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In this issue

Practice management

Consider 4 advantages of making telehealth a permanent part of your practice

Even though Congress didn't fully unleash telehealth services, instead extending the long-running telehealth waivers through September, making your telehealth services a permanent offering can improve your practice's financial health.

Best of all, you might be able to connect with a payer or local health care system that will cover the cost of the HIPAA-secure platform necessary to perform telehealth services, explains Matt Brown, vice president of telehealth and advisory services for Salt Lake City-based CHG Healthcare.

When considering whether to continue telehealth services or restart a dormant telehealth program, think of your patients as consumers first, Brown advises. One thing consumers look for is convenience, and compared to a trip to the practice, consumers see telehealth as very convenient and they've gotten used to it, Brown says.

"It's become part of their everyday way that they think about medicine and that it's practiced and so the convenience for a patient to not have to drive into the office, wait in the waiting room and to just be able to hop on and do a visit with their primary care provider is invaluable for the patient," Brown says. Practices should also be concerned about patient engagement.

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4 key advantages for the practice

Telehealth isn't just good for patients, Brown says. He identified several advantages that telehealth and other forms of virtual care create for practices and providers. If you have staff who ask "What's in it for us?" when you bring up the subject of telehealth, share this list of four ways it can help.

Increase efficiency and reduce burnout. "The first [benefit] is convenience," Brown says, giving the example of writing a refill. "Using asynchronous communications … takes me two minutes, versus a sit-down where somebody tells me all their symptoms and everything else that might take me 15 minutes to do," he says.

"[The provider] can do visits much cleaner and faster and more efficiently through telehealth," he adds.

In addition to freeing up a provider's time, telehealth and virtual care also make it more convenient for patients. A visit that would require a trip to the practice and time in the waiting room and exam room is accomplished in two minutes. Which leads to Brown's second point: Telehealth gives your practice a competitive advantage.

Beat old and new competitors. Offering telehealth services can give your practice an edge over traditional and new types of competition, Brown explains.

In the past, your practice competed with other medical groups of the same specialty who were in your area. But now your practice also competes with direct-to-consumer virtual care providers such as Hims & Hers Health Inc., Ro Health and Amazon Clinic, Brown says. Patients can see an all-virtual provider for some treatments and reserve trips to the practice for conditions that require in-person care. A practice that offers in-person care plus the convenience of telehealth will be in the best position to maintain its current patient population and attract new patients.

"It's really around meeting the consumer where they are and managing and providing the right type of tools for your patient population, so you don't lose them," Brown says.

Attract more recruits. Patients are not the only ones who will check your telehealth offerings. Physicians and other health care professionals who are entering the workforce used telehealth during the COVID-19 public health emergency (PHE) and see telehealth and other virtual care services as important tools in their patient care kit that offer them and their patients more flexibility in how and when they provide care, Brown says.

New physicians "actually survived the pandemic while they were in medical school and so they've experienced this telehealth in practice," Brown explains. And future generations of providers will have received virtual care training, he says. In response to the sharp increase in telehealth services during the PHE, the AMA worked with stakeholders to assemble the best practices and training protocols for the delivery of

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telehealth services, which it dubbed "webside manner," Brown adds.

These recent grads will gravitate toward employers who make those tools available. For a new provider, working for a practice that doesn't have a virtual care program would be like stepping back 20 years in time, he says.

A partner might cover the cost of telehealth tools. The end of the HHS Office for Civil Rights (OCR) waiver that allowed practices to use certain platforms that aren't HIPAA-secure meant that practices that weren't set up for telehealth before the PHE had to move to a paid platform or stop offering audio/video telehealth visits. But a partnership with a payer or health system can help your practice with the cost of a platform and other telehealth tools, Brown says.

CHG has noticed that more Medicare Advantage payers and health systems want to contract with independent practices and physician groups to provide telehealth services for their patient populations, Brown says. And those payers and providers help participating practices by providing a HIPAA-secure platform and other tools to perform telehealth visits, he adds.

"They are going to give you the software as well as the virtual capabilities that are going to function, and sometimes they'll even give you the hardware to be able to do it," he says.

The payer or health system will also provide training. "They'll give you instructions on how to handle a telehealth visit right they'll give you what best practices look like how long they should take," Brown says. In addition to free resources, partner practices will be at the front of the line to benefit from new patients who come in through the partner organization, which gives participating practices another competitive edge. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCE

- To succeed with telehealth, know your "webside manner": *www.ama-assn.org/practice-management/digital/succeed-telehealth-know-your-webside-manner*

Practice management

OK to promote your practice to outside patients, but watch poaching concerns

The recent closure of a major practice in Rhode Island, and the efforts of a separate practice to pick up their patients, raises the question: Is it out of line to actively solicit another provider's patients?

In April, the Rhode Island Department of Health posted an unusual announcement: That Anchor Medical, a large health system with offices in Providence, Lincoln and Warwick, "has announced it is closing effective June 30, 2025," and "current patients of Anchor Medical Associates are encouraged to immediately begin the search for a new primary care professional." Prior to announcing closure, Anchor served approximately 25,000 patients. Anchor itself made a similar announcement and suggested several local alternative providers on a "Patient Resources" page.

But Rhode Island's Thundermist Health responded more proactively than most: It posted a front-page notice on its website citing the "recent news about Anchor Medical Associates closing their offices" and the "concerns for many Rhode Islanders who need to find new primary care providers and pediatricians," and offered to book appointments. Also, Thundermist has made itself available to the press — for example, its CEO did an op-ed in the April 30 Warwick (R.I.) Beacon addressing the issue — and has been featured in stories in local news outlets.

Given the paucity of primary care providers in the state — "Rhode Islanders can't find doctors, and Anchor Medical closure will only make it worse," headlines the local PBS affiliate — Thundermist's aggressive approach seems appropriate and even public-spirited. But in less extreme circumstances, can you ethically and legally try to draw off a competitor's current patients?

First: Break no laws

HIPAA and other privacy laws prevent you from obtaining your competitors' patient records to solicit. And the sort of competitive advertising common in other fields probably wouldn't go over well with

patients. Further, if you misrepresent facts about the competitor, you can get in real trouble.

In a case brought before Fresno County [Cal.] Superior Court in 2015, for example, a local hospital accused regional doctors of "illegal and predatory conduct to misappropriate Plaintiffs' pediatric cystic fibrosis patients" by first accessing the patients' records from the hospital EHR via their remote access agreements, then by contacting "family members of some of Plaintiffs' pediatric cystic fibrosis patients to make false and misleading statements about Plaintiffs' cystic fibrosis center." The local hospital accused the doctors of making claims that the hospital could not provide adequate care and that the patients should transfer their care.

"What Thundermist is doing seems OK because Anchor is definitely closing," says David Davidson, a health care attorney with Dickinson Wright in Fort Lauderdale, Fla. "You could have some ethical issues if the system didn't announce but only, for example, released financials that made it look as if they weren't doing very well, and the other provider entity started running ads like, 'Is your health system going to be here tomorrow?' capitalizing on that [information]. You could even run into legal issues as regards unfair competition and even defamation."

While under ordinary circumstances patient poaching is frowned upon, it's generally not a legal issue unless the means of soliciting patients implicates other laws such as HIPAA or the anti-kickback statute.

For example, Davidson says, if you promoted your practice at an ancillary business that patients of multiple providers might use, such as an imaging facility or an ambulatory surgical center, "that would smell bad to me — you'd have to wonder whether [the provider] is paying this ASC or imaging center to tell people that." That might implicate state law violations on fee-splitting and patient brokering.

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.

Focus on patient welfare

James Stafford III, an attorney with Clark Hill PLC in Los Angeles, says that the safest course is to stick with "legally and ethically sound" outreach to patients such as "transparent social media announcements regarding service availability, educational community events that address health care continuity concerns, [and] clear communication about insurance acceptance and scheduling availability."

Richard F. Cahill, vice president and associate general counsel of The Doctor's Company in Napa, Calif., also suggests that you look to your professional associations and state boards for guidance on appropriate competitive marketing. The American College of Obstetricians and Gynecologists, for example, has a page on this, including the admonition that "physicians should consider not just the intent of any advertisement but also its effect on the public's view of the profession."

"The patient's welfare must remain the central consideration in all recruitment strategies," Stafford says. "When patient interests guide recruitment methodology, the resulting approach will generally align with legal and ethical principles. This patient-centered framework not only mitigates compliance risks but also builds enduring trust with both patients and providers — the true foundation of sustainable practice growth." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- Anchor Medical, Rhode Island: *www.anchormedical.org/*
- Thundermist Health Center, Rhode Island: *www.thundermisthealth.org/*
- State of Rhode Island Department of Health, "Information for Anchor Medical Associates Patients,:" April 11, 2025: *https://health.ri.gov/information-anchor-medical-associates-patients*
- Warwick Beacon, "RI's health care crisis demands urgent action," April 30, 2025: *warwickonline.com/stories/ris-health-care-crisis-demands-urgent-action,289390*
- ABC6 Providence, "Thundermist looking to recruit patients losing doctors due to Anchor Medical closure," April 10, 2025: *www.abc6.com/thundermist-looking-to-recruit-patients-losing-doctors-due-to-anchor-medical-closure/*
- PBS Rhode Island, "Rhode Islanders can't find doctors, and Anchor Medical closure will only make it worse," April 28, 2025: *https://thepublicsradio.org/health/rhode-islanders-cant-find-doctors-and-anchor-medical-closure-will-only-make-it-worse/*
- ACOG, "Ethical Ways for Physicians to Market a Practice," Nov. 2011: *www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/11/ethical-ways-for-physicians-to-market-a-practice*

Benchmark of the week

Critical care codes fall hard from COVID boom, resetting trend curve

Medicare utilization of many CPT codes, such as outpatient E/M codes, took a beating in the pandemic years. But use of the critical care code **99291** (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and add-on code **99292** (… ; each additional 30 minutes) jumped higher during that period.

That bump has subsided, however, and a review of 10 years of progress in critical care utilization suggests the codes have swiftly adjusted to pre-COVID levels.

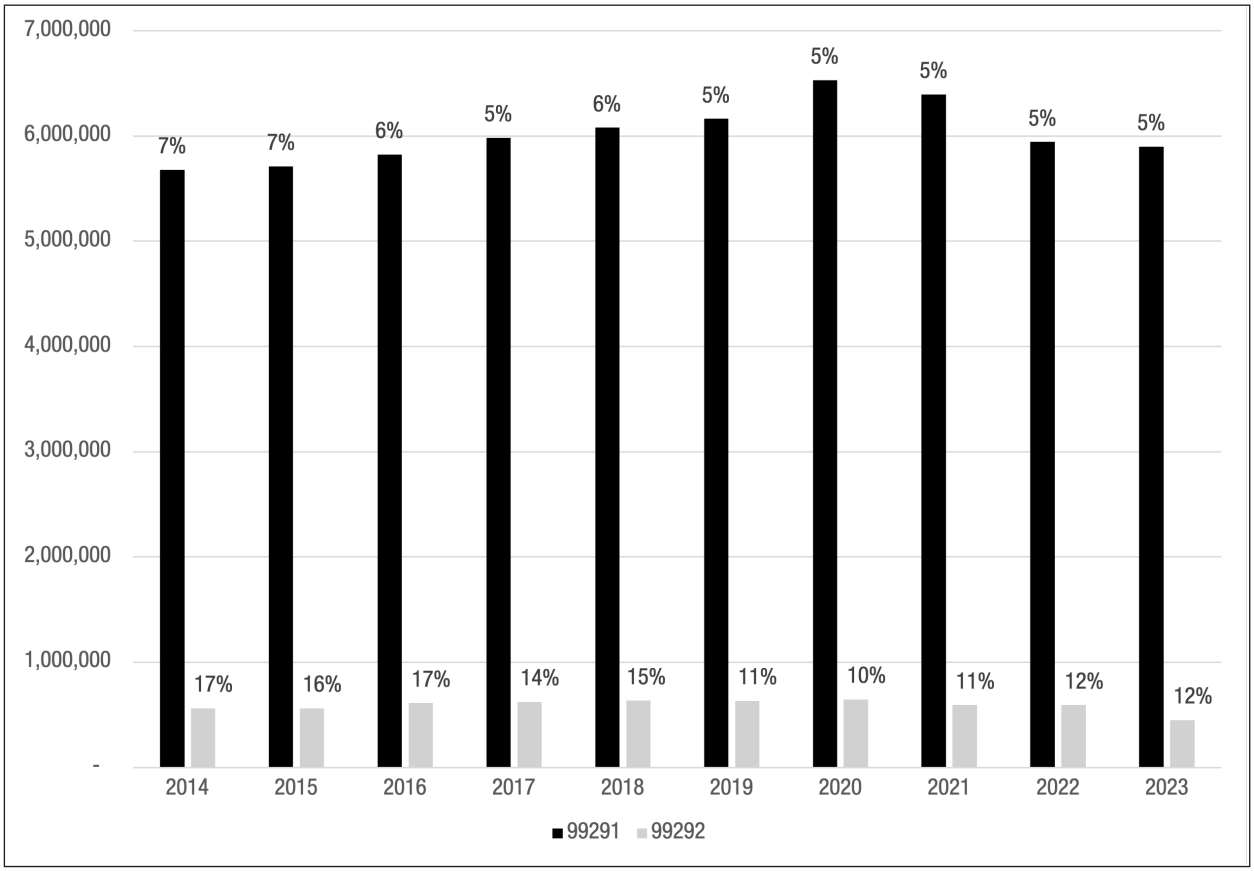
Looking at the much-more-used 99291, with more than 10 times as many claims as 99292 between 2014 and 2023, or 60.2 million claims vs. 5.9 million claims, you will find a slight upward curve from 2014 to 2019, an increase of 8.6%, from 5.7 million to 6.2 million claims. But in 2020, when the public health emergency was declared and many services took a big hit, utilization zoomed to 6.5 million, a nearly 6% gain in one year.

The decline from there has been swift, with utilization decreasing to 5.9 million claims in 2023, the most recent year of available Medicare claims data, which marks a three-year fall of 9.7%, leaving utilization only about 200,000 over 2014's totals and a little under the 6 million reached in 2017. The regression of 99292 is even more marked: from 561,977 in 2014 to 647,333 in 2020, a rise of 15%, and a drop to 449,751 in 2023, nearly 31% down from the peak.

Changes in denial rates are traditionally modest for these codes (*PBN 7/15/24*). As the chart shows, this remains true, especially for 99291, stuck at 5% for five years running.

The specialty with the most critical care code claims in 2023 is, expectedly, emergency medicine, with 1.7 million, or 29%, of all 99291 claims and 84,271, or 19%, of all 99292 claims. But not far behind are pulmonologists (18% and 16%) and critical care intensivists (12% and 17%). — *Roy Edroso* (*roy.edroso@decisionhealth.com*)

Critical care codes utilization, 2014-2023, with denial rates



Source: Part B News *analysis of 2014-2023 Medicare claims data*

Compliance

CMS says physician-owned hospital can move location, and add ER

Physician-owned hospitals must conform to strict rules under Medicare, but a recent advisory opinion (AO) from CMS suggests a way they can expand their offerings without losing their status.

In Advisory Opinion No. CMS-AO-2025-1, issued in February, CMS gave qualified approval to a physician-owned hospital that wanted to move to a new building eight miles from its current location. (As with all Advisory Opinions, the specifics that would identify the Requestor are redacted.)

In an interesting twist, CMS said that the hospital's plan to add an emergency department at the new address would not materially affect its status, given that the hospital "would continue to provide the same services apart from adding emergency services as the result of the addition of an emergency department at Hospital's new location," and also observe all the usual strictures of such facilities.

Physician-owned hospitals are prohibited from billing Medicare for designated health services by revisions to the Stark Law made in the Affordable Care Act of 2010 unless they were grandfathered-in prior to 2011 and meet requirements for exceptions such as the "whole hospital exception," which precludes changes in ownership status, number of licensed beds, operating and procedure rooms, and other aspects.

AOs are meant to apply solely to the Requestor's case, but nonetheless "people in the industry look at these as informing them what CMS would think if they were in a similar situation," says Charles B. Oppenheim, a partner with the Hooper Lundy Bookman firm in Los Angeles. Thus, it is at least "conceivable," Oppenheim says, that, all else being equal, a physician-owned hospital might be able to add a different service, e.g., a PET scanner, and get similar clearance from CMS.

What makes this especially notable is that the lack of emergency services has long been considered a distinguishing feature of physician-owned hospitals. The American Hospital Association has opposed reforms that would allow more such hospitals to bill Medicare partly on the grounds that they "provide limited or no emergency services, relying instead on publicly funded 911 services when their patients need emergency care."

This AO is the first issued by CMS since December 2021. CMS issues far fewer such decisions than OIG, which issued 13 in 2024, whereas CMS has issued only 17 in the past 20 years. That's in part because "OIG's jurisdiction is a little broader," Oppenheim says. "They cover several other statutes, e.g., the anti-kickback statute [AKS], beneficiary inducement, and a few others. Also, AKS is intent-based, so that covers a wider spectrum of conduct with potential gray areas, whereas Stark is intended to be a bright-line rule where you either comply or you don't, so there's less room to wonder whether you're OK." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- CMS, "Re: Advisory Opinion No. CMS-AO-2025-1," February 2025: *www.cms.gov/files/document/cms-ao-2025-1.pdf*
- AHA, "Fact Sheet: Physician Self-referral to Physician-owned Hospitals," February 2023: *www.aha.org/system/files/media/file/2023/02/Fact-Sheet-Physician-Self-Referral-to-Physician-owned-Hospitals.pdf*

Compliance

Keep tabs on OIG's Work Plan: A road map for compliance

Since 1976, the Office of Inspector General (OIG) has served as a compliance watchdog, overlooking all HHS programs and monitoring for instances of fraud, waste and abuse. While health care organizations can wait to investigate potential compliance issues until they receive an audit request or gain access to audit findings, you're better off taking a proactive approach. One important step is monitoring for additions to the OIG Work Plan.

Through its audit work, the OIG regularly highlights widespread problems that lead to inefficiencies, denials, improper payments and more.

When Leigh Poland, RHIA, CCS, CDIP, CIC, vice president of the coding service line at AGS Health in Washington, D.C., first started her coding career nearly 25 years ago, the OIG updated its Work Plan annually, outlining which areas it planned to examine throughout the year.

Today, the list is much more dynamic. The OIG now updates its Work Plan on a monthly basis, providing organizations with timely notifications about emerging issues. While the change did improve transparency, it also forced compliance teams to rethink timelines and processes, according to Sandy Giangreco Brown, MHA, BS, RHIT, CCS, CCS-P, CHC, CPC, CPCO, COC, CHRI, COBGC, PCS, vice president of revenue integrity and education at Spire Orthopedic Partners in Stamford, Conn.

When the OIG released its Work Plan annually, organizations may have felt more inclined to stay within those parameters throughout the year instead of responding to new compliance concerns, Giangreco Brown says. Gaining access to more information is always beneficial, but the shift to monthly updates placed more responsibility on organizations.

"Now that the updates are more frequent, we have to be on our toes and cognizant of trending issues," she says.

In the webinar "Exploring the OIG Work Plan," which launched on HCPro's Loyal Listener Library on November 15, Poland reviewed the OIG's upcoming focus areas and advised listeners on how to use the Work Plan to their advantage.

Stay focused

Health care organizations need to have an individual or team responsible for monitoring the OIG Work Plan and determining which items require them to act, Poland said.

"You can't audit everything, so you need to narrow down your focus areas and identify what audits need to be performed," she said. "Once you take those steps, you can assess the findings, determine what additional education is needed, and retrain staff members."

The first step in identifying which OIG concerns are of interest to your organization is reviewing the data, says Giangreco Brown. This includes analyzing how often the related items or services are provided, determining the total dollar amount attached to those claims, reviewing recent internal and external audit findings, tracking denials, and checking for previous audit requests, she says.

"In some instances, organizations will realize that they have already identified this issue and addressed it through education," she says.

In other instances, the OIG's focus areas can help organizations uncover errors that will ultimately need to be addressed. To prevent improper payments, denials and revenue leakage, you must stay up to date with the agency's upcoming focus areas and incorporate similar items into their internal audit workflows as needed.

Glimpse upcoming focus areas

The OIG is expected to release reports on several key topics in 2025 and beyond, and you can learn more about these upcoming audits in the Work Plan item descriptions. For example, the OIG may detail what organizations will be included in the audit, highlight pertinent time frames and provide background on its decision to add the item to the Work Plan. The agency will often cite its previous audit work related to the subject, which means you can review this material to better understand the need for further evaluation.

Compliant coding and billing of remote patient monitoring (RPM) services recently emerged as an area of concern for the OIG. The agency first announced it had set its sights on RPM services in 2023. Due to the uptick in demand for these services, the OIG felt the need to conduct additional research on how RPM services are used and the Medicare enrollees who use them.

The related audit report revealed that 43% of enrollees who received RPM did not receive all three of the components required to bill for the services — initial education, device setup and treatment management. Additionally, the number of enrollees who received RPM services was more than 10 times higher in 2022 than in 2019, and Medicare payments were more than 20 times higher.

Following the audit, the OIG signaled its intent to continue focusing on RPM services by adding another item to its Work Plan. Noting previous findings, the OIG announced it will audit Part B claims to determine whether these services were furnished and billed correctly.

To prepare for increased scrutiny of RPM claims, organizations should review the results from the OIG's preliminary audit, and you can review claims to ensure all criteria are met and all three components are clearly documented.

Poland advised organizations to review CPT guidelines for the three categories of RPM and therapeutic services (data transfer, data interpretation, and device/software setup and education), as the OIG analyzed the use of several of these codes in their initial audit and will likely do so again in its upcoming report.

Note the following recent additions to the OIG's Work Plan:

- Audit of Medicare Claim Lines for Which Payments Exceeded Charges.
- Joint Pain Management Therapies: Hyaluronic Acid Knee Injections.
- Medicare Part B Payments for Skin Substitutes.
- Medicare Part B Payments for Incident-To Services.

Looking ahead

Audits are inevitable. Organizations selected for an OIG audit must comply with all components of the audit request, says Giangreco Brown. She urges organizations to protect the integrity of their records.

"Lock down any and all records requested by the OIG," she says. "Ensure they are secure so that no changes can be made, such as adding addendums or correcting errors. These records should be copied, scanned, and sent to the appropriate locations."

The OIG has released valuable information and resources that can help organizations in their compliance efforts and assist in minimizing the risk of an OIG audit. For example, the OIG's General Compliance Program Guidance details relevant laws, authorities, resources and other information critical to understanding healthcare compliance (*see resources, below*).

In addition, the OIG is expected to release several versions of Industry Segment-Specific Compliance Program Guidance (ICPG) to help identify risk areas in particular settings. The agency already released ICPG for nursing facilities, and it is expected to release similar guidance for hospitals and clinical laboratories in 2025.

Along with accessing these resources, review the OIG's annual reports on HHS' top management and performance challenges. Published at the end of each year, these reports can provide additional insights into both long-standing and emerging areas of concern.

In the 2024 report, the OIG emphasized the need to prevent, reduce, and recover improper payments, urging HHS and healthcare organizations to pay attention to the following concerns:

- Aberrantly high-billing labs.
- Upcoded hospital stays.
- Genetic testing.
- Payment for skin substitutes.
- Unnecessary surgical, imaging and other procedural care.

Again, audits are inevitable. However, there are things organizations can do to identify and correct errors at an earlier point.

Reviewing these resources and monitoring for additions to the OIG's Work Plan allows practices to keep their finger on the pulse of common compliance issues across the health care industry. Although some organizations may think taking a proactive approach will add administrative burden, it will ultimately save them time, money and resources.

"Knowledge is power," says Giangreco Brown. — *HCPro staff* (*pbnfeedback@decisionhealth.com*) ■

Editor's note: *This article originally appeared in the NAHRI Journal.*

RESOURCES

- OIG remote patient monitoring audit report: *https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/*
- Audit of Medicare Claim Lines for Which Payments Exceeded Charges: *https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000881.asp*
- Joint Pain Management Therapies: Hyaluronic Acid Knee Injections: *https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000882.asp*
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- Medicare Part B Payments for Incident-To Services: *https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000901.asp*
- OIG's General Compliance Program Guidance: *https://oig.hhs.gov/documents/compliance-guidance/1135/HHS-OIG-GCPG-2023.pdf*
- Industry Segment-Specific Compliance Program Guidance (ICPG): *https://oig.hhs.gov/compliance/compliance-guidance/*