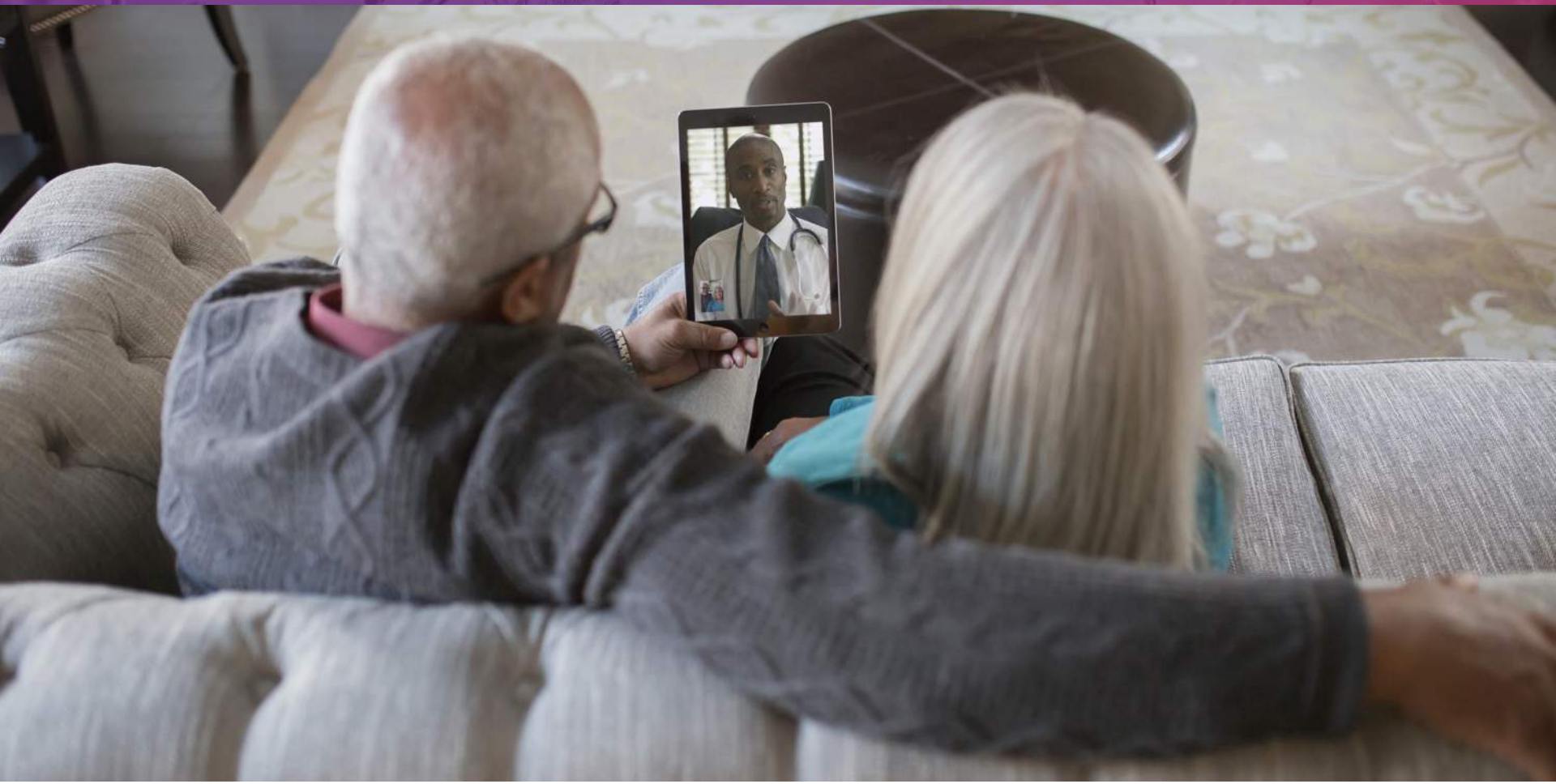

nthrive®
Keeping up with COVID-19
Webinar Series



Keeping up with COVID-19

Revenue Opportunities Using Telemedicine During and After the Public Health Emergency

Reimbursement opportunities for improving quality of care

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Speaker

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

Agenda

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

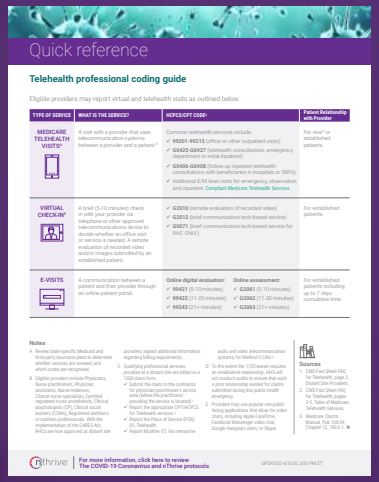
- Remote Patient Monitoring
- Chronic Care Management

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

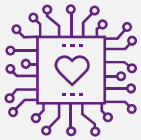
Before the Public Health Emergency Waiver(s)*

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)

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

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

https://www.cms.gov/files/document/covid-final-ifc.pdf

Medicare Telehealth Visits

A visit with a provider that uses telecommunication systems between the provider and patient.

Virtual Check-in

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.

E-visits

A communication between a patient and their provider through an online patient portal.

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

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Remote Patient Monitoring Codes

Initial Set-up	CPT 99453
Device and Supplies	CPT 99454
Monitoring and Treatment 20 min monthly	CPT 99457
Monitoring and Treatment additional 20 min	CPT 99458

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

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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	LOW END 18% participation	HIGH END 36% participation
Chronic Care Management	$46,852	$93,704
Complex CCM	$37,255	$65,094
Care Plan Development	$12,045	$21,024
Transitional Care Management	$54,049	$88,133
Total Annual Medicare Revenue*	$150,201	$267,955

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

REVENUE POTENTIAL

Remote Patient Monitoring

	CPT	REIMBURSEMENT	BILLED
Patient Onboarding and Education	99453	$18.77	once per episode of care
Kit / Supplies with Daily Tracking Alerts	99454	$62.44	once per 30 days
First 20 Minutes of Monitoring	99457	$51.61	once per 30 days
Additional 20 Minutes of Monitoring	99458		once per 30 days

REVENUE POTENTIAL

Remote Patient Monitoring

	LOW END 18% participation	HIGH END 36% participation
Patient Onboarding and Education	$20,496.84	$40,993.68
First 20 Minutes of Monitoring	$56,358.12	$112,716.24
Total Annual Medicare Revenue	$76,854.96	$153,709.89

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

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Webinar Series

Next Webinar

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
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