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Maya Angelou, the American poet, memoirist, and civil rights activist, famously wrote, “Do the best you can until you know better. Then when you know better, do better.” This is sound advice for physicians and can be applied to many areas of our practice. The era of COVID-19 is no exception. Every physician in Utah has made sacrifices in their personal and professional lives to slow the spread of the virulent disease. Please know that your efforts are appreciated. Not every word of advice, not every protocol, not every plan has been perfect. Some have aged poorly. So, shall we look back in condemnation upon those who espoused those ideas? No, but neither should we repeat mistakes. Every time you learn something valuable, use it and do better. As an organization, UMA will embody this ideal. Here’s what we know now: There is no reason to politicize COVID-19 or determine that your affiliation with a political party should make you endorse or oppose any recommendations from the CDC or the state health department.

As physicians, you have a responsibility to be a leader in the community. There has never been a time where more people are looking for leaders to guide them through the darkness than now. When it comes to health, you lead—whether you choose or not—with either action or inaction, with either words or silence. Our patients’ financial health matters to them as much as their physical health—until they get sick. You are a member physician of UMA not because you want to be a financial advisor or economic planner, but because you want to help assure or improve the health of your patients. Don’t be a bad example. If you exemplify that the economy is more important than public health, your statement or behavior will be used to justify many unsafe actions by others.

The credo from Angelou, “When you know better, do better” can be applied to all areas of your life. In June 2020, the UMA board affirmed and added our voice to the AMA pledge decrying racism in all its forms as well as police brutality (https://www.ama-assn.org/press-center/ama-statements/ama-board-trustees-pledges-action-against-racism-police-brutality). Part of it reads, “The AMA [and UMA] recognizes that racism in its systemic, structural, institutional, and interpersonal forms is an urgent threat to public health, the advancement of health equity, and a barrier to excellence in the delivery of medical care.” I hope current events
PRESIDENT’S MESSAGE

have inspired you to evaluate your words and deeds, both past and present, as they pertain to justice and equality—especially related to race. It is good to be introspective and challenge yourself—both personally and professionally. When confronted with your own biases, it can make you regret past actions (or inactions). While remorse is a natural consequence of having a well-developed conscience, it’s not as important as using experience to shape your future actions. If you fear remorse, though, it can cause the opposite of growth. It can make you try to rationalize and deny your biases, and therefore propagate their effects. Change is hard and scary. But less painful if your focus is on the good ahead rather than the ills of the past.

The year 2020 reminds me of the Disney animated film, Robin Hood. Therein the narrator sings, “Every town has its ups and downs. Sometimes ups outnumber the downs, but not in Nottingham.” It’s easy to feel like the “ups” have not outnumbered the “downs” in 2020. But there is plenty of reason for optimism as we try to learn from our experiences. Let’s not have a backward-focused view, but keep our gaze forward, applying the best lesson and practice possible.

At the time of writing this article (June 2020), we have had about 14,000 cases (456 per 100K) of COVID-19 and 143 deaths (4 per 100K) (https://www.cnn.com/interactive/2020/health/coronavirus-us-maps-and-cases). Compared to the estimates that some projected in February, both these figures are remarkably low. As you know, we are not done. The fight is not over. Thank you for doing your jobs. Thank you for representing the house of medicine wherever you go! You have done well. If you have done your best, then I am proud to call you my colleague. We will continue to know better, and united we will continue to lead and do better. ■

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While telehealth has been available for decades, its use as an effective and person-centered modality to deliver health care services has skyrocketed during the COVID-19 pandemic and public health emergency (PHE), especially with the lifting of several constraints on telehealth use. However, the common mindset is “We have to convert our in-person visits to telehealth.” While that is true to continue to keep people safe, cut down on use of personal protective equipment (PPE), and prevent loss of access and revenue, there are many additional opportunities to leverage telehealth.

Now that you have figured out the basics of telehealth, what else could you implement? Medicare telehealth services can be provided to both new and established patients with cost-sharing waived during the PHE. Below we present five of the top telehealth opportunities organizations can implement to achieve the quadruple aim1 of lowering per beneficiary cost, improving health outcomes, enhancing the patient experience and improving the work life of staff.

### Transitional Care Management (TCM)

In the Calendar Year 2020 Physician Fee Schedule Final Rule2, the Centers for Medicaid & Medicare Services (CMS) discusses the findings of Bindman and Cox3, indicating that beneficiaries that receive TCM have reduced readmission rates, lower mortality and decreased health care costs. The authors also found that use of TCM services is low. In response CMS increased reimbursement and removed several co-billing restrictions starting Jan. 1, 2020, including allowing TCM to be billed concurrently with the chronic care management codes. The updated TCM fact sheet from CMS is currently under revision, but other than the two changes noted above little has changed from the fact sheet dated January 2019. Note that during the PHE TCM services delivered by telehealth are in the category that must be delivered using “an interactive audio and video telecommunications system that permits real-time communication between you at the distant site, and the beneficiary at the originating site” as per the CMS Telehealth Services Booklet. These codes are not in the list of audio-only telehealth services allowed during the PHE. We have received reports from the field that the visual part of the telehealth visit is helpful for several reasons, including allowing the patient to show the clinician items and conditions in their home.

<table>
<thead>
<tr>
<th>Transitional Care Management Services</th>
<th>Code - Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least moderate complexity during the service period; face-to-face visit within 14 calendar days of discharge</td>
<td>99495 - $180.05</td>
</tr>
<tr>
<td>Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least high complexity during the service period; face-to-face visit within 7 calendar days of discharge</td>
<td>99496 - $237.86</td>
</tr>
</tbody>
</table>

Medicare Non-Facility Price for Utah as of June 11, 2020 from the Medicare Physician Fee Schedule Look-Up Tool. Note that during the PHE the Medicare reimbursement for all telehealth services for Rural Health Clinics and Federally Qualified Health Centers is $92.03.

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4. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup

Continued on page 8.
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Advanced Care Planning (ACP)

More than ever, ACP is a critical component of health care service delivery. Whether you are a nursing facility, primary care practice or specialty practice, all patients should be offered ACP even if completed prior to March 2020. Some individuals may prefer to add their preferences around hospitalizations and care decisions if they contract COVID-19. Whether or not to use ventilator therapy is a key consideration as well, especially for individuals who previously indicated they would like to be do-not-resuscitate or do-not-intubate (DNR/DNI). Note that completing advance directives is a best practice but is not a requirement to provide and bill for ACP. CMS has published an Advance Care Planning Fact Sheet5, and Comagine Health recently updated its Health Advance Care Planning Toolkit, available on request.

Table 2: CMS Codes for Advance Care Planning Reimbursement

<table>
<thead>
<tr>
<th>Advance Care Planning</th>
<th>Code - Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance care planning, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate</td>
<td>99497 - $84.64</td>
</tr>
<tr>
<td>Advance care planning, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)</td>
<td>99498 - $74.37</td>
</tr>
</tbody>
</table>

Medicare Non-Facility Price for Utah as of June 11, 2020 from the Medicare Physician Fee Schedule Look-Up Tool. Note that during the PHE the Medicare reimbursement for all telehealth services for Rural Health Clinics and Federally Qualified Health Centers is $92.03.

Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)

While providing DSMT and MNT is limited to specific target populations—those with diabetes and/or those with kidney disease—both services are key to optimizing care and fostering self-efficacy through self-management knowledge and skills. Even if you do not have staff credentialed to deliver these services, you can refer appropriately to ensure all individuals who have this benefit receive it. DSMT and MNT are grossly underutilized at 5–7% for a variety of reasons and can be delivered by telehealth as audio-only for the duration of the PHE. Additionally, providing these services comports with evidence-based guidelines:

“In accordance with the national standards for diabetes self-management education and support, all people with diabetes should participate in diabetes self-management education and receive the support needed to facilitate the knowledge, decision-making, and skills mastery necessary for diabetes selfcare.”

In the 2020 Standards, the American Diabetes Association also says: “All individuals with diabetes should be referred for individualized MNT provided by a registered dietitian nutritionist (RD/RDN) who is knowledgeable and skilled in providing diabetes-specific MNT at diagnosis and as needed throughout the life span, similar to DSMES.”

As a reminder, the Medicare DSMT and MNT benefits are for diabetes (type 1 or 2) or kidney disease (non-dialysis or post-transplant) and include:

- Initial - 10 hours of DSMT and 3 hours of MNT within a continuous 12-months
- Follow-Up - 2 hours each of DSMT and MNT per calendar year

This Centers for Disease Control and Prevention (CDC) Medicare Reimbursement Guidelines for DSMT7 is a good place to start learning about DSMT.

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7 https://www.cdc.gov/diabetes/dsmes-toolkit/reimbursement/medicare.html
**Table 3: CMS Codes for Diabetes Self-Management Training & Medical Nutrition Therapy Reimbursement**

<table>
<thead>
<tr>
<th>Diabetes Self-Management Training &amp; Medical Nutrition Therapy</th>
<th>Code</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes outpatient self-management training services, individual, per 30 minutes</td>
<td>G0108</td>
<td>$55.24</td>
</tr>
<tr>
<td>Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes</td>
<td>G0109</td>
<td>$15.37</td>
</tr>
<tr>
<td>Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.</td>
<td>97802</td>
<td>$36.82</td>
</tr>
<tr>
<td>Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes</td>
<td>97803</td>
<td>$31.94</td>
</tr>
<tr>
<td>Medical nutrition therapy; group (2 or more individuals); each 30 minutes</td>
<td>97804</td>
<td>$16.71</td>
</tr>
<tr>
<td>Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes</td>
<td>G0270</td>
<td>$31.94</td>
</tr>
</tbody>
</table>

Medicare Non-Facility Price for Utah as of June 11, 2020 from the Medicare Physician Fee Schedule Look-Up Tool. Note that during the PHE the Medicare reimbursement for all telehealth services for Rural Health Clinics and Federally Qualified Health Centers is $92.03.

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**Annual Wellness Visits (AWV)**

Many practices have been providing in-person Initial Preventive Physical Examinations (IPPE) and Annual Wellness Visits (AWV) for their Medicare patients. However, these visits can be provided by telehealth, and now may be a good time to conduct proactive outreach to those due for an IPPE or AWV. CMS has published the Annual Wellness Visit Booklet\(^1\) to help comply with the requirements for these visits, and the Comagine Health Annual Wellness Visit Implementation Guide\(^2\) is also helpful.

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Table 4: CMS Codes for Annual Wellness Visits

<table>
<thead>
<tr>
<th>Initial Preventive Physical Examination and Annual Wellness Visit</th>
<th>Code</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual wellness visit, includes a personalized prevention plan of service (PPS), initial visit</td>
<td>G0438</td>
<td>$166.59</td>
</tr>
<tr>
<td>Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit</td>
<td>G0439</td>
<td>$112.62</td>
</tr>
</tbody>
</table>

Medicare Non-Facility Price for Utah as of June 11, 2020 from the Medicare Physician Fee Schedule Look-Up Tool. Note that during the PHE the Medicare reimbursement for all telehealth services for Rural Health Clinics and Federally Qualified Health Centers is $92.03.

Lifestyle Changes and Screenings

From the news and the literature, we know that individuals with diabetes, hypertension and obesity are at higher risk for death and poor outcomes with COVID-19. Behavioral health concerns, like depression and anxiety are also more frequent. Telehealth visits can allow you to safely administer these assessments and provide counseling. There are additional lifestyle, screening and related telehealth opportunities listed below. For example, now may be the time that tobacco users are ready to quit.

Please email Trudy Bearden at tbearden@comagine.org for additional assistance or for a copy of any resources referenced in this article. Note that the author is not a billing professional. Check with your biller or coder for further guidance.

Table 5: CMS Codes for Lifestyle Changes and Screenings

<table>
<thead>
<tr>
<th>Lifestyle Changes and Screenings</th>
<th>Code</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. Tobacco Use Prevention and Cessation Counseling from the American Academy of Family Physicians</td>
<td>99406</td>
<td>$15.03</td>
</tr>
<tr>
<td>Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (99407 is not an add-on code; the two codes are never reported together)</td>
<td>99407</td>
<td>$28.81</td>
</tr>
<tr>
<td>Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making). Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)</td>
<td>G0296</td>
<td>$29.20</td>
</tr>
<tr>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and brief intervention, 15 to 30 minutes. Summary of Medicare Reporting and Payment of Services for Alcohol and/or Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services</td>
<td>G0396</td>
<td>$35.89</td>
</tr>
<tr>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and intervention greater than 30 minutes</td>
<td>G0397</td>
<td>$67.47</td>
</tr>
<tr>
<td>Annual alcohol misuse screening, 15 minutes. Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse</td>
<td>G0442</td>
<td>$17.51</td>
</tr>
<tr>
<td>Annual alcohol misuse screening, 15 minutes. Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse</td>
<td>G0443</td>
<td>$17.51</td>
</tr>
<tr>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
<td>G0443</td>
<td>$17.51</td>
</tr>
<tr>
<td>Annual depression screening, 15 minutes. Screening for Depression in Adults</td>
<td>G0444</td>
<td>$17.51</td>
</tr>
<tr>
<td>Annual, face-to-face intensive behavioral counseling (IBT) for cardio-vascular disease (CVD), individual, 15 minutes</td>
<td>G0446</td>
<td>$25.96</td>
</tr>
<tr>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
<td>G0447</td>
<td>$25.96</td>
</tr>
<tr>
<td>High-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes. Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs</td>
<td>G0445</td>
<td></td>
</tr>
</tbody>
</table>

Medicare Non-Facility Price for Utah as of June 11, 2020 from the Medicare Physician Fee Schedule Look-Up Tool. Note that during the PHE the Medicare reimbursement for all telehealth services for Rural Health Clinics and Federally Qualified Health Centers is $92.03.

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2. Doubeni A, Wilkinson J, Korsen N, Midthun D. Lung cancer screening guidelines implementation in primary care: a call to action. Ann Fam Med. May 2020;18(3):196-201. Figure 1 includes a decision tree, and Table 1 include lung cancer screening guidelines across organizations.
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The world is watching with concern the spread of the new coronavirus. The uncertainty is being felt around the globe, and it is unsettling on a human level as well as from the perspective of how investors and markets respond to crisis.

At UMA Financial Services, it is a fundamental principle that markets are designed to handle uncertainty, processing information in real-time as it becomes available. We see this happening when markets decline sharply, as they have recently, as well as when they rise. Such declines can be distressing to any investor, but they are also a demonstration that the market is functioning as we would expect.

Market declines can occur when investors are forced to reassess expectations for the future. The expansion of the outbreak has caused worry among governments, companies, and individuals about the impact on the global economy.

The market is clearly responding to new information as it becomes known, but the market is pricing in unknowns, too. As risk increases during a time of heightened uncertainty, so do the returns investors demand for bearing that risk, which pushes prices lower. Our investing approach is based on the principle that prices are set to deliver positive future expected returns for holding risky assets. We cannot tell you when things will turn or by how much, but our expectation is that bearing today’s risk will be compensated with positive expected returns. That has been a lesson of past health crises, such as the Ebola and swine-flu outbreaks earlier this century, and of market disruptions, such as the global financial crisis of 2008–2009. Additionally, history has shown no reliable way to identify a market peak or bottom. These beliefs argue against making market moves based on fear or speculation, even as difficult and traumatic events transpire.

As you assess your financial path forward, we encourage you to, if you haven’t already, develop a long-term plan that you can stick with in a variety of conditions. A developed financial plan, like a family emergency plan, will help you avoid chasing performance or attempting to outsmart the market; we suggest that you let markets work for you over time. A plan and a diversified investment portfolio can help you emotionally weather the destressing financial storms that will come. If you don’t have a plan or feel like your plan has gaping holes rendering it inadequate, please contact the experts in physician financial planning at UMA Financial Services (801.747.0800) to schedule an introductory appointment.
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Don’t Forget About the Blinders

By Christine Kwon, MD
originally published on the fammedvitalsigns.com blog

For family medicine residents, it's a given that we must work on other services. We're expected to adjust quickly and survive with professionalism and grace in a new environment that can feel hostile at times. Over the last two years, I feel that I have gotten pretty good at walking onto someone else's home turf and pretending I know what I'm doing long enough to eventually become a functioning member of the team. Despite my complaining, I do appreciate learning with the different residencies. I'm getting a chance to work with the specialists and learn with the residents in those fields. It's an opportunity to work with the best, so I try to take advantage of learning opportunities. However, I've also found myself thinking if I get one more “how do you not know what this is” look, I might flip a table.

Most other residencies produce experts rather than jacks-of-all-trades. Because of this inherent uniqueness of family medicine, I think the other residencies forget that for a significant portion of our residency we are off-servicers. They forget that we must learn more than just the medicine on these rotations. We have to adjust to a new culture, a new hospital, and a new EMR with new acronyms. We are expected to figure out how to function well on the team while stumbling through obstacles that other residents don't have to overcome.

And yet, the more I work as an off-servicer, the more I realize that we all have blinders on. They are a tool that we unconsciously use. We're so busy trying to survive residency that we don't have the bandwidth to consider the experiences of other residents. They help with the tunnel vision to see the light at the end of the tunnel, but they also keep us from remembering that every residency is different and prevent us from being as patient as we probably could be. These blinders impede us from remembering that things
we find normal in our residency might not be so normal in other residencies. I was so busy being frustrated at the other residents for not understanding me that I also failed to understand them. As it turns out, we all have blinders on.

I have found OB to be particularly challenging as an off-servicer. Anytime I’m on the L&D deck, I feel pretty incompetent. I’m never quite sure if I’m doing the right thing. But one day, as I sat trying to ‘fake it’ to the best of my abilities, I overhear an OB resident struggle to replete potassium. Trying to be helpful, I suggested doubling the amount of potassium, as 40 mEq wouldn’t be enough. She adamantly told me that she was sure the 40mEq should be enough. She whipped out her phone to recalculate how much to replete and again said, with certainty, that she was right. I remember thinking in that moment “Repleting potassium is literally the easiest thing to do in the world.” I was shocked she was using her phone to do the math, and that she was still calculating it incorrectly. We do it all day, every day on our medicine rotations. But I had forgotten that just because we did it all the time, didn’t mean that everyone did it all the time as well.

While I was in the MICU, I was having trouble navigating the EMR and the IM intern noticed. I think he was trying to be helpful and asked me, “So, [insert slightly longer than necessary pause and a mildly concerned look] how many inpatient rotations have you done?” I paused trying to figure out if he was only asking about adult medicine, or did OB and pediatrics count too? So, I asked him. He looked surprised and admitted that he had forgotten that we did “all that other stuff.” He didn’t wait to hear my answer after that. Obviously, I know the difference between internal medicine and family medicine, but to be honest, until I had to think about it that minute, I had sort of forgotten that IM didn’t do OB and pediatrics too. Until I was truly reminded of the difference, I had forgotten that not all residents did a little bit of everything, and I’m betting that they forget that we do. The blinders we have on make it so easy to assume that our experiences are universal, which ends up affecting how we interact with other residents.

We all have our blinders on. I think it goes without saying that all residencies are not the same, but in the daily grind, it’s easy forget that our experiences aren’t universal. We expect others to be as comfortable with certain parts of medicine as we are, while paradoxically expecting them to forgive our weaknesses. Residency isn’t easy. It’s hard for everyone. It’s easy to be frustrated at that apparent lack of empathy when you’re an off-servicer, but I think we all forget that we’re all exhausted and all just trying our best. We’re all so used to our own residency experience that that these blinders, that we unwittingly wear, hide the inconvenient truth that all residency experiences are not universal. To be clear, even with this revelation, I still get frustrated. But I think it has made me pause and remind myself about the blinders. It’s difficult in the moment, but I’ve found that remembering that everyone has blinders has made it a little easier to be an off-ervicer.

Christine Kwon, MD, is from Centennial, Colorado, and chose the University of Utah because of the unique opportunity to work in both community and university hospital settings, the community outreach programs, and the friendly faculty, staff, and residents. Her medical areas of interest include integrative medicine, hospice and palliative medicine, international medicine, patient education, and community outreach.

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As mentioned in the legislative report in the April/May 2020 issue of the *Utah Physician*, the legislature passed one bill on balance billing—a bill to collect information on the issue. This bill, SB 155, requires reports from physicians, hospitals, and other healthcare providers who bill out-of-network Utah patients for certain healthcare services provided from July 1, 2020, through June 31, 2021.

The healthcare services that need to be reported to the Utah Department of Insurance (DOI) include services provided in the emergency department under EMTALA, as well as any follow-on services that stabilize, improve, or resolve the condition of the patient. This includes the work of emergency physicians and physicians on call in the emergency department.

Because the purpose of this reporting is to look at balance billing, physicians will only need to keep track of billing for services provided to patients that have insurance for which the physician is out-of-network. Physicians providing these services will need to keep track of how many of these episodes of emergency care they bill for and how many of those that they then balance bill for during the 12 months from July 2020 through June 2021. They will need to keep track of these numbers for each insurer where they are not in-network and for whom they see patients. Balance billing means billing the patient for the difference between the physician’s charged amount and the insurer’s allowed amount. It does not include billing the patient for copayments, coinsurance, or deductibles.

For each out-of-network insurer, physicians will need to take those two numbers for the 12 month period and calculate the percentage of care episodes they balance billed a patient for emergency, out-of-network services compared with the total number of episodes they billed for those services and report those percentages, not send raw or individual patient information in to the DOI.

By January 4, 2022, physicians and others will need to report to the Utah Insurance Department the percentage of balance billing they did for patients of each insurer. We will give further information on where to report the data as we get closer to the reporting date. In the meantime, make sure you are collecting this data for the one year time period if you are balance billing for services given through an emergency department. The law makes physicians and other healthcare providers immune from civil liability for disclosing this information to the department. The report is also to include the specialty or subspecialty of the physician or other provider.

The insurers will also be submitting a report to the Insurance Department for the same reporting period. The insurers are to report whether they provided reimbursement for out-of-network emergency services directly to the patient and the percentage of emergency department claims received for Utah patients that were provided by out-of-network providers.

The Insurance Department will provide a written report to the legislature on the information received under this bill, however the detailed information providers and insurers submit to the Insurance Department will be protected from disclosure under the state’s GRAMA law. The Insurance Department will also report on the amount charged by air medical transport providers that engage in balance billing.

We hope the information reported will clarify the scope of balance billing in Utah, because most proposals to address the issue so far have been driven by anecdotes rather than a clear picture of the extent of the practice. We then can address the actual problem and find a workable solution rather than trying to find a solution to an issue that is not really known or backed up by any data.
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COPIC is proud to be the endorsed carrier of the Utah Medical Association. UMA members are eligible for a 10% premium discount.
Rarely, do we get an opportunity to directly observe a distinct event, which materially changes standard approaches to healthcare delivery. In 2018, we initially published our first article in JAMA introducing the “Medical Virtualist” and the following year, a subsequent piece regarding formalized training and establishment of core competencies in telemedicine. Since that time, there has been significant growth, nationally and globally, in the establishment of new telemedicine and virtual care programs. \(^{(1,2)}\)

None of us could have predicted the magnitude of the Coronavirus pandemic nor could we have projected the impact on care delivery. The healthcare industry is massively gearing up for virtual care on an emergency basis as clinically necessary and mandatory, movement restrictions are introduced. We suggest that this unprecedented expansion of virtual care in multiple modalities, will become our new norm.

A 2019 study by FAIR Health covering the period 2014-2019, showed an increase of 1,393% in non-hospital based, “provider to patient” telehealth visits, based on commercial insurance claims. This still accounted for only 0.104% of all medical claims. Despite the perceived value and convenience of virtual health, the majority of physicians, other clinicians and hospitals remained committed to “in person” encounters for cultural and economic reasons. Rural health and other situations short on specialties leveraged telehealth and the need in behavioral health and chronic disease management became apparent. A myriad of direct to consumer virtual health services, not requiring a physician visit, were also developed for oral contraception, erectile dysfunction, HIV prophylaxis and others.
Allison was bawling, she turned to me and said, ‘Mom, I got a D.’ It was the first time she called me ‘Mom.’

Lisa, adopted 16-year-old Allison
Contrast that norm with the experience in the past week at some of the nation’s leading integrated delivery systems and physician organizations.

In the third week of March, the Cleveland Clinic volume of virtual primary care visits increased by more than 26-fold. Advocate Aurora Health completed 11,000 video visits and 2500 e-visits within 12 days. A symptom checker on the website was completed 4000 times in one day! They will also be implementing an interactive, mobile-enabled symptom tracker for transition management of COVID and PUI’s (Person Under Investigation) discharged from hospitals and Emergency Departments. Advocate will also be leveraging telehealth in partnered SNF’s (Subacute Nursing Facilities) to reduce the need for provider entry into these facilities.

New York Presbyterian with Weill Cornell Medicine & Columbia Doctors already had a comprehensive telehealth and digital healthcare program across multiple specialties. Since the start of the COVID-19 pandemic, NYP’s telehealth utilization has increased by 45% over the span of 2 weeks. Soon it is projected that over 80% of ambulatory visits will be virtual. New York City has become the epicenter of the COVID-19 pandemic and leveraging telemedicine has shifted from being novel to being an absolute necessity.

The Hospital for Special Surgery in New York cancelled all elective procedures and limited in person clinical activity to urgent needs. Office visits and post-operative physical therapy (PT) all became “virtual.”

On a national scale, the closing of hundreds of PT clinics across the country may be transformational and accelerate innovation in that space.

One prototype, PTGenie.com provides remote, interactive PT, guiding patients through exercises remotely measuring and monitoring movement through sensors applied on the skin. Real time feedback is provided to the patient on a tablet.

Intermountain Healthcare based in Salt Lake City, has had experience with virtual health for several years. Their nurse triage call center, Health Answers increased its volume from approximately 50 calls a day to 3000 a day in the middle of March secondary to the COVID-19 pandemic. Nurses were redeployed across their system from other non-critical services. A pool of 6-10 nurses has mushroomed to 70 in the call center servicing the entire State of Utah. Connect Care, their telehealth video program was focused on meeting the needs of the non-COVID patients in the Intermountain Healthcare physician organization.

Early in March, medical practices, both independent and part of integrated delivery systems, began to move their scheduled visits to a virtual medium. Clive Fields, MD, Chief Medical Officer and co-founder of Village MD in Houston, reported that they have trained more than 350 providers on a new telehealth platform and expect 90% of their visits to be virtual. Village MD like many others are screening “essential visits” prior to accepting the appointment in an office location.

The major telehealth vendors have all experienced massive increases in virtual visits, enough to initially cause delays of hours for patients seeking access. This access is being alleviated by the contracting of more providers and vendor clients growing their own internal capabilities.

One major telehealth vendor processed over 100,000 risk assessment screenings for COVID-19 in only a few days in late April. To avoid excessive wait times companies are both ramping up recruitment as well as indicating to patients that they have reached their maximum capacity for a reasonable wait time. This is a new healthcare phenomenon of “virtual diversion” akin to the practice historically common in overwhelmed emergency departments.

Teladoc Health experienced a 50% increase in daily visit volume week over week in early March. Teladoc provided approximately 100,000 virtual visits in the past week. Chief Medical Officer Lew Levy, MD, commented “As we saw in the flu epidemic of 2018, a community’s healthcare system can be overwhelmed, and virtual care can provide needed relief.”

Remote Monitoring then and with COVID-19

Remote monitoring as part of routine patient care had not previously taken hold on scale. The desire to reduce readmissions prompted development of such programs for transitional care and severe chronic patients specifically Heart Failure. Remote monitoring of heart rate and rhythm expanded with the commoditization of measurement through the Apple watch and similar devices in addition to glucose monitoring in diabetes.

COVID-19 infection and quarantine should precipitate a significant escalation of remote monitoring of oxygen saturation, temperature and blood pressure coupled with virtual visits. This could be adequate for many infected patients if the mechanism for targeted monitoring and feedback to the primary care physician is in place. The capacity to provide these services is limited, largely due to inadequate platform infrastructure and training, and existing vendors are being overwhelmed with requests. There is every indication that this approach will exponentially scale.
More COVID-19 Observations

Medical Virtualists (physicians and other clinicians) keep as many patients as possible away from physician offices and hospitals. This coupled with the deferral of elective cases, is creating capacity for surging of COVID cases while conserving PPE and equipment for the sickest patients.

It is remarkable to hear from multiple centers across the country, about the redeployment of healthcare professionals from services that have been put on hold, to support virtual care and emergency services. This includes physicians and other clinicians usually active with elective cases, including many from ambulatory surgery centers.

The ability of physicians to use their licenses across state lines may also turn out to be one of the most dramatic changes brought by COVID-19 as it relates to the expansion of virtual health. We believe it unlikely that this will be easily reversed once the value of this method has been utilized on scale during the current crisis.

Virtual Health/The Medical Virtualist: Training and Education

The concept of virtual health is not new, but only a few months ago, this massive escalation and diversification of adoption seemed, economically and culturally, unlikely. Yes, it will become an intrinsic part of the healthcare space, which will require all physicians and other clinicians to have some degree of engagement, training and competence. It is not enough for new Medical Virtualists to be familiar or comfortable with the technology—this requires a level of expertise necessitating training and education to develop the skills set to provide high quality and appropriate virtual visits. This essential training includes understanding the importance of the “soft” skill set required to conduct telemedicine visits with a camera, as well as ensuring that providers at all levels are aware of technical and medicolegal standards. Appreciation of these essential training elements yields benefits for both providers and institutions by increasing care proficiency as well as awareness of potential risk.

We believe that in the coming years, there will be a subset of medical graduates who will identify virtual health as a chosen profession within different disciplines and only have a clinical interface with patients through telecommunications.

Beyond meeting consumer needs for value and convenience, this will offer new career options for physicians, with alternate lifestyles. The necessary skills for this role will become increasingly refined with the addition of remote monitoring and testing.

Weill Cornell Medicine, in collaboration with New York Presbyterian has accelerated the creation of a unique Center for Virtual Care (CVC) under the leadership of one of the authors (RS). The CVC provides training and certification in virtual care for practicing physicians, residents, advanced practice providers and other clinicians in all specialty areas, including “Web-side” manner, remote patient examination skills, and virtual provider to provider consultations. The center has already trained hundreds of clinicians in the last few weeks across the healthcare system during this COVID-19 pandemic.

One should note that virtual health is not restricted to the physician visit or the low acuity illness. In addition to meeting an acute need brought on by the COVID-19 crisis, virtual care delivers needed additional value and convenience to the full continuum of the healthcare system throughout the world.

References:

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Vaping and the Increased Risk for Youth Nicotine Addiction

From the Utah Department of Health

Since their introduction to the U.S. market in 2006, electronic cigarettes (or vape devices) have become extremely popular, especially among youth and young adults. Early electronic cigarettes (cig-a-likes) mimicked the look of cigarettes and were mainly intended to serve as smoking cessation devices. However, these products quickly evolved into devices that could be customized and re-filled with flavored e-liquid. The e-liquid flavors frequently use the names and taste of popular desserts, candy, or fruit. The latest designs (pods) resemble USB flash drives, lipstick tubes, necklaces, or other household items that can be easily concealed (Figure 1).

Innovative designs, sweet and minty flavors, and targeted marketing using social and digital media have been linked to high vape rates among youth and young adults.1,2

Utah youth vaping increased from 1.9% in 2011 to 10.5% in 2015, with a more modest increase to 12.4% in 2019.3

Utah vape rates are highest among older teens (15.1% for those ages 16–17)3 and young adults (14.6% for those ages 18–24).4

To address the rapid rise in vape product use among Utah youth, the Utah Department of Health has proposed rule R384-418 – Electronic-Cigarette Mandatory Nicotine Warning Signage and Sale Restrictions.

KEY FINDINGS

- Innovative designs, sweet flavors, and targeted marketing using social and digital media have been linked to high vape rates among youth and young adults.1,2
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- Utah vape rates are highest among older teens (15.1% for those ages 16–17)3 and young adults (14.6% for those ages 18–24).4
- To address the rapid rise in vape product use among Utah youth, the Utah Department of Health has proposed rule R384-418 – Electronic-Cigarette Mandatory Nicotine Warning Signage and Sale Restrictions.

Utah Vape Trends

In Utah, youth vaping increased from 1.9% in 2011 to 10.5% in 2015, with a more modest increase to 12.4% in 2019.3 Nearly 25% of Utah students in grades 8, 10, and 12 have tried vaping.3 In comparison, only 5.6% of Utah adults currently use vape products and 18.4% ever tried vaping4 (Figure 2).
Even though Utah law prohibits the sale of vape products to people under the age of 19, 16- to 17-year-olds report the highest rate of vaping (15.1%) among all surveyed age groups (Figure 3). More than 70% of Utah teens who currently use a tobacco product tried a vape product first. Among adults, vaping is most common among 18- to 24-year-olds and least common among adults aged 65 and older.

Nicotine Addiction

The rapid rise in youth vaping is particularly concerning because most Utah youth who vape use products that contain nicotine. Nicotine is highly addictive and has been shown to interfere with adolescent brain development. Research on the long-term effects of vaping is still limited; however, even a brief period of intermittent or continuous nicotine exposure can have lasting effects on cognitive abilities and mental health and increase susceptibility to other addictions later in life.

Health Effects

In addition to water, e-liquids contain a mix of solvents (typically propylene glycol and glycerin) and flavorings. The long-term effects of inhaling heated and aerosolized solvents, flavoring chemicals, and other carbonyl and volatile organic compounds are unknown. In addition, the use of larger batteries capable of heating liquids to higher temperatures has been linked to the formation of new toxicants such as formaldehyde.

Vaping devices lack regulations or standardization in their designs and can be customized by their users to deliver drugs other than nicotine. Both tank systems and vape devices that can be refilled with cartridges have been linked with THC and marijuana use. Contaminated vape cartridges that contained THC were identified as the cause for a serious lung disease epidemic in 2019 that led to 134 hospitalizations in Utah and more than 50 deaths in the United States.

Policy Recommendations

Regulations that make it harder for youth to access tobacco products are part of evidence-based practices in tobacco prevention and control and are expected to reduce youth use of vape products. Such regulations include:

1. Increasing the price of tobacco and vape products through excise taxes
2. Limiting the total number of tobacco retailers
3. Restricting where flavored tobacco and vape products are sold

Tobacco taxes are especially effective in reducing tobacco use among younger age groups since youth and young adults are two to three times more likely to respond to changes in tobacco product prices than adults. Limiting the number of total tobacco retailers in a local area has been shown to reduce youth experimentation with tobacco and assist tobacco users with quitting. Flavors hide the harsh taste of tobacco and make it easier for youth to try tobacco products. Since more than 80% of youth who use tobacco started with flavored products, flavor restrictions are expected to reduce youth tobacco initiation. Following a ban of flavored tobacco products in New York City in 2014, and a subsequent decrease in flavored tobacco product sales, numerous cities and
counties in Massachusetts, Rhode Island, Illinois, and California enacted flavor bans or restrictions. Flavor restrictions either ban flavored tobacco sales near schools or limit the sale of flavored tobacco to adult-only retail tobacco stores.8

To address the rapid rise in vape product use among Utah youth, the Utah Department of Health (UDOH) proposed rule R384-418 – Electronic Cigarette Mandatory Nicotine Warning Signage and Sale Restrictions. The new rule requires all tobacco retailers that choose to sell electronic cigarette products or electronic cigarette substances to display mandatory nicotine warning signs (Figure 4). It also restricts the sale of flavored electronic cigarette products and electronic cigarette substances to age-restricted retail tobacco stores.

Public Health Spotlight

Accessing Primary Care: The Unheard Voices

In 2019, staff with the Utah Department of Health Office of Health Disparities (OHD) conducted a qualitative study to evaluate one of its programs and to better understand challenges faced by Utah urban underserved communities in establishing a primary care provider. Thirty-five people from the neighborhood of Glendale (SLC) and the city of South Salt Lake participated in six focus groups. We encountered an array of participants: American-born, first-generation immigrants, refugees, single mothers, single grandparents, married couples, individuals experiencing homelessness, diverse races/ethnicities, etc. We found out access to health care is just the tip of the iceberg. The main portion of this iceberg is concealed beneath a system of structural inequities that must be addressed in order to improve the health of our communities.

Key takeaways

1. Cost is the main barrier: Most participants live paycheck to paycheck, they do not have access to disposable income; and access to health care is perceived as a commodity not as a priority.
2. Understanding a complicated system: Participants linked the term primary care provider (PCP) with having health insurance. Participants were fulfilling their primary care needs at free clinics, but did not see them as their PCP.
3. Trust: There was a lack of trust in the health care system in general; many lacked trust in the care they received at free clinics.
4. Stress: Financial concerns, challenging family situations, and rearing children under stressful circumstances fill out their day-to-day routine without leaving space or time for thinking about health.

A detailed report of the study is available at https://health.utah.gov/disparities/data.html.

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CME Calendar

JULY 2020
17 Utah Zero Suicide Virtual Summit
   Online, UMAF (6.5)
17 Half and Half MAT Waiver Training
   Online, UUCME (4.0)

AUGUST 2020
21 HCI Lynch Syndrome Conference
   ?, UUCME (2.0)

SEPTEMBER 2020
10–11 Metastatic Breast Cancer Research Conference,
   Online, UUCME (13.0)
17–18 The 7th Annual Excellence in Trauma Conference
   Murray, IHC (14.0)

OCTOBER 2020
2 Update in Diabetes Care, Online
   Online, IHC (6.5)
9 54th WINO Conference,
   Online, UUCME (6.5)
11–13 Heme Biosynthesis and the Porphyrias Program
   Chicago, UUCME (24.75)

NOVEMBER 2020
16 MOCA - Anesthesiology Simulation 2020
   SLC, UUCME (7.5)

DECEMBER 2020
7 MOCA - Anesthesiology Simulation 2020
   SLC, UUCME (7.5)

CME Spotlight

Title: Controlled Substances: Education for the Prescriber
When: On-demand Webinar
Where: Online at cme.utahmed.org
Provider: UMA Foundation
CME: 3.5 AMA PRA Category 1 Credits™

Following this activity, learners should be able to:

- Know existing laws and rules pertaining to prescribing controlled substances;
- Provide patients the care they need to restore and maintain their health;
- Mitigate the burdens of illness, injury and aging, including appropriate prescriptions for controlled substances when indicated;
- Minimize adverse effects of controlled substance use and reduce risks to the public health.

The following sites allow you to search databases to locate medical meetings throughout the country

ama-assn.org   eMedEvents.com
Recurring activities are scheduled at St. Mark's Hospital, IHC Hospitals, Primary Children's Medical Center, and the University of Utah School of Medicine. Contact the sponsor for specific information. For more information on the above listings, please call the provider at the phone number listed below.

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<td>Ogden, 801-747-3500</td>
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<td>ACP American College of Physicians, UT Chapter SLC</td>
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<td>ACS American College of Surgeons Email <a href="mailto:UtahATLS@gmail.com">UtahATLS@gmail.com</a> for info about ATLS Chicago</td>
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<td><a href="http://americanmedicalassociation.org">americanmedicalassociation.org</a></td>
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### The following websites offer online continuing medical education:

- cme.utahmed.org
- psnet.ahrq.gov/cme
- thedoctorschannel.com/cme
- freecme.com
- pri-med.com/pmo/OnlineCME.aspx
- medicine.utah.edu/cme
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- medscape.org
- vhl.com
- nejm.org/continuing-medical-education
- reachmd.com/programs
- cms.gov/Outreach-and-Education/Learn/
  Earn-Credit/Earn-credit-page.html
- primarycarenetwork.org
- emedevents.com
The Utah Medical Association affirms the AMA statement on violence and racism, and we add our voice to theirs:

The UMA joins the AMA in recognizing that racism in its systemic, structural, institutional, and interpersonal forms is an urgent threat to public health, the advancement of health equity, and a barrier to excellence in the delivery of medical care.

The UMA joins the AMA in opposing all forms of racism.

The UMA joins the AMA in denouncing police brutality and all forms of racially motivated violence.

The UMA, along with the AMA, will actively work to dismantle racist and discriminatory policies and practices across all of health care.
Migration of Complex Procedures to the ASC Setting
(Cardiovascular Interventions, Total Knee Replacement and Extended Recovery Services)

Mark A. Cotter, Esq.
Ray Quinney & Nebeker PC.

Utah’s ambulatory surgery centers (ASCs), comprised of nearly 100 state-licensed ASCs, continue to face the typical, recurring challenges, such as reimbursement rate pressures (both Medicare and commercial payors), attracting and retaining physicians with significant procedure volume in a manner compliant with health care fraud and abuse laws and, more recently, the unprecedented challenges posed by COVID-19 and its impact on elective procedures. At the same time, Utah ASCs benefit from national trends that favor the migration of cases to the outpatient ASC setting, including:

• changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings;
• ASCs offer patients greater convenience than Hospital Outpatient Departments (HOPDs), such as the ability to schedule surgeries more quickly, less risk of hospital acquired infections, etc.;
• for most procedures covered under the ASC payment system, beneficiaries’ coinsurance is lower in ASCs than in HOPDs; and
• physicians have greater autonomy in ASCs than in HOPDs, which enables them to design customized surgical environments, hire specialized staff and benefit from block time arrangements and more efficient operating room turnover time.

In recent years, changes in clinical practice and health care technology have accelerated the migration of higher complexity cases (with higher reimbursement and higher contributions to profit margins) away from the HOPD and to the outpatient ASC setting. Certainly, this has been occurring in a variety of specialties with commercial payors seeking to lower the cost of care. For instance, certain ASCs along the Wasatch Front offer total joint replacement and complex spine procedures for patients covered by commercial payors. Similarly, vascular access procedures for peripheral arterial disease have moved from the HOPD to the office-based lab or interventional suite (OBL).

The Centers for Medicare & Medicaid Services (CMS) has followed this trend in its annual updates of the ASC Covered Procedures List (CPL), and for 2020 has added six coronary intervention procedures1 — including cardiac stenting — and total knee arthroplasty2 to the CPL.

With respect to cardiovascular procedures, the expanded ASC CPL presents opportunities for both ASCs and OBLs. More specifically, we expect that:

• interventional cardiologists will be attracted to the development of single-specialty cardiology ASCs;
• existing multi-specialty ASCs willing to invest in a high resolution angiographic suite, specialized cardiology specific emergency equipment and experienced cardiovascular staff and physicians will evaluate service line expansion (perhaps as a satellite operation);
• interventional cardiologists, interventional radiologists and endovascular surgeons with existing OBL facilities will evaluate both (a) licensure and Medicare-certification as an ASC to realize higher ASC reimbursement rates (ASC facility fee, with the physician’s professional fee billed separately) than afforded by the enhanced professional fee in the OBL setting and (b) a hybrid model under which the facility alternates between a Medicare-certified ASC and an OBL on different days for different classes of patients/procedures (e.g., using certain contractual arrangements between different entities with different EINs and NPIs).

In addition, as the trend continues (more complex procedures added to the ASC CPL) the interplay (and, at times, tension) between federal/Medicare laws, rules and regulations and state laws will be increasingly important. For instance, Medicare rules define an “ambulatory surgical center” as a “distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission.” See, 42 CFR §416.2.

An ASC satisfies the criterion of being a “distinct” entity when it is wholly separate and clearly distinguishable from any other healthcare facility or office-based physician practice. An ASC does not have to be completely separate and distinct physically from another entity, if, and only if, it is temporally distinct. In other words, the same physical premises may be used by the ASC and other entities, so long

1 These procedures are: CPT code 92920 (Percutaneous transluminal coronary angioplasty; single major coronary artery or branch), CPT code 92922 (Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)), CPT code 92928 (Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch), CPT code 92929 (Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)), CPT code 92960 (Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch), and CPT code 92961 (Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)).

2 CPT code 27447 (Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)).

*Advertorial from Ray, Quinney & Nebeker
Migration of Complex Procedures to the ASC Setting
(Cardiovascular Interventions, Total Knee Replacement and Extended Recovery Services)

as they are separated in their usage by time. See, Medicare State Operations Manual, Appendix L. So, Medicare permits the same physical facility (premises and equipment) to be used by two separate entities (e.g., different Medicare-certified ASCs). However, the Utah Department of Health informally advises that it will not grant multiple licenses for the same physical location.

Generally, a physician clinic’s office-based procedure or operating room is exempt from licensure under the Utah Health Care Facility Licensing and Inspection Act. So long as an OBL is exempted by that provision under Utah law, the hybrid model under which the facility alternates between a Medicare-certified ASC and an OBL on different days is feasible. However, the OBL component, if used by multiple independent physicians performing procedures on the ASC CPL, would be outside the state licensure exemption and thus subject to potential action by the Department of Health for operation of an unlicensed health care facility (ambulatory surgery center).

An additional impact of the ongoing trend (more complex procedures added to the ASC CPL) is that the Medicare 24 hour rule\(^3\) will be tested, including relative to extended recovery services under Utah law. A number of ASCs are exploring extended recovery services for non-Medicare patients.\(^4\)

According to CMS, an ASC’s surgical services must be ones that ordinarily would not take more than 24 hours, including not just the time for the surgical procedure but also pre-op preparation and recovery time, following the admission of an ASC patient. These limitations apply to all of the ASC’s surgical services, not just to surgeries on Medicare beneficiaries who use the ASC. See, Medicare State Operations Manual, Appendix L. In contrast, Utah Department of Health regulations under the Health Care Facility Licensing and Inspection Act permit a freestanding ASC “to provide extended recovery care services which shall not exceed 24 hours” and the “facility shall provide services to no more than three patients, anywhere within the facility, between the hours of 10:00 p.m. and 6:00 a.m.” “Extended Recovery Services” means “patient care after the initial post surgery recovery period” and the “Initial Post Surgery Recovery Period” means “patient care no longer than six hours beyond the completion of surgery.” Those definitions can be read to authorize in excess of 24 hours (up to 6 hours (initial post-surgery recovery period) plus 24 hours (extended recovery services)).

So, if we posit that a Medicare-certified ASC will perform more complicated procedures (e.g., total knee arthroplasty) for non-Medicare patients (pre-authorized with the commercial payer) and provide extended recovery care services during an overnight stay as permitted under state law, it would seem that the facility is no longer an eligible ASC for Medicare purposes if the total time from admission to discharge is more than 24 hours. Exceeding the 24-hour time frame constitutes condition-level noncompliance with 42 CFR §416.25. See, Medicare State Operations Manual, Appendix L. This outcome, unfortunately, would implicate False Claims Act liabilities (recoupments, fines, penalties, etc.).\(^5\)

Therefore, well-advised Medicare-certified ASCs should hesitate to operate in a manner that violates the Medicare 24 hour rule (even if permitted under state law).

Further, the regulatory definition of an ASC limits its operations to surgical services only for patients who do not require hospitalization after the surgery. The term “hospitalization” means that a patient recognizes that some states permit the operation of “recovery centers” which provide postoperative care to non-Medicare ASC patients but are neither Medicare-certified healthcare facilities nor licensed hospitals. However, CMS takes the position that, if the recovery center would be considered a hospital if it participated in the Medicare program, an ASC that transfers patients to such a recovery center will likely not satisfy the Medicare definition of an ASC. See, Medicare State Operations Manual, Appendix L.

We can be certain that the trend of more complex procedures moving to the ASC setting will continue. Indeed, CMS has clearly demonstrated, when adding coronary intervention procedures to the 2020 ASC CPL, its willingness to consider Medicare cost savings in approving ever more complex procedures (notwithstanding its own conflicting regulations). In adding these procedures (for instance, same-day discharge percutaneous coronary interventions), CMS had to avoid its own regulations prohibiting ASC coverage for procedures involving “major blood vessels.” It did so by determining that “the involvement of major blood vessels is best considered in the context of the clinical characteristics of individual procedures.”

We would characterize this as a pragmatic reading of its own regulations to achieve a desired outcome, supported by a public policy goal of promoting cost savings, quality of care and patient experience. Regardless, that interpretation and policy underscores our expectation that Utah ASCs will continue to benefit from the shift of more complex cases to the outpatient ASC setting, notwithstanding the complexities of compliance with relevant federal and state laws.

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\(^3\) Patients admitted to an ASC will be permitted to stay 23 hours and 59 minutes, starting from the time of admission (see 73 FR at 68714 (November 18, 2008)). The time calculation begins with the admission and ends with the discharge of the patient from the ASC after the surgical procedure. While the time of admission normally would be the time of registration or check-in of the patient at the ASC’s reception area, for the purposes of compliance with the ASC CPL, would be outside the state licensure exemption and thus subject to potential action by the Department of Health for operation of an unlicensed health care facility (ambulatory surgery center).

\(^4\) Some states expressly permit post-ASC procedure recovery stays. For instance, Oregon now licenses “extended stay centers” which provide post-surgical and post-diagnostic medical and nursing services to patients recovering from surgical procedures performed in an affiliated ASC.

\(^5\) The False Claims Act imposes liability (among other grounds) on any person who “knowingly presents, or causes to be presented a false or fraudulent claim for payment or approval.” 31 U.S.C. § 3729(a)(1).
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