Telehealth Program Overview – Continuing A Successful Telehealth Program

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Agenda

- Telehealth In Massachusetts Overview
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  - Pandemic
  - Post-Pandemic
- Massachusetts State Rules and Regulations
  - Review of Massachusetts Legislative Update
  - Licensing Updates – Providing Services Across State Lines
  - 2022 Telehealth Coding and Billing Updates
- Expansion of Telehealth Services Post-Pandemic
  - Chronic Care Management
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- Best Documentation Practice
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- Audio/Video Versus Video Only Visits
- How to Improve Telehealth Patient Visits
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Overview Massachusetts Telehealth

- **Pre-Pandemic**
  - Limited Access to Telehealth Services.
  - Massachusetts Payers had limited services supporting Telehealth.
  - Payer reimbursement was inconsistent for Telehealth services.
  - Before the onset of the COVID-19 pandemic, utilization of Teleheath in the U.S. was minimal.
  - Telehealth was supported by high startup costs.
  - Daily workflow had to be reconfigured to support Telehealth services in the practice.
  - Provider buy-in was limited and often no interest at all.
  - Patient interest was limited.
  - Telehealth platforms were start up company's (example: NEPHO first Telehealth platform was based out of California).

Overview Massachusetts Telehealth

- **During Pandemic**
  - Telehealth offered **“Bridge”** to patient care.
  - Increased patient willingness to use Telehealth.
  - Increased provider willingness to perform Telehealth services.
  - Telehealth was used to enable remote evaluations between a patient and a provider, while respecting social distancing.
  - Use of “virtual visits” via phone or video/audio to address non-urgent care or routine management of medical or psychiatric conditions.
  - Online or app-based questionnaires was used to facilitate COVID-19 screening to determine the need for in-person care.

Overview Massachusetts Telehealth

- **Current State of Telehealth**
  - On October 15, 2021 Health and Human Services (HHS) approved the renewal of the Public Health Emergency (PHE).
  - Telehealth is being used to support patient care and keep people safe during the Flu Season.
  - Patient Care can be supported by Telehealth for:
    - Chronic Care Management (CCM)
    - Transitional Care Management (TCM)
    - Advanced Care Planning (ACP)
  - Telehealth Services are being reimbursed fairly – Payer Parity.
  - Telehealth Platforms are affordable, reliable, and accessible in all states.
  - All generations have become accustomed to Telehealth offerings.

Current Telehealth Rules and Regulations

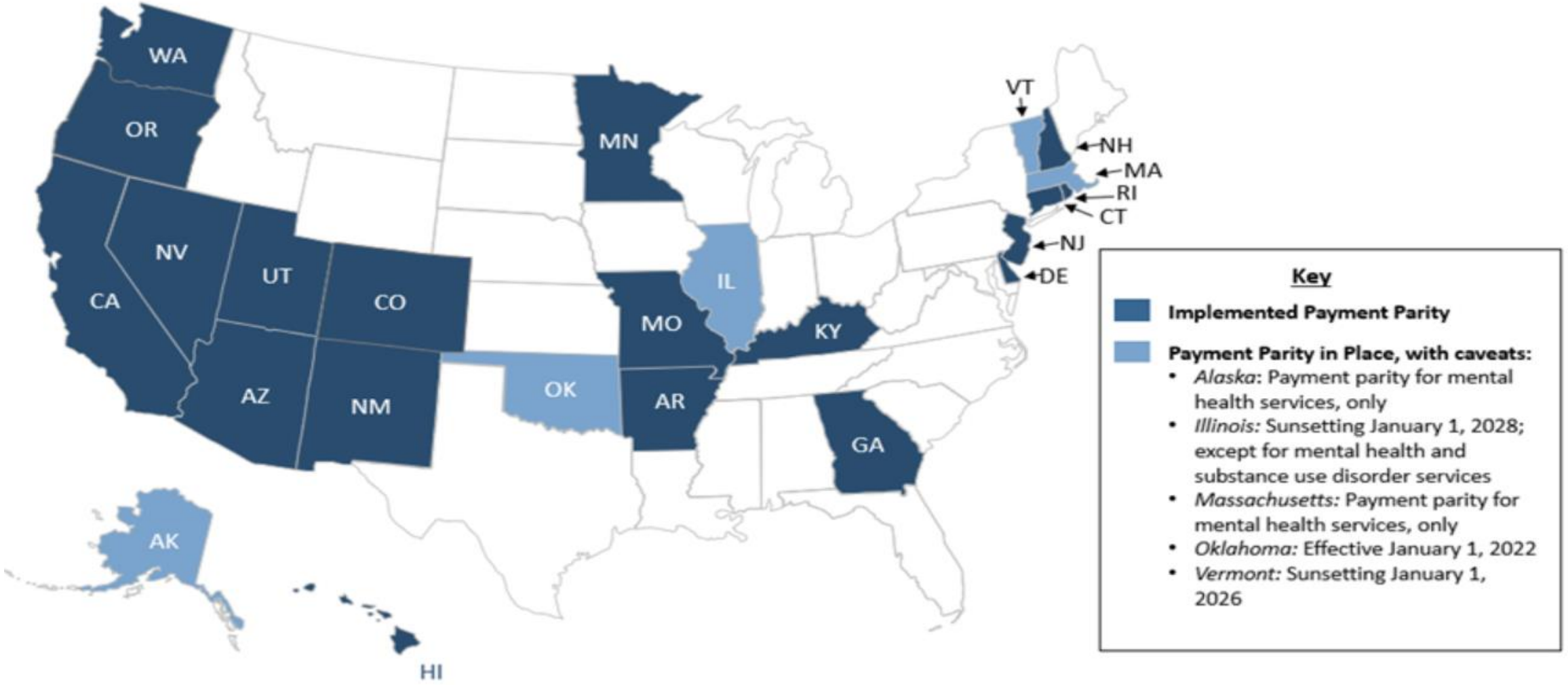
- With growing demand for telehealth, several changes have been made to telehealth policy, coverage and implementation, in order to make telehealth more widely accessible during the state of emergency. **https://www.cchpca.org/massachusetts/**
- The federal government has focused on loosening restrictions on telehealth in the Medicare program, including allowing beneficiaries from any geographic location to access services from their homes. HHS has waived enforcement of HIPAA for telehealth, while the Drug Enforcement Administration (DEA) has loosened requirements on e-prescribing of controlled substances. **https://www.mass.gov/orgs/massachusetts-controlled-substances-registration**
- On a state level, many state governments have focused on expanding telehealth in their Medicaid programs, as well relaxing state-level restrictions around provider licensing, online prescribing and written consent. Many states are also mandating fully-insured private plans to cover and reimburse for telehealth services equally to how they would for in-person care (service parity and payment parity). **https://mhealthintelligence.com/news/baker-signs-massachusetts-telehealth-bill-with-parity-provisions-into-law**
- Commercial insurers have voluntarily addressed telehealth in their response to COVID-19, focusing on reducing or eliminating cost sharing, broadening coverage of telemedicine and expanding in-network telemedicine providers. **https://www.cms.gov/newsroom/press-releases/cms-physician-payment-rule-promotes-greater-access-telehealth-services-diabetes-prevention-programs**

Massachusetts Legislative Update

- Governor Baker signed the Legislative Bill in January 2021.
- The bill has improved coverage for COVID 19 Testing and Treatment – and includes asymptomatic individuals.
- This bill has helped drive a shift from episodic care to care management, and has helped to embrace preventive care measures that improve long-term health outcomes and reduce waste and excessive use. This bill has helped lower visits to urgent care and the Emergency Room.
- This bill has supported chronic care management to patients with conditions such as; diabetes, vascular disease, weight management, and mental health. **https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes**
- This bill has helped to address areas of gaps in patient care management.
- This bill has helped to increase access to urgent care for Mass Health and eliminate referral requirements.

Payer Parity

Payment Parity requires that health care providers are reimbursed the same amount for telehealth visits as in-person visits. During the COVID-19 pandemic, many states implemented temporary payment parity through the end of the public health emergency. Now, many states are implementing payment parity on a permanent basis.



Massachusetts Division of Insurance

- Strengthening Telehealth Coverage: Mandates permanent payment parity for Behavioral Health services and established parity for Primary Care and Chronic Care Management for the next two years.
- Currently Audio only and E/M (face-to-face) are being reimbursed equally.
- It requires payers to cover all such services delivered via Telehealth that are also offered in-person, and to reimburse providers at the same rate.
- Permanent Expansion for scope of practice for NPs, Nurse Anesthetists, Psychiatric Nurse Mental Health Specialists & Optometrists.
- Protects consumers from surprise billing: This rule goes into effect for health care providers and facilities, and providers of air ambulance services on January 1, 2022, and for plan, policy, or contract years starting on or after January 1, 2022, for group health plans, health insurance issuers, and Federal Employees Health Benefits (FEHB) program carriers.

Telehealth State Licensing Guidance

- We urge each provider to be licensed in the state where the patient is located, unless there are provisions in place otherwise due to the pandemic.
- Keep a continuous eye on the changes for each state that you are seeing patients in and do not hold a license to practice, as changes are fluent.
- Federation of State Medical Boards that provides guidance by state, as each state has put in place their own rules and regulations in response to the pandemic.
- The FSMB website breaks down state specifics surrounding out-of-state physicians; pre existing provider-patient relationships; audio-only requirements.

Telehealth Licensing Recommendations

- Before the pandemic, seeing patients across state lines via telehealth without being licensed in the state the patient was physically sitting in was considered practicing without a license. The dust is still settling - although telehealth is the new normal, state medical boards will continue drive their own rules and regulations.
- We recommend you begin to analyze patient data to determine where your patients are living to best determine the states that each provider would benefit in obtaining a state license within.
- Additional licensing guidance can be found at: https://www.nepho.org/nepho-out-of-state-licensing-guidance/

Frequency Updates for Nursing Home Care

- CMS is reducing the frequency limitation for coverage of subsequent nursing facility care services furnished via Telehealth from once every 30 days to once every 14 days.
- The original 30-day restriction was due to concerns on the acuity and complexity of nursing facility residents, and to ensure nursing facility residents have frequent encounters with their admitting practitioner.
- CMS was persuaded that the use of Telehealth is crucial to maintaining continuity of care in nursing facilities, and to honor the independent medical judgment of treating clinicians to decide whether Telehealth vs in-person care should be used, depending on the needs of each specific resident.
- Frequency limitations have become a permanent rule.
- CMS declined to make any changes to the Telehealth frequency limitations for hospital inpatient visits and critical care consultations.

Documentation Requirements for Telehealth

- Providers delivering services via Telehealth must meet all health records standards required by the applicable licensing body as well as any applicable regulatory and billing provisions.
- Providers must include a notation in the medical record that indicates that the service was provided via Telehealth and confirm patient identity (e.g., name, date of birth or other identifying information as needed).
- If a service code is time-based, evidence of time must be documented.
- Best practices suggest including:
  - A statement that the service was provided using telemedicine or telephone consult.
  - The location of the patient.
  - The location of the provider
  - The names of all persons participating in the Telehealth service and their role in the encounter.

M.E.A.T: Monitor, Evaluate, Assess, Treat

These four factors help providers establish the presence of a diagnosis during an encounter and ensure proper documentation.

- Simply listing every diagnosis in the medical record does not support a reported HCC code and is not accepted by CMS (Medicare). Documentation must support evaluation and treatment for each condition that is captured as an ICD-10 CM.
- **M.E.A.T is an acronym for:**
  - M: Monitor—signs, symptoms, disease progression, disease regression
  - E: Evaluate—test results, medication effectiveness, response to treatment
  - A: Assess/Address—ordering tests, discussion, review records, counseling
  - T: Treat—medications, therapies, other modalities

Medical Necessity Defined

- **Medical Necessity Overview:**
  - America College of Medical Quality:
    - Medical necessity is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
  - America Medical Association (AMA):
    - In accordance with the generally accepted standard of medical practice.
    - Clinically appropriate in terms of frequency, type, extent, site and duration.
    - Not for the intended for the economic benefit of the health plan or purchaser or the convenience of the patient, physician or other health care provider.

Tips to Document Medical Necessity

- Identify a specific medical reason or focus for the visit (e.g., worsening or new symptoms).
- Document the rationale for ordering tests or referrals.
- Describe how the patient/caregiver has managed chronic conditions from the previous visit to present or explain acute symptoms; status of three chronic conditions may be used for History of Present Illness (HPI) credit.
- Include within the assessment and plan the provider's clinical impression, condition status, and treatment plan for each diagnosis assessed that day.
- Summarize the patient's health (e.g., improved, worsening, not responding as expected) and document services performed, treatments recommended, medication management, education/counseling, and goals of care conversations.
- Represent the patient complexity, overall patient risk level, and any aggregating factors or psychosocial challenges.
- Document initiation of, or changes in, treatment.
- Include patient and nursing instructions, therapies, and medications.

If It Isn't Documented It Didn't Happen

- **"If you didn't document it, it didn't happen."** This statement is often used in medical training as a method to strive for better documentation. This also helps to guard against malpractice suits.
- **"If you didn't document it, you're not getting paid."** This statement should be used more to support accurate reimbursement and patient management of care.
- Items to document during a patient encounter:
  - Plan of Service
  - What services are needed
  - Changes in the plan
  - Past & present treatment of physical and psychological conditions
  - Progress Notes
  - Health Information
  - Illnesses
  - Doctor's Orders
  - Medication
  - Unusual Incidents

Documentation Supports Coding & Billing

- **Fee for Service (FFS):** Although history and physical exam are no longer required to level the visit, they are still important components in establishing medical necessity, supporting medical decision making (MDM), and providing high-quality care. Documenting these components helps maintain continuity of care and assists other providers working with the patient. The assessment and plan (A/P) needs to be documented. If the total time is ambiguous or missing, the visit may be unbillable. If you document both MDM and total time, you can level the visit based on whichever is more advantageous, but you still must present documentation. Documentation of an A/P is also important in establishing medical necessity and maintaining continuity of care.
- **Risk Adjustment Diagnosis Coding Capture:** Detailed documentation and accurate diagnosis coding are critical for proper risk adjustment capture. Capture of HCCs are done on an Annual basis. All chronic conditions need a budget to manage care. When HCCs are captured documentation needs to support the diagnosis that is captured. There are many times HCCs are updated on an encounter but documentation is missing. This will affect the Risk Adjustment Factor that is created to manage patient care. Providing an update on a chronic condition will support diagnosis capture.
  - **Example:** Patient is being seen for Diabetes, A-Fib and CKD. The patient has started a insulin pump to better manage their blood sugar, A-Fib is stable and the patient follows up with Cardiology, CKD is improving as patient is now on a low-salt diet.

Overview of E/M Updates - FFS

- Updates to E/M were effective on January 1, 2021
- First updates in 24 years
- History and Exam are no longer key components of visit.
- The level of care will be driven by medical decision-making (MDM) **OR** by time.
- Time will include both face-to-face time and non-face-to-face time on the date of the visit.
  - Pre-Visit Review
  - Visit Encounter
  - Post-Visit Planning
- There is new MDM Table to calculate complexity in MDM

Medical Decision Making (MDM) Supported by Documentation

- **Using Medical Decision Making (MDM)**
  - the number and complexity of problem(s) that are addressed during the encounter
  - the amount and/or complexity of data to be reviewed and analyzed, and
  - the risk of complications, morbidity, and/or mortality of patient management decisions made at the visit associated with the patient's problem(s), the diagnostic procedure(s), and treatment(s).
- **The history and exam are focused on the reason for the visit. They are not key components supporting leveling.**

Risk Adjustment Coding Overview

- A patient's risk score is captured accurately by coding to their disease and conditions to the highest specificity. HCCs are diseases and conditions that are organized into body systems or similar disease processes. The top HCC categories include:
  - Major depressive and bipolar disorders
  - Asthma and pulmonary disease
  - Diabetes
  - Specified heart arrhythmias
  - Congestive Heart Failure
  - Breast and prostate cancer
  - Rheumatoid arthritis
  - Colorectal, breast, kidney

Diagnosis Capture During Telehealth Visits

- **Providers should document conditions they monitor and treat:** Diagnosis codes are not limited to what brought the patient to the office today. Any condition the provider monitors, evaluates, assesses, or treats should be included in the documentation.
- **Avoid using generic or unspecified codes:** Code to the highest level of specificity. Use of generic or unspecified codes does not fully support medical necessity and the management of care for the patient. Payers need to have an accurate picture of the patient's health status.
  - **Example:** Congestive heart failure should be coded by type and acuity. The term congestive heart failure is considered nonspecific, outdated, and inadequate to fully describe the condition. Documentation should be present in the record of systolic and/or diastolic failure or dysfunction and acuity.
    - Chronic diastolic (congestive) heart failure: I50.32
- **It is important to link manifestations and complications.** Providers need to make the link between a manifestation and complication. Some terms that can be used to link conditions are "because of," "related to," "due to," or "associated with."

Telehealth Documentation Examples

- Document plan of care for chronic conditions, condition status
  - **Example:** A Fib I48.91 – heart rate within normal limits, converting back to normal sinus rhythm, apixaban is helping to regulate heart rate
- Chronic conditions need to be captured/recaptured annually
  - **Example:** Depression (F33.8) or depression in remission (F33.4), Opioid dependence (F11.20) or opioid dependence in remission (F11.21) (Depression: when depression has stabilized coding depression in remission would be appropriate)
- Chronic conditions should be discussed and documented during a new patient visit
  - **Example:** New patient visit with the following chronic conditions: Hypertension I10, CKD stage 3 N18.31, Recurrent depressive disorder F33.8, Opioid dependence in remission F11.21
- Document confirmed chronic conditions to their highest specificity
  - **Example:** Diabetes with CKD stage 3: E11.22, N18.31 (1st code diabetes with chronic kidney disease then code chronic kidney disease)

Telehealth Exam Components Capture

- Exam components to help support a Telehealth exam:
  - **HEENT**: Use a flashlight or phone based light to look at the throat and nose
  - **Skin**: Have the patient press on a rash to observe any scaling or redness
  - **Cardiovascular**: Find pulses at the radial, carotid, femoral and jugular venous
  - **Abdominal exam**: Have the patient feel for masses and/or describe location of symptoms such as pain
  - **Musculoskeletal**: Self palpitation can be used to show locations of pain or point of tenderness. Range of motion can be assessed and directed by the provider
  - **Neurologic**: Observe patient gait, have them squat and get up and down from a chair and/or walk across the room

  Have the patient be more involved and interactive in the visit, have patient family members or care giver offer additional information to better support the reason for the visit. Include their information in the note to help support the visit medical necessity.

Services Supported by Telehealth

- Audio/Video evaluation and management visit:
  - Office/outpatient E/M visit, new: 99202-99205:
  - Office/outpatient E/M visit, established: 99212-99215
- Chronic Care Management (CCM):
  - 99490, 99439, 99491, 99437, 99487, and 99489
  - New code 2022: 99437
- Principle Care Management Codes (PCM):
  - 99424, 99425, 99426, 99427
- Transitional Care Management (TCM):
  - CPT Code 99495 — TCM services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, MDM of moderate complexity during the service period; Face-to-face visit, within 14 calendar days of discharge.
  - CPT Code 99496 — TCM services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; MDM of high complexity during the service period; Face-to-face visit, within 7 calendar days of discharge.

Telehealth Visit Requirements

Audio Only Coding & Billing

- Telephone or audio-only evaluation and management services for new and established patients cannot originate 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.
  - 99441: 5-10 minutes **comparable reimbursement** to E/M 99212
  - 99442: 11-20 minutes **comparable reimbursement** to E/M 99213
  - 99443: 21-30 minutes **comparable reimburs**ement to E/M 99214

Digital E/M Services

- Online digital E/M services for established patient for a period of up to 7 days, cumulative time during the 7 days. These codes can be billed once a week and cannot be billed within a 7-day period of a separately reported E/M service, unless the patient is initiating an online inquiry for a new problem not addressed in the separately reported E/M visit. These services must be initiated by the patient (e.g., patient portal, e-mail). **Medicare will cover these services for new patients during the public health emergency.**

Physicians report:	Qualified Non-Physician Professionals report:
99421: 5-10 minutes	98970: 5-10 minutes
99422: 11-20 minutes	98971: 11-20 minutes
99423: 21 or more minutes	98972: 21 or more minutes

E/M Audio/Video or Audio Only Exam Elements

- Exam: With some thoughtfulness providers are able to examine several organ systems.
  - Telehealth Exam Documentation:
    - Eyes: Appearance of pupils (equal, round, extraocular eye movements)
    - Ears, Nose, Mouth & Throat: External appearance of the ears and nose (scars, lesions, masses) and assessment of hearing (able to hear, asks to repeat questions)
    - Neck : Gross movement (degrees of flexion anterior, posterior and laterally)
    - Respiratory: Audible wheezing, presence and nature of cough (frequent, occasional, wet, dry, coarse)
    - Cardiovascular: Presence and nature of edema in extremities
    - Constitutional: General appearance (ill/well appearing, (un) comfortable, fatigued, attentive, distracted, (disheveled)
    - Chest: Inspection of the breasts, chest tenderness
    - Abdominal: Tenderness on self palpation or area of pain
    - Musculoskeletal: Exam of gait and station (stands with/without use of arms to push off chair; steady gait, broad/narrowed based)
    - Skin: Rashes, lesions, ulcers, and cracking
    - Neurologic: Examination of sensation (by touch)
    - Psych: Orientation to time, place, and person, recent and remote memory, mood and affect, mood lability (crying, laughing)

Resources

- **Shawn.m.bromley@lahey.org**
- https://www.manatt.com/insights/newsletters/covid-19-update/executive-summary-tracking-telehealth-changes-stat
- https://www.amazon.com/Adjustment-Documentation-Coding-Sheri-Bernard/dp/1622027337
- https://www.google.com/search?q=sdoh+meaning&rlz=1C1GCEB_enUS873US875&oq=sdoh&aqs=chrome.3.69i57j0i512j69i59j0i512l7.7053j0j7&sourceid=chrome&ie=UTF-8
- https://www.acog.org/practice-management/coding/coding-library/managing-patients-remotely-billing-for-digital-and-telehealth-services
- https://emuniversity.com/
- https://caravanhealth.com/CaravanHealth/media/Resources-Page/Telehealth_PhysicalExam.pdf