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Practice management

Short-term closing? To-do list includes emails to patients, call to counsel

In case your practice suffers a temporary closure due to an accident or emergency, have on hand a list of the parties you will need to contact and the questions you will need to ask.

Every so often a cataclysmic accident makes it impossible to keep a medical practice running *in situ*, at least for a short time. Pediatric Associates of Dayton, for example, lost a day on March 18 when a car crashed into its Kettering, Ohio, offices, WHIO-TV reports. The sudden absence of a provider or a loss of power could also take a practice offline for one or several days.

There are long-term closure protocols that apply when practices shut down or relocate, involving disposition of finances, and of patient records and employee files, among other documents (*PBN 8/22/22*, *9/12/22*). But it's also important to have a tight protocol handy for shorter interruptions that don't require major systemic shifts.

Cover the basics

If the cause of closure is structural, as in the Kettering case, the safety of patients, staff and contiguous homes and business should be the first concern. Remove your people, alert the neighbors, and call 911, police, fire, public utilities, or whatever department or agency directly relates to the cause.

While appropriate staff, service workers or consultants endeavor to fix the problem and get the practice back in action, management should contact the following:

Staff. Staffers who are offsite (e.g., on vacation, on sick day, working from home) need to know not to come in or log in until further notice. Onsite staff should be assigned roles in handling the practice draw-down.

"Providers need to ensure someone is in charge of clinical coordination, someone is managing calls, and someone else is handling external relationships, and that those people know the plan moving forward," says Paul Schmeltzer of the Clark Hill law firm in Los Angeles.

Payers. A heads-up is expected, and in some cases absolutely necessary, Schmeltzer says: For instance, "if the medical practice has contracts with insurers, a sudden disruption may trigger notice provisions or expectations under continuity-of-care clauses, particularly if patients are in active treatment or scheduled for urgent procedures."

Patients. All active patients should get a mass-email announcing the closure, an expected window of return, and that they'll be notified when you're back in business, as well as a separate communication when the closure is over. "Patients with urgent needs such as prescriptions, post-surgical follow-up, and high-risk conditions should be prioritized," Schmeltzer says.

The practice's website and social media should also carry the message, Schmeltzer says, and "voicemails and auto-replies should be updated immediately with practical details so that patients can access records, prescriptions and urgent care."

Legal counsel. Daniel O. Connor, a partner with Schenck, Price, Smith & King LLP in Pine Brook, N.J., who is chair of the firm's health care law department, suggests a conference on what "legal obligations must be satisfied and what rights can be asserted in the event of a sudden practice closure, such as rights and obligations under the practice's lease, bank financing documents, EHR vendor contracts, billing and collection service agreements and supply contracts." A review with counsel of the rest of your first-response protocol would also not go amiss.

Building management. This may also come up in the legal conference: Check your lease to see if it "requires the landlord to repair or rebuild office space, or if relocation is a possibility," Connor suggests.

Also, obtain an assessment as to when and whether the office will be physically capable of reopening.

"Sudden closures resulting from building damage can raise serious regulatory concerns," Schmeltzer says. "A provider cannot operate in a facility that has compromised structural integrity, and doing so might violate building codes, OSHA rules, or even Medicare's conditions of participation."

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If the EHR goes down

Whether it's a car crash or a power outage or something else, you may find your internet and your EHR offline. Given the sophistication of modern data storage, it's unlikely that a structural disaster will more than temporarily hinder access to patient records. A cyberattack is a different story, and requires an extensive, complicated response (*PBN 1/20/25*).

But if the event affects your internet service, Schmeltzer advises that you "resist the urge to resort to using personal email accounts, free cloud storage, or unsecured messaging because of the legal risk in using non-encrypted platforms to store or share sensitive patient information. If the medical practice cannot access their EHR, they should contact their EHR vendor and work to obtain emergency access or temporary relocation of servers to compliant environments."

If patent records are partly or fully inaccessible and this seems to be due to damage, management "can't simply point to the casualty event, throw up their hands and start new files," Connor says. Rather, the practice is "expected to assess the damage, salvage what can be salvaged and reconstruct the affected medical records to the greatest extent possible for future patient care."

If needed, Connor says the practice should look to "professional licensing boards and/or physician medical malpractice insurance carriers [for] guidance or white papers to reference in such instances. There may be third-party vendors that assist practice with salvaging business assets and records, including medical records."

However you retrieve or reconstitute data, the usual HIPAA protections apply — and that goes for any new data generated in the course of operations that you may find necessary to continue doing the practice's business offsite. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCE

- WHIO-TV, "Doctor's office closed for day after car crashes into building," March 18, 2025: *www.whio.com/news/local/car-crashes-into-kettering-building/Z7M5IB6CSVD6NE6IO7ESOW5BW4/*

Ask Part B News

Switching to concierge? Don't short-change existing patients

Question: *I'm thinking of transitioning my practice to a membership concierge model, but I suspect many of my current insured patients will object. Would I have to worry about getting sued or sanctioned?*

Answer: Your concern is understandable: NPR's "Shots" column recently told of a practice that made a similar transition, proposing to charge its patients membership fees, and received some very negative comments. ("I'm insulted and I'm offended," one said. "I would never, never expect to have to pay more out of my pocket to get the kind of care that I should be getting with my insurance premiums.")

Many transitioners want to keep their insured patients while also taking on membership-fee patients. If you do, the issue of disparity of treatment emerges; you don't want to create different classes of treatment based on how much your patients are or aren't paying.

"There are two ways it can be done: Either you don't take any insurance from anybody, or you say, 'we're going to continue to accept insurance, but charge you extra for things that insurance doesn't necessarily cover,'" says Christina M. Kuta, an attorney with Roetzel & Andress in Chicago.

If you continue to take insurance, in other words, you might offer membership patients services their insurers, whether commercial or Medicare, won't cover, such as "executive physicals," medical spa and cosmetic treatments, and charge a fee that covers these.

But even then, you might attract the negative attention of payers. Paul Schmeltzer of the Clark Hill law firm in Los Angeles says that when insurers find out about your new model — possibly from an angry beneficiary — they "may view this as double-dipping, which occurs when a provider charges the patient and bills the insurance plan as well." And even if that's not the case, you still may be violating contract terms.

"Most commercial insurance contracts say you cannot charge patients [they cover] anything extra other than copays, deductibles, etc., to be part of your practice," Kuta says. "We had a practice that was charging an annual fee for what it believed were services not covered by insurance, but [which] required patients to

pay that fee in order to continue to receive *any* services from the practice. Two different insurance companies called the practice after patients called the insurers to complain. They said, we're dropping you as a participating provider because you're not allowed to do that."

The popular concierge membership advantage of extra time and quicker appointments also presents a "grey area" with commercial insurers, Kuta warns. They may say "you're supposed to provide the medically necessary amount of time anyway," fee or no fee.

"I've recently seen some large payer insurance contracts that say you cannot treat our [beneficiaries] differently than other patients, so if you offer priority appointment times to any other patient, you have to offer priority time to our [beneficiaries]," Kuta says.

This is what CMS says

CMS has very strict rules about extra fees: If a provider wants to charge their beneficiaries for anything they cover, outside of the usual co-pays and deductibles, they have to opt out of enrollment.

"Sometimes providers want to start a 'side' concierge practice and keep their regular employment going until the concierge practice ramps up and they can quit their day job, so to speak," Kuta says. "But you cannot opt out of Medicare for one practice and stay in for another. If you're out, you're out for everything."

Opting out means signing an affidavit with CMS and a private contract with patients that bind you for a two-year term, during which neither you nor your patients can make Medicare claims for payment.

According to Terrence L. Bauer, CEO of Specialdocs Consultants, a concierge medicine consultancy based in Highland Park, Ill., some concierge practices maintain a business arrangement whereby providers who don't want to opt out of Medicare stick with it, "and the doctors who have elected to convert to the membership practice refer those patients to these colleagues." Opted-out providers are identified by their national provider identifiers (NPI).

"Practices may want to consider whether forming a new entity to house the concierge arm of their practice makes sense from a legal or financial perspective," suggests Brandon S. Zarsky, a partner in Frier Levitt's health care practice group in Pine Brook, N.J. "Providers who are owners of larger integrated group medical practices should also review their corporate documents to determine whether they are permitted to provide services through a concierge model while an owner of such an entity."

Even then you have to be careful, Schmeltzer says. For example, if you partner with a management services organization (MSO) or other entity to help set up your model, "if the concierge fee is shared with anyone referring patients or helping arrange care, this can trigger anti-kickback statute or state fee-splitting issues. To avoid scrutiny under anti-kickback statutes, the physician should carefully structure arrangements to ensure they reflect fair market value for administrative services and avoid payment tied to patient volume."

Self-pay OK?

Even if you go fully concierge — no insurance, no Medicare, just cash — you have to be careful about contract terms with your patient, Kuta says. For example, "you should have some sort of written agreement or policies with the patient that allow for circumstances that may fall outside the annual fee — that [the patient's] access can't be excessive, and if it is excessive and not based on what [the doctor] believes to be medical necessity, the doctor can terminate the contract."

Also, to avoid getting stuck when a patient genuinely requires care that goes wildly beyond what your membership fees will cover, Kuta suggests you consider language "saying that if certain services are beyond what is contemplated by the parties related to the service agreement, the provider can increase the rate or terminate the agreement." (Related to that, Kuta says to make sure that, under your state law and regulations, your charges won't be considered financially exploitative.)

Other enrollment terms Zarsky suggests you should make clear in the agreement include payment schedules, renewal guidelines and "a menu of included and excluded services. These agreements must also be drafted to comply with state and federal laws and regulations."

Beyond your legal responsibilities to existing patients — including whatever your state law says is appropriate notice, and volunteering to recommend appropriate alternate providers and timely transfer of patient records — you should craft a way to inform them of the switch that doesn't aggravate them. Enraged patients tend to complain to regulatory bodies, Kuta says, and

(continued on p. 6)

Benchmark of the week

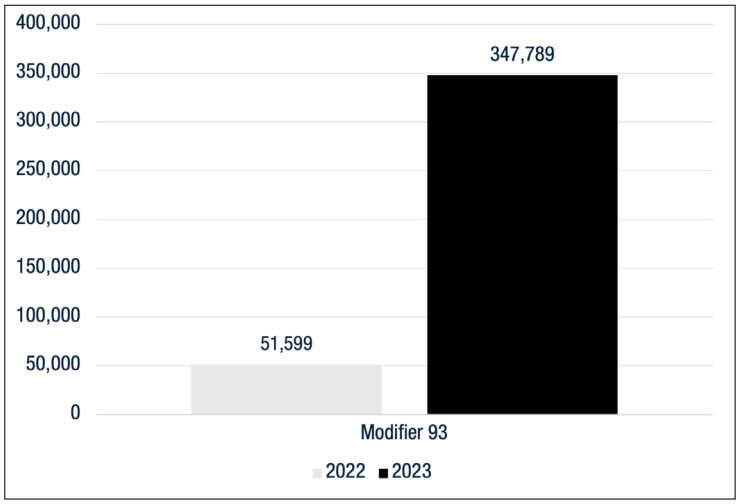
Modifiers tell the tale of audio/video vs. audio-only telehealth service

Telehealth services for Medicare Part B soared under the expansions that were first enacted during the COVID-19 public health emergency and have been extended by Congress several times. The expansions and waivers included coverage of audio-only services, including the popular telephone E/M services (**99441-99443**), which CMS reimbursed at rates equivalent to an office/other outpatient E/M encounter.

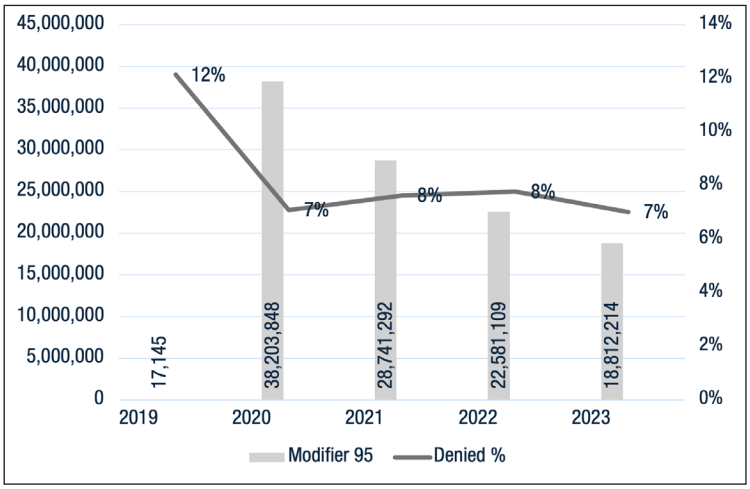
However, a look at the latest available data for Part B claims submitted with telehealth modifiers **93** (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system) and **95** (Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system) indicates that audio-only services lag far behind.

The AMA rolled out the audio-only modifier in 2022 and CMS required it for audio-only services in 2023 (*PBN 11/21/22*). The following chart shows that modifier 93 surged from nearly 52,000 claims to more than 347,000 claims in response. However, the second chart contains utilization and denial rates for modifier 95 from 2019-2023 and shows that, despite a steady annual decline after 2020, providers submitted more than 18 million claims for audio/video services in 2023. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*)

Audio-only modifier 93 claims, 2022-2023



Audio/video modifier 95 claims, 2019-2023



Source: Part B News *analysis of 2019-2023 Medicare claims data*

(continued from p. 4)

"no provider wants the Attorney General or a regulatory board or the state insurance commissioner sniffing around."

Bauer has assisted with many transitions and has talked down many patients who were unhappy with their providers' decision. "My response to them was, 'listen, your doctors had a choice: Either they continued to practice medicine in this model, or they were going to retire or do something other than practice medicine,'" he says. "So, if you have the choice of those two things, would you rather pay the membership fee and join the practice, or would you rather find a new doctor? The vast majority of the patients I spoke with joined the practice." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCE

- NPR, "Long wait for a rushed doctor's visit? Maybe you'll get more with a 'membership' fee," March 28, 2025: *www.npr.org/sections/shots-health-news/2025/03/28/nx-s1-5342632/concierge-membership-primary-care-doctor-shortage-rural-health-access*

Correct Coding Initiative

CMS assigned an absolute edit to most new CPT codes

To prevent denials of your claims for new CPT codes, share the final piece of the latest National Correct Coding Initiative (NCCI) update with your team.

CMS released the complete medically unlikely edits (MUE) file, which contains the adjudication indicators (MAI) on April 1, the day the new NCCI edits went into effect (*PBN 3/31/25*).

Part B News analysis of the MAIs for 70 new codes in the E/M, surgery, radiology, pathology/laboratory and medicine chapters of the 2025 CPT manual found that 55 codes have an MAI of 2 and 15 codes have an MAI of 3. A list of the reviewed codes sorted by MAI is available below.

An MAI of 2 is an absolute date of service edit. According to CMS, units of service (UOS) "in excess of the MUE value would be considered impossible because it was contrary to statute, regulation, or subregulatory guidance." In other words, you will lose the revenue for the extra procedures. You can't appeal the excess units of service and you cannot use an advanced beneficiary notice of non-coverage (ABN) to get around MUE or MAI limits, according to CMS.

New codes with an MAI of 2 include:

- Skin cell suspension autograph codes (**15011-15017**).
- Open intra-abdominal destruction of tumors or cysts (**49187-48190**) which replaced codes **49203-49203**.
- Prostate ablation with thermal ultrasound (**55881-55882**).
- Thoracic fascial plane blocks (**64466-64469**).
- Implantation of iris prothesis (**66683**), which replaced Category III code **0616T**.
- Magnetic resonance safety procedures (**76014-76019**).
- Telemedicine services (**98001-98016**).

CMS assigned an MAI of 3 to the remaining 15 codes. Excess units of service will trigger a denial that you can appeal, but the documentation must clearly demonstrate the medical necessity of the additional services.

New codes with an MAI of 3 include:

- Arthroplasty of intercarpal or carpometacarpal joints (**25448**).
- Chimeric antigen receptor T-cell therapy (**38225-38228**).
- Lower extremity fascial plane blocks (**64473-64474**).
- Vasoreactivity study (**93896-93898**).

Your coding staff should keep an eye on private plans that use the NCCI edits and reimburse for services that Medicare does not cover, such as the new skin cell suspension codes or the telemedicine codes. Private plans don't have to follow CMS' quarterly update schedule and might implement the new MAIs later in the year. Review updates from the plans your practice accepts to avoid a sudden wave of rejected claims.

See the chart, p. 7, for a breakdown of the codes which have an MAI of 2 and those that have an MAI of 3. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCES

- Practitioner services MUE table (Zip file): *www.cms.gov/files/zip/practitioner-services-mue-table-r1.zip*
- Medically unlikely edit FAQs: *www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-faq-library#mue*
- Revised modification to the medically unlikely edit (MUE) program: *www.cms.gov/files/document/revised-modification-medically-unlikely-edit-mue-program-mm8853.pdf*

Adjudication indicators and medically unlikely edits, effective April 1

MAI – 2			
Code	MUE	Code	MUE
15011	1	81558	1
15013	1	82233	1
15015	1	82234	1
15017	1	83884	1
49186	1	84394	1
49187	1	86581	1
49188	1	87513	1
49189	1	87564	1
49190	1	90480	1
51721	1	92137	1
53865	1	98000	1
53866	1	98001	1
55881	1	98002	1
55882	1	98003	1
60660	1	98004	1
60661	1	98005	1
64466	1	98006	1
64467	1	98007	1
64468	1	98008	1
64469	1	98009	1
66683	2	98010	1
76014	1	98011	1
76016	1	98012	1
76017	1	98013	1
76018	1	98014	1
76019	1	98015	1
81195	1	98016	1
81515	1		

MAI – 3	
Code	MUE
25448	4
38225	1
38226	1
38227	1
38228	1
61715	1
64473	1
64474	1
84393	1
87594	1
87626	1
93896	1
93897	1

Coding

HCPCS 2025 first quarter update brings nearly 150 changes

CMS recently published its HCPCS quarterly update, which brings 148 HCPCS Level II code additions, discontinuations and revisions. The changes, which became effective April 1, include:

- 83 added codes.
- 37 discontinued codes.
- 28 revised codes.

Added codes include:

- **A6611** (Gradient compression wrap with adjustable straps, above knee, each, custom).
- **A9154** (Artificial saliva, 1 ml).
- **C8004** (Simulation angiogram with use of a pressure-generating catheter [e.g., one-way valve, intermittently occluding], inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the angiogram, for subsequent therapeutic radioembolization of tumors).
- **E0201** (Penile contracture device, manual, greater than 3 lbs traction force).
- **E1022** (Wheelchair transportation securement system, any type includes all components and accessories).
- **E1832** (Static progressive stretch finger device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories).
- **G0183** (Quantitative software measurements of cardiac volume, cardiac chambers volumes and left ventricular wall mass derived from ct scan[s] data of the chest/heart [with or without contrast]).
- **G0566** (3d radiodensity-value bone imaging, algorithm derived, from previous magnetic resonance examination of the same anatomy).
- **L1933** (Ankle foot orthosis, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, off-the-shelf).
- **L5827** (Endoskeletal knee-shin system, single axis, electromechanical swing and stance phase control, with or without shock absorption and stance extension damping).

- **L6029** (Upper extremity addition, test socket/interface, partial hand including fingers).
- **L6031** (Replacement socket/interface, partial hand including fingers, molded to patient model, for use with or without external power).
- **L6032** (Addition to upper extremity prosthesis, partial hand including fingers, ultralight material [titanium, carbon fiber or equal]).
- **L6037** (Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, partial hand including fingers).
- **L6700** (Upper extremity addition, external powered feature, myoelectronic control module, additional emg inputs, pattern-recognition decoding intent movement).
- **Q2057** (Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose).
- **Q4356** (Abiomend membrane and abiomend hydromembrane, per square centimeter).
- **Q4363** (Amnio burgeon membrane and hydromembrane, per square centimeter).
- **Q4366** (Dual layer amnio burgeon x-membrane, per square centimeter).
- **S4024** (Air polymer-type a intrauterine foam, per study dose).

Discontinued codes include:

- **A9155** (Artificial saliva, 30 ml).
- **G0564** (Creation of subcutaneous pocket with insertion of 365 day implantable interstitial glucose sensor, including system activation and patient training).
- **G0565** (Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new 365 day implantable sensor, including system activation).
- **L8010** (Breast prosthesis, mastectomy sleeve).
- **M0223** (Intravenous injection, bebtelovimab, includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency).
- **M0240** (Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses).
- **M0247**(Intravenous infusion, sotrovimab, includes infusion and post administration monitoring).
- **Q4231** (Corplex P, per cc).
- **S4988** (Penile contracture device, manual, greater than 3 lbs traction force).

Revised codes include:

- **A4453** (Rectal catheter with or without balloon, for use with any type transanal irrigation system, each).
- **A4459** (Manual transanal irrigation system, includes water reservoir, pump, tubing, and accessories, without catheter, any type).
- **A6549** (Gradient compression garment, not otherwise specified, for daytime use, each).
- **C1739** (Tissue marker, probe detectable any method [implantable], with delivery system).
- **C9793** (3D predictive model generation for preplanning of a cardiac procedure, using data from cardiac computed tomographic angiography and/or magnetic resonance imaging with report).
- **E1028** (Wheelchair accessory, manual swingaway, retractable or removable mounting hardware, other).
- **E1801** (Static progressive stretch/patient actualized serial stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories).
- **L1932** (Ankle foot orthosis, rigid anterior tibial section, total carbon fiber or equal material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise).
- **L6692** (Upper extremity addition, silicone gel insert or equal, with or without locking mechanism, each).
- **L6698** (Addition to upper extremity prosthesis, lock mechanism, excludes socket insert). — *DecisionHealth staff* (*pbnfeedback@decisionhealth.com*) ■