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In this issue

Practice management

AI may ease the sting of burnout, but real solutions run deeper

As physician burnout continues to plague practices, managers may hope that artificial intelligence (AI) innovations such as always-on scribing will relieve the administrative burdens that contribute to it. But experts say the problem goes deeper than a technology fix.

Burnout has been a known problem in the heath care community for decades. The AMA's recent "AMA Organizational Biopsy" found that 41.9% of physician respondents "reported experiencing at least one symptom of burnout." The AMA headlined these findings "Physician burnout rate continues to decline, falling to nearly 42%." A closer reading shows that number is down only 1.3%, from 43.2%, in 2024.

Medscape's Medscape Physician Burnout & Depression Report 2026, based on a survey of 5,159 physicians and released in August, found that more than 80% of respondents "attribute most or all of their struggle to work, and two-thirds believe their burnout exceeds what professionals outside medicine experience."

AI time-savers

As with nearly every other industry, AI advocates have proclaimed their technology perfect for trimming physician tasks that take them away from patient work — for example, ambient listening, the always-on encounter recording that boosters say creates notes more efficiently than human scribes or doctors and thus cuts down on the review and revision physicians must perform before signing off (*PBN 4/1/24*).

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Merrie Wallace, chief revenue officer of Boostlingo in Austin, says that AI-powered translation and interpretation "can help providers connect with patients more efficiently when language barriers would otherwise create delays, additional coordination, or repeated communication," thereby reducing burnout by "reducing the administrative friction that surrounds patient care."

Workforce communications and engagement company Firstup's 2026 survey of hospital nurses found that their information overload had become so intense that "67% of nurses skim or delete workplace messages at least sometimes without fully reading the content — and 25% say they do it often."

The company's health care leader, Melissa Hensley, says the Firstup AI services the company offers to health care clients help them find messages that are relevant to them faster. "By delivering the right content to the right clinicians at the right time," Hensley says, "organizations can reduce communication volume while increasing engagement and impact."

Agnes Chang, M.D., a D.C.-area dermatologist starting up her own practice, sees AI as an operations advantage. "AI is a large part of how I plan to run it," she says, "covering my emails, my marketing operations, and frequently asked patient questions for which I already have written answers."

Beyond the time suck

The argument that time-saving technology will reduce busy work and ease burnout is intuitive and straightforward. But experts say there's more to beating burnout than that.

Podiatrist Mikel Daniels, owner of the We Treat Feet practice in Maryland, thinks ambient listening has been useful to his staff because he approached it "not as a shiny tech project but as a rescue mission for physicians who were falling behind on documentation" and worked to get his system in tune with his practice. "I still have to review and edit, but I almost never have to create an entire note at home from scratch," he says. "That change has done more for my sense of burnout than any wellness program ever did."

But Daniels has seen other providers lose the time ambient listening gives almost as fast as they gained it. "Instead of typing," he says, "they're reviewing drafts, fixing odd phrasing, worrying about hallucinations, and learning yet another workflow."

"Burnout isn't simply a function of working hard; physicians have always worked hard," says Joshua Tarkoff, M.D., pediatric endocrinologist with Nicklaus Children's Hospital in Miami. "It arises when an increasing share of the workday is devoted to activities that pull physicians away from patient care while simultaneously making it harder for patients to receive the care they need."

Can workflow changes ease burnout?

"Physicians are burned out because they've lost control of medicine," says Amit Gupta, M.D.,

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a urologist with Beverly Hills Urology and clinical associate professor of urology at Cedars-Sinai in Los Angeles. Physicians who find themselves "buried in bureaucratic requirements and spending hours fighting insurers over denials, delays and payment" are not likely to get back time with patients just because their administration time has been trimmed.

The reason, Gupta says, is that "software doesn't fix a problem that was created administratively."

Making small tasks more efficient doesn't guarantee the saved time will go back on the care side of the ledger — at least, not in a way that refreshes rather than depletes the physician's energy.

Saravanan Thangarajan, visiting scientist at Harvard T.H. Chan School of Public Health and Ariadne Labs at Brigham and Women's Hospital, Boston, puts it like this: "If an AI scribe drafts a note that the physician must review, correct, approve and remain accountable for, the burden has changed shape rather than disappeared. The key question is: Who gets the time AI saves — the clinician or the health system? If every recovered minute becomes another appointment, another inbox task, or a higher productivity target, AI has improved throughput, not the physician's working life."

Thangarajan previously worked on emergency medicine and public health in the state of Tamil Nadu in India, covering roughly 77 million people, and "that experience shaped my view of burnout: the setting may differ, but the underlying problem is remarkably consistent across health systems — technology cannot compensate for chronic overload, weak staffing, and too little control over the working day."

"We usually assume burnout is mainly a function of resources," Thangarajan adds, but his Tamil Nadu experience taught him that "it emerges when the work arriving exceeds the clinician's capacity to do it well and still leave work behind at the end of the day."

Consider the psychology angle

Some experts think the answer to burnout lies in the minds of the physicians themselves.

Often new physicians are put through "resiliency training" that's thought to improve their ability to cope with the enormous challenges of modern clinical work (*PBN 11/1/13*). But Ashley Gibson, a psychotherapist and founder of Meaning in Practice, a consultancy that addresses organizational burnout issues, thinks the approach should start on the other end — the dysfunction at the top of many practices, which she explores with clients via a framework she calls Maladaptive Organizational Copy Processes (MOCP).

Organizations, Gibson says, "have relational patterns, whether that's person-to-person or person-to-process. Those patterns can look like how authority is granted or withheld, how blame moves when something goes wrong, or whose competence gets questioned and whose doesn't. Those patterns get set at the top, then copied downward."

Most burnout interventions, Gibson says, treat it as "a resourcing problem, as if it would be solved by more staff, more tools, more time, more resilience." As an alternative, MOCP treats it "as a transmission problem and asks us to accurately diagnose what relational patterns are being copy-pasted, so we can more effectively intervene."

Also, technology interventions don't address "moral injury" — a term associated with combat post-traumatic stress disorder (PTSD) but increasingly used to talk about a cause of physician burnout.

Suzanne Gilberg, M.D., longtime OB/GYN and chief clinical officer at Monarch MD, a women's health practice in West Hollywood, Calif., says that for physicians "moral injury manifests as the emotional damage that can occur when you know what a patient needs, but are prevented from providing it due to forces outside of your control, like systemic or operational barriers."

Keep going

There are some AI-involved pilots that show real promise for burnout relief, not so much by offloading administrative tasks as by improving on processes already taken up by AI.

Andrey Meshcheryakov, head of ways to win practice at the Recombinators consultancy in Mendham, N.J., gives the example of a large language model (LLM)-based agentic workflow tool called MedAgentBrief created by Stanford University researchers and tested at a Stanford Health Care inpatient unit.

MedAgentBrief "synthesized an entire hospitalization" for physicians, Meshcheryakov says, producing clear summaries for discharge purposes. It also vastly

reduced the hallucinations that famously spoil AI's effectiveness, making it easier for clinical staff to weed those out. The researchers report that in a pilot program "physician burnout scores decreased significantly from before to after the intervention."

That system is still not quite ready for prime time, the researchers admit, suggesting areas to be addressed, adding: "Future work must also monitor for unintended consequences of efficiency gains. If health organizations repurpose AI-derived time savings into demands for higher throughput, the well-being benefits we observed could be negated, transforming a supportive tool into a mechanism for work intensification."

The more astute technologists seem to get the message.

While he's certain that the company he co-founded, Nexus Health AI, can help doctors do their work, CIO John Whitman is also clear that "technology cannot compensate for fundamentally unsustainable staffing, scheduling or administrative expectations. Flexible scheduling, appropriate staffing, team-based care and reducing unnecessary administrative work still matter. AI should complement those changes, not become an excuse to ask physicians to absorb even more work." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

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Compliance

Group services: Confidentiality agreements can negate, not create, compliance risk

CMS covers group services such as medical nutrition therapy (**97804**) and behavior intervention (**96164**). Now, CMS has put group services back in the spotlight with its proposed group E/M visit for patients with certain chronic conditions.

As part of the proposal, which CMS laid out within the proposed 2027 Medicare physician fee schedule, "beneficiaries must consent to confidentiality terms because personal health information [PHI] would be discussed in the group setting," according to the agency (*PBN 8/3/26*).

This type of confidentiality agreement is not HIPAA's notice of privacy practices that providers must give to all patients. A confidentiality agreement by a patient doesn't create additional HIPAA obligations or other compliance risks for a provider or other patients. But when a practice issues them correctly, they are a best practice, says Neal Eggeson, Eggeson Privacy Law, Fishers, Ind.

"A confidentiality agreement or contract distributed, explained to, and signed by all participants in a group setting would be considered a best practice for group services," Eggeson says. He adds that CMS' proposal "likely reflects a desire to codify [it]."

These agreements aren't legally enforceable by a patient against the provider because HIPAA doesn't apply to actions by another patient, by the provider against a patient "unless used to justify a patient's expulsion from the group service," or by one patient against another, Eggeson explains.

However, trust is essential to medical care and in group settings that includes fostering trust between participants. A confidentiality agreement can help patients feel safe and understand why they shouldn't share other members' information. In addition, if CMS finalizes the service with the confidentiality requirement, failing to get one could create improper payments.

Get an agreement, reinforce with reminders

To make sure your practice and your patients are protected, remind staff to be diligent in getting patient consent to a group service and their agreement to keep what other patients say to themselves.

"Assuming all patient-participants have consented to the group setting/service, the health care provider's compliance risk should be no greater than any other provider-patient situation," Eggeson says. "HIPAA's privacy regulations extend only to the provider's use and/or disclosure of PHI, so use/disclosure by anyone

(continued on p. 6)

Benchmark of the week

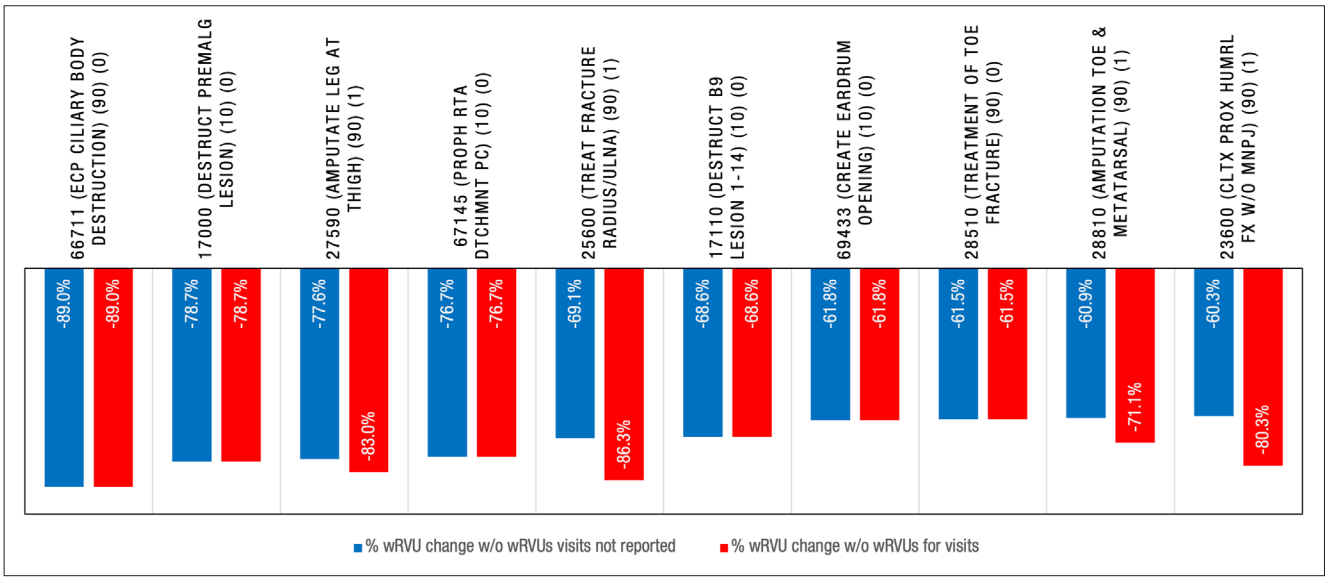
Global surgery period analysis reveals codes with the most to lose

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 blocks CMS from eliminating 10- and 90-day global surgery periods (PBN 7/14/14). While the agency can't take that drastic step, it continues to study the gap between provider effort and provider reimbursement for services with a post-operative period (PBN 7/27/26, 5/5/17).

As part of this scrutiny, CMS released data in the proposed 2027 Medicare physician fee schedule to illustrate the impact of the work relative value units (wRVU) during the post-operative period. Other information includes the average number of post-operative visits reported by providers for those procedures (PBN 9/11/25). *Part B News* analysis of the data shows that providers did not report any post-operative visits for 58% of the services reviewed and reported one visit for another 26% of services.

The chart below shows the top 10 procedures that would see the deepest wRVU cuts if their wRVUs were based on the number of post-operative visits reported by treating providers, and if no post-op wRVUs were assigned to the code at all. When the results are the same, it means providers did not report post-op visits for the service. The global period and average number of reported visits are included after each code's descriptor. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com)

Top 10 wRVU reductions for monitored procedures



Source: CY 2027 PFS Proposed Rule Global Surgical Services Visit Summary (zip file): www.cms.gov/files/zip/cy-2027-pfs-proposed-rule-global-surgical-services-visit-summary.zip

(continued from p. 4)

other than the provider should not affect the provider's compliance risk."

Eggeson emphasized the importance of informing every patient and getting their consent. The practice should document both in each patient's record.

Finally, the confidentiality agreement shouldn't be a one-and-done event. The provider "should take additional practical steps to reinforce the importance of mutual confidentiality in such settings," Eggeson says. — *Julia Kyles, CPC* (*julia.kyles@decisionhealht.com*) ■

Compliance

J-1 visa rules are changing; watch new deadlines, stay proactive

If you have providers who are in the U.S. on a J-1 visa, be aware that the Department of Homeland Security (DHS) is tightening its rules, which some observers believe will force some providers to leave the U.S. before their course of medical study, perhaps sooner than you expected to lose them.

The J-1 Exchange Visitor non-immigrant visa allows foreign medical residents to enter the U.S. for training, which often includes residency in a hospital or other clinical work arrangements. J-1 visas are used for residents in clinical medical training and research, explains Alison P. Hitz, member of the Clark Hill law firm in San Francisco, and employed by universities, teaching hospitals and research institutions.

Some J-1 docs may also work in physician practices in Health Professional Shortage Areas (HPSA) via the CONRAD-30 program waiver, which is one of a few conditions under which they may circumvent a foreign-residence requirement that requires J-1 visa holders to leave the U.S. for two years and reapply to come back (*PBN 7/10/23*).

Physicians also may work in the U.S. under the H-1B visa, which has preferable terms, but this became a less attractive option after President Trump raised the fee that sponsors would pay for such visas to $100,000 in a 2025 executive order (*PBN 3/30/26*).

Richard T. Herman, an immigration lawyer and founder and president of the Herman Legal Group in Cleveland, notes that courts, most recently the Court of Appeals for the First Circuit, have blocked the order and the fee pending further litigation. However, "H-1B sponsorship is not a simple substitute," Herman adds, as it has conditions such as prevailing-wage obligations and government filing fees that employers must meet.

Also, Herman says, J-1 physicians who are subject to the two-year foreign-residence requirement "cannot simply change to H-1B status without first satisfying that requirement or obtaining a waiver."

DHS says in the rule, finalized on July 17, that while a J-1 or other J visa "generally corresponds with the principal's period of admission" — what's known as duration of status, or D/S — "so long as the dependents are also complying with the requirements of their particular classifications," the Department is switching to an arrangement with "a specific date upon which an authorized stay ends."

For most J-1 physicians that would be a maximum of four years from entry. The rule's effective date is Sept. 15, 2026.

DHS says they expect visa-holders "will be able to complete their respective activities within their period of admission. However, those who are unable will generally be able to request an extension of their period of admission from an immigration officer."

Commenters to the proposed version of the rule referred to the "shortage of healthcare workers in the United States in various fields and raised concerns on the potential impacts of the rule to the U.S. healthcare system, including decreasing participation of physicians in the J-1 program."

To these comments, DHS responds that "the rule allows J-1 nonimmigrants who have timely filed for EOS [extension of stay] ... to continue employment and training activities, consistent with the exchange program, for up to 240 days beyond the expiration of their authorized period of admission," according to the final rule.

To other commenters who said the physician J-1 program has multiple checkpoints and "J-1 physicians are among the most vetted visa holders," DHS responded that it "disagrees that the current system provides sufficient oversight over the J-1 physicians and that recognizing the work of J-1 sponsors would be an effective mechanism to prevent fraud and abuse of the nation's immigration system."

Can your doctor stay?

The American Association of Medical Colleges (AAMC) notes in response to the rule that "approximately 16,000 residents and fellows — or 1 in 10 residents nationwide — utilize J visas to undergo training at U.S.-based academic health systems every year." AAMC adds: "At a time when the nation is facing a shortage of physicians and growing international competition for its top scientific minds, it is inadvisable to actively reduce our capacity to effectively train the health care workers and biomedical researchers that Americans rely on."

Hitz notes that J-1 physicians "will be able to request an extension of their period of admission by filing an extension application with USCIS [U.S. Customs and Immigration Service]," and hopes that USCIS "would understand that, for example, a cardiologist needs at least three years of internal medicine plus three years of cardiology training to be qualified for the job; therefore, they would understand the need for the extension and would grant it."

But Sheryl Thomas, a labor and employment counsel with the Snell & Wilmer firm in Phoenix, says that beyond the four-year problem "the transition rules are more complex than most media coverage suggests. Physicians already in the U.S. under duration of status will keep the 'D/S' notation on their I-94 [immigration form] after September 15, but that doesn't mean their situation is unchanged. The key date is the DS-2019 [J-1] program end date. Once that date passes, if training isn't complete, the physician must file for an extension with USCIS, regardless of what their I-94 says. Hospitals can't rely solely on the D/S notation; they need to track each physician's DS-2019 end date directly."

Also, Thomas notes, if a J-1 physicians travels internationally after September 15 — to visit family, for example — they'll get a new I-94 "with a fixed expiration date, even if their DS-2019 remains valid. This means hospitals must now monitor both the DS-2019 end date and the I-94 expiration date."

Will they still come?

It remains to be seen how USCIS will treat reasonable extension requests for J-1 physicians going forward.

Thomas says that she "expect[s] most well-documented cases to be approved ... the greater concern is timing. While USCIS aims to process J-1 extensions in about three months, actual processing times can be much longer due to significant backlogs."

Hitz notes that that Educational Commission for Foreign Medical Graduates (ECFMG), which runs Intealth, the organization that helps certify foreign-educated physicians and coordinate their credentialing in the U.S., has already started up training programs about the changes, and the larger medical organizations "have in-house international offices that specialize in immigration issues and will work to ensure J-1 visa holders can obtain the training and conduct the research that is needed."

Thomas advises that medical organizations with J-1 physicians start a "thorough inventory" now, making sure to:

- Track the DS-2019 end date for every J-1 physician, not just the I-94 notation, as the DS-2019 date triggers the extension requirement.
- Identify physicians transitioning between programs or whose training will extend beyond their current DS-2019 end date, regardless of their I-94 status.
- Flag anyone with upcoming international travel, as reentry after September 15 will result in a fixed I-94 expiration date.
- File extension requests as early as possible and incorporate this lead time into annual contracting and credentialing processes.
- Remember to include J-2 visa dependents of J-1 holders in extension filings, as their status is tied to the principal physician.

Thomas adds that further guidance from USCIS, ICE and DHS is expected before the September 15 effective date, so "keep your compliance procedures flexible to adapt as new information becomes available." — *Roy Edroso* (*roy.edroso@decisionhealth.com*)

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- American Association of Medical Colleges (AAMC), "AAMC Statement on Duration of Status Final Rule," July 17, 2026: *www.aamc.org/news/press-releases/aamc-statement-duration-status-final-rule*

Physician fee schedule

More PFS: FQHC, RHC updates plus drug inflation changes

Note several additional policy updates contained in the proposed 2027 Medicare physician fee schedule, including market basket rate updates for federally qualified health centers and more.

Federally qualified health centers (FQHC) and rural health centers (RHC). At FQHCs, care is reimbursed according to an FQHC prospective payment system (PPS) while RHCs are reimbursed according to an all-inclusive rate (AIR) with an upper statutory limit, with some variances for certain codes and services, such as chronic care management, which are based on PFS national non-facility payment rates.

Responding to commenter concerns that rural beneficiaries were missing out on care because RHCs are not currently paid for diabetes self-management training (DSMT) and medical nutrition therapy (MNT) as standalone services under AIR, CMS proposes to change that when the services are provided by a certified provider under the direct supervision of RHC professional staff.

Since the COVID pandemic, CMS has delayed proposed in-person initial visit requirements for mental health telehealth visits via FQHCs and RHCs. This was set to change in 2027, but, CMS acknowledges, Congress delayed this in the 2026 Consolidated Appropriations Act until the end of 2027.

CMS proposes to adjust the FQHC market basket by 2.5% for a FQHC PPS base rate amount of $212.91.

Medicare Prescription Drug Inflation Rebate Program. The Inflation Reduction Act of 2022 includes a Medicare Prescription Drug Negotiation Program, by which the federal government negotiates with pharmaceutical companies the prices to be paid by Medicare for selected drugs chosen each quarter, lowering their costs to Part D and, later, Part B beneficiaries via rebates (*PBN 8/29/22*).

In the proposed rule, CMS floats technical changes, such as clarification of "the definition of 'first marketed date,'" specific skin substitutes to be excluded from the list of Part B rebatable drugs, and changes in the methods used to isolate 340B-eligible drugs from other Part D drugs in rebate calculations. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

Ask Part B News

Monitor modifier 25 red flags: Watch frequency, replication

Question: *What are some red flags associated with modifier **25** (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) that might trigger payer audits?*

Answer: Payer plans have red flags included in their claims processing system, things that are going to make them say, "We might need to take a look at this. This might deserve some additional scrutiny." You'll notice patterns that are going to trigger audits.

One example is a high frequency of modifier 25 usage (i.e., using it all the time). If every time the provider bills, he or she always or consistently bills with modifier 25, that could be a red flag. Or when the same diagnosis is always being used for both services. There's nothing wrong with this, but that's going to trigger a red flag and possibly an audit.

Also, if payers pull any type of documentation and they notice a pattern — if they start pulling one or two and see that there's cloned, repetitive documentation — that's another thing that's going to be a red flag. Keep in mind that payers are not just reviewing documentation, they are analyzing trends across your entire practice. They're looking for overuse of copied forward documentation. Or they're looking for when the patient comes back and there's very minimum change since the last encounter, or between encounters before that.

Another red flag is when the medical decision-making language is exactly the same for every patient. Everything should be personalized to the patient.

These are all things that as soon as payers pull it — whether they get the red flags from the frequency through the automatic claims processing system or they're actually pulling documentation — that'll put you under additional scrutiny. — *HCPro staff* (*pbnfeedback@decisionhealth.com*) ■

Editor's note: *This information was provided by Corella Lumpkins, CPC, during the DecisionHealth webinar, "Master Modifier 25: Learn Documentation Strategies for Accurate Reimbursement and Reduced Denials."*