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Part B News
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In this issue

Compliance

CMS' vaccine rules lay out staff deadlines, how to handle hold-outs

Heed fresh guidance that CMS issued on its vaccine mandate, which the Supreme Court cleared in January. The new regulations clarify the rules for facilities and the providers, including those primarily toiling in practices, who work at them.

The Jan. 13 SCOTUS ruling on *Biden et alia v. Missouri* and *Becerra et alia v. Louisiana*, a tandem ruling that struck down a separate vaccine mandate for all employers with 100 or more workers, cleared CMS to enforce its mandate in all states but Texas, which was brought into the fold by a separate federal court ruling (*PBN blog 1/14/22*).

The mandate, laid out in an interim final rule (IFR) published on Nov. 5, 2021, requires two shots of Pfizer or Moderna vaccine, or one shot of the Johnson & Johnson vaccine, for staff of the 13 covered facility types. (Note: Boosters are not currently required.) While physician practices are not among the required facilities, the mandate covers employees who regularly interact with patients at them, such as physicians who round at hospitals, as well as facility employees who regularly interact with providers who see patients on a routine basis.

Watch state timelines

In one guidance document, posted initially Nov. 5, 2021, and updated Jan. 20, 2022, CMS stipulated deadlines for staff vaccinations. For those in states that had been in compliance with the mandate all along, the first dose was required on Jan. 27, 2022, and the second on Feb. 28, 2022.

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For all the states that had resisted the mandate except Texas, the deadlines are Feb. 14, 2022, and March 15, 2022. These states are Arizona, Alabama, Alaska, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri. Montana, New Hampshire, Nebraska, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Utah, West Virginia and Wyoming. Texas' deadlines are Feb. 22 and March 21, respectively.

But in other guidance memos, issued by CMS's Center for Clinical Standards and Quality, the agency further clarified that "facility staff vaccination rates under 100% constitute noncompliance under the rule," and that facilities would be subject to CMS surveys and survey timelines. These memos have guidance dates starting Dec. 28 for compliant states; Jan. 14 for states that had resisted the mandate; and Jan. 20 for Texas. (*See resources, below, for an example.*)

Upon 30 days after each guidance date, surveyors will expect all non-exempt staff to have one shot. Also at that time, "federal, state, accreditation organization and CMS-contracted surveyors will begin surveying for compliance with these requirements as part of initial certification, standard recertification or reaccreditation and complaint surveys," CMS states. By 60 days out, CMS and its surveyors will expect all non-exempt staff to have both shots.

Take note that CMS specifically excludes staff that have legitimate exemptions, such as religious or medical reasons arranged with their employers. Also, CMS requires that facilities maintain vaccination records for all covered staff and exemption records for exempt staff, though currently it is not clear how such records should be formatted: "Facilities have the flexibility to use the tracking tools of their choice," CMS states. "However, they must provide evidence of this tracking for surveyor review." CMS provides separate but similar guidance documents for each facility type (*see resources, below*).

How to handle a missed deadline

What happens if a covered staff member misses a vaccination deadline? If it's not an outright refusal, you should make a good-faith effort to accommodate the tardy employee, advises Robert L. Kilroy, partner with Mirick O'Connell in Westborough, Mass.

For example, suppose "someone is supposed to have been vaccinated by the 27th," Kilroy says, "and they tell their employer they're scheduled for a vaccination appointment on the 29th. I'm probably going to allow the individual to continue working, but masked up and social distanced. Or I would put them on administrative leave [until they vaccinate] with or without pay — that's an employer decision."

Remember, the idea is to protect patients and other employees. Delia Santana, PhD, RN, assistant provost for clinical affairs at Drew University in Madison, N.J., says this should guide the disposition of not-yet-compliant workers:

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***PART B NEWS* TEAM**

Maria Tsigas, x6023
Product Director
mtsigas@decisionhealth.com

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

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

Roy Edroso, x6031
Editor
redroso@decisionhealth.com

Julia Kyles, CPC, x6015
Editor
jkyles@decisionhealth.com

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"If a worker misses a vaccination deadline due to reasons within their control, then they are subject to the employer stated policy for unvaccinated employees," she says.

How to approach vaccine hold-outs

Refusers may claim a bona fide exemption under civil rights laws for religious or medical reasons. Erin J. McLaughlin, shareholder in the labor and employment group at Buchanan Ingersoll & Rooney PC in Pittsburgh, reminds you that in these cases employers must engage in what's known as an interactive process to determine whether the accommodation required to keep the employee presents an undue hardship to the organization (*PBN 2/22/21*).

"If an employee has an exemption request pending, my recommendation has been to provisionally grant the request and, if the employer has been granting accommodations, accommodate the employee consistent with other employees who have been granted an exemption," McLaughlin says.

Frank C. Morris Jr., a member of the Epstein Becker Green law firm in Washington, D.C., and co-chair of its Americans with Disabilities Act and public accommodations group, says while pondering this decision the facility "should consider a furlough or leave if a deadline is reached but the accommodation request has not yet been decided. Employers should consider making any leave during the consideration of an accommodation request paid, at least if the employee timely submitted the accommodation request."

But keep in mind, "if an individual is seeking an exemption, religious or medical, the employer is the one who makes that decision as to whether they'll accept it," Kilroy says. "If the employer says, 'no, we don't believe you're entitled to the exemption,' the individual may file with the EEOC [the U.S. Equal Employment Opportunity Council] based on discrimination."

If the employee hasn't come into compliance or been approved by the employer for a religious or medical exemption, "then I would go ahead and have them terminated," Kilroy says. This applies whether or not the employee is going to the EEOC. "They'll just have to deal with the litigation and present their evidence of undue hardship," Kilroy says. Such cases can go on for years, he adds, but you stand a good chance of prevailing: "For health care entities, the undue hardship defense based on the health risks posed to a vulnerable patient population is a powerful defense."

Whatever you do, be even-handed, Kilroy says: "The employer should just make sure that they handle all these cases the same — you don't want to allow some to continue to work while others aren't allowed."

Mind non-health laborers too

As CMS describes the "staff" covered by the mandate, it includes "individuals who provide care, treatment or other services for the [facility] and/or its patients, under contract or by other arrangement." Experts say this covers non-clinical workers who provide service on a continuing basis to the facility or its patients, ranging from cafeteria staff to construction workers on a long-term job — though those who are only in "ad hoc" for a brief spell, such as a repairman in for the day, may be considered exempt (*PBN 11/22/21*).

Christopher S. Dunn, a member of the Epstein Becker Green law firm in Nashville, says the layout of the workspace may affect the compliance need. If the construction is "a new wing separate from active care or treatment areas, then the IFR might not apply," Dunn says, "That argument would likely be strengthened if the facility creates a separate entrance reserved for construction employees only and the construction employees are barred from the cafeteria, restrooms and other parts of the existing facility."

But if the workers are in the way of patient or provider traffic, you'll have to card them. "You're going to need to ensure that they're vaccinated or not allow them onsite because the risk is too great to the organization," Kilroy says. He also points out that the record-keeping requirements of the mandate apply to outside vendors as well as in-house staff.

"The vendor would need vaccination records, either by vaccination card or from their provider or state immunization board," he says. "Unless it's totally ad hoc or completely remote, you need those records in real time, and the contracting office would need to provide them before allowing contractors to come onsite." — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCES

- "External FAQ: CMS Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule," CMS, updated Jan. 20, 2022: www.cms.gov/files/document/cms-omnibus-covid-19-health-care-staff-vaccination-requirements-2021.pdf

- "Guidance for the Interim Final Rule - Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," CMS, Jan. 20 (with links to facility guidance): *www.cms.gov/medicare-provider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/guidance-interim-final-rule-medicare-and-medicaid-programs-omnibus-covid-19-health-care-staff-2*

- "Guidance for the Interim Final Rule - Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," CMS Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, Jan. 20, 2022 (for Texas): www.cms.gov/files/*document/qso-22-11-all-injunction-lifted.pdf*

Billing

Discover 3 benefits in new critical care rules; provider training is a must

The new split/shared option for critical care services is a major change to Medicare's policy (*PBN 11/15/21*). But the ability to combine physician and non-physician practitioner (NPP) work is just one of the high-impact changes — with the potential to confer benefits on your practice — covered in CMS 100-04, Change Request 11181, which the agency published Jan. 14.

The updated policy could improve your practice's reimbursement for critical care services (**99291**-**99292**) by flattening common hurdles to payment in three different ways:

1. **Reaching the critical care threshold.** "For the first time, physicians and qualified non-physician practitioners will be able to aggregate the time spent in critical care and bill as a shared or split service," says Jean Acevedo, LHRM, CPC, CHC, CENTC, AAPC Fellow, president and senior consultant, Acevedo Consulting, Delray Beach, Fla. (*PBN 11/22/21*)

CMS also overturned its longstanding policy that required one physician or one NPP to meet the requirements for primary code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes), Acevedo says. The guidelines that CMS withdrew May 3, 2021, stated that the initial visit had to be "met by a single physician or qualified NPP. This may be performed in a single period of time or be cumulative by the same physician on the same calendar date."

"From a general perspective, it may be easier to reach the time threshold of 99291 now that physicians and [NPPs] in the same group practice can aggregate their critical care time," Acevedo says.

2. **Billing during the global surgical period.** Medicare streamlined its policy for billing critical care services during the global surgical period of another procedure. "Surgeons are now able to bill for the critical care they provide when their patient winds up in the unit for an unrelated condition," Acevedo says.

In addition, practices no longer have to juggle the modifiers for unrelated E/M services during the post-operative period (**24**) and significantly, separately identifiable E/M services (**25**) for unrelated critical care services performed during a procedure's global surgical period. Instead, you should now report the new modifier **FT** (Unrelated evaluation and management [E/M] visit during a postoperative period, or on the same day as a procedure or another E/M visit. [Report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated.]).

3. **Reporting critical care after another E/M service on the same date**. A third update states that "when an evaluation and management service is provided earlier in the day of critical care also being provided, the visit may be reported with modifier 25," Acevedo says. The original policy allowed providers to bill an unrelated critical care following an E/M service in some instances but stopped short of concrete billing guidance beyond advising practices to submit documentation to support the secondary claims. In addition, the original policy barred practices from billing critical care following an unrelated emergency department visit on the same day. The new rule does not include that restriction.

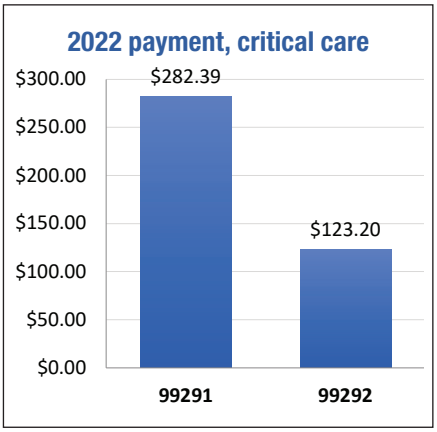
Mind compliance risks

However, all new policies increase compliance risks for practices, Acevedo warns. For example, Acevedo says the new split/shared visit option for critical care is a good thing but it requires that the practice bill under the name of the provider who performs the substantive portion of the visit.

(*continued on p. 6*)

Benchmark of the week

Critical care payments, bucking E/M trends, jumped 11% in 2020



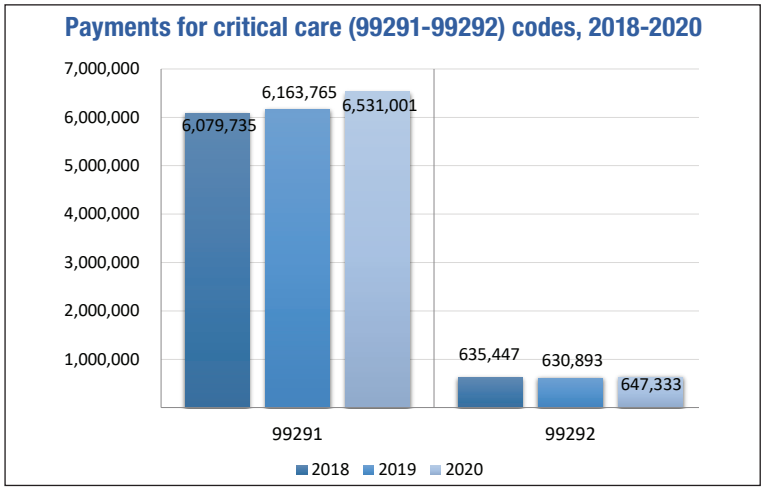
The toll of the COVID pandemic caused reduced services across many types of patient encounters in 2020, but critical care services didn't suffer. They expanded. Perhaps due to the health impact of the COVID scourge, practices increased revenue for critical care encounters (**99291-99292**) by more than 10% in 2020 compared to the year before.

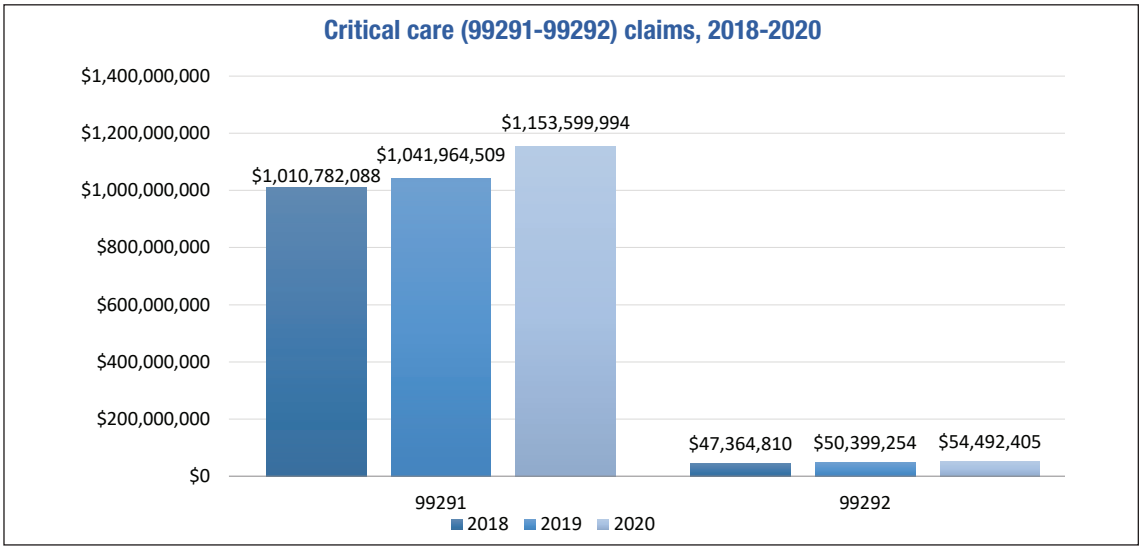
The 6.5 million claims for 99291 and the nearly 650,000 claims for add-on code 99292 returned more than $1.2 billion in payments to physician practices in 2020, according to the latest available Medicare claims data. That marks an increase of 11% in payments over 2019, when practices gained just shy of $1.1 billion for the two codes.

As providers reported additional critical care services, their claims increasingly went through unscathed. Total 2020 payments were aided by a three-year low in denial rates, which dropped to 4.7% for 99291 and 10.4% for 99292. In 2018, denial rates stood at 5.5% for 99291 and 15.1% for 99292.

Like many other services, critical care encounters are prone to reduced fees in 2022, as the Medicare Part B physician fee schedule took a cut to its conversion factor. Yet the codes still provide a significant return — $282.39 for 99291 and $123.20 for 99292 — under the 2022 non-facility fee calendar.

While the codes continued an upward climb in 2020, the specialty mix didn't diverge much from previous years. The same five specialties that reported the most critical care services in 2019 — emergency medicine, pulmonary disease, internal medicine, critical care and nurse practitioner — also topped the leaderboard in 2020, and total claims jumped for all of them. In 2020, emergency medicine led the way with 1.7 million claims for 99291, followed by 1.5 million claims for pulmonary disease. — *Richard Scott* (*rscott@decisionhealth.com*)





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

(*continued from p. 4*)

"Being able to correctly document the amount of time each provider spent, reporting that to billing and assigning the claim to the provider with the documented substantive portion of the service is going to raise the compliance risk factor," Acevedo says. "I expect confusion and mistakes while everyone is trying to find a way to do it right."

While it may be the norm to train coding staff on new policies first, practices should start by training physicians and NPPs on this policy because compliance depends on their understanding of the rules, Acevedo says.

Coding staff won't be able to tell who performed the substantive portion of a split/shared visit if providers don't document their work. And providers won't be able to accurately document their work if they don't know which activities count toward their time for a split/shared critical care visit.

"This is one of those areas where each practice providing critical care services should make a special effort to educate the providers," Acevedo says. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

RESOURCES

- CMS 100-04, Change Request 12275: *www.cms.gov/files/document/r10742cp.pdf*
- CMS 100-04, Change Request 11181: *www.cms.gov/files/document/r11181cp.pdf*
- CMS IOM 100-04, Chapter 12 (recovered from the HHS Good Guidance portal 1/10/2022): *https://bit.ly/3oo2RVp*

Compliance

Take care when you share clinical notes with patients, implement 5 tips

Under recent rule changes, your practice's physicians, qualified health care professionals and clinical staff should be prepared to share clinical notes with patients. The interoperability rule banning information blocking that took effect in 2021 may mean that more patients will be asking for their electronic health information (EHI) (*PBN 5/3/21*).

Here are five tips to share with everyone who is involved in documenting patient care.

1. **Review your documentation methods**. Tell treating practitioners to check whether their note taking needs general improvement, such as avoiding inappropriate copy-and-pasting. A patient will notice right away if several years of notes all mention a condition that was resolved after a month.
2. **Be mindful of what you put into the note.** Assure clinicians that they can continue to use medical terminology and abbreviations but they may need more description or clarification so that they aren't misinterpreted. "If a clinician expects the note to be confusing, the onus is on the clinician to … explain it," says attorney Jefferey Short with Hall Render in Indianapolis. Administrative staff can help by creating a list of common abbreviations that they send to patients along with the requested notes.
3. **Give thought to what should not be included in the note**. If it's relevant to patient care, it should be included, even if it might embarrass the patient or make her feel uncomfortable, says attorney Melissa Soliz with Coppersmith Brockelman PLC in Phoenix. But if it's not part of patient care, such as a referral to child protective services, you may want to set up separate record keeping, Soliz says. Likewise, psychotherapy notes, which are a clinician's personal notes, need to be separated out if you don't want them accessible to patients.
4. **Watch your language**. For example, if a patient reports that he has not been taking his prescribed medications as directed, note the statement in the patient's chart. Do not say that the patient is "untrustworthy" or "not dependable."
5. **When you think it would be inappropriate to share a note, see if an exception applies**. There are eight exceptions to the information blocking rule, which allow a provider to deny a request for access to EHI. For instance, state medical record laws typically require that the names of clinicians treating the patient be included in the clinical note. However, the federal interoperability rule may preempt state law. If, for example, a provider is treating a patient who has been violent against nurses in the past, the provider may have a reasonable belief that sharing the names of the nurses who were involved in treating the patient may put them in danger should the patient request his EHI. That may fall within the rule's "preventing harm" exception and those names may not necessarily be shared, Soliz says.

Warn administrative staff about fees

Pursuant to the new rule, if EHI is delivered to the patient or her personal representative in a purely electronic manner with no manual labor involved, the patient is entitled to the EHI without having to pay any fees. This includes clinical notes.

"Make sure you're not charging for patient information when it's in a purely electronic manner," notes Daniel Gottlieb, attorney with McDermott Will & Emery in Chicago. — *Marla Durben Hirsch* (*mdurbendirsch@decisionhealth.com*) ■

RESOURCE

- ONC Cures Act interoperability rule: www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-07419.pdf

Ask Part B News

Prescribing ivermectin for COVID isn't illegal but could raise compliance flags

Question: *We have a doctor who is prescribing ivermectin to his COVID patients. He isn't taking insurance reimbursement and characterizes this as an off-label use of the drug. Is he going to get in trouble?*

Answer: He could, but not for off-label prescriptions as such. "It's not that prescribing off-label is illegal — it's not," says Taylor Asen, partner with Gideon Asen in Portland, Maine, and a seasoned malpractice attorney. "Doctors can use their discretion. But if they violate the standard of care, they can be sued."

Ivermectin, per the National Institutes of Health, is an "antiparasitic drug that is used to treat several neglected tropical diseases." It is not approved as a COVID treatment by most medical authorities; the FDA, for instance, has explicitly warned against its use to treat COVID.

Nonetheless, studies of its effectiveness as a COVID treatment are ongoing, and it has been promoted by some physicians, celebrities and politicians. Republicans in the Kansas state legislature introduced a bill on Jan. 24 that would render physicians and pharmacists "immune from civil liability for damages, administrative fines or penalties for acts, omissions, health care decisions or the rendering of or the failure to render health care services," as well as from charges of "unprofessional conduct," for prescribing ivermectin for COVID (*see resources, below*).

"Generally speaking, if the legislature wants to pass a bill saying, 'you can't sue a doctor for prescribing ivermectin,' they can do that," Asen says. "They could pass a law saying doctors have to treat people with ivermectin. They can do anything they want unless it violates the Constitution; that's how our system works."

But in the absence of such a law, "malpractice rules in every state say you can sue a doctor if he violates the standard of care, and the standard of care is set by doctors," Asen says. "All of the major medical societies have made clear that, at this point, ivermectin is not an appropriate treatment for COVID-19, and doctors have to follow that standard of care in their field."

This doesn't make ivermectin-for-COVID against the law, but it does make your doctor vulnerable to a lawsuit if the patient later decides their treatment was inappropriate. It doesn't matter whether the patient asked for the treatment, either: "In most states, a patient can't consent to negligence," Asen says. "In other words, if you go to your doctor and say, 'I want ivermectin for my COVID,' that's no shield [against legal action]." Asen compares it to a patient asking the doctor for oxycontin.

Another potential risk for the provider: A complaint to the local medical board. Any formal complaint could potentially lead to disciplinary action up to and including removal of the provider's license (*PBN 10/4/21*). "The medical board in the state could still discipline physicians for prescribing the drug, even if doctors couldn't be sued for prescribing it," Asen says.

Note: Even if Kansas passes the hold-harmless law, it wouldn't necessarily immunize physicians from legal action "for failing to provide other treatments that are required under the standard of care," Asen says. "So, depending on how the bill is worded, if a doctor prescribes ivermectin but not the drugs that she should have prescribed, a lawsuit might be viable." — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCES

- "Why You Should Not Use Ivermectin to Treat or Prevent COVID-19," U.S. Food and Drug Administration, Dec. 10, 2021: www.fda.gov/consumers/consumer-updates/why-you-should-not-use-ivermectin-treat-or-prevent-covid-19
- Kansas Senate Bill #381: "AN ACT concerning health and healthcare; related to prescription medications; authorizing the prescribing and dispensing of drugs for off-label use to prevent and treat COVID-19 infections." http://www.kslegislature.org/li/b2021_22/measures/documents/sb381_00_0000.pdf]

Ask Part B News

Know the rules for CPT coding for cognitive assessment services

Question: *I have seen a lot of updates from Medicare about CPT code **99483** (Assessment of and care planning for a patient with cognitive impairment). We have never billed the service before. What are the reporting requirements for cognitive assessment and care planning services?*

Answer: CPT code 99483 describes assessment of and care planning for patients with cognitive impairment like dementia, requiring an independent historian. These services may be provided in an office or other outpatient facility, home, domiciliary or rest home and require the following elements:

1. Cognition-focused evaluation including a pertinent history and examination.
2. Medical decision-making of moderate or high complexity.
3. Functional assessment, including decision-making capacity.
4. Use of standardized instruments for staging of dementia.
5. Medication reconciliation and review for high-risk medications.
6. Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s).
7. Evaluation of safety (e.g., home), including motor vehicle operation.
8. Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks.
9. Development, updating or revision, or review of an advance care plan.
10. Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations and referral to community resources as needed, shared with the patient and/or caregiver with initial education and support.

Note that code 99483 cannot be used by psychologists, even though these professionals provide several of the services included in the code. Because 99483 is an E/M code, it may only be reported by physicians and physician extenders, such as nurse practitioners.

In addition, per CPT guidance, 99483 cannot be billed with any of the following services on the same date:

- Advance care planning — codes **99497-99498**.
- Brief emotional/behavioral assessment — code **96127**.
- Chronic care management — codes **99487** and **99489-99490**.
- Domiciliary, rest home, or custodial care services — codes **99324-99328** and **99334-99337**.
- Home services — codes **99341-99345** or **99347-99350**.
- Interactive complex psychotherapy — code **90785**.
- Medical team conferences — codes **99366-99368**.
- Office and outpatient E/M visits — codes **99201-99205**, **99211-99215**, and **99241-99245**. — *Sarah Gould* (sgould@hcpro.com) ■

Editor's note: Laurie Bouzarelos, MHA, CPC, consultant and founder of Provider Solutions Health Care Consulting in Centennial, Colo., answered this question during the HCPro webinar, **Break Down Outpatient Coding for Behavioral Health and Psychiatry**. Learn more: www.codingbooks.com/organization/physician-practices/yhha102721.

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