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Part B News
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In this issue

Compliance

IRS crackdown shows your COVID program responsibilities aren't over

An Internal Revenue Service (IRS) "moratorium" on a COVID relief program serves as a warning to providers who received tax credits, and it may speak to dangers beyond this specific program. Several other loan and grant opportunities, some of which stretch back to the early days of the pandemic, have requirements that you might have missed or not yet been asked for.

On Sept. 14, the IRS announced a moratorium on its processing of claims on Employee Retention Credits (ERC), a COVID-related program meant to assist businesses, including health care organizations, that "kept paying employees during the COVID-19 pandemic either when they were shut down due to a government order or when they had a significant decline in gross receipts during certain eligibility periods in 2020 and 2021."

Michael P. Strazzella, senior principal, government relations, health care industry group co-leader and co-head of office at Buchanan Ingersoll & Rooney PC in Washington, D.C., says that though much time has passed, "the lag time on this program has been years long, because they're doing a careful examination [of claims]. We know from some of our clients who received employee retention credits that it was a long, arduous process."

The IRS said it has stopped processing claims "amid rising concerns about a flood of improper Employee Retention Credit claims," and that "a substantial share of new claims from the aging program are ineligible and increasingly putting businesses at financial risk by being pressured and scammed by aggressive promoters and marketing."

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IRS commissioner Danny Werfel urged "people being pressured by promoters to apply for the Employee Retention Credit … to immediately pause and review their situation."

Loan holders hold the buck

Companies offering help with ERC applications — some established and reputable, others less so — have been easy to find online, as well as in many practice managers' inboxes. But whether or not you used one to apply for ERC, just because IRS is focusing on third parties doesn't mean they're the only targets, warns Mohamed Nabulsi, partner and health care practice group chair at Mandelbaum Barrett PC in Roseland, N.J.

"The taxpayer [who took the credit] ultimately is responsible even if they used a third party, whether it was a tax professional or one of these consulting firms that emerged with the program," Nabulsi says.

Nabulsi adds that reporters could have exaggerated the impact of the pandemic on their business or inflated their eligible expenses to maximize their credit in a number of ways: "For example, by including nonqualified wages or expenses unrelated to the purpose of the credit, which is the retention of employees; or by misrepresenting employee retention data — [e.g.] claiming that employees were retained when in fact they were laid off or terminated."

The IRS has posted a basic decision tree for compliant use of the program, which may be worth reviewing with your lawyer *(see resources, below)*.

What about other funds?

Experts say ERC isn't the only COVID program that remains a live issue for providers, even if they're sure that they've done everything right. For example, other agencies, including the Small Business Administration (SBA), which administered the Paycheck Protection Program (PPP) and Economic Injury Disaster Loans (EIDL); HHS' Health Resources and Services Administration (HRSA), which administered the Provider Relief Fund; and CMS, which administered the COVID-19 Accelerated or Advanced Payment Program and others, may ask at any time for evidence that you met their requirements.

"My big piece of advice is not to be complacent," says Melissa Wong, an attorney in Holland & Knight's Boston office and a member of the firm's national health care and life sciences industry group. "This is not necessarily a 'no news is good news' scenario."

Wong notes that some practices may have generally been diligent about their program requirements but may have missed a step, as with small practices she's seen "who realized that they didn't file [for PRF] when they should have, and they're trying to submit late." HRSA had specific requirements for late filers, including specific extenuating circumstances that they should be prepared to prove.

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"So far we haven't seen any fallout from filing late without the agreed-upon extension, but it will be interesting to see how that pans out," Wong says. "You should be prepared for a repayment obligation if you submitted very late without a permitted extension or extenuating circumstance."

Nabulsi, who has had clients approached by some of these agencies about their program participation in recent months, recommends a check-up.

"We typically advise clients to conduct a self-audit and, if they find that there may have been some misrepresentation of [the] type I described, they should come clean and refund the money via appropriate self-disclosure prepared by qualified legal counsel," Nabulsi says. "In my experience, the government is unlikely prosecute those who voluntarily come forward and self-disclose." — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCES

- IRS, "To protect taxpayers from scams, IRS orders immediate stop to new Employee Retention Credit processing amid surge of questionable claims; concerns from tax pros," Sept. 14: www.irs.gov/newsroom/to-protect-taxpayers-from-scams-irs-orders-immediate-stop-to-new-employee-retention-credit-processing-amid-surge-of-questionable-claims-concerns-from-tax-pros
- IRS, "Employee Retention Credit Eligibility Checklist: Help understanding this complex credit www.irs.gov/pub/newsroom/erc-eligibility-if-then-chart.pdf
- HRSA, "Request to Report Late Due to Extenuating Circumstances": www.hrsa.gov/provider-relief/reporting-auditing/late-reporting-requests

Compliance

HHS disability rule may require new equipment, from kiosks to scanners

A proposed rule from HHS' Office for Civil Rights (OCR) sets new standards for the accessibility of a variety of medical practice equipment to the disabled and may leave non-compliant practices vulnerable to fines and even lawsuits.

The proposed rule, "Discrimination on the Basis of Disability in Health and Human Service Programs or Activities," issued Sept. 14, follows the logic of previous HHS rules intended to extend access to health care to populations that previously encountered barriers, ranging from non-English speakers to trans patients (*PBN 8/8/22*).

The rule cites statistics such as "only 40.7% of physicians surveyed were confident of their ability to provide the same quality of care to patients with disabilities and only 56.5% strongly agreed that they welcome patients with disabilities into their practices." It proposes "to clarify the general prohibition on discrimination against qualified individuals with disabilities in the medical treatment context and elaborate on specific prohibitions in this context."

On the deep end, the rule discusses providers' responsibility not to let disability affect treatment decisions, except insofar as the disability makes treatment ineffective.

The rule "contemplates that if there's a condition that exists that would otherwise disqualify somebody from receiving lifesaving treatment, like an organ transplant, [the independent and non-discriminatory condition] has to be documented to make sure that there's compliance with that," explains J. Malcolm DeVoy, a partner with the Holland & Hart firm in Las Vegas.

DeVoy says this is reminiscent of HHS' guidance pertaining to "when certain states at the beginning of the COVID emergency enacted their emergency plans that hadn't been updated for compliance with section 1557 and they contemplated triage and prioritization of health care resources based on who is most likely to survive."

Watch scanners, touch-screens

The Americans with Disabilities Act (ADA) and its companion Amended Act mandate access to health care for disabled people, but they only call for "reasonable modifications of policies, practices, and procedures" to meet that end. The new rule would codify standards for medical organizations that take federal money for medical diagnostic equipment (MDE) and office reception equipment, such as kiosks. (**Note:** These standards would apply to diagnostic, not treatment, equipment.)

The rule refers to the ongoing work of the U.S. Access Board, formerly the Architectural and Transportation Barriers Compliance Board, a federal agency that develops national disability access standards under the ADA. OCR notes that the Board has set up "technical requirements for MDE used by patients in the supine, prone, or side-lying position (such as examination tables) and MDE used by patients in the seated position (such as examination chairs) [that] focus on ensuring that the patient can transfer from a mobility device onto the MDE." The rule proposes to codify these requirements into regulation.

The rule also proposes that health care organizations' websites and information kiosks come up to World Wide Web Consortium (W3C) standards for accessibility, WCAG 2.1 Level AA. The rule explicitly states that "voluntary compliance with technical standards for web accessibility has been insufficient in providing access" to disabled patients.

Sharon McLennon-Wier, executive director for the Center for Independence of the Disabled (NYCID) in New York City and a licensed mental health counselor (MHC), has experienced this failure to comply with standards herself as a blind person.

"A lot of medical facilities, especially lab facilities, are understaffed," McLennon-Wier reports, "so LabCorp and Quest Diagnostics have taken away their actual human staff to check in [patients] and put up kiosks, computer stations where a patient will come in and type in their name and their information. I'm a totally blind person and I use screen-reading technology called JAWS [Job Access With Speech] for Windows. I had to do blood work but I could not complete this task … because I was unable to input my information at Quest or LabCorp. They do not have any accessible screen-reading technology that would allow me to do so."

McLennon-Wier says conformity with WCAG standards is absolutely essential for the ability to use computer equipment in health care settings.

"If you are a blind person, or have another sort of disability that requires an adaptive keyboard, screen magnification and/or screen-reading technology on your computer, if it's not compliant with web content accessibility guidelines, 2.1 AAA or even section 508 of the Rehabilitation Act, you are screwed," McLennon-Wier says. "You can't use the computer. This particular provision allows people who use assisted technology to access their medical records like anybody else."

Where's the enforcement?

How a practice would be sanctioned under the rule for having, for example, an MRI machine that a quadriplegic patient can't use is an open question.

The rule proposes that "enforceable technical standards will help ensure clarity to recipients on how to fulfill their existing obligations under title II [of the Civil Rights Act of 1964] and section 504 [of the Rehabilitation Act of 1973]," but proposes no specific enforcement mechanism.

DeVoy believes that, once finalized, the rule would be "more or less something that the OCR could enforce through its administrative proceedings — issuing fines and sanctions, in the same way that it would with HIPAA [violations]."

Also, disabled persons might use the rule as grounds to sue. While the rule "doesn't create a private right of action in and of itself," DeVoy says, there's a "potential risk [that a litigant would say] this regulation derives from the ADA, and that could be a basis for private action. There's also a potential basis for private action under state statutes that require material compliance with all federal laws and regulations."

There remains some leeway for providers under the proposal, DeVoy notes: If an employer has 15 or fewer employees, for example, there's a two-year implementation time frame. Also, DeVoy says, OCR doesn't want to "significantly impair the ability of the recipient to provide its benefits or services." By the time of the final rule, accommodations for such practices should be clarified.

Michael P. Strazzella, senior principal, government relations, health care industry group co-leader and co-head of office at Buchanan Ingersoll & Rooney PC in Washington, D.C., believes the most immediate impact would be on medical equipment manufacturers, who will be pushed "to ensure that the equipment is standardized. Examination tables that go up and down are going to become the norm." Once that happens, provider compliance should fall into place.

A note on service animals

The rule also clarifies the difference between service animals that are covered by the ADA and permitted to accompany patients into health care settings — with the usual reasonable-accommodation caveats — and emotional support animals, which are not.

"The difference between an emotional support animal and a psychiatric service animal is the work or tasks that the animal performs," the rule states, though some service animals may "work" on patients' emotional and psychological issues, as with a "psychiatric service dog that can help some individuals with dissociative identity disorder remain grounded in time or place."

Comments on the rule are open until Nov. 13. — *Roy Edroso* (*redroso@decisionhealth.com*) ■

(continued on p. 6)

Benchmark of the week

2022 saw historic drops in Part B utilization and payment; tests rise

Based on just-released Medicare Part B claims data, the 15 most-billed codes in 2022 were similar to those in 2021 and 2020, with one major COVID-related exception. But overall Medicare utilization and reimbursement took a big hit compared to prior years.

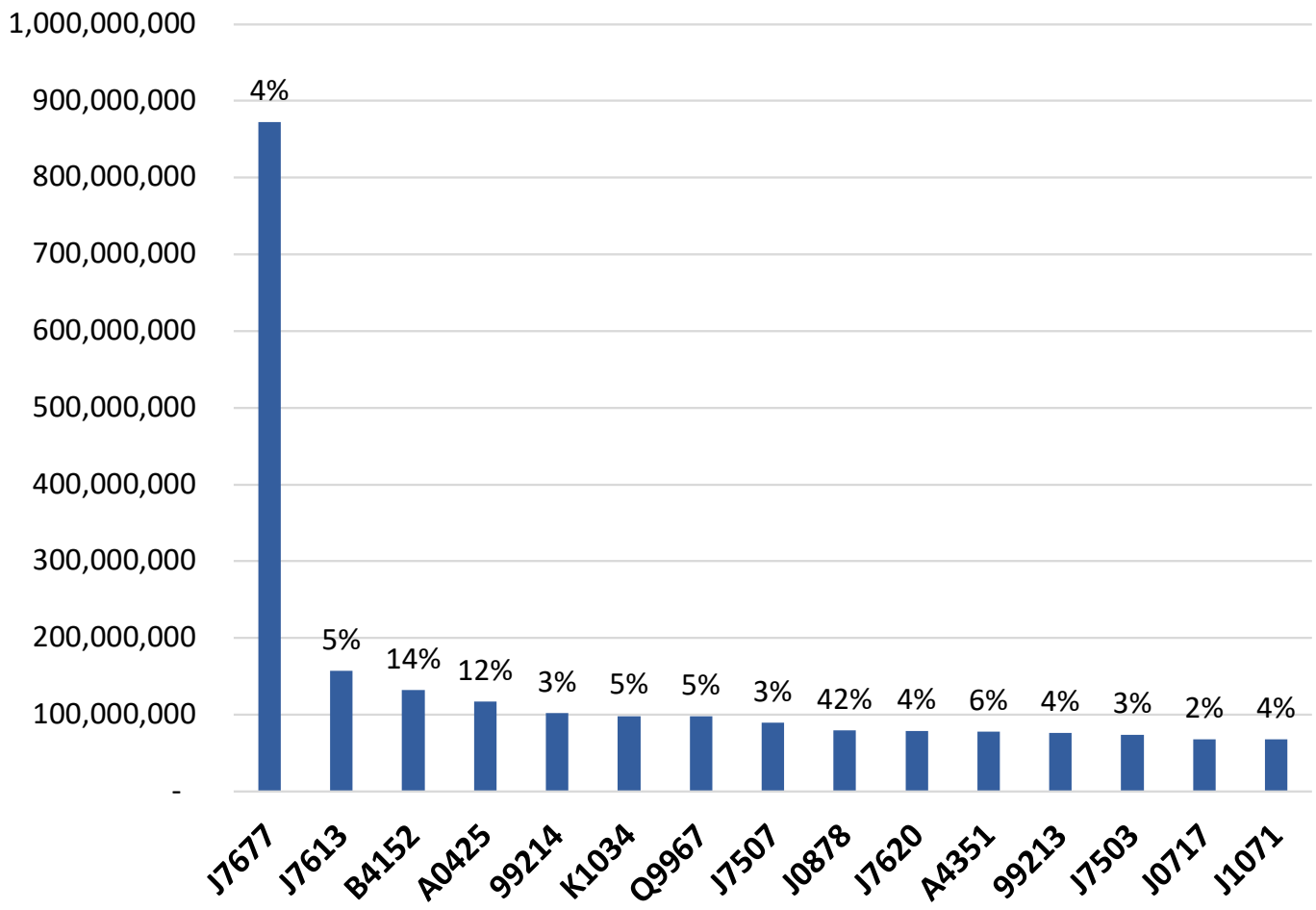
In 2022, providers saw a downturn in total utilization, from 6.5 billion claim lines in 2021 to 6.1 billion claims in 2022, according to 2022 Medicare claims data, the latest available. This is unexpected; even in the first pandemic year of 2020, utilization went up, if only by a hair, from 5.8 billion to 5.9 billion total claims.

Total year-to-year payments dropped, too – from $118.2 billion in 2021 to $115.9 billion in 2022, a 2% drop compared with the 11% rise in 2021 (*PBN 11/7/22*).

The 15 leaders in 2022 closely resemble 2021's. Once again, perennial top-seed **J7677** (Revefenacin inhalation solution, 1 mcgm) lapped the field, accounting for 14.3% of all claims. Practices billed it 872.8 million times, an increase from 756.7 million in 2021 (*PBN 3/27/23*). Code **Q9967** (Low osmolar contrast material, 1ml) moved from sixth to eighth place; E/M code **99214** jumped from seventh to sixth; and other drugs reshuffled, but only **J1071** (Inj, testosterone cypionate, 1 mg), **J7512** (Prednisone, 1 ml) and **J1439** (Inj, ferric carboxymaltose, 1 mg) fell slightly off the list to 16th, 17th and 19th place, respectively.

The new entrant in seventh place, **K1034** (Provision of COVID-19 test, nonprescription self-administered and self-collected use), wasn't even a code the year before. This was how CMS paid for the no-charge home COVID tests distributed starting in April 2022 and ending with the cessation of the public health emergency on May 11, 2023. Total payment amount for 2022 was just over $1 billion. **Note:** the 42% denial rate on J0878 (Injection, daptomycin, 1 mg) is an increase from the 37% rate the antibiotic pulled in 2021. – *Roy Edroso* (*redroso@decisionhealth.com*)

Top 15 Part B reported codes, by utilization, CY 2022, with denial rates



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

(continued from p. 4)

RESOURCE

- HHS/OCR, "Discrimination on the Basis of Disability in Health and Human Service Programs or Activities," Sept. 14: www.federalregister.gov/documents/2023/09/14/2023-19149/discrimination-on-the-basis-of-disability-in-health-and-human-service-programs-or-activities#citation-254-p63424

Ask Part B News

Pay attention to Medicare POS limits for procedures in non-facility (office) setting

***Question**: We had a provider perform an excision of prepatellar bursa (**27340**) in the office, place of service (POS) code 11. Patient has United Healthcare Shared Services-GEHA insurance. They denied the claim stating that CPT 27340 is not billable with POS 11. I have never had this issue before. Are there any coding rules/guidelines that prohibit use of some CPT codes at certain places of service or is this some weird payer-specific rule?*

Answer: It sounds like the insurer is following Medicare billing rules in this instance. In the Medicare physician fee schedule, code 27340 has an office "N/A" symbol by it. That means Medicare thinks the procedure should not be done in the office setting and won't pay for it to be performed there.

CMS gives a non-facility (e.g., office) N/A designation to a whole list of codes. If you look at a relative value unit (RVU) table, you'll find an "N/A," so coders will know right away that Medicare won't pay for the procedure in the non-facility or office setting.

To see the full list of codes with a non-facility N/A indicator, download the Medicare physician fee schedule relative value file, available at the following link: www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files.

CMS issues the list in a spreadsheet format, making it easy to sort or filter based on whether a code has a non-facility N/A indicator. You can then make note of which of your most often billed codes carry that designation for future reference. — *Laura Evans, CPC* (levans@decisionhealth.com) ■

Coding

Capture the beat: Correctly report CPT codes for cardio testing, monitoring

Review the most common types of external diagnostic cardiology tests, examine relevant CPT coding guidelines, and offer reporting advice from expert sources to ensure your billing patterns are capturing the right services.

Empower electrocardiography coding

An electrocardiography test, otherwise known as an ECG or EKG, records and reports the heart's electrical activity. From this report, the provider can assess the recording for abnormalities such as tachycardia, bradycardia, arrhythmias, flutters and fibrillations.

The process involves placing leads on the patient as he or she lays in a prone position. Leads are wires that connect plastic adhesive patches with conductive metal centers to the ECG machine.

"Typically, we may see a patient come to the emergency room saying that they're feeling like their heart is beating really fast … then the [provider] performs the ECG and they find it is actually that abnormal beat. So, an ECG is really important for them to have done," explains Gloryanne Bryant, RHIA, CDIP, CCS, CCDS, AHIMA-approved ICD-10-CM/PCS trainer, a coding and CDI compliance expert witness in Grass Valley, Calif.

- **12-lead ECG (CPT codes 93000-93010)**. A standard ECG includes 12 leads, which are divided into limb leads and precordial leads. The four limb leads are placed on the patient's arms between the shoulder and wrist, and on the legs between the hip and ankle after the areas have been sanitized and dried. They are often labeled RA, LA, RL, and LL for "right arm," "left arm," "right leg," and "left leg," respectively.

The six precordial leads, which are referred to as V1-V6, are placed on the chest. One is placed on either side of the sternum, and the remaining are placed in specific intercostal locations beneath the left pectoral and axillary region.

To report routine ECGs, coders would use one of the following codes:

- 93000 (ECG, routine ECG with at least 12 leads; with interpretation and support).

- 93005 (… ; tracing only, without interpretation and report).
- 93010 (… ; interpretation and report only).

Coders should not report CPT codes 93000-93010 with Category III codes **0525T-0532T**, per CPT parenthetical guidance.

- **Rhythm ECG (93040-93042)**. A rhythm ECG involves up to three leads. The provider places them on the right arm, left arm and left leg, respectively. To report a rhythm ECG, coders would use one of these CPT codes:
- 93040 (Rhythm ECG, 1-3 leads; with interpretation and report).
- 93041 (… ; tracing only without interpretation and report).
- 93042 (… ; interpretation and report only).

According to CPT guidelines, codes 93040-93042 describe a test used to help diagnose the presence or absence of arrhythmia after an event has occurred. Particularly, the documentation must include the provider's specific order for an ECG or rhythm strip "followed by a separate, signed written, and retrievable report."

- **ECG stress test (93015-93018)**. Stress tests, or stress exercise tests, are designed to record a patient's cardiac and pulmonary activity during exertion. Patients may walk or run on a treadmill, pedal a stationary bicycle, or health care providers may administer pharmacological agents to induce the patient's rapid heartbeat.

Upon completion of the activity, the provider may review the report and create a written interpretation of the findings. He or she may also either only be present for the ECG monitoring or assess the report. Coders must read documentation carefully to select the most appropriate code from the following to represent services rendered:

- 93015 (Cardiovascular stress test using treadmill or bicycle exercise, continuous ECG monitoring, with supervision, interpretation, and report).
- 93017 (… ; tracing only).
- 93018 (… ; interpretation and report only).

In addition to the ECGs, Bryant also encourages coders to thoroughly read the patient's personal and family medical history, as it could affect coding: "Maybe [the patient] has had a placement of a pacemaker, and so something's not working," she says. "Their past medical history is going to be important for the clinician to obtain and document in the medical record."

Assist ambulatory ECG monitoring services

Ambulatory ECG monitoring services allow physicians to observe patients' cardiac activity remotely for up to a month.

Of note, only CPT codes **93228**, **93229** and **93268-93272** are considered telemedicine services. However, most of the codes in this subsection report remote services, in which the patient returns home, but is monitored.

The provider equips the patient's chest with leads and connects them to the external monitor. It continuously records the patient's cardiac function, specifically the QRS and R-RR interval of the patient's ECG rhythm as he or she returns home and goes about daily activities.

- **Holter monitor (93224-93227)**. A Holter monitor is a form of external ECG recording system. It records and stores up to 48 hours of continuous electrical cardiac activity data.

The provider may ask that the patient keep a journal of activities conducted, such as exercising, eating or sleeping, or symptoms experienced, such as angina or shortness of breath.

After the directed time has passed, the patient returns to the facility to have the leads removed. From there, the provider can assess the recording and journal to identify instances of cardiac abnormalities.

Of note, code descriptions for range 93224-93227 do not include the "Holter" eponym, as seen below:

- 93224 (External ECG recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified healthcare professional).
- 93225 (… ; recording [includes connection, recording, and disconnection]).
- 93226 (… ; scanning analysis with report).
- 93227 (… ; review and interpretation by a physician or other qualified health care professional).

The CPT guidelines under "Cardiovascular Monitoring Services" clarify that coders can assign a code from range 93224-93227 for the use of Holter monitors.

CPT parenthetical notes state that coders should append modifier **52** (Reduced services) if the documentation indicates that there were less than 12 hours of continuous recording.

- **Mobile cardiac telemetry (MCT) monitor (93228, 93229)**. MCT monitors "have the capability of transmitting a tracing at any time, always have internal ECG analysis algorithms designed to detect major arrhythmias, and transmit to an attended surveillance center," according to CPT guidelines.

Clinical personnel at the monitoring station acquire and analyze the data transmissions and notify the physician or other qualified professional of cardiac events requiring immediate review. The patient can wear the monitors for up to 30 days.

Abnormal cardiac rhythms are automatically transmitted to the monitoring station, as well as segments selected by the patient during a symptomatic event.

The CPT codes for MCT monitors are as follows:

- 93228 (External mobile cardiovascular telemetry with ECG recording, concurrent computerized real-time data analysis and greater than 24 hours of accessible ECG data storage [retrievable with query] with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified healthcare professional).
- 93229 (… ; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified healthcare professional).

Coders should report CPT code 93228 only once per 30 days, per CPT parenthetical guidance. Additionally, coders should not report 93228 in conjunction with CPT codes 93224, 93227. Services reported by CPT codes 93228 and 93229 are considered telemedicine.

- **Event monitor (93268-93272)**. Event monitors record the ECG in a continuous loop. When symptoms occur, the patient activates the monitor. The ECG data is then permanently saved from the memory loop including the 60-90 seconds prior to the episode, the symptomatic period, and a period following cessation of the episode.

The patient then transmits the data to a receiving station, where a printout is generated and the physician or other qualified health care professional reviews and interprets the ECG data.

Coders should report this service only once per 30-day time period, with one of the following codes:

- 93268 (External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified healthcare professional).
- 93270 (… ; recording [includes connection, recording, and disconnection]).
- 93271 (… ; transmission and analysis).
- 93272 (… ; review and interpretation by a physician or other qualified healthcare professional).

Services reported with CPT codes 93268-93272 are considered telemedicine services.

- **Long-term continuous recorder (93241-93248)**. Long-term continuous recorders continuously record and store electrocardiographic data for longer than 48 hours and up to 7 days (93241-93244) or for longer than seven days up to 15 days (93245-93248).

The device includes both monitor and electrodes. It is compact, waterproof and is placed on the upper aspect of the left pectoral region. After obtaining a baseline, the patient goes about his or her daily life.

A professional collects the data from the monitor at the end of the study, the processing center technician assesses it and notifies the patient's healthcare provider of abnormalities. An initial findings report is generated for the physician's review and final interpretation.

CPT parenthetical guidance instructs coders to not report CPT codes 93241-93248 in conjunction with the following codes for the same monitoring period:

- 93224-93229.
- 93245-93248.
- 93268-93272.
- **99091**.
- **99453**, **99454**. — *Savannah Schmidt* (*pbnfeedback@decisionhealth.com*) ■