.

E/M Services – Emergency Department (ED)

CMS Adopts CPT Policy	CMS Policy	CMS Valuation

• CMS proposes to adopt the 2023 E/M guidelines to include:
  • New descriptor times
  • MDM
  • Certain time guidelines
  • Choice of MDM or time in the level selection
  • Elimination of history and exam requirements
• Will continue to allow ED and CC to be billed on same day
• ED visits do not have a reported time, so will be coded on MDM only:
  • 99281 Nurse visit in the ED
  • 99282 Straightforward
  • 99283 Low
	• Clarifies that documentation must indicate that the ED service was provided before the critical care service
	• If ED physician requests patient's physician to come in and determine if the patient should be admitted, the patient's physician should report initial hospital care visit if placing in observation or admitting to inpatient.
	  • ED physician bills ED code
	• Not dropping policy on same-day critical care and ED visits
		• CMS did not agree to reduced value of 99284, so:
		  • Maintaining values for 99282-99284, but reducing 99281
		  • Now a nurse visit code: .48 to .25

E/M Services – Skilled Nursing Facility (SNF)/Nursing Facility (NF)

CMS Adopts CPT Policy	CMS Policy	CMS Valuation

• CMS proposes to adopt the 2023 E/M guidelines to include:
  • New descriptor times
  • MDM
  • Certain time guidelines
  • Choice of MDM or time in the level selection
  • Elimination of history and exam requirements
• NPP may perform and bill an initial or subsequent NF service prior to the federally mandated initial NF comprehensive assessment by the admitting physician
• Patient admitted to SNF and initial NF assessment performed and then transferred to NF, not a new patient stay, so not appropriate to assign an initial NF visit code after the transition
	• An office visit or ED visit on the same day as NF initial assessment cannot be billed together.
	• Swing beds, hospital or NF, are billed based on place of service.
	• Since CMS does not recognize subspecialties, it will not allow different subspecialists of the same group to bill initial NF visits.
		• RUC valuation for NF codes are proposed by CMS to be adopted but questioning the value of the top initial and subsequent codes per the same 45-minute descriptor
		• CMS requests comment on the impact of the AMA's planned deletion of the annual NF assessment visit code 99318
		  • Anticipated to be billed as 99309 85% of the time which is 1.92 vs the 1.71 value of the current code

E/M Services – Home or Residence

CMS Adopts CPT Policy	CMS Policy	CMS Valuation

• CMS proposes to adopt the 2023 E/M guidelines to include:
  • New descriptor times
  • MDM
  • Certain time guidelines
  • Choice of MDM or time in the level selection
  • Elimination of history and exam requirements
• Adopting deletion of domiciliary, rest home, custodial care services (99324-99328 and 99334-99337) and merging them into home or residence services codes (99341, 99342, 99344-99345, 99347-99350) – MDM and time based
• Deleted home visit code 99343 (same MDM level as 99344)
	• *No further refinements.*	

99341	Home visit new patient	-1%
99342	Home visit new patient	9%
99344	Home visit new patient	-15%
99345	Home visit new patient	-5 %
99347	Home visit established patient	-10%
99348	Home visit established patient	-4%
99349	Home visit established patient	5%
99350	Home visit established patient	10%

Negative adjustment

Positive adjustment

Split/Shared…Partial Delay

- CMS is proposing to delay by one year the effective date of the split/shared visits policy finalized in CY 2022 (with a few exceptions).
- For CY 2023, clinicians will continue to have a choice of history, physical exam, MDM, or more than half of the total practitioner time spent to define the substantive portion, instead of using total time to determine the substantive portion.
  - "Therefore, the proposed paragraph would specify, for visits other than critical care visits furnished in calendar year 2022 and 2023, substantive portion means **one of the three key components (history, exam or MDM)** or more than half of the total time spent by the physician and NPP performing the split (or shared) visit."
  - More on this rule and impact on APPs on slide 28
- **Note:** Critical care changes are not delayed, and CMS corrected its error in the guidelines and reiterates that the full 30 minutes beyond the initial 74 minutes must be met to bill for the 99292.

Behavioral Health Services Expansion

- CMS proposes:
  - To expand access by permitting behavioral health services to be furnished by licensed professional counselors, marriage and family therapists, and other types of practitioners under **general supervision** instead of direct supervision when these services are incident to the services of a physician or non-physician practitioner
  - To pay for behavioral health integration service personally performed by clinical psychologists (CPs) or clinical social workers (CSWs) when provided as a part of a primary care team

Advanced Practice Provider Considerations

Advanced Practice Provider Considerations

- APPs = Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife, Certified Registered Nurse Anesthetists, etc.
- Proliferation of APP employment
  - Top 20 Most Requested Searches by Specialty (Merritt Hawkins 2022)
    - NP – Still #1
    - CRNA - #11
- Continued prevalence of productivity-based physician compensation
  - About 70-73% of employed physicians are compensated under a wRVU productivity-based model (SullivanCotter 2021)
- Continued issues with productivity generated by the APP and attributed to the Physician for compensation determination occurring even in a compliant billing process
  - Highly productive physicians in surgical specialties

APP Billing Considerations

- For 2022, such visits may be billed under the National Provider Identifier (NPI) of the physician or APP who either:
  - Documents the support for the history, exam, or medical decision making for the visit or
  - Provides more than 50% of the service time.
- For 2023, split/shared visits were initially supposed to be billed under the NPI of the individual who provides more than 50% of total visit time; however,
  - CMS proposed delay included in July 7 release of 2023 MPFS
  - Letter from nearly 20 physicians' organizations urged CMS to "reverse course" on the final rule
  - Delay proposed to 2024

Other Considerations

- What about APP supervision stipends for Physicians?
  - Use “extreme” caution – no double-dips!
    - Some consideration of supervisory compensation embedded in wRVUs, compensation per wRVU, etc.
  - Intended to compensate Physician for actual time spent with the APP
    - Reviewing a percentage of APP charts
    - Discussing chart reviews with the APP
- One Physician, multiple APPs
  - The Physician’s productivity level is finite
  - Only a modest difference in difference between using one APP or many APPs

Physician Arrangements

Recruitment Arrangement Considerations

- Provision of support that's more than reasonably necessary
- Excluding income from other sources in support amount calculation
- Physician practice guarantee of repayment
- Identification and tracking of expenses
- Lack of identified and/or supportable community need
- Recruiting into a large, well-funded group
- "Side by side" recruiting
- Options when the recruit isn't "working out"
- Amending recruitment agreements

Benchmarking

- COVID-19 impact
- Assuming survey data increases year over year
- “Cherry picking” survey tables and survey data
- Survey data definitions
- Correlation of survey tables
- Behavior of productivity data and ratios
- Location, location, location

Cybersecurity

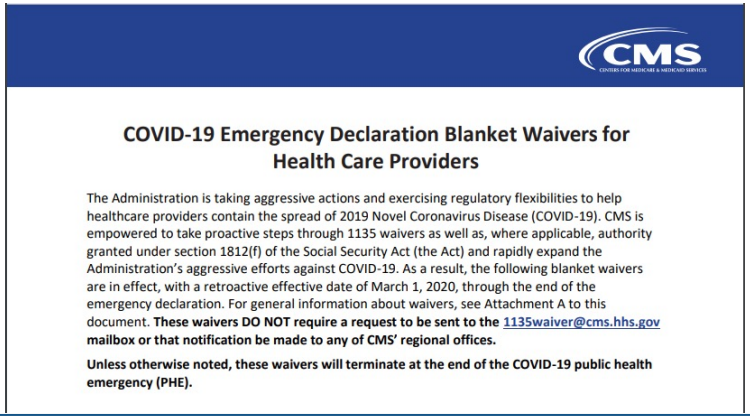
Cyber-Fraud

- DOJ Civil Cyber-Fraud Initiative announced October 2021
  - Utilization of FCA to pursue cybersecurity-related fraud by government contractors and grant recipients
- Entities or individuals putting U.S. information or systems at risk held accountable if
  - Knowingly providing deficient cybersecurity products or services
  - Knowingly misrepresenting cybersecurity practices or protocols
  - Knowingly violating obligations to monitor and report incidents and breaches
- Proactively update cybersecurity and information systems security policies
- Regularly review contractual terms
- Monitor enforcement actions
- Ensure incident response plans are up to date, they are used and tested

Ending the Public Health Emergency

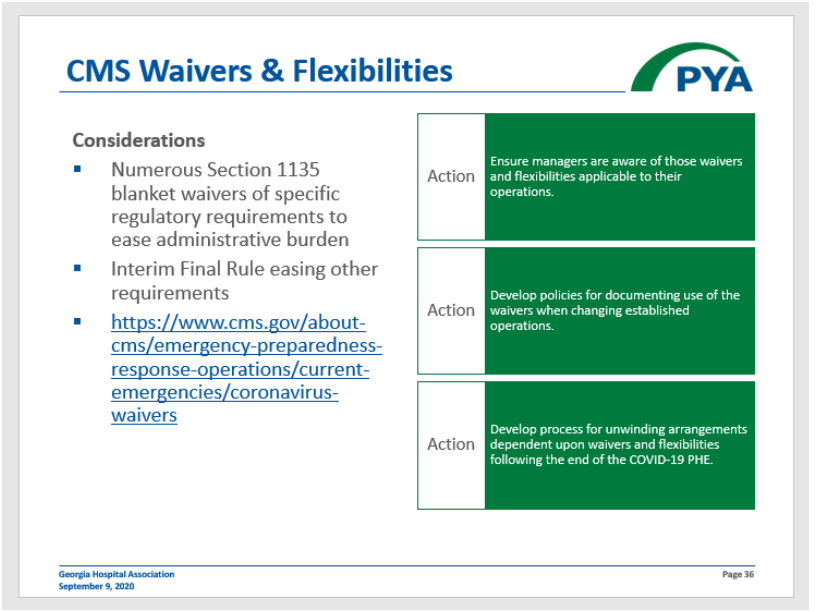
“Prepare to Return to Normal”

- CMS blog post released on August 18, 2022
  - “Creating a Road Map for the End of the COVID-19 Public Health Emergency”
  - References January 22, 2021 letter sent by Acting HHS Secretary to governors across the country indicating HHS will provide states with 60 days notice prior to ending the PHE
  - Current renewal expires October 13, 2022
  - “Prepare for the end of these flexibilities as soon as possible”
- https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf



Waivers & Flexibilities

- https://www.cms.gov/coronavirus-waivers
  - Physicians and Other Clinicians
  - Hospitals and Critical Access Hospitals, Ambulatory Surgery Centers, and Community Mental Health Centers
  - Teaching Hospitals, Teaching Physicians and Medical Residents
  - Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities)
  - Home Health Agencies
  - Hospice
  - Inpatient Rehabilitation Facilities
  - Long Term Care Hospitals & Extended Neoplastic Disease Care Hospitals
  - Rural Health Clinics and Federally Qualified Health Centers
  - Laboratories
  - Medicare Shared Savings Program
  - Durable Medical Equipment, Prosthetics, Orthotics and Supplies
  - Medicare Advantage and Part D Plans
  - Ambulances
  - End Stage Renal Disease Facilities
  - Participants in the Medicare Diabetes Prevention Program



Waivers & Flexibilities

Then….

Action	Ensure managers are aware of those waivers and flexibilities applicable to their operations.
Action	Develop policies for documenting use of the waivers when changing established operations.
Action	Develop process for unwinding arrangements dependent upon waivers and flexibilities following the end of the COVID-19 PHE.

Now….

Action	Review inventory of waivers relied upon during the PHE.
Action	Review fact sheets and other guidance to fully understand the degree to which the waivers will roll back – fully or partially? Ex - telemedicine
Action	Work with department leadership to develop formal plan to ensure operations are poised to “return to normal”
Action	Update audit work plan to monitor.

How can we HELP?

A national healthcare advisory services firm providing consulting, audit, and tax services