Keeping up with COVID-19
Webinar Series
Keeping up with COVID-19

Revenue Opportunities Using Telemedicine During and After the Public Health Emergency

Reimbursement opportunities for improving quality of care
Virginia Gleason  
CPHRM, CCM, CDIP  
Senior Manager, Advisory Services

- Diverse background in acute care hospital operations and regulatory compliance
- 25+ years of experience in academic, acute care, county, critical access and children’s hospital settings
- Specializes in Case Management, Utilization Review, Compliance and CDI program design, implementation, regulatory guidance and education
- Proven ability to reinvigorate hospital operations
Telehealth
- Before the Waivers
- During the Public Health Emergency

Types of Telehealth Visits
- Documentation for Telehealth
- Coding and Billing for Telehealth Reimbursement

Other Virtual Patient Monitoring
- Remote Patient Monitoring
- Chronic Care Management

Future of Telemedicine Post COVID-19
COVID-19 Coronavirus Protocols and Tools

nThrive protocols

nThrive quick reference

nThrive COVID-19 Coronavirus Portal
nthrive.com/covid19
Medicare Telehealth Services

Before the Public Health Emergency Waiver(s)*

- **Geographic**
  Patients had to reside in a rural area

- **Location**
  Required patients to be physically present at a health care facility when services were provided (think facility fee)

- **Service**
  Limited to CMS list of approved telehealth services

- **Technology**
  Required telecommunications technology with audio and video capabilities that permit real-time interactive communication

*Some exceptions existed: Telestroke, substance use disorder, ESRD, Medicare Advantage Plans, Medicare Shared Savings Program, CMMI Initiatives*
Public Health Emergency Waivers

**JAN 31**
President declared a public health emergency under the Public Health Service Act.

**MAR 6**
President signed Telehealth Services During Certain Emergency Periods Act of 2020 (TSDCEPA).

**MAR 17**
Centers for Medicare and Medicaid Services (CMS) expanded Telehealth Waivers.

**MAR 27**
Coronavirus Aid, Relief and Economic Security Act (CARES Act) signed into law.

**MAR 31**
Secretary of HHS issued Interim Final Rule with Comment Period.

This is part of the larger Coronavirus Preparedness and Response Supplemental Appropriations action.

<table>
<thead>
<tr>
<th><strong>Medicare Telehealth Visits</strong></th>
<th>A visit with a provider that uses telecommunication systems between the provider and patient.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Virtual Check-in</strong></td>
<td>A brief (5-10 minutes) check in with your provider via telephone or other approved telecommunications device to decide whether an office visit or service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.</td>
</tr>
<tr>
<td><strong>E-visits</strong></td>
<td>A communication between a patient and their provider through an online patient portal.</td>
</tr>
</tbody>
</table>
Types of Telehealth Visits Included

- Physician visits
- Emergency visits
- Nursing facility initial admit and discharge
- Hospice visits
- Therapy services (PT/OT/ST)
Who can provide Telehealth

- Physicians
- Advanced Practice Providers
- Clinical psychologists
- Clinical social workers
- Registered dietitians
- Nutrition professionals
Virtual Check-ins
HCPCS G2012 or G2010

- Not limited to rural settings
- Consent required
- During the Public Health Emergency (1135 Waiver)
  - Available to both new and existing patients
E-Visits
99421-99423 and G2061-G2063

- Not limited to rural settings
- No geographic or location restrictions
- Generally initiated by the patient
- Consent required
- During the Public Health Emergency (1135 Waiver)
  - Available to both new and existing patients
Other Virtual Services

- Remote Patient Monitoring
- Ambulatory Care Management
Remote Patient Monitoring vs Chronic Care Management

- In place before COVID-19 and remain after
- Improve patient outcomes
- Support patient-centered, preventative care models
- Reimbursement separately from the Physician visit E/M
Evolution of Remote Patient Monitoring

**JAN 2018**
Initially went “live” with CPT 99091

**JAN 2019**
New codes recognized

**MAR 2019**
Technical correction issued
March 14 – effective immediately

**JAN 2020**
Final Rule
Effective January 1
Allowing General Supervision
Remote Patient Monitoring and COVID-19

Remote Patient Monitoring “Waivers”
• RPM available to new and established patients
• Can be provided for acute and chronic conditions
• Allowed for patients with only one disease and that disease can be acute
• Example: RPM can be used to monitor a patient’s oxygen saturation levels using pulse oximetry

Benefits of Remote Patient Monitoring during the Pandemic
• Ability to monitor pulmonary functions, temperature, blood pressure and symptom progression using digitally connected devices
• Communication of treatment modifications and other self-care while adhering to social distancing recommendations
• Treatment and monitoring at home to free up hospital resources
• If symptoms progress and hospitalization is necessary care can be arranged

Remote Patient Monitoring is NOT “telehealth” or “telemedicine”
• Originating site requirements do not apply
# Remote Patient Monitoring Codes

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Set-up</td>
<td>99453</td>
</tr>
<tr>
<td>Device and Supplies</td>
<td>99454</td>
</tr>
<tr>
<td>Monitoring and Treatment 20 min monthly</td>
<td>99457</td>
</tr>
<tr>
<td>Monitoring and Treatment additional 20 min</td>
<td>99458</td>
</tr>
</tbody>
</table>
Medicare Care Management Services

- Transitional Care Management
- Chronic Care Management
- Principal Care Management
Timeline for Medicare Care Management

**JAN 2015**
- CMS implemented Medicare reimbursement for Chronic Care Management

**JAN 2017**
- Separate reimbursement for care plan development
- Introduction of Complex Chronic Care Management

**JAN 2020**
- Introduction of Principle Care Management
- Transitional Care Management can be billed in the same month as Chronic Care Management
Chronic Care Management
CPT 99490 or 99491

Patients with two or more chronic conditions expected to last at least 12 months
Chronic Care Management
KEY COMPONENTS

- **Initial Face-to-Face visit**
  (can be via telemedicine during the PHE)

- **Obtain verbal or written consent**
  for Chronic Care Management

- **Develop an Electronic Comprehensive Care Plan**
  - Person-centered based upon physical, mental, cognitive, psychosocial, functional and environmental assessment
  - Comprehensive with particular focus on chronic conditions being managed
  - Provided to the patient and / or caregiver
  - Available and shared timely with all individuals involved in the patient’s care

- **At least 20 minutes per month**
  and include
  - Interactions with patients/caregivers to review medical record, test results and provide self-management education
  - Ensure patient is receiving preventative services
  - Communication with patient’s other health care providers
  - Exchange health information and manage care transitions with home and community-based services
  - Access to physician or other qualified health care professionals or clinical staff 24/7 to address urgent needs
Transitional Care Management
CPT 99495 and 99496

Monitoring “successful” transition from the hospital to community setting
Transitional Care Management

**KEY COMPONENTS**

- **Physician (or Advanced Practice Provider) Oversight and Management of Care**
  - 30-days Post Discharge
    - Home
    - LTC
    - Assisted Living

- **Communication within 2 business days of discharge**

- **Face-to-Face visit within 7 (high complexity) or 14 (moderate complexity) days**
  - Communication of agencies/services available to patients in the community
  - Education to support self-management
  - Assistance in accessing care/services patient may need in the community

- **Care Management Interaction with Patient and/or Caregiver(s)**
  - Obtaining and reviewing discharge information
  - Review need for follow-up tests or treatment
  - Interaction with other health care professionals involved in patient’s after care
  - Assistance in scheduling follow-up visits
Principal Care Management
G2064 or G2065

Management of a specific condition
(e.g. Pulmonologist managing respiratory status post COVID
or Endocrinology managing diabetes)

Not limited to patients with a single chronic condition
Principal Care Management

KEY COMPONENTS

✔️ Qualifying Condition
  • Expected to last 3 months to 1 year
  • May have resulted in recent hospitalization
  • Patient at risk of:
    Death
    Acute Exacerbation / Decompensation / Functional Decline

✔️ Develop an Electronic Comprehensive Care Plan
  • Particular focus on the condition being managed
  • Provided to the patient and/or caregiver
  • Shared timely with all individuals involved in the patient’s care (specifically the patient’s Primary Care)
Fee Schedule and Reimbursement Notes

Reimbursement in Addition to the Physician or APP’s E/M
Key Reimbursement
NOTES

Development of Care Plan (G0506)
• Add-on code to the CCM-initiating visit
• When the time and effort involved in care plan development is beyond the “usual time and effort involved in underlying E/M service”
• G0506 is not available to RHCs and FQHCs

Principal Care Management
• Billed simultaneously by multiple specialties (e.g. Cardiology for arrhythmia and Endocrinology for diabetes)
• Billed simultaneously with CCM and TCM
• Not available to FQHCs and RHCs in a month

RPM Code for Extra 20 Minutes
• Add-on code available for those patients that receive at least an additional 20 minutes of remote monitoring interaction in a month
# Revenue Potential

## Care Management for Primary Care

Assuming practice panel of 500 Medicare beneficiaries *

Applying 2018 national average payment rates

<table>
<thead>
<tr>
<th>Service</th>
<th>Low End</th>
<th>High End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Care Management</td>
<td>$46,852</td>
<td>$93,704</td>
</tr>
<tr>
<td>Complex CCM</td>
<td>$37,255</td>
<td>$65,094</td>
</tr>
<tr>
<td>Care Plan Development</td>
<td>$12,045</td>
<td>$21,024</td>
</tr>
<tr>
<td>Transitional Care Management</td>
<td>$54,049</td>
<td>$88,133</td>
</tr>
<tr>
<td>Total Annual Medicare Revenue*</td>
<td>$150,201</td>
<td>$267,955</td>
</tr>
</tbody>
</table>

*Reasonable practice panel for primary care is 1,200 to 1,900 (JABFM)

*Annual revenue potential per practice
## REVENUE POTENTIAL

Remote Patient Monitoring

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT</th>
<th>Reimbursement</th>
<th>Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Onboarding and Education</td>
<td>99453</td>
<td>$18.77</td>
<td>once per episode of care</td>
</tr>
<tr>
<td>Kit / Supplies with Daily Tracking Alerts</td>
<td>99454</td>
<td>$62.44</td>
<td>once per 30 days</td>
</tr>
<tr>
<td>First 20 Minutes of Monitoring</td>
<td>99457</td>
<td>$51.61</td>
<td>once per 30 days</td>
</tr>
<tr>
<td>Additional 20 Minutes of Monitoring</td>
<td>99458</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## REVENUE POTENTIAL
Remote Patient Monitoring

<table>
<thead>
<tr>
<th></th>
<th>LOW END</th>
<th>HIGH END</th>
</tr>
</thead>
<tbody>
<tr>
<td>18% participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Onboarding and Education</td>
<td>$20,496.84</td>
<td>$40,993.68</td>
</tr>
<tr>
<td>First 20 Minutes of Monitoring</td>
<td>$56,358.12</td>
<td>$112,716.24</td>
</tr>
<tr>
<td>Total Annual Medicare Revenue</td>
<td>$76,854.96</td>
<td>$153,709.89</td>
</tr>
</tbody>
</table>
VALUE

Remote Patient Monitoring & Outpatient Care Management

- Improved patient outcomes
- Reduced readmissions
- Improved patient satisfaction
- Increased reimbursement
Questions

Contact Virginia Gleason at nthriveevents@nthrive.com
From Patient to Payment,® nThrive empowers health care for every one in every community.®

nThrive.com
The CARES Act Impact on Healthcare Funding and Program
April 16 at 1 p.m. ET
Register Today!
https://www.cvent.com/d/fnqfhg

Presented
Matt Dardenne
Senior Corporate Counsel
nThrive