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Part B News
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In this issue

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Physician contracts

Mind legality of firing MD for embarrassing the practice; better to go no-cause

The recent dismissal of a physician who bothered his employer with a self-published book is a good reminder that providers can affect your practice by their actions outside the office, and that you should be prepared for it in their contract terms.

Generally, physicians who get into legal trouble or have certain kinds of behavioral issues that are not strictly illegal, such as alcoholism, will also have trouble with their licensing boards, and when their license to practice medicine is suspended or encumbered as a result, that will give their employer a reason to cut them loose (*PBN 8/3/20*). But some physician issues aren't that cut-and-dried.

A Mayo Clinic doctor, Steven Weiss, M.D., got in the papers recently when he self-published a book called "Carnage in America: Covid-19, Racial Injustice, and the Demise of Donald Trump," in which he identified himself as a Mayo Clinic doctor. Weiss was later fired. Mayo Clinic explained that it let Weiss go for "reasons beyond the publication of a book," according to reporting in USA Today. However, the paper published part of the correspondence between Weiss and Mayo Clinic authorities, in which the latter cited "unauthorized use of confidential business information, self-identification as a Mayo employee without appropriate approval, inappropriate use of patient identifiers, and derogatory and unprofessional commentary placing Mayo in a negative light" among their issues with Weiss.

The morals clause

The terms of Weiss' contract are not known, but it's not unusual for practices to stipulate that doctors are expected not to embarrass their employers — what is sometimes referred to

Avoid fiscal drain on facet renovations

Significant changes are coming to services that represent hundreds of millions of dollars for anesthesia, pain management and physiatry specialists. Medicare administrative contractors (MAC) have put forth a uniform coverage policy. Discover what's in it during the July 14 webinar **Facet Renovations: Understand and Follow the New Uniform Policy for Blocks and Radiofrequency Ablations**. Learn more: *https://codingbooks.com/ympda071421*.

as a "morals clause," of the sort that gives Hollywood production companies and brand managers the right to break contract with a performer or endorser whose behavior redounds unfavorably to them.

"If the language includes any disparagement or morality clause, typically covering any actions considered detrimental to the practice, termination is likely a protected action," says Travis Cox, an attorney with the Chamblee Ryan law firm in Dallas.

Such a clause needs to be clear about the need to protect the "goodwill and reputation" of the practice, says Elisaveta "Leiza" Dolghih, a partner at Lewis Brisbois Bisgaard & Smith LLP in Dallas.

Complaints of being "cancelled" by employers are common today. But remember that while "the First Amendment protects our freedom of speech from intrusion by the government, private actors are not subject to the First Amendment," says Anna L. Schroeder, attorney with Eastman & Smith Ltd. In Toledo, Ohio.

That doesn't mean that employees of private employers have no rights, Schroeder says. Under the National Labor Relations Act, for example, employees have "the right to discuss unlawful conduct occurring in the workplace, like discrimination or harassment, for example."

Also, some states such as California have laws that "protect political speech of private employees," says Dolghih, and you and your legal team will want to gauge how far that protection extends to your physicians in any given case.

Robert L. Kilroy, partner, chair of the labor, employment and employee benefits group at Mirick O'Connell in Westborough, Mass., offers a scenario: "If, for example, someone is speaking out in a way that's adverse to the Republican party or the Democratic party and the CEO or the Board is of the other persuasion, and they make a decision based on what might fit within politically protected speech under state law."

Also, Kilroy says, while it's understandable that practices don't want their physicians bad-mouthing them in public, you have to be very careful about appearing to retaliate against speech that has to do with a legitimate gripes that might have legal implications — like a whistleblower case.

"By way of example, if you had a physician going to leadership and complaining about a quality-of-care issue and it falls on deaf ears such that leadership ignores the concern and takes no action, and ultimately, the physician gets so frustrated they say something that gets some public airing, then if the employer were to fire the physician, you can almost certainly expect a whistleblower claim," Kilroy says. "And if I'm defending the hospital employer, it becomes very difficult then, because a jury is going to say, 'Wait a minute, were you fired because of a social media post or were you fired in retaliation for raising the underlying quality issues?'"

However, employee speech and beliefs "aren't absolutely protected," Schroeder says. For one thing, if the

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doctor were an at-will employee rather than contracted — as most of your non-clinical staff and, indeed, most U.S. employees are — they could be fired for pretty much any non-protected speech. And their free speech rights don't mean they can break the law, as when doctors breach HIPAA in social media (*PBN 6/6/13*).

Tash Benjamin, principal and business manager of communications firm TKing Enterprises in Brooklyn, N.Y., says depending on what the physician says in his book or other outlet "there may be other laws that apply, such as defamation, fraud, etc., that may give the employer the right to terminate the employment contract for legally sound reasons."

Point to the code

One possible defense against physician behavior that egregiously sullies the practice's reputation — for example, controversial or even racist remarks out of the office — is an overt reference to well-established physician ethical standards in their contract.

Savera Sandhu, partner and health care practice leader at Newmeyer Dillion in Las Vegas, counsels her clients who draft physician contracts "to use the code of medical ethics given by the American Medical Association, and include it as part of the policies and procedures that each applicable employee receives."

Sandhu refers to Chapter 9 and Chapter 10 of the AMA Code of Medical Ethics, which respectively describe a physician's requirement to self-regulate and inter-professional relationships.

The code calls on physicians to "uphold standards of professionalism," Sandhu notes, and contains a directive "that the physician not only apply the code of ethics to his or her professional standards of practice but also to society at large. Arguably, a provision in a physician's contract that provides for practice standards and ethical compliance could apply the AMA's language along with the institution's own environment of respect, inclusion and professionalism."

Referring to the authority of your policies and procedures in a contract isn't uncommon; most physician contracts "include something to the effect that the physician agrees to uphold professional standards and conduct as provided in the [organization's] policies and procedures in addition to federal and state as well as local laws," Sandhu says.

Contracts and policies and procedures aren't the only instruments that bind employees and partners, says Michael B. Brohman, shareholder with Roetzel & Andress in Chicago.

"You'll probably have an employee handbook that is binding upon all employees," Brohman says. "And it's not unusual for an employment contract to have a provision that says if there's any inconsistency between what's in your employment contract and in the employee manual, the employee manual will govern the conditions of employment. Most employee manuals are really aimed at the staff, but they could be applied to physician employees as well. And there can be provisions in the manual about social media" and other areas.

"If a physician makes a [racist] comment outside of the office, [contract terms] are still triggered because you've got the responsibility to uphold the professional practice of medicine and to maintain the regard of your profession and your community," Sandhu says. "One could argue that includes not making racist comments."

The no-cause approach

But while morals clauses, P&P references and similar employer protections do show up in contracts, "you're not going to typically see a termination-with-cause provision which allows for immediate termination based on the physician making a statement in social media or, you know, some other public context," Kilroy says. "You just don't see that much, in part because it's pretty squishy — it's hard to identify exactly what you're talking about, what specific type of statements would constitute cause, and so on."

Instead, Kilroy says, "we're more likely talking about a termination without cause, which in the vast majority of physician agreements will say something like, after five years of employment the physician has rights to a year's notice before you terminate, and earlier may be three months' notice."

Have a question? Ask *PBN*

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for your. Email askpbn@decisionhealth.com with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

In such cases, "the contract/employment agreement could be drafted in a manner that allows the employer to avoid retaining the physician during the notice period, however, by permitting the employer to accelerate the separation date and pay the physician for the notice period, but without having the physician actually work (and remain an employee) during such notice period," Kilroy adds.

It's no-fuss, no-muss, and the practice doesn't have to get into the potentially thorny issue of why they're parting company with the physician — a good alternative if you can afford it.

One word of advice: If you take that approach, "don't assign the employee to do any services during that period of time," Brohman says. "Pay the person and basically instruct them to stay home — because you don't want somebody who knows they're leaving to be around other employees." — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCES

- USA Today, "'Didn't expect to be fired;' Mayo dismisses Wisconsin doctor who wrote book on COVID pandemic," July 2, 2021: www.usatoday.com/story/news/health/2021/07/02/mayo-clinic-fires-doctor-who-wrote-book-covid-pandemic-experience/7835833002/
- AMA Code of Ethics: www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview

Compliance

First in series of surprise billing rules promises big payment, patient info changes soon

The first of an anticipated series of rules related to surprise billing is out, and suggests that the government will enforce a low ceiling for out-of-network charges — and require practice physicians to explain to an unprecedented degree what payment options the patient has.

The "Requirements Related to Surprise Billing; Part I" interim final rule — a joint production of the U.S. Treasury Department, the Office of Personnel Management, the Department of Labor and HHS — was revealed on July 1, ahead of its Federal Register filing. It begins putting into place a plan mandated by the Consolidated Appropriations Act of 2021, specifically in its "No Surprises Act" section, to do away with surprise and balance billing in health care.

Laying the groundwork

This rule is largely informational, laying the groundwork for future rules that will put its edicts into effect — the next of which, a "Part II" rule, is expected as soon as August; indeed, that rule is already on the US. Office of Management and Budget's Office of Information and Regulatory Affairs' "dashboard," traditionally the last stop before a rule is made public via the Federal Register.

The more immediate relevance of the Part I rule is for insurers and hospitals, which have been the focus of negative press owing to the sometimes astonishing charges associated with surprise billing, the catch-all name for the costs of medical goods and services that are higher than expected due to misunderstandings about health care coverage, usually when received out of the beneficiary's network.

The rule prohibits surprise billing and prior authorization in emergency and ambulance services, which are prone to these practices due to their unexpected nature, as well as in "nonparticipating providers at participating facilities in certain circumstances."

"Among other requirements, these interim final rules require emergency services to be covered without any prior authorization, without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility with respect to the services, and without regard to any other term or condition of the plan or coverage other than the exclusion or coordination of benefits or a permitted affiliation or waiting period," the rule says.

The Act also announces a general prohibition against balance billing, which the rule defines as "the practice of out-of-network providers billing patients for the difference between (1) the provider's billed charges, and (2) the amount collected from the plan or issuer plus the amount collected from the patient in the form of cost-sharing."

Expect more changes soon

The Part II and other related future rules will specify how this new order will work. It is expected to map out an independent dispute resolution (IDR) process "that allows plans and issuers and nonparticipating providers and nonparticipating emergency facilities to resolve disputes over out-of-network rates," according to the rule. These upcoming rules will also specify what kind

(*continued on p. 6*)

Benchmark of the week

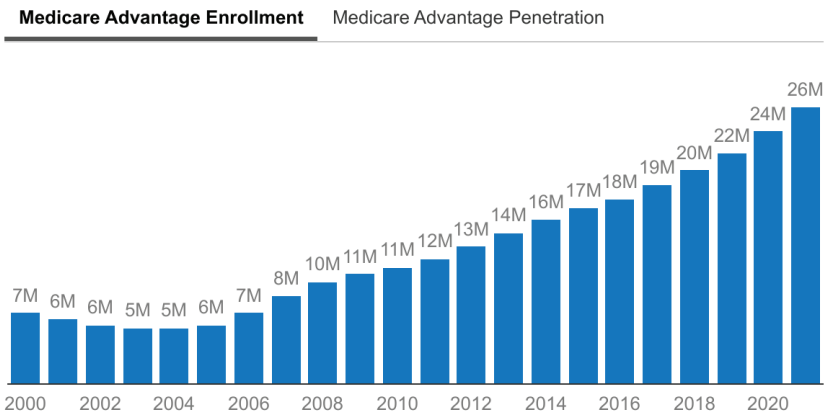
Medicare Advantage takes another bite out of traditional FFS enrollment

Medicare Advantage enrollment galloped forward at a 10% rate between 2020 and 2021, as the private plan alternative to original Medicare now has lassoed more than four in 10 (42%) beneficiaries.

In 2021, Medicare Advantage plans are serving 26.4 million out of the 62.7 million Medicare patients overall, according to a June 21 report from the Kaiser Family Foundation (KFF) detailing the latest Medicare enrollment figures. As the charts below show, Medicare Advantage growth has progressed at a steady, unwavering clip over the past 15 years, and projections say that the strong pace will continue.

A decade ago, Medicare Advantage plans covered 12 million individuals, which represented a market penetration of 25%. Between 2011 and 2021, market penetration has increased 68%. By 2030, the private plan alternatives is expected to cover more than half (51%) of total Medicare beneficiaries, according to analysis by the Congressional Budget Office (CBO).

Total Medicare Advantage Enrollment, 2000-2021



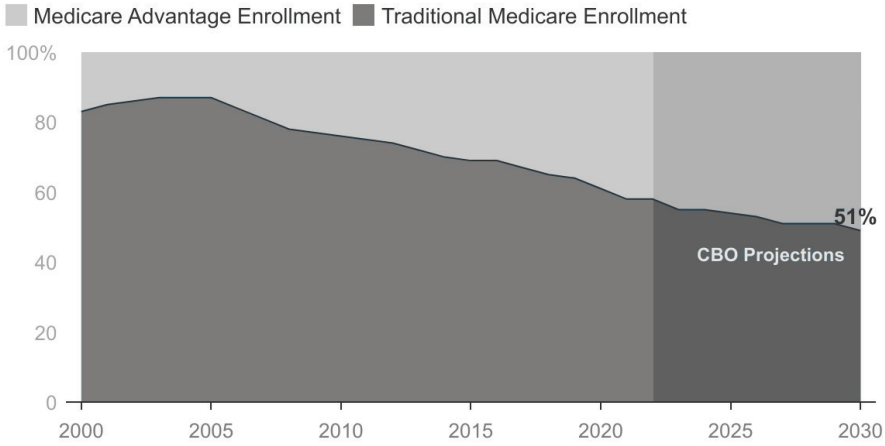
NOTE: Includes cost plans as well as Medicare Advantage plans. About 62.7 million people are enrolled in Medicare in 2021
SOURCE: KFF analysis of MPR, "Tracking Medicare Health and Prescription Drug Plans: Monthly Report," 2000-2005; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2006-2017; CCW data from 20 percent of beneficiaries, 2018; and Medicare Enrollment Dashboard 2019-2021. Enrollment numbers from March of the respective year.

KFF

Already, two states – Florida and Minnesota – have a Medicare Advantage penetration of more than 50%. About two dozen other states, including the highly populous states of California (45%), New York (46%) and Texas (45%), sit above the national market penetration rate in 2021, according to the KFF report. Several states are below the national rate of 42%, with Wyoming (4%) and Alaska (1%) having the lowest percentages of beneficiaries enrolled in Medicare Advantage plans.

As the ranks grow, you're likely to work with two of the nation's largest insurers when treating Medicare Advantage patients. UnitedHealthcare, the nation's largest private insurer, holds 27% of the Medicare Advantage market share nationally, while Humana covers another 18% of the market. State-based BlueCross BlueShield plans control 14% market share nationally, with Aetna, a division of CVS Health, covering 11%. – *Richard Scott* (*rscott@decisionhealth.com*)

Medicare advantage enrollment and traditional Medicare enrollment, past and projected



SOURCE: KFF analysis of MPR, "Tracking Medicare Health and Prescription Drug Plans: Monthly Report," 2000-2005; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2006-2017; CCW data from 20 percent of beneficiaries, 2018; and Medicare Enrollment Dashboard 2019-2021. Enrollment numbers from March of the respective year. Projections for 2022 to 2030 are from the March Congressional Budget Office (CBO) Medicare Baseline for 2020.

KFF

Source: *www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/#*

(*continued from p. 4*)

of new coverage information insurers will need to give to providers and providers will need to give to patients.

"If you are one of those physicians who either works in an emergency department or is in a physician office but works sometimes in facilities and often treat patients out-of-network, pay careful attention to the first set of regulations that implement the No Surprises Act as they emerge," says Matthew Albright, chief legislative affairs officer at health care solutions company Zelis in Washington, D.C., "because come January 1, there will be new notices you'll have to put together [for plans and your patients] and details on whether you'll be reimbursed according to state laws or the No Surprises Act."

Claire Ernst, MGMA's associate director, government affairs, says the trade organization is "glad that the regulation was released 'on time' to give providers a chance to prepare. This regulation is critical, but only the first [in a series]. We are anxious to see the next regulation supposedly set to be released this August that will cover the IDR process." — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCES

- "What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing," CMS, July 1, 2021: *www.cms.gov/newsroom/fact-sheets/what-you-need-know-about-biden-harris-administrations-actions-prevent-surprise-billing*
- Pre-publication release, "Requirements Related to Surprise Billing; Part I," HHS: *www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf*

HIPAA

New HITECH amendment rewards good cybersecurity hygiene

Now's a great time to shore up your cybersecurity practices. A new amendment to the Health Information Technology for Economic and Clinical Health (HITECH) Act requires the HHS Office for Civil Rights (OCR) to take into account whether your practice adopted "certain recognized security practices" if it investigates your practice for HIPAA compliance. The amendment applies to business associates, too.

The amendment, signed January 5 to little fanfare, is intended to encourage health care providers and other organizations covered by HIPAA to adopt strong cybersecurity programs to better protect patient information. That means if your practice can show that it has used statutorily recognized standards for at least 12 months, it may see reduced fines, an early or favorable termination of an audit, and other remedies.

"It works like a safe harbor," says Elizabeth Litten, attorney with Fox Rothschild in Princeton, N.J.

There's no penalty if you don't implement these standards, and OCR can't increase fines or otherwise penalize you if don't have the additional measures in place.

The "recognized security practices" that apply are the standards, best practices, guidelines, methodologies, procedures and processes developed under either:

- The National Institute of Standards and Technology (NIST) Act.
- The Cybersecurity Act of 2015.
- Other programs or processes derived from another law, such as New York's Stop Hacks and Improve Electronic Data Security Act (SHIELD Act).

OCR has confirmed to DecisionHealth, publisher of *Part B News*, that it is incorporating the amendment into its HIPAA enforcement program.

Cyberattacks spur government action

The health care industry is particularly vulnerable to cyberattack, and providers account for 79% of all health care breaches, according to Lee Barrett, CEO and executive director of the Electronic Healthcare Network Accreditation Commission (ENHAC), a voluntary self-governing standards development organization, in Simsbury, Conn.

Hacking and other cybercrimes comprised a whopping 71% of HIPAA breaches in the first two months of 2021, according to Serena Mosley-Day, senior advisor for HIPAA compliance and enforcement at the OCR, speaking at the virtual Thirtieth National HIPAA Summit in March.

Many of the breaches are due to poor cybersecurity hygiene, such as lack of network segmentation or nonexistent password rules, according to Nicholas Heesters, senior advisor for cybersecurity at OCR, also speaking at the Summit.

"Using best practices may have stopped or mitigated a breach … and avoided a [subsequent OCR] enforcement action," Heesters says.

"I suspect that during the pandemic people were lax about cybersecurity," says attorney Michael Kline,

also with Fox Rothschild. "There are real challenges in 2021; providers are in various stages of undress."

A lot of physicians mistakenly believe that cyberattackers won't bother them because they have fewer patients than a larger provider. But in reality cybercriminals love physician practices because there are fewer controls in place, Barrett says. And even providers that have taken cybersecurity measures can still become a victim of cybercrime.

And then in comes OCR.

"Providers' systems are being hijacked," Barrett says. "Then OCR comes back at these organizations after the attack and levies additional fines on them. So they're being whacked on all fronts."

For example, an orthopedic practice in Athens, Ga., was the victim of a hacker who extracted its patient database and demanded money for a copy of the database. After the OCR investigated the practice had to pay a $1.5 million settlement and enter a corrective action plan to resolve allegations of "longstanding, systemic noncompliance" with HIPAA privacy and security rules, the OCR announced Sept. 21, 2020.

Details under development

The amendment allows the entity to determine what practices to take but doesn't provide additional guidance. It's unclear what or how much cyber hygiene is needed to qualify for the safe harbor, and whether partial adoption of cybersecurity measures will count. Yet it's likely that OCR will take into account good faith efforts, Litten says.

"OCR gets ticked off when you know there's a gap and don't fix it. Here the safe harbor is an absolute factor," Litten says. To the extent your practice tried to improve its cybersecurity and prevent breaches, that gives you something to hold up when you have a mea culpa, Litten says.

"Even responding to OCR is a big expense. If you can say upfront what steps you took, you may be able to nip that in the bud and make it less painful," she adds.

Barrett agrees. "That's the big value proposition, to minimize the double whammy of the attack plus OCR," he says.— *Marla Durben Hirsch* (*mdurbenhirsch@decisionhealth.com*) ■

RESOURCES

- The HITECH amendment: *www.congress.gov/116/bills/hr7898/BILLS-116hr7898enr.pdf*
- The National Institute of Standards and Technology (NIST) Act: *www.govinfo.gov/content/pkg/USCODE-2019-title15/html/USCODE-2019-title15-chap7-sec271.htm*
- The Cybersecurity Act of 2015: *https://epic.org/privacy/cybersecurity/Cybersecruity-Act-of-2015.pdf*
- The New York SHIELD Act: *https://ag.ny.gov/press-release/2017/ag-schneiderman-announces-shield-act-protect-new-yorkers-data-breaches*
- HHS OCR press release – orthopedic clinic settlement: *www.hhs.gov/about/news/2020/09/21/orthopedic-clinic-pays-1.5-million-to-settle-systemic-noncompliance-with-hipaa-rules.html*

HIPAA

More than 8 million patients affected by HIPAA breaches this year

Check on your practice's network and email security protocols. A look at breaches reported by health care providers shows that hacking and IT incidents were associated with the largest breaches in the first six months of the year.

One incident can cause a lot of trouble. A *Part B News* review of reportable breaches on the HHS Office for Civil Rights' (OCR) open cases list revealed that 140 hacking/IT incidents affected more than seven million patients. And these incidents aren't just happening to hospitals and health systems. For example, a 15-doctor practice in Nevada experienced a breach that impacted 50,000 patients.

A review of breaches reported by providers also illustrates that the risks of low-tech breaches such as theft or loss of paper records persist. Use the following charts to understand where providers face the greatest risk, and keep in mind that published breaches don't reflect the complete scope of the problem. It takes time for a practice to discover, investigate and report a breach. Some reported breaches aren't published because they fall below the 500-patient threshold. And of course, some practices choose to live dangerously and don't report a breach. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

Ask Part B News

Go to the source when you count review of external notes

***Question**: I understand how to count tests that are ordered or reviewed for office visits (PBN 6/28/21). But I'm not sure how to count "the prior review of external note(s) from each unique source." Does the review of one note from one physician or qualified health care professional (QHP) from a different group or specialty count as one source?*

Answer: That will depend on the source of the note. For example, if the treating practitioner reviews three notes from one hospital, the hospital is the unique source and the treating physician gets credit for reviewing one note.

If the practitioner reviews three notes from practitioners of a different but identical specialty who are in the same health system, the health system is the unique source and that counts as one note.

But if the treating practitioner reviews a note from a hospital, a note from physician at another practice and a note from a physician of a different specialty in your practice, that's three unique sources and the practitioner gets credit for three notes.

Keep the following definitions from the CPT guidelines close at hand until the new requirements become second nature:

"External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization."

"A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM." — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■