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Part B News
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In this issue

Enrollment

Time out: Encourage compliance with a stay of enrollment review

Use Medicare's new "stay of enrollment" rule to warn your staff: CMS' easier option for non-compliance is still hard on the practice's finances.

The new option could also be called a stay of revenue because it will cut off your Medicare payments for up to 60 days and result in a penalty such as deactivation or revocation of enrollment if you don't fix the problem before the stay expires.

Understand the basics of a stay

The stay of enrollment is a new tool that CMS can use in response to minor slip-ups that put a practice out of compliance. If your practice or an enrolled member of your practice has a compliance issue that can be fixed by submitting certain enrollment forms, CMS might impose a stay, which will not affect your enrollment status (*PBN 7/24/23*). CMS describes the stay as an "action that's less burdensome on providers and suppliers than a deactivation or revocation of your Medicare enrollment," in CMS 100-08, Change Request 13449.

The details of the stay also highlight how serious CMS is about using enrollment compliance to control who does — and does not — receive payment. The stay allows CMS to protect Medicare funds by withholding payments to providers who fall out of compliance, without subjecting you — and Medicare administrative contractors (MAC) — to the burdens associated with re-enrolling.

Before it considers imposing a stay, CMS will apply a two-part test to the situation:

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1. Are you non-compliant with at least one enrollment requirement?
2. Can you fix the problem by submitting the applicable CMS form (ACF)?
   - Form CMS-855 (Medicare enrollment application).
   - Form CMS-20134 (Medicare enrollment application for Medicare diabetes prevention program (MDPP) suppliers).
   - Form CMS-588 (Electronic Funds Transfer authorization agreement).

When the answer to both questions is yes, CMS could decide to impose a stay of enrollment that lasts up to 60 days, rather than a penalty, such as deactivation or revocation of your enrollment, which would require you to re-enroll in the program.

CMS gives examples of problems that would meet the test in the change request, including a provider who fails to "report a change in its address from 10 Smith Street to 20 Smith Street," and a physician who doesn't "report a change in his/her practice location's ZIP code," in a timely manner.

If CMS places your practice or a provider who works at your practice in the stay of enrollment timeout corner, the stay will begin on the date of the postmark on the notification letter, which will also tell you how to get back in compliance.

A stay can last up to 60 days; CMS can impose a shorter stay and can impose more than one stay if a provider has multiple compliance issues that qualify for a stay. The agency will determine the length of a stay for each issue of non-compliance. In addition, CMS will not extend a stay beyond the 60-day limit, Andrew Wake, attorney at law with Parsons Behle & Latimer in Boise, Idaho, explains.

Watch for common compliance flaws

While there are a wide range of ways enrolled providers can fall out of compliance that are covered by the new rule, you should be alert to enrollment mistakes that medical practices regularly make.

"The most common items that can trigger a stay of enrollment are changes to ownership/managing control or a change of address that are not reported to Medicare," says Jessica Hoge, director of operations for nCred, a physician credentialing company based in Chattanooga, Tenn.

"To avoid issues, it is important for practices to regularly review their Medicare enrollment record to verify all information is current. I recommend setting up an annual review process to confirm all information on the Medicare record is accurate," Hoge says.

No pay during a stay

During a stay of enrollment, your MAC will reject claims for any services performed during the pause. Pay will pick up again if you "resume compliance" by fixing the problem that triggered the stay, but you must do it before the stay expires.

Consider an example from the change request that shows the importance of a rapid response to a stay of enrollment:

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"To illustrate, assume a provider receives a stay notification letter on March 1 because the provider had failed to timely report an address change via the Form CMS-855B. The letter requests the provider to submit this ACF. The provider does so on March 10. The stay thus ends on March 10. Note that the contractor need not have begun processing the ACF for a stay to be lifted. Even if the application is later returned, rejected, or denied, the stay ceases on the date the application is submitted."

Your practice would then need to resubmit any rejected claims or submit claims that it held during the stay.

CMS can skip the stay

Make sure your staff understand that CMS is not required to impose a stay in response to compliance problems described by the new rule. The agency can decide not to act at all, or it can go directly to deactivating or revoking your enrollment.

"According to CMS, '[its] authority to impose a stay would be discretionary. More specifically, [its] authority to apply a revocation, deactivation, or a stay lies within [its] discretion' (81 F.R. 78818, 79272)," Wake says. "That is, CMS maintains that it has the power to impose a stay, deactivation or revocation on a case-by-case basis based on its own discretion," he explains.

"It's possible that the same instances that could trigger a stay could also trigger a revocation, as CMS has discretion to decide which to impose," according to Robert Slavkin, chair of Akerman LLP's health care practice group in Orlando and Danielle Gordet, associate, health care with Akerman's Miami office, in response to questions from *Part B News*.

"For example, CMS may impose a deactivation or revocation (if grounds exist for either) without first applying a stay," they explain.

Expect deactivation if you miss the deadline

If you receive a stay of enrollment notice, mark the deadline on your calendar and aim to resolve the problem well ahead of the deadline. If you aren't in compliance by the end of the stay period, not only will your rejected claims remain unpaid, but your enrollment will also be in jeopardy.

"Failure by the provider or supplier to bring itself into compliance within the 60-day stay of enrollment period could have consequences" for claims provided during the stay and for the provider's enrollment and billing privileges, Wake says.

"The regulations directly address the first issue. They make clear that claims associated with services provided during the 60-day period are potentially payable if the provider or supplier brings itself into compliance within that period and are not payable otherwise" (42 CFR §424.541[a][2][ii][B]), he says.

The new rule does not explain exactly how CMS will respond when a provider doesn't "resume compliance." For example, the rule does not call for automatic revocation or deactivation when a provider misses the stay's deadline. But it is a safe bet that it will prevent non-compliant providers from receiving Medicare funds.

"If the non-compliance persists when the stay ends, CMS has the discretion to proceed with imposing a deactivation or revocation," write Slavkin and Gordet.

"Though nothing is automatic, where a provider or supplier has been given an opportunity to remedy non-compliance and has not taken that opportunity, they should expect at least deactivation of billing privileges," Wake says. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCE

- CMS 100-08, Change Request 13449: *www.cms.gov/files/document/r12524pi.pdf*

Health IT

CMS' loans for Change Healthcare hack may not be worth it: Expert

Both CMS and UnitedHealth Group (UHG) have offered cash loans to practices impacted by the recent Change Healthcare hack. But an industry expert cautions that the CMS package might not be your best course of action.

The cyberattack on the UHG-run clearinghouse and payment processor discovered on Feb. 21 has disrupted cash flow at thousands of medical businesses (*PBN 3/18/24*). At the time of publication, UHG has offered a timeline that has all affected functions restored by the week of April 8. But some practices are likely to still struggle, and even those whose services have been restored may have trouble making up financial shortfalls suffered during the outage.

To this end, UHG through its Optum division is offering to its clients access to a "temporary funding assistance program." CMS, acknowledging the large number of Medicare providers affected, has offered "Change Healthcare/Optum Payment Disruption (CHOPD) Accelerated Payments to Part A Providers and Advance Payments to Part B Suppliers." (Note that only Part B suppliers, not Part B providers, are eligible.)

This response is reminiscent of the outset of the COVID-19 pandemic, when CMS, empowered by Congress, released billions in advance and accelerated payments as well as some outright grants to help providers through the hard times (*PBN 2/13/24*).

However, Jeffrey I. Davis, health policy director at McDermott+Consulting in Washington, D.C., warns that, with the CMS CHOPD program, eligible providers and suppliers should be cautious.

"We've been advising clients that some of the terms and conditions associated with both the Medicare program and the UHG package are stringent, and that they should only use those as a last resort," Davis says.

Davis notes that, for one thing, the CMS program only makes 30 days' worth of Medicare payments available. On the one hand, Davis says, "that's a small amount, especially if Medicare is a small proportion of your overall revenue. Then you have 90 days to pay it back interest-free." In that circumstance it's a small risk.

On the other hand, if you can't meet the 90-day deadline, "starting on the 91st day, they start recouping at a very high interest rate — over 12%," Davis says. "And that's set in statute. During the COVID-19 pandemic, Congress actually stepped in and made the interest rate lower, around 4%, but [since the PHE ended] they don't have that flexibility."

As for the UHG package, the original terms and conditions from March 1 "were very stringent ... including required payments of loans within five days of receiving notice," Davis says. For example, "they [reserved the right] to recoup funds immediately and without prior notification, with options to change [terms] simply by providing notice."

But UHG has made some changes since then.

For one, on UHG's "How have the program terms and conditions been changed since the program launched on March 1?" page: "Legal terms and conditions of the program have been modified for all participating providers, regardless of date of program enrollment. All providers will have 45 business days to return funds once an invoice is sent by us. We will not send the invoice until after claims processing or payment processing services have resumed and payments impacted during the service disruption period are being processed."

UHG also said it had "removed the right to debit your account to make repayment to us. We have also removed all requirements around arbitration, indemnification, limitation of liability, and our ability to change the terms of the agreement." This may make their package more attractive to you. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- UHG, "Information on the Change Healthcare Cyber Response": *www.unitedhealthgroup.com/changehealthcarecyberresponse*
- CMS, "Change Healthcare/Optum Payment Disruption (CHOPD) Accelerated Payments to Part A Providers and Advance Payments to Part B Suppliers," March 9: *www.cms.gov/newsroom/fact-sheets/change-healthcare/optum-payment-disruption-chopd-accelerated-payments-part-providers-and-advance*
- Optum, "Temporary Funding Assistance Program for providers": *www.optum.com/en/business/providers/health-systems/payments-lending-solutions/optum-pay/temporary-funding-assistance.html*
- CMS, "Change Healthcare/Optum Payment Disruption (CHOPD) Accelerated Payments to Part A Providers and Advance Payments to Part B Suppliers," March 9: *www.cms.gov/newsroom/fact-sheets/change-healthcare/optum-payment-disruption-chopd-accelerated-payments-part-providers-and-advance*

Benchmark of the week

Active status for Category III codes doesn't lead to active billing

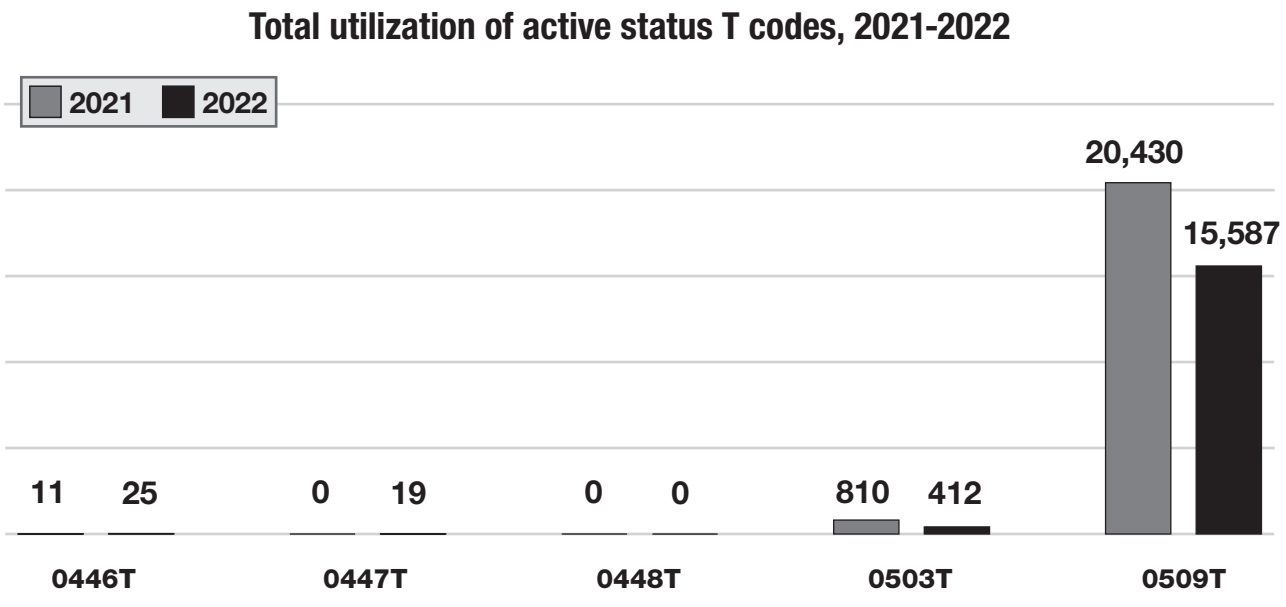
CMS lists most Category III — or temporary — codes as carrier-priced. That means that each Medicare administrative contractor (MAC) will decide whether it will pay for a service on a case-by-case basis. In recent years the agency has granted active status to a few temporary codes, but a look at early Medicare Part B claims data shows that active status doesn't generate a lot of buzz.

An electroretinography code (**0509T**) is the only service that exceeded the three-digit mark, and reporting dropped after the first year of coverage. On the other end of the scale, interstitial glucose sensor codes (**0446T-0448T**) struggled to register at all. On the chart below, a "0" indicates there were fewer than 11 claims for the service. Medicare doesn't report data for services with fewer than 11 claims per year to protect patient privacy.

As background, CMS has granted active status to the Category III codes listed below. Note that **0503T** has been deleted and replaced by a permanent code. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com)

0446T	(Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training)
0447T	(Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision)
0448T	(Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation)
0503T*	(Noninvasive estimated coronary fractional flow reserve [FFR] derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model)
0509T	(Electroretinography [ERG] with interpretation and report, pattern [PERG])

Deleted and replaced by code **75580 (Noninvasive estimate of coronary fractional flow reserve [FFR] derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional), Jan. 1, 2024.*



Source: Part B News *analysis of 2021-2022 Medicare claims data*

Coding

CMS update: Code caregiver training services based on number of patients

Update your staff with the latest information about caregiver training services (CTS) from CMS. A set of frequently asked questions on health-related social needs answers some lingering questions about the CTS for behavior management/modification (**96202-96203**) and functional performance (**97550-97552**). **Note:** See the box on this page for the full descriptors.

Few limits, but medical necessity rules

CMS did not place limits on how often you can report CTS or the diagnoses that will support the service. For example, the agency writes that there "are no limits to how often CTS can be billed, however, the medical necessity of CTS for the patient should determine the volume and frequency of the training." The treating providers must document the medical necessity for each encounter, CMS explains in its FAQs.

CMS will also allow a wide range of providers to perform the service when medically necessary, including clinical social workers, marriage and family therapists, and mental health counselors.

Count patients, not caregivers, when you code

Remind your treating providers and coders that the words "group" and "individual" in the codes' descriptors are based on the number of patients who are being cared for, not the number of caregivers the provider trains during a session. "Practitioners should select the appropriate group or individual CTS code based on the number of beneficiaries represented by caregivers receiving training," according to CMS.

For example, if a provider gives 60 minutes of functional performance training to three people who are caregivers for the same patient, you should report individual functional improvement CTS codes 97550 (30 minutes) and two units of 97751 (15 minutes each).

If the provider gives functional improvement training to four people who are caregivers for four different patients, you should report four units of group functional improvement CTS code 97552. That is, you should report one unit of service for each patient. The group code does not have a time requirement.

If the provider gives functional performance training to six people who are caregivers for three different patients, you would report three units of service.

The group behavioral management CTS codes follow the same per-patient coding rule, according to CMS. For example, if the provider gives 60 minutes of behavioral management CTS to three people who are caregivers for three patients, you should report three units of 96202.

No code for individual behavior management care

Remind schedulers, coders and providers that you don't have a coding option if a provider gives behavior

Coding

Know full descriptors for caregiver training services

Use the latest guidance from CMS to correctly code caregiver training services (*see story above*). Below, you will find the full descriptors that shed light on your coding and billing designs.

Behavioral management/modification — group sessions

- **96202** (Multiple-family group behavior management/modification training for parent[s]/guardian[s]/caregiver[s] of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional [without the patient present], face-to-face with multiple sets of parent[s]/guardian[s]/caregiver[s]; initial 60 minutes).
- **96203** (… ; each additional 15 minutes [List separately in addition to code for primary service]).

Functional performance — Individual or group sessions

- **97550** (Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community [e.g., activities of daily living {ADLs}, instrumental ADLs {iADLs}, transfers, mobility, communication, swallowing, feeding, problem solving, safety practices] [without the patient present], face to face; initial 30 minutes).
- **+97551** (… ; each additional 15 minutes [List separately in addition to code for primary service]).
- **97552** (Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community [e.g., activities of daily living {ADLs}, instrumental ADLs {iADLs}, transfers, mobility, communication, swallowing, feeding, problem solving, safety practices] [without the patient present], face to face with multiple sets of caregivers).

management/modification CTS for an individual patient's caregivers. "The code descriptors for CPT codes 96202 and 96203 are specific to training provided in a group setting," CMS writes in its FAQ. The code descriptors state "multiple-family group" and "with multiple sets of parent(s)/guardian(s)/caregiver(s)" and you can't tack together individual sessions performed at different times on the same day to meet the group requirement.

Make sure your team isn't confused by the functional improvement codes. They "are not for behavior management/modification," CMS explains.

Share more documentation tips

Make sure your providers include the number of patients when they document these encounters. If the chart simply gives the number of people who attended the training, you won't be able to code the visit. The treating provider should also confirm who attended group visits. You could wind up with overpayments if your practice relies on scheduling information to count attendance.

You should also remind providers to note the start and stop or total time for their CTS encounters and whether any caregivers arrived late or left before the session ended. Group functional performance code 97552 doesn't have a time component, but it might be easier for providers to document the time, rather than remember that it is the exception to the rule. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCES

- Health-related social needs FAQ: *www.cms.gov/files/document/health-related-social-needs-faq.pdf*
- MLN Booklet – Health Equity Services in the 2024 Physician Fee Schedule Final Rule *www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0*

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.

Practice management

Patient assault underlines need for tight office entry restrictions

A recent attack by a man who conned his way into a chiropractor's office is a reminder to ensure basic security is followed in all cases — and that more than basic security is likely worth the investment.

Various news outlets reported the story of a March 18 incident at Clements Chiropractic in Long Beach, Calif., caught on security cameras, in which an unhoused man who asked to use the office's bathroom was admitted and proceeded to sexually assault a patient on a massage table. The man was apprehended and turned over to authorities.

Generally, violent incidents in medical offices and facilities appear to be on the increase. Usually it's health care workers who bear the brunt: The most recent U.S. Bureau of Labor Statistics tally, from 2018, showed that 73% of nonfatal workplace injuries and illnesses due to violence were suffered by health care workers, and a National Nurses United survey of nurses published in February 2024 found that 45% of respondents "reported an increase in workplace violence on their unit[s] in the previous year."

But patients and other authorized visitors can also be victimized, as in recent mass shootings at medical facilities in Tulsa and Atlanta, and in this case (*PBN 6/20/22*, *6/12/23*).

The rise in incidents has pushed many practices to step up their security measures (*PBN 6/19/21*). But as the Long Beach case shows, sometimes even an apparently anodyne exception to basic security protocol can lead to disastrous results.

First step: Put up a sign

No legal action against Clement Chiropractic has been reported. While the decision to admit a non-patient seems unwise, Abbye Alexander, co-managing partner of Kaufman Dolowich LLP's Orlando office and co-chair of the firm's health care and managed care practice group, says that with premises liability cases "it really depends on circumstances — [e.g.,] whether a key is required to be obtained from the office for the use of the outside bathroom." Juries might also be led to consider practice history and custom, and the character of the neighborhood.

"Each doctor's office is going to be different," Alexander says. "In some, they buzz people in, in others they don't."

Doctors' offices are more likely than other offices to be approached by non-patients, says Timothy Dimoff, founder and president of SACS Consulting & Investigative Services in Akron, Ohio. "Medical facilities have a unique image — among the general public, and also among criminals — as a public-access place where they can get a bathroom, or get warm, and other types of assistance," Dimoff says. And, given the circumstances, some staff may be prone to make what seem to be needful exceptions to access rules.

It's worth reiterating to staff that no admission to unauthorized personnel means exactly that. Dimoff also suggests you put up a sign saying restrooms are for customers only. "Criminals and people with bad intent look for facilities that don't have signage," he says. "It's the frontier of preventing a lot of this and, simple as it is, it's very effective.

Above and beyond strict regulation of who does and does not get access, Dimoff thinks security cameras are a good deterrent, and badge and even biometric entry credentials can be helpful "because it tells you date and time and who accessed that entrance," in case there are questions about incidents after the fact. But the best policy is strict gatekeeping. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- U.S. Bureau of Labor Statistics, "Fact Sheet | Workplace Violence in Healthcare, 2018," April 2020: *www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm*
- National Nurses United, "High and rising rates of workplace violence and employer failure to implement effective prevention strategies is contributing to the staffing crisis," February 2024: *www.nationalnursesunited.org/sites/default/files/nnu/documents/0224_Workplace_Violence_Report.pdf*

Coding

HCPCS 2024 first quarter update brought nearly 100 changes

CMS published its HCPCS quarterly update in March, which heralded the sum of 94 HCPCS Level II code additions, discontinuations and definition revisions. The changes, effective April 1, included:

- 62 added codes.
- 21 discontinued codes.
- 11 revised codes.

Many of the new codes are for injections and skin substitutes, but there are some for neuromodulation stimulator systems, vascular embolization procedures, rehabilitation systems, durable medical equipment (DME) and traditional healing services, among others.

Added codes include:

- Addition to lower extremity (**L5783**)
- Addition, endoskeletal knee-shin system (**L5841**)
- Adhesive clip (**A4438**).
- Docking station for use with oral device/appliance (**K1037**).
- Fertility cycle (contraception and conception) tracking software application (**A9293**).
- Home blood glucose monitor (**E2104**).
- Home ventilator (**E0468**).
- Integrated lancing and blood sample testing cartridges (**A4271**).
- Intra-vaginal motion sensor system (**S9002**).
- Neuromodulation stimulator system (**A4593-A4594**).
- Penile contracture device (**S4988**).
- Pessary (**A4564**).
- Rehabilitative power wheelchair accessory (**E2298**).
- Repair of enterocutaneous fistula small intestine or colon (**C9796**).
- Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame (**L1320**).
- Traditional healing service (**H0051**).
- Transcutaneous tibial nerve stimulator (**E0736**).

Revised codes include:

- **A4561** (Pessary, reusable, rubber, any type).
- **A4562** (Pessary, reusable, non rubber, any type).
- **E2001** (Suction pump, home model, portable or stationary, electric, any type, for use with external urine and/or fecal management system).
- **J3425** (Injection, hydroxocobalamin, intramuscular, 10 mcg).
- **J7516** (Injection, cyclosporine, 250 mg).
- **J9029** (Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose).

Discontinued codes include:

- **0354U** (Human papilloma virus (HPV) by quantitative polymerase chain reaction [qPCR]). — *Savannah Schmidt* (*savannah.schmidt@hcpro.com*) ■