GHA | Garfunkel Health ADVISORS

Garfunkel Wild

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HEALTH CARE COMPLIANCE NEWSLETTER

COMPLIMENTARY WEBINAR

Major Changes to E/M Coding and Documentation Requirements in 2023 – Will You Be Ready?

Hospitalists and Emergency Department Providers	Nursing Home and Home Health Providers
Tuesday, November 8, 2022 | 12:00 pm - 1:00 pm (EST)	Wednesday, November 9, 2022 | 12:00 pm - 1:00 pm (EST)
Register Here	Register Here

On January 1, 2023, the second round and the biggest changes in decades to the documentation and coding guidelines for Evaluation and Management (E/M) services will go into effect. Join Garfunkel Health Advisors and Garfunkel Wild, as we provide practical guidance on the most important changes, as well as discuss best practices for lowering audit and compliance risks.

Whom this will affect: The American Medical Association's (AMA) new 2023 E/M coding changes will affect every health care professional that bills for any of the following visit types:

- inpatient/observation level care
- emergency department
- inpatient/outpatient consultations
- nursing facility
- home/residence

Why you need to attend: The E/M revisions will require health care professionals to modify their documentation, coding, and billing practices in these settings. Mastering the new E/M revisions will be critical to ensuring payment integrity, avoiding unnecessary denials and/or delays in reimbursement. Your health care professionals, staff, and EMR system depend on the correct implementations of the new AMA 2023 guidelines to ensure that your practice is capturing all it's entitled reimbursement and is not up-coding services.

In this issue

Be On The Lookout:

Additional E/M Updates Scheduled To Become Effective January 2023

♦ Article by **Alicia Shickle**

The American Medical Association ("AMA") has approved and updated the CPT 2023 E/M guidelines on its website, and those changes will take effect on January 1, 2023. These changes will involve both deletion and revision of specified codes.

The following codes will see major revisions in 2023.

- Hospital services, inpatient and observation care.
- Consults.
- Emergency department services.
- Nursing facility services.
- Home and domiciliary services.

For example, Hospital Observation Services E/M codes 99217-99220 will be deleted, as will be Consultations E/M codes 99241 and 99251 and Nursing Facility Services E/M code 99318. Included in the codes that will be revised are Hospital Inpatient and Observation Care Services E/M codes 99221-99223, 99231-99239, Consultations E/M codes 99242-99245, 99252-99255, and Emergency Department Services E/M codes 99281-99285.

Given the impending implementation date that is less than six months away, your practice has limited time to prepare for this next round of significant E/M guideline and code changes. Fortunately, Garfunkel Health Advisors ("GHA") continues to keep abreast of such prospective changes and other industry changes in order to assist its clients in preparing themselves accordingly to avoid reimbursement issues down the line. No doubt more training is needed for practices to ready themselves for such changes in order to ensure documentation and coding compliance, and GHA is fully available to provide such guidance and training.

Protect Your Medical License:

Use certified coders to help ward off licensure sanctions

♦ Article by **Andrew L. Zwerling**[1]

There has been a steady trend of increased scrutiny by governmental agencies responsible for investigating complaints against physicians and for prosecuting acts of professional misconduct by physicians, including the coding and billing practices of physicians. All practitioners should be aware that billing improprieties may constitute a form of professional misconduct that such agencies may rely upon in taking action against a physician's medical license – up to and including revocation of a physician's license.

Typically, awareness of governmental scrutiny comes in the form of a letter to the physician advising the physician that he or she has the opportunity to be interviewed by the agency concerning allegations of potential coding or billing improprieties. Those interviews must be taken seriously. No physician should undertake such an interview without careful and comprehensive preparation, because a failure to do so may result in inaccurate or incomplete statements being made at the interview by an unprepared practitioner, with otherwise avoidable licensure sanctions the result. (Nor should a physician ever participate in an interview without counsel present.) Part of the preparation in the context of alleged coding and billing improprieties is retaining the input of a certified coder – a service offered by Garfunkel Health Advisors – to conduct an audit of the billing records in question to see whether or not there were actionable billing errors, so that the physician is in a position to advance the strongest possible defense to the allegations.

Even those physicians who have not been the unfortunate recipient of such an agency interview letter should, on a regular basis, have a certified coder conduct should a review as a preventive measure. Careful attention to one's billing and coding practices, even when such functions are handled by outside vendors, should be high on a physician's priority list to avoid governmental involvement.

Avoid Reduced Reimbursement:

Respond properly to the Final Rule For Split/ Shared Services

♦ Article by **Alicia Shickle**[2] **and Simon Chaykler**[3]

Ever since CMS released the 2022 Medicare Physician Fee Schedule Final Rule for Split/Shared Services (the "Final Rule For Split/Shared Services") Garfunkel Health Advisors ("GHA") has busily been assisting clients in responding properly to these new requirements and by conducting provider outreach and education. These comprehensive efforts by GHA are designed to ensure that clients avoid running afoul of these new mandates and thereby suffer the consequences, including reduced reimbursement.

CRITICAL COMPONENTS OF THE FINAL RULE FOR SPLIT/ SHARED SERVICES

Under the Final Rule For Split/Shared Services, split/ shared services refers to "Evaluation and Management" ("E/M") services provided in a facility setting by both a physician and a non-physician provider ("NPP") in the same group. The term "facility" refers to hospital settings (including inpatient and outpatient settings, the emergency department, observation care and critical care) and skilled nursing facilities. (Importantly, the Final Rule For Split/Shared Services does not apply to office settings.) The visit is billed by the physician or practitioner who provides the "substantive portion" of the visit.

For 2022, a practitioner is said to have provided the "substantive portion" of the visit if the practitioner either performs one of the key components of the visit in its entirety

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– history, physical examination and medical decision-making – or provides services for more than 50% of the total visit time, and upon meeting those criteria can bill for the encounter with a modifier FS. Originally, CMS had stated in the Final Rule For Split/Shared Services that by 2023, the "substantive portion" of the visit was solely to be defined as more than half of the total time spent. In the CY 2023 proposed final rule, however, CMS states that it will continue to use the broader definition that also encompasses the practitioner performing one of the key components of the visit.

All medical records must include the identity of the practitioners who performed the visit, as well as the time spent by each practitioner in order to assess who provided the "substantive portion" of the visit. CMS states "any individual who is authorized under Medicare law to furnish and bill for their professional services, whether or not they are acting in a teaching role, may review and verify (sign and date) the medical record for the services they bill, rather than re-document notes in the medical record…" Sufficient medical record documentation is the key to proper reimbursement.

YOU NEED NOT NAVIGATE THIS MURKY LANDSCAPE ALONE

Careful attention to these coding and documentation requirements is critical. Garfunkel Health Advisors can assist you in implementing these new guidelines correctly and efficiently and in conducting a baseline audit to assess whether your existing system fully complies with the Final Rule For Split/Shared Services.

Properly Address Billing and Overpayment Issues:

Use billing and documentation experts to ensure payer rules are being followed

♦ Article by **Peter Hoffman**[4]

It is not at all unusual for health care providers to discover potential billing and overpayment issues in the course of their day-to-day operations. Such issues may arise in any number of ways. For instance, they may be identified as the result of a provider's internal compliance efforts, including compliance program audits or reviews, or as a result of internal investigations into errors found by billing or other personnel. They may also be identified as a result of external factors, such as payer audit findings that raise billing and payment questions that extend beyond the time period covered by the audit, or by external complaints. Regardless of how an issue arises, however, it is important that providers timely investigate the matter and take appropriate corrective action. Often, however, providers are unaware of what they must do to – and when they must do it – in order to avoid legal peril. For example, providers who identify federal health care program overpayments are required to report, return and explain the overpayments within 60 days from the date they are identified. The failure to do so can have severe consequences, including potential liability under the federal and/or state False Claims Acts. Timely refund obligations also commonly exist elsewhere in the law, including in contractual network agreements between a provider and a payer. It is essential that providers be mindful of, and abide by, these obligations. Even if providers are aware of the need to act, they often do not know how to proceed or do not have the expertise needed to do so.

These matters often pose complex and difficult factual, coding and legal issues: Payment policies and rules may vary from payer to payer, may change over time and are often unclear; myriad legal issues may exist depending on the payers and providers involved. When an issue is first identified, it is often important to have billing and documentation experts review the matter in conjunction with legal counsel in order to ensure that the correct payer rules and laws are being followed, and that the matter is timely and appropriately addressed. Consulting with a documentation and coding expert, such as Garfunkel Health Advisors, and legal counsel early in the process may help ensure that the issue is appropriately handled and that a provider's exposure is appropriately mitigated, to the greatest extent possible.

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