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Medical Practice Compliance Alert

News, tools and best practices to assess risk and protect physicians

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CMS

Out of the split pool: Stark update restricts physician compensation arrangements

By: Marla Durben Hirsch

Review your practice's internal compensation agreements and be prepared to make changes by the end of the year. CMS' latest update to the Stark physician self-referral law reduced physicians' compliance burdens in many ways (*MPCA 12/2020, 1/2021, 2/2021, 3/2021*). But CMS also tightened the requirements regarding how physician groups can pool and distribute their profits.

The Stark Law is intended to ensure that a physician's medical judgment is not compromised by improper financial incentives that encourage referrals for unnecessary services. It prohibits physicians from referring Medicare beneficiaries to health care providers, including providers in their own medical practices, for designated health services (DHS) unless an exception applies.

The Stark Law's in-office ancillary services exception allows physicians to refer ancillary DHS, such as laboratory and imaging services, to their own group practice and to be paid based on profits from referrals of DHS, so long as, among other things, the compensation doesn't directly take into account the volume or value of the referrals.

New rule stops split pooling

Group practices have had some flexibility in how they distribute profits from DHS to the group as a whole or to subgroups of at least five physicians (sometimes called "pods"), says attorney Lester Perling, with Nelson Mullins Riley & Scarborough in Washington, D.C. For instance, a practice can create physician

Your favorite compliance event returns to Orlando

DecisionHealth's **Billing & Compliance Summit** will be live and at Hilton Orlando Lake Buena Vista, Nov. 8-10. Learn about hot topics like the 2022 CPT code update, the latest privacy & security risks, and compliance for practice managers during the day. Then cross the street and stroll around Disney Springs during the evening. View the complete agenda and register today: www.codingbooks.com/billing-compliance-summit. And remember to reserve your hotel room at our special rate before they're gone.

pods based on different criteria, such as productivity, seniority, location, or specialty, and distribute profits in different ways to each pod.

One popular compensation formula is known as split pooling. Medical groups pool physicians by specialty in subgroups and distribute profits from DHS on a service-by-service basis, such as distributions of profits from physical therapy services to a group of orthopedic surgeons or profits from imaging to a group of radiologists.

The new Stark rule clarifies that distribution by service line was not the original intent of the statute, since it could incentivize physicians to order unnecessary DHS to boost the amount they'd receive in distribution, according to attorney Kristen Andrews Wilson, with Steptoe & Johnson in Wheeling, W.Va.

In other words, when a group practice wants to distribute profits from DHS, it can't pool profits of different types of DHS and distribute it on a service-by-service basis. For example, a practice can't distribute profits from lab services to one group of physicians and distribute the profits from diagnostic imaging to a different group of physicians.

Instead, medical groups need to aggregate profits from all DHS before distributing the money in order to qualify for the in-office ancillary services exception, says attorney Aleah Schutze, with Steptoe & Johnson in Louisville, Ky.

The clarification aims to reduce some creative manipulation of the rule, according to attorney Ann Bittinger, Bittinger Law Firm, in Jacksonville, Fla, speaking at the ABA Health Law Section webinar "Adjusting Profit Plans to Fit the New Stark Rule," May 20.

"The act of pooling all profits takes an individual physician further away from directly receiving profits from the DHS he referred," explains Rud Blumentritt, CPA/ABV, CVA, partner, with the valuation and consulting firm HORNE in Baton Rouge, La., also speaking at the webinar.

Practices that use a split pooling model shouldn't wait to update their compensation arrangements; the provision goes into effect Jan. 1, 2022. After that, split pooling arrangements will clearly violate the Stark law, Wilson warns.

Additional scrutiny expected

Physician groups should take this change seriously. The Department of Justice has investigated internal physician compensation profit sharing arrangements that it believed violated Stark (*MPCA 10/13/2014*). Practices should anticipate increased government enforcement action and whistleblower lawsuits related to this new aspect of Stark compliance.

Practices will need to tread carefully to get this right. This is a complex and confusing part of the Stark law. ■

RESOURCE:

Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations: www.federalregister.gov/public-inspection/2020-26140/medicare-program-modernizing-and-clarifying-the-physician-self-referral-regulations

CMS

Stark update goes beyond split pooling restrictions

By: Marla Durben Hirsch

CMS' prohibition against split pooling distributions of profits from designated health services (DHS) is one of the most significant changes in the update to the Stark Rule released November 2020 (*see story, p. 1*). Practices that use split pooling will need to update their compensation arrangements by Jan. 1, 2022. CMS also took the opportunity to further clarify how pooling and distribution of profits need to work to comply with the Stark Law's in-office ancillary services exception, which will help practices understand CMS' expectations. "It's positive to get clarity from CMS," says attorney Kristen Andrews Wilson, with Steptoe & Johnson in Wheeling, W. Va.

What stays the same

Practices can still use productivity, seniority, or other eligibility standards for allocation that doesn't take into account referrals for DHS, and these standards can differ for different physician subgroups (also called "pods").

The rule also still allows practices to divide profits among subgroups of physicians, so long as a subgroup contains at least five physicians, on the theory that would be a sufficiently large number of physicians to reduce the chance that the compensation would directly relate to an individual physician's volume or value of referrals, Wilson says.

What will change

The methodology for distributing profits now has to be the same for everyone in the pod, and now a doctor can only participate in one pod; previously physicians could be members of more than one, says attorney Aleah Schutze, with Steptoe & Johnson in Louisville, Ky.

The new rule also clarified other aspects of the exception applicable to compensation arrangements. For instance, the distribution needs to be based on actual profits, that is revenue minus expenses, not simply revenue. Payments based on revenue alone could be an inducement for physicians to make additional DHS referrals to the practice, says Schutze.

Some other changes to keep in mind include:

- If a medical group is less than five physicians, the distribution of profits must be based on the entire group.
- DHS profits need to be divided in a reasonable and verifiable manner not directly related to the volume or value of the physician's referrals of DHS.

Group practices can distribute revenues from services that aren't DHS any way they wish.

The new provisions will go into effect Jan. 1, 2022. ■

OIG

You can give patients a lift – or a Lyft – to appointments

By: Marla Durben Hirsch

When your patients miss appointments and even skip treatments because they don't have reliable transportation, you can help without running afoul of the anti-kickback law thanks to a safe harbor created in 2016 and updated in 2020.

The local transportation safe harbor to the Anti-Kickback Statute (AKS) protects physicians and other providers who offer patients free or discounted transportation services related to their medical care (*MPCA 1/2017*).

When the safe harbor was first published the arrangement had to meet the following requirements:

- The transportation is for medically necessary services.
- The transportation services must be in a policy that is applied in a consistent manner.
- It can't be based on the volume or value of federal health care business the practice has or expects to receive from treating a patient.
- It can't be used for air, luxury, or ambulance transportation.
- The provider can't publicly market the availability of the service.
- The practice can't market health care services to patients during the ride – either with advertisements or through the drivers.
- Payment for transportation can't be per patient.
- The service can only be offered to new patients after they have scheduled an appointment and established patients.
- Patients who live in an urban area must be picked up within 25 miles of the provider. The range is 50 miles for patients who live in a rural area.
- The provider must cover the full cost of transportation. It can't shift the cost to any federal health care program, other payers or people.

A provider doesn't have to send employees to pick up patients. The arrangement can include taxi rides, vouchers or transit smart cards. Providers can also provide a shuttle service if certain requirements are met. The ride can be to and from the patient's residence or another provider and doesn't have to be planned in advance.

The safe harbor is flexible regarding the parameters of the policy on providing local transportation. The HHS Office of Inspector General (OIG) suggested, for example, that a provider can ask all patients if they have reliable modes of transportation, offer it to patients with a history of missing appointments or specific needs criteria, or only when patients ask for it.

Safe harbor expanded

The OIG update issued November 2020 tweaked this local transportation safe harbor in a couple of ways (*MPCA 12/2020*):

1. The mileage limit for rural areas was increased from 50 to 75 miles
2. The 25 and 75 mileage limits will not apply to local transportation if a patient is discharged from an inpatient facility following admission or released from at least 24 hours of observation and transported to the patient's residence or other

residence of the patient's choice (such as a friend or relative).

The OIG did not expand the safe harbor further, as contemplated in the proposed rule issued in 2019 (*MPCA 11/2019*). For example, the OIG solicited comments on — but opted not to go with — extending the elimination of the distance requirement to transportation to the patient's home from outpatient or ASC services. However, the OIG did clarify that the safe harbor does apply to rideshare arrangements and to potential other forms of transportation available in the future, such as self-driving cars. ■

RESOURCES:

Transportation safe harbor, 2016: www.govinfo.gov/content/pkg/FR-2016-12-07/pdf/2016-28297.pdf

Final rule – Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements: www.govinfo.gov/content/pkg/FR-2020-12-02/pdf/2020-26072.pdf

Proposed rule – Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements: www.federalregister.gov/documents/2019/10/17/2019-22027/medicare-and-state-healthcare-programs-fraud-and-abuse-revisions-to-safe-harbors-under-the

Ask MPCA

New diagnosis? Correct the claim, but expect pushback from your MAC

By: Roy Edroso

Question: We've had a claim denied on the basis of medical necessity because the provider's original diagnosis was not covered. Now the provider, after further analysis, has determined that the actual issue is different from what she had originally thought and she wants to change her diagnosis and treatment. Can we resubmit the previous claim with the new diagnosis?

Answer: First, adhere to a standard rule of thumb: "Only report a diagnosis code that is known to be true at the time of the service," advises Nancy Enos, FACMPE, CPC, CPMA, CEMC Emeritus, principal of Enos Medical Coding in Warwick, R.I.

There are some instances in which a provider may perform a procedure that confirms or excludes a diagnosis but does not return a result until later. This is common in surgery, where the post-operative diagnosis will be more accurate, Enos says.

Maria Montecillo of Medical Cost Advocate Inc. in Wyckoff, N.J., gives the example of a primary diagnosis of low back pain on a claim for an MRI of the lumbar spine. The Medicare administrative contractor (MAC) is likely to deny as "an MRI is not necessary for the majority of low back pain issues," Montecillo says.

But what if the MRI report comes back and indicates that the patient has a spinal cord tumor? Montecillo believes simply resubmitting the claim with a new diagnosis won't do; instead, she says, it may be appropriate to file a corrected claim with the corrected diagnosis. "Write 'corrected claim and diagnosis' prominently on the claim form," Montecillo says. Also, a call to the claims department to discuss it could help keep the corrected claim in good standing.

But there's a good chance your MAC will disagree. Margie Scalley Vaught, CPC, CPC-H, CCS-P ACS-EM, ACS-OR, a coding consultant based in Chehalis, Wash., points to a common orthopedic diagnosis of **S83.241A** (Other tear of medial meniscus, current injury, right knee, initial encounter). The doctor may order an MRI, "so the ordering diagnosis would be contusion, pain in knee, effusion knee, etc., with signs and symptoms documented," Vaught says. "If they used the S83.241A, they are saying they already know that the patient has a right knee medial meniscal tear — thus, there is no medical necessity to order the MRI."

"I always learned from the ICD-10 guidelines that you code for what you know at the time of the service, not for what you find out days later," Vaught says. "If you knew they had that problem, why order the test?" ■

Billing & coding compliance

Separate compliance fiction from fact to simplify E/M coding

By: Julia Kyles, CPC

Make sure staff don't add complications to the new guidelines for office visits (**99202-99215**). The AMA created the new guidelines to ease the administrative burden on physicians and qualified health care professionals, but the changes should also benefit coding staff, said Barbara Levy, M.D., co-chair of the CPT/RUC workgroup on E/M, during the AMA webinar "The 2021 E/M Office Visit Technical Corrections," May 25. For example, the history and physical exam are no longer used to calculate

the level of an office visit, which eliminated the work of counting those elements.

However, a review of questions submitted to CPT Assistant, various Medicare administrative contractors (MACs) and medical billing and coding forums indicate that some coders could be overthinking the guidelines, creating extra work and improperly coding claims. Here are four basic tips to reduce confusion and compliance risk:

1. **Keep close tabs on official guidance.** You should have a file of guidelines on your practice's network, regularly check for updates and note when the information was published or changed. It may be years before your MAC or another outside auditor conducts a review of the claims you submitted in 2021. The auditor may not remember to apply the rules that were in effect in 2021, which in turn could unleash a flood of denials even though your claims were compliant. Your copy of the guidance that was in effect when you submitted the claims could be your only defense against hefty overpayment demands.
2. **Ask CMS or your MAC.** Take advantage of free events like the Open Door Forums conducted by CMS and Ask the Contractor sessions hosted by MACs to get answers to specific questions about how to document or code office visits or anything else. Save the responses in your guidance file. Asking for clarifications will also show you were trying to do the right thing.
3. **Code and train based on current guidelines,** even if you think CMS will introduce tougher guidelines in the future. While it is natural to want to keep the practice ahead of new compliance requirements, your coding and training needs to be backed up with official guidance to avoid confusion and distrust. Training that isn't supported by the guidelines may increase staff resistance to learning new rules if tougher requirements do go into effect and increase your exposure to compliance snafus.
4. **Work together on internal policies that go beyond official guidelines.** Practices may institute internal policies that go above and beyond the official requirements, but everyone should have a chance to offer input on the policies and why they're being put in place, and understand the difference between voluntary internal policies and external guidelines.

Replace compliance fiction with fact

Rumors, confusion about the new guidelines and anxiety about making mistakes can all give rise to compliance fictions around the new requirements for office visits. Start with these fictions and facts to keep everyone on the right track and supplement the information with specific guidelines from MACs and payers when needed.

Fiction: Over the counter (OTC) drugs are always minimal or low risk.

Fact: The risk of an OTC drug will vary from patient to patient. For example, ibuprofen could be high risk for a patient who is on anti-coagulants, Levy said during the CPT/RBRVS 2021 Annual Symposium, Nov. 20, 2020.

Fiction: Treating clinicians must document an extensive history and physical exam for high level visits but low-level visits may have little or no history and physical exam.

Fact: The treating practitioner makes that call. The new guidelines call for a "medically appropriate history and/or physical, when performed." However, the treating physician or QHP determines the "nature and extent" of the history and/or physical exam for each visit.

What's medically appropriate for each patient is "in the eyes of the clinician," said Peter Hollman, M.D., co-chair of the CPT/RUC workgroup on E/M, during the May 25 webinar. CMS added that "the history and exam components will be performed when they are reasonable and necessary, and clinically appropriate."

Fiction: The treating practitioner can never count tests toward medical decision making if the practice also billed for the test. That's always double dipping.

Fact: "Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation but may be counted as ordered or reviewed for selecting an MDM level," the March 9 update to the guideline states. This allows practitioners to count simple tests such as dipstick urine tests or quick strep tests that are also billed by the office, "since there is no … interpretation included in these tests," Hollman said during the May 25 webinar. "Our original educational advice was that you could not report this wasn't really practical," Hollman said.

Fiction: Practices should only count an ordered test toward MDM when there is a signed order in the patient's chart.

Fact: Practices may count a test that the treating clinician considered but decided not to order "after shared decision making," according to updated guidance issued March 9. During the May 25 webinar Levy gave the example of a patient who wants an MRI for their headaches because their neighbor was just diagnosed with a brain tumor. Or the practitioner may decide against a test that would normally be performed based on the risk to the patient. The new guidelines allow physicians and QHPs to get credit for the work involved in those discussions, but it must be documented, Levy emphasized.

Fiction: When counting data, the physician must meet the requirements for a variety of data types to qualify for Category 1. For example, they must order a unique test and review a unique test for Limited and order a unique test, review a unique test and talk to an independent historian for Moderate/Extensive.

Fact: You can reach the requirements for Category 1 with a combination of data types or one data type. For example, if the practitioner reviews two unique tests, they've met the requirement for Category 1 – Limited. If a practitioner reviews external notes from three unique sources, they've met the requirement for Category 1 – Moderate and Extensive.

Fiction: To count an independent interpretation of a test the treating practitioner must write a complete interpretive report.

Fact: "A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test," the guidelines explain.

Fiction: A "unique test" means all tests in a category or chapter of the CPT manual: pathology/laboratory, diagnostic imaging or medical tests such as electrocardiograms and nerve conduction studies.

Fact: A unique test is defined by the CPT code, not the category, Levy explained during the May 25 webinar.

Fiction: To code based on time the physician or QHP must document the exact time he spent on each activity on the date of service,

Fact: The CPT guidelines are silent on how to document time. If your MAC has issued guidance, follow that.

Fiction: If the practitioner indicates a visit should be coded based on time but doesn't accurately record the time for the visit the practice can't bill the visit at all.

Fact: The practice may use the documentation to code the visit based on medical decision making.

Fiction: If a time-based visit receives a higher level than it would for MDM-based coding, the practice should code the lower-level MDM code.

Fact: A practice has the option to code each office visit based on the method — time or medical decision-making — that is most advantageous for that visit. ■

RESOURCES:

CMS Medlearn Matters 12071: www.cms.gov/files/document/mm12071.pdf
CPT® E/M code and guideline changes (includes March 9 update): www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
Playback of "The 2021 E/M Office Visit Technical Corrections," recorded May 25 (free with registration): https://tinyurl.com/AMAEM525recording

Privacy & security

New HITECH amendment rewards good cybersecurity hygiene

By: Marla Durben Hirsch

Now's a great time to shore up your cybersecurity practices. A new amendment to the Health Information Technology for Economic and Clinical Health (HITECH) Act requires the HHS Office for Civil Rights (OCR) to take into account whether your practice adopted "certain recognized security practices" if it investigates your practice for HIPAA compliance. The amendment applies to business associates too.

The amendment, signed January 5 to little fanfare, is intended to encourage health care providers and other organizations covered by HIPAA to adopt strong cybersecurity programs to better protect patient information. That means if your practice can show that it has used statutorily recognized standards for at least 12 months, it may see reduced fines, the early and/or favorable termination of an audit, and other remedies.

"It works like a safe harbor," says attorney Elizabeth Litten, with Fox Rothschild in Princeton, N.J.

There's no penalty if you don't implement these standards, and OCR can't increase fines or otherwise penalize you if don't have the additional measures in place.

The "recognized security practices" that apply are the standards, best practices, guidelines, methodologies, procedures, and processes developed under either:

- The National Institute of Standards and Technology (NIST) Act.
- The Cybersecurity Act of 2015.
- Other programs or processes derived from another law, such as New York's Stop Hacks and Improve Electronic Data Security Act (SHIELD Act).

OCR has confirmed to *Medical Practice Compliance Alert* that it is incorporating the amendment into its HIPAA enforcement program.

Cyberattacks spur government action

The health care industry is particularly vulnerable to cyberattack, and providers account for 79% of all health care breaches, according to Lee Barrett, CEO and executive director of the Electronic Healthcare Network Accreditation Commission (ENHAC), a voluntary self-governing standards development organization, in Simsbury, Conn.

Hacking and other cybercrimes comprised a whopping 71% of HIPAA breaches in the first two months of 2021, according to Serena Mosley-Day, senior advisor for HIPAA compliance and enforcement at the OCR, speaking at the virtual Thirtieth National HIPAA Summit in March.

Many of the breaches are due to poor cybersecurity hygiene, such as lack of network segmentation or nonexistent password rules, according to Nicholas Heesters, senior advisor for cybersecurity at OCR, also speaking at the Summit.

"Using best practices may have stopped or mitigated a breach — and avoided a [subsequent OCR] enforcement action," Heesters says.

"I suspect that during the pandemic people were lax about cybersecurity. There are real challenges in 2021; providers are in various stages of undress," says attorney Michael Kline, also with Fox Rothschild.

A lot of physicians mistakenly believe that cyberattackers won't bother them because they have fewer patients than a larger provider. But in reality cybercriminals love physician practices because there are fewer controls in place, says Barrett. And even providers that have taken cybersecurity measures can still become a victim of cybercrime.

And then in comes OCR.

"Providers' systems are being hijacked. Then OCR comes back at these organizations after the attack and levies additional fines on them. So they're being whacked on all fronts," Barrett says.

For example, an orthopedic practice in Athens, Ga. was the victim of a hacker who extracted its patient database and demanded money for a copy of the database. After the OCR investigated the practice had to pay a $1.5 million settlement and enter a corrective action plan to resolve allegations of "longstanding, systemic noncompliance" with HIPAA privacy and security rules, the OCR announced Sept. 21, 2020.

Details under development

The amendment allows the entity to determine what practices to take but doesn't provide additional guidance. It's unclear what or how much cyber hygiene is needed to qualify for the safe harbor, and whether partial adoption of cybersecurity measures will count. Yet it's likely that OCR will take into account good faith efforts, says Litten.

"OCR gets ticked off when you know there's a gap and don't fix it. Here the safe harbor is an absolute factor," Litten says. To the extent your practice tried to improve its cybersecurity and prevent breaches, that gives you something to hold up when you have a *mea culpa*, Litten says.

"Even responding to OCR is a big expense. If you can say upfront what steps you took, you may be able to nip that in the bud and make it less painful," she adds.

Barrett agrees.

"That's the big value proposition, to minimize the double whammy of the attack plus OCR," he says. ■

RESOURCES:

The HITECH amendment: www.congress.gov/116/bills/hr7898/BILLS-116hr7898enr.pdf
The National Institute of Standards and Technology (NIST) Act: www.govinfo.gov/content/pkg/USCODE-2019-title15/html/USCODE-2019-title15-chap7-sec271.htm
The Cybersecurity Act of 2015: https://epic.org/privacy/cybersecurity/Cybersecruity-Act-of-2015.pdf
The New York SHIELD Act: https://ag.ny.gov/press-release/2017/ag-schneiderman-announces-shield-act-protect-new-yorkers-data-breaches
HHS OCR press release – orthopedic clinic settlement: https://www.hhs.gov/about/news/2020/09/21/orthopedic-clinic-pays-1.5-million-to-settle-systemic-noncompliance-with-hipaa-rules.html

Workplace compliance

OSHA issues rules for health care, relaxes guidance elsewhere

By: Tammy Binford

On June 10, the Occupational Safety and Health Administration (OSHA) announced updated guidance along with new rules for frontline health care employers. The latest word from OSHA reflects new guidance from CDC in May that says fully vaccinated people can safely go without masks and physical distancing in most situations.

OSHA is easing its COVID-19 recommendations for fully vaccinated — and non-health care — workplaces, but the agency is still advising employers to take steps to protect any unvaccinated workers.

Previous OSHA guidance, released in January, instructed employers not to treat vaccinated and unvaccinated employees differently because, at that time, there wasn't sufficient evidence related to the risk of transmission of the virus by vaccinated people.

How can an employer know whether employees have been vaccinated? On May 28, the Equal Employment Opportunity Commission (EEOC) updated its technical assistance to clarify that employers may ask, but any documentation an employer requires must be kept confidential and separate from regular personnel files.

In addition to OSHA's new guidance, the agency announced an emergency temporary standard (ETS) aimed at lessening risk for frontline health care workers most likely to have contact with people infected with the virus.

A closer look at the ETS

OSHA's announcement says the ETS is aimed at protecting workers facing the highest coronavirus hazards — those working in settings where suspected or confirmed COVID patients are treated. That includes hospitals, nursing homes and assisted living facilities; emergency responders; home health care workers; and employees in ambulatory care settings where suspected or confirmed COVID patients are treated.

OSHA's health care directed ETS says, among other things, that:

- Nonexempt facilities must conduct a hazard assessment and have a written plan to mitigate virus spread.
- Health care employers must provide some employees with N95 respirators or other personal protective equipment.
- Employers must ensure six feet of distance between workers, and in situations where that isn't possible, they should erect barriers between employees where feasible.
- Covered employers must provide workers with paid time off to get vaccinated and to recover from any side effects.
- Covered employees who have the virus or may be contagious must work remotely or otherwise be separated from other workers if possible or be given paid time off, up to $1,400 per week. For most businesses with fewer than 500 employees, tax credits in the American Rescue Plan may be reimbursed through these provisions.

Rebecca C. Seguin-Skrabucha, an attorney with Bodman PLC in Troy, Mich., explains the ETS "imposes legal requirements on covered health care employers."

For other employers, guidance, on the other hand, serves as a summary of best practices and "creates no new legal obligations."

"An employer that violates the ETS may be assessed civil penalties on a per-violation basis," Seguin-Skrabucha says. An employer that fails to act in accordance with the guidance is subject to penalties only "if the employer's divergence interferes with the provision of a safe and healthful workplace."

OSHA priorities, future actions

Albert L. Vreeland, an attorney with Lehr Middlebrooks Vreeland & Thompson, P.C., in Birmingham, Ala., says both the ETS for health care employers and the updated guidance for other employers "shows that OSHA is prioritizing protections for unvaccinated employees and relaxing requirements for vaccinated employees."

"With this in mind, employers can relax mask and social distancing requirements for vaccinated employees," Vreeland says. "Unvaccinated employees who cannot social distance in their jobs should still be required to wear masks."

Soon after taking office, President Joe Biden directed OSHA to issue rules for all employers, but "as the vaccine rollout has been faster and more successful than originally anticipated, the 'emergency' justification for the rule for general industry lessened," Vreeland says.

"But because of the continuing heightened risk of exposure for health care workers, OSHA concluded there was still an emergency need for specific measures," Vreeland says. "Unless there is another surge in infections, I expect this will be the last of the COVID-specific rules."

Seguin-Skrabucha urges employers to review state and local requirements. If more restrictive than federal guidance, state and local rules control. She also says employers should take the guidance seriously and remember that requiring physical distancing and face coverings for unvaccinated individuals are still recommended. ■

Workplace compliance

When patients refuse masks, stand on rights or work to accommodate

By: Roy Edroso

With many Americans refusing to wear masks in public despite the continuing COVID-19 health emergency, you should be prepared for patients who argue that they can't and won't wear one to your practice.

Alan Hawksby, M.D., a transplant surgeon at Oklahoma University, reproduced on Twitter a card he says "anti-maskers" are circulating that announces that the bearers are "exempt" from wearing masks under the Americans with Disabilities Act (ADA). The theory goes that because ADA requires businesses, including medical practices, to make "reasonable accommodation" for people who claim a disability, any patron who claims they can't wear a mask because of a disability must be allowed not to wear one.

The cards also claim that HIPAA means their bearers don't have to explain the medical reason for their refusal.

Web magazine Vox reports that "a urologist in Florida, who requested anonymity because of fear of losing his job ... had his first patient refuse to wear a mask on May 13." The patient became abusive, Vox further reports, and "called 911 to complain he was being denied medical care."

Some providers are tolerant of patients who don't or won't wear a mask. Johnny Franco, M.D., a plastic surgeon in Austin, Tex., generally requires masks, but says, "I've discussed it [with staff] and have not had an issue. To treat [patients], after all, sometimes we have to take off their masks — for lip injections, for example. It all has to be seen in context."

Franco gives all his patients a COVID-19 questionnaire. If they have symptoms, "they will be asked to reschedule their appointment for two weeks," he says. "When they confirm, they're screened again at the

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check-in." They also do curbside check-in and keep their waiting room clear. Franco and his staff are comfortable with that measure of control, he says.

"If it's somebody we've treated previously, and now they don't want to mask, you have two competing obligations — one to the community, and one to your patient," Franco says. "We don't want to abandon our patients."

Elizabeth Greene, a partner in the litigation and health law groups at Mirick O'Connell in Worcester, Mass., warns that whatever your feelings about a patient refusing to mask, the existence of ADA requires that you take any such requests seriously.

"Typically, public accommodation issues are nuanced and heavily fact-specific," Greene explains. "Legal counsel can greatly assist in determining how best to navigate such situations in a manner designed to protect the provider and staff, while striving to ensure access to services for the disabled patient."

Your rights matter

The ADA does allow for the practice to protect its staff and other patients from harm — including that of a potential COVID-19 infection from an unmasked person — under §36.208, the "Direct Threat" exception.

This section says that the law "does not require a public accommodation to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of that public accommodation when that individual poses a direct threat to the health or safety of others."

The law further states that "in determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: The nature, duration and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices or procedures or the provision of auxiliary aids or services will mitigate the risk."

Greene compares the situation of a patient who claims a disability that prevents them from following your masking rule to that of a patient who brings a support animal to a practice that does not normally allow pets.

"In general, a physician's office, as a place of public accommodation, is required to accommodate an individual seeking care with an emotional support animal," Greene notes. "However, that general statement is tempered by the reality of needing to ensure a safe environment for all in the office setting."

If the support animal creates a risk of harm to the provider or staff — a significant risk that it would bite or exacerbate allergies, for example — "the patient might be refused treatment, and it would be appropriate for there to be an interactive process with the patient in order to determine whether care could be provided without running a risk of harm from the support animal," Greene explains.

Lean into the 'interactive process'

"Providers faced with a patient who claims they cannot wear a mask due to an existing disability — whether physical or mental — should speak with the patient (preferably by phone or while maintaining appropriate social distance) in an attempt to identify an accommodation that can be offered that would both ensure the safety of the provider and staff, as well as ensure provision of appropriate medical care," Greene says.

Depending on the situation, a provider may opt to schedule such a patient service at the end of the day, when all other patients have left, with staff outfitted for maximum protection. That could ensure that "only the provider, donned with additional PPE, which may include face shield, N95 mask, gloves and gown, interacts with the patient, and following the patient encounter, ensures proper sanitizing of the space where treatment was provided," Greene adds.

However, "there has to be a determination as to whether [the accommodation] is reasonable," says Jennifer L. Curry, an attorney and shareholder with the Baker Donelson law firm in Baltimore. "Potentially, employees may not want the added risk." If your determination is there's no way to way to ensure their safety while providing appropriate care, you would be within your rights to require a mask or ask the patient to seek care elsewhere. ■

RESOURCES

Vox, "Doctors' new coronavirus threat: Patients who refuse to wear masks," May 22: www.vox.com/2020/5/21/21266413/coronavirus-face-masks-trump-cdc-n95