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In this issue

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Compliance

If your employees won't vaccinate, tread carefully before taking action

While the COVID-19 vaccination campaign expands and becomes a topic at your practice, you can't ignore anti-discrimination and labor laws. If you want to mandate that your employees get vaccinated, make sure you're not missing a step before you declare yourself ready to dismiss those who abstain.

The arrival of the COVID vaccines — two of which have been cleared under FDA emergency use authorization (EUA) — marks a significant step in the capacity to emerge from the year-long lockdowns (*PBN 2/15/21*). As health care workers are at or near the head of the line to obtain the vaccine in many states, health care facilities have been hustling to get their people inoculated (*PBN 1/21/21*).

But many Americans are balking at the vaccine — and that includes health care workers. An October 2020 survey of nurses by the American Nurses Foundation found that 36% of respondents would not voluntarily accept vaccination against COVID-19. More recent polls returned similar results: On Dec. 31, the Los Angeles Times reported that "so many frontline workers in Riverside County have refused the vaccine — an estimated 50% — that hospital and public officials met to strategize how best to distribute the unused doses."

Vaccinations against contagious diseases are not universally required in health care settings. Some states like California require health care workers to be immunized against mumps, rubella and other such diseases. But no federal law does so — even flu shots are only "recommended" by the CDC for such workers.

Master the modifier maze

Coding modifiers can make or break your revenue. Knowing the correct modifier to attach to your claims can spell the difference between payment and denial. From E/M modifiers -24 and -25 to procedural modifiers, including the -59 and -X modifier subsets, the extended 75-minute program, **Master the Modifier Maze: Your Key to Reimbursement, from E/M to Procedural Services** starring popular coding podcaster Terry Fletcher, will help you clean your claims. Learn more: *https://codingbooks.com/ympda032321*.

"I am unaware of any [law] that requires health care employees to get vaccinated against COVID," says Erin J. McLaughlin, shareholder in the labor and employment group at Buchanan Ingersoll & Rooney PC in Pittsburgh.

Should you require?

"Certainly employers may require them so long as they are consistent with business necessity -- and health care is one of those areas in which, objectively, an employer could argue that it is consistent with business necessity," McLaughlin says. But "there are various considerations employers should consider in deciding whether to require the vaccine. "

If you do, you can also ask for proof of vaccination, notes Brett Holubeck, a labor and employment lawyer with Liskow & Lewis in Houston and proprietor of the Texas Labor Law Blog (texaslaborlawblog.com). The U.S. Equal Employment Opportunity Council (EEOC) suggests as much in a Dec. 16 guidance that says asking an employee to show proof of COVID-19 vaccination is not in itself a "disability-related inquiry," which would probably be held discriminatory under federal law (*PBN 2/13/20*).

But do you want to require them? The upside seems worth it, but McLaughlin encourages you to think through the possible ramifications.

For example, the current vaccines have not been through ordinary FDA testing, McLaughlin says. "If something happened to an employee who was required to get the vaccine by an employer, does the employer have potential liability?"

On the other hand, it's also possible that a patient may claim injury from catching COVID-19 from an unvaccinated employee — though proving your practice was the source of infection during a global pandemic might be a heavy lift.

Be interactive

When an employee refuses with cause — a religious objection, say, or a condition such as pregnancy — you may be required to "reasonably" accommodate them, if possible. You should approach their refusal carefully and conduct a careful analysis based on the employee's rights under whatever laws apply. For example, you may have to consider the Americans with Disabilities Act, Title VII, Pregnancy Disability Act and state laws.

You must be ready to "engage in the interactive process to accommodate employees that have a disability that prohibits them from getting the COVID vaccine, cannot take the vaccine for religious reasons, or are pregnant or breastfeeding," Holubeck says.

This means you should take into account the following items, Holubeck advises:

- Document the request and give the employee a copy to show that you have done so.
- Find out from the employee what task the disability or religious objection is hindering or preventing the employee from doing — in this case, getting the vaccine.
- Tell the employee that the company will look for ways to accommodate.

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***PART B NEWS* TEAM**

Maria Tsigas, x6023
Product Director
mtsigas@decisionhealth.com

Marci Geipe, x6022
Senior Manager, Product and Content
mgeipe@simplifycompliance.com

Richard Scott, 267-758-2404
Associate Manager, Content
rscott@decisionhealth.com

Roy Edroso, x6031
Editor
redroso@decisionhealth.com

Julia Kyles
Editor
jkyles@decisionhealth.com

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- Explore possible accommodations with the employee based on the employee's job duties and the problem that needs to be corrected.

In this process, however, you should avoid questions about, or requests for proof of, the employees' medical condition. "Questions about employees that could not receive the vaccine could be a disability-related inquiry that will trigger obligations and rights under the Americans with Disabilities Act (ADA)," Holubeck cautions. The questions you do ask must be "job-related and consistent with business necessity."

If the employee can be accommodated and the practice's needs are met with extra protective equipment or reassignment, then that's a win all around. If not, "employees may be excluded from the workplace," Holubeck says. But even then, you should conduct a "careful analysis" of your conduct — preferably with your attorney — to make sure you haven't engaged in discriminatory conduct.

4 other employee tips

- **Educate staff.** Don't assume that everyone on the team has the same access to vaccine facts as you. One medical practice got creative. "We created an internal video series devoted to debunking COVID vaccine myths," says Mark Leontides, M.D., founder and medical director at Reproductive Medicine Associates (RMA) of Connecticut in Norwalk. When RMA staff members expressed specific concerns about the vaccine, the facility addressed them in their "myth-busting" series.

That outreach goes out to RMA's patients and to staff via "social media posts, videos, and interviews, as well as through direct patient communication," Leontides says. "We completely understand the concern surrounding such a new vaccination. However, we believe that an explanation of the science has been the best way to calm any fears."

- **Be sensitive.** That's always a good idea, but especially so in such a fraught area — not only to avoid discrimination charges but also for the health of your practice and good will of your employees. Even if you can't accommodate the employee and feel comfortable you could reasonably release them, you can "continue to pursue alternatives that are not just terminating the employee," McLaughlin says. That could mean "putting them on unpaid leave, for example, or into a role in which they're not regularly interacting with other people," she adds.
- **Offer incentives.** You may get more employees to vaccinate with incentives, such as with gifts or days off. These should be small, Holubeck warns. "Anything too large can cause legal trouble, as employees that cannot get the vaccine for legitimate reasons may have a possible claim for discrimination," he says.
- **Be consistent.** If you have a policy, stick to it. "I would not be inclined to propose to an employee that they can take it later [if they want to 'wait and see," McLaughlin says. "I would reserve the accommodations for the folks who require it by lawful exemption." — *Roy Edroso* (*redroso@decisionhealth.com*) ■

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- "New Survey of 13K U.S. Nurses: Findings Indicate Urgent Need to Educate Nurses about COVID-19 Vaccines," press release, American Nurses Foundation, Oct. 29, 2020: *www.nursingworld.org/news/news-releases/2020/new-survey-of-13k-u.s.-nurses-findings-indicate-urgent-need-to-educate-nurses-about-covid-19-vaccines*
- "What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws," EEOC, Dec. 16, 2020: *www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws*

2021 E/M office visits

Mind the time rules: There are two ways of tracking time for E/M visits

Practices can use the new time-based coding method for E/M office visits (**99202-99205, 99212-99215**) and continue to use counseling/coordination of care time for other E/M visits that have a typical time associated with the code. But if coding staff and billing practitioners confuse the two methods, you will be confronted with improper coding and payments.

Share the updated guidance in the 2021 CPT manual with staff to explain that time "may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service."

For other E/M services, time "may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service" (emphasis in the original text).

Your electronic health records (EHR) and online coding tools may pose a risk, too. For example, a system that prompts the user to enter a session start and stop time — such as 10:00 a.m. to 10:25 a.m. — is appropriate for a visit that is coded based on counseling/coordination of care but is not appropriate for office visits. It might

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cause undercoding if the user only counts the time spent on counseling or coordination of care during an office visit.

However, it will cause upcoding if the user enters the time from the minute the provider starts to prepare for the patient visit on the day of the encounter to the minute the clinician signs off on the patient's chart the same day, especially if the system then prompts the user to tack on the prolonged services add-on codes (**99417** or **G2212**).

Solution: Restrict the session time option to codes that still have a typical time. To accurately code office visits, make sure software systems allow a way to count time spent on the nine related services that contribute to the total amount of time:

1. Preparing to see the patient.
2. Obtaining/reviewing a separately obtained history.
3. Performing a medically appropriate examination and/or evaluation.
4. Counseling and educating the patient, family or caregiver.
5. Ordering medications, tests or procedures.
6. Referring and communicating with other health care professionals (when not separately reported).
7. Documenting clinical information in the electronic or other health record.
8. Independently interpreting results (when not separately reported) and communicating results to the patient, family or caregiver.
9. Coordinating care (when not separately reported).

The system should capture the time spent on each activity the provider performed for a visit or the total time for all performed activities.

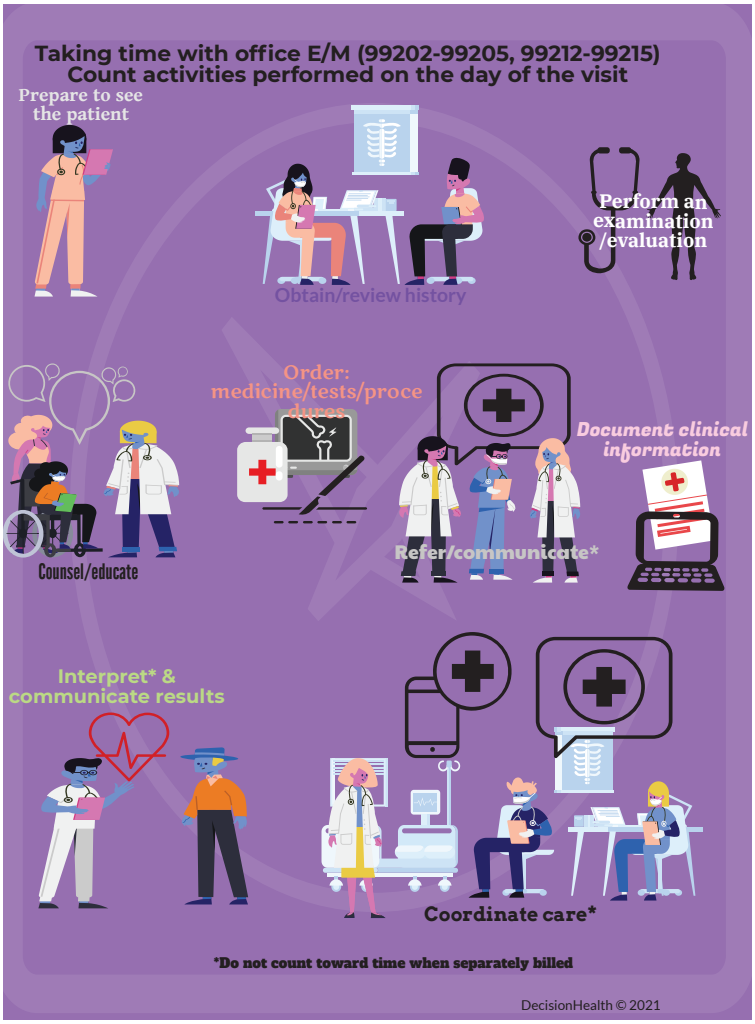
As an extra safety measure, your software systems should remind users that they cannot count activities the billing physician or qualified health care professional (QHP) performed before or after the date of the time-based office visit. And remind staff of this day-of rule for time-based office visits: They can only count time for activities performed by the physician or QHP on the date of the face-to-face encounter, not the 24-hour period following the face-to-face encounter.

Counseling/coordination of care rules unchanged

While you're verifying compliance with the new rules for time-based coding, review compliance with the long-standing counseling/coordination of care rules:

- When the physician or QHP spends more than 50% of the visit on counseling and/or coordination of care, the visit may be coded based on time.
- Use the code's typical time to determine if the service passed the threshold.
- Time spent counseling people involved in the patient's care or decision-making for the patient should be counted.
- Count face-to-face time in non-facility settings, such as the patient's home or domicile, and floor time in facility settings such as the hospital or a skilled nursing facility.
- The practitioner should document the extent of the counseling/coordination of care.

Finally, check your software: The EHR should never list the activities associated with time-based office visits when the encounter occurred outside of the office/other outpatient setting. — *Julia Kyles, CPC* (jkyles@decisionhealth.com) ■



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Benchmark of the week

X modifier use skyrockets, and denial rate drops for the 59 replacement

Despite the fact that the four X modifiers still don't have a totally defined role as an alternative to modifier **59** (Distinct procedural service), their utilization continues to expand. A drop in denial rates shows that they may be worth rolling the dice on.

Earlier *Part B News* analysis of CMS numbers suggested that the four modifiers had been used 3.4 million times in 2018 — a substantial gain over 2015, the first year they were reimbursed by Medicare (*PBN 12/27/19*). But the most recent numbers from CMS suggest that practices reported the X modifiers 5.4 million times in 2018, and that in 2019 their use increased 11% to 6.1 million claims.

This is remarkable because CMS hasn't required the X modifiers nor given much explanation as to how they're to be used beside the self-evident purposes suggested by their descriptors — **XE** (Separate encounter), **XS** (Separate structure), **XP** (Separate practitioner) and **XU** (Unusual non-overlapping service).

Occasionally, the agency will include X guidance in a note on 59, as when it mentioned XS in an edit bypass in February 2019, but that's rare (*PBN blog 2/19/19*). The National Correct Coding Initiative (CCI) Policy Manual updates are more likely to give X modifier guidance than CMS is (*PBN 12/27/19*). Assessing the situation in the 2021 predictions issue, *Part B News* surmised that CMS would not make any big announcements in that regard this year (*PBN 12/21/20*)

But Medicare providers have not only keep using these modifiers, they are using them to an unprecedented degree — and they seem to be getting better at it, too. The overall denial rate on the millions of X modifier claims in 2019 is 12%, while the overall denial rate on 59 is 13%. And the X modifier denial rate went down; it was 16% in 2018.

Note: The X modifiers are still used much less often than 59 — which was used nearly 40 million times — and they are used across a larger number of codes. While the most-claimed X combo, XS with **17003** (Destruction, premalignant lesions, second through 14 lesions), appeared 529,072 times, there are 16 codes that were used more often than that with 59, which was used with 17003 nearly 4 million times.

As you can see by the charts below, the denial rates on the codes most often used with each X modifier can be steep, so you should definitely pick your shots. But the odds seem to be turning in your favor. — *Roy Edroso* (*redroso@decisionhealth.com*)

Most used codes with XE, with denial rates, 2019

Code	Modifier	Claims	Denial rate
93010	XE	91,041	4%
P9603	XE	60,348	38%
88185	XE	38,979	17%
93000	XE	32,041	4%
96372	XE	12,017	4%

Most used codes with XS, with denial rates, 2019

Code	Modifier	Claims	Denial rate
17003	XS	529,072	3%
17000	XS	257,584	3%
11721	XS	170,539	7%
11102	XS	113,038	4%
96372	XS	98,084	15%

Most used codes with XP, with denial rates, 2019

Code	Modifier	Claims	Denial rate
95940	XP	15,578	43%
93010	XP	12,435	2%
88305	XP	11,865	19%
88312	XP	11,268	17%
88185	XP	6,600	13%

Most used codes with XU, with denial rates, 2019

Code	Modifier	Claims	Denial rate
96372	XU	153,392	6%
93000	XU	141,148	4%
87798	XU	140,370	21%
G0444	XU	131,588	15%
J7192	XU	92,283	1%

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

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Practice management

Patients not back from COVID-19? Mobilize your tech outreach, harness your data

If you still need to get patients back in the office after a year of COVID-inflicted downturn, put your focus on the methods that kept patients showing up before the plague hit, including the trusty, if sometimes overlooked, patient portal.

Practice managers know all too well the impact of coronavirus on their patient flow. In a survey conducted at the height of the first wave of COVID-19, researchers from Johns Hopkins Bloomberg School of Public Health found that more than two in five patients "reported forgoing medical care," according to findings from the period between March and July 2020 published in the Jan. 21, 2021, issue of the Journal of the American Medical Association (JAMA).

More ominously, a July 2020 research letter to JAMA found that in the U.S. in March and April "more than 50% of excess deaths were attributed to underlying causes other than COVID-19," and suggested "secondary pandemic mortality caused by disruptions in society that diminished or delayed access to health care" as a possible cause (*see resources, below*).

In some cases, the pandemic has played havoc with schedules — and with patients' idea of when and how often they're supposed to see their doctors. Vanguard Communications Group, a health communications company in Denver, hasn't see a big jump in no-shows among their client specialty practices during the past COVID year, according to Stephanie Wilson, Vanguard's vice president. But Wilson thinks some practices may have a hard time rebounding.

"In situations where patients have a recurring appointment — for example, with a primary care practice or an OB-GYN that who might have multiple touch points with their patients through the year — if the practice did not have strong, established communication methods with their patients before, it could very well have led to a higher rate of patient miscommunication and no-shows as things transitioned during COVID-19," Wilson says.

For example, "say a practice only uses one or two channels, and some patients miss that communication," Wilson says. "They might not know their appointment got rescheduled because of a shutdown, or that their appointment was migrated to a telehealth call versus an in-person appointment."

Of course, the effect on individual practices will vary, and some practices have reported a strong comeback in recent months. But for those that aren't, getting patients to return to their doctors' offices might require a change in strategy.

Get them on portals

For elderly patients especially, getting patients on your practice portal may move the attendance needle, recommends Jeanette Ball, R.N., client solutions executive at CTG in Buffalo, N.Y.

While portals don't get a lot of discussion these days, their importance has been underscored by the advent of COVID-19 vaccines and the inability of many seniors to sign up for them because of limited access to health IT. A study from the University of Michigan Institute of Healthcare Policy & Innovation, for instance, shows that "45% of adults aged 65 to 80, and 42% of all adults aged 50 to 80, said they had not set up an account with their health provider's portal system."

It's not just appointment access that suffers when portals are neglected, either: A recent study found that, in chronic kidney disease (CKD) patients, "both knowledge and health status were higher in those using the portal — along with a trend of less disease related stress," according to the findings appearing the Feb. 9 edition of Kidney Medicine.

"Portals are more important than ever before," Ball says. "Before, they were kind of nice to have; now they're essential."

Use population health

Some practices rely on their insurers' coverage-gap reports to find out what patients to reach out to.

"Insurance companies will keep track through billing of when patients are due for mammograms or whatever [the service] is," Ball says. "They send it to the practices and say, 'You know, here's your patients that we think need these services.'"

But be careful: One problem is that "those reports are 90 days old at least," Ball cautions. "They could have already had the test, and the insurance company doesn't

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know it. And sometimes those people aren't even associated with those insurances anymore."

Ball thinks practices should use their own data or work with health IT partners who can do it for them to create reports and find out which patients might be missing their expected appointments, such as wellness checks and scheduled preventive services, and then reach out.

"I would turn to my data systems and start pulling up things like zip codes and start thinking about social determinants and pulling in those high-risk patients and finding patients within their communities that perhaps need extra care," Ball says.

Work the phones, and everything else

If your patients are having trouble making it into the office, make sure your pre-appointment notification schedule is covering all the bases.

"Practices that have multiple touch points, such as text and phone call reminders 48 hours before the appointment, have fewer no-shows than practices that have limited communications ahead of the appointment — often email — or practices that don't have any appointment reminder," Wilson says. "Text reminders by far seem to be the best method in combating no-shows because it's direct and easier for patients to engage with than a phone call. But other engagement points, such as requiring paperwork before scheduling an appointment, also seem to go a long way in reducing no-shows."

Wilson says one unexpected involvement booster is online new-patient paperwork — the kind of forms patients used to fill in at the office.

"We found that, with the couple of clients who required their paperwork to be completed before patients were allowed to schedule, patients were a little more engaged because they already invested their time completing the paperwork, and so the patients tended to take the scheduled appointments a little more seriously," Wilson says. "We had one practice struggling with no-shows pre-pandemic. Once they started requiring that paperwork ahead of time it actually cut down their no-shows to nearly zero each month." — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCES

- "Reports of Forgone Medical Care Among US Adults During the Initial Phase of the COVID-19 Pandemic," JAMA, Jan. 21, 2020: *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775366*
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PAS 2021

Billing

Watch 10 compliance areas that impact remote patient monitoring

Incorporating remote patient monitoring into a physician practice can improve patient care and boost a practice's revenue stream (*PBN 2/15/21*).

"It's an opportunity and exciting. Telehealth and remote patient monitoring are redefining how to deliver health care," said attorney Rachel Goodman, with Foley & Lardner in Tampa, Fla., speaking at the Physician-Legal Institute's Health Care Delivery and Innovation Virtual Conference in September. "It's a different world."

However, remote patient monitoring brings its own set of compliance issues that can trip up the unwary. These include:

- **Device selection**. The device must be approved by the Food and Drug Administration and capture physiologic data. Practices also need to choose carefully which device and vendor to work with, since the data needs to be reliable and valid, said Richard Romero, senior vice president of the Coker Group in Brentwood, Tenn., also speaking at the conference.
- **Billing snafus**. There are five main CPT codes for remote patient monitoring, but the rules for them vary and can be confusing. For instance, the analysis and interpretation of data code (**99091**) can only be rendered by a physician or other qualified health care practitioner, and Medicare requires direct supervision of staff. Collection of data (**99453-99454**) must be ordered by a qualified practitioner, but the services can be performed by staff, including a vendor's staff, Goodman said. Those codes, as well as management of treatment (**99457-99458**), allow for general supervision.
- **HIPAA**. While a vendor providing services would have access to individual patient records as a business associate, practices don't want to grant vendors wholescale access to their medical records, since that could violate HIPAA's security and privacy restrictions. "A vendor should not be going through your records to determine who should get remote patient monitoring," Goodman said.
- **Fraud and abuse**. Since remote patient monitoring typically requires the use of a third-party vendor, the deal needs to be at fair market value to avoid kickback allegations. "[One can't] get too great of a deal," Romero warned. The fraud and abuse laws can also be implicated if the provider isn't sufficiently involved, since the services need to be ordered by a qualified clinician. "It can't be a turnkey arrangement [with a vendor]. You need skin in the game," Goodman noted. There can also be medical necessity issues. "Make individual assessments. Don't do remote patient monitoring with all patients with a particular condition," Goodman said.
- **State laws**. Some states have different requirements for remote patient monitoring that need to be followed. For instance, providers typically need to be in the state where the patient is located, and the scope of practice laws may require direct supervision even where Medicare requires only general supervision, Goodman said. Some states don't allow fee splitting between the physician and the vendor, so you may not be able to have the vendor market on your behalf.
- **Device logistics**. The practice will need to determine whether the device can be remotely adjusted and whether the vendor should set automatic critical and panic alerts, Romero said. Other operational questions include how devices will be cleaned and collected, and whether, depending on the device, patients get to keep them.
- **Education**. Staff will need to be properly trained about how to perform the data analytics, and patients may need to be trained in how to handle the equipment, Romero said. Billers will need to learn how to bill and code for the services. Any contracted staff from a vendor will also need to be included in any training, such as HIPAA compliance.
- **Accountability**. While a vendor may be performing much of the services, the practice is still on the hook for clinical or other issues. "Don't lose sight of the fact that even if you hire a remote monitoring vendor, you're responsible. It's done under your supervision," Goodman said.
- **Patient cost-sharing**. Patients may be on the hook for a portion of the cost. For instance, Medicare requires patients to pay 20%. However, since the patient usually won't be in the office when receiving the service, the practice won't be able to collect the patient cost sharing at the time of service and will need an alternative method to obtain these payments, Goodman said.
- **Malpractice liability**. Remote patient monitoring raises questions about the standard of care and product liability. "Talk to your malpractice insurer to make sure you have appropriate coverage," Goodman said. — *Marla Durben Hirsch* (*pbnfeedback@decisionhealth.com*) ■

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