MCACC Practice Survival in the Midst of Covid
PRACTICE SURVIVAL IN THE MIDST OF COVID-19
6:00-7:15 PM
Wednesday, April 22, 2020
AGENDA

ACC & MedAxiom: Member Resources

Opportunities
Telehealth/Virtual Services
  o What is available for the office setting and how to use them -- telehealth codes, virtual codes, E-visit codes.
  o Do the waivers from CMS help?
  o Tips from the trenches.

CARES Act
  o Learn how clinicians may benefit from programs in both the stimulus and the healthcare components of this relief package.

Program Impact
  o Take-aways from the recent MedAxiom survey on program impacts of COVID pandemic.

Q&A/Open Forum
The premier source for CV organizational performance solutions

400+
CV ORGANIZATIONS

The bastion of science, education and quality for the individual practicing cardiologist

52,000+
CV PROFESSIONALS

ONE PROFESSIONAL HOME
for the entire cardiovascular team

SHARED MISSION
To transform cardiovascular care and improve heart health
WE ARE

PROVIDERS, THOUGHT LEADERS & INNOVATORS

MEMBERSHIP
Thousands of providers, administrators and clinicians sharing data, experience, technology, insights and innovation that move us all forward.

CONSULTING
Custom and proven solutions based on current trends, proprietary data and tools, and hundreds of years of combined, hands-on CV experience.

VENTURES
Accelerating the adoption of products and services that enable physicians to achieve the quadruple aim and working together to transform CV healthcare through creative and innovative solutions.
A COMMUNITY ROOTED IN BI-DIRECTIONAL ACCESS & BI-DIRECTIONAL EDUCATION

**400+ CARDIOVASCULAR ORGANIZATIONS**

PRIVATE • ACADEMIC • HOSPITAL-OWNED

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- **460+** Coding Managers
- **700+** Cardiovascular Coders
- **3,500+** C-Suite Leaders

**46 STATES**

**1,800+ LOCATIONS**

**30+ INDUSTRY PARTNERS**

- Devices
- EMR/IT
- Imaging
- Pharmaceuticals
- Revenue Cycles
- Service Providers
ACHIEVING THE QUADRUPLE AIM, TOGETHER

Better Outcomes

Lower Costs

Improved Patient Experience

Improved Clinician Experience
LET’S TALK
TELEHEALTH…
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DEFINITIONS

Telemedicine

Telehealth
(Real-time Audio & Video)
E&M service Codes

Virtual Check-Ins
(Telephone, Image, etc.)
CMS G2012

Audio Only – Telephone Visits
CPTs 99441-99443

E-Visit
(Portal, email, EMR, etc.)
CPTs 99421-99423

Remote Patient Monitoring
(RPM)
(Digital Technology to collect data and transmit securely)
G2010, 99453, 99457-58
Patients may receive Telehealth (audio and video) services anywhere – HHS technology flexibilities. (Facetime, Skype, etc.)

Expanded the list of services eligible to be reported

Will pay providers same as in-person visits for all diagnoses.

May report E&M’s based on MDM and time as proposed for 2021 to new and established patients.

Physicians licensed in one state can provide services to beneficiaries in another state. State licensure laws still apply.

May reduce or waive cost-sharing.

CMS Telehealth – Interim Final Rule

COVID-19 – PHE (effective 3/6/20)
Established Visit

99214

Performed by a Physician located at his normal service location (POS 11 – Office) - Patient located at home

Connected via Ipad/Iphone Facetime application

Documentation of telehealth provider, pt. location, consent, COVID-19 PHE visit.

Documentation supports moderate MDM = 2 or more stable chronic illnesses- prescription drug management

Claim filed with 99214 – Modifier 95 – POS 11 = Reimbursed at Non facility rate $110.
# Telehealth Visit Flow

**Triage and Appointment Request - 1 to 5 days prior to appointment:**
- Patients identified as part of triage process
- Communication to patient with shared decision making language – options and documented in call note – RN or MA
- Identify – Telephone/Audio
  - Telephone Only
  - Portal/Digital Only
- Appointment changed by scheduler to telehealth visit
  - (appropriate app't type)
- Insurance verification process – pt. financial responsibility
- Chart prep to assure all records available

**Day of Appointment Clinical:**
- Clerical team to check-in all virtual patients at the beginning of the day
- Clerical team to reconcile all appointments at end of the day and reassign missed appts as No-Show – to follow No-Show protocol
- MA to call patient in similar manner to typical flow for rooming
- MA to review consent – see slide for verbage
- MA to obtain medication list, allergies, review PMH, PSH, FH, SH and ROS
  - MA to obtain home VS – HR, BP if available
- MA to communicate to patient that provider will be contacting patient and assure audio/visual capabilities available – provide timeframe
- MA to follow-up for orders and send after visit summary either electronically (ideal) or via mail

**Day of Appointment Provider:**
- Open encounter in EMR and call patient via audio and video option
- Verify and document verbal patient consent
- Provide encounter as similar to face to face visit
- Document, place orders, assign billing code
- Sign Encounter

**Revenue Cycle:**
- Verify app't type – Telephone/Audio
  - Telephone Only
  - Portal/Digital Only
- Verify documentation components
- Assign correct codes, modifiers and place of service based on the payer
- File or Hold claim
## Learning from others

<table>
<thead>
<tr>
<th>For Provider</th>
<th>For Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make sure patient can hear and see you.</td>
<td>Provide practice session with patient.</td>
</tr>
<tr>
<td>Make sure face is well lit and camera is at eye level with your face and body centered – allow the patient to see your non-verbal cues.</td>
<td>Have patient record Wt, BP and HR if able.</td>
</tr>
<tr>
<td>Private and professional environment and consider headphones.</td>
<td>Patient to prepare list of questions.</td>
</tr>
<tr>
<td></td>
<td>Patient to have medication bottles to review.</td>
</tr>
</tbody>
</table>
1. Offer video/audio visit as primary option with audio only as second
2. Have patient engage caregiver/family member to assist with video option if needed
3. Transparency around insurance coverage and co-pays
4. Use scheduling team as superusers of technology to teach patients how to use the technology
5. Create a goal for your team to encourage all to engage as many patients as possible with the video/audio visit
6. Develop a ‘how-to’ video
CMS direction has been if you are outside the patient’s room, through a window, etc. bill the hospital encounter as you normally would, i.e. Rounding Visit, H/P, etc.

Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services?

Services should only be reported as telehealth services when the individual physician or professional providing the telehealth service is not at the same location as the beneficiary. That doesn’t mean that service conducted via a video or through a window cannot be reported.
G2012 - Brief communication technology-based service, e.g., virtual check-in, by a physician or QHP; 5-10 mins of medical discussion ($15 Reimbursement, wRVU 0.25)
Duration of the PHE Medicare separate payment for audio-only visits described by CPT codes 99441-99443 as outlined on page 125 in the Interim Final Rule with Comment.

May be used for New or Established patients

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>CMS National NON – Facility MPFS</th>
<th>wRVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99441</td>
<td>Telephone E&amp;M service by a physician or QHP; 5-10 minutes of medical discussion</td>
<td>$13.35</td>
<td>0.25</td>
</tr>
<tr>
<td>99442</td>
<td>11-20 minutes</td>
<td>$26.71</td>
<td>0.5</td>
</tr>
<tr>
<td>99443</td>
<td>21 or more minutes</td>
<td>$39.70</td>
<td>0.75</td>
</tr>
</tbody>
</table>

Not reported with 99421-23 for same problems

No E&M prior 7 days nor leading to an E&M

Distinguished by the length of the medical discussion
### E-VISITS

**Online Digital Evaluations - Portals**

<table>
<thead>
<tr>
<th>Physician - APP</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>99421 – Online digital evaluation and</td>
<td>• Cumulative service time within a 7-day time frame needed to evaluate,</td>
</tr>
<tr>
<td>management service, for an established</td>
<td>assess, and manage the patient:</td>
</tr>
<tr>
<td>patient, for up to 7 days, cumulative</td>
<td>• Ordering of tests</td>
</tr>
<tr>
<td>time during the 7 days; 5-10 minutes</td>
<td>• Prescription generation</td>
</tr>
<tr>
<td>99422 – 11 to 20 minutes</td>
<td>• Separate digital inquiry for new and unrelated problem</td>
</tr>
<tr>
<td>99423 – 21 or more minutes</td>
<td>• Digitally stored communication</td>
</tr>
<tr>
<td>- Educate pts. On availability</td>
<td>• May include more than one provider responding to the same patient</td>
</tr>
<tr>
<td>- Patient Initiated – consent required</td>
<td>• G2061- 63 for non-physician practitioners <strong>who are unable to bill</strong> E/M</td>
</tr>
<tr>
<td>annually</td>
<td><strong>services.</strong> CMS &quot;physical, speech, occupational therapists, clinical</td>
</tr>
<tr>
<td>- Excludes clinical staff time</td>
<td>psychologists**</td>
</tr>
</tbody>
</table>

Patients initiate through HIPAA secure such as EHR portal, secure email, or other digital applications which allow digital communication.
<table>
<thead>
<tr>
<th>Service Category</th>
<th>CPT® Code</th>
<th>CPT® Code Description</th>
<th>CMS National NON-Facility MPFS</th>
<th>CMS National Facility MPFS</th>
<th>wRVU</th>
<th>*Additional AMA CPT® Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>99453</td>
<td>Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.</td>
<td>$ 18.77</td>
<td>$ 18.77</td>
<td>0</td>
<td>30-day reporting period for 99454. Calendar Month reporting for 99457. 99453 reportable only once. Device used must be a medical device as defined by the FDA. Use with other services: billing is permitted for the same service period as CCM and TCM. CPT code 99457 and 99091 may not be billed together for same billing period and beneficiary.</td>
<td></td>
</tr>
<tr>
<td>99454</td>
<td>Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient)</td>
<td>$ 62.44</td>
<td>$ 62.44</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99457</td>
<td>Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes</td>
<td>$ 51.61</td>
<td>$ 32.84</td>
<td>0.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99458 + each additional 20 minutes</td>
<td>(List separately in addition to code for primary procedure)</td>
<td>$ 42.22</td>
<td>$ 32.84</td>
<td>0.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99091</td>
<td>Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored99 and/or transmitted by the patient and/or caregiver to the physician or QHCP, requiring a minimum of 30 minutes of time, each 30 days</td>
<td>$ 59.19</td>
<td>$ 59.19</td>
<td>1.1</td>
<td>Collects and interprets physiologic data. The data is stored digitally and may be transmitted by the patient and/or the caregiver to the provider. The report should contain the time it took the provider to acquire, review, interpret the data, and modify any care plan. A minimum of 30 mins every 30 days must be spent in the collection and interpretation of data to report this service. Bundled with EM on same day.</td>
<td></td>
</tr>
<tr>
<td>G2010</td>
<td>Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward) by a physician or other qualified health care professional</td>
<td>$ 12.27</td>
<td>$ 9.38</td>
<td>0.18</td>
<td>Follow-up with the patient could take place via phone call, audio/visual communication, secure text messaging, email, or patient portal communication and must be compliant with HIPAA. Services may involve pre-recorded patient-generated still or video images. Follow-up with the patient within 24 business hours.</td>
<td></td>
</tr>
</tbody>
</table>

Remote Patient Monitoring Services

***Revised may be furnished to new patients and can be used for either chronic or acute conditions.
KEY TAKEAWAYS

Assign staff to monitor all incoming payer information

Facilitate ongoing communication plan to providers and staff – develop a task force or workgroup to manage the changes and new processes required

Programs considering holding claims

Monitor any claims and denials if you are sending claims

Develop a patient engagement strategy for Telehealth and monitor
Regulatory & Legal COVID Summary

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President/CEO
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REGULATORY PERSPECTIVE

CMS
Telehealth
✓ CMS exceptions 3.17.20
✓ CMS relaxed 3.28.20
Advanced Payment

AMA relief letter – Recoupment changes
Re-payment to 2 yrs
Direct financial practice support

Stark exceptions
Lease arrangements

Fair Market Value

Personal service arrangements

18 specific waivers

Be careful and link to COVID

Document….document
Provider support
✓ For those on production-based contracts, implementing models that utilize historical norms to mitigate production reductions
  - Example: Rolling 12-month average

Recognize providers are on the front lines, therefore in harm’s way

Providers are also critical to rebuild post-COVID
HIGHLIGHTS OF TELEMEDICINE

- Be careful with modifiers – 95 vs GT
- Be careful with POS – 11 vs 02 vs 19 vs 22
- New vs established
- Be careful with documentation
  - No touch exam
  - Hospital telehealth “clarification”
- Be careful with “trying video” vs having video
FFCRA- Families First COVID Response Act
✓ < 500 employees - emergency sick and leave

CARES: Coronavirus Economic Security Act
✓ SBA - loans
✓ Financial Support for hospitals & providers
✓ Payroll Protection
✓ Tax credits/deferred tax payments
✓ Emergency loans

COVID #4
✓ Senate passed 4/21/20

Executive orders from Michigan
PROPOSED COVID #4

- Rapid, accurate, inexpensive testing
- Antibody testing
- Strengthening PPE
- Liability protection
- Eliminate prior auth
- Defer AUC & remove MIPS penalties for 2020
### Increased financial stability
- Open more loans for small business aka physician practices
- New PPP funding
- $320-$349B in additional funding
- $75B for hospital & providers

### Telehealth solutions
- Continue current exceptions through 2020
- Long term solutions
- Phone parity to office visits
- Payment
ATTESTATION POTENTIAL PITFALLS

| ✅ | For stimulus $$ - 30 days |
|   | ✓ How used – no Ex pay |

| ✅ | PPP: 25% cap on overhead |

| ✅ | Do not “double-dip”…or triple-dip |

| ✅ | A company may not receive the Employee Retention Credit if the company obtains a Small Business Interruption Loan under the PPP. |

| ✅ | Retention credit 3/12/20 – 12/31/20 & |
|   | FFCRA is 4/1/20-12/31/20 |
Emergence

Have a plan

- **COVID-19 Awareness**
  - Know your zip code
  - Incidence
  - Prevalence
  - Clusters
  - CDC guidelines

- **Preparedness**
  - PPE
  - Testing
  - Supply chain
  - HR

- **Patient Safety**
  - Communication
  - Screening
  - Testing (?)
  - Visitors or not
  - Social Distancing
The Guidelines for Opening Up America Again can be found here:
https://www.whitehouse.gov/openingamerica/#criteria

The Guidelines for Opening Up America Again can be found here:
Virtual Services Tool
Navigate Updated Virtual Coding, Documentation & Reimbursement Guidelines

ACCESS THE TOOL
We are seeing a shift in staffing with so much of the work rescheduled. Programs are shifting as much work virtually as possible but furloughed and paid leaves are a reality. The survey data suggest that there may be additional pressure for private groups, especially early-on.
At the time of this survey, over 20% of MedAxiom member programs were closing 50% or more of their clinics. Based on ad hoc feedback, many clinics have remained open for new patients and urgent needs only.
Almost 60% of programs have changed physician staffing coverage with the majority creating a rotating hospital and/or clinic coverage model. The survey found that 31.1% have adjusted staff to remove higher risk physicians from face-to-face work.
According to the survey findings, many programs have either moved their routine visits or transitioned them into virtual or telehealth visits. A significant change in reimbursement has allowed this to occur while maintaining some revenue flow. Patients are able to stay home while seeing their providers.
We have also seen a significant number of imaging studies rescheduled with a similar trend for those that are maintained. Programs described reviewing all imaging schedules with the goal to move all elective studies to a safe time. Programs will need to be ready for a significant wave of volumes in the next few months as well as assure that none of these have fallen through the cracks.
Procedure impact is similar to imaging studies. Programs have been forced by their hospitals and for safety of the patients to reschedule elective CV procedures. A program in New York noted a 90% decrease in their CV procedures during this time. The survey shows that most programs are seeing a 50 to >75% reschedule rate in CV procedures to a later time. This has been a rapidly moving target with ‘stay at home’ mandates, staffing safety and employment issues contributing. The good news is that the trends for cancellations are the same as reschedules, meaning that these procedures are not ‘lost’ but rather the timeline has been extended.
All programs expect to see a significant revenue decline with the greatest impact in Q2 at this point. This is not surprising given the decrease in almost all services that cardiologists provide.
MEDAXIOM’S COVID-19 RESOURCES

MedAxiom.com/COVID19
JOIN US THURSDAY

WEBINAR
COVID-19 and the CV Service Line:
Legal and Federal Support Update – Part 7
April 23, 5 - 6:30 p.m. ET

REGISTER
Webinar Series: COVID-19 and the CV Service Line
Now Available On-Demand
Virtual Services Tool
Navigate Updated Virtual Coding, Documentation & Reimbursement Guidelines

ACCESS THE TOOL