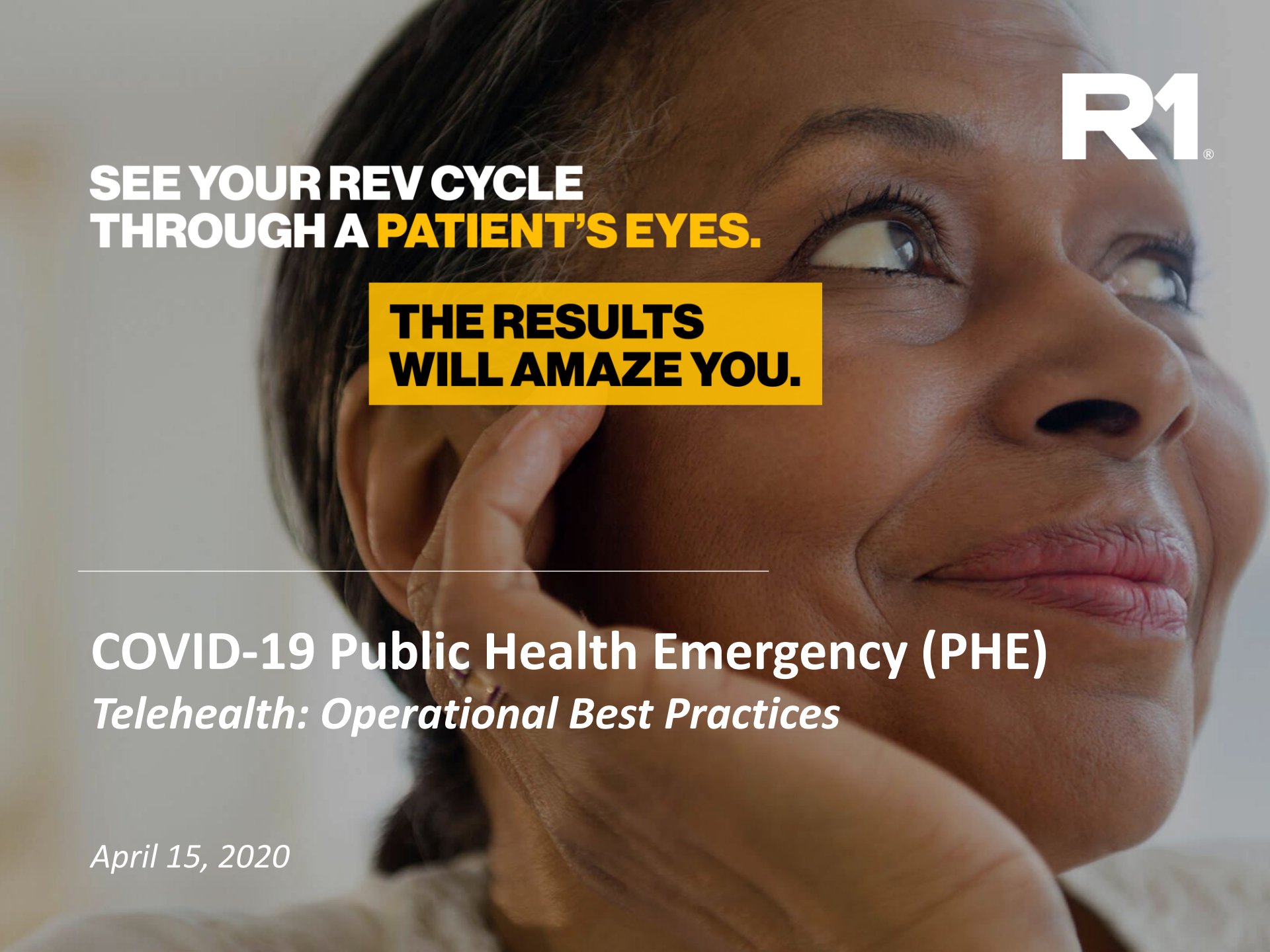


COVID-19 Public Health Emergency (PHE)

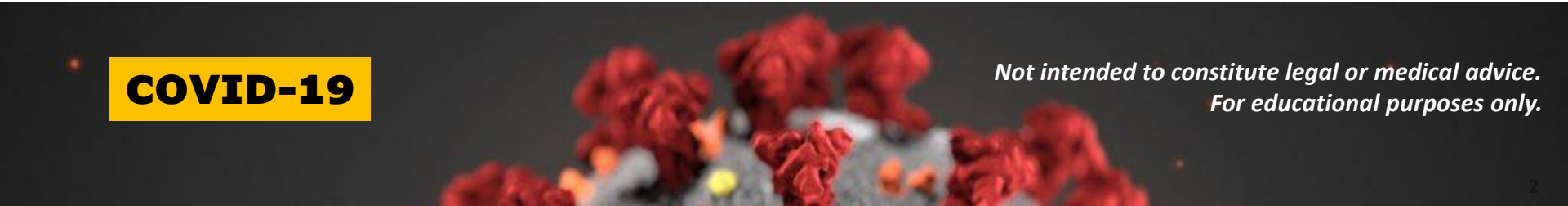
Telehealth: Operational Best Practices

April 15, 2020

Disclaimer

The purpose of this presentation is to briefly cover updates related to healthcare technology-enabled service changes in response to the novel coronavirus, discussing operational best practices incorporated with regulatory reference. As physicians continue implementing their COVID-19 plans, all decisions should be implemented with the assistance of your legal and compliance resources.

To the best of our knowledge, this information was correct at the time of publication. Given the fluid situation, and with updated guidance issued daily, please be aware that some or all of this information may no longer apply.



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Today's R1 Regulatory Team

Amber Thomas, JD – Vice President, Regulatory Compliance & Operational Audit

Amber has been leading the regulatory advisory and guidance function at R1 RCM since 2015. Prior to joining R1, Amber was the compliance officer for the largest public hospital in the United States, Jackson Memorial Hospital & Holtz Children's Hospital in Miami, Florida. Amber began her career as a regulator at the Centers for Medicare & Medicaid Services, Division of Technical Payment Policy and then served in the Office of General Counsel for CMS's Program Integrity Division. Amber also practiced law at a mid-size regional law firm where she focused on legal and regulatory issues in health care transactions between physician groups and hospitals.

Kathryn S. Beard, JD – Manager, Regulatory Compliance

Kathryn has more than ten years' experience in healthcare. As a Regulatory Compliance Manager, Kathryn proactively monitors legislative and regulatory developments at the federal, state, and local level to ensure the organization is prepared to properly implement changes. Kathryn's primary areas of research and analysis are provider reimbursement and enrollment in the federal healthcare programs, surprise billing legislation, scope of practice laws and regulations, and state requirements that may impact revenue cycle management service providers. She has authored and edited multiple publications on healthcare compliance and Medicare/Medicaid reimbursement, led webinars as moderator and presenter, and guest-lectured law students on the Medicare and Medicaid programs.

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Today's R1 Operations Team

Yvonne Russell, CPC, CPMA, CDEO, CFPC – Director of Auditing and Coding

In her position, Yvonne directs provider education operations to physicians, advanced practice providers, nurses, practice administrators, and ancillary personnel in acute and ambulatory settings. She works with physician groups to implement internal audit processes for coding accuracy, policies, and procedures to ensure an efficient and healthy revenue cycle. Her expertise enables process improvements for physician organizations by analyzing coding trends and make recommendations to improve overall clinic reimbursement. Yvonne was the billing Director at Medical Edge for five years prior to joining R1. Yvonne specializes in Medicare Risk Adjustment and is an expert in clinical documentation improvement.

Priya Patel, MPH – Director of Revenue Cycle Services

Revenue Cycle Expert with strong ability to leverage skills in project management, change management, industry experience and the strategic use of business intelligence tools to evaluate company performance, build organizations and solve problems in the hospital and physician revenue cycle arena with over 20 years of experience. Priya has worked with Process Improvement/Lean staff related to process improvement initiatives and RIEs resulting in increased point of service collections, increased pre-registrations and increased patient satisfaction scores resulting a multiple million dollar return on investment. Priya has overseen end-to-end revenue cycle organizations for several hospitals, including comprehensive improvements that cover every phase of the revenue cycle within the hospital and physician practice space. Focus areas include: shared services, process standardization and integration, workflow automation, technology optimization, workforce planning and the patient experience.

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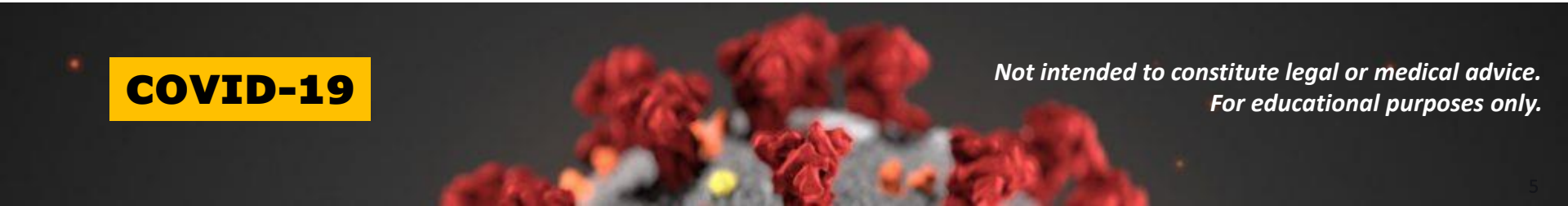
COVID-19 PHE

On January 30, 2020, the Secretary of the U.S. Department of Health and Human Services (HHS) declared a Public Health Emergency (PHE) related to the 2019 novel coronavirus disease (COVID-19).

COVID-19 is highly contagious; during the PHE, virtual care services are helping to minimize exposure for patients and providers. Both government and private payers are expanding the availability of these services to provide maximum flexibility.

With the ability to perform more technology-enabled services as a result of the COVID-19 PHE, medical groups need to be armed with the operational information to implement these services in an expedited and compliant manner. The following provides operational best practices incorporated within the regulatory framework when providing technology-enabled services.



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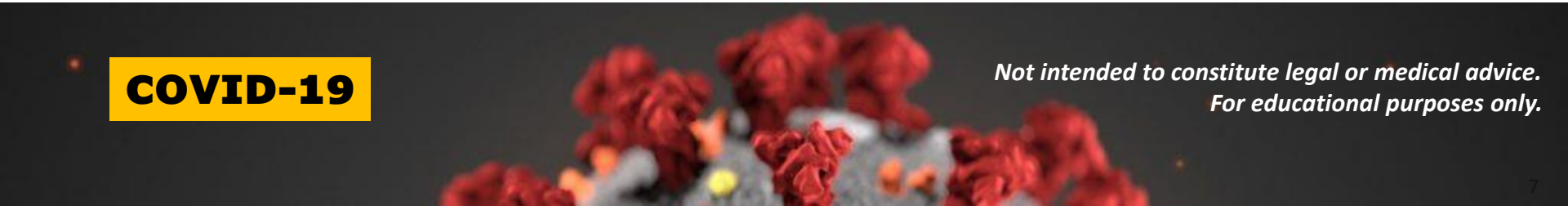
Telehealth Services During the PHE

Telehealth Services During the PHE

1. Know the Types of Technology-Enabled Services

- **Telehealth Visits**
  - Use of telecommunication technology for office, hospital, and other services generally provided in-person
  - Considered the same as in-person visit; paid at the same rate
- **Virtual Check-Ins**
  - Brief communication with a practitioner via telephone or information exchange (e.g., image or video)
  - Practitioners could also respond to patient communications via text message, email, or patient portal
- **e-Visits**
  - Patient initiated communication via online patient portal
  - Practitioners who cannot bill independently can provide certain e-Visit services
- **Remote Patient Monitoring (RPM)**
  - Sometimes referred to as “remote physiologic monitoring”
  - Mainly for the care of patients with chronic conditions



Telehealth: Operational Best Practices

Telehealth: Operational Best Practices

2. Know the Scope of Applicable Waivers

- We recommend reviewing CMS 1135 blanket waiver rules and allowances for your state of practice. These may relax provider enrollment guidelines, including approval for FFS along with other criteria.
- We recommend reviewing CMS's list of **Medicaid Waiver States** for up-to-date information about state waivers CMS has granted as well as State Plan Amendments (SPA).
  - https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

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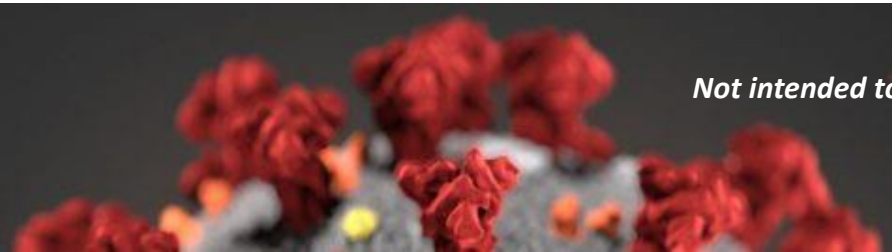
3. Know which services can now be billed for new and existing patients

- For the duration of the COVID-19 PHE, CMS is exercising enforcement discretion to relax requirements related to the new or established patient aspect of the code descriptors for telehealth services, virtual check-ins, and remote patient monitoring.
- We recommend referencing the CMS toolkit for up-to-date releases regarding COVID and the public health emergency.
  - https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit



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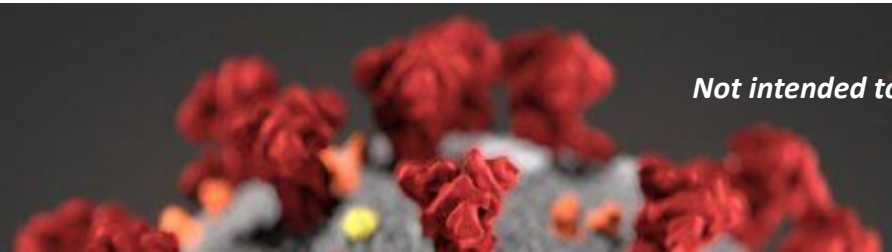
4. Understand telephone communications rules

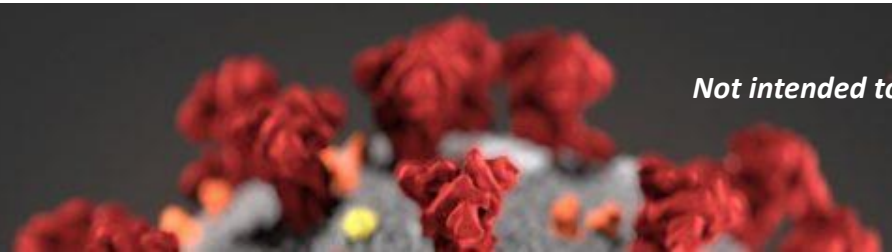
- For the duration of the COVID-19 PHE, CMS established separate payment for CPT codes 99441-99443 and 98966-98968, which can be furnished using *audio-only* modalities. These are telephone E/M visits that were not previously covered by Medicare.
- These services can be furnished to *both new and established* patients, even though these codes are intended for established patients only. During the PHE, CMS is exercising enforcement discretion to relax enforcement of this aspect of the code descriptors.
- A modifier is not needed unless specified (e.g., Illinois Medicaid).



Telehealth: Operational Best Practices

5. Establish electronic medical record workflows

- We recommend detailed tips and tricks for providers by host system for all telehealth and virtual check-in visits.
  - This should include process and scripting for obtaining consent as virtual check-ins have been expanded to cover new patients and documentation guidelines for all providers and telemedicine visits
- We recommend creating new appointment types allowing for more controlled workflow for providers. For example, create a virtual provider office ("VPO") to help drive the workflow.



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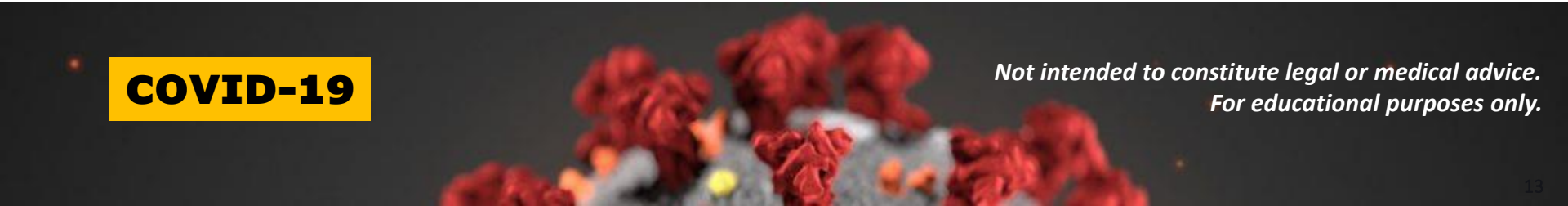
6. Add telemedicine and COVID-19 related CPT/HCPCS to the CDM

- CMS expanded the list of ordinarily covered telehealth codes to now include more than 80 additional codes during the PHE.
  - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- As physician medical groups create pop-up clinics, related CPT/HCPCS and departments should also be built and placed on hold.

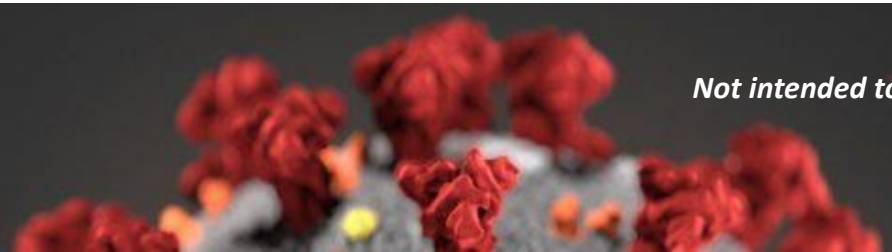
NOTE: Qualifying originating site, geographic limitations, frequency restrictions, and other criteria have been relaxed during the emergency.



Telehealth: Operational Best Practices

7. Develop pricing for newly added codes

- We recommend following a set standard at your organization related to pricing.
- When allowable, price the expanded telehealth CPT/HCPCS code set at the same rate as when that service is provided in person.



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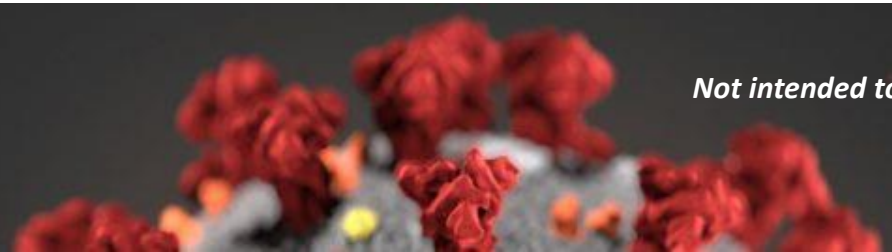
8. Know when to append billing modifiers

- We recommend that “95” modifiers be appended on all **telehealth (audio and video)** services unless otherwise specified by the payer.
- A “CS” modifier should be applied for Medicare patients when an E&M results in **an order for** administration of a COVID-19 clinical diagnostic laboratory test and relates to:
  - The furnishing or administration of such test OR
  - To the evaluation of the patient for purposes of determining the need for a COVID-19 test.
- Commercial and Medicaid payer billing specifications varies and, in some instances, yet to be provided.



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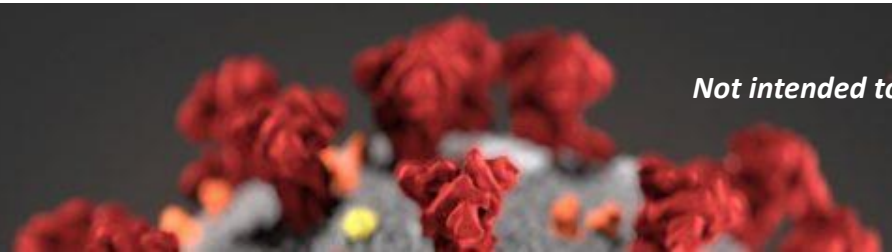
9. Establish "pre-claim release" holds in the host system

- We recommend configuring edits to stop claims **prior to billing** based on the presence of the 95 modifiers or whatever modifier your regional payers have requested (e.g., modifier GT) for telehealth claims. This will allow for coder and biller review.
- We recommend configuring edits to analyze claims **prior to billing** based on the POS code for telehealth claims.
- Holds should also be built for all telemedicine codes, including virtual check-in codes.
- If needed, correct claims for telehealth services based on a thorough review of payer-specific guidelines, including newest guidance from CMS on diagnostic and antibody testing.



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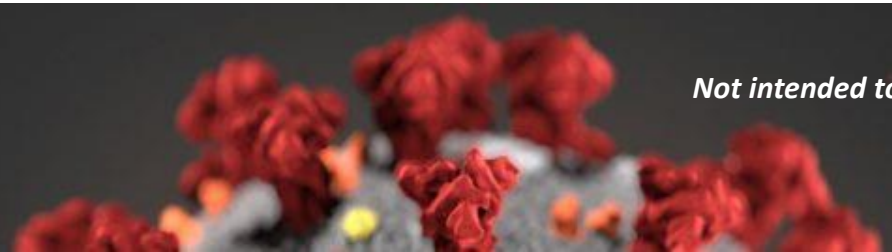
10. Develop a major commercial payers and governmental plans coverage matrix for each market

- Document the requirements and rules for billing telehealth for these payers.
- We recommend use of a resource similar to ***R1's Payer Telehealth Matrix*** for analysis of top payers.
- Note, recent federal legislation has imposed requirements on payers to reimburse for certain COVID-19 related services.
  - https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf



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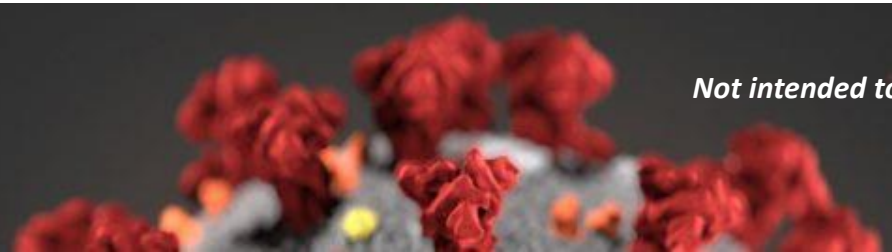
11. Conduct quality reviews of claims before release

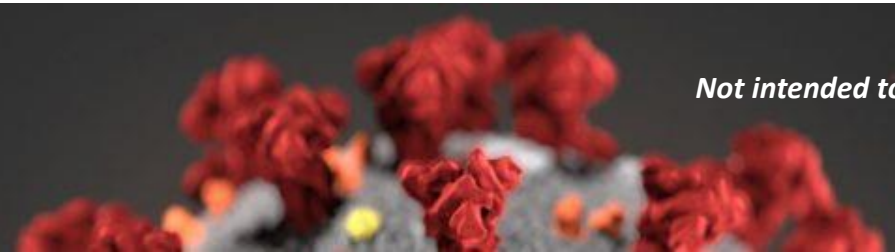
- We recommend releasing claims based on payer guidance received. As noted previously, if specific guidance is not received, we recommend following Medicare guidelines (unless you are awaiting further guidance from a payer).
- We recommend daily tracking on:
  - Pre-bill holds while claims are being released.
  - Daily staff productivity and establishing triggers for contingency if backlogs occur (e.g., additional contract support, overtime).
  - Denials, payments and potential educational opportunities for providers.



Telehealth: Operational Best Practices

12. Provide tip sheets to all providers of telehealth services

- We recommend identifying providers who will be trained on each telemedicine vertical and assess staffing skills and determining which providers can provide what services.
- For example, for virtual check-ins, CPT codes 98966-98968 describe assessment and management services performed by practitioners who cannot separately bill for E/M services.
- These virtual check-in codes may be furnished by, among others, **licensed clinical social workers, clinical psychologists, and physical therapists, occupational therapists**, and **speech language pathologists** when the visit pertains to a service that falls within the benefit category of those practitioners.



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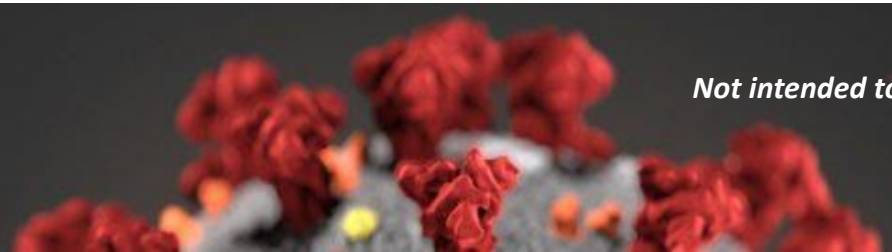
13. Strategically leverage your revenue cycle partners

- Points of contact and communication distribution should be formalized during daily COVID/telemedicine huddles. These huddles should include operations leadership, IT leadership, revenue cycle leadership and medical leadership with ad hoc compliance representation.
- We recommend webinar training for providers, clinic operations and revenue cycle staff. Sessions should be recorded to allow for reference as well as FAQ documents.
- Training focus should also include hospital-based services and nursing home guidance.



Telehealth: Operational Best Practices

THANK YOU – Q & A

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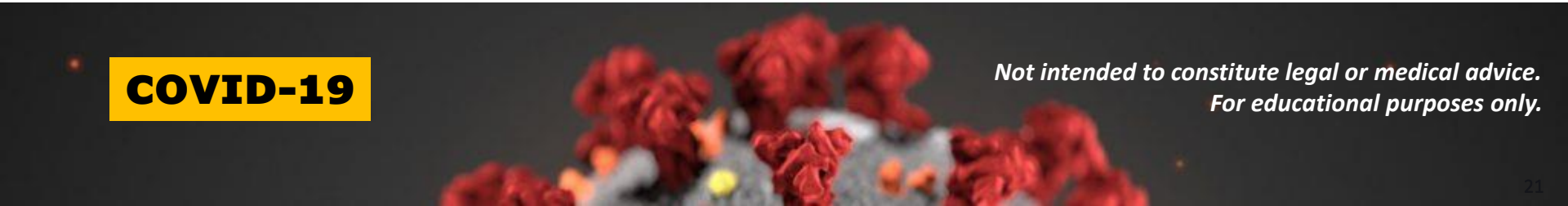

Closing Remarks