EVOLUTION OF TELEHEALTH AND THE REVENUE CYCLE – LESSONS LEARNED FROM UPMC AND A RYAN WHITE CLINIC

Panel

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DISCLOSURES

None of the presenters listed below have any relevant financial interests to disclose:

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LEARNING OBJECTIVES

At the conclusion of this activity, the participant will be able to:

1. Identify aspects of telehealth billing, e.g., application of modifiers, Place of Service codes and documentation requirements.
2. Define how applying logic and automation will reduce billing errors.
3. Draw conclusions about how simplification of evaluation & management documentation requirements will improve billing opportunities.
4. Critically think about what telehealth visits may look like post-pandemic.

Part 1: Overview of Telemedicine and Adoption During COVID-19 Era

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Telemedicine:

The use of medical information exchanged from one site to another via electronic communications to improve patients' health status.[1]

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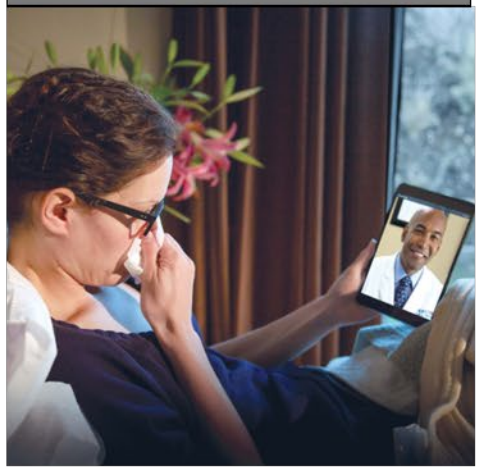
Asynchronous Provider to Provider

eConsults

Asynchronous Patient to Provider

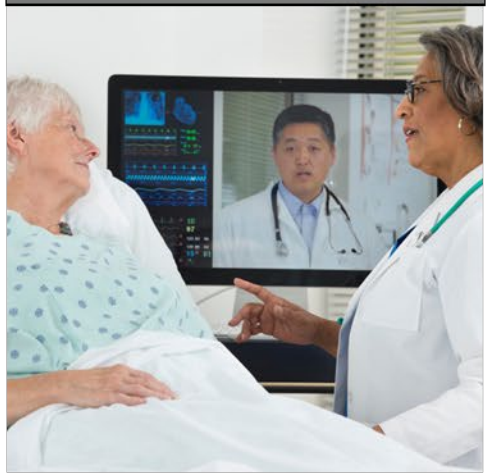
eDermatology

Synchronous Provider to Patient



Home Video Visit

Synchronous Provider to Provider/Patient



Telestroke

Remote Patient Monitoring

CHF Monitoring

1. *American Telemedicine Association*

Telemedicine in the Pre-COVID Era

Limited Telemedicine Adoption & Use Due To

Reimbursement

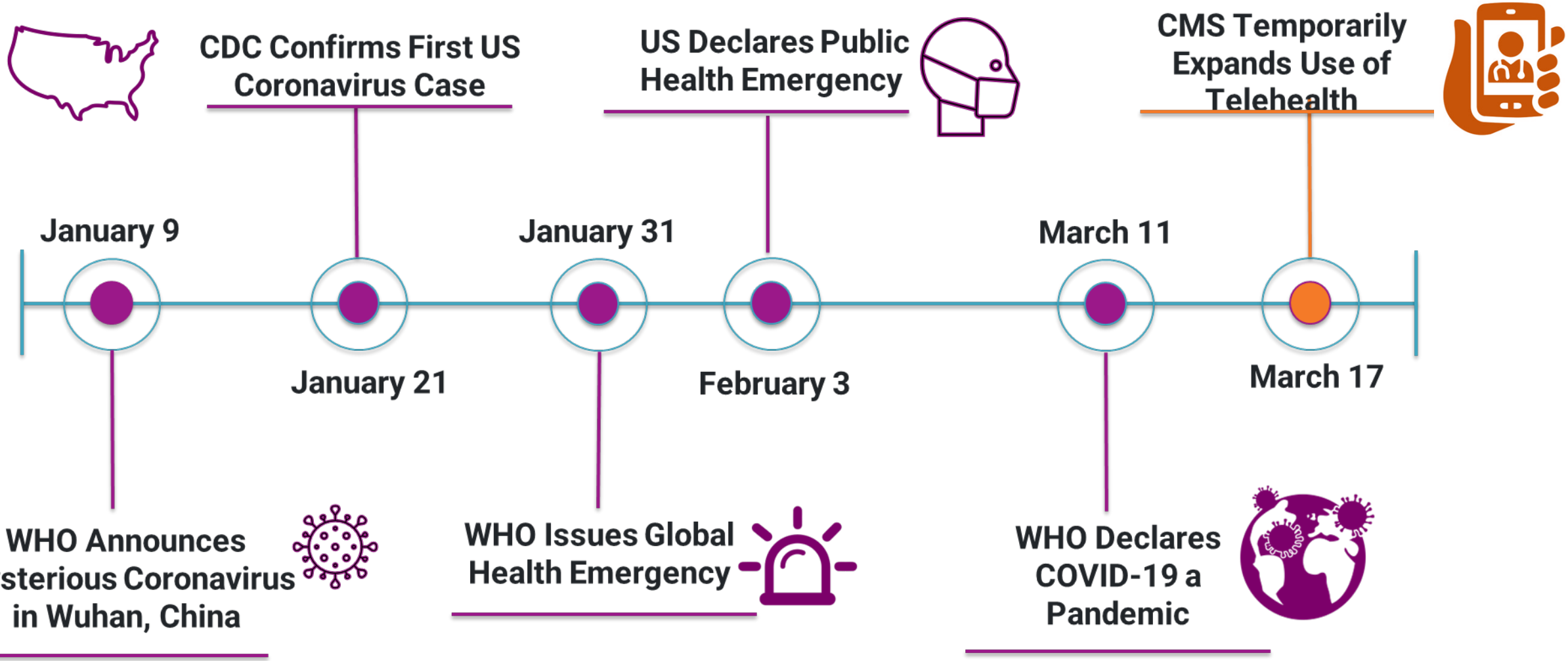
Regulatory

Physician Adoption

Patient Adoption

Technology Budgets

Early 2020 Milestones of the Coronavirus



Significant Temporary Reimbursement Changes

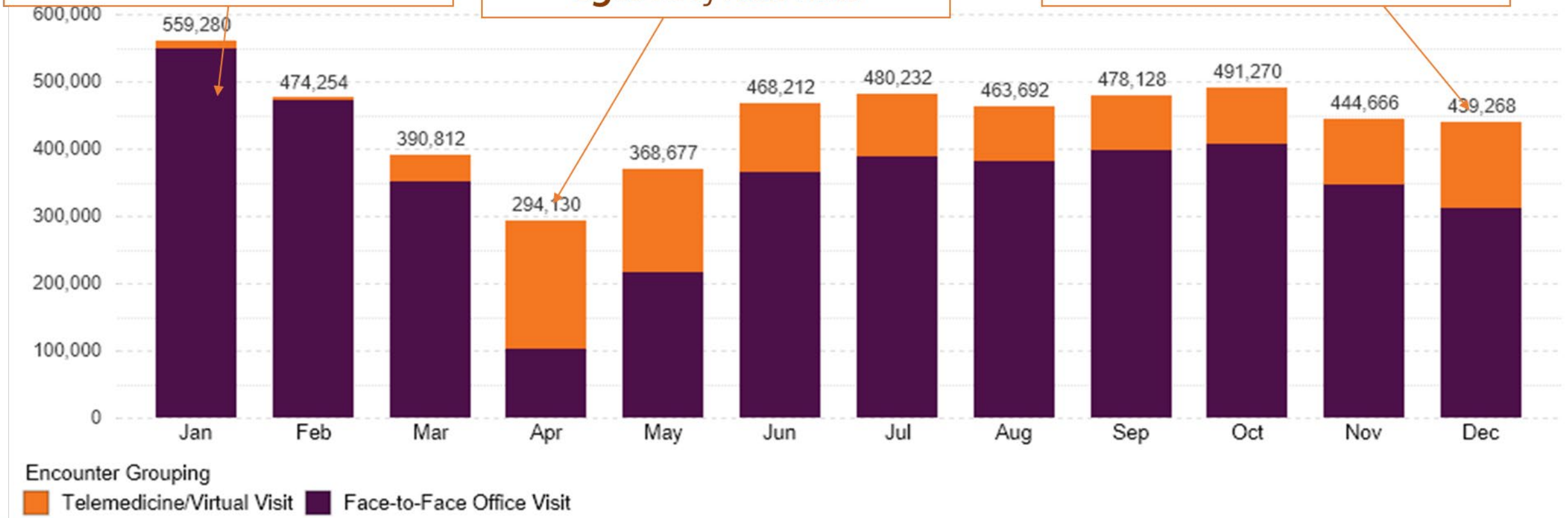
- Can bill when patient conducts visit at home
- Geographic restrictions removed
- Additional billable services added to list of Telehealth services
- Non-HIPAA compliant technologies including FaceTime and Skype may be used (Office of Civil Rights, look the other way)
- Audio-only (telephone) codes expanded and reimbursement parity with video visits
- Expanded Medical Decision Making to be utilized for E&M services, enhancing reimbursement opportunities

2020 UPMC Ambulatory Face-to-Face & Telemedicine

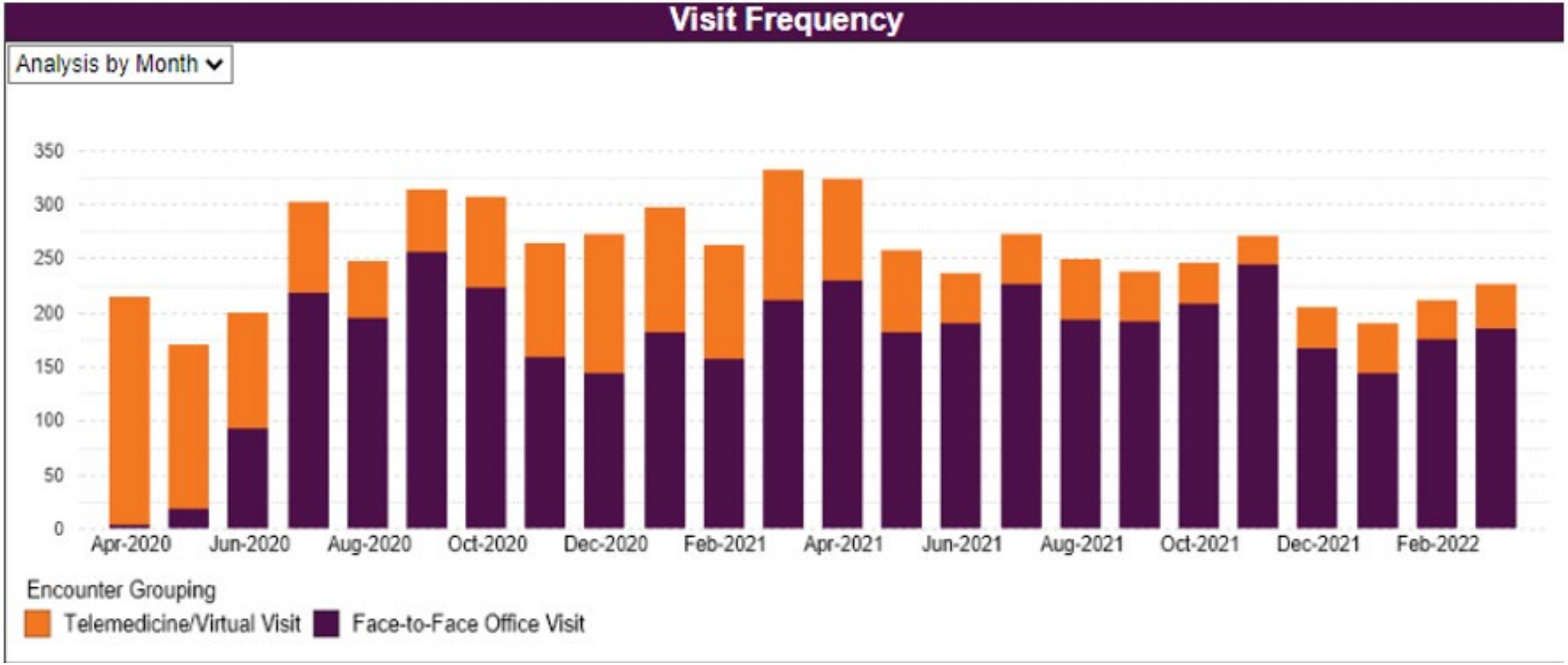
January 2020:
11,224 Visits via Telemedicine
2.0% of Total Visits

April 2020:
192,955 Visits via Telemedicine
65.6% of Total Visits

December 2020:
126,606 Visits via Telemedicine
28.8% of Total Visits

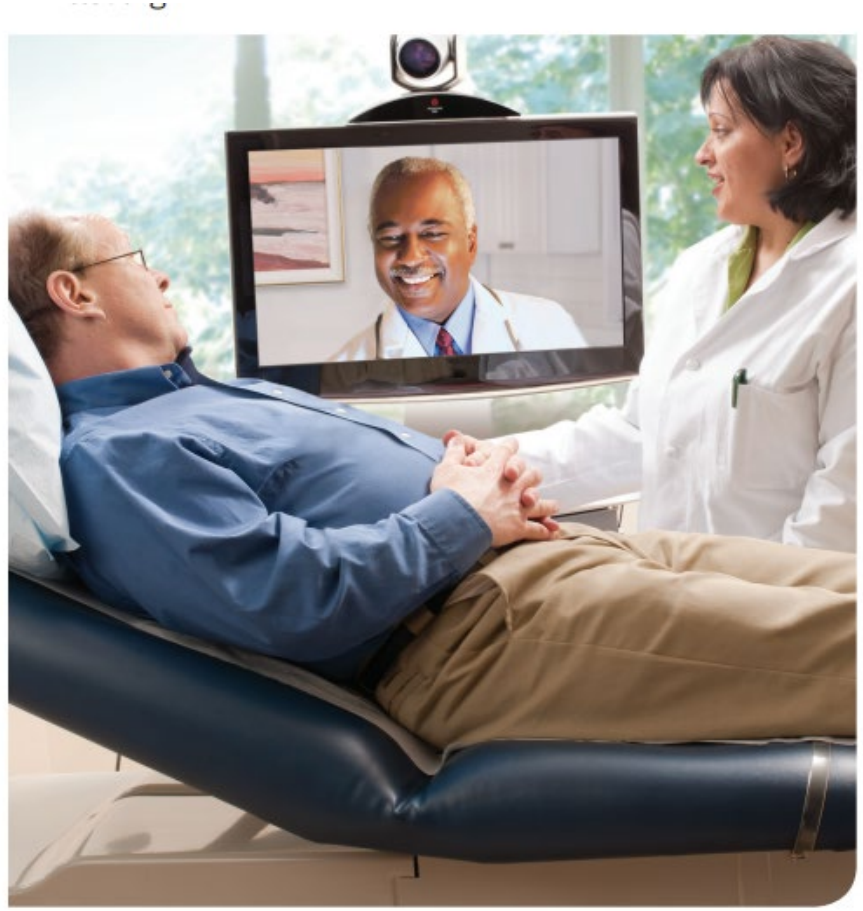


PACT (Ryan White) Clinic Face-to-Face & Telemedicine Encounters



UPMC Outpatient Telemedicine Centers

- Connect people and health care providers in small or rural hospitals and outpatient locations *(6 currently)* right to UPMC specialists.
- Aid in the diagnosis and care of urgent conditions, as well as support complex and chronic cases.
- Use HIPAA-secure equipment in a patient exam room with a staff member who oversees live video outpatient visits.



How Does This Work With Our Ryan White Program?

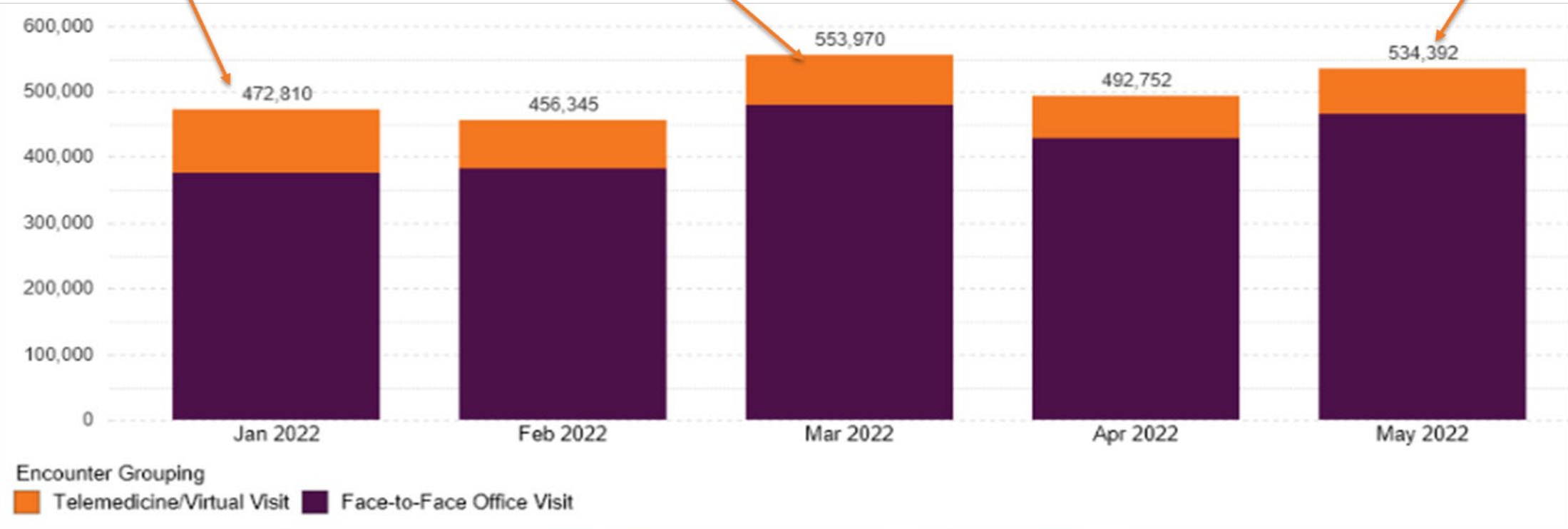
- We offer UPMC Telemedicine Centers to patients in outlying areas
- Provides convenience to our clients by keeping services close to home
- Partnering with a regional Part B recipient provider, we now can also provide services in client's home with staff traveling to them with telemedicine equipment "in a suitcase" with physician in Pittsburgh
- Patients get their bloodwork and immunizations locally

UPMC Ambulatory Face-to-Face & Telemedicine

January 2022:
96,279 Visits via Telemedicine
20.4% of Total Visits

March 2022:
74,834 Visits via Telemedicine
13.5% of Total Visits

May 2022:
68,019 Visits via Telemedicine
12.7% of Total Visits



Part 2: Logic and Billing

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and

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Revenue Cycle Pre-Pandemic

- Prior to pandemic UPMC was utilizing Telemedicine but not system-wide
  - Teleconsult centers and specialty pilot programs - primary use cases
- Reimbursement significant hurdle to adoption
  - Reduced rates for some payers with many not covering at all
- System goal was to have 100,000 Telemedicine visits between July 2020 and July 2021
  - Started with **scheduling by visit type** (to identify telemedicine visit)
- And then…

UPMC Approach to the Challenges of Telehealth

- CPT codes approved for Telehealth
- What documentation is required?
- Who can perform these services?
- What is the required Place of Service?
- Is a modifier required?
- Provider education a must

Approved Code Examples

Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements?	Medicare Payment Limitations
92012	Eye exam establish patient	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92014	Eye exam&tx estab pt 1/>vst	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92507	Speech/hearing therapy	Available up Through December 31, 2023	Yes	
92508	Speech/hearing therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	Yes	
92521	Evaluation of speech fluency	Available up Through December 31, 2023	Yes	
92524	Behavral qualit analys voice	Available up Through December 31, 2023	Yes	
94005	Home vent mgmt supervision	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Bundled code
96170	Hlth bhv ivntj fam wo pt 1st	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Non-covered service
96171	Hlth bhv ivntj fam w/o pt ea	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Non-covered service

Place of Service & Modifiers Used in Telehealth Visits

Place of Service

- 02 - Telehealth Provided Other than in Patient's Home
- 10 - Telehealth Provided in Patient's Home
- 11 - Office (Caveat for some payers)
- 21 - Inpatient Hospital (Caveat for some payers)

Appropriate Modifier Usage

- 95 – synchronous telemedicine (two-way live audio visual)
- GT – interactive audio and video telecommunications
- GQ – asynchronous telecommunications system
- G0 – telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke;

Employing Logic and Automation to Manage Constant Change

- "Held claims" at onset of pandemic as rules and requirements rapidly changed
- Claims with a Telemedicine place of service (POS), modifier, or Telemedicine-only CPT codes would qualify for hold
- Collaborated with IT to build individual payer rules, starting with Medicare, to apply appropriate place of service and modifiers
- *Even in a small practice suggest gathering this information as you go to provide a guide for billing.*

Timely & Effective Communications

- Communication vital during first six months of information gathering
- Daily updates shared with revenue cycle leadership
- Escalated issues as necessary
- Responded to questions as soon as possible

UPMC Coder's Guide

- Created a guide for coding staff to track payor communications and claims, kept up-to-date by payer
- Countless revisions required
- UPMC has the scale to centralize functions, but even small clinics should consider tracking info (by spreadsheet, etc.)
- Illustration below

Telemedicine Coding Crosswalk

		Medicare, Advantra, Gateway Medicare, UPMC for Life, Freedom & Security Blue		
Type of Service	CPT Code and Description	Code Changes	POS	Caveat
Initial and Subsequent In-Patient Visit	**Initial** 99221 Level 1 Initial In-Patient Visit (30 minutes) requires documentation 99222 Level 2 Initial In-Patient Visit (50 minutes) requires documentation 99223 Level 3 Initial In-Patient Visit - (70 minutes) requires documentation **Subsequent** 99231 Level 1 Subsequent In-Patient Visit (15 minutes) requires documentation 99232 Level 2 Subsequent In-Patient Visit (25 minutes) requires documentation 99233 Level 3 Subsequent In-Patient Visit (35 minutes) requires documentation Consults 99251- 99255 (Crosswalk to 9922X or 9923X)	No CPT Code Change Required Append 95 modifier Telestroke use GO modifier	POS 21/ POS based on hospital status	
Initial and Subsquent Outpatient Office	Establish 99211 - 99215 99201-99205 99245 (Crosswalk to 9921X or 9920X) New Consult 99241-	No CPT Code Change Required Append 95 modifier	POS 11/ POS 90057	

Illustration of Coder's Guide

Telemedicine Coding Crosswalk

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Initial and Subsquent Outpatient Office	Establish 99211 - 99215 New 99201-99205 Consult **99241-** **99245** (Crosswalk to 9921X or 9920X)	No CPT Code Change Required Append 95 modifier	POS 11/ POS 90057	
E-Consults Interprofessional consultations Verbal and Written report	99446, Interprofessional telephone/internet/electronic health record 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 healthcare professional; 5-10 minutes of medical consultative discussion and review 99447...; 11-20 minutes of medical consultative discussion and review 99448...; 21-30 minutes of medical consultative discussion and review 99449...; 31 minutes or more of medical consultative discussion and review	No CPT Code Change Required Modifier 95	POS 21/ POS based on hospital status	
E-Consults Interprofessional Consultations Written report	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 healthcare professional, 5 minutes or more of medical consultative time	No CPT Code Change Required Modifier 95	POS 21/ POS based on hospital status	
Request for E-Consults	99452, Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified healthcare professional, 30 minutes	No CPT Code Change Required No modifier	POS 21/ POS based on hospital status	
Telehealth In-Patient Initial Consult	G0425- Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth G0426...; typically 50 minutes communicating with the patient via telehealth G0427...; typically 70 minutes or more communicating with the patient via	No CPT Code Change Required Append 95 modifier Telestroke use G0 modifier	POS 21/ POS based on hospital status	Telestroke use G0 modifier
Telehealth In-Patient Follow-Up Consult	G0406- Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth. G0407...; 25 minutes communicating with the patient via telehealth. G0408...; 35 minutes communicating with the patient via telehealth	No CPT Code Change Required Append 95 modifier Telestroke use G0 modifier	POS 21/ POS based on hospital status	
Telehealth Critical Care Consult	G0508 - Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth. G0509 - Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	No CPT Code Change Required Append 95 modifier Telestroke use G0 modifier	POS 21/ POS based on hospital status	
Telephone Evaluation and Management Physician or Other Qualified Healthcare Professional	99441 Telphone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service or procedure 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. 99442....; 11 - 20 minutes of medical discussion 99443....; 21-30 minutes of medical discussion.	No CPT Code Change Required Append 95 modifier	department's default POS of the provider	UPMC for life - no modifier and POS 02
	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	G2010 No CPT Code		

AETNA | Amerihealth | Cigna | Highmark | Humana ALL plans | **Medicare Products** | MA Products | UPMC HP Commercial

Staying Ahead of Payer Variation

- **Lack of parity means different rules**
  - Pennsylvania lacks payer parity = different billing requirements
  - Our solution was to hold and release claims in waves
  - Focused on largest payer volume first
- **Communication is key**
  - Reliance on contracting team to relay updates
  - Monitor payer websites for updates
  - Information shared broadly
- **Lack of consistency continues to this day**
  - Not all payers provide clear policies or code lists to make proactive changes
- **Monitor Denials Closely**
  - We monitor denial work queues to ensure issues are reviewed and resolved
  - Multiple instances where payer revised their place of service requirements, yet their system was not updated to reflect the change

CPT Logic

- In order to create and maintain various payer rules, central Coding Dept maintains payer grid with rows for audio and video codes, POS, and modifiers and separate columns by various payer groups
- Code sets originally limited to office visit E&Ms and various audio-only codes
- Later expanded, starting with Medicare's Telehealth services list as well as individual payers with clear sets of billable codes in their telehealth policies
- Over time, revised and rebuilt rules as payers who had once followed the same logic changed
- We needed to change automation to reflect those changes
- Resulted in additional charge lag and testing
- **Maintaining flexibility and being able to adjust logic by service date will be particularly important as we approach the potential public health emergency end date**

Employing Automation

- Worked with our IT team to build a utility to stamp claims based on visit type to distinguish audio-only and video visits
- Goal: **Standardize** as much as possible to limit confusion on system communications and billing
- A claim getting the necessary remit stamp drives what codes are allowable in work queues and what POS and modifier should be attached or suppressed
- Challenges with non-scheduled visits and incorrectly scheduled that require periodic batches of remit code stamping that IT performs for us
- A “clean claim” scheduled appropriately and with a billable Telemedicine code should not be held by our claim edit logic

Ensuring Documentation Compliance

- **Telemedicine visits require specific documentation and amount of time spent**
  - Engaged Corporate Compliance and Legal to create standard attestation language for audio-only and audio/video visits
  - Facilitated process quickly to incorporate into provider training and education
- Initially worked with department administrators and relationship management team to troubleshoot documentation issues – escalated, resolved and educated
- We also held team town hall meetings or providers to show how to handle documentation in the electronic medical record and fielded questions.
- Today we follow up directly with individual providers and periodically audit for accuracy

Average Claims Held

Time Period	Average Encounters Held
Apr-Jun 2020	224,158
Jul-Sep 2020	81,516
Oct-Dec 2020	45,246
Jan-Mar 2021	29,814
Apr-Jun 2021	15,252
Jul-Sep 2021	8,667
Oct-Dec 2021	7,905
Jan-Mar 2022	9,712
Apr-Jun 2022	6,385

Telemedicine Volume

Year	Telemedicine Visits
2020	1,084,412
2021	967,380
2022 (Jan-May)	**377,520**

Work in Progress - Snapshot of Medicare Reimbursement

UPMC
Telemedicine Reimbursement Analysis - Physician
Top 5 CPT's According to Volume - Medicare Only
June - December '21

Note - reflects fully adjudicated accounts with zero balance only. Includes Service Areas 10, 11, 24, 25 & 60.

CPT & PROCEDURE DESCRIPTION	Telemed Transaction Volume	Telemed Avg Reimbursement
99213 - EST,LEVL Ill, OFFICE/OUTPT VISIT	107	$ 66
99214 - EST,LEVL IV OFFICE/OUTPT VISIT	98	$ 88
99204 - NEW,LEVL IV, OFFICE/OUTPT VISIT	33	$ 115
99215 - EST,LEVL V, OFFICE/OUTPT VISIT	43	$ 147
99212 - EST,LEVL Il, OFFICE/OUTPT VISIT	55	$ 44

CMS Approved Telehealth Services

Year	Number of Covered Services
2019	98
2020	191
2021	251
2022	278

Part 3: How A Physician Bills

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New Changes

- CMS has formally adopted the new AMA E/M coding rules and they went into effect **January 1, 2021**
- "Patient over Paperwork"
- Level of service determined by medical decision making (MDM) or time
  - No longer require elements from history and physical examination
- These new E/M guidelines only apply to:
  - **New Patient Office Visits 99202-99205**
  - **Established Patient Office Visits 99212-99215**

E/M Codes by Time and MDM

E/M code New Patient*	TIME (minutes)	MDM
99201	Removed from 2021 code set	Removed from 2021 code set
99202	15-29	Straightforward
99203	30-44	Low level
99204	45-59	Moderate level
99205	60-74	High level

E/M code Established Patient	**TIME (minutes)**	**MDM**
99211	NA	Minimal (i.e. RN visit
99212	10-19	Straightforward
99213	20-29	Low level
99214	30-39	Moderate level
99215	40-54	High level

* New patient is one who has not received services within the practice in the last 3 years

By Time

Total time on the <u>date of service</u> = face-to-face + non-face-to-face time

- **This includes:**
  - Preparing to see patient (reviewing tests and outside records)
  - Obtaining history from patient
  - Performing a medically appropriate exam/ evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medication, tests, or procedures
  - Referring and communicating with other providers
  - Documenting clinical information in the EHR
  - Independently interpreting results
  - Care coordination

- **Must document how much time was spent on the visit**
  - Epic SmartPhrase: **.billingtime**
- "Total time (face-to-face and non-face-to-face) spent on today's visit was *** minutes. This included preparation for the visit, performance of a medically appropriate history and examination, and orders for medications, tests or other procedures."

Medical Decision Making (MDM)

- 3 elements of MDM
  - Element 1: Number and acuity of problems addressed
  - Element 2: Complexity of data reviewed and analyzed
  - Element 3: Risk of complications and/or morbidity or mortality
- **Only need 2 of 3 elements**
- History and physical exam do not count towards MDM
  - Clinically relevant information should be documented, or for medico-legal reasons
- Will need to document the components that are being counted as part of MDM
- **Components do not need to happen on the same day as the encounter**

AMA/CMS Guidelines

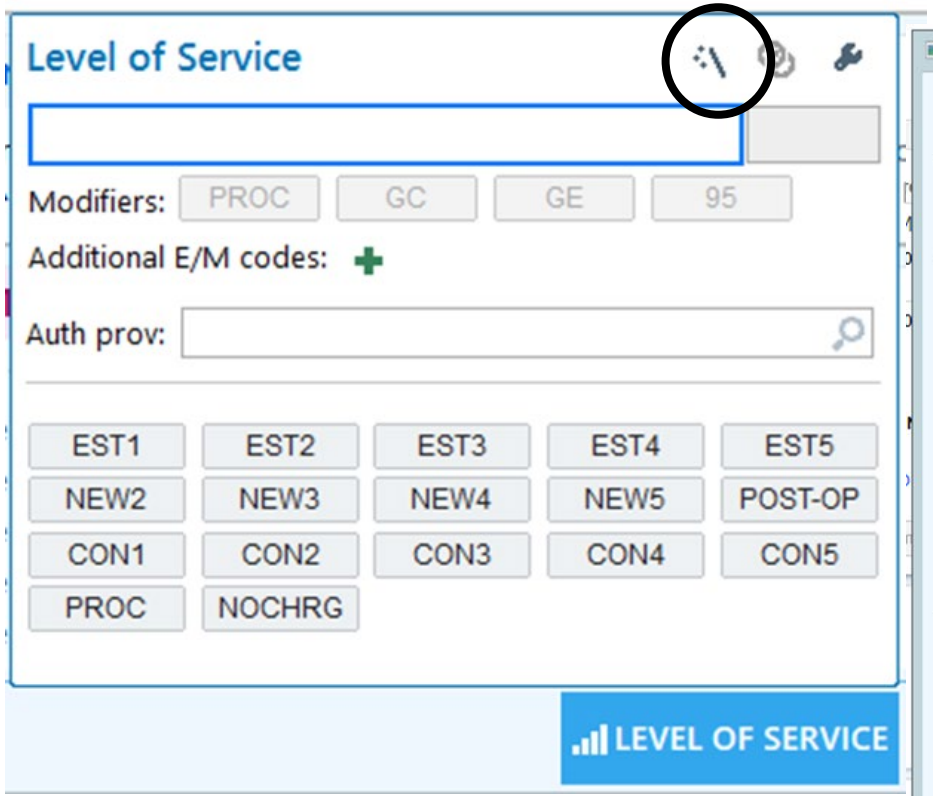
Code Level	MDM (Need 2 of 3 for level of billing)			
		Number and Complexity of Problems Addressed	Amount/Complexity of Data Reviewed	Risk of Complications and Morbidity
99202 (15-29 min) 99212 (10-19 min)	Straight-forward	• 1 self-limited or minor problem	• Minimal to none	• Minimal risk from additional testing/treatment

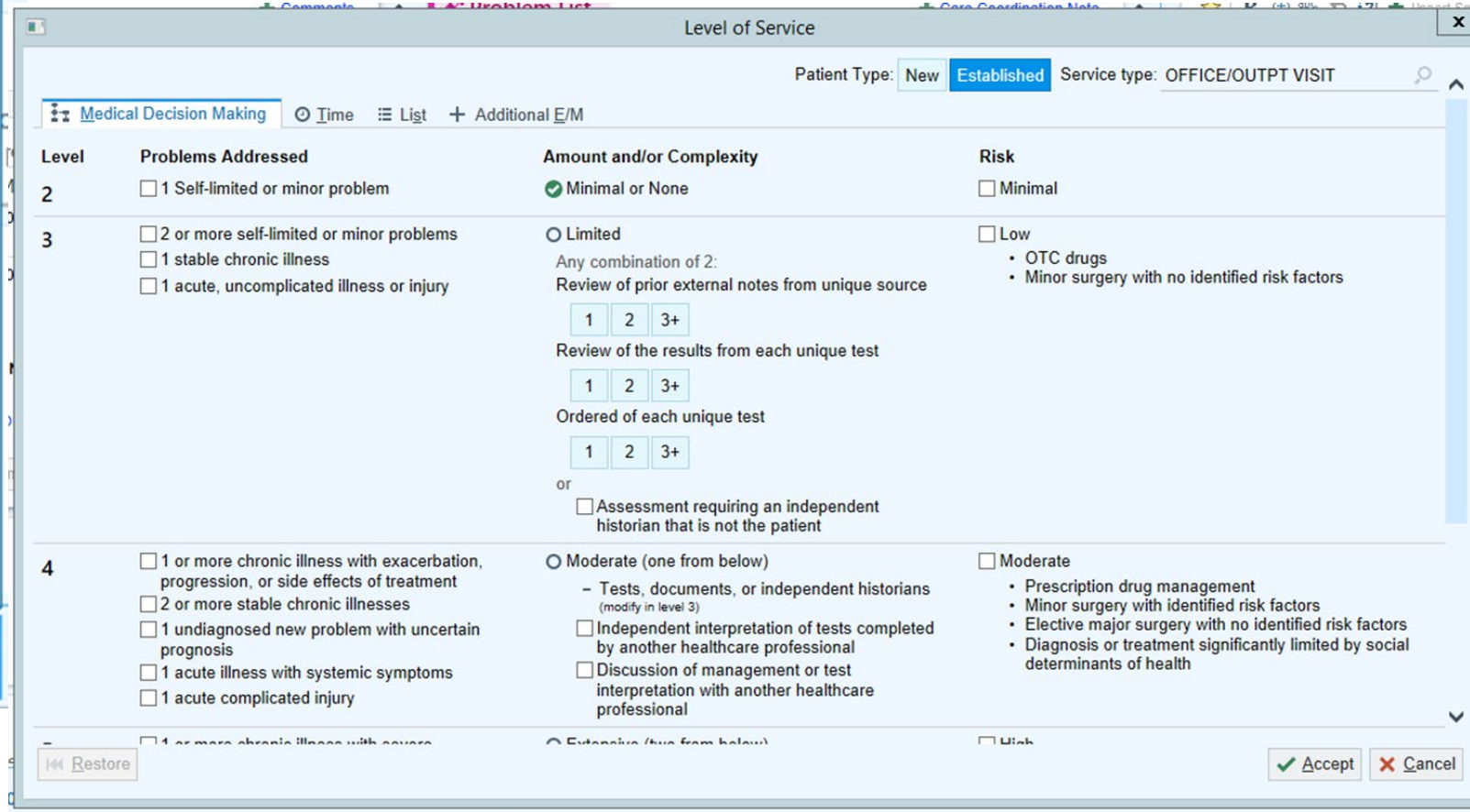
99203 (30-44 min)
 	
99213 (20-29 min)
	Low	• 2 or more self-limited/minor problems
		• 1 stable chronic illness
		• Acute uncomplicated illness/injury
			Must meet 1 of 2 requirements:
			• Category 1: Tests and documents (any combo of 2)
			  • Review of prior external notes
			  • Review of results of each unique test
			  • Ordering of each unique test
			  OR
			• Category 2: Assessment requiring an independent historian
				• Low risk of morbidity from additional testing or treatment

99204 (45-59 min)
 	
99214 (30-39 min)
	Moderate	• 2 or more stable chronic illnesses
		• 1 or more chronic illness with mild exacerbation or side effect of treatment
		• 1 undiagnosed new problem with uncertain prognosis
		• 1 acute illness with systemic symptoms
		• 1 acute complicated injury
			Must meet 1 of 3 requirements:
			• Category 1: Tests, documents, historian (any combo of 3)
			  • Review of prior external notes
			  • Review of results of each unique test
			  • Ordering of each unique test
			  • Assessment requiring an independent historian
			  OR
			• Category 2: Interpretation of Tests
			  • Independent interpretation of a test performed by another provider (not separately reported)
			  OR
			• Category 3: Discuss management/tests
			  • Discussion of management or tests with an external provider
				• Prescription Drug Management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205 (60-74 min) 99215 (40-54 min)	High	• 1 or more chronic illness with severe exacerbation/progression, or side effects of treatment • Acute or chronic illness or injury that may pose a threat to life or bodily function	**Same as Moderate but requires 2 of 3 categories**	• Drug therapy requiring intensive monitoring for toxicity • Decision for elective major surgery with identified patient or procedure risk factors • Decision for emergency major surgery • Decision regarding hospitalization • Decision for DNR or to De-escalate care

EpicCare Assistance





Billing for Phone Visits

- Phone telehealth (audio only):
  - Must use phone E/M codes 99441-99443 which are based on time
- Epic Smartphrase = .telemedphone

"This consultation was provided via telemedicine from patient's home using audio telecommunications technology between the patient and the provider. Verbal consent has been received. *** minutes were spent consulting with the patient."

Billing for Video Visits

- Video telehealth (audio-video):
  - Can be billed on either time or MDM using the E/M codes
  - Use ‘95’ modifier to indicate that this was a synchronous visit
- Various modalities:
  - Vidyo, Zoom, Doximity, Abridge, Skype, Facetime
- Epic Smartphrase = .telemedicine

“This consultation was provided via telemedicine from patient's home using two-way, real-time interactive telecommunications technology between the patient and the provider. The interactive telecommunication technology included audio and video. Verbal consent has been received.”

Example Case

ASSESSMENT AND PLAN:

1. **HIV**
- Will continue ABC/3TC/DTG; pt with excellent adherence.
- Check safety labs (CBC, LFT's, BUN/Cr) and viral load today.

2. **Anal dysplasia**
- Recent anoscopy with ASCUS pathology repeat in 1 year.

3. **COPD**
- No recent exacerbations. Quit smoking years ago.
- Continue Incruse Ellipta and uses albuterol as needed.

4. **Wrist mass**
- Based on exam likely bony vs ganglion cyst - will start with xray today and U/S to evaluate bone vs cystic lesion and need for next steps.

5. **Healthcare maintenance**
- Received flu vaccine this year. Looking for COVID vaccine appt and walked him through a few options. Last colonoscopy in January of 2019 with recommendation to repeat in 2021.

- Number and Complexity of Problems:
  - 3 chronic
  - 1 undiagnosed new problem
- Amount of Data:
  - Ordered 6 unique tests
  - Reviewed 1 test
- Risk:
  - Prescription drug management

MDM 99214

Physician's Perspective

- Less documentation required with the changes
- Changes focus to where we already spend most of the visit:
  - Medical decision making
  - Counseling (i.e. time)
  - Reviewing
- Easier to support higher levels of service
- Video visits can be conducted and billed similarly to face-to-face
- Allows me to finish notes faster!!

Part 4: If I Had a Crystal Ball

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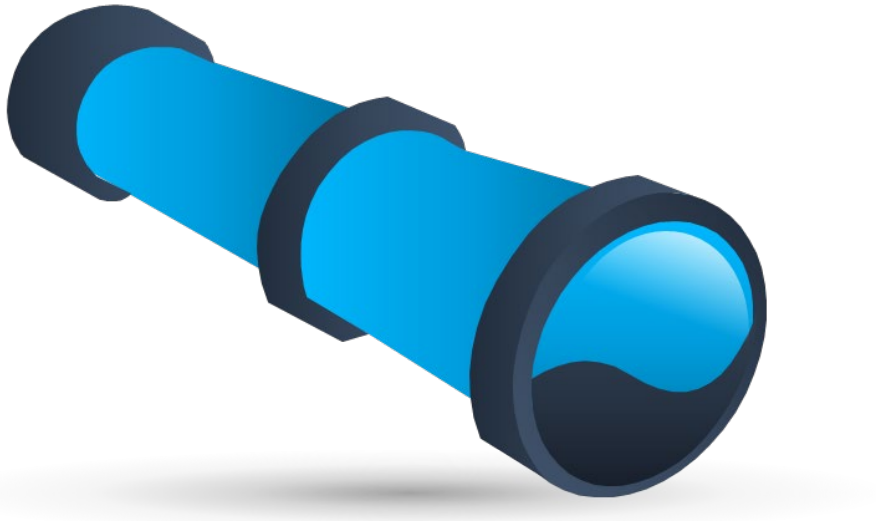
"The genie's out of the bottle on this one."

-Seema Verma, Administrator for CMS

What Might Telemedicine Look Like When Public Emergency Ends



Post-pandemic

- Out-of-State licensing
- New vs. Established patients
- Reimbursement
- What will Medicare do?
- Audio/Video vs. Phone visits
- Use of technologies, e.g., Skype, Facetime, Zoom, etc.

Part 5: Lessons Learned

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NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Resources

1) For up-to-date codes permitted by CMS for telemedicine:

https://www.cms.gov/files/zip/list-telehealth-services-calendar-year-2022-updated-06172022.zip

2) CMS Medicare Learning Network

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo

3) American Telemedicine Association https://www.americantelemed.org/

4) Center for Connected Health Policy (national policy resource)

https://www.cchpca.org/

5) CPT E/M Office Revisions | AMA (ama-assn.org) (Medical Decision-Making table)

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Thank you!