Managing Risk Adjustment in Light of the Pandemic: A Focus on Telehealth

Presented By:

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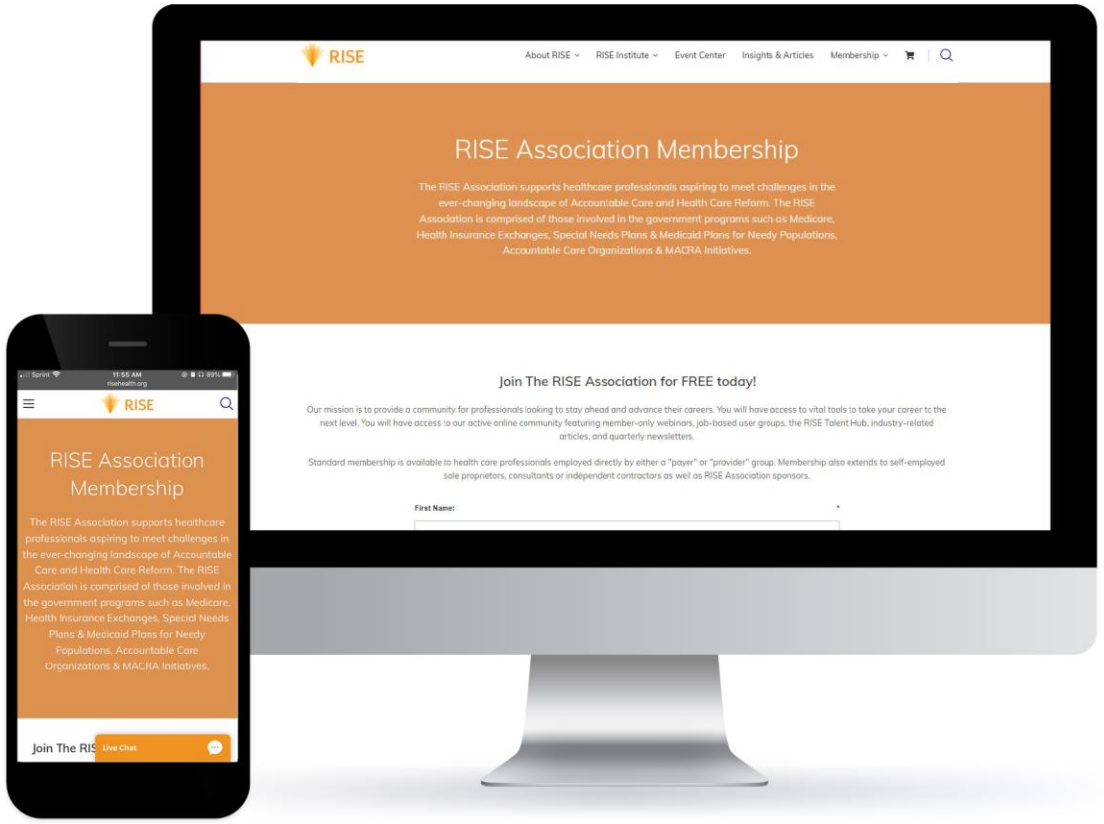

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Agenda

- Background
- Telehealth
- Billing, Coding, and Payments
- Clinical Examples
- Risk Adjustment Impact and Strategies
- Discussion

Change Healthcare Speakers:

Keith Mazzoni, Director of Federal Programs
Keith has worked in the Medicare Advantage risk adjustment space since 2007. Before Change Healthcare, he was the risk adjustment program director at a large mid-Atlantic regional plan with over 125,000 MA members. Having worked for both sides, he understands the unique challenges faced by vendors and insurers in the risk adjustment market.

Cheryl Sisteck, Lead Data Analyst, Risk Adjustment
Cheryl is a health data management professional with extensive experience in risk adjustment and payer-provider relations. Cheryl brings a diverse perspective to the healthcare industry with knowledge of health plans, integrated delivery systems, and physician groups as well as in quality, medical management, and operations.

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CHANGE HEALTHCARE

Section 1.0

BACKGROUND

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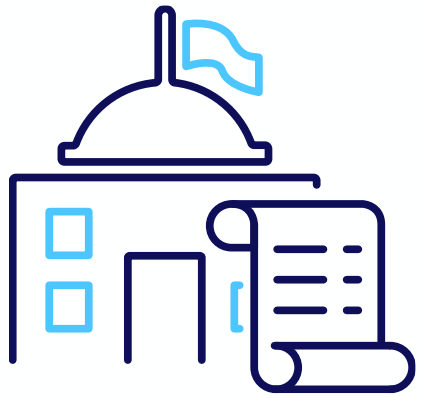
Background

The Coronavirus Preparedness and Response Supplemental Appropriations Act



- Signed into law on March 6, 2020.
- Allowed the Secretary of the Department of Health and Human Services (HHS) to waive certain Medicare telehealth payment requirements during the Public Health Emergency (PHE).
- Allowed beneficiaries in all areas of the country to receive telehealth services, including in their homes as of January 31, 2020.
- Removed limitations on where Medicare patients are eligible for telehealth.

Remains in effect until the PHE ends

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Background

1135 Waivers: Increases access to needed services by allowing the Centers for Medicare & Medicaid Services (CMS) to waive some requirements across Medicare, Medicaid, and CHIP

- Streamlines provider enrollment processes.
- Allows care to be provided in alternative settings, i.e., in unlicensed facilities if a licensed facility is evacuated.
- Waives prior authorization requirements.
- Suspends some nursing home screening requirements to provide necessary administrative relief.
- Extends deadlines for appeals and state fair hearing requests.

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Section 2.0

TELEHEALTH

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General Telehealth Guidelines

Who

A range of providers, such as:

- Doctors
- Nurse practitioners
- Clinical psychologists
- Registered dieticians and nutritionists
- Licensed clinical social workers

What

Telehealth is the use of electronic information and telecommunication technologies to support long-distance clinical healthcare, patient and professional health-related education, public health, and health administration

When

- Effective as of January 31,2020
- Remains in effect until PHE ends

Where

Services provided by a clinician via telehealth vs. normal locations:

- Emergency department
- Initial nursing facility and discharge visits
- Home visits
- Therapy services

How

- Providers may use interactive applications (apps) with audio and video capabilities to visit with their patients for an even broader range of services
- Audio phone only are also acceptable for evaluations

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Virtual Services – Telehealth Overview

Distant site practitioners that provide and get payment for covered telehealth services (subject to state law) can include:

- physicians
- nurse practitioners
- physician assistants
- nurse midwives
- certified nurse anesthetists
- clinical psychologists
- clinical social workers
- registered dietitians
- nutrition professionals

- HHS announced a **policy of enforcement discretion for Medicare telehealth services** furnished pursuant to the waiver under section 1135(b)(8) of the Act.
- To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a practitioner, **HHS will not conduct audits to ensure that such a prior relationship existed** for claims submitted during this PHE.
- HHS Office for Civil Rights (OCR) will exercise enforcement discretion and **waive penalties for HIPAA violations against health care providers that serve patients in good faith** through everyday communications technologies, such as FaceTime or Skype, during PHE.

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Providers' Points

- New and established patients may utilize telehealth visits.
- Services can be provided via telehealth for patients with acute and/or chronic conditions.
- May reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.
- Bill for telehealth visits at the same rate as in-person visits.
- Supervise their clinical staff using virtual technologies when appropriate, instead of requiring in-person presence.
- Telehealth fulfills many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice, and home health.

- Home Health Agencies can provide more services to beneficiaries using telehealth, so long as it is part of the patient's plan of care and does not replace required in-person visits as ordered on the plan of care.
- Hospice providers can also provide services to a Medicare patient receiving routine home care through telehealth when feasible.
- Physicians or other professionals providing telehealth service ***not*** at the same location as the beneficiary.

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Virtual Services – Virtual Check-Ins

In 2019, Medicare started making payments for brief communications or Virtual Check-Ins (VCIs)

VCI defined: short, patient-initiated communications with a healthcare practitioner.

- VCIs pay professionals for brief (5-10 min) communications that mitigate the need for an in-person visit.
- Patient must understand terms of service; however, provider may educate them prior to the patient agreement.
- VCIs can be conducted with a broader range of communication methods – the practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

Separate from VCIs, captured video or images can be sent to a physician:

- Doctors and certain practitioners may bill for these virtual check-in services through several communication technology modalities, such as telephone.
- HHS Office for Civil Rights (OCR) will exercise enforcement discretion and **waive penalties for HIPAA violations against healthcare providers that serve patients in good faith** through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 pandemic.

HCPCS code G2010: Remote evaluation of recorded video and/or images.

HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in.

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Virtual Services – E-Visits

An e-visit is when a beneficiary communicates with their doctors usually through online patient portals

- Applies to all locations including the patient's home, and in all areas (not just rural).
- Applies to **established patients only** who must generate the inquiry:
  - Communication can occur over a 7-day period.
  - Patient must verbally consent to receive virtual check-in services.
- Coinsurance and deductible apply to these services.

Services may be billed using CPT codes 99421-99423 (physicians, nurse practitioners, physician assistants).

Separate codes required for clinicians who may not independently bill for evaluation and management visits, including:

- physical therapists
- occupational therapists
- speech language pathologists
- clinical psychologists

These e-visits should use bill codes G2061-G2063.

Effective from March 1, 2020 until the end of the PHE

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Section 3.0

OPERATIONAL ISSUES: BILLING, CODING, AND PAYMENTS

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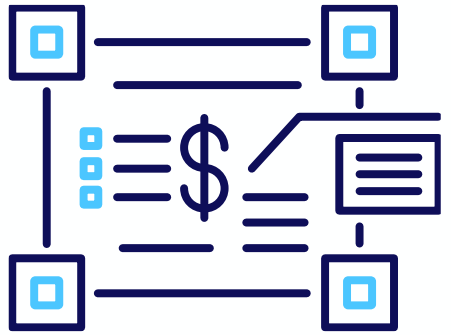
Coding, Billing, and Payments



- **Medicare telehealth services are generally billed as if the service happened in-person.**
- For Medicare telehealth services, the **claim should reflect the designated Place of Service (POS)** code 02-Telehealth, to indicate the billed service occurred as a professional telehealth service from a distant site.
- Medicare pays the **same amount for telehealth services** as it would for in- person.
- The use of **telehealth does not change out-of-pocket costs** for beneficiaries with original Medicare. Beneficiaries are generally liable for their deductible and coinsurance.
- HHS Office of Inspector General (OIG) is providing **flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits** paid by federal healthcare programs.

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Coding, Billing, and Payments *(continued)*

- **Billing for Medicare telehealth services is limited to professionals.**
  - Like other professional services, Critical Access Hospitals can report telehealth services under CAH Method II.
  - If a beneficiary is in a healthcare facility (even if facility is not rural or in a health professional shortage area) and receives telehealth service, the facility is only eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014.
- **CMS is not requiring additional or different modifiers associated with telehealth services under these waivers.**
- **Consistent with current rules, three scenarios with modifiers are required on Medicare telehealth claims:**
  - When a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required.
  - When a telehealth service is billed under CAH Method II, the GT modifier is required.
  - When a telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required.

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Telehealth Matrix

Type of Service	What is the Service	HCPCS/CPT Code	Patient Relationship with Provider
Medicare Telehealth Visits	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth service include: • 99201–99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship. HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
Virtual Check-In	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-Visits	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

Source: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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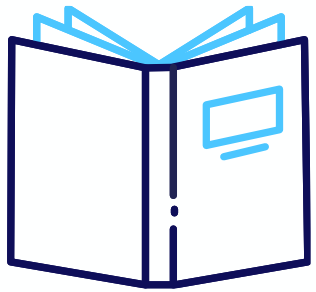
Official Coding Guidelines

April 1 through September 30, 2020

COVID-19 Infections (Infections due to SARS-CoV-2)

- Code only confirmed cases; assign code U07.1, COVID-19.
- As documented by the provider, documentation of a positive COVID-19 test result, or a presumptive positive COVID-19 test result.
- Exception - hospital inpatients "confirmation" does not require documentation of the type of test performed.



Presumptive positive COVID-19 test results should be coded as confirmed

- If documented as "suspected," "possible," "probable," or "inconclusive" COVID-19, do not assign code U07.1. Assign a code(s) explaining the reason for encounter (such as fever) or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.
- Sequencing of codes: When COVID-19 meets the definition of principal diagnosis, code U07.1 first, followed by the appropriate codes for associated manifestations, except in the case of obstetrics patients.

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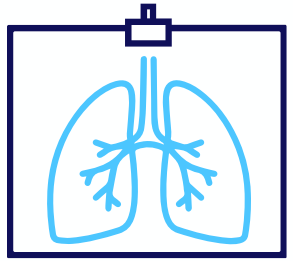
Acute Respiratory Illnesses Due to COVID-19

- **Pneumonia:** Confirmed due novel coronavirus (COVID-19): assign codes U07.1, COVID-19, and J12.89.
  (Other viral pneumonia)



- **Acute Bronchitis:** Confirmed as acute bronchitis due to COVID-19: assign codes U07.1, and J20.8.
  (Acute bronchitis due to other specified organisms)
- **Bronchitis:** Code using U07.1, not otherwise specified (NOS) due to COVID-19 and J40.
  (Bronchitis, not specified as acute or chronic)

- **Lower respiratory infection:**
  - If COVID-19 is documented as associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, codes U07.1 and J22. Unspecified acute lower respiratory infection should be assigned.
  - If COVID-19 is documented as associated with a respiratory infection, NOS, codes U07.1 and J98.8. Other specified respiratory disorders should be assigned.
- **Acute respiratory distress syndrome (ARDS):** ARDS due to COVID-19, assign codes U07.1, COVID-19 and J80.
  (Acute Respiratory Distress Syndrome)

Source: https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

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Screening and Possible Exposure

- Possible exposure to COVID-19, but ruled out after evaluation: **assign the code Z03.818.**
  (Encounter for observation for suspected exposure to other biological agents ruled out)
- Exposure to COVID-19 and confirmed: **assign the code Z20.828.**
  (Contact with and suspected exposure to other viral communicable diseases)
- COVID-19 screening, asymptomatic, no known exposure and results are unknown or negative: **assign code Z11.59.** *(Encounter for screening for other viral diseases)*
- COVID-19 screening, asymptomatic with positive result, AND exposure confirmed or suspected (not ruled out), and exposed individual tests negative or test results are unknown: **assign code Z20.828.**
- Patient has signs/symptoms of COVID-19 with actual or suspected COVID-19 exposure: **assign Z20.828.**

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Signs and Symptoms Coding

For patients presenting with any signs/symptoms (such as fever, etc.) and where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptom, such as:

- **R05 Cough**
- **R06.02 Shortness of breath**
- **R50.9 Fever, unspecified**

Diagnosis code B34.2, Coronavirus infection, unspecified, would generally not be appropriate for COVID-19, because the cases have universally been respiratory in nature, so the site would not be "unspecified."

- *If provider documents "suspected", "possible," or "probable" COVID-19,* ***do not*** *assign code B97.29.*

Coding guidance or "probable" COVID-19, **do not assign code B97.29.** Assign a code(s) explaining the reason for encounter (such as fever, or Z20.828).

Coding Guidance Reference: https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

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Diagnostic Tests

Codes effective on April 1, 2020 for dates of service on or after February 4, 2020

- **U0001:** Specifically for CDC testing laboratories to test patients for SARS-CoV-2.
- **U0002:** Non-CDC laboratory tests for SARS-CoV-2/2019 (COVID-19).
- **Clinical diagnostic laboratories:** To identify and reimburse specimen collection for COVID-19 testing, CMS established two Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:
  - **G2023** - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source.
  - **G2024** - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source.

These codes are billable by clinical diagnostic laboratories

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Section 4.0

CLINICAL EXAMPLES

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Polling Question

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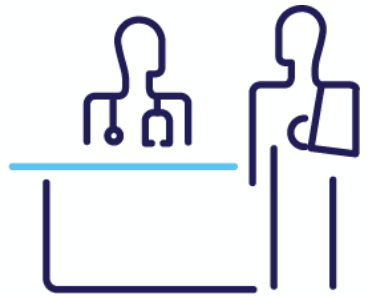
Clinical Example – Physician Office

- 60-year-old female with ESRD, Multiple Sclerosis, Hypertension, Diabetes, and recent Hip Fracture – at home post SNF stay.
- During a follow-up visit via telehealth visit, physician notes an open wound on the patient's lower left leg. Patient states she developed upon returning home.
- On further examination by provider via telehealth, it is determined to be a pressure ulcer.

Capture

- **Known Conditions:**
  - ESRD
  - Multiple Sclerosis
  - Diabetes
  - Status Post Hip Fracture
- **New Condition**:
  - Pressure Ulcer



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Clinical Example – Inpatient

- 73-year-old man admitted via ER due to shortness of breath. Patient has CHF, COPD, and Hypertension; Rule out Myocardial Infarction.
- Upon further testing (labs, EKG, and Echocardiogram), patient determined to have an infarction of the inferior wall of the heart.

Capture

- **New Condition:**
  - Acute Myocardial Infarction
    - left inferior wall
- **Known Conditions:**
  - CHF
  - COPD
  - Hypertension

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Clinical Example – Hospice

A terminally ill 85-year-old male with heart failure has been receiving hospice services and recently developed a fever, sore throat, and cough.

- Patient diagnosed with suspected COVID-19 and hospice plan of care now includes medications for symptom management.
- Mildly short of breath but does not require supportive oxygen therapy.
- Patient's wife concerned about potential for worsening cardiac and respiratory symptoms due to patient's risk for increased complications due to COVID-19.
- Hospice plan of care updated to include remote patient monitoring with telecommunications system to assess patient's daily weight and oxygen saturation levels.
- Plan of care identifies measurable goal that patient will maintain oxygen level above 92% and patient will not gain more than 2 pounds in a 24-hour period.
- Plan of care identifies interventions if either of these goals are not met.
- Remote patient monitoring allows for more expedited modifications to plan of care in response to patient's changing needs.

Capture

- **New Condition:**
  - COVID19
- **Known Condition**:
  - Heart Failure

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Section 5.0

RISK ADJUSTMENT IMPACT AND STRATEGIES

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Impact to Risk Adjustment

Potential increase in membership across all lines of business (Medicare, Medicaid, and Commercial)
All departments, i.e., Enrollment, Health Assessment Surveys, Medical Management

Revenue

- Decreased provider visits.
- Decreased newly identified HCCs.
- Decreased reconfirmation of HCCs.
- Decreased revenue:
  - Per Member Per Month (PMPM)
  - Mid-Year Payment
  - Final Payment

Data Validation (RADV) – CON15 Suspended

- No solicitation of providers for on-site review of records.
- Potential review records with remote access to EMR or via other electronic methods.
- May submit data via Central Data Abstraction Tool (CDAT).
- Potential extension of close-out date for audit.

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Prospective Strategies

Considerations

- Claim System Edits
- Clearinghouse
- Provider Network and Services
- Copayments and Deductibles

Home Assessments

- Use telehealth.
- Define conditions that may be assessed prior to assessments.
- Identify members who have not seen their primary care provider (PCP).

Providers' Offices

- Work in conjunction with the offices.
- Encourage annual wellness visits (AWV) to capture chronic conditions.
- Prioritize Members/Patients:
  - No visit in last three (3) months.
  - Patients with three (3) or more unconfirmed HCCs.
  - Specific high-value unconfirmed HCCs.
  - Develop incentive program for/with providers.
  - Ensure claims contain chronic conditions and newly identified conditions.
  - Use E & M codes where possible in claim submission.

Member Engagement

- Leverage engagement tools to educate, provide resources, and encourage telehealth visits.

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Retrospective Strategies

- Potential to **review records via remote access** (EMR).
- Potential for **providers to submit records via fax/portal/USPO.**
- **Leverage Risk Adjustment Analytics.**

Defined Chase Lists:

- COVID-19 members.
- Members with greater than three unconfirmed HCCs.
- Members with no visit in calendar year.
- Specific member sub-populations:
  - ESRD
  - Duals
  - Designed HCCs

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DISCUSSION & QUESTIONS

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Section 7.0

APPENDIX

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Section 7.1

CODES

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Virtual Services – Virtual Check-Ins

In 2019, Medicare started making payments for brief communications or Virtual Check-Ins (VCIs)

HCPCS code 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 evaluation and management (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.

HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified healthcare professional who can report evaluation and management (e/m) 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.

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Virtual Services – E-Visits

- An e-visit is when a beneficiary communicates with their doctors usually through online patient portals:
  - **99421:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes.
  - **99422:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11– 20 minutes.
  - **99423:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.
- Clinicians who may not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:
  - **G2061:** Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes.
  - **G2062:** Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes.
  - **G2063:** Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Effective from March 6, 2020 until the end of the PHE

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Section 7.2

LEVEL OF CARE (LOC)

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Level of Care (LOC)

Acute Care

- May bill for services provided outside their institution.
- Emergency departments of hospitals may use telehealth services to quickly assess patients to determine the most appropriate site of care.
- Allows hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19.
- Emergency Medical Labor and Treatment Act (EMTALA) - New rules ensure that patients can be screened at alternate treatment and testing sites, which are not subject to EMTALA during the national emergency.

Post-Acute Care

- Waives requirement that patients at inpatient rehab facilities receive at least 15 hours of therapy a week.
- Waives site-neural payment rate provision for Long-Term Care Hospitals that don't have at least a 50% discharge payment percentage.
- Allow physician assistants and nurse practitioners to order home health services for Medicare beneficiaries.
- Encourages the use of telecommunication systems for Home Health services furnished during the PHE.
- Face-to-face encounters for recertifying eligibility for hospice care could be conducted via telehealth.

Dialysis

- Individuals receiving home dialysis wouldn't be required to have periodic in-person assessments to qualify for telehealth services.

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Section 7.3

RESOURCES

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Resources – Telehealth

- **President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak:** https://www.cms.gov/newsroom/pressreleases/president-trump-expands-telehealth-benefits-medicarebeneficiaries-during-covid-19-outbreak
- **Medicare General Telehealth Information:** https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html
- **Medicare Telemedicine Health Care Provider Fact Sheet:** https://www.cms.gov/newsroom/fact-sheets/medicaretelemedicine-health-care-provider-fact-sheet
- **Medicare Telehealth Frequently Asked Questions (FAQs) March 17, 2020:** https://edit.cms.gov/files/document/medicare-telehealth-frequently-askedquestions-faqs-31720.pdf
- **Medicare General Information on Telehealth and Telehealth Codes:** https://www.cms.gov/Medicare/Medicare-GeneralInformation/Telehealth/Telehealth-Codes
- **Telemedicine Toolkit:** https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf
- **ESRD Telemedicine Toolkit:** https://www.cms.gov/files/document/esrd-provider-telehealth-telemedicine-toolkit.pdf
- **HCPCS codes and the Physician Fee Schedule:** https://www.cms.gov/Medicare/Medicare-GeneralInformation/Telehealth/Telehealth-Codes

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Resources – COVID-19

- **Coverage and Payment Related to COVID-19 Medicare:** https://www.cms.gov/files/document/03052020-medicare-covid-19-factsheet.pdf
- **COVID-19 Guidelines:** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf
- **COVID-19 Mailbox for Policy and Benefit Questions:** https://MA-COVID19-policybenefits.lmi.org
- **Official Coding Guidelines – April 1 through September 30, 2020:** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf
- **Telehealth and COVID-19:** https://www.cms.gov/files/document/03052020medicare-covid-19-fact-sheet.pdf CMS Telemedicine General Policy Guidance

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