Suit up
Protect Yourself in a Telehealth Audit

North Country TRC

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Presenters

Michelle Hager is the Managing Partner of Blue Cirrus Consulting LLC. Since founding the company in 2010, Michelle has led Blue Cirrus to become a trusted management consulting partner and leading Telehealth advisory firm within the healthcare industry nationwide. She is dedicated to her passion for educating healthcare providers, advocates and legislators on the benefits and value of Telehealth services.

Michelle is a frequent invited speaker at conferences across the country to include: National HIMSS, ATA, Regional TRC Events, APHA, and ASHP. Michelle is a participating member on the Advisory Board of Center for Telehealth and e-Health Law, ATA Industry Council, National HIMSS Telehealth Workgroup and is the currently President of the South Carolina HIMSS Chapter.

Her over 20-year career beginning as a Pharmacy Technician and IT Analyst led her to become a Director at a leading healthcare Fortune 15 Company, working with the National Health Service to oversee the largest system conversion of the 3rd largest payroll in the world spanning across multiple European countries. She has her Bachelor's Degree from Florida State University and in her free time enjoys spending time with her husband Brad, son Ethan and their new pup Monty.

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Objectives

Confidently Document Telehealth Services

- Overview of “Telehealth Evolution” February 2020-Present
- Review OIG Workplan for Telehealth Services
- Review General Telehealth Documentation Principles
- Strengthen your understanding of Telehealth Exam Documentation
- Dive into Documenting for Audio Visits, eVisits and Remote Patient
- Review the Importance of Medical Necessity

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Telehealth Timeline Overview

- Pre-March 2020

Limited Telehealth Care Delivery – Specific Use Cases

- March - 2020 to January 2021

Telehealth – "Anything Goes" under Waivers

- January 2021 - Forward

Navigating the "New Normal" – Audits are back!

The Other Shoe Drops: OIG To Audit COVID-19 Telehealth Home Health Services | Healthcare Law Blog (sheppardhealthlaw.com)

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Office of Inspector General (OIG) announces Telehealth Governance & Audits

January 2021 – Audits of Medicare Part B Telehealth Services During the COVID-19 Public Health Emergency

- **Phase 1 -** Phase one audits will focus on making an early assessment of whether services such as evaluation and management, opioid use disorder, end-stage renal disease, and psychotherapy meet Medicare requirements
- **Phase 2 -** Medicare Part B telehealth services related to distant and originating site locations, virtual check-in services, electronic visits, remote patient monitoring, use of telehealth technology, and annual wellness visits to determine whether Medicare requirements are met.

Audits of Medicare Part B Telehealth Services During the COVID-19 Public Health Emergency (hhs.gov)

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General Telehealth Documentation – What stays the same?

Parity to In Person Services – Documentation must meet <u>all</u> requirements required for in- person to bill the code

General principles of documentation include:

- The medical record should be complete and legible
- The documentation of each patient encounter should include the:
  - Reason for the encounter and relevant history, physical examination findings, prior diagnostic results
  - Assessment, clinical impression, or diagnosis
  - Medical plan of care
  - Date and legible identity of the observer

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-presentation-handout.pdf

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General Telehealth Documentation – What is different?

Additional Documentation to Consider

- Consent (Verbal or written)
- Location of patient (Shared with provider)
- Location, credentials of provider (Shared with patient)
- Names & Credentials of those in the room
- Right to terminate telehealth and request alternative care
- Platform being used to conduct service (i.e. Secure Platform)

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The Telehealth Exam

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Critical Practices related to the Telehealth Exam

Preparation

- Creation of standardized practices and procedures for physician directed patient performed “self exam”
- Create a list of items in a patient at home “tool kit” and share prior to visit

Explanation

- Documentation should always match the modality utilized
- Add necessary narrative to identify how “hands on” elements were obtained

Escalation

- If diagnostics may be required, have a plan for terminating the visit, sending patient prior to visit, or deploying devices
- In case of emergency, have an escalation plan

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Strengthen Telehealth Exam Documentation

Identify Potholes

The Electronic Medical Record and guided examination templates

Copy forward and use of macros

2021 Evaluation and Management guideline changes

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Strengthen Telehealth Exam Documentation

Avoid Potholes: Show Your Work!

- Documentation should **always support the modality utilized**
- When “hands on” examine elements are obtained add **supporting narrative** on how they were obtained
- **Review all copied notes and macros** in your telehealth documentation to ensure descriptions are appropriate
- All pertinent and relevant history and exam elements obtained during the patient the visit should be documented in the record to **ensure continuity of care**

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Audio Visits, eVisits, and Remote Patient Monitoring

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Virtual Check-in's & Audio E/M Codes

Virtual Check-In's

- Pre Pandemic/Continue Post Pandemic
- Codes G2012/G2252 (G0071 RHC/FQHC)

Telephone Evaluation & Management Codes

- Allowed by most carriers during pandemic/Payers considering permanently
- Codes 99441-99443

Telephone codes billed as parity to Evaluation & Management Codes

- Allowed during pandemic by some payers/Unlikely to continue post pandemic
- Codes 99202-99215

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Virtual Check-in's & Audio E/M Codes

Document consent - patient initiated and verbally agrees to service

Document Provider/Patient relationship (outside of PHE must be established)

Document total time spent in discussion with patient

Timing – Cannot be related to an E/M service by same provider in past 7 days and phone call should not end in decision to see patient in next 24 hours or next available urgent appointment

Document reason for service and clinical advice rendered and medical necessity diagnosis

"Virtual Check-in's" with CMS allow for additional secure forms of communication (i.e. text, e-mail). If communication is not telephone ensure method of communication is documented

MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET | CMS
AMA CPT Professional Book

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eVisits

Non-face-to-face, patient-initiated communications with the physician through a secure online patient portal
99421-99423 & G0261-G0263

- The message exchange in portal would serve as documentation of service
- If not indicated in exchange, additional documentation should demonstrate patient initiated
- If not indicated in exchange, provider/patient relationship should be documented (outside of PHE must be established)
- Document total cumulative time spent in discussion with patient over the course of 7 days
- Cannot be reported on the same day(s) of an E/M service
- Provider should summarize clinical assessment and plan if not outlined in exchange
- Check with patient portal or EHR vendor for templates or modules for this service

MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET | CMS
AMA CPT Professional Book

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Remote Patient Monitoring

General Documentation Considerations

- Document reason (medical necessity) for monitoring, physiological parameter to be monitored and summary of plan (must be minimum of 16 days outside of PHE)
- Patient consent to be monitored and provider/patient relationship
- Device (brand/model) used (must meet FDA definition of medical device)
- Monitoring of multiple parameters/separate devices should only be reported once per provider per 30 days

2021 Medicare Remote Patient Monitoring FAQs: CMS Issues Final Rule | Blogs | Health Care Law Today | Foley & Lardner LLP

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Remote Patient Monitoring

Specific Code Documentation Considerations

Set-up and Education to patient (99453) – Document summary of education and who provided and plan that monitoring will be min. of 16 days

Collection of data and programming (99454) – Flow sheet of data digitally collected over **30 day time period**

Care team communication with patient/care giver during **each calendar month (**99457/99458)– flow sheet of documentation from each member of the care team with time and cumulative time each month

Care team communication with patient/care giver (99091) – CMS & AMA discrepancy. Would not expect 99091 and 99457/58 to be billed simultaneously on regular basis

For self reported blood pressure and continuous glucose monitoring use more specific CPT Codes (99473/99474; 95250 respectively)

2021 Medicare Remote Patient Monitoring FAQs: CMS Issues Final Rule | Blogs | Health Care Law Today | Foley & Lardner LLP

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Medical Necessity

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Medical Necessity Still Matters!

Article 29-G, Telehealth Delivery of Services: "…a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth…"

Modality should be used as an equal alternative to in person service	Utilization of the modality alone, does not make the service reimbursable	Accessibility is not equal Reasonable and Necessary

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Key Takeaways

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Key Takeaways

Parity "Telehealth Services"	Audio Only	eVisits	Remote Patient Monitoring
• Documentation guidelines for code remain the same • Include script/template/prompts to capture key components specific to telehealth modalities	• During PHE there have been multiple ways to report • Lesson confusion by creating organizational policy • Payers may reimburse virtual check in codes **or** telephone E/M – track payer policies • Recommend following same basic guidelines for each code set unless otherwise specified in a policy	• Use actual portal message exchange as documentation • Time based Code – include cumulative time spent over 7 days of exchange • Leverage your portal/EHR vendor for workflows and templates	• General Documentation and code specific documentation requirements to keep in mind • Multiple components over various time periods. Leverage EHR, and workflows to manage documentation • Guidelines are evolving – many grey areas still exist

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Brief History of Telehealth: Past & Present

Past	Present	Relevance
Originating site restrictions	Originating site limitation was eliminated	The PHE accelerated the need to perform services via audio/visual
Restrictions to allowable services to patient home	Expansion of services allowed to patient home	Proposals for future regulations still challenge the appropriateness of services to home
Direct to consumer targeted low acuity patients/conditions	Regulatory requirements broadened	Post PHE regulations are still being formulated

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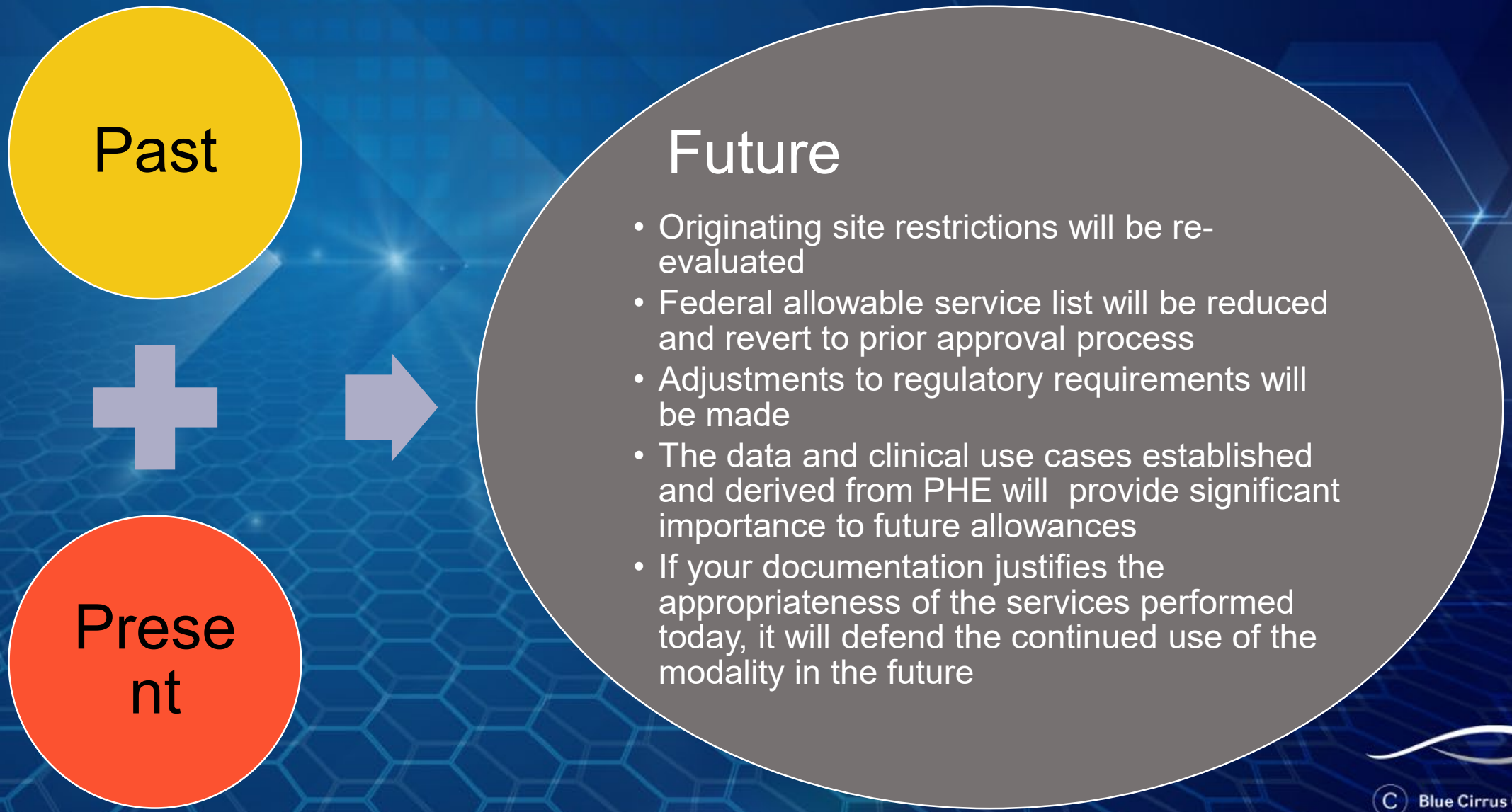
Importance of Documentation and Consideration of the: Future



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Questions

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