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Medical Practice Compliance Alert

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

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Patient care

Be prepared to share clinical notes with patients

By: Marla Durben Hirsch

Your practice should take a look at how its clinicians document patient encounters and procedures. The new interoperability rule that bars information blocking requires providers to share electronic patient health information (ePHI) with patients who request it, and that includes clinical notes (*MPCA 11/2020, 8/2020, 7/2020*).

Many providers write their notes for internal use: for themselves, to assist with coding and billing of claims, to coordinate care with other providers, and to support claims in the event of an audit. They typically don't consider that patients may end up reading them. In fact, there has been a misconception that before the interoperability rule providers didn't have to share their clinical notes with patients, says attorney Melissa Soliz, with Coppersmith Brockelman PLC in Phoenix.

Patients have always had the right to access these notes under HIPAA; the difference now is that the new interoperability rule makes it much harder to deny the request.

"It's a paradigm shift. HIPAA made most disclosures permissive at the option of the covered entity. [Now] the patient's right to access is absolute. You're required to share unless an exception applies," says attorney Jefferey Short, Hall Render, Indianapolis. The goal of the rule is to put patients in control of data related to their care, Short points out. The new access and sharing requirements are effective April 5.

Most notes must be shared

The interoperability rule requires providers to deliver all United States Core Data for Interoperability (USCDI) data elements when a patient requests them. This currently includes eight types of clinical documents:

1. Procedure note.
2. Discharge summary.
3. History and physical.

4. Progress note.
5. Consultation note.
6. Imaging narrative.
7. Laboratory report narrative.
8. Pathology report narrative.

There are benefits to sharing notes with patients. It gives them more information about their health history and conditions. Patients can also flag when a note is incorrect. "It helps with patient care," says Soliz.

But while sharing clinical notes increases patient/provider communication, it can increase documentation burdens, such as the need to spell out physician shorthand or add explanations so a patient understands what's written.

Clinicians also need to be aware that some information put in a note may be legally problematic; the sharing of clinical notes needs to be reconciled with other laws, such as those involving minors or abuse, which may require that some information be excluded from what is given to the patient.

"It's complicated, especially if you're subject to multiple laws," says Soliz.

Some notes are excluded

The rule does not apply to psychotherapy notes that are separated from the rest of the medical record or to information compiled in reasonable anticipation or use in a civil, criminal, or administrative action or proceeding. ■

RESOURCE:
ONC Cures Act interoperability rule: www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-07419.pdf

Billing & coding compliance

Problem solving: Navigate 'low' vs. 'straightforward' MDM

By: Julia Kyles, CPC

Increase your understanding of the revised problem element for office-based medical decision-making (MDM) coding with the answers to questions posed during the CPT® and RBRVS 2021 Annual Symposium, Nov. 17-20, 2020.

Straightforward MDM

Question: The patient has a history of urinary tract infections (UTI) and the patient said urinary tract infection is his chief complaint. The doctor orders an in-house urinalysis to confirm the diagnosis and prescribes an antibiotic. Is that straightforward (99202, 99212) MDM under the new guidelines for office visits?

Answer: No, the scenario looks like it would be low in terms of the problem, said Barbara Levy, M.D., co-chair of CPT/RUC Workgroup on E/M, during the symposium.

"My definition of a straightforward problem is if I had just called my mother and asked her about it, she would have told me what to do," Levy said.

The advice might be to eat some chicken soup and ice cream or to sleep in for the day. In other words, a straightforward problem does not typically require intervention by a health care professional. It requires reassurance and a phone call to mom, Levy explained.

Prescriptions may be a treatment

Dr. Mom — or Dad — is also useful in understanding when a prescription is a treatment as described in the definition for acute, uncomplicated illness or injury, said Peter Hollmann, M.D., co-chair of the E/M workgroup, in response to a related question. The new definition states in part that an acute, uncomplicated illness or injury is "a recent or new short-term problem with low risk of morbidity for which treatment is considered."

Whether a prescription is a treatment will depend on what is prescribed, and chicken soup and ice cream aren't treatment, Hollman said.

"So we don't consider fluids and even really Tylenol treatment. You can give common sense Dr. Mom advice, but a treatment is where you are really seriously thinking of potentially using an antibiotic, another diagnostic study, those type of things," Hollmann said.

The UTI scenario is a really good example of low-level medical decision making with a straightforward problem that does require treatment to prevent longer-term complications, Levy added.

Business relationships

Marketing, practice support from manufacturers raise fraud risk

By: Marla Durben Hirsch

Review any form of help you receive from corporations such as pharmaceutical companies and medical device manufacturers. While physicians know to say no to all expenses-paid vacations from manufacturers, accepting less obvious forms of remuneration could also violate the Anti-Kickback Statute.

Advertising help or fraud?

Utah-based medical device maker Merit Medical Systems Inc. (MMSI) agreed to pay $18 million to resolve allegations that it paid kickbacks to physicians and hospitals to use its products. Under the guise of an internal program called the Local Advertising Program, MMSI allegedly provided millions of dollars in free advertising assistance, practice development and support, and educational grants to induce the providers to buy and use the company's devices.

For instance, MMSI ran radio and bus ads about uterine fibroids that looked like public service announcements. However, rather than directing people to contact their physician for more information, the ads steered people to physicians who were chosen by MMSI as a reward for past sales and to induce future sales.

"To qualify [for the advertising support] you needed to be a high-end user or commit to be one. Also, the patient [calling] doesn't know that the provider the patient is being sent to has a deal with the device company and whose medical judgment is tainted under the law," says attorney Veronica Nannis, Joseph Greenwald & Laake, Greenbelt, Md. Nannis is one of the attorneys who represented the whistleblower — MMSI's former compliance officer — in the original lawsuit against MMSI.

In another scheme, MMSI teamed up with local physicians to offer community health talks to consumers about particular diseases. While the talks were ostensibly educational programs intended to provide physicians with practice development and support, the only physicians who participated in the events — and received the publicity — were ones who only used MMSI's devices, according to Nannis.

Such arrangements also raise patient care concerns. It's not necessarily the best device for the patient, Nannis says.

Ignorance is no defense for physicians

While physician practices are aware that they can't accept cash, lavish meals or vacations in exchange for referrals, anything of value can be a kickback, says attorney Michael Volkov, Volkov Law, San Diego.

"Remuneration is broadly defined. Marketing assistance is not the standard [kickback but] is of value because otherwise you'd have to buy it," he notes.

Physicians are not immune from prosecution. Accepting remuneration designed to drive patient referrals can implicate them in the kickback scheme. For example, a physician in Hawthorne, Calif. Agreed to pay $215,228 to resolve allegations that he accepted kickbacks from a local hospital, according to a Department of Justice announcement released March 3.

"For doctors, the ignorance defense is going away." They need to protect themselves by not engaging in fraudulent activities, says Darcy Devine, CVA, ASA, BuckheadFMV, a health care appraisal company in Atlanta.

Note that a physician can be guilty of violating the Anti-Kickback Statute even if the services rendered to patients were medically necessary and reasonable.

"The DOJ is vigilant about these issues and will scrutinize any arrangement based on incentives," says attorney Jay Holland, Joseph Greenwald & Laake. Holland also represented the whistleblower against MMSI.

Arrangements with manufacturers can be particularly troublesome because of the nature of their business, and you can't assume the manufacturer has a robust compliance program, Holland says.

"There's always an inherent risk because the core of the company is to make sales. An aggressive sales team will use methods to increase sales. There's a lot of pressure and competition by manufacturers, so be careful what lines are crossed," says Holland.

Providers should also expect more vigorous enforcement and an emphasis on compliance with the new Biden Administration, according to Volkov. "There was $8 billion a year in recoveries with Obama; they didn't come close to that during the Trump Administration," he says. ■

RESOURCES:

MMSI settlement announcement: www.justice.gov/opa/pr/medical-device-maker-merit-medical-pay-18-million-settle-allegations-improper-payments

Hawthorne-based physician settlement announcement: www.justice.gov/usao-cd-ca/pr/south-bay-doctor-settles-federal-lawsuit-alleging-he-accepted-illegal-kick-backs-patient

Business relationships

Take 4 steps before you accept advertising, practice support

By: Marla Durben Hirsch

Free help with marketing or practice assistance from a medical manufacturer can put you on the wrong side of the Anti-Kickback Statute (*see story, p. 3*).

"A kickback is a kickback; it doesn't matter what form," says attorney Veronica Nannis, Joseph Greenwald & Laake, Greenbelt, Md.

It also doesn't matter if the manufacturer offers a kickback without prompting from the physician who takes it. The physician could still face investigations, prosecution, expensive settlements and worse. To avoid running into compliance trouble, consider these tips:

1. **Scrutinize the assistance the manufacturer is offering,** including how the support is structured. For example, if a manufacturer runs an ad that says "contact your local specialist" it benefits all practitioners, not simply physicians who use the manufacturer's products. "It's a different story when the advertising is directly for a particular provider. Then it's more akin to cash," says attorney Jay Holland, also with Joseph Greenwald & Laake.
2. **Try to fit the arrangement into a safe harbor.** For instance, the Anti-Kickback Statute allows subsidies to physicians to obtain or maintain electronic health record (EHR) systems, which is a form of practice support. However, the arrangement should meet all of the conditions of the safe harbor, notes Darcy Devine, CVA, ASA, BuckheadFMV, a health care appraisal company in Atlanta. For example, the EHR subsidy safe harbor specifically prohibits basing the subsidy on the value or volume of referrals. In addition, some potential donors — such as laboratories — are excluded.
3. **Demonstrate that inducements aren't the reason for the arrangement.** To violate the Anti-Kickback Statute, there must be intent to induce or reward referrals. If there is no such intent, then the statute doesn't come into play. For instance, a physician can work with a device company that picks up the tab for provider or patient education programs, so long as it's truly for education and not done to induce use of the product. "There are ways to craft arrangements with manufacturers to advance mutual interests without violating the Anti-Kickback Statute," says attorney Michael Volkov, Volkov Law in San Diego.
4. **Document that the arrangement is appropriate.** "Doctors are not shielded from government action. They need to be more considerate of documenting support for their activities. Don't rely on the entity paying them [to do that]. The entity often doesn't have substantiation," says Devine. For example, if the doctor performed a service, they should document what the service was, what time they spent on it and how much they were paid. If they gave a presentation, they should save the presentation and keep the program brochure, Devine advises. ■

Business relationships

OIG still wary of PODs, review the list suspect arrangements

By: Marla Durben Hirsch

Before your doctors start or invest in a physician-owned distributorship (POD), make sure they know the arrangement will increase their compliance risk and be subject to intense scrutiny by investigators *(MPCA 11/2020, MPCA 6/2020)*.

The HHS Office of Inspector General (OIG) issued a Special Fraud Alert, March 26, 2013. In it, the OIG warned that PODs raise four major concerns associated with kickbacks:

1. Corruption of medical judgment.
2. Overutilization.
3. Increased costs to federal health care programs and patients.
4. Unfair competition.

PODs excluded from new safe harbors

The OIG signaled that it remains suspicious of PODs in the wide-ranging update to the Anti-Kickback Statute, which went into effect Jan. 19 (*MPCA 12/2020*). The rule specifically excludes PODs from the new safe harbors for value-based arrangements.

The OIG reiterated that PODs are "inherently suspect" under the Anti-Kickback Statute and reaffirmed its guidance in the Special Fraud Alert. If your physicians decide to push ahead with a POD, make sure they know what sort of arrangements will increase an investigator's suspicions.

7 characteristics that are particularly suspect

1. The size of the investment offered to each physician is based on the volume or value of devices used by the physician.
2. Distributions are not made in proportion to ownership interest, or physician-owners pay different prices for their ownership interests based on the volume or value of the devices they use.
3. The POD uses threats or promises to get facilities such as hospitals and ambulatory surgical centers (ASC) to purchase the POD's devices. For example, the POD's owners say they will refer patients elsewhere if the facility does not purchase devices from the POD. The POD might also promise or hint that they will perform more surgeries at the facility if it purchases devices from the POD. Requiring a facility to enter an exclusive purchase arrangement with the POD will also increase the appearance that the deal is fraudulent.
4. Physician-owners are required, pressured, or actively encouraged to drive business to the POD or are threatened when they fail to use the POD's devices for their patients.
5. The POD retains the right to repurchase a physician-owner's interest if the physician doesn't refer, recommend, or arrange for the purchase of the POD's devices.
6. The POD is a shell corporation that does not conduct appropriate product evaluations, maintain sufficient inventory at its own facility, employ enough people to run the POD or maintain continuous oversight of distribution.
7. The POD's physician-owners flout a facility's requirement to disclose conflicts of interest.

5 characteristics that increase fraud risk

The alert also identified a number of characteristics that increase risk and may be used to show the physician-owners intended to violate the law:

1. The POD only serves the patient base of its physician-owners rather than sell to facilities based on referrals from physicians who aren't part of the POD.
2. The POD generates disproportionately high rates of return for physician-owners. Because PODs often have minimal investment risk a high rate of return increases the likelihood that one purpose of the arrangement is to allow physician-owners to profit from their ability to dictate the devices to be purchased for their patients and that the physician-owner's medical judgment will be distorted by financial incentives.
3. The volume or value of a particular physician-owner's recommendations or referrals closely correlates to that physician-owner's return on investment.
4. Physician-owners change their utilization patterns near the time they invest in the POD in a way that increases their use of the POD's devices.
5. The physicians-owners are the only users of the devices sold or manufactured by their POD.

The OIG did not say all PODs are unlawful and lawfulness also depends on the intent of the parties, but physicians should know that investigators aren't automatically swayed by the effectiveness of the POD's

products when determining intent. "Claims — particularly unsubstantiated claims — by physician-owners regarding the superiority of devices designed or manufactured by their PODs," do not prove lawful intent, the OIG states. ■

RESOURCES:

The HHS Office of Inspector General Anti-Kickback Safe Harbor Rule: www.govinfo.gov/content/pkg/FR-2020-12-02/pdf/2020-26072.pdf

The HHS Office of Inspector General Special Fraud Alert on PODs: https://oig.hhs.gov/fraud/docs/alertsandbulletins/2013/POD_Special_Fraud_Alert.pdf

COVID-19

If your employees won't vaccinate, tread carefully before taking action

By: Roy Edroso

While the COVID-19 vaccination campaign expands and becomes a topic at your practice, you can't ignore anti-discrimination and labor laws. If you want to mandate that your employees get vaccinated, make sure you're not missing a step before you declare yourself ready to dismiss those who abstain.

The arrival of the COVID vaccines — two of which have been cleared under FDA emergency use authorization (EUA) — marks a significant step in the capacity to emerge from the year-long lockdowns. As health care workers are at or near the head of the line to obtain the vaccine in many states, health care facilities have been hustling to get their people inoculated.

But many Americans are balking at the vaccine — and that includes health care workers. An October 2020 survey of nurses by the American Nurses Foundation found that 36% of respondents would not voluntarily accept vaccination against COVID-19. More recent polls returned similar results: On Dec. 31, the Los Angeles Times reported that "so many frontline workers in Riverside County have refused the vaccine — an estimated 50% — that hospital and public officials met to strategize how best to distribute the unused doses."

Vaccinations against contagious diseases are not universally required in health care settings. Some states like California require health care workers to be immunized against mumps, rubella and other such diseases. But no federal law does so — even flu shots are only "recommended" by the CDC for such workers.

"I am unaware of any [law] that requires health care employees to get vaccinated against COVID," says Erin J. McLaughlin, shareholder in the labor and employment group at Buchanan Ingersoll & Rooney PC in Pittsburgh.

Should you require?

"Certainly employers may require them so long as they are consistent with business necessity -- and health care is one of those areas in which, objectively, an employer could argue that it is consistent with business necessity," McLaughlin says. But "there are various considerations employers should consider in deciding whether to require the vaccine. "

If you do, you can also ask for proof of vaccination, notes Brett Holubeck, a labor and employment lawyer with Liskow & Lewis in Houston and proprietor of the Texas Labor Law Blog (texaslaborlawblog.com). The U.S. Equal Employment Opportunity Council (EEOC) suggests as much in a Dec. 16 guidance that says asking an employee to show proof of COVID-19 vaccination is not in itself a "disability-related inquiry," which would probably be held discriminatory under federal law.

But do you want to require them? The upside seems worth it, but McLaughlin encourages you to think through the possible ramifications.

For example, the current vaccines have not been through ordinary FDA testing, McLaughlin says. "If something happened to an employee who was required to get the vaccine by an employer, does the employer have potential liability?"

On the other hand, it's also possible that a patient may claim injury from catching COVID-19 from an unvaccinated employee — though proving your practice was the source of infection during a global pandemic might be a heavy lift.

Be interactive

When an employee refuses with cause — a religious objection, say, or a condition such as pregnancy — you may be required to "reasonably" accommodate them, if possible. You should approach their refusal carefully and conduct a careful analysis based on the employee's

rights under whatever laws apply. For example, you may have to consider the Americans with Disabilities Act, Title VII, Pregnancy Disability Act and state laws.

You must be ready to "engage in the interactive process to accommodate employees that have a disability that prohibits them from getting the COVID vaccine, cannot take the vaccine for religious reasons, or are pregnant or breastfeeding," Holubeck says.

This means you should take into account the following items, Holubeck advises:

- Document the request and give the employee a copy to show that you have done so.
- Find out from the employee what task the disability or religious objection is hindering or preventing the employee from doing — in this case, getting the vaccine.
- Tell the employee that the company will look for ways to accommodate.
- Explore possible accommodations with the employee based on the employee's job duties and the problem that needs to be corrected.

In this process, however, you should avoid questions about, or requests for proof of, the employees' medical condition. "Questions about employees that could not receive the vaccine could be a disability-related inquiry that will trigger obligations and rights under the Americans with Disabilities Act (ADA)," Holubeck cautions. The questions you do ask must be "job-related and consistent with business necessity."

If the employee can be accommodated and the practice's needs are met with extra protective equipment or reassignment, then that's a win all around. If not, "employees may be excluded from the workplace," Holubeck says. But even then, you should conduct a "careful analysis" of your conduct — preferably with your attorney — to make sure you haven't engaged in discriminatory conduct.

4 other employee tips

1. **Educate staff.** Don't assume that everyone on the team has the same access to vaccine facts as you. One medical practice got creative. "We created an internal video series devoted to debunking COVID vaccine myths," says Mark Leontides, M.D., founder and medical director at Reproductive Medicine Associates (RMA) of Connecticut in Norwalk. When RMA staff members expressed specific concerns about the vaccine, the facility addressed them in their "myth-busting" series.

That outreach goes out to RMA's patients and to staff via "social media posts, videos, and interviews, as well as through direct patient communication," Leontides says. "We completely understand the concern surrounding such a new vaccination. However, we believe that an explanation of the science has been the best way to calm any fears."

2. **Be sensitive.** That's always a good idea, but especially so in such a fraught area Ñ not only to avoid discrimination charges but also for the health of your practice and good will of your employees. Even if you can't accommodate the employee and feel comfortable you could reasonably release them, you can "continue to pursue alternatives that are not just terminating the employee," McLaughlin says. That could mean "putting them on unpaid leave, for example, or into a role in which they're not regularly interacting with other people," she adds.
3. **Offer incentives.** You may get more employees to vaccinate with incentives, such as with gifts or days off. These should be small, Holubeck warns. "Anything too large can cause legal trouble, as employees that cannot get the vaccine for legitimate reasons may have a possible claim for discrimination," he says.
4. **Be consistent.** If you have a policy, stick to it. "I would not be inclined to propose to an employee that they can take it later [if they want to 'wait and see," McLaughlin says. "I would reserve the accommodations for the folks who require it by lawful exemption." ■

RESOURCES:

"New Survey of 13K U.S. Nurses: Findings Indicate Urgent Need to Educate Nurses about COVID-19 Vaccines," press release, American Nurses Foundation, Oct. 29, 2020: www.nursingworld.org/news/news-releases/2020/new-survey-of-13k-u.s.-nurses-findings-indicate-urgent-need-to-educate-nurses-about-covid-19-vaccines

"What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws," EEOC, Dec. 16, 2020: www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws

Ask MPCA

No EHR? Be ready to invoke information blocking exceptions.

By: Roy Edroso

Question: Our practice does not have electronic health records (EHR). Instead, we keep paper patient records. I understand the new information blocking rule requires that I give my patients their protected health information (PHI) in whatever format they request. Will I be in violation of the rule if I can only give them paper?

Answer: The information blocking rules from CMS and the Office of the National Coordinator for Health Information Technology (ONC) were issued a year ago and their deadlines are rolling out in stages; the first stage hit April 5.

These rules tighten up a number of requirements concerning patient access, including the patient's right to PHI access in the format of their choice, which could be in email or electronic form. That would seem to be a problem for a practice like yours that does not carry patient data electronically — or even for a practice that, for whatever reason, is temporarily offline and can't retrieve the electronic patient health information (ePHI) for patients who demand it.

However, note that there is an exception that applies to situations like yours. It is known as the Content and Manner exception, which "establishes the manner in which an actor must fulfill a request to access, exchange or use ePHI in order to satisfy this exception," according to ONC. "An actor may need to fulfill a request in an alternative manner when the actor is: Technically unable to fulfill the request in any manner requested; or cannot reach agreeable terms with the requestor to fulfill the request."

"The gist is that if the technology isn't there, the 'actor' must provide the content [ePHI] in a manner that is technologically feasible," says David Halpert, chief, client team at Roji Health Intelligence in Chicago. Halpert notes that the AMA seems to see it the same way: the EHR-free physician "will not be considered an information blocker as long as they provide the [ePHI] they actually have access to and in a format agreed upon between the physician and requester," the AMA says in a guidance document.

But don't expect to get away without an EHR forever, warns Kara Gainer, director of regulatory affairs for the American Physical Therapy Association (APTA).

"While CMS has for now exempted certain providers from having to participate in the MIPS [Promoting Interoperability] category because they know that these providers don't have [certified electronic health record technology], we are expecting it to be in the near future that CMS will require all eligible clinicians to have CEHRT or submit a hardship exemption," Gainer says. "CMS also would like to move away from claims-based reporting, so that too will push providers to use an EHR or registry to submit data. And soon Advanced APMs will require all participants of the APM entity to use CEHRT, so that too is going to be a driving force to certified EHRs."

Gainer thinks that "the government will continue to afford small providers more flexibilities than all of the other providers." But trends suggest complete non-involvement with EHR technology will go the way of leeches sooner than later. ■

RESOURCES

ONC "Information Blocking Exceptions": www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf

AMA guidance on Information Blocking: www.ama-assn.org/system/files/2020-10/onc-final-rule-ama-summary.pdf

Billing & coding compliance

2021 E/M guidelines reshaped by dozens of technical corrections

By: Julia Kyles, CPC

Your 2021 CPT® manual doesn't have the final word on how to document and code E/M visits. You need the Errata and Technical Corrections in CPT® 2021 for the freshest E/M guidance.

Four technical corrections — "clarifications of original Panel intent for the current code structure" — make important changes to the guidelines, with most of the new information concentrated in the medical decision making (MDM) definitions for office and other

outpatient visits (**99202-99215**). The AMA posted the additional guidance March 9, but it is retroactive to Jan. 1.

Here's an overview of what's new:

Two revisions to the general E/M guidelines refine the following concepts:

1. Activities that don't count toward a time-based visit.
2. Separately reported tests and interpretation.

The remainder of the changes are exclusive to MDM-based office visits.

The number and complexity of problems addressed guideline expands on the concept of morbidity and explains how risk is defined for this element (as opposed to the Risk element).

The instructions for selecting a code provide more information on when to count an ordered test.

Five new MDM definitions were added:

1. Analyzed.
2. Combination of data elements.
3. Discussion.
4. Unique – test and source.
5. Surgery.

Four MDM definitions were revised to better explain the following terms:

1. Drug therapy requiring intensive monitoring for toxicity.
2. Independent historian.
3. Risk.
4. Test.

This off-schedule update should serve as a reminder to bookmark the Errata & Technical Corrections page and check it on a regular basis. The CPT editorial panel does not have a set schedule for the updates and changes may crop up at any time after the manual is published. ■

RESOURCE:

Errata and Technical Corrections in CPT® 2021: www.ama-assn.org/system/files/2020-12/cpt-corrections-errata-2021.pdf

Audit adviser

CCM expands again, as use spreads across a wide variety of specialties

By: Roy Edroso, with additional reporting by Julia Kyles, CPC

While it may be a common perception that chronic care management (CCM) services fall entirely under the primary care umbrella, the latest Medicare data show that the series of codes (**99487, 99489, 99490-99491, G0506**), are under use by a broad cross-section of specialties.

Primary care specialty groups, such as internal medicine, general practice, and family practice, are well-represented in the use of the four CPT codes — 99490, 99491 and complex CCM codes 99487 and 99489 — and the HCPCS CCM initiating visit code

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G0506, according to data from 2019, the latest year of available Medicare claims statistics. The three primary care specialties are responsible for 3.7 million, or 70%, of the 5.3 million total claims. Nurse practitioners and physician assistants together accounted for another 497,658, or 9.5%, of overall CCM claims.

But as you can see from the 2019 numbers, specialties such as cardiology and nephrology are also racking up big numbers. In fact, taken together, four cardio-based specialties — cardiology, cardiac surgery, cardiac electrophysiology, and interventional cardiology — account for 368,241 CCM-related claims.

The 5.3 million total CCM claims across all specialties in 2019 are up 7% from 4.9 million in 2018. The overall denial rate is steady at 5%. Pediatric medicine's 30% denial rate wipeout on 99489 isn't the worst performance in 2019, by the way; interventional pain management was denied on 59% of its G0506 claims.

Denials aren't the only risk associated with chronic care management codes. Regular tinkering at the code and descriptor level mean that a practice could accidentally submit claims that are based on outdated information and rack up overpayments that need to be returned in a timely fashion. A practice that reports a deleted code, such as **G2058** — introduced in 2020 and replaced with code **99439,** Jan. 1 — will tell carriers that it isn't keeping up with coding changes, which can be a sign of abuse or fraud. In addition, an audit by the HHS Office of Inspector General (OIG) found that poor oversight of 99490 resulted in overpayments (*MPCA 12/2019*). ■

RESOURCE:

OIG audit report: https://oig.hhs.gov/oas/reports/region7/71705101.asp