

Medical Practice Compliance Alert

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



Rules & regulations

CMS plans to tinker with Stark compensation arrangements, again

By Marla Durben Hirsch

If your practice has indirect compensation arrangements (ICA) with hospitals, labs or other designated health service providers, you may need to revisit those agreements. CMS is proposing to update the Stark physician self-referral rule to make more ICAs subject to Stark's requirements.

Under a previous version of Stark, unbroken chains of financial relationships between a referring doctor (or immediate family member) and an organization that provides designated health services created a prohibited ICA if, among other things, the doctor received aggregate compensation that varied with or was based on the volume or value of referrals or other business generated between the two. If an ICA existed, then it was subject to the Stark law and the arrangement needed to fit within a Stark exception to be lawful.

The rationale was to stop overutilization, inappropriate steering of patients to certain partners to increase profits, and other fraudulent activity. The rule was geared for the most part to situations where doctors receive compensation pursuant to equipment and space leases and items and supplies on a per-use or per-click basis, such as a physician who owns a lithotripsy service used by a hospital.

Change will correct 2020 lapse

CMS' 2020 update to the Stark physician self-referral law changed the analysis on what constitutes an ICA. The revised rule added a requirement that to be an ICA, the unit of compensation the doctor received had to be either not fair market value or there had to be a positive correlation between the doctor's compensation and the doctor's referrals to the health care provider (*MPCA 12/2020*).

This change narrowed the kinds of arrangements that would be deemed ICAs and thus subject to Stark, according to attorney William Maruca, with Fox Rothschild in Pittsburgh

But that could change under a provision in the proposed 2022 Medicare physician fee schedule which would state the relationship can avoid being an ICA only if the compensation arrangement involves compensation for services the physician

In this issue

1, 4, 5 Rules & regulations

CMS plans to tinker with Stark compensation arrangements, again

CMS designs drastic changes to its split/shared policy

HHS rule creates new protections for providers in civil enforcement actions

2, 3, 6 Privacy & security

OCR uncovers widespread breach notification failures

Take a 6-step test of your practice's breach notification process

9 steps to meet the HIPAA cybersecurity safe harbor

7 Billing & coding compliance

Prepare for a coding upgrade, review new, revised codes now

personally performs. Other arrangements, where the physician receives compensation for leases, items and supplies, or for the services performed by employees, other physicians or independent contractors would be considered an ICA and would need to meet an exception. CMS says that this component was “inadvertently omitted” from the 2020 rule.

It’s unclear whether this new proposed change applies to services “incident to” a physician’s services.

Physician practices should consider submitting comments on this proposed change. For instance, practices could point out whether they believe the change is reasonable, ask for clarification regarding how the change applies to the “incident to” rules or suggest that the allowed compensation be expanded to include services performed on behalf of a physician.

Comments are due Sept. 13, 5 p.m., ET. The quickest way to submit them is through the www.regulations.gov website. Reference CMS-1751-P to make sure your comment is captured and reviewed. ■

RESOURCES:

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

Proposed 2022 Medicare physician fee schedule: www.govinfo.gov/content/pkg/FR-2021-07-23/pdf/2021-14973.pdf

Privacy & security

OCR uncovers widespread breach notification failures

By Marla Durben Hirsch

Prepare for more scrutiny of your practice’s patient breach notification process, now that the HHS Office for Civil Rights’ (OCR) new HIPAA audit report has revealed deficiencies in covered entities’ breach notification letters.

Of the 166 practices and other covered entities that the OCR audited, a whopping 161 of them had suffered a reportable breach of protected health information (PHI). While many organizations met the 60-day deadline for notifying patients, more than two-thirds of the letters were missing vital information.

Understand the basics

A breach is the acquisition, access, use, or disclosure of PHI in a manner not allowed by the HIPAA privacy rule and compromises the security and privacy of the PHI.

Under HIPAA’s breach notification rule an organization that experiences a breach of unsecured PHI must notify the affected patients and HHS. If 500 or more people are affected by a breach, the organization must also notify the media. PHI is unsecured when it is not encrypted.

While it’s understandable for providers to run into compliance issues regarding some of the more complex and confusing aspects of the breach notification rule, it’s surprising that the report found so many entities dropping the ball when it came to the content of the breach notification letters, since the rule is clear on what they need to say, notes attorney Elizabeth Litten, with Fox Rothschild in Princeton, N.J.

“It’s lockstep regarding what to do,” she says.

HIPAA requires a breach notification letter to be in plain English and include:

- A brief description of the breach, including the dates of the breach and breach discovery, if known.
- A description of the types of information that were involved in the breach.
- The steps patients should take to protect themselves from potential harm, such as monitoring their bank statements.
- A brief description of what the provider is doing to investigate the breach, mitigate the harm, and prevent further breaches.
- Contact information for the provider, such as a website, toll-free telephone number, or email address.

The audit found that the information most often missing included a description of the types of PHI involved in the breach, any steps the individuals should take to protect themselves from potential harm, how to contact the entity, and an explanation of the entity’s investigation and mitigation activities. Simply stating “We investigated and took appropriate action,” is not sufficient, according to the OCR.

The OCR specifically notes in the report that the audits are intended to enhance industry awareness of particular HIPAA compliance obligations and enable the OCR to better “target technical assistance” regarding problems identified through the audits.

Publishing the report puts providers on notice of what the OCR expects, according to attorney Michael Kline, also with Fox Rothschild.

The issues uncovered during the audit “will be priority areas for enforcement,” he says. ■

RESOURCES:

OCR Audit report: www.hhs.gov/sites/default/files/hipaa-audits-industry-report.pdf

HHS guidance on breach notification: www.hhs.gov/hipaa/for-professionals/breach-notification/index.html

Privacy & security

Take a 6-step test of your practice's breach notification process

By Marla Durben Hirsch

No one likes to think that their practice will experience a HIPAA breach, but every practice must be ready to deploy a breach notification to patients before the 60-day deadline (*see story, p. 2*). A practice that doesn't have a plan to inform patients affected by a breach of unsecured patient protected health information (PHI) will be exposed to patient anger, investigations and costly fines.

Here are six steps to make sure your practice is ready in the event of a breach.

1. **Assign tasks, create a template letter.** You should have at least one person who is assigned to handle breach notifications, which includes creating a notice template in advance and determining how to notify patients, such as by email — when the practice has the patient's permission — first-class mail or by posting a notice on the practice's website in the event of a breach. Your practice doesn't need to create a sample letter from scratch (*MPCA 2/18/2013*). Check with state or specialty medical associations, professional coding organizations and your medical malpractice carrier.
2. **Review your breach notification letters.** Your breach notice template should contain areas for all required breach notice elements that are listed by the HHS Office for Civil Rights (OCR). The elements include the steps patients should take to protect themselves from potential harm, a brief description of what your practice is doing to investigate the breach and contact information for patients who have questions. However, your HIPAA-response specialist should customize and review the letter before it's sent. If you hire a consultant to create a model or finalize a specific letter, don't assume that the letter is complete; review it

and have it corrected if it isn't accurate. For example, the letter may claim the practice has completed its investigation before it has done so, or it may give an incorrect contact phone number. “OCR has raised the bar. It's your responsibility. You can't rely on outside consultants,” says attorney Michael Kline, with Fox Rothschild in Princeton, N.J.

3. **Keep an eye on the calendar.** You must provide the notice without unreasonable delay and in no case later than 60 days after the practice discovers a breach. A practice that misses the deadline can expect to pay the price. For example, Presence Health paid a \$475,000 settlement to the OCR to resolve allegations that it took 100 days after discovering a breach to send breach notification letters out to patients. And watch those state deadlines. Some states have even shorter breach notification timeframes.
4. **Don't underestimate who needs to be notified.** Sometimes it can be difficult to pinpoint which patients have been affected by a breach within the 60-day notification timeframe. In those instances, err on the side of caution and notify everyone who might be affected, and indicate that the practice is still investigating the breach, says attorney Elizabeth Litten, also with Fox Rothschild. If you aren't sure about who is affected or if you have outdated contact information for 10 or more people affected by the breach, you'll need to post a notice on your website's homepage or on broadcast media for at least 90 days.
5. **Record the steps you took to notify people about a breach.** “It's useful to document,” says Kline. For instance, some providers in OCR's recent HIPAA audit couldn't demonstrate compliance with the breach notification requirements because they hadn't documented what they'd done.
6. **Remember your other breach notification obligations.** Have the link to report to HHS handy in case the breach involves 500 or more patients, and create a model press release for the media if you determine that is the appropriate notification method (*MPCA 1/20/2014*). ■

RESOURCES:

OCR Audit report: www.hhs.gov/sites/default/files/hipaa-audits-industry-report.pdf

HHS guidance on breach notification: www.hhs.gov/hipaa/for-professionals/breach-notification/index.html

Presence Health resolution agreement: www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/presence/index.html

*Rules & regulations***CMS designs drastic changes to its split/shared policy***By Julia Kyles, CPC*

Take careful notice of CMS' proposed split/shared visit policy if your practice's physicians and qualified health care professionals (QHP) regularly team up for hospital visits. CMS' plans for split/shared visits in 2022 bear little resemblance to the original policy.

In fact, the proposed plan contains elements of the split/shared policy for time-based office visits with a few extra twists, according to *Medical Practice Compliance Alert* analysis of the proposed 2022 Medicare physician fee schedule released July 13 (*MPCA 8/2021*).

CMS recently withdrew its guidelines for split/shared visits from Internet-only Manual 100-04, Chapter 12, §30.6, and stated it would create a new policy through the rulemaking process (*MPCA 6/2021*). Under CMS' proposed split/shared policy, two things would stay the same:

1. The visit must be performed by a physician and a QHP who are from the same group and who can bill Medicare directly for E/M services.
2. The service may be performed in the hospital setting — i.e., observation, inpatient, outpatient or emergency department.

But notable differences include CMS' plan to lift the restrictions on billing split/shared visits for nursing facility visits and critical care services.

Perhaps the most striking difference is that practices would have to use the time-based guidelines for office E/M visits to determine which treating practitioner bills the service. The physician and the QHP would add up the time they spent on any of the nine covered activities, such as preparing to see the patient, performing an appropriate exam or counseling the patient or family members, and bill under the name and national provider identifier of the practitioner who performed more than half of the total time for the visit.

Here's an example from the proposed rule:

"If the [QHP] first spent 10 minutes with the patient and the physician then spent another 15 minutes, their individual time spent would be summed to equal a total of 25 minutes. The physician would bill for this visit

since they spent more than half of the total time (15 of 25 total minutes)." If the QHP performed the majority of the visit, it would have to be billed by the QHP.

CMS also indicates that a face-to-face visit would not be required to count time for a facility-based split/shared visit, and therefore bill the visit. For example, when outlining the activities that count toward a visit, CMS states that time should be calculated based on the performance of the specific activities "regardless of whether or not they involve direct patient contact."

Does this mean one practitioner could spend time on services that don't require a patient visit, such as ordering tests, consulting with other practitioners and coordinating care, while the other practitioner performs the in-person portions, such as the physical exam? CMS doesn't say.

CMS will maintain the requirement to combine overlapping time introduced by the new office E/M visits, and "overlapping time could only be counted once for purposes of establishing total time and who provided the substantive portion of the visit," CMS states in the proposed rule.

For example, if the physician and QHP each spend 10 minutes with the patient and meet for another five minutes to discuss the plan of care, the five minutes could be counted toward the physician's visit to give her 15 minutes — and the full 25 minutes could be billed by the physician.

CMS did not specify that, for the purposes of billing a visit, practices should use the codes' typical times, or what to do if both providers perform the same amount of time. A commenter on the rule has asked for clarification. Another area that needs clarification is how the visits will be coded. CMS notes that practices could still use medical decision making to report the services in the proposed rule.

Other proposed revisions to the policy include:

- A new modifier: "There will be a modifier needed" to report split/shared facility visits, observes Melissa Billman, director of billing services, CE Medical Group, Murray, Utah. The modifier will allow Medicare to track these services.
- New medical record requirements: "Medical records would have to list and note the two providers that treated the patient," Billman says. Practices should note that the billing practitioner "should be the one signing the records," Billman says.

- CMS also seeks comment on a variety of related topics, including how it should define a group and whether emergency department services need special guidelines. “Additionally, we are seeking public comment on whether there should be a different listing of qualifying activities for purposes of determining the total time and substantive portion of split (or shared) emergency department visits, since those visits also have a unique construct,” the agency states.

Early expert reaction is negative

Health care consultants and attorneys who read the proposed rule gave the plan poor reviews.

“I don’t understand the need to do this,” says Maxine Lewis, CMM, CPC, CPC-I, CPMA, CCS-P, president, Medical Coding Reimbursement Management, Cincinnati. Lewis predicts the modifier requirement will cause confusion and frequently be forgotten.

“I can say it’s good that you can bill based on time, but — and you have to get through all the ‘buts,’” Lewis says.

The proposed plan “portrays a revisionist history of how shared visits were covered,” says David Glaser, shareholder, Fredrikson & Byron’s Health Law Group, Minneapolis. Glaser did not mince words in his critique of the proposal, which he described as “terrible.”

“Under the manual language defining shared visits, if the physician walked in and said, ‘How are you doing?’ to the patient, thereby obtaining history elements, it was appropriate to bill a shared visit. That is totally consistent with the way the incident to rules work; there is no ‘minimum threshold’ the supervising physician must meet to bill,” Glaser says.

“Time is a bad way to determine how important someone’s work is,” Glaser says. “The proposal sets up a situation where you might have a physician have a 20-minute conversation with a [nurse practitioner (NP)], but if the NP spends an additional one minute with the patient, the physician isn’t allowed to bill at all for the service the physician provided, and the total time of 41 minutes between the two professionals is compensated as 21 minutes of NP time. That is ill-conceived.”

Glaser also dismissed the signature requirement as a “purely bureaucratic” requirement. “A signature proves absolutely nothing,” Glaser says. The note simply needs to clearly indicate who performed the service.

Plan could pass as-is

This proposal has garnered little attention and fewer direct objections according to a review of the published comments for the proposed rule. To date CMS has received four comments on the split/shared component of the rule. CMS could interpret silence on the matter as approval of the plan and roll it out in its current form. Members of the public have until Sept. 13, 5 p.m., ET, to submit a comment. ■

Rules & regulations

HHS rule creates new protections for providers in civil enforcement actions

By Marla Durben Hirsch

Providers now have additional safeguards should they get caught up in an HHS civil enforcement action. The Transparency and Fairness in Civil Administrative Enforcement Actions Rule, effective Jan. 12, was released by HHS and designed to improve accountability, clarify the proper use of guidance by agencies during an investigation or other enforcement action, and provide more opportunities for providers to be heard when they are the subject of one.

Here’s how the new rule levels the playing field for practices and other providers:

- Civil enforcement actions (defined as actions with legal consequences taken by HHS based on alleged violation of the law) must be based on violations of statutes and regulations. HHS can’t use guidance documents to impose binding requirements or prohibitions except as authorized by law or expressly incorporated into a contract.
- There must be more fairness and notice in civil enforcement actions so that providers have reasonable certainty or fair warning of what a legal standard requires. There will no longer be an “unfair surprise” about interpretations or when imposing penalties or adjudging past conduct.
- Providers have a new opportunity to be notified about and contest agency determinations before the agency takes most civil enforcement actions.
- HHS must give fair notice on new or expanded claims of jurisdiction (such as a claim to regulate a new subject matter) in either the Federal Register or the new HHS guidance repository.

“Enforcement needs to be fair and transparent,” says attorney Brenna Jenny, with Sidley Austin, LLP in Washington D.C. Jenny is a former HHS Deputy General Counsel.

The rule is a companion rule to the new Good Guidance Practices Rule allowing providers to petition against guidance not based on statutes or regulations that have not gone through applicable public notice and comment rulemaking (*MPCA 6/2021*).

If a provider is subject to claims denials, exclusion, civil monetary penalties, or other enforcement action based on noncompliance with a guidance document that was not based on a law or regulation, the rule provides a new avenue to challenge the enforcement action, says attorney John Retzinger, with Epstein Becker & Green in Los Angeles. ■

RESOURCES:

Transparency and Fairness in Civil Administrative Enforcement Actions Rule: www.federalregister.gov/documents/2021/01/14/2021-00592/department-of-health-and-human-services-transparency-and-fairness-in-civil-administrative

Good Guidance Practices final rule: www.federalregister.gov/documents/2020/12/07/2020-26832/department-of-health-and-human-services-good-guidance-practices

Privacy & security

9 steps to meet the HIPAA cybersecurity safe harbor

By Marla Durben Hirsch

The HITECH Act amendment that creates a safe harbor for practices and other covered entities that demonstrate a robust cybersecurity program is a great incentive to beef up your organization’s cybersecurity hygiene (*MPCA 7/2021*).

Follow nine steps to take advantage of this safe harbor:

1. **Start with the basics.** Review how well you comply with HIPAA to see what needs improvement. This includes your cybersecurity policies and procedures, training, software updates, daily computer backups, and management of identified vulnerabilities. “Make sure your cyber hygiene is at the highest level,” says Lee Barrett, CEO and executive director of the Electronic Healthcare Network Accreditation Commission (ENHAC), Simsbury, Conn.

2. **Make a commitment to fit into the safe harbor.** “You need someone to captain the project, some money and time,” says attorney Michael Kline, with Fox Rothschild in Princeton, N.J. “If you haven’t done anything it’s less defensible,” he points out.
3. **Document what you’ve done to improve your cybersecurity.** Your practice will need to identify which of the cybersecurity statute’s “recognized security practices” it opted to comply with and then follow through. “You’ll need to show that you followed the provisions of [an applicable] law,” says attorney Elizabeth Litten, also with Fox Rothschild.

The amendment provides some leeway in which law to utilize, but Litten suggests that providers rely on the Cybersecurity Act of 2015. HHS issued voluntary cybersecurity practices and recommendations for providers of all sizes based on this law in 2018 (*MPCA 8/2021, 6/2021, 5/2021, 2/2019*). The NIST framework has a lot of tedious details. It’s more realistic to look at the Cybersecurity Act’s voluntary guidelines, Litten says.

4. **Hire a consultant to bring the practice up to speed** if your practice lacks the staff power. Some practices that don’t have the capability internally may need to outsource this task. “Practices need to ratchet the bar up on their hygiene and putting [that responsibility] on a practice’s administrator is a risk because the administrator doesn’t have the knowledge [of IT] and to know what to look for,” says Barrett.
5. **Start the clock ticking.** To take advantage of the safe harbor, you need to demonstrate that you have been complying for at least 12 months. So the sooner your practice implements the statutory cybersecurity measures, the sooner you can hit that one-year mark.
6. **Make your actions effective.** Nicholas Heesters, senior advisor for cybersecurity at the HHS Office for Civil Rights (OCR), confirmed at the virtual Thirtieth National HIPAA Summit in March that one criterion the OCR will look is whether the steps the practice took to reduce the risk of a breach are working.

7. **Find out who is offering financial support.** The rules that revised the Stark physician self-referral law and the Anti-Kickback Statute made it easier for physicians to receive cybersecurity technology and services from organizations such as hospitals and accountable care organizations (*MPCA 3/2021*). This may be an easy, inexpensive way to beef up your cybersecurity. Just make sure to comply with those rules when accepting this assistance. Hospitals and software vendors may even offer additional resources, such as a mini cybersecurity assessment, says Litten.
8. **Select certified health IT vendors.** Using electronic health record and practice management systems that have security accreditation or certification is another way to enhance your own cybersecurity, and less expensive than obtaining it directly from an accrediting organization. “You don’t have to go through certification/accreditation yourself,” but you can find out whether your vendor has this credential and ask your vendor to go through this if it hasn’t already,” says Barrett. “The more vendors hear this request, the more likely the vendors will explore it,” he says.
9. **Watch for additional clarification from the OCR.** The amendment is short and vague; stakeholders should expect further guidance as the government begins to apply it to investigations. “We’ll have to work it out over time,” says Timothy Noonan, deputy director for health information privacy for the OCR, also speaking at the Summit. ■

RESOURCES:

The HITECH amendment: www.congress.gov/116/bills/hr7898/BILLS-116hr7898enr.pdf

NIST cybersecurity framework: www.nist.gov/cyberframework/online-learning

Billing & coding compliance

Prepare for a coding upgrade, review new, revised codes now

By Julia Kyles, CPC

Prepare your practice for compliant billing and coding in 2022 with a preview of the annual code updates contained in the proposed 2022 Medicare physician fee schedule released July 13.

Keeping up with new codes means more than keeping revenue on track. Claims with deleted codes are a red flag for fraud. For example, that someone

is automatically billing for services that weren’t performed and not paying attention to updates. At the very least, it says a practice isn’t keeping up with the rules, which can trigger unwanted attention and audits. Reporting codes that have been revised based on outdated definitions and guidelines can create faulty documentation and improper payments that lie hidden until a chart audit.

The proposed rule includes a list of new services that will be covered under the Part B fee schedule in 2022, which means most new laboratory codes aren’t listed in this proposed rule. CMS provides the full descriptors for the codes along with placeholder codes that will be updated in the 2022 CPT Manual. However, take note: The descriptors in your 2022 CPT manual may vary slightly from what is listed in Table 13 of the proposed rule.

You’ll find more information about the new codes in Addendum B — Relative Value Units (RVU) and Related Information Used in CY 2022 Proposed Rule, including the global periods and the relative value units that will determine the national payment. You can comment on the proposed RVUs until Sept. 13, 5 p.m., ET.

Use the following overview to understand the coding changes that may impact your practice.

E/M services: Care management

Add-on codes will be a notable addition to chronic care and principal care management codes in 2022. Physicians and other qualified health care professionals (QHP) who report the 20-minute chronic care management (CCM) service (**99491**) will be able to bill for additional time spent on the services in 30-minute increments thanks to a new code. In addition, the E/M codes that will replace 30-minute principal care management (PCM) codes **G2064** and **G2065** will each have a primary code based on who performed the service and a 30-minute add-on code.

CMS plans to tweak reimbursement for the primary PCM code downward to bring it within a couple of dollars of the pay for 99491. However, CMS solicited comments “on whether keeping professional PCM and CCM at the same value creates an incentive to bill CCM instead of billing PCM when appropriate.”

Finally, CMS is “interested in understanding more about the standard practice used by practitioners to obtain beneficiary consent for these services.”

Anesthesia

Utilization concerns prompted the deletion of codes for anesthesia for percutaneous image-guided procedures of the spine (**01935-01936**) and the creation six new codes. Based on the descriptors, the codes reflect the complexity of the procedure and the section of the spine. CMS assigned a base unit value (BUV) of 4 to four of the codes and reserved the BUV of 5 currently assigned to 01935-01936 for anesthesia performed with neuromodulation or intervertebral procedures.

Cardiovascular system

A code was created “as a new add-on code to report transcatheter placement and subsequent removal of cerebral embolic protection device(s),” CMS says in the proposed rule. The code’s descriptor states, “Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure).”

You’ll find three new codes to “describe open and thoroscopic left atrial appendage management procedures when performed as stand-alone procedures or in conjunction with other procedures. The codes represent new technology and surgical techniques that may be used to treat atrial fibrillation at the time of another surgical procedure,” CMS says in the proposed rule. The two new primary codes will have a 90-day global period, according to Addendum B.

There will be two new codes “to report endovascular stent repair of coarctation of the thoracic or abdominal aorta” and one new code “to report trans-luminal angioplasty for repair of native or recurrent percutaneous coarctation of the aorta,” CMS explains in the proposed rule.

You will report a new code for endoscopic radial artery harvest via an endoscopic approach, and **35600** will shed its add-on code status and be revised “to only include an open approach for the upper extremity harvesting procedure,” CMS says in the proposed rule. The new descriptor will be “Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open.” The current descriptor is “Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure).”

According to the Relative Value Scale Update Committee (RUC) of the AMA, the services are performed almost exclusively with CABG procedures, CMS says in the proposed rule.

Digestive system

The description of the new code for drug-induced sleep endoscopy is the same as what is described for code **31575** with the additional component of the patient being sedated. The descriptor for the new code will be “Drug induced sleep endoscopy; with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep disordered breathing; flexible, diagnostic.” The procedure is performed with a flexible endoscope or laryngoscope and has a global period of 000.

Per-oral endoscopic myotomy (POEM) involves the visualization and dissection of the esophageal muscle layers via an endoscope to treat esophageal motility disorders such as achalasia. The new code’s descriptor will be “Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM]),” and CMS assigned a 90-day global period. “This procedure accomplishes a comparable myotomy to what traditional open and laparoscopic myotomy (Heller),” CMS states.

Urinary system

Four CPT Category III codes that report periurethral adjustable balloon continence devices will be replaced by four permanent codes. A comparison of code descriptors indicates the Category III codes are **0548T-0551T**. However, CMS agreed with the RUC recommendation that the permanent codes be carrier-priced.

The permanent codes for placement of the balloon continence device include image guidance rather than fluoroscopy, which is included in the Category III codes and will have a 10-day global period. The balloon removal and adjustment codes will have a 0-day global period.

Nervous system

Two new codes for a novel procedure called laser interstitial thermal therapy (LITT) will be added to the nervous system chapter of the 2022 CPT manual. The intracranial procedure includes one or more burr holes, with magnetic resonance imaging guidance. One code describes a single trajectory for one simple lesion. The second code describes multiple trajectories for “multiple or complex lesion(s).”

The procedure “involves multiple steps and movements of the patient through the hospital for different stages of the procedure. The typical facility does not have an interoperative MRI suite (a small minority of academic medical centers may), so patient transport is necessary,” CMS explains in the proposed rule. The service will have a 0-day global period.

Watch for two add-on codes for lumbar arthrodesis decompression to treat conditions such as lateral recess stenosis. The codes will be reported when “performed in conjunction with posterior interbody arthrodesis at the same interspace,” CMS states in the proposed rule.

Three new CPT codes will replace three Category III codes (**0466T-0468T**) that are currently reported as add-on codes to cranial nerve neurostimulator codes **64568-64570**, according to CPT manual guidelines.

The permanent codes describe stand-alone services and will have a 90-day global period. Practices should also take note of the changes to the descriptors in the permanent codes. For example, the descriptor for 0466T is “Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (List separately in addition to code for primary procedure).” The descriptor for the code that replaces it will be “Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to an existing pulse generator.”

A primary and add-on code pairing will be used to report thermal destruction — such as radiofrequency ablation — of the intraosseous basivertebral nerve to treat low back pain. The primary code describes treatment of the first two vertebral bodies has a global period of 10 days. The add-on code will be reported for each additional vertebral body. Image guidance is part of the service, which follows the established pattern for pain management procedures that have been added in recent years. But unlike other radiofrequency ablation procedures to treat pain, this one is only priced for the facility setting.

Eye and ocular adnexa

You’ll see two permanent codes for extracapsular cataract removal with insertion of anterior segment aqueous drainage device, without extraocular reservoir in place of Category III codes 0191T and 0376T, plus a new Category III code for insertion of anterior segment

aqueous drainage device without cataract removal. The permanent codes will have a global period of 90 days.

A permanent code for inserting a drug eluting implant into the lacrimal canaliculus will replace Category III code **0356T**. The code will have a 0-day global period and take note of a change to the descriptor: The Category III code includes punctal dilation and implant removal when performed. The permanent code includes punctal dilation but does not mention dilation.

Auditory system

Four new codes for magnetic transcutaneous attachment to an external speech processor will replace two existing codes next year. The codes will have a 90-day global period. A comparison of the current list of CPT codes to Addendum B of the proposed rule indicates the codes slated for deletion are **69715** and **69718**, which describe implantation and replacement of osseointegrated implants with mastoidectomy.

decisionhealth
an hcpro brand

**SUBSCRIBER
INFORMATION**

Have questions on a story? Call or e-mail us.
1-855-CALL-DH1

MEDICAL PRACTICE COMPLIANCE ALERT TEAM

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

Marla Durben Hirsch, x6015
Content specialist
mdurbenhirsch@decisionhealth.com

Julia Kyles, CPC, x6015
Content specialist
jkyles@decisionhealth.com

Medical Practice & Hospital community!

 www.facebook.com/DecisionHealthMP
 www.twitter.com/DH_MedPractice
 www.linkedin.com/groups/4048762

SUBSCRIPTIONS

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

REVENUE CYCLE FORUM

To join the free medical practice revenue cycle forum, our free Internet forum for revenue cycle specialists, including compliance managers and auditors, go to <http://practiceforum.decisionhealth.com/> and register.

COPYRIGHT WARNING

Copyright violations will be prosecuted. *Medical Practice Compliance Alert* shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal photocopying or electronic redistribution. To report violations contact: Brad Forrester at 1-800-727-5257 x8041 or email bforrester@dlr.com.

REPRINTS

To request permission to make photocopy reprints of *Medical Practice Compliance Alert* articles, call 1-855-CALL-DH1 or email customer service at customer@decisionhealth.com. Also ask about our copyright waiver, multiple copy and site license programs by calling the same number.

Medical Practice Compliance Alert® is a registered trademark of DecisionHealth. *Medical Practice Compliance Alert* is published 12 times/year by DecisionHealth, an HCPro brand, 100 Winners Circle, Suite 300, Brentwood, TN 37027. ISSN 1047-1863. www.decisionhealth.com Price: \$547/year.

Copyright © 2021 DecisionHealth, an HCPro brand, all rights reserved. Electronic or print redistribution without prior written permission of DecisionHealth is strictly prohibited by federal copyright law.

decisionhealth
an hcpro brand

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered and is NOT intended to be used as a substitute for legal advice. It is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the service of a competent professional should be sought.

The CPT Editorial Panel also made “revisions to differentiate implantation, removal and replacement of the implants,” CMS explains in the proposed rule. For example, in the descriptor for **69714** (Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy), the words “cochlear stimulator; without mastoidectomy” will be deleted.

Radiology

Four codes for trabecular bone score — an imaging service used to evaluate osteoporosis — will debut next year. Two codes include an interpretation and report of the image, the other two describe technical aspects of the procedure and will be practice expense-only codes.

Laboratory and pathology

Clinical pathology consult codes 80500 and 80502 will be replaced with four new codes that are modeled after the codes for office E/M visits: The consults will be coded based on the amount of medical decision-making or time. For example, “Pathology clinical consultation; for a clinical problem with limited review of patient’s history and medical records and straightforward medical decision making. When using time for code selection, 5-20 minutes of total time is spent on the date of the consultation.” In addition, there will be a prolonged service code for each additional 30 minutes.

Medicine

The Category III code for capsule endoscopy of the colon (**0355T**) will be replaced with a permanent code that will have the same descriptor: “Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report.” Note that Medicare administrative contractors issued local coverage determinations that allow coverage of the carrier-priced Category III code earlier this year, so practices don’t need to wait to perform this service.

Transesophageal and transthoracic echocardiography for congenital cardiac anomalies for the assessment of cardiac structures will pick up a “new add-on code to describe the 3D echocardiographic imaging and post-processing,” during the primary procedure.

“The 3D imaging could be performed as a follow-up to a 2D transthoracic echocardiogram,” CMS states.

Cardiac catheterization for congenital defects will be reshuffled next year. Five new codes that include

“imaging guidance by the proceduralist to advance the catheter to the target zone” will replace four current codes. A comparison of the current CPT codes to Addendum B of the proposed rule indicates that **93530-93533** will be deleted. In addition, cardiac output measurement codes **93561-93562** will be replaced by one add-on code that can be reported in conjunction with the new cardiac defect codes.

As is the case with the codes they are replacing, the professional component of each code will be covered. The global code and the technical component will be carrier-priced.

Outpatient pulmonary rehabilitation code (**G0424**) will be replaced by two new codes that describe the service performed with or without continuous oximetry monitoring. CMS will cover both codes, but it expects that providers will only report the continuous oximetry monitoring code “since it is our understanding that pulmonary rehabilitation is typically provided with pulse oximetry, and therefore, we expect little to no utilization next year” of the service without oximetry monitoring, according to the proposed rule. Practices should take this as a warning that reporting the non-oximetry code may get their claims flagged.

CMS intends to cover the five new remote therapeutic monitoring (RTM) codes. But it has several questions about the codes. For example, it isn’t sure who is supposed to perform the services. For example, CMS notes that “according to RUC documents, primary billers of RTM codes are projected to be nurses and physical therapists,” and that stakeholders have suggested that the new codes were created “to allow practitioners who cannot bill [remote physiologic monitoring (RPM)] codes to furnish and bill for services that look similar to those of RPM.”

RPM codes are E/M services and off-limits to providers such as physical therapists. However, the RTM services contain incident-to services, and “as constructed currently cannot be billed by, for example, physical therapists,” CMS says. It seeks comments on how to rectify the matter. ■

RESOURCES:

Proposed 2022 Medicare physician fee schedule: www.govinfo.gov/content/pkg/FR-2021-07-23/pdf/2021-14973.pdf

Addendum B — Relative Value Units (RVU) and Related Information Used in CY 2022 Proposed Rule (zip file): www.cms.gov/files/zip/cy-2022-pfs-proposed-rule-addenda.zip