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We're now PsychBilling Coach! New name, same services.

Learn To Get Paid, Legally & Ethically

Hi Susan,

Will changes to the definition of independent contractor apply to therapists?

The US Department of Labor has redefined "independent contractor."

Why could this be important?

Group practice owners will need to take a careful look at the new rules. If you're classifying your clinicians as contractors, you may need to determine if they still meet the definition. Please do this with the advice of an accountant and/or employment lawyer.

According to the compliance guide, this has to do with the Fair Labor Standards Act, not taxes. The new DOL rules, apparently, don't change the IRS rules regarding who is an independent contractor. The rules are similar, but the DOL goes into more detail. From my reading, if there is a challenge to a company

regarding classification, the DOL can investigate and make a determination. If employees are incorrectly classified as independent contractors, the penalties to a business could be significant:

- Back wages, if the worker was underpaid;
- Back taxes
- Damages *(possibly as a result of not receiving benefits, such as health insurance)*
- Civil monetary penalties
- Attorney fees / court costs of litigation.

But I write about this not just to inform group practice owners. I'm speculating *(fantasizing?)* about the possibility that a smart, hungry employment lawyer out there will be willing to represent private practice therapists in a class action suit against insurance companies. It's long been my belief that insurance payers, while loudly proclaiming that providers are independent contractors, in fact have gained enough control over the relationship to where they *could* be considered employers. At least in part. And even if in part, might that not bring some badly-needed relief to private practices? As well as perhaps improving access to care for clients? One can only hope - and keep in mind, everything I say here could apply to medical practices too. Not just mental health. Tell your medical colleagues!

Consider these statements in the FAQ put out by the Department of Labor concerning the new rule:

- Whether the potential employer controls economic aspects of the working relationship should also be considered, including control over prices or rates for services ... by the worker.

- Actions taken by the potential employer that go beyond compliance with a specific, applicable federal, state, tribal, or local law or regulation and instead serve the potential employer's own compliance methods, safety, quality control, or contractual or customer service standards may be indicative of control.

- The following facts, among others, can be relevant: whether the worker determines or can meaningfully negotiate the charge or pay for the work provided; whether the worker accepts or declines jobs or chooses the order and/or time in which the jobs are performed...

- If a worker has no opportunity for a profit or loss, then this factor suggests that the worker is an employee. *(Next time a payer tells you that they won't negotiate fees, remind them of this...)*

- ...whether the work performed is an integral part of the potential employer's business. *(Without providers on their panel, what would an insurance company offer their customers?)*

I'm cherry-picking what supports healthcare providers being considered employees. There are certainly factors that would counter this conclusion, most importantly that no insurance payer has the right to prevent you from contracting with any other insurance payer. But the new rules state that ALL factors must be considered when determining who is a contractor vs. employee.

To my knowledge, on the federal level, the status of healthcare providers in private practice as employees vs. contractors as pertains to their relationship with insurance companies, has never been legally examined. Isn't it time?

Questions?

Call the Wage and Hour Division's (WHD) Division of Regulations, Legislation, and Interpretation (DRLI) at (202) 693-0406.

2024 Medicare Telehealth Coding SNAFU

CMS works at a snail's pace, but the "Change Request" has FINALLY been issued to fix underpaid POS 10 telehealth claims, per this news bulletin from NGS. In my experience, it usually takes contractors about 30 days to make the changes to processing systems and start re-processing claims to pay at the correct rates. **Even though the link is specific to NGS, all Medicare contractors have been given the same Change Request by CMS. All underpaid claims will be reprocessed** - but no ETA yet has been given. More waiting...

Whether you continue to hold claims, or submit them now, is your choice. Just don't code improperly. **2024 Telehealth sessions where the client is at home should be coded POS 10, NO MODIFIER 95.** The screenshot below is from the 2024 Physician Fee Schedule - the ultimate authority on All Things Medicare Rules.

78876 Federal Register / Vol. 88, No. 220 / Thursday, November 16, 2023 / Rules and Regulations

the distant site. The statute requires Medicare to pay a fee to the site that hosts the patient. This is analogous to the circumstances under which the facility PE RVUs are used to pay for services under the PFS. That is why we believe that the facility PE RVUs most accurately reflect the resource costs for telehealth services when the home is not the originating site. We note that beginning in 2025, most telehealth services will once again be subject to the statutory restrictions under section 1834(m)(4), including the limitation on payment for telehealth services to those furnished in specified originating sites and in areas that are designated as a rural health professional shortage area or in a county that is not included in a Metropolitan Statistical Area and to

which we believe the resource costs will continue to be incurred by the originating site, where the patient is located, and not by the practitioner at the distant site. Therefore, we continue to believe that paying for claims billed with POS 10 at the non-facility rate while continuing to pay for claims billed with POS 02 at the facility rate most accurately captures the resource costs inherent in these types of telehealth visits.

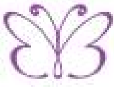
Comment: A commenter requested that CMS clarify that CMS will pay the PFS non-facility rate for any service appended with POS 10, not just mental health services.

Response: We clarify that any service appropriately billed with POS 10 will be paid at the non-facility rate.

treatment, or management of an ongoing behavioral health, mental health, or SUD issue.

Response: After consideration of public comments, we are finalizing as proposed that beginning in CY 2024, claims for telehealth services billed with POS 10 will be paid at the non-facility PFS rate. Claims billed with POS 02 will continue to be paid at the facility rate. In addition, we are clarifying that modifier '95' should be used when the clinician is in the hospital and the patient is in the home, as well as for outpatient therapy services furnished via telehealth by PT, OT, or SLP.

f. Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations



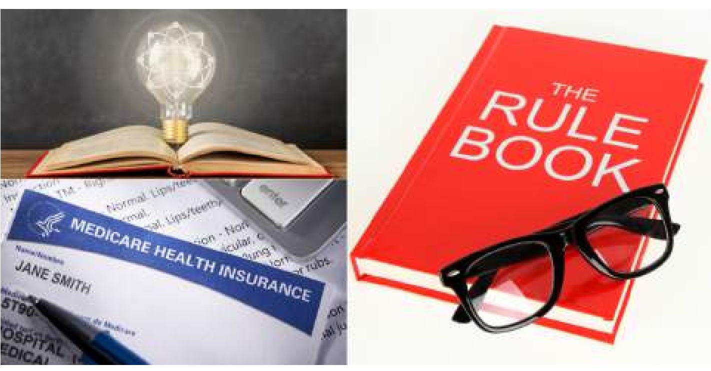
You're a Medicare provider! *(or soon will be!) What now?!?*

You need to get paid! Do you know how?

Here's just a partial list of what's covered - click the link below to see the rest!

- Benefits
- Secondary/supplemental plans
- Setting up Medicare billing
- Understanding eligibility returns
- Does your client have Medicare Advantage instead? How to find out!
- Common billing errors & how to avoid them
- ... And much more!

Buy Now!



Medicare means rules. A lot of them.

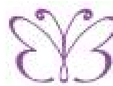
Medicare doesn't make the rules easy to find or understand. This workshop translates Medicare-ese into plain language and answers your day-to-day questions.

All topics are explored in terms of Medicare Advantage and Original Medicare. Partial list:

- Telehealth
- Documentation & Audits
- Appeals & clawbacks
- Incident-to / coverage for supervisees?
- When can't you collect from clients?
- Resources for help
- ... And much more!

Buy Now!

Buy both and SAVE!



Cyberattack on Change Healthcare!

It sounds like a science fiction plot, but on Wednesday, February 21, all operations of Change Healthcare were brought to a halt. As of Monday February 26, all systems are still offline.

Think air travel on September 12, 2001, and you'll get the idea. No eligibility inquiries can be made. No claims are going in. No payments are processing. And no remittances are being issued.

Whoever your clearinghouse is: Office Ally, Eligible (Simple Practice), Waystar, Trizetto, Availity, Claim.MD - ALL clearinghouses are impacted. They severed connections to Change early last Wednesday to ensure the security of their operations.

Who is Change Healthcare? What does this mean for you?

Change is the largest claims clearinghouse in the US. In 2022, after years of back and forth with the Department of Justice, they were acquired by Optum. The purchase price was in the billions.

When we submit an electronic claim, it might relay through several "intermediaries" before arriving at the intended payer. Payers have the right to decide which clearinghouses they'll accept inbound transmissions from, and over the years exclusive arrangements have developed. Meaning that only one clearinghouse - often Change Healthcare - is the electronic gateway to and from the payer.

At this time, it remains to be seen what the outcome will be, but **reimbursement delays are almost certain**. Lost claims are likely. So are erroneously rejected ones, as the industry frantically makes new emergency connections in order to stay online.

It's difficult to know who handles which functions of a payer. For example, take Aetna. Their eligibility inquiries, claims status, and provider portal functions are handled through Availity. But if you want to enroll for EFT and ERA - you guessed it: Change Healthcare.

Click here to subscribe to status updates.

And click here for a 17-page list of payers utilizing Change Healthcare, courtesy of Claim.MD.

Fight Back Against Clawbacks!

Protect your income!

Friday, March , 2024

YES, there ARE ways to successfully fight clawbacks!

But no one wants you to know how.

- How to therapeutically partner with your client on clawbacks.

10 am Pacific / 1 pm Eastern

- What steps can you take to prevent clawbacks?
- What documentation will save you when they attempt to claw back?
- Ways to fight back that you never knew existed! And what NOT to do.
- Basic Coordination of Benefits Rules - knowing these can prevent clawbacks!
- Discussing CoB with clients.
- Secondary claims: why are they so ****** hard? (And lead to clawbacks?)
- If you refuse to pay, can you make sure they don't grab it from another client? *(Yes - sometimes. Register & find out more!)*
- How does it work with government payers?
- Who are the final authorities over clawbacks?

Register Today!

15% off to mailing list subscribers - use code Coach15 at checkout.

Act now - Offer expires March 1, 2024.

Tricare providers: Can you opt out of Medicare? Maybe not.

It's come to my attention that if you're participating with Tricare, you may not be allowed to opt out of Medicare. I was unable to find anything on Humana Military (East Region) to indicate one way or the other. However, the HNFS website (West Region) has a January newsletter that states (page 3):

Mental Health Providers and Medicare Participation

As of Jan. 1, 2024, Medicare will cover mental health care services provided by marriage and family therapists (MFT), mental health counselors (MHC) and licensed professional counselors (LPC).

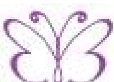
What does this mean for TRICARE network providers?

Per Health Net Federal Services' (HNFS) TRICARE Provider Participation Agreement, network providers eligible to participate in Medicare must have a signed Medicare CMS-460 Agreement or agree to participate with Medicare on a claim-by-claim basis for dual-eligible beneficiaries (those eligible for TRICARE and Medicare).

HNFS will look for Medicare enrollment or per-claim agreement for MFTs, MHCs and LPCs as part of its credentialing process moving forward.

I wonder who wrote this? **There is NO SUCH THING as a "single case agreement" with Original Medicare**. Possibly Medicare Advantage - IF you're not opted out.

Something to think about, if you're a Tricare provider and considering opting out of Medicare.



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