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Part B News
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In this issue

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Practice management

NPPs get hired without licenses, despite exclusion; keep your guard up

A no-longer-licensed physician assistant (PA) was hired by a practice and worked as a PA on thousands of cases before being found out, leading to a prison sentence for her and a potential loss of thousands in billings for the practice. The case is a reminder that you have to make sure not only that your clinical workers meet specific licensing requirements, but also that you don't let them veer out of compliance and put you and your patients at risk.

Though Theresa Pickering had experience as a PA, she had been without a valid license since she lost her Mississippi credentials in 2015, when she was discovered to have "falsely claimed to have a supervisor physician and falsely represented herself to be a physician" in a drugs-and-fraud scheme, according to an indictment filed against her in Georgia in 2022. In fact, in addition to losing her license, Pickering was also convicted of Medicaid fraud, served a prison sentence and was excluded from federal health care programs by HHS.

Yet in 2019 Pickering was hired and went to work at Greater Atlanta Family Medicine (GAFM) in Norcross, Va. Over about a year and half she was responsible for "4,200 fraudulent claims for reimbursement, seeking at least approximately $147,000," according to the indictment.

"Pickering treated patients, diagnosed illnesses, ordered diagnostic tests and lab work, handled sick visits, and prescribed drugs to patients, none of which was authorized by law based on [her] lack of licensure as a physician's assistant and exclusion from federal health care programs," the indictment states. She was also charged with using the identity of a locum tenens doctor working at the practice without the doctor's knowledge to write prescriptions.

Prepare for prior auth for facet joints

Effective July 1, 2023, you'll need a prior authorization for facet joint interventions (64490-64495 and 64633-64636) performed in the outpatient setting. And that's not the only risk to your facet claims. The HHS Office of Inspector General (OIG) checked on compliance with the new uniform local coverage determination (LCD) and found significant problems. Ward off challenges by tuning into the live webinar **Facet Joint Interventions: Prepare for Prior Authorizations and More Medicare Audits** on June 6. Learn more: *www.codingbooks.com/ympda060623*.

Found guilty of health care fraud, Pickering was sentenced to 33 months in prison and ordered to pay $48,742 in restitution, about a third of the fraudulent claims. While it's not specified in the legal judgment, it's likely the practice will be on the hook for at least some of the remaining claims.

Don't trust, verify

Experts agree there was no way for Pickering to have been hired with her record without some major failure in vetting by the practice.

"Verifying a provider's license is as basic as it gets when hiring clinicians — step number one, always for licensed positions," says Sam Arora, CEO of the Arora Group, a health care staffing company in Gaithersburg, Md. "If a facility is not [doing] something that basic to protect their patients, there will be questions about what else it may or may not be doing."

While the Pickering case is particularly egregious, circumstances have made it easier for a similar slip-up than it used to be, says Elizabeth L.B. Greene of Mirick O'Connell in Worcester, Mass.

"There is a shortage of medical providers across the country, which may make some practices more likely to bring on providers more quickly, in an effort to ease the burdens on their overworked providers and support their patients," Greene says.

Manpower shortages are general in U.S. health care at present (*PBN 4/10/23*). They're especially dire in nursing and can lead to provisional hiring that can slip into the danger zone, according to Alice Benjamin, APRN, MSN, ACNS-BC, FNP-C, CCRN, CEN, CV-BC, chief nursing officer and correspondent for nursing community resource *Nurse.org*.

"When someone graduates from nursing school, they're not able to use 'protected professional titles' until they're actually fully licensed — but sometimes employers are so eager to hire [nurses], they'll do it before they're fully licensed with the expectation that getting licensed will be uneventful and within a reasonable and usual time frame," Benjamin says.

Different states have different limitations on the kind of work nurses hired on this basis can do. In California, "they have something called Interim Practice Permit where a recent nursing school graduate or a licensed nurse from another state can pay fees to get an interim permit that allows them to practice [before full licensing]," Benjamin says. "You have to be supervised; there's a time limit and the expectation is that you'll take the boards and be fully licensed." Under such circumstances it's possible that, unless the provider and the practice stay on top of things, a provider might drift into actions that exceed their scope of practice.

Greene adds that fraud schemes, including fraudulent credentials, "have become increasingly easy to obtain and difficult to ferret out" in recent years, adding to the danger.

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Not just the license

Nadia de la Houssaye, co-leader of the Jones Walker law firm's health care litigation team and chair of the firm's health care industry telemedicine team in Lafayette, La., says that along with a "background check, criminal records included," every clinical hire should be checked against the National Practitioner Data Bank.

"The NPDB was established in 1986 under the Health Care Quality Improvement Act as a tool to prevent what happened in Georgia — incompetent practitioners going state to state without disclosing adverse actions related to licensure, clinical privileges, malpractice lawsuits and other major disciplinary review," de la Houssaye says. A query "can prevent occurrences like this because it mandates reporting a host of adverse events involving a health care provider."

"In situations like this there should be a system of checkpoints to make sure the provider has met all their requirements until they're fully licensed to practice," Benjamin adds.

Also, de la Houssaye says, "licensure requirements are regulated at the state level, [and] one of the more difficult areas to navigate is whether a particular state requires that a mid-level enter into a collaboration agreement with a physician to oversee the mid-level's patient care. In many states, including Louisiana, you have to file a collaboration agreement with the state licensing board before you can get licensed."

But none of these were issues in the Pickering case. "The hirer did not run a background check nor review the NPDB, state licenses, nor other certifications," de la Houssaye says. "If they did, there was screaming evidence that the practitioner was lying about her credentials."

And just as Pickering had to face the consequences of her actions when she was found out, so will the practice — at the very least having to pay back the insurance claims on which Pickering was cited.

"Running a practice is expensive," de la Houssaye says. "Every time an entity runs a background check, there is a cost and time element to it. Some small practices may not have the resources. But frankly in today's world, you can't afford to not run a background check." — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCE

- U.S. Department of Justice, "Former physician's assistant sentenced for health care fraud after posing as a licensed practitioner," April 18, 2023: www.justice.gov/usao-ndga/pr/former-physicians-assistant-sentenced-health-care-fraud-after-posing-licensed

Compliance

Proposed HIPAA rule would protect PHI related to reproductive health care

Prepare to update your HIPAA compliance plan. A proposed rule issued by the HHS Office for Civil Rights (OCR) on April 12 would require stronger guards on protected health information (PHI) related to reproductive health care (*see sidebar, p. 4*).

The OCR published the HIPAA Privacy Rule to Support Reproductive Health Care Privacy in response to the Supreme Court decision *Dobbs v. Jackson Women's Health Organization*.

"Since the *Dobbs* decision, there has been concern among clinicians that a patient's protected health information could be used to criminalize patients for seeking and clinicians for providing needed reproductive health care," says Rachel Tetlow, director of federal affairs with the American College of Obstetricians and Gynecologists (ACOG).

"This has been especially concerning among clinicians who may treat patients who travel out of state for abortion care," Tetlow says. "Some have expressed concern that including a record of that care in the patient's files could put both the patient and the clinicians themselves in legal jeopardy. These worries are shared among patients and could result in patients delaying or avoiding needed health care."

Covered PHI disclosures now prohibited

The OCR also expressed concern that the fear of prosecution might prevent patients from seeking and providers from performing reproductive health care. Current HIPAA regulations permit covered entities, including providers, health plans and business associates, to disclose PHI "for the purpose of a subpoena, court order or to law enforcement as evidence of criminal conduct on its premises," says Sara Shanti, partner with Sheppard Mullin in Chicago.

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Even though the current rule implies that providers can decide whether they will disclose PHI, the rule isn't likely to stand up to a court order, Shanti cautions. "Where an administrative or court order requires disclosure, it would likely prevail over any HIPAA defense. Additionally, HIPAA allows the disclosure of PHI for a purpose required by law, like where a state requires reporting of a certain condition or procedure," she says.

The proposed rule would change that by prohibiting covered entities "from using or disclosing PHI for an investigation or proceeding against any person in connection with seeking, obtaining, providing or facilitating reproductive health care," Shanti says. "The entities would also be prohibited from using PHI to identify a person in order to initiate any such activity."

According to the proposed rule, the prohibition would cover PHI related to three scenarios:

1. A patient who lives in a state where a service or treatment covered by the rule is illegal seeks or receives the service or treatment in a state where it is legal.
2. A patient who receives a service or treatment that is required by federal law, such as miscarriage management under the Emergency Medical Treatment and Labor Act (EMTALA).
3. A patient who lives in and seeks or receives a covered service or treatment in a state where it is legal.

The prohibition would not apply if the service or treatment described in the rule is performed in a state where it is illegal.

"Overall, this proposed rule takes important steps to protect patients and physicians from misuse of reproductive health care information. ACOG greatly appreciates the approach taken by the [OCR] and looks forward to providing more detailed feedback on these provisions as well as their implementation, education, and resources ahead of the final comment deadline," Tetlow says.

Proposed rule requires attestations, updated NPPs

"The proposed rule would also require a specific attestation, with a clear statement that PHI disclosed for certain oversight or judicial purposes is not for any criminal, civil or administrative investigation into or proceeding against any person in connection with seeking, obtaining, providing or facilitating reproductive health care," Shanti says.

According to the OCR, providers and other covered entities would need to receive a signed attestation from the person, organization or legal entity that requests covered PHI in the following situations:

- Health oversight activities.
- Judicial and administrative proceedings.
- Law enforcement purposes.
- Disclosures to coroners and medical examiners.

Tetlow describes the attestation requirement as an important obligation that creates a minimal burden on practices. "ACOG is in agreement with the [OCR] that the minimal burden this would incur on practices and covered entities is overshadowed by the benefits of increased protection of reproductive health care information from inappropriate use," she says.

Providers would also need to update their Notice of Privacy Practices (NPP), Shanti says.

Compliance

OCR seeks public input on reproductive health definition

The HHS Office for Civil Rights (OCR) intends to create a specific definition for reproductive health to clarify the types of protected health information (PHI) that are covered by the proposed update to the privacy rule (*see story, p. 3*). The OCR would define reproductive health care as "care, services, or supplies related to the reproductive health of the individual," according to the proposed rule released April 12.

The term would apply to health care performed or prescribed by a provider and "care, services, or supplies furnished by other persons and non-prescription supplies purchased in connection with an individual's reproductive health."

The OCR intends for the definition to be as broad as possible and created an extensive list of examples, including contraception, pregnancy-related health care, infertility treatments and treatment of the reproductive system. However, the agency requested public comment on the definition and whether a separate definition of reproductive health care is necessary. Comments on the proposed rule are due June 16. – *Julia Kyles, CPC* (*jkyles@decisionhealth.com*)

RESOURCES

- Proposed rule – HIPAA Privacy Rule to Support Reproductive Health Care Privacy: www.federalregister.gov/d/2023-07517
- Submit a comment online: www.regulations.gov/document/HHS-OCR-2023-0006-0001

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Benchmark of the week

Total ABN modifier use up in 2021, but three of four fell hard

Practices' use of the four modifiers related to advance beneficiary notices of non-coverage (ABN) was steady overall between 2020 and 2021. But gains and losses in 2021 were differently distributed than they had been the previous year, with three modifiers taking a nosedive.

An earlier review of the first pandemic year (2020) figures showed claims with **GX** (Notice of liability issued, voluntary under payer policy) and **GZ** (Item or service expected to be denied as not reasonable and necessary) were climbing, while claims with **GA** (Waiver of liability statement issued as required by payer policy, individual case) and **GY** (Item or service statutorily excluded, does not meet the definition of any Medicare benefit) were dropping (*PBN 4/25/22*).

This new analysis looks at the claims numbers from 2015 to 2021. The overall rise in ABN claims as determine by the utilization of these modifiers was modest overall. In 2015, there were 143.5 million claims with the ABN modifiers; in 2021, there were 148.2 million, which marks a slight drop from the 148.5 million total in 2020.

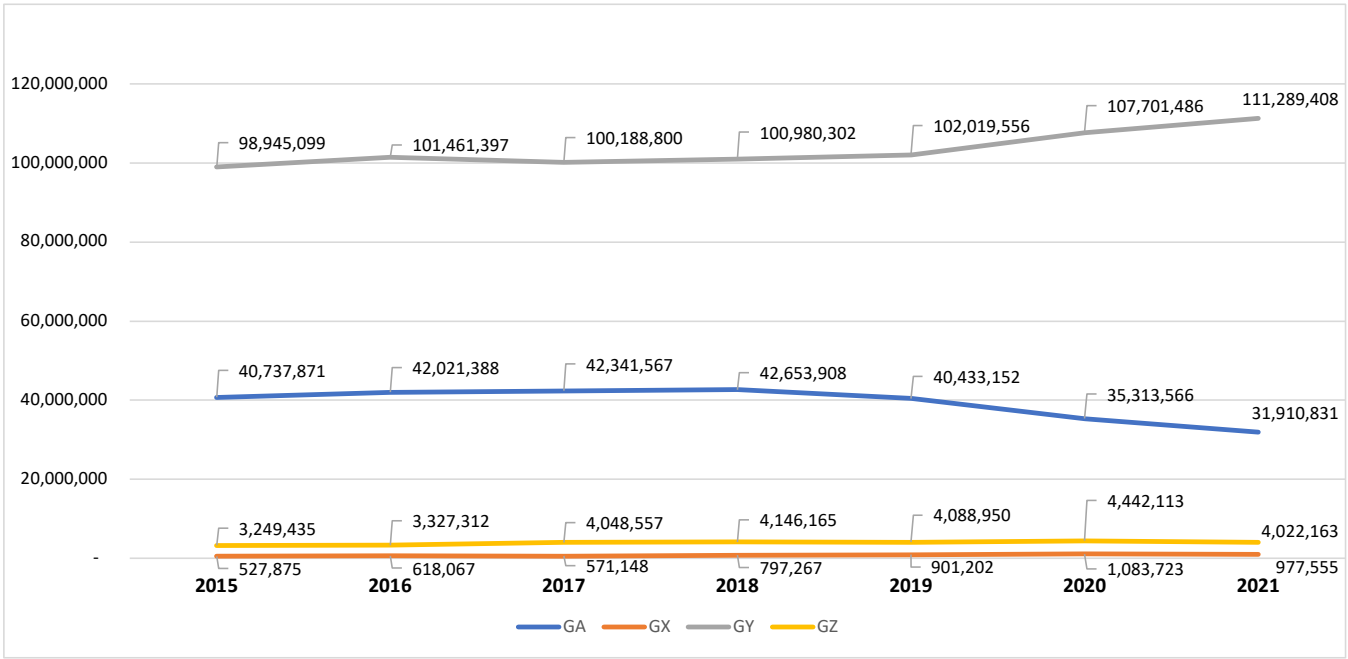
As the chart shows, GX and GZ were on the rise between 2015 and 2019: GZ rose about 26% over those five years and GX surged 71%.

GY trended slightly up over the first five years in review, rising 3%, while GA trended slightly down, by 0.7%. The pandemic does not seem to have altered those trends on GY and GA much beyond what the prior years were promising: from 2020 to 2021, GY use rose 3.3%, a figure presaged by the steady climb (1% in 2018, 1% in 2019) that preceded it.

GA's 9.6% drop seems big compared to the five-year trend, but between 2018 and 2019 it fell 5.2%, so it was already showing signs of a fall. Modifiers GX and GZ, however, took a sudden dive; from 2020 to 2021, GZ dropped by 9.4%, and GX by 9.7%.

In 2021, the 10 most-used code/ABN modifier combos accounted for 86.1 million, or 58%, of all such claims. Claims for **A4520** (Incontinence garment, any type, each) with GY topped the list, while **B4152** (Enteral formula, 100 calories) was the leader with GA. The top code with GX was **A9276** (Sensor; invasive [e.g., subcutaneous]) with 476,491 claims, and with GZ the leader was **B4152** with 311,994 claims. – *Roy Edroso* (*redroso@decisionhealth.com*)

ABN modifier utilization, 2015-2021



Source: Part B News *analysis of 2015-2021 Medicare claims data*

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Under the current rule the NPP must include permitted disclosures of PHI. According to the proposed rule, providers would update their NPPs to include prohibited disclosures "in sufficient detail for an individual to understand this prohibition and the proposed attestation requirement."

Comment on the rule, follow HIPAA to the letter

Members of the public can comment on the proposed rule until June 16. Until the OCR issues a final version of the proposed rule, practices should stick to current HIPAA requirements. For example, practices must apply the minimum necessary standard to all PHI disclosures.

"Practices should follow due diligence with protecting all health information, including reproductive health care information. This includes following HIPAA Privacy Rules around prohibitions of use and disclosure of such information and following relevant health information technology standards for electronic exchange of information set forth in [the] regulation," Tetlow says. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

RESOURCES

- Proposed rule – HIPAA Privacy Rule to Support Reproductive Health Care Privacy: www.federalregister.gov/d/2023-07517
- Proposed rule fact sheet: www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/hipaa-reproductive-health-fact-sheet/index.html
- Submit a comment online: www.regulations.gov/document/HHS-OCR-2023-0006-0001

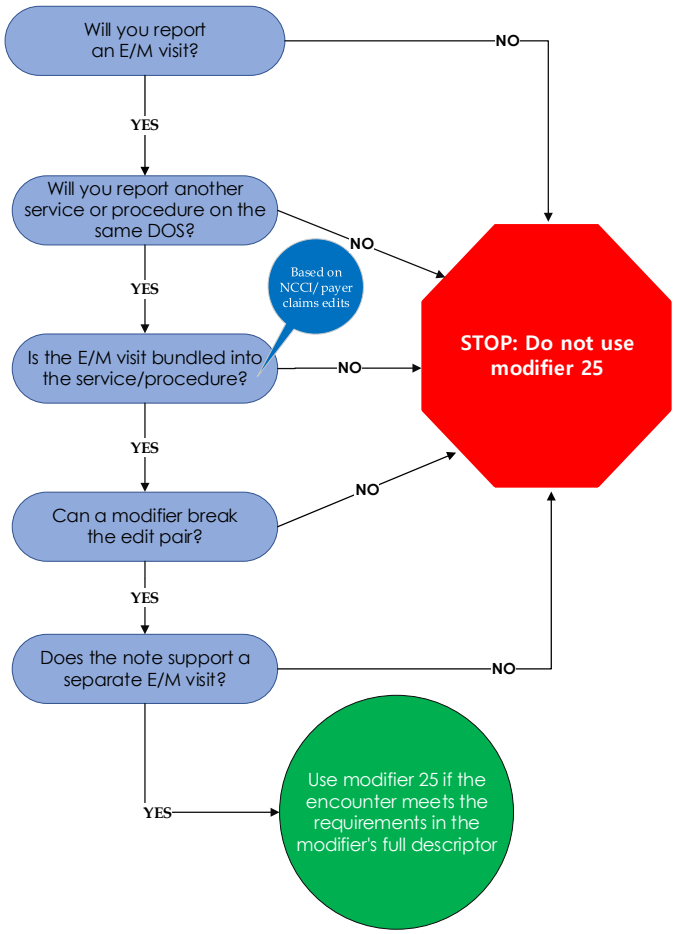
Coding

Modifier 25 decision tree can prevent denials, claims errors

Use this decision tree to improve your staff's accuracy when turning to modifier **25** (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) (*PBN 5/1/23*).

Using a decision tree can reduce easy-to-avoid denials and claims errors that tell payers the practice doesn't understand how to use the modifier. For example, even though the modifier should only be appended to an E/M code, a review of the latest Medicare Part B claims data shows that providers regularly append the modifier to procedure codes.

Modifier 25 decision chart



Also, be sure to read the full descriptor for modifier 25 when you train coders and providers. The short descriptor at the front of the CPT manual doesn't contain all of the details you need to accurately report claims. For example, the full descriptor explains that the E/M visit "is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported," based on the relevant E/M guidelines. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

Billing

Find expert tips to dodge real-time CPT coding and billing errors

Editor's note: *In this issue,* Part B News *welcomes guest author Thea Sinclair, content writer at Medcare MSO, which offers comprehensive RCM services for 40-plus medical specialties, to provide a roadmap for avoiding common coding and billing snafus that can lead to revenue loss.*

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Receiving payments for rendered physician services relies on clean claim submission with accurate CPT codes. Healthcare providers and coders alike can increase revenue cycle management (RCM) efficiency by adhering to medical coding and billing best practices.

This article reviews common CPT coding and billing errors, their causes, and gives strategies for preventing them. The bulk of this article focuses on E/M coding and compliance strategies for physician practices.

What role does medical coding play in health care?

Medical coding drives payment for diagnostic and procedural services. Diagnoses have associated ICD-10-CM codes, and procedural services have associated CPT and HCPCS Level II codes. Insurance providers, such as Medicare and Medicaid, receive service claims with these codes.

Medical coding errors can result in delayed, denied or reduced compensation. If a practice or facility receives multiple denials, it will face paperwork, stress and lost revenue.

Assess damage from inaccurate coding and billing

Medical fraud occurs when staff intentionally or unintentionally falsify claims for financial advantage. Medical abuse describes the practice of not providing patients with medically necessary services and professionally recognized standards of care.

"The difference between 'fraud' and 'abuse' depends on specific facts, circumstances, intent, and knowledge," a CMS MLN booklet explains.

Unfortunately, medical fraud and abuse are common in fast-paced emergency medicine practices, and they result in severe federal penalties and fines.

Keeping up with code updates

CMS incorporated the AMA CPT Editorial Panel's proposed changes to the code descriptors and documentation standards for E/M office visit CPT codes **99201-99215** in the final 2020 Medicare physician fee schedule. For E/M visits, the agency authorized providers to use either medical decision-making or total time beginning in 2021, which was a change from the E/M documentation rules established in 1995 and 1997.

The new guidelines also removed code 99201 and the need for detailed patient history and physical examination as part of E/M coding requirements. Further updates to E/M codes were introduced in the 2023 CPT code set.

"The process for coding and documenting almost all E/M services is now simpler and more flexible. We want to ensure that physicians and other users receive full administrative relief from the E/M code revisions. The AMA is assisting physicians and [health care] organizations in preparing for the E/M code revisions by providing authoritative resources to anticipate the operational, infrastructural, and administrative workflow adjustments that will result from the impending transition," Jack Resneck Jr., M.D., president of the AMA, stated in an announcement.

Variations to E/M codes made up a sizable chunk of the revision. CMS modified the documentation and coding criteria for E/M visits to reduce administrative burdens and improve the efficiency of the coding process. These changes affected not only practices but also nursing homes, hospitals and in-home care providers.

Payers reject claims for many reasons

If staff members do not keep up with changes to CPT and ICD-10-CM codes, it could hurt revenue. Denied claims are unpayable by insurers. Billing problems, missing paperwork, poor patient coverage and other factors can lead to denials.

An explanation of benefits (EOB) is a document created by insurers outlining the details of a denial to a practice. A practice can choose to appeal or reprocess a claim that was initially denied. This involves investigating the reason for the denial by addressing identified issues and resubmitting a claim for payment.

The following points are commonly identified coding and billing errors, their causes, and ways to reduce them.

- **Incorrect use of codes**. Assigning codes based on inaccurate documentation can result in revenue losses. Medical coders and billers should be familiar with

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the latest CPT and ICD-10-CM guidelines and adhere to compliance requirements. Avoiding billing errors during claim submission contributes to an efficient RCM cycle.

- **Upcoding**. Upcoding occurs when codes are inaccurately assigned for complicated services that were never performed. For example, an oncology coder may review documentation for a highly complex patient and accidentally code a higher-level visit service.

To prevent upcoding, the coding and billing team should get complete information on complex patient cases before submitting claims to payers. The coders and billers can obtain complete information by querying physicians when needed.

- **Unbundling codes**. Some procedural services are "bundled," or billed with other services performed during the encounter. Reporting individual parts of the procedure using several CPT codes, rather than using a single combination code, is called unbundling. Unbundling may lead to revenue losses in the form of claim rejections.
- **Not complying with the National Correct Coding Iniatiative (NCCI)**. CMS introduced the NCCI to ensure that billing teams focus on submitting Medicare Part B claims with correct codes.

"If staff members do not keep up with changes to CPT and ICD-10-CM codes, it could hurt revenue. Denied claims are unpayable by insurers. Billing problems, missing paperwork, poor patient coverage and other factors can lead to denials."

"NCCI has two provider-type choices of Procedure to Procedure (PTP) code pair edits and three provider-type choices of Medically Unlikely Edits (MUEs)," a CMS MLN booklet explains.

CMS works with the AMA and national medical and surgical societies to create edits. Edits indicate which codes should and should not be reported together and the maximum units of service that coders can report for a single patient on a single date of service.

- **Appending inappropriate modifiers**. Modifiers are used to provide additional information about procedural services. Using inappropriate modifiers can lead to claim denials and delayed payments. Appropriate documentation is necessary to justify the use of modifiers and to ensure seamless billing.

How to reduce the effects of coding errors

Maintaining an efficient revenue cycle is crucial for health care providers, and coding errors pose a serious threat to the financial side of medical practices. Medical practices can take the following actions to minimize the chance of coding errors before submitting claims.

- **Implement an efficient claim submission process**. Ensure a proactive claim submission process with efficient billing mechanisms to reduce the chance of errors that lead to claim denials. The billing and coding team should make an effective claim scrubbing process to reduce revenue leakages and obtain high-performing revenue cycles. Monitor claims carefully before submission to optimize this process.
- **Stay au courant**. Try to stay up to date with the latest payer guidelines and industry rules related to the medical billing process. Also keep patient information secure according to the Health Insurance Portability and Accountability Act (HIPAA) guidelines.
- **Dodge coding pitfalls**. Avoid upcoding, fraudulent unbundling, incorrect use of modifiers and mistakes in CPT codes. Doing so will encourage swift payments from insurance payers and increase profitability. Keep a vigilant eye on the claims and find the root cause for denials.
- **Try out new tech**. Incorporate technology in the radiology billing codes process to reduce coding errors. The use of automation makes workflows more efficient and reduces the time spent in billing and coding. It also allows providers and practice staff to spend more time with patients.
- **Outsource coding and billing to third-party medical billing companies if it makes sense to do so**. This can reduce the administrative workload of providers and practice staff. In-house revenue cycle management teams require training and this may not be cost-effective. — *Thea Sinclair* (pbnfeedback@decisionhealth.com) ■

Editor's note: *Thea Sinclair is content writer at Medcare MSO, which offers comprehensive RCM services for 40-plus medical specialties and aims to help health care facilities maximize profits. Opinions expressed do not necessarily reflect those of DecisionHealth, HCPro or any of its subsidiaries.*

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