Calling shots: The PHE will persist, billing snags loom, CCM will rise

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2022 predictions

For our annual predictions issue, *Part B News* assessed the topics, the challenges and the opportunities coming at medical practices in 2022. After consulting with industry insiders and taking the temperature of our readers, *Part B News* compiled 12 predictions of future-shaping events. [*For more predictions, go here.*]

Prediction: The COVID public health emergency (PHE) will continue into 2023. As the Omicron variant rages and vaccination rates remain below the target of health officials, little will change on the ground that would allow HHS to drop PHE status.

“Unless we can achieve substantial levels of vaccination and also widespread use of sensible precautions, including appropriate masks and distancing, it is unlikely that we can beat this back,” says Jeremy Levin, M.D., chairman of the industry group Biotechnology Innovation Organization (BIO).

Some observers like Matthew Fisher, general counsel for Carium, a virtual care platform, based in Worcester, Mass., expect COVID to go from epidemic to endemic — that is, from something we’re trying to destroy to something we’re trying to find a way to live with.

Kathleen Jordan, senior vice president, medical affairs at online health company Tia, believes “we will be dealing with COVID for many years to come, albeit with more tools of immunization, testing and treatments, so at some point we as a nation need to normalize our efforts and invoke some of these emergency measures into our everyday lives and planning.”

Phoenix Mourning-Star, PhD, senior analyst and CEO of Results International Research in Washington, D.C., predicts that “in light of the stalled Build Back Better bill, the Biden administration will follow the Obama administration [example] in attempting to push through a series of less controversial COVID bills under the guise of more general health-based legislation and executive orders” to try and get America out of the woods despite the hostile political environment.”

Levin sees some hope in the research and development COVID has spurred: oral treatment drugs, existing therapies that have shown promise, such as steroids, and variant-specific boosters. But until vaccination rates rise and other preventive measure are more seriously followed, the PHE will remain in motion.

Prediction: Facility-based split/shared policy will create coding errors, and CMS won’t offer additional guidance in the new year.

Common problems that plague E/M documentation will be exacerbated by the split/shared policy that CMS is mandating for 2022, says Nancy Clark, CPC, COC, CPB, CPMA, CPC-I, COPC, AAPC Fellow, senior manager, Eisner Advisory Group, Iselin, N.J. (*PBN 11/15/21*).

“As such, I am concerned that new requirements will pose additional challenges for providers and staff, resulting in a combination of incorrect coding, billing and documentation deficiencies,” which will lead to a negative impact on revenue, Clark says.

Front-end denials will be another problem for practices, Clark says. “For example, at this time, while CMS has identified [modifier **FS** for these services], we may still see differing requirements for commercial carriers,” she says. “The resulting impact on reimbursement, both initially and due to subsequent retroactive audits, could significantly reduce collections.”

The new policy also is likely to suppress split/shared billing in the facility, at least after the first year of the policy. “For years, many qualified health care professionals [such as physician assistants and nurse practitioners] have performed the majority of hospital visits with a review and sign off by the physician and billed under the physician,” says Lynn Anderanin, CPC, CPB, CPMA, CPPM, CPC-I, COSC, senior coding educator, Healthcare Information Services, Park Ridge, Ill. “I don’t think this will change what is being done. Practices will just receive a lower reimbursement. Physicians will not feel it is worth their time to perform more of the visits for 15% reimbursement.”

The ability to bill split/shared services based on medical decision-making (MDM) in 2022 will likely delay abandonment of such billing practices in the facility setting. It would be “foolish” not to take advantage of the one-year reprieve that allows

MDM-based billing, says David Glaser, shareholder, Fredrikson & Byron's Health Law Group, Minneapolis. But in 2023, when time-based billing is the only option, many practices will drop split/shared billing, he predicts.

Anderanin does not expect to see and more details on the new policy. "CMS probably will not have any more guidance, keeping it open for interpretation," she predicts.

Prediction: **Care management revenue will surpass $366 million in 2022**. With an expansion of service options and elevated payment rates, it's not outlandish to think that hitting the $366 million mark for the suite of chronic care management (CCM) and the new batch of principal care management (PCM) codes will materialize.

Why $366 million? Because that's double the total payments that providers gained in 2020, the last year of available Medicare claims data, when providers returned $183 million in payments for the various CCM and PCM services, and *Part B News* likes to go bold with its predictions.

The cost and utilization trends surrounding CCM, which has been on the rise for several years running, make the leap seem attainable. Just consider some numbers. In 2020, providers reported 5.6 million CCM claims, with base code **99490** accounting for the lion's share — or 4.9 million claims — of the activity. Providers gained $146 million on 99490 services alone.

For CY 2022, CMS boosted pay rates on the series of CCM codes. Per-service fees for 99490 are on pace to rise more than 50% (*PBN 12/6/21*). More than one-third of respondents (35%) to the *Part B News 2022 Predictions Survey* said they would report the newly established CCM add-on code (**99437**) in 2022. Another 19% said they are planning to use the new PCM CPT codes. Were providers to report the same number of CCM claims in 2022 as they did in 2020, that alone would return more than $300 million in payments. Factor in expected growth, plus the new code offerings, and the $366 million threshold seems like a good bet.

In boosting the pay rates, CMS labeled care management services a "crucial" part of Medicare coverage, according to the final 2022 Medicare physician fee schedule. The more lucrative payments may give practices a good reason to take CCM services in house, rather than providing them through a third-party vendor, says Betsy Nicoletti, CPC, president of Medical Practice Consulting in North Andover, Mass.

Nicoletti says that outsourcing CCM services can have drawbacks. Not only are practices losing out on revenue, they may be creating a disconnect between the care provided, the oversight of the practice and the patient's perception of who is in charge. Whether practices decide to bring CCM in house or not, the services should continue to thrive in 2022.

Prediction: Insurers will start to penalize the unvaccinated. While most eyes are focused on government action, some experts think the private sector will quietly steal a march: Levin of Biotechnology Innovation Organization expects some insurers will "consider raising premiums for those who are not vaccinated. It's like smoking — it makes your premiums go up. I anticipate that will be an incentive to get vaccinated."

Prediction: Telehealth flexibilities will go permanent beyond behavioral health in 2022.

Key aspects of Medicare's telehealth policy, including eligible services, sites of care and patient access, are controlled by law. Congress acted to expand access to behavioral health services starting Jan. 1, 2022, but most telehealth waivers that CMS has created will expire with the end of the PHE. However, experts that *Part B News* spoke to believe something will happen this year, and we'll go a step further and say that Congress will intervene to make telehealth expansion permanent — beyond COVID and beyond behavioral health.

Currently, Congress is working on bills that would allow for additional telehealth expansions, but "there needs to be more of a concerted public effort from the invested communities and industry sectors to put more of a spotlight and pressure on Congress in that regard," says Fisher of Carium.

Fisher predicts that Congress will look for proof that expanding telehealth won't drain CMS funds or open the door to fraud. "Some of the common concerns or contrary argument would be that permanent coverage of telehealth will just drive up utilization and costs and that there will just be fraud left and right," Fisher says. "Congress wants some hard data to refute their concerns even though the same issues exist even for already covered services."

"The crystal ball is fuzzy," says Amy Turner, RN, BSN, MMHC, CPC, CHC, CHIAP, director of advisory solutions for Ventra Health, citing the unknowns of the ongoing COVID crisis and providers' concerns about the disease. "Some practices I work with, their telehealth volume ebbs and flows with the surges," Turner says. Other practices reserve telehealth for services such as medication refills for stable patients. However, some providers aren't concerned about the disease and have reverted to in-person-only visits, Turner observes. Turner believes these patterns will continue to shift into 2022 as new variants arise.

"I've seen a growing number of predictions that COVID will go into the endemic stage next year," Fisher says. The endemic stage of the disease — where it is consistently present in certain regions — would create a major push for new laws, Fisher explains. He adds that, without permanent changes, "that means we're just going to go back to how things were at the beginning of 2020 without keeping the changes that have occurred, which would be quite disruptive. "My gut feeling is that, in 2022, there will be bigger changes," Fisher predicts.

Prediction: Value-based models will be less episodic, more well-rounded. The word on Capitol Hill is that CMS' value-based nerve center, the Center for Medicare and Medicaid Innovation (CMMI), is less interested than it used to be in small-bore, condition-specific value-based initiatives, such as bundled payment schemes for orthopedic or other major interventions to drive down cost and increase coordination of care.

"CMMI is doing a reassessment of all of the different models that it's been running, and my understanding is it wants to reduce the number of those [episodic] models," Fisher of Carium reports. "The focus seems to be shifting to more comprehensive models."

Faisal Khan, senior legal counsel and hospitals and health systems practice lead at Nixon Gwilt Law in Cleveland, agrees. "The CMS value-based models to date have been very specialty-, tertiary care-, disease specific-focused, which is not the solution to improving Americans' health care outcomes," he says. "The real value is improving the health of Americans so that they do not need [this kind of] care."

Khan notes that CMMI head Liz Fowler said in an Alliance for Health Policy briefing in October "that she does not believe additional focus on specialty models is a long-term solution" and "more involvement and focus on getting more safety net providers is of real value, as well as focusing on models that decrease inequitable outcomes."

The benefit Fisher sees here is "thinking about care more comprehensively, which should create a more fundamental shift in all operations, as opposed to if you focus just on oncology or specific types of surgeries."

Fisher thinks this aligns with what he sees as a push in commercial value-based organizations to engage in more 'virtual-first' care" — a model in which patients are assessed by telemedicine before any in-person care, so as to "determine an appropriate continuum of care that incorporates all the different types and modalities of intervention."

Also, heads up: Theresa Hush, CEO of Roji Health Intelligence, a consultancy and data registry in Chicago, expects CMMI to "collapse some of the existing payment models and move toward mandatory adoption. The transition to risk has been slower than the CMS budget will allow, so the movement away from fee-for-service will undoubtedly accelerate in conjunction with this integration of payment models."

Prediction: Audits will rise again, increasing compliance risk.

Practices should make sure their documentation request response process is in good order. Several health care veterans predict that audit activity will increase next year.

"Are we going to see a lot of audit activity? Absolutely," Turner of Ventra Health says.

Audits can be a nuisance, but they are much worse for practices that aren't on the ball. If a practice doesn't respond to a documentation request in a timely manner, the payer will deny the claim. When a review of the records reveals problems, the practice may be subject to a range of negative effects, including overpayment demands, more audits and, in severe cases, large settlements or suspension of their enrollment.

"The lack of payer policy knowledge is going to become more and more obvious as audits happen and revenue decreases because they keep doing procedures that aren't medically necessary or are investigational," Turner says.
Practices may face audits of their E/M office visits in 2022.

"With changes to the E/M office and outpatient bell curve, I think there will be increase in auditing for visits," Anderanin of Healthcare Information Services says.

Medicare's new split/shared policy will be another area where E/M visits trigger audits, predicts Clark of Eisner Advisory Group. "As has occurred after other regulatory changes, I expect insurance carriers to conduct periodic audits of the codes billed and request supporting medical record documentation," Clark says.

An end-of-year influx of audits are a taste of what's to come, Glaser of Fredrikson & Byron's Health Law Group warns. His clients have experienced a spike in audits from a variety of sources, including Targeted Probe and Educate (TPE) audits, recovery audits and uniform program integrity contractor audits.

"Something's up that isn't going away. It's like all of a sudden the dam broke," Glaser says. The sudden flood increases the urgency of building a solid documentation request response. "One thing to be clear about: It is a request for stuff, it isn't demands for dollars. Most of what I'm seeing is send records, send records, send records," Glaser says.

Prediction: Expect surprises from the No Surprises Act — with good-faith estimates ambushing all practices.

The No Surprises Act (NSA), passed Dec. 27, 2020, as part of the Consolidated Appropriations Act, takes effect Jan. 1 and will contain some twists for practices in 2022, predicts attorney Kimberly Ross Clayson with Myckowiak Associates in Detroit.

One surprise will be the good faith estimate portion of the law, Glaser says (*PBN 10/7/21*). He believes very few providers are aware that when a practice — or anyone who has a professional health care license — treats a patient who won't be using insurance "you will need to give them a good faith estimate," Glaser says.

Patients who should receive an estimate include those who don't have insurance, those who choose to pay out of pocket for a visit or procedure and those who have unusual plans, such as Amish medical aid, Glaser says.

"If you fail to give them an estimate, or the patient can say the estimate is off by more than $400, there's a mechanism that allows them to dispute the bill," Glaser says.

Vicki Myckowiak, founding partner of Myckowiak Associates, forecasts other portions of the NSA will have a significant impact on some specialty providers, such as anesthesia practices. "I think the No Surprises Act may have the unintended effect of increasing facility subsidies to anesthesia groups (or moving them toward employment)," Myckowiak says.

Insurance companies could use the law to cut payment to anesthesia groups, and to survive groups would need to look elsewhere for revenue, such as subsidies from the facilities where they work, Myckowiak explains.

Anesthesia won't be the only specialty impacted. Other hospital-based providers, such as emergency doctors, will be hit as well. Myckowiak observes one feud over payments that supports her prediction: the American Society of Anesthesiologists has accused BlueCross BlueShield of North Carolina of using the law to force anesthesiologists and other hospital-based providers into lower-paying contracts.

The courts may provide more NSA surprises in 2022. "I note that there is pending litigation on this topic," Myckowiak says.
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Resources

"American Society of Anesthesiologists accuses BCBSNC of abusing No Surprises Act" HealthCare Finance, November 23, 2021" *www.healthcarefinancenews.com/news/american-society-anesthesiologists-accuses-bcbs-north-carolina-abusing-no-surprises-act*

BACK TO TOP