April 27, 2020 | Volume 34, Issue 17

Part B News
partbnews.com
COLLECT EVERY DOLLAR YOUR PRACTICE DESERVES

In this issue

Coronavirus

Be careful of HHS' terms and conditions behind your provider relief payment

You may be excited about the money you're expecting — or have already received — from the feds from the Provider Relief Fund program. But be aware that you're required to attest to certain terms and conditions, and not all of them are obvious.

The CARES Act, signed into law March 27, contains a number of business bailout mechanisms for businesses affected by the COVID-19 public health emergency, including Small Business Administration (SBA) loans and the Accelerated and Advanced Payment Program (APP), which is specific to medical practices (*PBN 4/9/20*).

Possibly the most anticipated piece of the law for many providers is the Provider Relief Fund, which has already begun disbursing electronic payments to Medicare providers in amounts equivalent to 6.2% of their fee-for-service reimbursements in 2019 (*PBN 4/20/20*). The Fund represents $30 billion of a $100 billion earmark for health care providers; the remaining $70 billion will be distributed to non-Medicare providers, rural health outlets and medical entities deemed especially impacted by COVID-19.

These payments are grants, not loans, and don't have to be paid back — unless CMS or another federal agency decides you aren't entitled to the money or have spent it inappropriately. Also, CMS is requiring that you attest that you are eligible and will use the funds the way they're meant to be spent. So it's a good idea to make sure you understand the terms.

Maintain therapy service revenue

Starting January 1, therapy service claims must be submitted with new payment modifiers when therapy assistants provide a certain level of service. Practices must understand how and when these modifiers should be appended now, because in less than two years, the modifiers will carry payment adjustments. Get all the details during the webinar **Stay Up to Date and Compliant on Coding Changes for Therapy Services** on May 19. Learn more: *https://codingbooks.com/ympda051920*.

DecisionHealth
a Simplify Compliance brand

You are required to attest to terms and conditions within 30 days of receipt of your payment at the CARES Provider Relief Fund portal (*see resources, below*). Before you sign, be aware that there are two criteria for your payment: your eligibility to receive it and the terms on which you may use it.

Who's getting it?

At the portal, you'll be asked to submit your tax identification number (TIN), which is the basis of attribution for the payment. That means that many employed providers will not get a payment, as they are contracted with an entity holding the TIN.

This can be especially thorny if your practice is owned by an organization that decides it is entitled to all the payments regardless of their expenses, says Robert H. Iseman, a partner in the health services practice group at Rivkin Radler in Albany, N.Y.

According to the HHS fact sheet on the Fund, the recipient entity certifies that it:

- Billed Medicare in 2019.
- Provides or provided after Jan. 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19.
- Is not currently terminated from participation in Medicare.
- Is not currently excluded from participation in Medicare, Medicaid and other federal health care programs.
- Does not currently have Medicare billing privileges revoked.

Don't worry about tracking down your patients to see if any tested positive. HHS is interpreting "possible or actual cases of COVID-19" to mean pretty much anyone who came into your office after January 31 for treatment, "even if they came in for acne," Iseman says.

How can they spend it?

The Fund specifies that payments are to be "used to prevent, prepare for and respond to coronavirus." But it also covers "health care-related expenses or lost revenues that are attributable to coronavirus," HHS says.

Iseman explains how this could play out in the real world: Conceivably, a cardiologist could find "patients didn't want to sit in my waiting room due to COVID-19, so I have lost [a certain amount of] revenue; therefore I am entitled to use [these funds] to pay for staff and expense [since Jan. 31], as those are things I would have otherwise have had revenue to pay for."

As to spending the grants, providers may be encouraged by remarks by CMS Administrator Seema Verma, who told reporters in an April 7 White House briefing that "health care providers can spend that any way they see fit."

But Alex Lee, an associate with the Einhorn Barbarito law firm in Philadelphia, warns against taking too liberal a stance. "It is clear that Ms. Verma's statement that the funds can be used as providers 'see fit,' while intended to signal a broad interpretation, cannot

Simplify Compliance
Learn, Comply, Succeed

SUBSCRIBER INFORMATION

Have questions on a story? Call or email us.

***PART B NEWS* TEAM**

Maria Tsigas, x6023
Product Director, Information, Print Subscription Products and Services
mtsigas@decisionhealth.com

Marci Geipe, x6022
Senior Manager, Product and Content
mgeipe@simplifycompliance.com

Steven Andrews, x3171
Managing Editor, Coding
sandrews@hcpro.com

Richard Scott, 267-758-2404
Associate Content Manager
rscott@decisionhealth.com

Roy Edroso, x6031
Editor
redroso@decisionhealth.com

Jim Dresbach, x5031
Editor
jdresbach@decisionhealth.com

Medical Practice & Hospital community!
www.facebook.com/DecisionHealthPAC
www.twitter.com/DH_MedPractice
www.linkedin.com/groups/12003710

SUBSCRIPTIONS
Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email: customer@decisionhealth.com

DECISIONHEALTH PLEDGE OF INDEPENDENCE:
Part B News works for only you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. For nearly three decades, we've been independently watching out for the financial health of health care providers and we'll be there for you and your peers for decades to come.

CONNECT WITH US
Visit us online at: www.partbnews.com.

CEUS
Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email customer@decisionhealth.com.

ADVERTISING
To inquire about advertising in *Part B News*, call 1-855-CALL-DH1.

Part B News® is a registered trademark of DecisionHealth. Part B News is published 48 times/year by DecisionHealth, 100 Winners Circle, Suite 300, Brentwood, TN 37027. ISSN 0893-8121. pbncustomer@decisionhealth.com Price: $647/year.

be taken literally, and is not in fact completely in line with the terms and conditions which show that there are actually a number of specifically prohibited uses of the funds," Lee says.

Be aware also that your payment could be audited down the road — and, if it amounts to more than $150,000, you are required by the terms and conditions to file a detailed quarterly report to HHS of where the money's going. In fact, HHS reserves the right to require a spending report of any recipient at any time, regardless of amount.

To help avoid trouble, follow these rules:

- No appearance of double-dipping. For one thing, "Providers should make sure other sources of reimbursement that are used to cover expenses or losses don't cover the same things," Lee says.

For example, a provider might be receiving funds from the Paycheck Protection Program (PPP), a low-interest SBA loan that's supposed to be spent on designated categories such as payroll costs, rent, mortgage interest or utilities, Lee explains. "To the extent those PPP funds fully reimburse those categories of expenses, the funds received from provider relief fund should not be used for those expenses, but for other purposes — even if mixing and matching of different sources of funds to different expenses would result in essentially the same outcome," he says.

This may seem over-cautious and even futile; Iseman points out that "money is fungible" and devoting financial resources to one area frees up resources in another. But the federal government is notoriously a stickler for such bookkeeping niceties, so play along.

- Be reasonable in your interpretation of what's COVID-19-related, instructs Jenny G. Givens, a partner with the Gary Reed firm in Dallas. "If a physician left a practice just prior to January 31, 2020, for reasons unrelated to COVID-19, and the group closed its offices on February 6 due to COVID-19, it does not seem reasonable to utilize the grant received by the group to reimburse its lost revenues from this physician's departure," Givens says. "If he were staying and his billings evaporated, then sure, that could be lost revenue due to COVID-19, which the group could reimburse using grant funds."

Overall, "use very conservative estimates and steer the funds, if appropriate, toward health care expenses related to COVID-19," Givens advises.

- Keep a separate account. Givens suggests you keep the Provider Fund payments in a separate bank account to eliminate confusion — and auditor suspicion. "Track [expenses] bit by bit, make note of every payment and demonstrate the need to use the funds for what you spent them on," she adds.

Watch salaries, coinsurance

Be aware that another condition of payment is that you "not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network recipient," according to HHS guidance.

Patient responsibility sums can be very high out of network, and add up to significant revenue in large organizations, Givens says. To be forced to accept an in-contract level of coinsurance for out-of-network patients could be a huge loss for your practice.

Also, if you're thinking of giving one of your executives a raise, make sure their salary doesn't exceed $197,300. While you can certainly use Fund payment for payroll, including executive salaries, the Further Consolidated Appropriations Act of 2020 restricts salaries paid out of federal grants to that amount. Note that there are many other statutory exclusions to the use of the funds, such as "Promotion of Legalization of Controlled Substances" and "Pornography," in the final pages of the fact sheet.
— *Roy Edroso (redroso@decisionhealth.com)* ■

RESOURCES

- CARES Provider Relief Fund portal: https://covid19.linkhealth.com/#/step/1
- HHS Relief Fund fact sheet: www.hhs.gov/sites/default/files/relief-fund-payment-terms-and-conditions-04132020.pdf

Telehealth

Large telehealth denials should prompt practices to review evolving billing rules

While you may be flying by the seat of your pants in your office or from a remote telework location, that shouldn't stop you from buckling down to get the most reimbursement possible for your practice. Those who dole out reimbursements passed along some unwelcome news in recent days, and reports have shown coders are having a difficult time navigating paper telehealth insurance claim forms.

On April 15, National Government Services, the Medicare administrative contractor (MAC) covering New York and nine other states, issued the following statement regarding telehealth coding procedures:

"We have received a high volume of paper CMS-1500 claim forms for telehealth services with dates of service during the public health emergency (PHE) that we have to reject because they are improperly coded with two different place of service (POS) codes on one claim." The paper claims that are getting denied might have POS 11 (Office) as well as POS 02 (Telehealth), NGS says

The CMS-1500 Form is sometimes referred to as the AMA form. The CMS-1500 Form is the prescribed form for claims prepared and submitted by physicians or suppliers, whether or not the claims are assigned.

NGS provided the following guidance to correctly file for telehealth: "If you are offering telehealth services as part of the PHE, those claims should be submitted with the POS from where the face-to-face service is normally performed (e.g., office POS 11, hospital POS 21) and include modifier **95** to identify this as a telehealth service during the PHE."

It's easy to see why the new guidance may be sowing confusion. In recent years, CMS had moved away from modifier 95 and had instructed providers to report the new telehealth POS 02. But during the COVID-19 emergency, you should return to using modifier 95 on your telehealth claims.

Health care experts watching intently noticed CMS guidelines aimed at reducing burdens may in fact be creating another burden — a deluge of updates. Coding expert Margie Vaught, CPC, of Chehalis, Wash., explains that CMS could be providing too much information and coders are missing the updates.

"This is a case of CMS updating and changing policies and regulations with offices not being able to keep up with the current statute," Vaught says.

As part of the larger COVID-19 updates, CMS will now pay for more than 80 additional services when furnished via telehealth (*PBN blog 4/6/20*). These include emergency department visits, initial nursing facility and discharge visits, and home visits, which must be provided by a clinician that is allowed to provide telehealth.

Attorney Carrie Nixon, co-founder and managing partner of Nixon Law Group and CEO of Nixon HealthNexus, agrees that health care office practices are getting bombarded with government oversight.

"Medical billers, coders, providers and many other important players in health care are having a difficult time keeping track of all of the changes that are coming at them rapid-fire from CMS," Nixon says. "The changes, for the most part, are helping to ease restrictions and increase access to care during the COVID crisis, but those changes are constantly evolving, and what was the latest information two days ago on issues like this one is often out of date two days later."

Problems in the Palmetto State

Filing improper telehealth claims does have a lengthy history. According to an OIG report released this month, 96% of South Carolina's Medicaid fee-for-service telehealth payments from July 1, 2014, through June 30, 2017, were insufficiently documented and deemed unallowable.

Of the 100 Medicaid fee-for-service telemedicine payments examined in the random sample, only three payments were allowable. In regard to the 95 unallowable payments, the providers documented neither the start and stop times nor the consulting site location of the medical service.

The remaining two unallowable payments were actually for in-office consultations, not telemedicine services. This noncompliance occurred because South Carolina did not give providers formal training on telemedicine documentation requirements or adequately monitor compliance, according to the report.

Benchmark of the week

Enrollment growth slows, but 'Welcome to Medicare' rises steadily

Though the rate of Medicare enrollment growth has slowed, the Initial Preventive Physical Examination (IPPE) meant to welcome patients to the program continues to grow steadily.

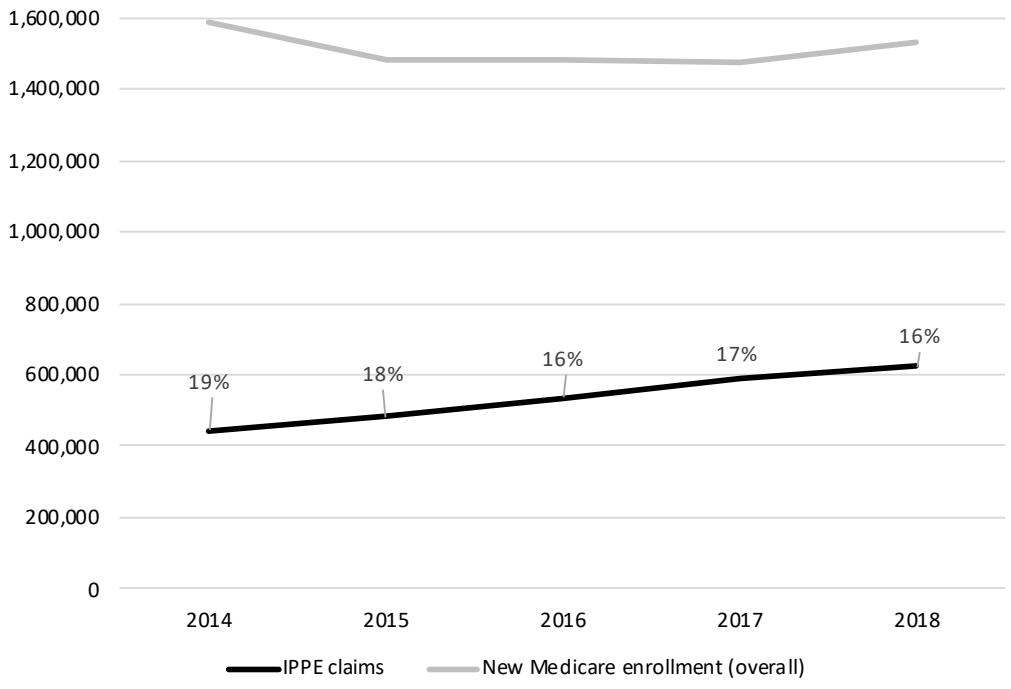
The IPPE service has come a long way in recent years. In 2009, it appeared on a mere 119,767 claims; by 2018, those IPPE claims grew to 621,484 in total, a 419% increase. The use of IPPE experienced a huge growth spurt between 2010 and 2013, moving from 141,426 to 414,951 claims, a 193% jump. That coincided with the debut of the annual wellness visit (AWV) — perhaps owing to public education that informed enrollees of the difference, thereby boosting both services (*PBN 12/6/10*). That rate of growth has slowed, but IPPE continues an upward trend.

It's also interesting that IPPE grows as Medicare patient enrollment growth has been weak. That rate fell below 3% in 2015 and has stayed there. According to CMS statistics, the number of traditional Medicare enrollees actually dropped slightly in 2018; only a slightly larger rise in Medicare Advantage and other Medicare plans kept enrollment in positive numbers. The number of Medicare Advantage enrollees has been growing faster than traditional Medicare for years now (*PBN 5/23/16*).

The specialties claiming IPPE the most are unsurprising: Family practice and internal medicine together make up 34% of claims, with nurse practitioners, physician assistants and general practice coming up behind. The slightly surprising sixth-place finisher, with 4,289 claims, is obstetrics/gynecology.

Denial rates for IPPE aren't great, so remember to follow a checklist of necessary steps when you conduct one — and of course make sure it's the patient's first and only IPPE (*PBN 5/1/17*). — *Roy Edroso* (*redroso@decisionhealth.com*)

IPPE claims and new Medicare FFS enrollment, 2014-2018, with IPPE denial rates



Sources: Part B News *analysis of Medicare claims data; CMS Office of Enterprise Data and Analytics, CMS Chronic Conditions Data Warehouse*

The OIG estimated unallowable payments totaled at least $2.1 million during the audit period.

Resolve the problems

As the COVID-19 pandemic escalates and plateaus, Nixon feels coders have to melt away the avalanche of information and use fundamental judgement along with CMS edicts.

"I think coders have to just do the best they can by staying on top of information released by CMS or their local MAC — and this means checking every single day for newly announced changes," she says.

In short, coding expert Maxine Lewis of Cincinnati, Ohio, offers sage advice during this uncertain time about getting certain payments. "Remember, the goal of a coder is to get the claims paid … it would be wise to follow their [CMS'] rules," Lewis says. — *Jim Dresbach (jdresbach@decisionhealth.com)* ■

RESOURCES:

OIG South Carolina coding report: https://oig.hhs.gov/oas/reports/region4/41800122.pdf

CMS payment work sheet: www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf

Medicare Advantage

CMS lets MA providers do telehealth risk adjustment; tight documentation advised

Medicare Advantage (MA) providers can now do risk adjustment by telehealth, but you are advised to tighten up on your documentation and not go further than good judgment allows.

CMS has been letting out the telehealth string for Medicare Advantage providers since before COVID-19 hit, allowing MA plans to cover telehealth delivery of many traditional Medicare-covered services (*PBN 4/18/19*). Subsequently, the public health emergency (PHE) pushed the agency to issue a blanket waiver for traditional Medicare providers that eschewed originating site and other stringent requirements (*PBN blog 4/1/20*).

In its 2021 Announcement for Risk Adjustment issued April 6, CMS hinted that it was considering a telehealth risk adjustment decision in response to the emergency. On April 10, CMS issued a brief memo, "Applicability of diagnoses from telehealth services for risk adjustment," stating MA organizations "that submit diagnoses for risk adjusted payment are able to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient, or professional service, and from a face-to-face encounter."

That policy applies as long as the visits involve an "interactive audio and video telecommunications system that permits real-time interactive communication."

Risk adjustment uses a combination of demographic and "disease burden" information to determine future costs for patients on which provider payments under MA and other risk-based reimbursement plans are based, explains Debra Rossi, CCS, CCS-P, CPC, CPMA, executive director at RR Health Strategies in Hauppauge, N.Y. Disease burden is derived from diagnosis codes submitted in the medical record and documented as a result of a face-to-face visit, which by the new guidance can mean a telehealth encounter.

While "the telehealth physical exam may have limitations [versus] an in-person one in some details … in our compliance reviews of the documentation of telehealth visits, we are seeing many components of a physical exam performed and documented based on the patient's presenting problems and condition," Rossi says.

Guidance on telehealth from Medicare administrative contractors (MAC) gives a clue to how this is possible, Rossi explains.

In a Q&A from National Government Services (NGS), for example, the MAC says, "Examination via telehealth is limited, but it is permissible for a provider to document pertinent observations, such as skin color, skin lesions/rashes, quality of respiration and evidence of wheezing or dyspnea, vital signs as reported by the patient. When this is done, these factors may also contribute to the level of coding."

This suggests to Rossi that a provider examining for risk adjustment purposes can work within the same limitations — including vitals taken by the patient rather than the provider — and still arrive at a diagnosis.

Emily H. Wein, a health care lawyer with Foley & Lardner LLP in Washington, D.C., agrees that the MAC guidance is a good guide. "When we've approached CMS

on coverage matters, if there's not published guidance they'll usually refer us to the appropriate MAC," Wein says. "I've encountered this recently [regarding] remote patient monitoring and enrollment matters. Often CMS central defers to MACs on claims processing matters."

As a precaution, however, Wein suggests MA providers new to telehealth go a step further and walk through their reasoning in notes. "Maybe in the initial stages providers should take extra efforts to show professional judgement was exercised in using telehealth, not just assert 'the MAC said I could,'" she advises.

"As everything seems to be moving and developing quickly, I think providers should be prepared to support their reasoning and decision making," Wein adds.

If you're unsure that you can make the diagnosis, however, don't push it. "It's always a standard of care that if the provider doesn't feel they can diagnose or treat via telehealth, they need refer the person for in-person care, whether with the telehealth provider or another in-person provider," Wein cautions. "If they can't perform the service asked of him or her remotely, they need to say so."

Neither should you offer a provisional diagnosis for risk adjustment purposes contingent on the patient coming in when the emergency lifts. "I don't know if the subsequent visit would be reimbursable," says Thomas (T.J.) Ferrante, a health care lawyer and senior counsel with Foley & Lardner in Tampa. "If you think the provider had enough under the current emergency guidance, what would be the justification for bringing the patient in again?"

Finally, get comfortable with telehealth risk adjustment, because there's a good chance it's here to stay.

"What's interesting is, in the guidance I don't see anything stating it's COVID-19-specific," Ferrante says.

"The NGS guidance — and all MACs have something similar out there now — may eventually change and go back to 'normal,'" Ferrante adds. "But the memo seems to open it up to all risk adjustment based on diagnosis." — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCES:

- CMS risk adjustment memo, April 10: www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf

Coronavirus

Continuing presence of coronavirus brings new obligations related to OSHA

As employers begin looking beyond the immediate effects of the COVID-19 pandemic and start thinking of bringing people back to work, they will be wise to realize the new virus means permanent changes related to their obligation to provide a safe workplace.

Christopher Sutton, an attorney in the Denver, Colo., office of Perkins Coie LLP, advises and defends employers on matters related to the Occupational Safety and Health

Administration (OSHA), and he says it's a new day in terms of keeping workers safe.

Employers must "understand the COVID virus is here and will be for the foreseeable future," Sutton says. "Companies should establish a plan."

While the Occupational Safety and Health Act doesn't reference the coronavirus or COVID-19 and no specific regulation addresses it, the Act's General Duty Clause requires employers to provide a workplace free of recognized hazards. In March, the virus was formally identified as a recognized hazard in the workplace, meaning employers are obligated to take steps to prevent employees from transmitting the disease at work.

OSHA has been issuing various documents in recent weeks, including an enforcement plan released April 13 intended as guidance for its area directors as they prioritize complaints about workplace exposures. The guidance also lets employers know what they can expect in terms of agency inspections and enforcement.

Sutton says OSHA is "classically and chronically underfunded," and there is no way the agency can inspect all the facilities where credible complaints have been made. "This is a monster in that respect," he says, but employers are no less obligated to take steps to keep their workplaces safe.

No escape

Employers need to evaluate the nature of the coronavirus hazard in their workplaces, and they need to understand that it is pervasive. "There's no employer that will escape the impact from the coronavirus," Sutton says.

Decisions on what steps to take will have to be made case by case, but Sutton says examples of steps to incorporate in a plan may include screening employees for fever, putting out questionnaires, testing employees for the virus on a regular basis, preventing anyone testing positive from entering the workplace, sending infected workers home, doing contact tracing within the workplace and educating employees.

Employers also may need to institute engineering controls, such as installing the plastic screens many stores are using to protect checkout clerks, Sutton says. Other measures may include enforcing six-foot distance rules and requiring face masks.

Employers also will need to have plans for different kinds of employees. For example, a health care worker in an employer's on-site clinic will need a different plan than another employee in a different job.

"The real issue that people haven't grasped yet fully is — whether or not the transmission occurred at the workplace" — the employer must determine whether it took reasonable measures to prevent it, Sutton says.

If not, the employer will be dealing with a work-related injury that, depending on the type of employer, will have to be reported on an OSHA 300 log, which the agency uses to evaluate the safety of a workplace, understand industry hazards and implement worker protections. A workplace-related case of COVID-19 also could become a workers' compensation claim, he says.

Putting an effective plan in place can help employers stay in operation by not losing employees to sickness or quarantine and can keep workers' compensation insurance rates down, according to Sutton. An employer's "bottom line is going to require it," he says.

Julie S. Lucht, an attorney with Perkins Coie LLP in Seattle, Wash., also notes that some states are putting in place government-mandated restrictions to mitigate the risk as employers begin to reopen, and those will need to be incorporated in an employer's policy related to protecting against the virus.

Relaxed enforcement

In addition to OSHA'S April 13 enforcement plan, the agency released a policy on April 16 outlining discretion in enforcement of agency standards when employers act in good faith during the COVID-19 crisis.

"In light of the coronavirus disease 2019 (COVID-19) pandemic, OSHA understands that some employers may face difficulties complying with OSHA standards due to the ongoing health emergency," the memorandum states, adding that business closures and various COVID-19-related restrictions in some ways make compliance not feasible or even pose an unreasonable risk.

The memorandum says that when employers are unable to comply with certain OSHA standards but have made good-faith attempts to comply, the agency "shall take such efforts into strong consideration in determining whether to cite a violation." — *Tammy Binford* (*pbnfeedback@decisionhealth.com*) ■