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In this issue

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Practice management

As practice burnout boils over, take bold steps to hold and head it off

Even as pandemic pressures fade, symptoms of burnout in medical providers are getting worse rather than better, recent findings show. Practices that want to stem the tide should take advantage of tested methods and metrics — as well as some more imaginative ones — to help hold the line.

On Sept. 13, the journal Mayo Clinic Proceedings published results from a survey of U.S. physicians taken in late 2021 and early 2022 that found "mean emotional exhaustion and depersonalization scores were higher in 2021 than those observed in 2020" — the former by 38.6%, the latter by 60.7%. The study also found that the percentage of physicians exhibiting at least one manifestation of burnout grew between 2020 and 2021 by nearly 25 points.

Management consultancy Bain and Company found in survey results published Oct. 11 that 25% of clinicians surveyed, including nurses and non-physician practitioners as well as physicians, were considering switching careers, with 89% of these respondents citing burnout as a cause.

Experts tell *Part B News* that burnout and the job dissatisfaction it causes in medical practice are not generally improving, and that it is causing employment disruptions.

That's what the money's for

Traditionally, practices have dealt with job dissatisfaction, to the extent they could, by offering employees more money. But for many practices, this may not be an option; for others, it may not reach the core challenges.

Stu Schaff, founding principal of Intentionate Healthcare Advisors in Chicago, says that "in most situations [when

physicians leave], I have found that the underlying issue is typically not that they feel they're not paid enough — it's typically that they don't have the support they need."

Previous studies have shown that health care workers start to wander, or leave their field entirely, when the work itself becomes onerous to them (*PBN 11/8/21*). In the latest Annual Regulatory Burden report from the Medical Group Management Association (MGMA) issued this month, an overwhelming 89% of practice professionals polled said that "the overall regulatory burden on [our] medical practice over the past 12 months has increased." Prior authorization was the burden most often named, as it had been the year before, with 81.9% of respondents calling it "very or extremely burdensome." But a new source of stress also emerged: Second on the list was "Surprise billing and good faith estimate requirements," which were only added to practice responsibilities this year (*PBN 6/20/22*).

COVID also remains a concern. The second most-cited reason for job dissatisfaction in the Bain study, at 41%, was "personal health and safety," followed by "family or friends' health and safety" at 25%.

"The pandemic has just piled on all the other drivers of burnout that were in place before the pandemic and have obviously continued," says Robert Morton, assistant vice president, department of patient safety and risk management with The Doctors Company in Napa, Calif. "Short staffing was already an issue [in health care], but it's grown worse because so many health care professionals are leaving."

Consider a tech fix

While paying each or even selected staff members more for their services may not be an efficient or even feasible hedge against burnout, investments in practice infrastructure may help.

"Nobody's really paying enough attention to workloads and workflows and whether or not an organization is truly properly staffed, and using technology to the best of their ability to offload work," says John Guiliana, medical director, podiatry with Modernizing Medicine (ModMed) in Boca Raton, Fla. "Other industries are light years ahead of health care in automating certain processes."

Guiliana says he sees "many practices that aren't using technology associated with, for example, making the billing process easier, such as automated eligibility checking or recall of patients; many practices are still employing human resources to actually make phone calls to remind patients of their appointment. These are the type of processes that, when automated, can lower that threshold of burnout."

Girish Navani, CEO of eClinicalWorks, adds that "streamlining workflows definitely can smooth operations, resulting in fewer communication gaps and fewer things falling between the cracks, so people don't have to multitask too much."

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Above and beyond workflow and other administrative fixes, Navani also suggests intervention on the patient care side, or what he calls "making the patient copilot with [the provider]." That could happen by using a digital interface so patients "fill out more in-depth self-assessment." Programmatic chat bots, which can help triage patients, and scribe technologies can also give clinicians needed breathing room (*PBN 5/24/21*).

This can work on a macro level as well, Navani says. For instance, population health programs from Medicare and commercial insurers that reimburse for patient outcomes "can also augment your reimbursement while enhancing your way of practicing medicine" (*PBN 10/29/18*). And it can work at the micro level: "Workload and workflows can mean, for example, work set-up — the ergonomics alone can make a dramatic difference," Guiliana says. "Time and motion studies are hardly ever done in private practice settings, but when I have done time and motion studies in private practices, and then point out the time units and the amount of motion that takes place to create one simple [clerical] task, and then make suggestions for alternatives, it significantly reduces the stress level."

Use the tools

Burnout has been an issue long enough that some of the best minds in medicine and medical management have turned their attention to it. "Organizations can start really by using the validated instruments that have already been in place for some time to measure burnout and well-being and organizational costs," Morton says.

The best-known measurement tool is Maslach's burnout inventory, a "medical personnel" version of which is commercially available. Morton also recommends the National Academy of Medicine's "National Plan for Health Workforce Well-Being," issued in October, and the U.S. Surgeon General's "Addressing Health Worker Burnout: Advisory on Building a Thriving Health Workforce," issued in May.

One huge benefit for practices is that these instruments offer an "evidence-based approach to action … which is great if you're working with physicians, because it's first-nature for them," Morton says.

Morton also suggests branching out into other kinds of group management approaches that have worked outside health care and relate to specific burnout-related concerns. For example, if you want clarity on how your staff are feeling, rather than pass out questionnaires you might explore the "humble inquiry" approach popularized by Edgar Shein, which "is about asking open-ended questions that we don't know the answer to, so that the front line staff who are experiencing the burnout drivers can tell you" what's on their minds, Morton says.

"One of the drivers of burnout is a breakdown in community," Morton says. "Breaking bread together, an age-old tradition, cultivates a sense of belonging, respect, and connection which rebuilds community."

Start on the same page

Schaff believes that "one of the root causes of burnout is when someone's expectations don't meet reality." That can be particularly true when providers join a practice.

This stems from both sides: With management, Schaff says, "in most situations you'll recruit a health care provider, and the employer's attitude is, you're a doctor, you know 'how to doctor,' you'll figure it out." As for the provider, they may be inhibited or just plain scared to interrogate the situation they're getting into, particularly in an era of huge medical school debts: Schaff says he's seen physicians who, when they're pre-sented with with a contract, become "so worried that they're going to lose the job if they even ask questions that they just sign it."

But no other profession is run like that, Schaff notes. "When you have a job, typically there's a job description, standard operating procedures, etc., that dictate what that job looks like, how you'll be supported in doing that job, what the outcomes are supposed to look like and so on," he says.

Schaff thinks joining a practice should begin with a dialogue in which the prospect and practice management each talk about what they want and set up goals to meet those requirements. After hiring, regular review can keep everyone in sync, and the unspoken disap-pointments that lead to dissatisfaction becomes less likely.

This applies to practice workers at all levels, Guiliana says: "When I ask many private practitioners to show me their job descriptions, they have it up in their brains, but they have nothing in writing," he says. "That causes somebody to take a job that they truly

don't understand, and then shortly thereafter they become very disenchanted with that job."

"One good thing about my prescription of actually talking to each other and listening to each other and being clear about what you expect from one another is that you can do that today — you don't have to set up or put in a new software system," Schaff says. "It's just a matter of practicing it, and the more you do it, the better you get at it." — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCES

- "Changes in Burnout and Satisfaction With Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic," Mayo Clinic Proceedings, Sept. 13, 2022: *www.mayoclinicproceedings.org/article/S0025-6196(22)00515-8/fulltext#%20*
- "A Treatment for America's Healthcare Worker Burnout," Bain and company, Oct. 11, 2022: *www.bain.com/insights/a-treatment-for-americas-healthcare-worker-burnout/*
- MGMA Annual Regulatory Burden report, October 2022: *www.mgma.com/getmedia/099f8c3b-1e4b-4a36-ac2e-18c9215eb2dc/2022_MGMA-Regulatory-Burden-Report-FINAL.pdf.aspx?ext=.pdf*
- "National Plan for Health Workforce Well-Being," National Academy of Medicine, October 2022: *https://nam.edu/initiatives/clinician-resilience-and-well-being/national-plan-for-health-workforce-well-being/*
- U.S. Surgeon General, "Addressing Health Worker Burnout: Advisory on Building a Thriving Health Workforce," May 2022: *www.hhs.gov/surgeongeneral/priorities/health-worker-burnout/index.html*

Health care reform

CMS seeks comment on payer-agnostic data directory with potential provider savings

A request for information (RFI) for a payer-agnostic provider directory is a sign that CMS is pushing harder for an interoperability standard in health care data exchange that also will include private payers.

CMS announced on Oct. 7 an RFI toward the goal of developing a payer-agnostic "National Directory of Healthcare Providers & Services," or NDH. Finding "the fragmentation of current provider directories requires inefficient, redundant reporting from providers," the RFI seeks comment on how best to assemble "a CMS-developed and maintained, Application Programming Interface (API)-enabled, national directory."

The RFI notes that centralization of, and ready digital access to, provider information is already required under federal laws, but government studies have found it lacking; for example, annual reviews to assess the accuracy of issuers' machine-readable provider data files from qualified health plans (QHP) under the Affordable Care Act have "found that no more than 47% of the provider entries we reviewed from the machine-readable provider data files included a complete set of accurate telephone numbers, addresses, specialties, plan affiliations, and whether the provider is accepting new patients."

Federal health care and health IT officials have been trying to improve things with tech initiatives and specifications such as Fast Health Interoperability Resources (FHIR), but have been slow to implement them (*PBN 3/30/20*). In 2020, the U.S. Office of the National Coordinator's "FHIR At Scale Taskforce" (FAST) concluded that "there should be one directory that acts as a centralized data hub to build trust, improve accuracy, and reduce the administrative burden on providers that submit data to multiple directories," the RFI says.

It appears the NDH would start with data from the National Plan & Provider Enumeration System (NPPES) and the Provider Enrollment, Chain, and Ownership System (PECOS), as well as Medicare Compare. It also would combine data from other HHS information sources, such as the Administration for Community Living's (ACL) Eldercare Resource Locator and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Behavioral Health Resource Locator, according to questions contained in the RFI. Other questions point directly to the inclusion of non-government payer information, e.g., "Understanding that individuals often move between public and commercial health insurance coverage, what strategies could CMS pursue to ensure that an NDH is comprehensive both nationwide and market-wide?"

In other words, the NDH "would be payer-agnostic and public-private," says Faisal Khan, senior legal counsel and hospitals and health systems practice lead at Nixon Gwilt Law in Cleveland.

(continued on p. 6)

Benchmark of the week

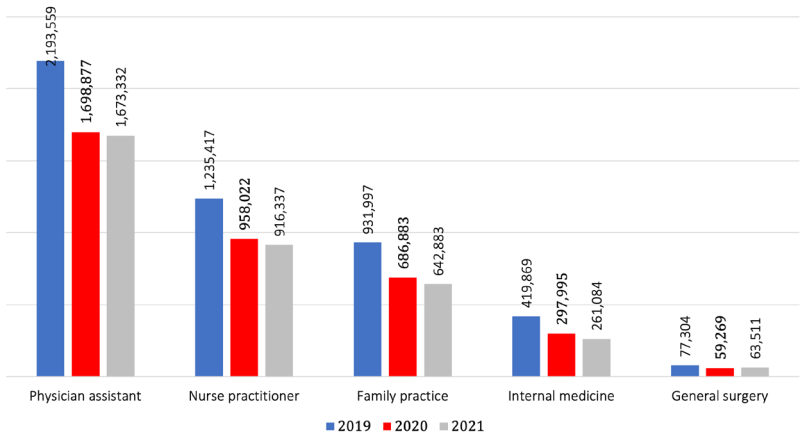
After emergency medicine, PCPs and surgeons take over ER

Thanks to popular media, the public may think that physicians and nurses who specialize in emergency medicine are the only providers who work in the emergency department. But the latest Medicare Part B data for emergency department E/M visits (**99281-99285**) reveals that members of any specialty can and do provide emergency department services (*see story, p. 6*).

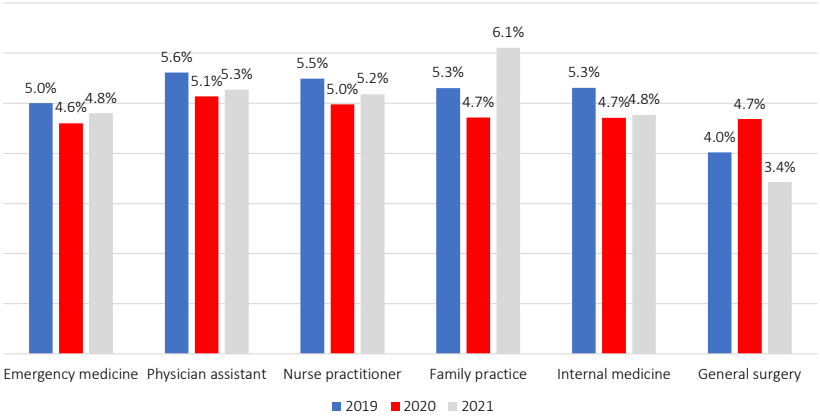
Emergency medicine specialists dominate claims for emergency E/M visits. They reported an average of 13.5 million claims in 2019, 2020 and 2021. However, as the first chart below shows, after emergency medicine, primary care specialties and general surgery take the lead in reporting emergency department visits. Physician assistants and nurse practitioners occupy second and third place, respectively. General surgery comes in a distant fifth, and utilization by other specialties shows a steady drop off. For example, general practice follows general surgery with approximately 35,000 claims in 2021.

The second chart shows the denial rates for emergency medicine specialists and the top five non-emergency specialties. In most cases the non-emergency specialties had denial rates that were within a percentage point of the top reporters. This may indicate that the specialties have a solid understanding of how to report the codes. In fact, general surgery's denial rates were lower than emergency medicine's in 2019 and 2021, and family medicine was the only specialty that had a denial rate above 5% during the three-year period covered by this review. These specialties will need to train staff and update their software to keep their low-denial track records in 2023 (*PBN 8/8/22*, *10/17/22*). — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*)

Emergency department E/M by the top 5 non-emergency medicine specialties, 2019-2021



Denial rates for top emergency E/M specialties, 2019-2021



Source: Part B News *analysis of 2019-2021 Medicare claims data*

(continued from p. 4)

Who would benefit?

For providers it would be nothing but net benefits: The RFI cites a 2019 Council for Affordable Quality Healthcare (CAQH) study that finds "transitioning directory data collection to a single streamlined platform could save the average physician practice an estimated $4,746 annually."

Paul F. Schmeltzer, a health care attorney with Clark Hill in Los Angeles, believes its efficiencies would also "free up providers to see more patients."

Would private insurers welcome inclusion in such a directory? Schmeltzer thinks so, because the NDH "could reduce the burden on providers and payers by creating a single, centralized system that would promote real-time accuracy for patients." Depending on how the program shakes out, insurers might also be able to "access and use NDH data to their own benefit, including targeting consumers, and maximizing it for commercial and operational uses," Schmeltzer adds.

"I think some private insurers would welcome the transparency and use such a federal directory to perhaps increase the bandwidth of their provider network and bring new physicians and providers within their network of participating providers," Khan says. He also thinks "increased transparency at the federal level will consequentially cause changes within private insurers to demonstrate 'their' physicians are more qualified and competent than the providers of other payers."

"Provider data is an integral and often underemphasized type of health data that has an incredibly high error rate, so it is great that the agency recognizes its importance," says Neel Butala, M.D., chief medical officer and co-founder at health care consultancy HiLabs in Bethesda, Md. "If successful, this initiative may pave the way for standardization of other types of data in health care."

"The common purpose or goal amongst all of these initiatives such as the 21st Century CURES Act and the proposed NDH is interoperability," Schmeltzer says. "I see the objective of operability as improving the exchange of health information and the use of that information once it is received, thereby making it easier for providers to deliver patient-centered, value-driven care, and thereby improving patient's health outcomes, while reducing costs for both the patient and provider."

The 60-day public comment period closes on Dec. 6, 2022. — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCES

- CMS, "Request for Information; National Directory of Healthcare Providers & Services," Oct. 7, 2022: *www.federalregister.gov/documents/2022/10/07/2022-21904/request-for-information-national-directory-of-healthcare-providers-and-services*
- CAQH, "The Hidden Causes of Inaccurate Provider Directories," 2019: *www.caqh.org/sites/default/files/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf*

Have a question? Ask *PBN*

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email *askpbn@decisionhealth.com* with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

Ask Part B News

Let the reason for the encounter drive coding for ED visits

***Question**: How do you report emergency department visits by a provider who is not on the emergency department staff?*

Answer: It depends on the reason for the encounter, according to CMS policy and the CPT guidelines that will go into effect Jan. 1, 2023. Emergency medicine involves unscheduled treatment of patients who come to the hospital's emergency department for immediate medical attention. You report emergency department visits with codes **99281**-**99285**.

"Any physician seeing a patient registered in the emergency department may use emergency department visit codes (for services matching the code description). It is not required that the physician be assigned to the emergency department," states Internet-only Manual 100-04, chapter 12, §30.6.11 (A).

The CMS policy went into effect Jan. 4, 2010, and is codified in the 2023 CPT manual.

"We added some guidelines and articulated current practice that was not explicit prior to this in CPT that allowed physicians and qualified health care professionals that are not ED staff to use these codes when

appropriate," said Barbara Levy, M.D., co-chair of the AMA's CPT/RUC Workgroup on E/M, during the Aug. 9 webinar E/M 2023: Advancing landmark revisions across more settings of care.

The note for an emergency department visit should indicate the immediacy of the service. For example, the notes might show that the doctor was on-call at a local hospital and had to go to the emergency room at 3 a.m. Another example would be a physician who went to the ER to treat a patient who was having chest pains and difficulty breathing.

You should report an emergency department visit with an office/other outpatient code (**99202-99215**) if the physician asks the patient to meet him or her in the emergency department as an alternative to the physician's office and the patient is not registered as a patient in the emergency department, according to Internet-only Manual 100-04, chapter 12, §30.6.11 (C).

The 2023 CPT manual echoes this policy with guidance to use an office/other outpatient E/M code when the visit takes place in the emergency department "for the convenience of a physician or other qualified health care professional."

Remind providers that accurate revenue for emergency department visits (place of service 23) depends on whether their documentation supports an emergency visit or an office visit. And train coders to contact the billing practitioner when they aren't sure. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

RESOURCES

- AMA webinar – E/M 2023: Advancing landmark revisions across more settings of care, Aug. 9, 2022: *https://portal.inxpo.com/ID/NTT/AMA* (log in or registration required).
- Internet-only Manual 100-04, chapter 12, §30.6.11 (A and C): *www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf*

Billing

Virtual incident-to is an option through 2023

Physicians can provide virtual direct supervision thanks to one of the many waivers that CMS created in response to the COVID-19 pandemic (*see story, p. X*). Virtual direct supervision gives the practice more flexibility to bill incident-to services, but it is not a permanent policy.

CMS will leave the virtual direct supervision policy in place until the end of the year that the COVID-19 public health emergency (PHE) expires. The latest PHE renewal pushed the expiration date to Jan. 12, 2023. Therefore, unless CMS issues a new policy, the earliest the waiver could expire is Dec. 31, 2023.

CMS asked for input on whether it should make the waiver permanent in the proposed 2023 Medicare physician fee schedule. It did not indicate whether it would act on any comments it received.

Virtual direct supervision is not one of the five-month telehealth extensions that Congress included in the Consolidated Appropriations Act of 2022 (*PBN 4/4/22*). – *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

RESOURCES

- Consolidated Appropriations Act of 2022: *www.congress.gov/bill/117th-congress/house-bill/2471/text*
- Proposed 2023 Medicare physician fee schedule: *www.govinfo.gov/content/pkg/FR-2022-07-29/pdf/2022-14562.pdf*

Ask Part B News

Virtual incident-to visits are still a choice during COVID-19 PHE

***Question**: We conducted a sample review of claims for 2021 and found two visits that were performed by the physician assistant (PA) but billed incident-to on days when the physician was not in the office. When we investigated, we found more claims with the same problem. According to the documentation for each visit the physician was at home but "present" through a real-time, audio/visual Zoom connection. Is there an exception that allows us to bill incident-to this way?*

Answer: Yes, there is an exception during the COVID-19 public health emergency (PHE). CMS created several waivers in response to the COVID-19 PHE, including a revision to the direct supervision requirements that are part of the incident-to rule. According to the document Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19:

"Medicare Physician Supervision Requirements: CMS has temporarily modified the regulatory definition of direct supervision, which requires the supervising physician or practitioner to be 'immediately available' to furnish assistance and direction during the service, to include 'virtual presence' of the supervising clinician through the use of real-time audio and video technology."

You should look for same incident-to red flags that apply to traditional incident-to encounters. For

example, if the physician performs procedures during the PA's visits, she would not be immediately available. If the patient brought up a new problem with the PA and the physician did not create a new plan of care, that would not be an incident-to visit. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

RESOURCE

- Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19: *www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf*

Ask Part B News

Check state scope laws on who may debride mycotic nails

***Question**: I would like clarification on whether only MDs, DPMs, APRNs or PAs are allowed to perform and bill Medicare for debridement of mycotic nails (codes **11720** and **11721**) in the office setting, when all the other criteria for the procedures have been met. Recently, I have been asked about a nail technician or medical assistant performing these procedures under supervision of a MD or DPM and billing the services to Medicare as incident to. I have found no information to suggest that this is appropriate. Am I correct in stating that nail technicians or medical assistants are not qualified to perform this service?*

Answer: It will depend on your state's scope of practice laws or regulations, advises podiatrist Dr. Michael Warshaw, DPM, CPC. This issue "has been floating around in my profession for years," he adds.

"A nail technician or a podiatric/medical assistant is not a licensed individual," he explains. "Therefore, if they perform this service in the office of a podiatrist, in reality it is being performed under the license of the podiatrist."

That's why it's critical to refer to the state-level policies. Warshaw recommends contacting your state medical board or podiatry board and obtain in writing any scope of practice requirements for nail technicians or medical assistants, including the services they are permitted to perform in a podiatrist's office.

Debridement of mycotic toenails is covered by Medicare in two ways, Warshaw adds:

- In an otherwise healthy individual, nail debridement is done to treat symptoms such as pain, difficulty with ambulation or secondary infection; or
- As routine foot care for an "at risk" patient. "This is based upon a covered systemic disease (examples: diabetes or heart disease) and what is referred to as 'class findings,'" Warshaw explains. "Class findings are the associated complication(s) resulting from the disease (The Class Findings direct you to select the appropriate Q modifier that needs to be appended to the CPT code/codes that are billed)."

"Per Medicare, the reason that 'at risk,' routine foot care is covered is due to concern that if an 'unlicensed individual' or the patient himself performs the nail debridement, for example, the patient runs the risk of infection or loss of limb," he adds.

"I believe that this would be problematic, not only from a Medicare standpoint, but also from a medical-legal standpoint if an unlicensed individual performs the service [in a podiatrist's office] without approval from the state medical or podiatry board," Warshaw explains. — *Laura Evans, CPC* (*levans@decisionhealth.com*) ■

RESOURCES

- CMS IOM 100-02 Chapter 15, Section 290: *www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*
- American Association of Medical Assistants state scope of practice law site: *www.aama-ntl.org/employers/state-scope-of-practice-laws*

Brief

CMS releases deductible, premium rates for CY2023

On Oct. 13, CMS published 2023 rates for Medicare Part B premiums and deductibles, and beneficiaries will see a slight decrease in out-of-pocket costs compared to current-year rates. The 2023 Part B deductible will be $226.00, a modest decrease from the revised 2022 amount of $233.00 (*PBN 8/29/22*).

Total monthly premiums for Part B enrollment, which are tiered on a scale tied to the enrollee's income, range from $164.90 to $560.50 in 2023. That again marks a slight dip from the range of $170.10 to $578.30 in 2022.

The Part A deductible for the first 60 days is up to $1,600 in 2023 from a rate of $1,556 the year before, and coinsurance rates also are rising. The Part A base premium will be $506 per month. For more, see MLN Matters 12903 and Change Request Transmittal R11641GI. ■