

Physician Organizations

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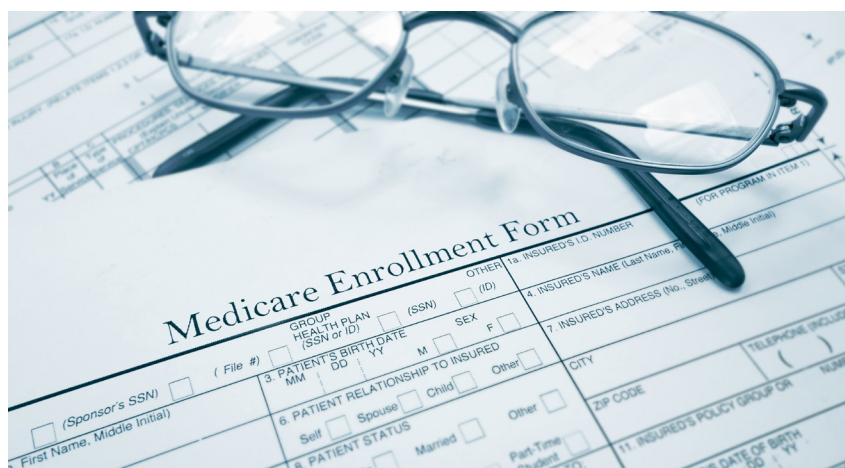
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Coming Soon to a Medicare Advantage Network Near You . . . New Provider and Supplier Enrollment Requirements

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Under provisions of the 2017 Medicare Physician Fee Schedule Final Rule (Final Rule), providers and suppliers in Medicare Advantage (MA) organization networks and certain other designated plans are now required to be enrolled in Medicare in an “approved status.” Centers for Medicare & Medicaid Services (CMS) data show that a large percentage of MA providers and suppliers already are enrolled in Medicare.¹ Therefore, relatively few providers and suppliers will need to enroll in Medicare to meet this new requirement and no issues of beneficiary access or network adequacy are anticipated. Nevertheless, CMS believes this enrollment requirement is necessary to prevent fraud and abuse and to protect Medicare enrollees by ensuring that services are provided by qualified providers and suppliers.

Importantly, providers and suppliers that are already enrolled and billing Medicare do not separately need to enroll to comply with these new regulations. In-network providers and suppliers that are *not* already enrolled in Medicare and that are currently providing services to MA enrollees, however, *will* need to enroll in Medicare to continue to provide services to MA enrollees.² CMS notes that in expanding provider and



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supplier enrollment requirements, MA organization enrollees will now have the same protections against unqualified and fraudulent providers and suppliers as fee-for-service and Part D program beneficiaries.³

Providers, suppliers, and MA plans also should be aware that this regulatory change creates a new requirement for MA organizations to verify provider and supplier enrollment as detailed below. Failure to comply with this requirement could result in sanctions and termination. These new regulations are effective in 2019, on the first day of the plan year.

Providers and Suppliers Affected

The Final Rule requires providers and suppliers to enroll in Medicare to provide health care items or services to a Medicare enrollee who receives his or her Medicare benefit through an MA organization. CMS clarified that in this context, providers and suppliers must be enrolled in Medicare in an “approved status,” meaning that the provider or supplier is enrolled in the Medicare program and such enrollment has not been revoked. A submitted enrollment application alone is not sufficient; to be enrolled in an “approved status” the enrollment process must be completed.⁴ Further, a provider or supplier deactivated because of a lack of claims submission is not considered in an “approved status.” Rather, such providers or suppliers must reactivate their enrollment by contacting their Medicare Administrative Contractor (MAC) and following reactivation procedures.⁵

The enrollment requirement applies to a wide range of providers and suppliers, but it does not apply to out-of-network or non-contract providers and suppliers.⁶ Only in-network providers and suppliers are included to minimize the impact on beneficiaries. Further, the Final Rule does not change the types of providers and suppliers eligible to enroll in Medicare; only providers and suppliers that meet those statutory definitions will be required and allowed to enroll in Medicare.⁷ For example, Programs of All-Inclusive Care for the Elderly (PACE) organization staff members that are not of a provider or supplier type that is eligible to enroll in Medicare are not subject to the Final Rule.⁸ (PACE is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a facility.) The following is a list of providers and suppliers subject to the new enrollment requirement:

- Network providers and suppliers; first-tier, downstream, and related entities (FDR) (these are entities that contract with MA organizations to provide services to beneficiaries);
- Providers and suppliers participating in PACE;
- Suppliers in Cost Health Maintenance Organizations (Cost HMOs) or Competitive Medical Plans (CMPs) (Cost HMOs and CMPs are a type of Medicare health plan available in certain parts of the country and are sponsored

either by employer or union group health plans or offered by companies that do not provide Part A services);

- Providers and suppliers participating in demonstration and pilot programs (these programs generally are time-limited special projects that test improvements in Medicare coverage, payment, and quality of care);
- Locum tenens suppliers that provide physician staffing services for hospitals, outpatient medical centers, government and military facilities, group practices, community health centers, and correctional facilities; and
- Incident-to suppliers that furnish integral, but incidental, professional services in the course of diagnosis or treatment of an injury or illness.

Plan Obligations

The Final Rule imposes a new obligation on MA organizations to ensure that providers and suppliers comply with the enrollment requirements.⁹ MA organizations that do not ensure that providers and suppliers comply with the Medicare enrollment requirement may be subject to sanctions and termination as an MA organization.¹⁰ Although existing regulations already address basic requirements for MA provider credentialing, CMS believes that an additional obligation to ensure provider and supplier compliance with the enrollment requirements is warranted given the risks due to fraudulent or unqualified providers and suppliers.

Not surprisingly, this requirement to make MA organizations responsible for verifying the Medicare enrollment of providers and suppliers generated a number of comments from stakeholders. These comments ranged from the potential burden imposed on MA organizations to whether MA organizations should be given access to CMS’ Provider Enrollment, Chain and Ownership System (PECOS). Several commenters were concerned with the potential penalties for plans given that legitimate errors could occur as a result of not receiving new enrollment information in a timely manner.

In its response to these comments, CMS rejected the notion that verifying provider and supplier enrollment will be overly burdensome. In fact, CMS believes it has made compliance “simple” by providing a file of enrolled providers and suppliers.¹¹ This online file is public and already has been made available to MA organizations. Once determined, CMS will announce through an established process such as a Medicare Learning Network (MLN) article how often the file will be updated.¹² MA organizations will be expected to check this enrollment file to ensure that all providers and suppliers are validly enrolled and not revoked from Medicare. Checking this file will be the only way for MA organizations to determine whether a provider or supplier’s enrollment has been revoked. If a revocation has occurred, the provider or supplier will not be included in the enrollment file. CMS will not otherwise be communicating revo-

cations to MA organizations.¹³ And the Final Rule does not require providers and suppliers to notify MA organizations of a revocation, although an MA organization could impose this requirement contractually with its providers and suppliers.¹⁴ Because this online file has been made available, CMS declined to give MA organization full access to PECOS.

In response to commenters concerned about the potential penalties to MA organization for noncompliance with this enrollment requirement, CMS stressed that it will work with MA organizations as this requirement is implemented and that the agency will use its discretion to determine the appropriate action to take against noncompliant plans after consideration of “all relevant factors.”¹⁵ CMS also noted that plans have more than two years to make the necessary changes needed to comply with this requirement. For this reason, CMS declined to include a grandfathering provision or offer a grace period for MA providers and suppliers who are un-enrolled.¹⁶

1 See Preamble to Final Rule, 2017 Medicare Physician Fee Schedule, 81 Fed. Reg. 80170, 80447 (Nov. 15, 2016).

2 81 Fed. Reg. at 80452.

3 *Id.* at 80451.

4 *Id.* at 80445.

5 *Id.* at 80453.

6 *Id.* at 80445.

7 *Id.* at 80454.

8 *Id.* at 80457.

9 *Id.* at 80170 (to be codified at 42 C.F.R. § 422.204(b)(5)).

10 *Id.* (to be codified at 42 C.F.R. § 422.222(b)).

11 *Id.* at 80449.

12 *Id.*

13 *Id.*

14 *Id.* at 80456.

15 *Id.* at 80452.

16 *Id.* at 80453.

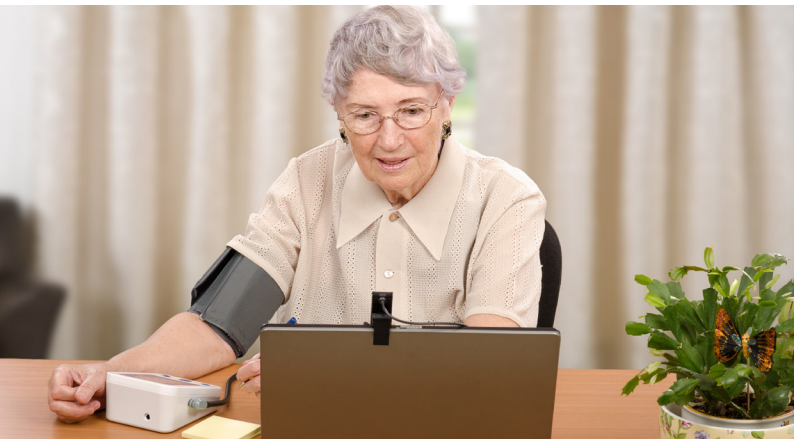


The Government Continues to Gradually Embrace Telehealth Services

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On November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) released its 2017 Medicare Physician Fee Schedule (PFS), which, among other things, expanded the list of services that may be furnished to Medicare beneficiaries via telehealth to include: (1) end-stage renal disease (ESRD)-related services for dialysis, (2) advance care planning services, and (3) critical care consultations.¹ The expanded reimbursement of telehealth services by CMS combined with the enactment of the 21st Century Cures Act (Cures Act)² on December 13, 2016 and other similar legislation signal that the government is slowly embracing telehealth services.

Overview of Certain Requirements for Billing and Payment for Telehealth Services

To understand the limitations on Medicare reimbursement of telehealth services, we must be aware of the rigid conditions required for Medicare to make payment for telehealth services under the PFS. The service must be on the list of Medicare telehealth services and meet all of the following requirements:³

- The service must be furnished via an interactive telecommunications system;
- The service must be furnished by a physician or other authorized practitioner;
- The service must be furnished to an eligible telehealth individual; and
- The individual receiving the service must be located in a telehealth originating site.

When all of these conditions are met, Medicare pays a facility fee to the originating site and makes separate payment to the distant site practitioner furnishing the service.⁴

The statutory framework, which defines an “originating site” and describes the geographic qualifications for the originating site to be eligible for reimbursement for telehealth services, significantly limits the provision of reimbursement-eligible telehealth services to Medicare beneficiaries. Under the statutory framework, “originating sites” only consist of the following:⁵

- Offices of a physician or practitioner;
- Hospitals;
- Critical Access Hospitals (CAHs);
- Rural Health Clinics;
- Federally Qualified Health Centers;
- Hospital-based or CAH-based Renal Dialysis Centers;
- Skilled Nursing Facilities; and
- Community Mental Health Centers.

In addition, each originating site must either⁶ (a) be located in a rural health professional shortage area (HPSA),⁷ or (b) be located in a county that is not included in a metropolitan statistical area (MSA).

New Codes and Reimbursement Rates for Telehealth Services

CMS added the following codes⁸ to the list of telehealth services for calendar year 2017 on a category 1 basis: (1) ESRD-Related codes (90967-90970); (2) advance care planning Current Procedural Terminology (CPT) codes (99497 and 99498); and (3) telehealth consultations for a Patient Requiring Critical Care Services (G-codes G0508 and G0509).

PFS established that the telehealth originating site facility fee for January 1, 2017 to December 31, 2017 is \$25.40.⁹ This is a 1.2% increase over 2016.¹⁰

Additional Support for Telehealth via Recent Federal Legislation

Through the Cures Act, Congress directs CMS to:¹¹

- Expand eligible originating sites beyond those originating sites currently allowed by CMS and ensure that any expansion of telehealth services under the Medicare program (a) recognizes that telemedicine is the delivery of safe, effective, quality health care services, by a health care provider, using technology as the mode of care delivery; (b) meets or exceeds the conditions of coverage and payment with respect to the Medicare program if the service was furnished in person, including standards of care, unless specifically addressed in subsequent legislation; and (c) involves clinically appropriate means to furnish such services;

- Provide information on specific types of Medicare beneficiaries whose care could be improved by expanding telehealth services;
- Provide information on all projects currently being conducted by the CMS Innovation Center which are related to telehealth services;
- Provide information on services with volume that may be improved via a telehealth module or platform;
- Identify barriers that would prevent the expansion of the list of telehealth services; and
- Provide a report to Congress by December 14, 2017 addressing the issues described above.

In addition, the Cures Act provides a directive to the Medicare Payment Advisory Commission (MedPAC) to provide information, using quantitative and qualitative research methods, to the committees of jurisdiction of the House of Representatives and the Senate that identifies:

- The telehealth services for which payment can be made under Medicare Parts A and B;
- The telehealth services for which payment can be made under private health insurance plans; and
- With respect to services identified and payable by private health insurance plans, ways in which payment for such services might be incorporated into such Medicare fee-for-service program (including any recommendations for ways to accomplish this incorporation).¹²

The Expanding Capacity for Health Outcomes (ECHO) Act¹³ was enacted the day after the Cures Act and seeks to leverage prior initiatives in telehealth to connect rural areas and urban centers. Specifically, the ECHO Act requires the Department of Health and Human Services (HHS) to analyze certain initiatives that:¹⁴

- Address mental and substance use disorders, chronic diseases, prenatal and maternal health, pediatrics, pain management, and palliative care;
- Address health care workforce issues, such as specialty shortages and primary care workforce recruitment, retention, and learning support;
- Relate disease prevention, infectious disease outbreak, and public health surveillance; and
- Deliver health care services in rural areas, frontier areas, HPSAs, medically underserved areas, medically underserved populations, and to Native Americans.

The ECHO Act requires HHS to develop technology-enabled collaborative learning and capacity building models.¹⁵ Further, HHS must deliver a report to Congress by December 2018 that addresses the above, discusses the impact of the capacity building models, and includes recommendations on how to reduce obstacles to implement such models to benefit and expand telehealth.

The Cures Act and the ECHO Act demonstrate Congress' intent to invest in telehealth services and related technology and platforms. Further, these pieces of legislation have applied pressure on HHS and CMS to embrace telehealth services.

What to Watch for in 2017 and Beyond

While CMS has expanded its list of telehealth services to include (a) ESRD-related services for dialysis, (b) advance care planning services, and (c) critical care consultations, such expansion is tempered by the statutory restrictions surrounding the limited definition of an “originating site” and the rural geographic qualifications required for an originating site to allow for telehealth services to be reimbursed by Medicare. However, the Cures Act and the ECHO Act encourage CMS and HHS to invest in, implement initiatives for, and expand reimbursement for telehealth services. Attorneys, clients, and other interested stakeholders should monitor CMS' and HHS' responses to Congress in 2017 and 2018 regarding telehealth as required by the legislation discussed herein. Any changes to the current statutory requirements that increase eligibility for an “originating site” or expand reimbursement eligibility beyond a rural area would provide greater flexibility in reimbursement for telehealth services by Medicare, which in turn, would expand access to care for beneficiaries.

1 Medicare Physician Fee Schedule 2017, 81 Fed. Reg. 80170 (Nov. 15, 2016).

2 Pub. L. No. 114-255 (Dec. 13, 2016).

3 42 C.F.R. § 410.78(b).

4 81 Fed. Reg. 80193.

5 42 C.F.R. § 410.78(b)(3).

6 42 C.F.R. § 410.78(b)(4). In addition, an entity participating in a federal telemedicine demonstration project that has been approved by, or received funding from the Department of Health and Human Services also may be eligible as an originating site regardless of its geographic location.

7 81 Fed. Reg. 80193. Effective January 1, 2014, rural HPSAs are those located in rural census tracts determined by the Federal Office of Rural Health Policy of the Health Resources and Services Administration. Defining “rural” to include rural census tracts within MSAs allows for a broader inclusion of originating sites and, thus, expands access to services via telehealth to Medicare beneficiaries.

8 *Id.* at 80198. CMS chose not to expand the list of telehealth services for observation care, emergency department visits, critical care evaluation and management (E/M), psychological testing, and physical, occupational, and speech therapy.

9 *Id.* at 80201.

10 *Id.*

11 Cures Act, Section 4012.

12 Cures Act, Section 4012(b).

13 Pub. L. No. 114-270 (Dec. 14, 2016).

14 *Id.*

15 An example of a capacity-building model is the University of New Mexico's Project ECHO, which seeks to use continuing medical education to connect specialists with primary care providers in rural areas through the use of interactive video conferencing technology.

CMS Expands Medicare Payment for Chronic Care Management and Behavioral Health Care Services

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The 2017 Medicare Physician Fee Schedule (MPFS) Final Rule¹ (Final Rule) offers expanded revenue opportunities for physician practices that furnish care management services to their patients who have chronic and/or mental health conditions. This article focuses on new payment policies under the Final Rule that (1) make it easier and more financially attractive to provide chronic care management (CCM) services, (2) establish new billing codes for prolonged evaluation and management (E/M) services, and (3) establish new billing codes for behavioral health care integration (BHI) activities.

These new billing codes and relaxed CCM standards result from the efforts of the Centers for Medicare & Medicaid Services (CMS) to enhance financial support for comprehensive care management and coordination of care. While these codes do not pay based on performance, the care management and coordination elements of patient care will become increasingly important as U.S. health care continues the paradigm shift from paying for volume to paying for value and population health management. This trend is evidenced by the establishment of various types of shared savings programs that focus on accountable care organizations (ACOs), bundled payment programs, and particularly the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPM) Quality Payment Program tracks under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Practitioners who fail to dedicate resources to tracking quality of care measures and coordinating patient care will risk being doubly penalized: first, they will see Medicare reimbursements decrease and second, they will not capture the potential additional revenues authorized by Medicare.

Easing of Chronic Care Management Billing Requirements

Since January 2015, Medicare has been paying physicians, nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists (CNS), certified nurse midwives (CNM)² and their physician practice entities, federally qualified

health centers (FQHCs), and rural health clinics (RHCs) a CCM monthly fee under Current Procedural Terminology (CPT) code 99490 (approximately \$43 per month in 2017)³ to coordinate care for Medicare beneficiaries, who have multiple chronic conditions (e.g. high blood pressure, diabetes, COPD). Required CCM service elements include:

- Use of a certified electronic health record (EHR);
- Beneficiary consent;
- Care management and planning, including a plan of care;
- Enhanced access to care and communication; and
- Continuity and coordination of care.

Historically, the number of Medicare beneficiaries receiving CCM under CPT 99490 has fallen far short of expectations. CMS has acknowledged complaints that CCM services are underpaid and subject to burdensome requirements that prevent physician practices from providing valuable CCM services to Medicare beneficiaries who need these services. CMS has responded by relaxing various service elements and billing requirements for CCM services and establishing new billing codes to encourage practitioners to furnish the much needed CCM.

The Final Rule provisions relaxing CCM service elements and billing requirements became effective on January 1, 2017. These principal revisions include:

- Medicare CCM standards are now more closely aligned with CPT standards;
- The requirement to furnish a comprehensive E/M visit, annual wellness visit (AWV), or initial preventive physical examination (IPPE) and initiate the CCM service as part of this visit or exam now applies only for new patients and patients who have not been seen within 12 months prior to commencement of CCM;
- Beneficiary consent is still required, but can now be documented in the medical record in lieu of obtaining written consent;
- Care plans and clinical summaries can now be shared by fax as well as other electronic means, so long as information is available on a timely basis;
- Access to an electronic care plan is no longer required outside of normal business hours, so long as the care providers have timely information;
- Standards for clinical summaries have been removed;
- The beneficiary's authorization for electronic communication of his or her medical information with other treating providers is no longer required;
- Beneficiary consent, receipt of care plan, and communications with home-based and community-based providers are



no longer required to be documented in the HER—documentation in the medical record is now sufficient; and

- The supervision standard for FQHCs and RHCs has been reduced from direct to general.

Although outsourcing of clinical staffing is allowed, CMS has warned that the billing practitioner needs to be involved in oversight and management and that CCM service elements are not satisfied if the billing practitioner provides too little oversight or if there is a lack of clinical integration between the billing practitioner and any third party that provides outsourced CCM services.

New Medicare Chronic Care Management Codes

Beginning January 1, 2017, Medicare began paying for complex CCM services under two new CPT codes, 99487 (\$94 per month) and 99489 (\$47 per month). These complex CCM codes require satisfaction of all CCM requirements under CPT code 99490, as well as the following additional elements: (a) Documented moderate or high complexity of

medical decision making; and (b) at least 60 minutes of clinical staff time per month (rather than 20 minutes for regular CCM services under 99490). Code 99489 is an add-on code for each additional 30 minutes of clinical staff time after the 60 minutes under 99487.

CMS established a new add-on billing code, G0506, which provides an additional payment (\$64) for extensive, outside the usual effort, face-to-face assessment and care planning performed personally by the billing practitioner (not clinical staff) during the initiating visit. This code can be billed in addition to the E/M, AWV, or IPPE code, but can only be billed once for a given beneficiary.

New Medicare Billing Codes for Prolonged E/M Services

The Final Rule established new Medicare payment for non-face-to-face prolonged E/M services under existing CPT codes 99358 (\$113) for the first 60 minutes and 99359 (\$55) for additional 30 minute increments. This payment is in addition to the payment under the underlying E/M code. Code 99358 potentially applies when a practitioner person-

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ally spends an additional 31 minutes⁴ non-face-to-face time in performing the E/M service beyond the typical time, as assumed for purposes of MPFS rate-setting for the E/M code.⁵ Code 99359 provides additional payment for 16-30 minute increments in excess of the first 60 minutes.

CMS will not allow CPT codes 99358 and 99359 to be reported during the same month as the complex CCM codes 99487 and/or 99489 or in the same 30-day period as the transitional care management (TCM) services code. CPT codes 99358 and 99359 can be billed in the same month as regular (not complex) CCM codes but neither can be reported as an add-on to a CCM initiating visit, code G0506.

Psychiatric Collaborative Care Model (3 New Codes: G0502, G0503, and G0504)

The Final Rule established four new BHI billing codes, three of which apply to care provided under the psychiatric Collaborative Care Model (CoCM) by a primary care team consisting of a treating practitioner and a behavioral health care manager working in collaboration with a psychiatric consultant. The three CoCM “G” codes⁶ describe psychiatric collaborative care management directed by the treating practitioner in consultation with a behavioral health care manager:

- **Code G0502:** Initial psychiatric collaborative care management for the first 70 minutes in the first calendar month satisfying the following elements:
 - Patient outreach and engagement by the treating physician;
 - Initial assessment of the patient and development of an individualized treatment plan;
 - Review (and modification, if recommended) of the treatment plan by a psychiatric consultant;
 - Entry of the patient in a registry, follow-up tracking, and participation in weekly caseload consultation with the psychiatric consultant; and
 - Brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
- **Code G0503:** Subsequent psychiatric collaborative care management for the first 60 minutes in a subsequent month satisfying the following elements:
 - Tracking and appropriately documenting patient follow-up and progress using the registry;
 - Weekly caseload consultation with the psychiatric consultant;
 - Ongoing collaboration and coordination of patient mental health care by the treating practitioner and any other treating mental health providers;

- Additional review of progress and recommendations for treatment changes;
 - Brief interventions using evidence-based techniques; and
 - Monitoring of patient outcomes using validated rating scales, along with relapse prevention planning as the patient achieves remission of symptoms or other treatment goals.
- **Code G0504:** Additional 30 minutes of behavioral health care manager activities in a calendar month, in consultation with a psychiatric consultant and directed by the treating practitioner.

The CoCM services can be furnished when the beneficiary has one or more psychiatric or behavioral health conditions (including substance abuse disorders) that, in the treating practitioner’s judgment, warrant a behavioral health care assessment, a care plan, and brief interventions. In its commentary, CMS elaborated on several key points: (1) the patient must present with a psychiatric or behavioral health condition that, in the clinical judgment of the treating practitioner, warrants referral to the behavioral health care manager for further assessment and treatment through CoCM services; (2) the diagnosis may be preexisting or established by the treating practitioner; and (3) the CoCM codes are not limited to a particular set of behavioral health conditions.

The CoCM codes can only be reported by a treating practitioner who directs the behavioral health care manager and oversees the beneficiary’s care. The practitioner must remain involved in ongoing oversight, management, collaboration, and assessment for the duration of the time that she is reporting it. CMS expects most CoCM services to be performed by primary care practitioners, but recognizes that the CoCM codes also can be billed in other medical specialty settings when the practitioner manages the beneficiary’s behavioral health and other conditions. CMS generally does not expect psychiatrists to bill the CoCM codes, because psychiatric work is defined as a sub-component of the CoCM codes.

The Final Rule also describes the roles and qualifications of the behavioral health care manager and the psychiatric consultant, both of whom are subject to the “incident to” rule as well as licensure, scope of practice, and other state law restrictions. The Final Rule revised the “incident to” regulation to extend the general supervision (rather than the more stringent direct supervision standard in place for most “incident to” services) to the CoCM and general BHI codes.⁷

The behavioral health care manager must have formal education or specialized training in behavioral health. CMS recognizes social work, nursing, and psychology as acceptable disciplines. The responsibilities of the behavioral health care manager include:

- Providing the following elements of service in consultation with the psychiatric consultant:

- Care management services and assessment of needs
- Behavioral health care planning, including managing treatment plan revisions for patients who are not progressing or whose status changes
- Brief interventions
- Ongoing collaboration with the treating practitioner
- Registry maintenance;
- Consulting with the psychiatric consultant on a weekly basis;
- Maintaining a collaborative, integrated relationship with the care team members; and
- Maintaining the ability to engage the beneficiary during off hours and have a continuous relationship with the beneficiary.

CMS now recognizes that some CoCM services can be contracted out to third parties and that a behavioral health care manager may provide his services from remote locations. The behavioral health care manager must be available to provide services on a face-to-face basis, but CMS does not require face-to-face services.

The psychiatric consultant must be a medical professional (e.g., a psychiatrist or an NP with psychiatry board-certification) trained in psychiatry and qualified to prescribe the full range of medications. The psychiatric consultant advises and makes psychiatric and other medical care recommendations that are communicated to the treating practitioner, typically through the behavioral health care manager. The psychiatric consultant does not typically see the beneficiary or prescribe medications, except in rare circumstances, but should facilitate referral for direct psychiatric care when clinically indicated.

General Care Management for Behavioral Health Conditions (Code G0507)

CMS added a new general BHI code (G0507) covering care management services of behavioral health conditions for at least 20 minutes of clinical staff time per month. The following elements must be satisfied:

- Initial assessment or follow-up monitoring, including validated rating scales;
- Behavioral health care planning relating to behavioral/psychiatric problems;
- Facilitating and coordinating care; and
- Continuity of care with a designated member of the care team.

Like the three CoCM codes, code G0507 is reported by the treating practitioner for services furnished when the beneficiary has one or more psychiatric or behavioral health conditions that, in the treating practitioner's clinical judg-





ment, require a behavioral health care assessment, behavioral health care planning, and interventions.

Services under code G0507 may be provided by the treating practitioner or by clinical staff under her direction. Clinical staff members providing services under G0507 are not required to satisfy specific qualifications such as those set forth in the CoCM standards for a behavioral health care manager or psychiatric consultant.

All of the CoCM and general BHI codes require an initiating visit that is separately billable, as well as prior beneficiary consent.

Assessment and Care Planning for Patients with Cognitive Impairment (Code G0505)

New code G0505 will cover assessment and care planning for patients with cognitive impairment, such as Alzheimer's disease or dementia, if the following elements are satisfied:

- Cognition-focused evaluation including history and examination;
- Moderate or high complexity medical decision making;
- Functional assessment, including decision making capacity;
- Use of standardized instruments to stage dementia;
- Medication reconciliation and review for high-risk medications (if applicable);

- Evaluation for neuropsychiatric and behavioral symptoms, including depression;
- Evaluation of safety, including motor vehicle operation;
- Identification of caregiver(s), caregiver's knowledge, caregiver's needs, social support, and caregiver's willingness to give care;
- Advance care planning and palliative care needs; and
- Creation and sharing of a care plan with the patient and/or caregiver with initial education and support.

All of the specified elements under G0505 must be performed by the billing practitioner.

Conclusion

The new Medicare CCM, prolonged E/M, BHI and cognitive assessment payment policies offer opportunities to provide expanded care management services while generating potentially significant additional revenue. The CCM and BHI billing codes are generally not mutually exclusive,⁸ and can be billed for the same time period so long as applicable standards are satisfied, although duplicate counting of time must be avoided. Practitioners need to establish appropriate policies and procedures to ensure that all requirements are satisfied and documented for billing and compliance purposes.

Physician practices, FQHCs, and RHCs that have considered furnishing CCM in the past but have ultimately decided not to do so because of the administrative demands or reimbursement levels may wish to re-evaluate the pros and cons of furnishing CCM services, whether standard (CPT code 99490) or, in the case of physician practices but not FQHCs and RHCs, complex (CPT codes 99487 and 99489). Practices that are already furnishing CCM services should update policies and procedures to reflect the new standards.

1 81 Fed. Reg. 80170 (Nov. 15, 2016).

2 In the interest of simplicity, this article generally refers to the billing physician or other qualifying health care professionals as "practitioner."

3 Unless otherwise noted, reimbursement amounts set forth in this article are approximate national averages for services furnished in a non-facility setting.

4 Under the CPT mid-point rule, CPT 99358 can be billed after the mid-point of 60 minutes (i.e., at least 31 minutes) of additional time.

5 See Physician Time downloadable file, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>.

6 G codes (rather than CPT codes) will initially be used because the new CPT codes that have been approved by the CPT Editorial Panel will not be ready until 2018.

7 The "incident to" regulation already applied the general supervision standard to chronic care management and transitional care management.

8 CMS has noted that CPT code G0506 (extensive assessment and care planning) cannot be billed by a single practitioner on the same day as code G0505 (cognitive and functional assessment) or as an add-on for a BHI initiating visit or services.

The Doctor Is In (Sort Of): An Analysis of the Practice of Concurrent Surgery

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In October 2015, the *Boston Globe* published an article that focused on the practice of “concurrent surgeries” (also known as overlapping surgeries) at Massachusetts General Hospital (MGH).¹ The article ignited a public debate about whether concurrent surgeries were safe for patients, and whether they were being used as a method to increase operating room efficiency or to increase revenue for hospitals and physicians. The debate eventually led to a U.S. Senate inquiry and the American College of Surgeons (ACS) reevaluating their guidelines on concurrent surgeries.

The article defined concurrent surgery as the practice of a surgeon working two operating rooms at the same time moving back and forth from one to the other. This practice is actually not unique to MGH and occurs at many teaching hospitals. Surgeons are supposed to be present for critical parts of each surgery and also immediately available should a problem arise. However, as the article revealed, concurrent surgeries come with the risk of surgeons not adequately monitoring the multiple operating rooms, and in the case of MGH, allegedly not being present for operations, leaving residents and fellows to perform surgeries unsupervised for prolonged periods of time, and patients being under anesthesia longer than necessary.

Proponents of concurrent surgery believe this practice can be a valuable method to train surgical residents as well as efficiently use hospital operating rooms. These proponents note that research studies indicate that concurrent surgeries do not increase harm to patients. In a study conducted at the University of Virginia, researchers evaluated cardiothoracic surgeons running two operating rooms with residents performing noncritical aspects of the surgery.² According to the study, researchers found this practice of overlapping surgeries did not negatively affect patient outcomes or length of hospital stay. Nevertheless, there is little data or research on the cost-effectiveness, efficacy, or frequency of concurrent surgeries publicly available from government and national quality control organizations such as the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), the Agency for Healthcare Research and Quality (AHRQ), or The Joint Commission.³ Opponents of the practice raise concerns about patient safety and surgical efficacy, in addition to the issue of patient consent and whether patients should be informed of this practice.

This article examines federal government guidelines and guidance from the ACS on the performance of concurrent surgery and addresses related informed consent issues.

Medicare Claims

CMS has provided guidance on overlapping surgeries to academic medical centers billing Medicare. The Medicare Claims Processing Manual states that for a teaching surgeon to bill Medicare, the teaching surgeon must be physically present “during the critical or key portions” of the two overlapping operations.⁴ If the teaching surgeon cannot be present during a non-critical or non-key portion of a surgical



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procedure, then that surgeon must arrange for another qualified surgeon to be present to immediately assist a surgical resident should any problems arise. However, CMS has failed to define what constitutes a “critical or key portion” of surgery, leaving the definition open to interpretation and at the discretion of the surgeon and hospital.

Teaching surgeons who bill Medicare for surgeries when they are not present during a critical or key portion of a surgery may be guilty of violating the False Claims Act and may be subject to civil monetary penalties. In recent years, actions have been taken against academic medical centers for inadequate supervision of residents by teaching physicians who scheduled overlapping surgeries but were not available during the critical or key portions of the surgery. From 2004–2016, the OIG settled with nine teaching hospitals for inappropriate billing practices related to concurrent surgeries.⁵ Recently, Vanderbilt University Medical Center (VUMC) settled a False Claims Act suit brought by three physician whistleblowers alleging that VUMC tried to maximize their reimbursement by submitting false claims that did not meet Medicare’s billing requirements for concurrent surgeries.⁶ According to the allegations, VUMC utilized an aggressive scheduling system that forced surgeons to overbook their schedules, which left residents to perform the critical portions of the surgery. In 2016, the University of Pittsburgh Medical Center entered into a \$2.5 million settlement with the Department of Justice related to allegations that neurosurgeons submitted false claims to Medicare without participating in or supervising surgeries to the extent required.⁷

Outside of the academic medical center setting, there is little guidance on concurrent surgeries as the CMS Conditions of Participation (CoPs) and interpretive guidelines do not mention concurrent or overlapping surgeries.

U.S. Senate Inquiry

In March 2016, the U.S. Senate Finance Committee launched an inquiry into the effectiveness and transparency of concurrent surgeries and sent letters to 20 hospitals and health systems (including MGH) requesting information. Specifically, the Finance Committee sought information including detailed records and policies on each hospital’s practice and management of concurrent surgeries between 2011 and 2015. In its letter, the Finance Committee explained its concerns that patients were not being informed of concurrent surgery practices and that, in some cases, steps had been taken to actively conceal this practice from patients.

After evaluating the responses from the hospitals and health systems, the Finance Committee published a report (Senate Report) in December 2016 expressing concern over concurrent surgery practices. According to the Senate Report, less than half of the 20 hospitals queried had adequate policies outlining requirements for concurrent and overlapping surgeries. However, during the course of the Senate inquiry,

17 of the 20 hospitals modified or created new hospital policies specific to concurrent and overlapping surgeries.

According to the Senate Report, CMS currently does not intend to modify the CoPs to provide clarifications on concurrent surgery practices. CMS officials responding to the Senate query noted the CoPs state that surgical services must be provided in accordance with acceptable practices as established by nationally recognized professional associations. Consequently, hospitals should consider reevaluating their policies on concurrent surgery to ensure they are in accordance with guidelines promulgated by professional associations like the American College of Surgeons.

American College of Surgeons Guidelines

The ACS reexamined their guidelines related to overlapping surgeries and released updated guidelines on April 12, 2016.⁸ The ACS guidelines distinguish “concurrent surgeries” from “overlapping surgeries” by defining: (1) concurrent surgery as when the critical components of operations for which the primary attending surgeon is responsible are occurring at the same time; and (2) overlapping surgery as when the critical components of the first operation have been completed and the primary attending surgeon performs critical portions of a second operation in another room. The ACS guidelines state the primary attending surgeon should be in the operating suite or immediately available for the entire surgical procedure with some exceptions. The ACS guidelines largely reiterate the rules established under Medicare; however, the guidelines do define a “critical or key” portion of an operation as “those segments of the operation when essential technical expertise and surgical judgment are required in order to achieve an optimal patient outcome.”⁹ While the critical or key portions of a surgical procedure are determined by the primary attending surgeon, the guidance goes on to specify that the performance of overlapping procedures should not negatively impact the timely flow of either procedure. Surgeons may delegate non-critical portions of an operation to a qualified practitioner but the guidelines are clear that patient safety is paramount when delegating duties during overlapping surgeries.

According to the ACS guidelines, the most common scenario for overlapping surgeries occurs when the critical or key portions of the first surgery have been completed and there is not a reasonable expectation that the surgeon will return to the operation. This allows the surgeon to begin the second operation while a qualified practitioner (i.e., an individual licensed to perform the delegated portion of the operation) performs the non-critical portion of the first operation. This typically occurs during wound closures and other routine portions of the procedure. While these guidelines provide some best practices for managing concurrent surgeries, it is important to note that these are voluntary and non-binding guidelines.

Informed Consent

Informed consent is when a patient consents to a course of treatment or procedure after the medical provider has given the patient sufficient information for the patient to understand the risks and benefits of the treatment or procedure. Failure to obtain informed consent could result in a claim of battery (i.e. unpermitted touching). If the patient claims that the physician did not communicate sufficient information about the procedure to the patient, the physician could be susceptible to a malpractice claim or a disciplinary action.

The CMS CoPs, the ACS guidelines, and the Senate Report all emphasize a hospital's and physician's responsibility to obtain properly documented informed consent after providing the patient with all information necessary for him to properly evaluate and consent to a proposed course of treatment or procedure. The CoPs state that the patient or her representative (as allowed under state law) has the right to make informed decisions regarding her care, including the right to be informed of her health status, be involved in care planning and treatment, and be able to request or refuse treatment.¹⁰ The ACS guidelines add that surgeons should inform patients of the different types of qualified medical providers that will participate in their surgery (i.e., residents,

physician assistants, nurse practitioners, etc.) and their roles in the procedure. If an emergency situation arises that causes the surgeon to leave the operating room, the patient should be informed subsequently.

The Senate Report also urged hospitals to develop policies that require surgeons to sufficiently inform patients that their surgery might be overlapped with another surgery. In addition, hospitals were advised to develop consent forms that indicate the surgeon has informed the patient and the patient explicitly consents to the concurrent surgery. This explicit consent may be obtained by having the patient provide his initials on the consent form specifically mentioning the concurrent surgery.

Hospitals should have processes and procedures that guarantee patients or their representatives are given adequate information to make an informed decision about a procedure involving a concurrent surgery. Along with the discussion of the risk and benefits of the procedure, it may also be prudent to discuss with the patient the types of medical providers who will be assisting in the procedure and the possibility that the surgeon may perform the patient's procedure concurrently with another patient's procedure. Ideally, the patient should have a clear understanding of how concur-

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rent surgeries will be managed and of the hospital's policies and procedures regarding emergencies during concurrent surgeries. Additionally, it is paramount that hospitals and physicians obtain written documentation of the information provided to the patient and the patient's consent to the course of treatment or the procedure.

Conclusion

Hospitals should review their concurrent surgery practices, policies, and procedures to ensure they encourage and guarantee patient safety as well as foster the efficient use of operating rooms. These policies and procedures should be consistent with the applicable CMS Medicare Claims Processing Manual, ACS guidelines, and the Senate Report recommendations. They should clearly address issues such as who may perform concurrent surgeries, which procedures may overlap, the level of oversight required from surgeons during certain parts of the procedures, and adequately informing patients of overlapping surgeries and the involvement of multiple providers during surgery. Furthermore, hospitals should consider developing consent forms that specifically mention that concurrent and overlapping surgeries may or will be performed. To adequately inform patients of concurrent surgery, hospitals also may consider developing educational materials to help patients understand concurrent surgeries so that they can make an informed decision on whether they want to be part of a concurrent surgery. Educating patients on concurrent surgeries and ensuring hospital policies and procedures and management of concurrent surgeries are consistent with the CMS Medicare Claims Processing Manual, ACS guidelines, and the Senate Report recommendations is vital to avoiding malpractice exposure as well as liability under the False Claims Act and other federal and state health care billing statutes.

- 1 *Clash in the Name of Care*, THE BOSTON GLOBE, available at <http://apps.bostonglobe.com/spotlight/clash-in-the-name-of-care/story/>.
- 2 Marlene Busko, *One Attending Surgeon, Two ORs Can Be Safe, Efficient*, MEDSCAPE (Apr. 29, 2014), available at <http://www.medscape.com/viewarticle/824280>.
- 3 U.S. Senate Finance Committee Staff Report, *Concurrent and Overlapping Surgeries* (Dec. 6, 2016), available at <https://www.finance.senate.gov/imo/media/doc/Concurrent%20Surgeries%20Report%20Final.pdf>.
- 4 CMS Manual System: Pub 100-04 Medicare Claims Processing: Transmittal 2303, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>.
- 5 U.S. Senate Finance Committee Staff Report, *supra* note 3, at 7.
- 6 *Vanderbilt University Settles FCA Suit with Physicians*, LAW360, (Jan. 27, 2017), available at <https://www.law360.com/articles/885497/vanderbilt-university-settles-fca-suit-with-physicians> (subscription required).
- 7 U.S. Senate Finance Committee Staff Report, *supra* note 3, at 7.
- 8 AMERICAN COLLEGE OF SURGEONS, *Statements on Principles*, available at <https://www.facs.org/about-ac/s/statements/stonprin#anchor172771>.
- 9 *Id.*
- 10 See 42 C.F.R. § 482.13(b)(2).

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A wide-angle photograph of the Golden Gate Bridge in San Francisco, California. The bridge's iconic red-orange towers and suspension cables are prominent, stretching across the frame from the left towards the right. The bridge spans a deep blue body of water, with the city skyline and hills visible in the background under a clear sky with some light clouds. The lighting suggests a late afternoon or early morning setting.

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