Virtual Communications and Tele Health

John Waltko, CPA
Vice President
Regulatory and Financial Reporting

QUORUM | Learning Institute™

Creating a Sustainable Future for Healthcare Organizations

Today's Presenter

John Waltko, CPA

Vice President, Regulatory & Financial Reporting

As Vice President of Regulatory and Financial Reporting, Mr. Waltko is a senior level consultant with over 30 years in the healthcare industry.

Mr. Waltko specializes in Medicare and Medicaid program payment issues, underlying Medicare and Medicaid program regulations, monitoring of developing federal public policies and estimating payment impacts and operating challenges such policies have on health care providers.

His experience includes a variety of financial areas such as budgeting, rate setting, financial forecasting, mergers and acquisitions due diligence, financial and operational auditing and hospital turnaround engagements with focus on Medicare and Medicaid reimbursement and payment issues.

Prior to joining Quorum in 1994, John was a Manager with a Big 4 CPA firm in healthcare consulting practice. John entered health care industry in 1984 with a large fiscal intermediary as a Senior Auditor in provider reimbursement and audit. John is a Certified Public Accountant.

Reimbursement by Physician Practice Settings

	Physician Practice Setting			
	Non Provider Based Physician Practice	Provider-Based Physician Practice	Rural Health Clinic	FQHC
Physician & Mid Level Practitioner Professional Services	Physician Fee Schedules (PFS)	PFS	Cost-Based Reimbursement: Costs / Visits = Reimbursement per Visit	PPS specific to FQHCs
Practice Operating Costs: Nurses, building costs, etc.		PPS Hospital: APC CAH: Cost Based		
Standard Conversion Factors:	$36.05 (1)	$24 (2) + $107 (3)	$85 (4)	$156.00

(1) Payment for Professional Services and costs of operating practice: separate payment for each service provided that can be assigned a HCPCS/CPT code. CMS proposes to reimburse at same amount for EM service levels II to V: $93 & $23 for Level I, Established Patient

(2) Professional Services still reimbursed under Physician Fee Schedule but at reduced amount:

(3) Hospitals receive an APC payment for technical services. CAH obtain cost based reimbursement for technical services. CMS revised APC Payment to single rate regardless of EM Level in 2017, Code G0473, APC = $115.76 : CMS proposing in PFS rule to pay single rate for EM services, Level II to V

(4) All inclusive payment rate: Payment is for professional services and other defined “incident to” services and related costs

Physician Fee Schedule(PFS) 2019 Final Rule
Reimbursing for Population Health Management

- CMS starts reimbursing for multiple services starting with ACA passage in 2010
  - Zero co insurance for preventive services
  - Transitional Care Management & Chronic Care Management
  - Annual Physical(Wellness Visit) + Welcome to Medicare Visits
  - Advanced Care Planning
  - Prolonged Care Management Services & CCM for Behavioral Health
  - Significant Telehealth Service Expansions in CY 2018 and 2017
  - Chronic Care Management and Care Coordination in behavioral health
- Each of the above is a Population Health type service

Physician Fee Schedule(PFS) 2019 Final Rule
CMS Continues Population Health Management Payment

- Trend Continues in CY 2019
  - Significant Changes in CMS Payment Policy CY 2019 & 2021
    - Telecommunications
    - Telehealth expansion including stroke patients
    - Evaluation and Management Medical Record Chart Documentation Changes
      - Allowing Time and Medical Decision Making (MDM) as versus
      - 1995 or 1997 Documentation Guidelines for Evaluation and Management Services
    - Evaluation and Management Services Payments
      - Single Rate for Levels II to Level IV
      - Additional “add on” Payments with new Add on Codes

PFS Final Rule 2019
Evaluation and Management Services

- Documentation Standards for Home Visits
  - Removes requirement for Medical Record documenting medical necessity of a “Home Visit” versus visit being performed in practice setting
  - Pub 100-04, Claims Processing Manual, Chapter 12, Section 30.6.14.1.B
- Same Day Payment for EM services prohibition
  - CMS does not pay for 2 EM services provided on same day
    - EM provided by same doctor or doctor in same Medical Group
    - Some exceptions: generally another visit required due to injury/fall etc.
  - CMS solicited comments:
    - Recognizes that practice of medicine has changed
    - Increase in multiple specialist since Same Day Payment Policy Adopted
    - Many practices schedule the second EM service for another day
  - CMS HAS DID NOT change Same Day Payment Rule in final rule

Reducing Redundancy in the Medical Record Chart: CY 2019

- Documentation standard for Evaluation and Mgt Service
  - Billing Practitioner must:
    - Re-document a defined list of required elements typically:
      - Patient History
      - Pertinent Past, Family and Social History (PFSH)
  - Based on 1995 and 1997 Framework
  - CMS Historical Position
    - Medical decision making requires accurate and timely health information
    - CPT code elements will still include elements of history and exam
    - General Principles of Medical Exam from 95 and 97 still in place

Reducing Redundancy in the Medical Record Chart: CY 2019

- CMS Adopts Revised EM Documentation Guideline:
  - Established Patients:
    - Practitioner Reviews and Updates History and PPFSH
    - Document what has Changed
      - Patients father dies of sudden heart attack
    - Document what has not Changed but is pertinent
      - Patient is still in abusive family relationship
  - Review and Update documented by:
    - Describing new Review of Systems and or PFSH Information *or*
    - Noting no change from previous visit
    - Noting the date and location of ROS and PFSH within Chart

Reducing Redundancy in the Medical Record Chart: CY 2019

- New and Established Patients
  - Practitioner no longer required to reenter information in the medical record regarding the chief complaint and history
    - Ancillary Staff of Patient can enter chief complaint and history
    - Practitioner will notate in chart that information was reviewed and verified

Physician Fee Schedule : 2019 Final Rule
Telehealth Services Covered and Payable

- Telehealth services coverage requirements
  - Furnished via an interactive telecommunications system
  - Furnished by a physician or other authorized practitioner
  - Furnished to an eligible telehealth individual
  - Individual receiving service must be located in a CMS defined telehealth *originating site*
    - *HPSA in a Rural Census Track*
    - *County NOT in a Metropolitan Statistical Area*
      - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html

Physician Fee Schedule : 2019 Final Rule
Telehealth Services Covered and Payable

- Why Telehealth in Rural Communities?
  - Access to Specialist in Rural Community Hospital
  - Reduces transfers out of hospital
  - Get Ahead of the Game:
    - Social Media and younger generation
    - Technology Advances are exploding in telehealth and electronic devices
- CMS Has been aggressively expanding covered and payable telehealth services past 2-3 years
  - For complete list of covered type telehealth services, go to:
  - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html

Physician Fee Schedule : 2019 Final Rule
Telehealth Services Covered and Payable via SUPPORT Act

- Removes Originating Site Requirement for:
  - Treatment of Substance Abuse or
  - Co-Occurring Mental Health Disorder
  - Patient can be at Home
  - Effective July 1, 2019!!
- New Benefit Category for Opioid Use Disorder: CY 2020
  - Patient under a Opioid Treatment Program
  - CMS seeking comments and will be defining OTPs & Payments
- State Medicaid Programs will follow

Physician Fee Schedule : 2019 Final Rule
Telehealth Service Additions for CY 2019

HCPCS Code	Description	Comment	PFS National Rate
G0513	Prolonged preventive service(s) beyond the typical service time of the primary procedure in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes	List separately in addition to code for preventive service provided	$62.35
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	List separately in addition to code G0513:additional 30 minutes of preventive services	$62.35

Physician Fee Schedule : 2019 Final Rule
Telehealth Service Additions for CY 2019

- Telehealth for Stroke Patients
  - Telehealth stroke services originating sites re defined
    - Hospital
    - Critical Access Hospital
    - Mobile Stroke Unit
      - Mobile Unit
      - Furnishes services to diagnose, evaluate and treat symptoms of acute Stroke
      - Detailed sub regulatory guidance from CMS soon
  - BBA of 2018 REMOVED Originating Site of Service Requirements
    - Sites do not need to be in HPSA or Rural Area
    - Telehealth Stroke can now be provided to a patient in any originating site regardless of geographic locations
    - New Service Modifier added to claim

Physician Fee Schedule: 2019 Final Rule
Communication Technology Services: Virtual Health Services

- CMS solicited comments in 2018 PFS Rules:
  - How do we expand telehealth within current statutory framework?
  - Most of Telehealth Services *restricted by originating site restrictions*
- CMS has long paid for services when provided remotely
  - Diagnostic Test Reads
  - CCM services provided by ancillary staff
- CMS conclusions
  - Telehealth Statutory Restrictions DO NOT apply to all services rendered "remotely"
  - Telehealth Statutes only apply when Patient and Doctor are having a direct interaction!
- CMS now adding additional services that will be payable and *not subject to* Telehealth Restrictions!!
  - Similar to Telehealth and other Population Health Covered Services Expansions
  - Sends Signal to Private Carriers: Telecommunications is a viable health care practice

Physician Fee Schedule: 2019 Final Rule Communication Technology Services!!

Brief Description	Code	Code Description and Other CMS Comments
Virtual Check-Check In: Brief Communication Technology-based Services	G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours *or soonest available appointment*; 5-10 minutes of medical discussion
		Qualified Health Care Professional Defined: billing practitioner. The code explicitly requires direct interaction between the patient and billing practitioner. Billing for Co Ordinated Care Services provided by nurses and other clinicians is payable under CCM and TCM services
		For Established Patients Only!! Practitioner needs a relationship with patient and basic knowledge of medical condition and needs. Services must be medically necessary and noted in chart Co Insurance will apply since CMS cannot Waive co insurance statute
Services are also Billable and Payable when provided in Rural Health Clinics or FQHC setting: PFS National Unadjusted payment is $13.34		

Physician Fee Schedule: 2019 Final Rule Communication Technology Services!!

Brief Description	Code	Code Description and Other CMS Comments
Virtual Check-Check In: Brief Communication Technology-based Services	G2012	When Patient comes into office for Medical Visit, Check In Service bundled into EM Visit Service and Payment
		CMS anticipates using this service extensively for opioid use disorders and other substance abuse disorders since several components of Medication Assisted Therapy (MAT) could be done virtually
		Realtime audio-only telephone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission
		Verbal Consent from Beneficiary, noted in Medical Record Chart
		No frequency limitation, though CMS will monitor
Services are also Billable and Payable when provided in Rural Health Clinics or FQHC setting: PFS National Unadjusted payment is $13.34		

Physician Fee Schedule: 2019 Final Rule Communication Technology Services!!

Service	Code	Code Description and Other CMS Comments
Remote Evaluation of Pre-Recorded Patient Information	G2010	Remote evaluation of *recorded video and/or images submitted* by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
		Store and Forward Technology: create specific coding that describes the remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology: Could expand to patient monitoring
		Stand Alone Payable service not provided 7 days before or after visit with same doctor or qualified medical professional
		Distinct from virtual check in service since the service is *not provided real time*
		Payable on *established patients only*
Services are also Billable and Payable when provided in Rural Health Clinics or FQHC setting: PFS Payment is $ 9.37		

Physician Fee Schedule: 2019 Final Rule Communication Technology Services!!

Service	Code	Code Description and Other CMS Comments
Remote Evaluation of Pre-Recorded Patient Information	G2010	Qualified Medical Professional: Video reviewed by billing practitioner and not nurses or other clinicians
		Beneficiary consent either verbal or written
		Follow up with patient can be verbal or other electronic means such as text, email, patient portal communication
Services are also Billable and Payable when provided in Rural Health Clinics or FQHC setting: PFS Payment is $ 9.37		

Physician Fee Schedule: 2019 Final Rule Communication Technology Services!!

Service	Code	Descriptions	Time
Inter-professional Internet Consultation	99446	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional	5-10
	99447	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional	11-20
	99448	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional	21-30
	99449	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	31 +
CMS ceased paying for these services in 2014			

Physician Fee Schedule: 2019 Final Rule Communication Technology Services!!

Service	Code	Code Description	Time
Interprofessional Internet Consultation	99451	Interprofessional telephone/Internet/***electronic health record*** assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time	5
	99452	(Interprofessional telephone/Internet/***electronic health record*** referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes	30
These six codes describe assessment and management services conducted through telephone, internet, or electronic health record consultations furnished when a patient's treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a consulting physician or qualified healthcare professional with specific specialty expertise to assist with the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact with the consulting physician or qualified healthcare professional			
Since services are currently bundled into EM service, typically specialist schedules a separate visit with the patient resulting in inefficiencies and increased costs to the Medicare program. In addition, by allowing payment, promotes team approach to medical care and population health management setting the stage for expanded capitated payment models			

Physician Fee Schedule: 2019 Final Rule Communication Technology Services!!

Service Code	Other CMS Comments
Inter-professional Internet Consultation	Beneficiary Consent required, verbal, and noted in medical record chart
	Beneficiary Co Insurance does apply
	Services must be provided by practitioners that can bill Medicare program directly.
CMS ceased paying for these services in 2014	

Communication Technology Services!!
Covered and Payable Service Payment Rates

Code	Time	RVUs			Rate	Service Type Description
		Work	Facility	Malp.		
99446	05-10	0.35	0.14	0.20	$18.39	See previous slides for detailed description
99447	11-20	0.70	0.27	0.30	$36.04	
99448	21-30	1.05	0.41	0.50	$54.78	
99449	30 +	1.40	0.54	0.70	$72.80	
99451	30 +	0.70	0.29	0.05	$37.48	Payment same since CMS believes 99452 is greatly undervalued relative to 99451 and thus striking middle ground until further data compiled.
99452	05 +	0.70	0.29	0.05	$37.48	

Medicare PFS Final Rule

CMS is distinguishing covered and payable tele-communications(Virtual Communication) services from covered and payable telehealth services by ____

01 Not requiring patients to be located in rural areas

02 Patients will not have to be located in a HPSA

03 Real time telecommunication technology will not be required

04 1 and 2 and 3

THANK YOU

Intended for internal guidance only, and not as recommendations for specific situations. Readers should consult a qualified attorney for specific legal guidance.

Creating a Sustainable Future for Healthcare Organizations

QUORUM | Learning Institute™