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In this issue

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Billing

Final prior auth rule sets long lead times — and short payer deadlines

With the release of the Interoperability and Prior Authorization Final Rule, which CMS dropped on Jan. 17, providers are poised to gain a dose of relief after seeking redress to onerous prior authorization (PA) requirements for years. But it's not coming as soon as proposed.

The final rule is the long-delayed follow-up to a Dec. 6, 2022, proposed rule promising shorter and stricter timelines for payer responses to prior authorization requests, easier and faster exchange of data via application programming interfaces (API) conforming to the latest Fast Healthcare Interoperability Resources (FHIR) tech standards, and more (*PBN 12/19/22*).

There are a few tweaks to the proposed rule, notably the timelines: Most features must be fulfilled by 2027, including provisions that require API development and enhancement, although "certain operational provisions," such as annual payer reporting of API usage metrics to CMS, are due in 2026.

While the final rule also promises quick and easier exchange of other kinds of information among payers, providers and patients, the PA element of the rule is the marquee attraction for many practices. Dissatisfaction with slow, cumbersome PA protocols has been a running theme of surveys of physicians and industry leaders for many years (*PBN 3/21/22*).

The final rule has most of the reforms anticipated in the proposed rule. As proposed, Medicare Advantage (MA) organizations are among the payers impacted by it, joining state Medicaid and Children's Health Insurance Program (CHIP) Fee-for-Service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and ACA Qualified

Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFE).

Commercial plans and Medicare fee-for-service plans are not covered. Also, QHP issuers offering only QHPs in the Federally-facilitated Small Business Health Options Program Exchanges (FF-SHOPs) are exempt, and all ACA QHPs are excused from the API requirements, for now.

Due dates extended

While there had been talk of tightening the deadlines for payer response to PA requests to 24 hours for expedited requests, the final rule stipulates a 72-hour deadline for expedited requests, though regular requests retain the proposed seven-day deadline.

The PA requirements apply only to covered items and services. Authorizations of drugs are excluded as, CMS says, "the standards and processes for issuing prior authorizations for drugs differ from those that apply to medical items and services."

Payers face toughest burden

Much of the heavy lifting under this rule is done by payers. They will not only have to conform to the new technical standards and respond to requests within the stated deadlines, but also "send notices to providers when they make a prior authorization decision, including a specific reason for denial when they deny a prior authorization request."

Impacted payers also have to create, or have created for them, compliant APIs to exchange most health care data, including PA requests and responses, and "annually report to CMS certain metrics about patient data requests made via the Patient Access API," the rule states.

Martin A. Corry, chair of the government relations and public policy department with Hopper Lundy Bookman in Washington, D.C., finds this significant because "every final rule is just a precursor to another proposed rule," and the reported data "will inform future rulemaking or legislative action" that could lead to future reform.

MIPS measure added

Providers have a new mandatory MIPS measure to report, "Electronic Prior Authorization," under the Promoting Interoperability category.

The final measure is not as onerous as the one proposed. While CMS had contemplated a numerator/denominator measure, the finalized measure requires providers to "either submit an attestation (yes/no) regarding whether they used the Prior Authorization API to submit at least one prior authorization request electronically — that is, via a compliant API — or claim an applicable exclusion to report the modified Electronic Prior Authorization measures."

CMS notes that many MIPS participants will be excluded based on the inability of their payers to offer compliant API service; however, if they fail to attest positively or cite an exclusion, they will fail the measure and the category and receive a zero Promoting Interoperability score.

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***PART B NEWS* TEAM**

Maria Tsigas, x6023
Product Director
maria.tsigas@hcpro.com

Marci Geipe, x6022
Senior Manager, Product and Content
marci.geipe@hcpro.com

Richard Scott
Content Manager
richard.scott@hcpro.com

Roy Edroso, x6031
Editor
roy.edroso@hcpro.com

Julia Kyles, CPC, x6015
Editor
julia.kyles@hcpro.com

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HIPAA break

There had been some confusion over a perceived HIPAA conflict having to do with the health IT payers and providers were accustomed to use and the newer standards required by new rules.

Robert Tennant, vice president, federal affairs at the Workgroup for Electronic Data Interchange (WEDI) in Washington, D.C., explains: "The law currently requires covered entities — providers, payers, clearinghouses — conducting an electronic transaction for prior authorization to use the X12 278 transaction standard. In the proposed rule, CMS proposed to essentially require this X12 278 standard to be sandwiched in between the APIs in order to be compliant with the law."

WEDI and other stakeholders pointed out that this would be cumbersome and potentially cause a HIPAA risk, as patient data transfers between two standards might prove insecure. In the final rule, CMS extends "enforcement discretion" if covered entities implement FHIR-based PA APIs but don't use the X12 278 standard.

Enforcement remains murky

CMS refrained from specifying an enforcement agency or program to make sure payers do as they are bid according to the rule.

"Each CMS program oversees compliance under existing program authorities and responsibilities for the different types of payers impacted by these API requirements," the rule states. "Oversight and compliance procedures and processes vary among these CMS programs and CMS may choose from an array of possible enforcement actions, based on a payer's status in the program, previous compliance actions, and corrective action plans."

If payers do not comply timely, providers are directed to "contact the payer to obtain the status of the request and determine if supporting documentation is needed to complete the processing of the authorization or if there are other reasons for the delay in a decision," according to the final rule. Payers can request an extension of up to 14 days, but that requires action on their part.

What happens when providers do not gain appropriate responses from the payer? "Patients and providers may submit an inquiry or complaint to the appropriate authority, depending on their coverage," the rule says.

4 things to do ahead of time

Providers don't have the technical burdens suffered by payers. It's likely that electronic health record (EHR) and practice management system (PMS) vendors will come up with compliant health IT for their clients by the deadline.

Nonetheless Tennant has some future action items you should start thinking about planning:

- **See who's covered.** "Look at your patient base and try to determine how many [or what percentage] of your plans are covered and how many of your patients are potentially impacted," Tennant says. This will affect what you tell stakeholders like your EHR vendors what you need from them.
- **Prep for a health IT vendor conference.** You probably meet at intervals with your software vendors. Tennant suggests you ask them: "What are your plans? When do you plan to support this?" After which, "you'll want to know the timeline and the cost."
- **Talk to uncovered payers as well.** Though your commercial payers aren't required to do so, they may come into compliance as a business measure; if they don't, some providers might cut them out. Tennant says at your future meetings — during contract negotiations, for instance — you should ask, "Even though you're not required to under law, will you be supporting the FHIR APIs? If so, when are you likely to begin testing with us?"
- **Prepare to make an address book.** Each one of the plans you work with that is covered by the rule will have a different "FHIR endpoint," a sort of address for FHIR transmissions. You'll have to know these, so "think about making a FHIR Endpoint Directory, like an address book for APIs," Tennant says. "Ask your vendor if they will be compiling these payer FHIR endpoints." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- CMS, "CMS Interoperability and Prior Authorization Final Rule CMS-0057-F," Jan. 17, 2024: www.federalregister.gov/public-inspection/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

Coding

Preview updated ICD-10-CM coding guidelines for April 1

The CDC posted updated FY2024 ICD-10-CM guidelines on Monday, Jan. 22, which included a sequencing update for sepsis due to postprocedural infection.

The guidelines changes will take effect April 1, along with the April coding changes update.

Two codes are being added under sequencing guidance found at I.C.1.d.5.b, Sepsis due to a postprocedural infection, to state:

> *For sepsis following a postprocedural wound (surgical site) infection, a code from T81.41 to T81.43, Infection following a procedure,* ***T81.49, Infection following a procedure, other surgical site,*** *or a code from O86.00 to O86.03, Infection of obstetric surgical wound,* ***or code O86.09, Infection of obstetric surgical wound, other surgical site,*** *that identifies the site of the infection should be sequenced first, if known. Assign an additional code for sepsis following a procedure (T81.44) or sepsis following an obstetrical procedure (O86.04). Use an additional code to identify the infectious agent. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.*

The language under secondary diabetes mellitus due to pancreatectomy (I.C.4.a.6.b.i) will also be updated to provide further clarity. It will now state:

> *For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code E89.1, Postprocedural hypoinsulinemia. Assign a code from category E13* ***as the principal or first-listed diagnosis*** *and a code from subcategory Z90.41, Acquired absence of pancreas, as* ***an*** *additional code. — Megan Herr (megan.herr@decisionhealth.com)* ■

RESOURCE

• ICD-10-CM full guideline changes: https://tinyurl.com/hwbxx5c4

preventive-services/medicare-wellness-visits.html#AWV

Compliance

Use empathy, 'treatment plans' to spur provider engagement with compliance

If you struggle to get your compliance message across to physicians and qualified health care professionals (QHP), make sure that you can clearly communicate what you need from the provider and why you need it, and that you do so in a way that make sense to them.

That's a lesson that Jay Anstine learned early in his career and it shapes the way he works with providers. Anstine is the president of Bluebird Health Law Partners in Fort Collins, Colo., and author of *Navigating the Politics of Healthcare — A compliance officer's guide to communication, relationships and gaining buy-in.*

When you prepare for a compliance-related conversation with providers, craft an answer to the question "What do you want from me?" Anstine says. "Anticipating the question is one way to show that you know your audience," he explains.

"That came about because early on in my career I ran into an issue where I hadn't thought about that question, and [when I was asked] I never really answered the question and it was a legitimate question that should have been staring me right in the face. And so I think that has always been seared into my mind. Just make sure you always go through a mental process to prepare for the discussion. That's always the one question that I make sure I can I answer and that's true whether [I'm speaking to a] physician or clinician or even a CEO or a CFO to somebody on the administrative side," Anstine says.

Create a 'treatment plan' for each compliance problem

Showing that you've taken time to understand your audience can transform a one-way lecture into a two-way conversation and is an essential step in gaining provider buy in. "You have to spend some time critically thinking through things from their point of view and your point of view and anticipating questions," Anstine says.

Before you meet with providers, he suggests that you define the message you want to convey to the provider, the information you need from them, your goal and what you want from the provider to help achieve that goal.

(continued on p. 6)

Benchmark of the week

CMS drops prior authorization rule, projecting billions in group savings

After CMS finalized a regulatory path for easing the burden of prior authorizations, the agency offers some bullish projections on financial savings: Under the rule, individual and group physician practices would save $1.2 billion in the first year of implementation and more than $16 billion over 10 years.

The Interoperability and Prior Authorization Final Rule that CMS released Jan. 17 brings relief to physician practices seeking pre-approved services by payers (*see story, p. 1*). As background, the agency estimates that individual and group physician practices spend about 14 hours per week — totaling 728 hours per year — on the administrative work that clinicians and practice staff spend clearing service authorizations demanded by payers. That work costs practices upward of $52,000 per year.

By streamlining the approval process, CMS projects an average savings of about $21,000 per individual or group practice. Nationally, the cost-savings would amount to $1.2 billion among practices in 2027, when the new regulatory guidelines fully kick in. Between the period of 2027 and 2036, as more practices adopt the interoperability guidelines that undergird the regulatory changes, total savings would surpass $16 billion (including hospital-directed Part B services).

CMS tabulated data from multiple sources to arrive at its cost projections, including the 2022 AMA prior authorization survey data and its own clinical labor pricing estimates. Practices are likely to face a technological learning curve, as the agency predicts that roughly 25% of MIPS eligible clinicians will be set up to participate in the interoperability standards in 2027, a penetration that would increase to 50% of the nearly 200,000 individual and physician group practices by 2036. — *Richard Scott (richard.scott@decisionhealth.com)*

Total annual cost of prior authorization paperwork for physicians and group practices

Title	Hours/week	Hours/year	Labor cost ($/hour)	Total cost per staff (hours * labor)
Physicians	0.7	35.7	$210.44	$7,510
Registered nurses	9.0	467.5	$76.94	$35,969
Clerical	4.3	224.8	$40.76	$9,164
Total	14.0	728.0		
Total cost per individual and group physician practice per year				**$52,642**

Total savings for a single individual and group physician practice adopting final rule provisions

Title	Hours/year	Assumed percent reduction in hours	Total reduced hours per year	Labor cost ($/hour)	Total reduced dollar spending per year
Physicians	35.7	10%	3.6	$210.44	$751
Registered nurses	467.5	50%	233.7	$76.94	$17,984
Clerical	224.8	25%	56.2	$40.76	$2,291
Total per practice	**728**		**293.5**		**$21,026**

Total hours (millions) and dollars (billions) saved over 10 years, per proposals

Year	Savings per practice (hour)	Savings per single practice ($)	% of practices adopting the final rule	Total number of individual and group physician practices	Reduced hours per year (millions)	Reduced cost per year ($ billions)
2027	294	$21,026	27.5%	199,543	16.1	$1.2
2028	294	$21,026	29.3%	199,543	17.2	$1.2
2029	294	$21,026	31.4%	199,543	18.4	$1.3
2030	294	$21,026	33.5%	199,543	19.6	$1.4
2031	294	$21,026	35.8%	199,543	21.0	$1.5
2032	294	$21,026	38.3%	199,543	22.4	$1.6
2033	294	$21,026	40.9%	199,543	24.0	$1.7
2034	294	$21,026	43.8%	199,543	25.6	$1.8
2035	294	$21,026	46.8%	199,543	27.4	$2.0
2036	294	$21,026	50.0%	199,543	29.3	$2.1
					Total	**Total**
					221.0	**$15.8**
					Grand total including hospitals	**Grand total including hospitals**
					229.3	**$16.5**

Source: Tables K4, K5 and K6, CMS Interoperability and Prior Authorization Final Rule, www.cms.gov/files/document/cms-0057-f.pdf

(continued from p. 4)

"I think that's something that resonates with physicians because it models what they do with patients. The patient comes in to see them for a problem and they have to not only diagnose the problem, but they have to put together a treatment plan for how they're going to resolve whatever the issue is. Taking that approach also helps in the communication with physicians," Anstine explains.

Be prepared to explain why

In addition to telling providers what you want from them, you should be prepared to explain why in a way that makes sense to them. "They definitely want to know the 'why' behind the information you're telling them," Anstine explains.

When you talk about the "why" of compliance, stick to the ultimate goal that you want the provider to achieve, and use scenarios that make sense to them.

For example, if you're working on HIPAA, it might seem like a good idea to tell the provider they need to comply with HIPAA and recite relevant sections of the law. According to Anstine, it is better to focus on a clear goal. In this case, you need providers to safeguard patient health information. Your sample scenarios should involve situations the provider is likely to encounter. Anstine gives the example of what the provider should do if there are several people in a patient's room when they check on a patient they have admitted to the hospital. To safeguard the patient's privacy, the provider should take time to get the patient's consent to speak in front of the others in the room, or ask the visitors to leave the room, Anstine says.

Don't overload providers with extra information. "With physicians, less is usually better," Anstine says. "This isn't my original analogy, but if somebody asks for a recipe to cook chili, you want to give them the chili recipe. Don't give them the entire cookbook. Just stick to what you know, what the issue is, what the concern is and why, and then what you need them to do or what you would like from them," Anstine suggests.

If a provider wants specific citations, you can share them at the end of the training.

Ask 'why' when your providers are disengaged

It can be frustrating when providers seem to ignore compliance training, but don't give up or get angry. "Try to dig into the reasoning behind the disengagement," Anstine says. It could be that they don't understand something you've told them or they might feel overwhelmed by what you've asked them to do.

One way to circumvent disengagement is to ask for feedback during your training. You should be prepared for "the good, the bad and the ugly" but don't take negative comments about compliance personally, Anstine says.

You can then work on a solution to whatever is causing the disengagement. "People have positions and interests and the interest is what you want to dive into," he says, giving the example of a physical therapy practice that initiates an internal review of its documentation. A director who is tasked with helping to monitor documentation refuses to help. That would be his position, Anstine explains. But if it turns out that the reason why is he is short-staffed and overwhelmed, that was his interest. Rather than focus on the fact the director said no, a compliance manager could find out why he said no and come up with solutions to that problem, Anstine says. *— Julia Kyles, CPC (julia.kyles@decisionhealth.com)* ■

Practice management

Worried practice buyers will hobble care? Get it in writing during contracting.

Independent practices that become the target of an acquisition by a larger group or system should take steps to protect their autonomy in the contract stage. A recent survey shows that many physicians employed by large entities are dissatisfied with reduced authority and concerned with the resulting impact on care.

The survey of employed physicians who were not "employed by practices either wholly or majority owned by physicians, or faculty groups or medical schools," conducted by NORC at the University of Chicago, was released by the Physicians Advocacy Institute (PAI) in November 2023.

Among the more notable findings are that 47% of respondents said, "practice policies or incentives frequently led them to adjust treatment options to reduce costs"; 37% "report moderate or low autonomy in making clinical decisions"; 61% "have moderate or low autonomy to refer patients outside of their ownership structure/system"; and 70% "report [their] employer uses incentives for physicians to see more patients."

Some 90% of these respondents are employed by hospitals and health systems, as opposed to the private equity (PE) firms that are increasingly absorbing the market. One study, for example, finds that PE health care acquisitions increased 600% between 2012 and 2021 (*see resources, below*). But the common issue is physician control of care, a concern that may be familiar to doctors who have transitioned from independent to employed status.

Daniel B. Frier, co-founder of the Frier Levitt firm and chairman of its health care group in Pine Brook, N.J., is sympathetic. "In many cases, doctors are treated as a necessary evil — widgets in the delivery of care," Frier says. "This has surely come at a price to the personal, one-on-one care patients deserve. Physicians are often pressured into conflicting roles, including producing more work RVUs while reducing the cost of care [and] avoiding referral leakage by keeping patients within a hospital system or group practice."

Are the worries real?

The push to increase patient load to boost revenue is frequently cited as a cause of physician burnout (*PBN 4/10/23*). But there are trade-offs in any change in business practice, including ownership. One of the signal attributes, and advantages, of employed status is the ability to offload many administrative aspects of medicine, including referral sourcing, to management.

"A lot of doctors are very happy when they sell," says Ericka L. Adler, shareholder and health care practice group manager at the Roetzel & Andress firm in Chicago. "For many of them it's just life as usual, but without the administrative burdens and with some added efficiencies."

Gary W. Herschman, board member and member of the firm at Epstein Becker Green in Newark, N.J., says physician concerns over autonomy can be a matter of perception, owing to the difficulty of transitioning from full to limited authority.

"When doctors enter into these partnerships, they know that they are giving up business control over their medical practices," Herschman says. "This can cause issues for some doctors who have been managing their groups for years, and are control freaks and micromanagers. But most younger doctors aren't like that — they just want to practice medicine without the headaches of practice management and administrative duties."

Herschman mainly works with specialty surgical groups and private equity platforms, and "these issues regarding clinical autonomy haven't come up with the groups I have advised." He acknowledges things may be different with the mainly hospital-employed physicians in the PAI cohort — most of whom, he notes, are "from pediatrics and general medicine, where a lot of consolidation happened five to 20 years ago, with Optum and other big national companies buying up primary care groups. Their experiences are quite different from what we're seeing with these [more recent] specialty private equity platforms."

Sometimes, Adler says, physicians may perceive management to be interfering with care when they're actually simply addressing compliance issues to which the physicians have not previously been attentive — for example, "what type of testing has to be supervised, or how to bill incident to. In these situations private equity is actually helping the doctors better comply with the law."

Board insulation

Physicians have many protections from care intrusion in law and regulation. For example, most states require, often through corporate practice of medicine (CPOM) laws, that acquiring entities have medical boards that get between administrators and the physicians on the line and insulate them from direct interference.

And when the law fails to do so, buyers generally create such boards of their own volition. "I know that in our deals, we see physician boards in almost every transaction," Adler says.

Herschman finds that PE firms that enter the field generally take appropriate steps to insulate their physicians from direct interference in care by non-medical management — which would also insulate these firms from the perception that they're doing so.

"Generally, agreements contractually require [those firms] to not interfere with clinical judgment," Herschman says.

Are CPOM breaches a care issue?

As autonomy complaints persist, they are sometimes reflected in legal battles. One active lawsuit, brought by the American Academy of Emergency Medicine Physician Group (AAEM-PG) against Envision Healthcare Corporation in the U.S. District Court of Northern California, offers an example.

AAEM-PG's case against Envision hinges on a claim that the company violates California's CPOM law, which prohibits non-medical ownership of medical

entities, by creating shell "professional corporations" that include doctors but which do not actually manage the business.

Their complaint also states that Envision interferes with patient care. For example, AAEM-PG believes that Envision "creates 'benchmarking' reports that compare physician performance to Envision-created standards, intending to modify the exercise of their independent medical judgment … these performance standards have medical implications and violate the corporate practice doctrine."

To date, eight states, including Massachusetts and New York, have passed health care transaction review laws that would allow state governments to approve or deny health care acquisitions, much as the Federal Trade Commission does at the federal level.

Get it right from the start

However real or tenuous the connection between aggressive management and care quality may be, Adler says in her practice and experience getting both owner and employee expectations straight in the contract phase is key to avoiding dissatisfaction down the road, and that your demands can get as granular as employee physician workload and support.

"When we do these transactions, we try very hard to write the documents in a way that preserves the doctors' right to control what they view as care," Adler says. "That might include where they are sent to work, support staffing, the number of days a week they work, how much time they're going to spend with their patients — whatever it is that they view as important."

"I have seen too many physicians take the easy way out, rather than carefully and deliberately shop around, negotiate, protect the intellectual property that is their clinical knowledge base," Frier says. "Demanding provisions that give the physician unilateral control over clinical decision-making and referral decisions is critical."

Frier recommends that you "negotiate a contract when you do not absolutely need it and you can do without it. This puts physicians in the best position both financially and psychologically to negotiate a favorable agreement. Many physicians wait until they have a gun to their heads to make a move, and this is the worst time to do so." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- Physicians Advocacy Institute, "The Impact of Practice Acquisitions and Employment on Physician Experience and Care Delivery," November 2023: www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/NORC-Employed-Physician-Survey-Report-Final.pdf?ver=ylnykkKFPb3EZ6JMfQCelA%3d%3d
- American Antitrust Institute, "Monetizing Medicine: Private Equity and Competition in Physician Practice Markets," July 10, 2023: www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf

Ask Part B News

Continue to use the practice address when the place of service is 10

Question: *We know the place of service (POS) rules for telehealth services changed this year. Did that change the address we should report in Box 32 of the CMS-1500 form when a patient receives a telehealth visit while at home (POS 10)? We're not sure if we should use the patient's home address or continue to report the practice's address. In addition, our providers occasionally perform telehealth services while they are at home. Which address should we use in that scenario?*

Answer: You should continue to use the practice's address in both scenarios. "Put the address of the distant site provider (the person performing the service) in Box 32," states a guide published by the Center for Connected Health Policy (CCHP). "The practitioner should enter on the claim the address where they typically practice," according to the CCHP's synopsis of a letter from CMS.

You would only report the provider's home address if they usually treat patients at their home address and that address is on file with the Provider Enrollment, Chain, and Ownership System (PECOS). CMS delayed the mandatory home enrollment requirement for at least one year. "Through CY 2024, we will continue to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home," according to the final 2024 Medicare physician fee schedule. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCE

- Center for Connected Health Policy – Billing for Telehealth Encounters, July 2023: www.cchpca.org/2023/07/2023BillingGuideFINAL.pdf