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Business operations

To add a non-medical service to your business, avoid 3 crucial errors

Your practice can increase revenue and improve patient satisfaction with the addition of non-medical services, such as spa treatments, fitness programs or healthy cooking classes. But the first step to adding a non-medical service is to make sure everyone who will be involved is willing and able to invest time, effort and money in the business venture.

Non-medical services don't create improper coding or billing risks, but practices can make costly mistakes that doom a new enterprise and leave it in worse financial shape than when it started. If your practice is considering non-medical services, make sure you avoid three common mistakes that that can turn the next great business idea into the next great disaster.

Don't skip the forward planning and research

Non-medical services performed by non-medical staff are not subject to scope-of-practice restrictions, but the non-medical service will have a better chance of succeeding if it aligns with your medical practice.

"Consider what services are going to compliment which services you're currently providing so your patients can take advantage of it," says David Zetter, PHR, SHRM-CP, CHCC, CPCO, CPC, COC, PCS, FCS, CHBC, CMUP, PESC, CMAP, CMAPA, CMMP, senior health care consultant for Zetter Healthcare Management Consultants in Mechanicsburg, Pa.

Your next step is to make sure your patients want the service. Reliable patient feedback is crucial to the planning process. But practices regularly fail to determine patient need, warns Debra Phairas, president, Practice & Liability Consultants, Napa, Calif.

"You want to do some research over a period of time, at least a year," Zetter says. You should also check out the local competition. For example, if you want to add gym services but there is a popular fitness chain near your office, you might need to differentiate your gym to make it more attractive to patients.

Or you might need to pick another idea. Just keep in mind that "the goal of adding non-medical services to a practice is to address the needs of the patients receiving care at the practice," says Erin Duffy, partner and vice-chair, health practice group, Duane Morris, Philadelphia.

Don't dive in without understanding the work involved

Most physicians and non-physician practitioners have never run a business even if they run their medical practice. "They think they can do it on their own; they think they can bootstrap it," Zetter says.

However, an investment in an expert's help can mean the difference between the successful and profitable launch of the new service and a lot of wasted time and effort. For example, the practice will need to prepare a working capital projection and a capital budget "to assure this [new service] makes sense financially," Phairas says. The practice will also need to create and regularly update a *pro forma* — a forecast of a business' financials, such as projected future income, budget or expenses – for each new service it wants to offer, Zetter says.

Deciding whether the non-medical service should be a separate business is another crucial step. It isn't always necessary but "is generally advisable from a liability perspective. You wouldn't want a medical practice to be responsible for an issue that occurred during the use or provision of a non-medical service," Duffy says.

In addition, some states have a corporate practice of medicine doctrine, which "doesn't allow a layperson to have any ownership in a practice," Zetter explains.

"If you believe you may want additional partners, including non-medical partners, you may want to create another company so they can buy in. For example, a physician has to be a 51% owner in a medical practice in California," Phairas says.

Finally, the practice's decision-makers should avoid the common error of ignoring the experts they hire. Zetter's company normally terminates clients who persistently ignore the consultants "because we don't want to be associated with a loser," Zetter says.

Don't skimp on risk evaluation and reduction

Whether your practice creates a separate business for the non-medical service or keeps it under one umbrella, you will need to take steps to reduce compliance risks that could leak from one side of the business to the other. For example, your practice will need to safeguard protected health information (PHI) from employees of the non-medical branch, Zetter says. Zetter gives the example of a dermatology practice that also has a med-spa and has separate software to make sure the med-spa staff can't access PHI.

Your practice should also make it clear whether the practice or a non-medical provider is performing a service,

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Duffy advises. Otherwise "this could lead to the practice being sued for services provided by the non-medical provider," she says.

Remember to involve your medical malpractice carrier to ensure you're adequately covered on the non-medical side of the business. "The non-medical provider should have its own liability insurance because the practice's malpractice insurance would not cover any issues that occurred with the non-medical services," Duffy explains.

Finally, if medical staff will provide services for the non-medical side, make sure they're fully trained on those services. "For example, many primary care and obstetrician-gynecologists also offer cosmetic services like botox and fillers or laser treatments but they have been trained to do so," Phairas says. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

Compliance

Advocacy groups seek a fix for 'convener' issues in good faith estimates

A flurry of stakeholder complaints around the "convener" requirement for good faith estimates (GFE) that are a product of the No Surprises Act of 2020 has put pressure on CMS to take action. Experts predict CMS will bend on the requirement but is unlikely to remove it entirely.

Several major health care industry groups have issued statements in recent days calling for CMS to make changes related to this convener requirement, which asks providers to create charge estimates for some patients that cover not only their own services but those of downstream providers (*PBN 1/10/22*).

For example, the American Hospital Association (AHA) executive vice president Stacey Hughes asked CMS administrator Chiquita Brooks-LaSure to extend its "enforcement discretion" on the convener requirement beyond next Jan. 1, according to a June 6 open letter.

"Due to the lack of currently available automated solutions, this process would require a significant manual effort by providers, which would undoubtedly result in the convening provider being unable to meet the short statutory timeframes for delivering good faith estimates to the patients and could also lead to inadvertent errors," Hughes wrote.

The American Medical Group Association (AMGA) also sent an open letter to Brooks-LaSure from its president and CEO Jerry Penso, M.D. The letter includes examples of clinical cases that make the creation of accurate GFEs burdensome — for example, "a radiological exam that identifies a suspect abnormality that could result in any number of reasonably expected outcomes and treatment plans."

Assessing the impact of GFEs

It's unclear how many organizations have faced a significant impact from the convener requirement, but Darryl Drevna, AMGA's senior director of regulatory affairs, says some AMGA members who are part of health systems have been hit hard. Some members have told Drevna their systems have generated 45,000 to 50,000 GFEs since the policy took effect Jan. 1, 2022.

Experts and health care personnel seem to agree the convener job poses difficulties. According to a survey from the Workgroup for Electronic Data Interchange (WEDI), formal advisors to HHS on health IT, 86% of respondents say it would be very difficult or difficult "for providers and facilities to determine who should be the 'convening provider/facility.'" Some 83% of respondents supported delaying the requirement "until there is standardized data exchange process in place to communicate information between convening providers and co-providers/co-facilities."

Paul Johnson, the former Phoenix mayor who runs the care coordination company Redirect Health in Scottsdale, Ariz., says his company also operates a clinic that has to follow policies that have stemmed from the No Surprises Act, and "from the clinic side these rules are really hard and we're struggling to implement them."

However, Johnson also acknowledges that "from our customers' standpoint, balance billing and disclosure are high priority issues" and believes the convener requirement can be doable if all parties are cooperating. As a care coordinator he routinely works with hospitals on billing for multiprovider service costs, and finds that "when we work with hospitals around the country, we find a lot of them are very cooperative about helping us get a price and editing downstream costs," Johnson says. "Granted, a lot of others try to play games — they give us a price and send a balance bill to our customer." Johnson thinks for some

hospitals this is still "a standard course of business... But [NSA] is helping address that system issue."

Other experts point to additional issues that have to be squared away.

"Groups within the provider community have been communicating both formally and informally with CMS about these requirements," says David McLean, partner with Hall Booth Smith PC in Atlanta. "For example, take mental health providers. It's very difficult to put together a GFE for their services because you're looking at an open-ended term of illness and you can't really create an upfront estimate."

Drevna says the technical issue is a major part of the convener problem "There's no way to automate this process," he says. "Our EHRs don't have the capability to transmit this sort of information or even communicate provider-to-provider … Systems aren't set up to share billing details provider-to-provider. They're designed to work with payers."

Rajesh Voddiraju, founder and group president at Health iPASS, a Sphere company in Chicago, sees an obstacle in the eligibility "black box" that hides the enrollment or insurance status of providers from practices that are not subscribed to the same plan. "We need a registry that democratizes this information so that anyone in the chain, including the patient, will be able to examine all the providers' statuses," he says.

Voddiraju hopes that "market movers" in the industry will push for greater transparency. "The government should expand the administrative simplification mandate [to make] payers provide network participation status," he says.

Will CMS relent?

In recent months, CMS has been bombarded by lawsuits related to NSA rules (*PBN 3/7/22*). In response, the agency "has promised that it will address all of the concerns raised in the challenges to the interim final rule early this summer," McLean says. "But we've yet to have an indication of when a revised rule is to be expected other than this sort of nebulous promise."

Experts tell *Part B News* they believe CMS is operating in good faith, and that provider organizations are on board with the general mission of preventing surprise billing.

"CMS implemented this essentially on an emergency basis in their interim final rule — like, this is something that's so critical it needs to be done right away," Drevna adds. "So it came up fast and caught everyone off guard."

"I think generally there's support in the provider community [for the idea] that we need to avoid surprise bills to patients and have price transparency so they can make good decisions," McLean says. "The litigation and all these other disputes revolve around the mechanics of how best to do that." — *Roy Edroso* (redroso@decisionhealth.com) ■

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Coding

FY2023 ICD-10-CM: Head injury, dementia codes dominate extensive diagnosis code update

It's final: Providers will have 1,491 ICD-10-CM code changes to prepare for by Oct. 1 this year, including 1,176 new codes, 287 deletions and 28 code revisions.

The comprehensive final FY2023 ICD-10-CM code set, including code lists, tabular and index addenda and the 2023 Official Guidelines for Coding and Reporting, were issued June 10 on the CDC website.

In one of the most extensive changes, the codes for dementia were expanded to allow coding for specific behavior disturbances. Although codes currently exist for dementia with and without behavioral disturbances, there is a need for additional detail on other key associated disorders, particularly psychotic disorders, mood disorders and anxiety, the proposals stated.

(continued on p. 6)

Benchmark of the week

Post-op E/M visits fall sharply in wake of COVID incursion

Much like standard E/M office visits, lab tests and other services, separately reported postoperative patient encounters took a sharp dive in 2020 as practices grappled with the first wave of the COVID-19 public health emergency (PHE).

A Part B News analysis of Medicare claims data involving modifier **24** (Unrelated evaluation and management service by the same physician during a postoperative period) reveals a net 21% decrease in office visit encounters (**99211**-**99215**) for established patients between 2019 and 2020. Claims for the most-billed postoperative encounter, 99213, fell from 594,000 in 2019 to 474,000 in 2020. Across the series of five office visit codes billed with modifier 24, payment fell by more than $10 million over the two-year period.

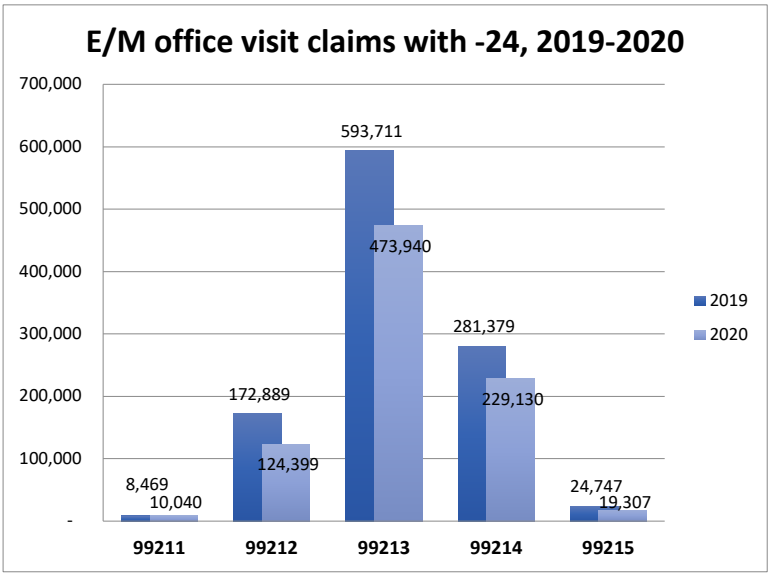
Subsequent inpatient postoperative encounters (**99231**-**99233**) also decreased, but to a lesser degree. The most-reported service with modifier 24, 99232, saw a claims decrease of about 32,000 claims between 2019 and 2020, a 15% reduction. Payments for the inpatient services edged lower by about $2.4 million over the period in review.

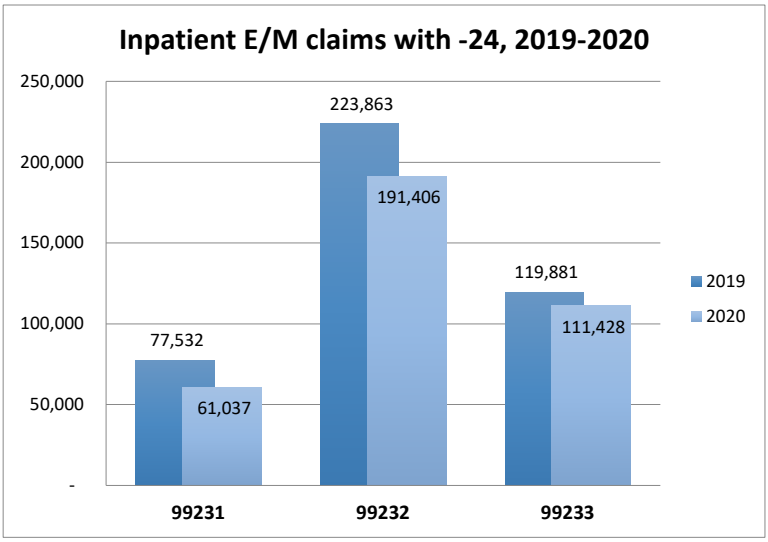
Critical care services, meanwhile, sustained a lesser rate of loss. Total claims for primary code **99291**-24 slipped by 8%, falling from 60,454 claims in 2019 to 55,697 claims in 2020. Revenue dropped by about a half of a million dollars.

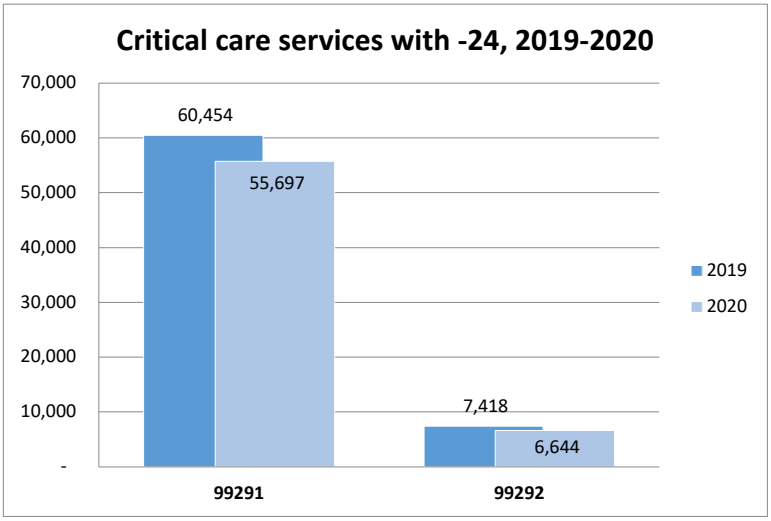
Several specialties appear to have been impacted by the reduced claims more than others, according to a review of the top specialties reporting 99213 during a postoperative period in 2020. The leading specialties that reported 99213-24 in 2020 include orthopedic surgery (84,000 claims), dermatology (80,000 claims), podiatry (77,000 claims), ophthalmology (56,000 claims) and physician assistant (35,000 claims).

— *Richard Scott* (*rscott@decisionhealth.com*)

Source: Part B News *analysis of 2019-2020 Medicare claims data*







(continued from p. 4)

Some of the new codes include:

- **F02.811** (Dementia in other diseases classified elsewhere, unspecified severity, with agitation).
- **F02.A11** (Dementia in other diseases classified elsewhere, mild, with agitation).
- **F02.B11** (Dementia in other diseases classified elsewhere, moderate, with agitation).
- **F02.C11** (Dementia in other diseases classified elsewhere, severe, with agitation).

These are just four of the 83 new codes added to Chapter 5 (Mental, Behavioral and Neurodevelopmental disorders (**F01-F99**).

A new guideline was added for the assignment of dementia (categories **F01**, **F02** and **F03**), which states that selection of the appropriate severity level (unspecified, mild, moderate or severe) "requires the provider's clinical judgment and codes should be assigned only on the basis of provider documentation unless otherwise instructed by the classification. If the documentation does not provide information about the severity of the dementia, assign the appropriate code for unspecified severity."

Under the codes for Huntington's (**G10**), Parkinson's (**G20**) and Alzheimer's disease (**G30**), you will be prompted to use an additional dementia code from the expanded dementia code lists, if applicable.

Acute head injury codes expanded

Some 86 new codes were finalized for head injuries in section **S00**-**S09** (Injuries to the head), including the following concussion codes:

- **S06.0XAA** (Concussion with loss of consciousness status unknown, initial encounter).
- **S06.0XAD** (Concussion with loss of consciousness status unknown, subsequent encounter).
- **S06.0XAS** (Concussion with loss of consciousness status unknown, sequela).

A range of additional codes were added for more serious brain injuries, ranging from traumatic cerebral edema (**S06.1XA**) to primary blast injury of brain with loss of consciousness (**S06.8A**).

Slipped epiphysis coding gets more specific

Practices will find a total of 35 new codes and nine revised codes in Chapter 13, Diseases of the musculoskeletal system and connective tissue (codes **M00-M99**).

Among the additions are new codes for intervertebral annulus fibrosus defects (**M51.A**), which describe a hole that can develop in the annulus, or outer layer of an intervertebral disc as a result of a disc herniation. Note that the codes describe the hole caused by the herniation, not the herniation itself. New tabular instructions tell you to code first the herniation. Report the M51.A codes based on the region (lumbar or lumbosacral) of the spine and the size of the defect (small or large).

You'll also find new codes for back muscle wasting and atrophy not elsewhere classified for each spinal region (**M62.5A**).

A new M code category (**M96**) has also been added for rib and sternum fractures associated with chest compression and cardiopulmonary resuscitation (CPR).

More code change highlights

- The cardiovascular system chapter is slated to expand, with new combination codes for atherosclerosis and refractory angina pectoris, involving native coronary arteries, different types of coronary artery bypass grafts and heart transplant. Example: **I25.732** (Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with refractory angina pectoris).
- Other circulatory code changes include deletion and replacement of 10 codes for conditions such as noninflammatory pericardial effusion (**I31.3**), ventricular tachycardia (**I47.2**) and thoracic aneurysm with rupture (**I71.1**) and without rupture (**I71.2**).
- Three new codes will be added to category **Z55**-**Z65** (Persons with potential health hazards related to socioeconomic and psychosocial circumstances), including **Z59.82** (Transportation insecurity), **Z59.86** and **Z59.87** (Material hardship).
- Category **Z79** (Long term [current] drug therapy) will see the addition of 15 new codes including **Z79.85** (Long-term [current] use of injectable non-insulin antidiabetic drugs). A new guideline was added to Chapter 4 (Endocrine, Nutritional, and Metabolic Diseases) advising that if the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes **Z79.4** (Long term [current] use of insulin) and Z79.85. If the patient is treated with

both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes **Z79.84** (Long term [current] use of oral hypoglycemic drugs) and Z79.85. — *DecisionHealth Staff* (*pbnfeedback@decisionhealth.com*) ■

RESOURCE

- FY2023 ICD-10-CM final code update: *www.cdc.gov/nchs/icd/Comprehensive-Listing-of-ICD-10-CM-Files.htm*

Practice management

Amid escalating gun violence, consider tech, environment fixes to boost safety

A rash of gun violence around the nation, including a June 1 shooting at the St. Francis Hospital campus in Tulsa, is a cue to consider security upgrades to protect your practice and patients.

The Tulsa patient who killed four people, including the doctor who was treating him, before committing suicide had no trouble entering the premises without official clearance. He entered via the parking garage, the kind of security shortfall that Celina Burns, chief commercial officer at the IntelliCentrics credentialing and security firm in Flower Mound, Texas, believes will be less acceptable to administrators in the days ahead.

"There can be hundreds of people walking the hallways of a hospital at any given moment, including [besides patients and providers] vendors, such as representatives of pharmaceutical and medical device companies," Burns says.

While you may not want to make big changes based on the threat of intruder violence, you should consider, along with your normal concern for the people in your office, your responsibilities under the Occupational Health and Safety Act (OSHA) and your exposure to legal liability in the event of an attack (*PBN 7/19/21*).

According to Gene Petrino, a security consultant and co-founder of Survival Response LLC in Coral Springs, Fla., a typical security reassessment would include an evaluation of the physical practice environment and may call for new design elements to enhance safety, such as lighting that makes it easier for both staff and security cameras to see what's going on in what would otherwise be dead spots.

You might also want to consider having certain areas, such as the front desk, behind protective glass. While "bullet-resistant glass is expensive, bullet-resistant film is much more affordable and can be easily installed," Petrino says. You also could have a more secure door built for the passageway from the waiting room to the exam rooms.

You may want to consider other security measures as well, such as access control systems, security guards or metal detectors, with an eye toward deterrence. Petrino mentions the "Pathways to Violence" analysis by researchers Frederick Calhoun and Steve Weston, which shows assailants usually go through "research and planning" and "probing" phases, in which they consider the likelihood that their attack would succeed, before committing to action (*see resource, below*).

"The shooter in Tulsa knew that there wasn't anything stopping him," Petrino says. "But in other circumstances, if someone says, 'I can't get past that door, this is going to be hard to do,' that's going to reduce their chances."

Petrino thinks employee training is of limited use and often just serves as a crutch. "There are a lot of administrators in health care who claim safety as a priority, but when it comes to taking action, they just check boxes: 'We did our training,'" he says. But Petrino acknowledges the importance of policies and procedures and an action plan so that staff know what they're expected to do in the event of an incident (*PBN 5/18/15*).

Track your visitors

You might also consider elevating your awareness of who's in your facility — and who's not supposed to be there. Burns' company offers a digital badge system that allows clients to issue visitors a more technologically advanced version of the usual sticker or lanyard — one that not only tracks the movements of visitors within the space, but also alerts security if the visitor is going where they're not permitted.

This applies not only to staff, physicians and patients, but also to vendors and other business visitors. Visitors register their digital credentials and are allowed or denied access based on levels of clearance, time of appointment and similar factors, which may be updated in real time by the facility.

"In the last few weeks, not surprisingly, we've seen a doubling-down on the amount of discussion and investment in security at all points of entry from the C-suite," Burns says.

Burns notes an added advantage of having a fresh security system: "Having a safe environment really has a direct impact on workforce engagement and turnover," she says. "We've all heard the stories about the pandemic patient population, about how some patients are more angry, volatile and in some cases abusive, and how that's contributed directly to turnover. So this doesn't just contribute from a digital security perspective but also relates to workforce engagement and turnover prevention."
— *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCE

- Pathways to Violence: www.gov1.com/public-safety/articles/resources-learning-the-pathways-to-violence-can-prevent-violent-attacks-CzgELMuBwEA2qcP8

Practice management

CMS won't cut record-high Medicare premiums until 2023

Hopes that CMS would make a mid-year cut to Medicare Part B premiums were dashed by an agency release suggesting they would be trimmed in 2023 instead.

On May 19, four-and-a-half months after HHS Secretary Xavier Becerra revealed that he had instructed CMS to "reassess" the premiums, CMS released a report that recommended "incorporating the savings realized from the difference between assumed and actual Part B spending into the 2023 Part B premium determination."

The current average premium sits at $170.10, a 14% hike from the 2021 rate of $148.50. The larger-than-usual increase had been meant to "cover the potential costs of Aduhelm and similar drugs" to the Medicare trust fund, CMS Administrator Chiquita Brooks-LaSure noted in a May 27 press release. Aduhelm, a new and expensive Alzheimer's drug, had at that time been cleared by the FDA, and it was anticipated that federal payers would be obliged to pay full freight for the treatment (*PBN 6/21/21*).

Becerra's January 10 call for reassessment was prompted by an announcement from Biogen, the maker of Aduhelm, that it was cutting the price of its treatment by half, from about $56,000 a year to $28,000. Shortly thereafter, CMS revealed that it would only pay for Aduhelm treatment dispensed in certain clinical trials, further reducing Medicare's financial exposure and exciting speculation that CMS would reduce premiums even sooner than 2023 (*PBN 5/2/22*).

Some public officials publicly called for a quicker cut. "I recognize the unprecedented nature of the request but believe it is justified given the unique circumstances," U.S. House Representative Angie Craig (D-Minn.) wrote in an open letter to CMS on April 22, 2022.

But Alan J. Sager, Ph.D., professor of health law, policy and management and director of the health reform program at Boston University School of Public Health, thinks an earlier cut was always unlikely. "People running large organizations — public or private — value consistency and stability," Sager says. "They hate to admit they were wrong in setting an excessive 2022 premium back in November of 2021, and hate to be seen as changing their minds in the middle of 2022." Sager also thinks the Biden administration worried that a 2022 cut "might have looked like pre-election fishing for votes."

A 2023 cut is not absolute, either: "The actual 2023 Part B premium determination will occur this fall and will reflect additional information, such as actual 2022 claims data and the funding status of the Part B account during 2022," CMS says. But between the Aduhelm draw-down and the recent downturn in U.S. budget deficit numbers, the chances of a reduction appear promising.
— *Roy Edroso* (redroso@decisionhealth.com) ■

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- CMS, "Report to the Secretary: Reexamination of the 2022 Medicare Part B Premium," May 19, 2022: www.cms.gov/files/document/cms-report-secretary-2022-medicare-part-b-premium-reexamination.pdf
- CMS, "CMS Releases Analysis on 2022 Medicare Part B Premium Reexamination," May 27: www.cms.gov/newsroom/press-releases/cms-releases-analysis-2022-medicare-part-b-premium-reexamination
- "Representative Angie Craig Urges CMS Administrator to Rescind Price Increase for Medicare Part B Premiums," April 22, 2022: https://craig.house.gov/media/press-releases/representative-angie-craig-urges-cms-administrator-rescind-price-increase

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