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Contents

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CMS Eyes Time-Based Visits; Observation/ Inpatient Codes Have Twist for Consulting M.D.s

In a new Medicare transmittal, CMS puts providers on notice that evaluation and management (E/M) levels of service based on time will come under scrutiny, raising the stakes for the credibility and volume of the documentation, an attorney said.[1]

According to transmittal 11,842, CMS said its "reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit."

The language suggests that providers should be prepared for reviews of how they spend their time with patients and "be careful to document what they're doing during that time," said Richelle Marting, an attorney and certified coder in Olathe, Kansas. It fits with another assertion in the transmittal that "the volume of documentation should not be the primary influence upon which a specific level of service is billed." What Marting dislikes about this dynamic is that "it's incredibly challenging to defend a provider when you have a medical reviewer disputing that a provider's time was reasonable and appropriate. My reaction to this challenge is that the provider doesn't seem to get the benefit of the doubt."

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Proposed Rule Would Require SNFs to Reveal Private Equity Owners; More Screening Is Here

In a Feb. 15 proposed regulation, CMS said it will revise the Medicare enrollment form to require owning and managing entities of Medicare skilled nursing facilities (SNFs) to disclose whether they are a private equity company or real estate investment trust.[1] CMS also would require disclosure of SNF managers and owners on the 855A enrollment form. The requirements dovetail with a provider enrollment provision in the final 2023 Medicare Physician Fee Schedule (MPFS) rule that puts SNF owners through more rigorous screening before opening the gates to Medicare patients.[2]

The goal of the proposed regulation, which implements Sec. 6101(a) of the Affordable Care Act, is "to improve care and accountability."

CMS said concerns are mounting about the quality of care in nursing homes, especially when they're owned by private equity and other types of investment firms. The regulations point to several reports. For example, the National Bureau of Economic Research in February 2021 published an analysis that concluded private equity (PE) ownership "increases the short-term mortality of Medicare patients by 10%, implying 20,150 lives lost due to PE ownership over our twelve-year sample period. This is accompanied by declines in other measures of patient well-being, such as lower mobility, while taxpayer spending per patient episode increases by 11%,'' according to a summary in the February proposed rule.

continued

The proposed rule also would require SNFs to reveal information on the enrollment form about their owners and managers, including every member of the governing body and every person who is an officer, director, member, partner, trustee or managing employee of the facility. There are also disclosure requirements for Medicaid nursing facilities (NFs). "Knowing who these parties are through their disclosures on the Form CMS–855A and to States would: (1) provide additional transparency that may assist CMS and other regulators in holding nursing facilities accountable; and (2) allow consumers to select facilities with better knowledge of their owners and operators," the rule states. The information would be made publicly available. The CMS website already has a search function that allows people to look for deficiencies at nursing homes by type of ownership (e.g., nonprofit, for profit) and bed size.[3]

As a practical matter, however, attorney Judy Waltz said it isn't apparent specifically how CMS will use the newfound details about ownership interests. "I don't know what CMS does with it at the end of the day," said Waltz, with Foley & Lardner LLP in San Francisco. Maybe CMS will shift survey resources under the Medicare conditions of participation to private equity/REIT-owned SNFs on the grounds they pose more risk. But survey resources are already stretched thin. Otherwise, "all I can figure is this is a public shaming," Waltz said. "You can't just terminate a facility because it's owned by a private equity firm."

She noted that CMS in the MPFS rule "bumped up enrollment requirements to make it harder for supposed bad actors to get into the business." SNFs were moved from a low to a high "categorical risk designation" at enrollment and from low to medium at revalidation. The high-risk category requires everyone with a 5% or greater direct or indirect ownership interest in a SNF to submit fingerprints for a national background check to the Medicare administrative contractor, which will do a fingerprint-based criminal history record check using the FBI's Integrated Automated Fingerprint Identification System.

Disclosures Are Required When Ownership Changes

CMS said in the proposed rule that requiring Medicare SNFs and Medicaid NFs to disclose more information related to their ownership and management structures will increase transparency. SNFs would have to disclose the following on the 855A:

- "Each member of the governing body of the facility, including the name, title, and period of service of each such member.
- "Each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity.
- "Each person or entity who is an additional disclosable party of the facility.
- "The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another."

The data would also have to be reported when there's a change in ownership. ✧

Endnotes

1. Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities, 88 Fed. Reg. 9,820 (Feb. 15, 2023), https://bit.ly/414cbQg.
2. Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs To Provide Refunds With Respect to Discarded Amounts; and COVID-19 Interim Final Rules, 87 Fed. Reg. 69,404 (Nov. 18, 2022), https://bit.ly/3iwZP1i.
3. Centers for Medicare & Medicaid Services, "Quality, Certification and Oversight Reports (QCOR)," last accessed February 17, 2023, https://qcor.cms.gov/report_select.jsp?which=0.

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Big Changes Loom With FTC Rule on Noncompetes, Six HHS Proposals

If the Federal Trade Commission (FTC) has its way, noncompete clauses for workers will become a thing of the past. But the regulation proposed by the FTC on Jan. 19 doesn't apply only to future noncompetes.[1] It would require health care and other employers to cancel noncompete clauses that are currently in effect, one of several aspects of the proposed rule that could prove challenging to comply with.

"The FTC is requiring employers to rescind existing noncompetes for current and former workers," said Martie Ross, a consulting principal at PYA. Employers must inform them in writing within 45 days of the effective date of the final regulation, and FTC has provided a model notice for that purpose. "You are deemed in compliance if you use it," she noted.

The proposed rule on noncompete clauses, "which sent shock waves through the business community," is one of six pending rules with significant implications for health care organizations, along with new developments in the No Surprises Act, Ross said at a Feb. 8 webinar held by PYA. The proposed rules address Part 2 confidentiality of substance use disorder records, Medicare Advantage plans, the rights of conscience and other areas. Since these proposed rules came down in December and January, another was proposed affecting skilled nursing facilities (see story, p. 1).

'The FTC Went as Big as it Could'

According to the FTC, employers are engaging in an "unfair method of competition" in violation of Section 5 of the FTC Act by entering into or trying to enter into or maintain a noncompete clause with a worker. The proposed rule would ban noncompetes "categorically" with a limited exception for noncompetes between the buyer and seller of a business.

Although the FTC's jurisdiction is limited to the for-profit world, nonprofits aren't exactly off the hook. If a hospital employs physicians through a for-profit subsidiary or is part of a joint venture that's organized as a for-profit entity, "the FTC has taken the position they can go after you," Ross said.

There's also a twist with buyouts of noncompetes. Suppose a physician employed by a multispecialty practice wants to accept a job with a hospital. The physician's contract with the practice may have a liquidated damages clause, which allows the physician to buy themselves out of the noncompete for a specified amount. "If the hospital wants to employ the physician, it may agree to fund the buyout, structuring it as a forgivable loan," Ross explained. That's where the FTC's proposed rule comes in again. It not only would prohibit a noncompete clause, it arguably would erase the loan obligation stemming from it, she said.

"The FTC went as big as it could in the proposed rule," Ross noted. It solicited comments and will make modifications in the final rule. The question is how it will ultimately be reined in, she said.

CMS Releases Key FAQs on Good-Faith Estimate

On another topic, the No Surprises Act, there have been several head-turners between December and early February. A big one: HHS Feb. 10 told the independent dispute resolution (IDR) entities not to "issue new payment determinations until receiving further guidance" in light of a recent court decision voiding regulatory provisions (see story, p. 5). But there are others. In an answer to frequently answered question (FAQ) 3 about the good-faith estimate (GFE) requirement under the No Surprises Act, HHS freed hospitals and other "convening" providers indefinitely from a requirement that would have been enforced Jan. 1, 2023.[2] Although providers must continue to give uninsured and self-pay patients good-faith cost estimates of their own services, for now, they don't have to worry about incorporating the costs of associated services from co-providers.

In FAQ 4, CMS shed light on how federally qualified health centers (FQHCs) and other providers and facilities that offer sliding fee discounts would comply with the GFE requirement.[3] It's a long answer, depending on whether the patient is new or established and whether the provider has adequate information about the patient (e.g., income, family size). CMS included a sample schedule of expected charges for new patients for office visits and lab tests. Kathy Reep, a senior manager with PYA, said she's concerned it will be burdensome for providers to publish something like this for every service they provide—especially when patients are "shoppers" inquiring about prices versus established patients.

In another December development, HHS and the Labor and Treasury departments, which are all responsible for the No Surprises Act, raised the administrative fee from $50 to $350 for using the IDR process when there's a disagreement between providers and payers about the out-of-network payment. "The amount in controversy for some physicians will be less than the cost to file the dispute," Reep said. That's separate from the fee providers must pay the IDR entity, which is another $350 to $700, Ross said. The fees will have a chilling effect on providers who are inclined to push back on payers they think are underpaying them, she said.

Confusion Mounts With Notice of Privacy Practices

In another proposed rule affecting health care organizations, the HHS Office for Civil Rights (OCR) is trying to harmonize the Confidentiality

of Substance Use Disorder (SUD) Patient Records under 42 C.F.R. Part 2 with HIPAA, but there are some challenges because unlike HIPAA, Part 2 regulates the records created by Part 2 programs, regardless of who receives the records, Ross said.[4] For example, SUD providers are required to obtain patient consent every time they access their records. To reduce that burden, a Part 2 rule proposed in December allows SUD programs to ask patients for a one-time consent for the use and disclosure of their SUD information for treatment, payment and operations. When patients agree, a covered entity or business associate is permitted to treat the information like protected health information (PHI) under HIPAA. There's a trade-off for that leeway. Part 2 programs will face the breach notification obligations of HIPAA and its civil and criminal penalties if the proposed rule is finalized.

OCR also used the Part 2 proposed rule to incorporate changes to HIPAA's notice of privacy practices (NPP) that debuted in the 2021 proposed HIPAA Privacy Rule and to sweep the Part 2 notice requirement into the NPP, Ross said. Or Part 2 entities can keep their own notices separate if they're revised with, among other things, a standard heading—Notice of Privacy Practices (Part 2 Program). Either way, OCR would kill the acknowledgement of receipt requirement. Interestingly, the Part 2 rule gives programs 24 months from the date the final rule is published to comply and also "tolls" it until OCR publishes the final accounting of disclosures rule required by the Health Information Technology for Economic and Clinical Health (HITECH) Act, although Ross noted OCR hasn't yet published a proposed version. "They want to simplify the process for accounting of disclosures," she said.

Four More Proposed Rules

Here's a brief rundown of the other proposed rules summarized in the webinar:

- Safeguarding the Rights of Conscience as Protected by Federal Statutes.[5] "There's a tortured history" of what OCR has tried to do here, but it boils down to ensuring employees aren't forced to do something they have a moral or religious objection to, Ross said. This rule has been "a political hot potato," introduced in 2009, revised in 2011 and 2019, and with another round of revisions proposed in January. The bottom line: organizations should have a process to address circumstances when employees have a moral or religious objection, validate that it's genuine and ensure patients "receive appropriate care," she said.
- Medicare Advantage (MA) policy and technical changes.[6] Among other things, the rule requires MA plans to follow traditional Medicare's policies on coverage criteria and medical necessity determinations, including the two-midnight rule. The rule also proposes changes to the Medicare 60-day overpayment rule. According to the 2016 regulation interpreting the 60-day rule, providers are obligated to use reasonable diligence to identify overpayments by doing proactive compliance activities to monitor for overpayments and investigating potential overpayments in a timely manner. Now CMS envisions replacing "reasonable diligence" with language more consistent with the False Claims Act's knowledge standard. "Under the proposed rule, a provider or supplier has identified an overpayment if it has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment," according to CMS.
- Advancing interoperability and improving prior authorization processes.[7] Among other things, the proposed rule would require faster turnaround times for MA prior authorization. Currently MA plans are required to respond to urgent requests for prior authorization within 72 hours and to standard requests within 14 days. The proposed rule would change it to no later than seven calendar days for standard requests and leave the 72-hour deadline intact. Payers would be required to provide a specific reason for denying prior authorization.
- Adoption of standards for health care attachments transactions and electronic signatures.[8] The regulation is designed to promote more consistent, reliable communications between providers and health plans, according to Ross and Reep. "Be aware and monitor what's happening within the standard setting committees, so we are able to comply with requirements for attachments without major software expenses," Reep advised.

Contact Ross at mross@pyapc.com and Reep at kreep@pyapc.com. ✧

Endnotes

1. Non-Compete Clause Rule, 88 Fed. Reg. 3,482 (Jan. 19, 2023), https://bit.ly/3k0g6g6.
2. Nina Youngstrom, "HHS Tables Co-Provider Part of Good Faith Estimate in No Surprises Act; RFI Had Impact," *Report on Medicare Compliance* 31, no. 44 (December 12, 2022), http://bit.ly/3XzBs1E.
3. Centers for Medicare & Medicaid Services, "FAQs About Consolidated Appropriations Act, 2021 Implementation – Good Faith Estimates (GFEs) For Uninsured (Or Self-Pay) Individuals – Part 4," December 27, 2022, https://go.cms.gov/3I1GtdH.
4. Nina Youngstrom, "Proposed Part 2 Rule Brings It Closer to HIPAA, Including Enforcement, Consent, NPP," *Report on Medicare Compliance* 31, no. 43 (December 5, 2022), http://bit.ly/3lHaxUn.
5. Safeguarding the Rights of Conscience as Protected by Federal Statutes, 88 Fed. Reg. 820 (Jan. 5, 2023), https://bit.ly/40XWCtd.
6. Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare

Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications, 87 Fed. Reg. 79,452 (Dec. 27, 2022), https://bit.ly/3K8zDWo.

7. Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program, 87 Fed. Reg. 76,238 (Dec. 13, 2022), https://bit.ly/3uW6XXR.
8. Administrative Simplification: Adoption of Standards for Health Care Attachments Transactions and Electronic Signatures, and Modification to Referral Certification and Authorization Transaction Standard, 87 Fed. Reg. 78,434 (Dec. 21, 2022), https://bit.ly/3Eb0xsI.

CMS Transmittals and *Federal Register* Regulations, February 10-February 16

Transmittals

Pub. 100-04, Medicare Claims Processing

- An Omnibus CR to Implement Policy Updates in the CY 2023 PFS Final Rule, Including (1) Removal of Selected NCDs (NCD 160.22 Ambulatory EEG Monitoring), and, (2) Expanding Coverage of Colorectal Cancer Screening - Full Agile Pilot CR, Trans. 11,865 (Feb. 16, 2023)

Pub. 100-03, Medicare National Coverage Determinations

- An Omnibus CR to Implement Policy Updates in the CY 2023 PFS Final Rule, Including (1) Removal of Selected NCDs (NCD 160.22 Ambulatory EEG Monitoring), and, (2) Expanding Coverage of Colorectal Cancer Screening - Full Agile Pilot CR, Trans. 11,865 (Feb. 16, 2023)

Pub. 100-07, State Operations Provider Certification

- Revisions to State Operations Manual (SOM), Chapter 7, Trans. 213 (Feb. 10, 2023)
- Revisions to State Operations Manual (SOM) Chapter 5, Trans. 212 (Feb. 10, 2023)

Pub. 100-08, Medicare Program Integrity

- Eighth General Update to Provider Enrollment Instructions in Chapter 10 of CMS Publication (Pub.) 100-08, Trans. 11,859 (Feb. 16, 2023)

Pub. 100-02, Medicare Benefit Policy

- An Omnibus CR to Implement Policy Updates in the CY 2023 PFS Final Rule, Including (1) Removal of Selected NCDs (NCD 160.22 Ambulatory EEG Monitoring), and, (2) Expanding Coverage of Colorectal Cancer Screening - Full Agile Pilot CR, Trans. 11,865, (Feb. 16, 2023)

Federal Register

Proposed rule

- Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities, 88 Fed. Reg. 9,820 (Feb. 15, 2023)

HHS: IDR Payment Decisions Are on Hold Under No Surprises Act

In the wake of a court decision on the independent dispute resolution (IDR) process under the No Surprises Act, HHS on Feb. 10 put payment determinations on hold.

A notice posted on the CMS website stated that "effective immediately, certified IDR entities should not issue new payment determinations until receiving further guidance from the Departments. Certified IDR entities also should recall any payment determinations issued on or after February 6, 2023."[1]

As they wait for more guidance from the departments, IDR entities should "continue working through other parts of the IDR process as they wait for additional direction from the Departments." The other departments overseeing No Surprises Act implementation are Treasury and Labor.

The IDR process was established to settle payment disputes between providers and payers about out-of-network payments. When they can't negotiate a payment on their own, a provider or payer initiates IDR and both submit a payment offer to an IDR entity, which picks a winner. According to the No Surprises Act, IDR entities are supposed to consider the qualifying payment amount (QPA) and seven other factors (e.g., the patient's acuity and complexity of the services provided). The QPA is the plan's median contracted in-network rate for the specific service furnished in the patient's geographic area as of Jan. 1, 2019, adjusted for inflation.

QPA Gets all the Attention

The stage was set for a court battle when the Oct. 7, 2021, regulation implementing the IDR process required arbitrators to presume the bid closest to the QPA is the correct one, which was seen as favoring insurers. In response, the Texas Medical Association (TMA) sued the departments in the U.S. District Court for the Eastern District of Texas, which vacated the regulation in February 2022. The departments went back to the drawing board and crafted a new regulation instructing IDR entities to first consider the QPA and then evaluate whether other factors justify a departure from the QPA. TMA again sued the departments, arguing the new regulation still was inconsistent with the statutory language, said Martie Ross, a consulting principal at PYA.

Once again, the court agreed with TMA. "The court concluded the IDR entities should have discretion to evaluate the factors identified in the statute, rather than being directed to give deferential treatment to

the QPA," she explained. "The departments now are considering whether to appeal the court's decision or revise the regulation consistent with the court's interpretation of the statute."

Ross thinks the big story is in the surge of IDR filings. "They're an order of magnitude greater than CMS ever anticipated," she said. According to the initial report on the IDR process, "disputing parties initiated 90,078 disputes through the Federal IDR portal, significantly more than the number of disputes the Departments initially estimated would be submitted for a full year." Ross said CMS apparently didn't anticipate that payers would use the IDR process "as a sword," pushing providers out of network and only paying the QPA.

Meanwhile, the TMA also appealed the increase in filing fees from $50 to $350 for using the IDR process.

Contact Ross at mross@pyapc.com. ✧

Endnotes

1. Centers for Medicare & Medicaid Services, "Payment disputes between providers and health plans," February 10, 2023, http://bit.ly/412b6rR.

CMS Eyes Time-Based Visits

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The emphasis on reviews of time reflects the change in the way that providers assign codes in the wake of the American Medical Association's 2021 update to the E/M guidelines for office and outpatient visits and for most other E/M visits in 2023. Physicians and advanced practice providers (APPs) select codes based on time or medical decision-making without factoring in the extent of the patient history or exam. The definition of time is also more expansive. Instead of physicians/APPs documenting they spent more than 50% of their time on counseling and coordination of care, CPT and CMS now allow activities outside the face-to-face encounter with the patient, such as ordering medications, tests or procedures.

The transmittal also addressed the brand-new assimilation of observation codes and hospital inpatient codes, which presents compliance challenges. CPT merged the codes, and CMS followed suit in the 2023 Medicare Physician Fee Schedule (MPFS) rule, dubbing the combined services "inpatient or observation care services," but then splintered the billing instructions by physician type. According to the transmittal, "Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient's observation services began. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes."

In other words, when patients are admitted as inpatients, the attending physician—"the boss of the care"—bills inpatient codes, and the same goes for consulting physicians (e.g., cardiologists), said Ronald Hirsch, M.D., vice president of R1 RCM. But when patients are in observation, the consultants bill with office or other outpatient codes, he said. Only the physician managing the care bills for the observation codes. Hirsch considers this counterintuitive; "Consultants are going to do the same assessment and cognitive review, but they have to use a different set of codes," he noted. "Consultants have to figure out what status the patient is in and what coding paradigm to use. It's extra work for no reason" (see chart, p. 7). Hirsch thinks the CPT editorial panel and CMS missed an opportunity to truly simplify coding selection.

There's also a risk of errors with place-of-service (POS) coding. "The thing I want everyone to remember is to continue to use the correct place of service," said Betsy Nicoletti, a consultant in North Andover, Massachusetts. Even though the CPT code is the same for observation and inpatient services, the POS code may be different, depending on whether the patient is admitted as an inpatient or receiving observation services. "If you use the right CPT code but the wrong POS code, the risk is claims denial," Nicoletti noted. Complicating matters, private payers may use different codes for consultations.

Hirsch has heard that some physicians are under the misimpression that observation as a service is disappearing completely and that all patients should be admitted as inpatients. Obviously, that's not true. CPT and CMS have only reshaped coding.

CMS Takes a Position on Time Thresholds

In the transmittal, CMS takes a firm position on something it seemed to have punted to the AMA in the MPFS rule. CMS now requires providers to meet or exceed the minimum time thresholds to report a CPT code, Marting said. "When practitioner time is used to select visit level, the full time must be completed; the general CPT rule regarding the midpoint for certain timed services does not apply," the transmittal states.

It's not clear if CPT and CMS are on the same page here. Typically, the CPT book only requires providers to pass the midpoint of the time associated with the code to bill for the service, and CMS had only said in the MPFS rule that it would be helpful if AMA would clarify its intent in the E/M guidelines to avoid payment

Chart: Code Selection by Admitting and Consulting Physicians for Inpatient, Observation Services

Here's a quick reference tool for code selection for admitting and consulting physicians developed by Betsy Nicoletti, a consultant in North Andover, Massachusetts (see story, p. 1). "CPT combined the codes for inpatient and observation services in 2023, simplifying code selection for the admitting physician. For consulting physicians treating Medicare patients who have observation status, Medicare requires the consultant to use office and outpatient codes. Medicare doesn't recognize consultation codes, and only allows the admitting physician to use the initial inpatient and observation code set," she explained. "As always, practices will need to check with commercial payers about what codes a consulting physician will use." Contact Nicoletti at betsy@betsynicoletti.com.

Inpatient and Observation

In this place of service/status of patient	For this payer	Then	Use this category of code
Inpatient or observation status-initial service by **admitting** physician	If Medicare	➡	Initial hospital service 99221-99223 with AI modifier
	If commercial	➡	Initial hospital service 99221-99223 with no modifier
Inpatient or observation status initial service by **consulting** physician	If Medicare	➡	Office/outpatient codes 99202-99215
	If commercial	➡	Inpatient consultation codes 99252-99255 Check with payers
Inpatient or observation status-follow up visit by **admitting** physician	For all payers, all doctors	➡	Subsequent hospital visits 99231-99233
Inpatient or observation status-follow up visit by **consulting** physician	If Medicare	➡	Office/outpatient codes 99212-99215
	If commercial	➡	Subsequent hospital visits 99231-99233
Inpatient or observation status-discharge day by **admitting** physician	For all payers	➡	Discharge code 99238 99239 (greater than 30 minutes)
Inpatient or observation status – discharge day by **consulting** physician	If Medicare	➡	Office/outpatient codes 99212-99215
	If commercial	➡	Subsequent hospital visits 99231-99233
Inpatient or observation status-part of global surgery	For all payers	➡	No separate charge

Note: "If Medicare" = "Medicare or other payer that does not recognize consults."

Inpatient or observation CPT® codes include 99221-99223, inpatient consult codes 99251-99255, discharge codes 99238-99239, and subsequent hospital visit codes 99231-99233.

Key points: Continue to use the correct place of service code.

variations, Marting said. Now CMS in the transmittal is flat-out requiring a minimum threshold for reporting the codes. "That's really interesting. They didn't take such an explicit position through rulemaking," Marting noted.

CMS also adopted the CPT definition of medical decision-making, she said, as was reiterated in the transmittal. "As of January 1, 2023, for most E/M visit families, practitioners will select visit level based on the level of medical decision making (MDM) or the amount of time spent by the physician or non-physician practitioner." Certain types of services don't have the choice and will bill either with time (e.g., critical care) or MDM (i.e., emergency room visits). Although providers aren't required to factor in exams and history to code selection anymore, the transmittal states that "for all E/M visits, history and physician exam must be performed in accordance with code descriptors."

That begs the question of whether performing a history and exam is always imperative, Marting said. The use of the phrase "in accordance with code descriptors" indicates that performing a history and

exam is only necessary if appropriate. And the E/M section of the CPT coding guidelines states that history and exam must be documented "when performed," which implies they're not universally performed.

She explained some specialties and/or encounters don't necessarily require a physical exam, including mental health and telehealth visits and visits for a new cancer diagnosis. "The whole purpose of the E/M changes is to focus on documentation that is clinically relevant rather than checkboxes and bullet points." But she figures this will be "a whole new debate."

Hirsch is concerned that auditors will have their own opinions of what amount of history or physical examination is appropriate and deny claims if they determine the documentation is inadequate. "It will be interesting to watch as claims are audited if they second guess physicians here," he said.

Contact Hirsch at rhirsch@r1rcm.com, Marting at rmarting@richellemarting.com and Nicoletti at betsy@betsynicoletti.com. ✧

Endnotes

1. Centers for Medicare & Medicaid Services, "Internet-Only Manual (IOM) Updates to Pub. 100-04, Chapter 12 for the New Hospital Inpatient or Observation Care Code Family, Nursing Facility Visits Code Family, Billing the Substantive Portion of a Split (or Shared) Visit, Changes for Prolonged Services, and Updates to the IOM with Policies Finalized for Office/Outpatient E/M Visits in the CY2020 and CY2021 Final Rules," Trans. 11,842, Pub 100-04 Medicare Claims Processing, February 9, 2023, https://go.cms.gov/3S1Ublb.

NEWS BRIEFS

◆ **Florida Cardiology P.A., Sandeep Bajaj, Karan Reddy, and eight other physicians have agreed to pay $2 million to settle false claims allegations** that they submitted inflated claims to Medicare and Medicaid and billed for services while the physicians were outside the United States, the U.S. Attorney's Office for the Middle District of Florida said Feb. 13.[1] "According to the lawsuit and settlement agreement, Dr. Bajaj and Dr. Reddy caused Florida Cardiology to bill for more intravascular stents than were actually inserted into patients; Dr. Bajaj caused Florida Cardiology to bill for radiofrequency ablations that were not performed by him and in some instances, were not performed by a qualifying provider; and all ten physician-defendants caused Florida Cardiology to bill for procedures and services while they were outside the United States," the U.S. attorney's office alleged. Florida Cardiology allegedly also submitted false claims to TRICARE and the Federal Employee Health Benefits Program. The case was set in motion by a whistleblower and the Department of Justice and state of Florida intervened in the qui tam lawsuit with their own complaint.

◆ **The HHS Office of Inspector General has updated its work plan.** Items include a review of nursing home citations related to the use of anti-psychotic drugs.[2]

◆ **According to UCLA Health, "the use of analytics tools on the UCLA Health website and mobile app" led to a data breach that potentially exposed personal data from some 94,000 individuals.**[3] Specifically, UCLA Health said in its data breach notification that the tools used on an appointment request form may have captured and transmitted "certain limited information" to third-party analytics providers, which it did not name. "In April 2020, UCLA Health began using analytics tools from third-party service providers on our public website, UCLAHealth.org, and a related mobile app to understand how our community interacted with them," the health system said in its breach notification. "Analytics tools allow organizations to review website and app activity in the aggregate to develop more effective and efficient communication. When in June 2022 UCLA Health learned of concerns related to the use of these analytics tools by health-care providers, we disabled them. Additionally, UCLA Health initiated a review, supported by a third-party forensic firm, to complete a comprehensive analysis of the use of these analytics tools on its website and mobile apps, evaluate what data these analytic tools collected, and determine to whom the data belonged." Information that may have been collected included information about providers and Internet Protocol addresses of website visitors, UCLA Health said.

Endnotes

1. U.S. Department of Justice, U.S. Attorney's Office for the Middle District of Florida, "Florida Cardiology, P.A. And 10 Physicians Agree To Pay $2 Million To Settle False Claims Act Liability," news release, February 13, 2023. http://bit.ly/3IyPhcc.
2. U.S. Department of Health & Human Services, Office of Inspector General, "Recently Added Items," last accessed February 17, 2023, http://bit.ly/2AxFtyP.
3. UCLA Health, "UCLA Health Data Notice," January 13, 2023, https://bit.ly/3jewx8l.