NORTHWEST OHIO OSTEOPATHIC ASSOCIATION

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Telemedicine, Remote Patient Monitoring and Chronic Care Management

Dr. Murthy Gokula, MD, CMD

Geriatrics Specialist/CEO

STAYHOME IWILL PC

Dr. Nikhila Gandrakota, MBBS, MPH

Dr. Nithin Kurra, MBBS, MPH

Dr. Medha Cherabuddi, MBBS

Objectives

Explain	• Explain CPT coding for RPM and CCM Codes.
Increase	• Increase patient engagement, satisfaction of patients and families
Describe	• Describe how RPM can help with early detection of disease decompensation and intervention, patient education, improves patient–physician relationship.
Assess and evaluate	• Assess and evaluate patients with objective data and develop care plans dynamically with continuous connected care.

Outline

Overview of RPM Billing codes

Why use Remote Patient Monitoring?

Driving Engagement

Improving patient satisfaction

Is Telemedicine same as Telehealth?

- Telehealth is different from telemedicine because it refers to a *broader scope of remote healthcare services* than telemedicine

- The term telehealth includes a broad range of technologies and services to provide patient care and improve the healthcare delivery system. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

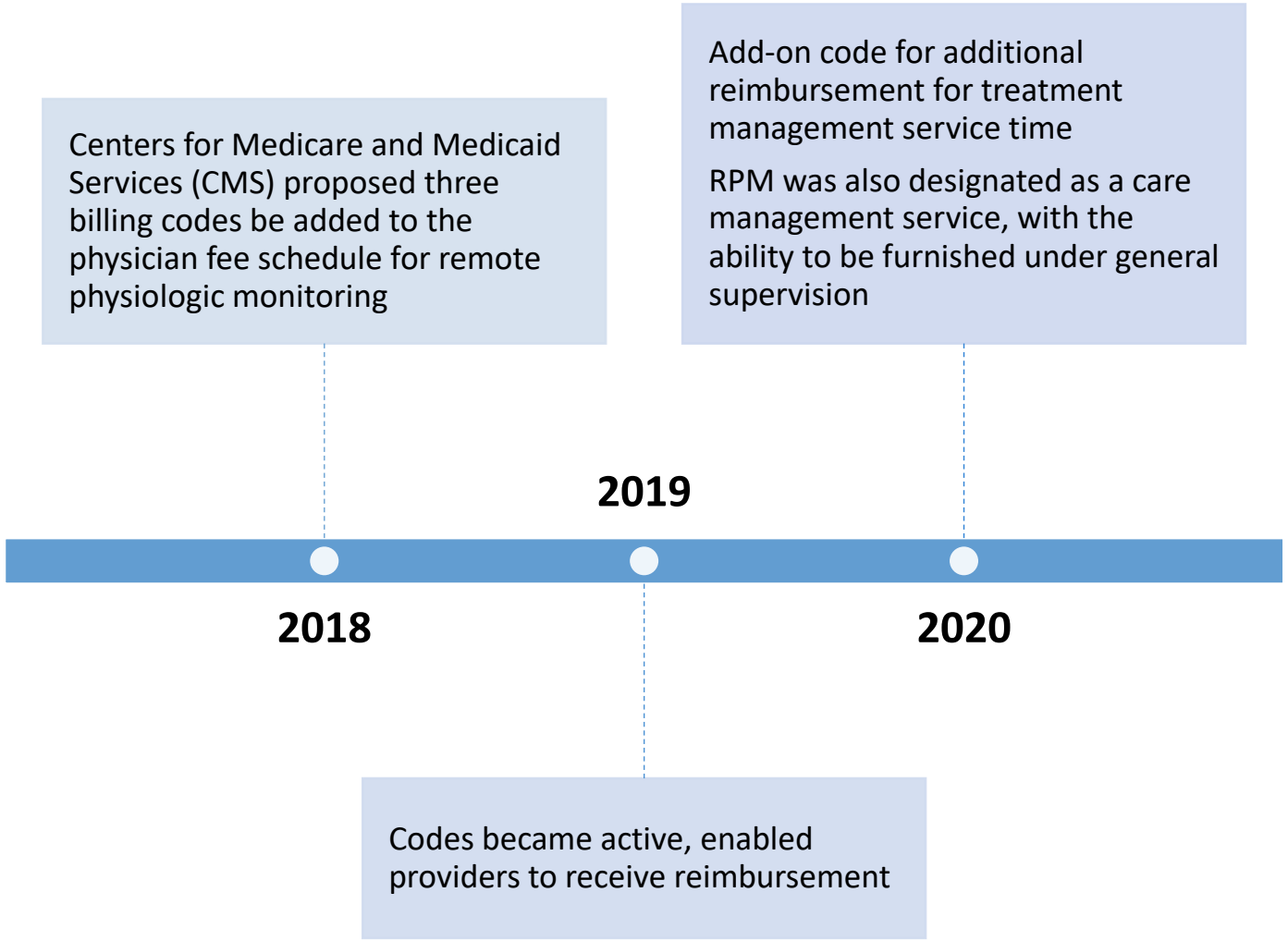
- Telemedicine is a subset of telehealth that refers solely to the provision of health care services and education over a distance, using telecommunications technology

Remote Physiologic Monitoring

Remote physiologic monitoring (RPM) is a clinical service that uses technology to enable monitoring of patients' physiologic data outside of conventional clinical settings.

The provider can be reimbursed for the onboarding and patient education on the program, the device supply, patient monitoring and management of their condition.

RPM- BILLING CODES



Why Implement Remote Patient Monitoring?

- Frequent stream of data provides insights to patient health status while they are recovering / between visits / outside point-of-care
- Enables faster interventions at signs of deterioration, helps prevent readmissions, provides effective navigation to the appropriate level of care if help is needed
- More efficient time management – allocate time and resources to patients that need the most attention
- Increases patient loyalty and satisfaction / improves ability to self manage

WORK FLOW

- Provider identifies a patient who could be a good candidate for RPM
  - a. Inclusion criteria
    - Medicare (Original or Medicare Advantage) patient
    - Has at least one physiological parameter that is poorly controlled or is otherwise high-risk, with the recommendation being to limit initial focus to blood pressure and blood sugar until workflows are optimized
    - Patient expresses a desire to improve his/her medical condition
    - Patient would be able to use a device to measure his/her own physiological parameter, or has somebody at home do it for them
  - Exclusion criteria
    - Patient is already receiving RPM through another provider

WORK FLOW

- Provider (or support staff) communicates to patient their desire to implement the RPM program, expected value of program, potential patient responsibility (copay = 20%, so ~$20-40/month) if they do not have supplemental insurance/Medigap
- Provider (or support staff) obtains verbal consent and documents consent in the chart
- Provider documents medical necessity (what is being measured, why, goals, [see above])
- Provider orders RPM services for the patient, either via integration in EMR (placing an order, just like placing any other order), or using online interface of RPM vendor, or fax (depends on which vendor chosen)
- RPM vendor receives order and calls the patient to verify understanding of program and desire to participate. RPM vendor documents conversation
- RPM vendor sends appropriate device to patient by mail

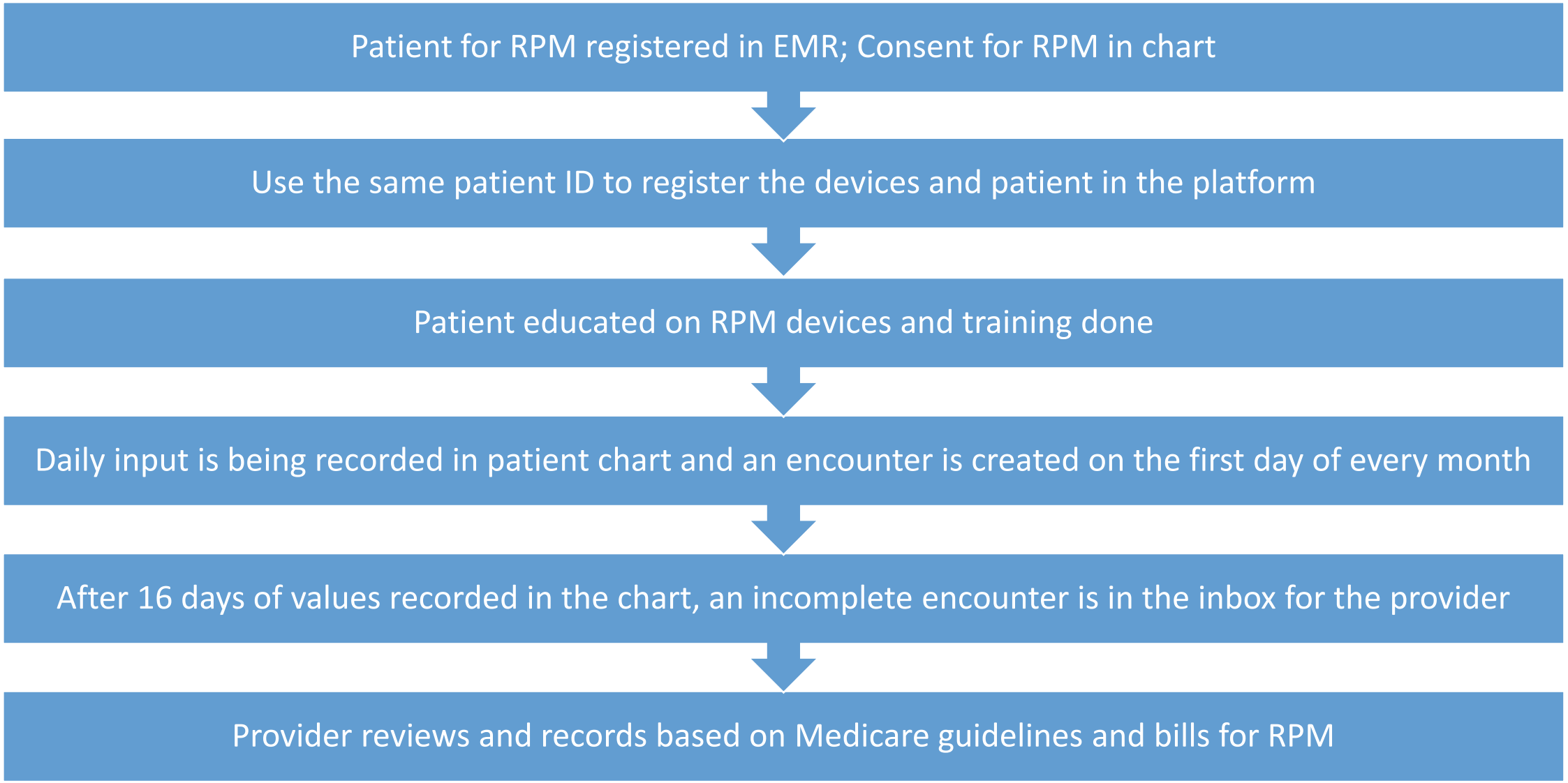
WORK FLOW

- RPM vendor sets the threshold physiological parameters for the patient on the platform based on the practice's settings (these can also be patient-specific)
- RPM vendor calls the patient after the device is delivered and onboards the patient over the phone. RPM vendor performs the first measurement with the patient on the phone to verify understanding and ability
- RPM vendor initiates patient onto reminder service
- Patient performs daily measurement
- RPM vendor's clinical team reviews each incoming result on a daily basis
- RPM vendor's clinical team calls patients when results are concerning and/or above thresholds. Some conversations uncover concerning issues, resulting in an escalation, which is sent to the practice's designee of choice.

WORK FLOW

- Practice designee receives the escalation notice, pulls up patient chart in the EMR and performs and documents their response
  - Call the patient directly
  - Ignore
  - Arrange for follow up appointment
  - Refer to specialist
  - Ask RPM vendor to do something (e.g., “call patient and have them see us tomorrow”)
- Billing data exported monthly and sent to practice

Workflow for Remote Patient Monitoring



RPM- CPT Codes

CODE 99453

REIMBURSEMENT: F $18.77 NF $18.77

Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate),initial; set-up and patient education on use of equipment

Lay terms: Reimbursement available for initial set-up, onboarding, and training of technology and equipment.

Requirements: One time reimbursement, can be billed "once per episode of care". Patient must be monitored for more than 16 days before billing.

F- Facility NF-non-facility

RPM- CPT Codes

CODE 99454

REIMBURSEMENT: F $62.44 NF $62.44

Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

Lay terms: Provides reimbursement for the supply of the remote monitoring equipment / technology to the patient for transmission of measurement readings and alerts/ notifications via electronic means for review. Physiologic measurements could include weight, blood pressure, blood oxygen levels, etc.

Requirements: Device used must be a medical device as defined by the FDA. Not reported if less than 16 days of readings. Can be reported once each 30 days.

F- Facility NF-non-facility

RPM- CPT Codes

CODE 99457

REIMBURSEMENT: F $32.84 NF $51.61

Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes

Lay terms: Monitoring, evaluation and review of data, treatment adjustments, interventions, and other treatment management services provided by physician / staff / other qualified healthcare professional for patient. This code represents the first 20 minutes of clinical staff/physician/other qualified health care professional's time.

Requirements: Can be billed once per calendar month. Requires some point of "interactive communication" with the patient or caregiver, such as a phone call, text message or email.

F- Facility NF-non-facility

RPM- CPT Codes

CODE 99458

REIMBURSEMENT: F $32.84 NF $42.22

Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes

Lay terms: Monitoring, evaluation and review of data, treatment adjustments, interventions, and other treatment management services provided by physician / staff / other qualified healthcare professional for patient. This code represents the second 20 minutes or more of clinical staff/physician/other qualified health care professional's time.

Requirements: 99458 can be billed each additional 20 minutes of treatment management service time. Requires some point of "interactive communication" with the patient or caregiver, such as a phone call, text message or email.

F- Facility NF-non-facility

LEGACY RPM 99091

- Description:
  - Collection and interpretation of physiologic date (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulations (when applicable) requiring a minimum of 30 minutes of time, each 30 days
- Who Can Bill: MD/Qualified Health care provider
- Coding Tips
  - May be billed only once per 30 days
  - Interaction with patient not required
  - Does not include payment for equipment, clinical staff, and supplies
  - Cannot be billed with other care management codes.

OUTSOURCING RPM

- Vendors offer full-service RPM programs
- Provider key responsibilities
  - identify the patients for whom monitoring would be beneficial
  - communicate which parameter to monitor
  - provide medical decision making
  - respond to escalated alerts
  - Bill
  - Identify Patient → RPM vendor manages program → Provider manages MDM and escalated alerts

Financials

Code	Summary	Reimbursement (Medicare Allowable)	Vendor Fee	Net to Practice
99453	RPM set up	$19 one time	$15 one time	$4 one time
99454	Device/Data	$64 /mo	$25 /mo	$39 /mo
99457	RPM first 20 min	$51 /mo	$20 /mo	$31 /mo
99458	RPM add'l 20 min[8]	$51 /mo	$20 /mo	$31 /mo
Total				$101 /mo

Number of Enrolled Patients	Net Income / month (After vendor fees)	Net Income / year (After vendor fees)
10	$1,010	$12,120
100	$10,100	$121,200
1,000	$101,000	$1,212,000
10,000	$1,010,000	$12,120,000

Parameters for RPM Billing

- Patient consent to the program must be recorded in medical record, there is also a 20% co-pay as a Part B service
- An established patient-provider relationship is required to provide RPM services
- Requires the use of a medical device as defined by the FDA
- Ordered by a physician or other qualified healthcare professional
- Treatment management services are to be provided by physician / staff / other qualified healthcare professional (subject to state law scope of practice and supervision requirements)
- Data must be wirelessly synced for evaluation
- Patient must have one or more acute or chronic conditions

Points to Remember

- Can be billed in the same months as CCM, TCM, and BPI
- Billing provider must have at least one face-to-face visit with the patient in the preceding 12 months
- Time accrued on a day spent performing an E/M visit is recorded cannot be counted towards 99457/8.
- Report codes only once per 30 days regardless of the number of parameters measured

Points to Remember

- Don’t count time related to another reported service
- The initial set-up code (99453) can be billed after 16 days of monitoring. The transmission code (99454) should be billed at the end of each 30-day monitoring period or after monitoring has ended (if less than 30 days). 99457/8 are billed on a calendar month basis.
- Document the following in the medical chart :
  - Medical condition to be monitored, its severity and history
  - Medical necessity and rationale for monitoring
  - Goals of RPM for this patient

Do not Bill RPM at:

- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Home Health Agencies
- However, the visit with the patient can be billed.

Challenges with RPM

- Device Management (Selection, Purchasing, Storing, Shipping, Maintenance)
- Patient Engagement (Candidate selection, software/ hardware onboarding, compliance)
- Workflow integration (EMR integration, documentation of medical necessity)
- Billing/ Coding (integration into current RCM process)

Vendor Assessment

- Key elements to explore:
  - 1. Device management
    - Types of devices offered
    - FDA approved
    - Physiological parameters measured
    - Ease of use
    - Connectivity medium (WiFi, Bluetooth, cellular, other)
    - Shipping and tracking
    - Returns and cleaning
    - Who buys the device
    - Minimum purchase orders

Patient Engagement

- Patient engagement
  - Onboarding onto the service
  - Verification and documentation of consent
  - Reminders to measure
  - Engagement recovery
  - Games and prizes
  - Churn rate (% of patients lost each month)

Clinical support

- Clinical support
  - Is there a clinical monitoring service
  - How are alerts responded to
  - How are alerts filtered
  - How are escalations communicated
  - How is communication with patient performed, timed, and documented
  - Average alerts per patient per week
  - Typical engagement minutes per patient per month

Workflow integration

- Workflow integration
  - How orders/referrals for RPM services are generated
  - Integration into EMR (ordering, receiving data)
- Billing/coding
  - Is work timed automatically or manually
  - Types of reports generated
  - Ability to export data in format ingestible by practice
  - Ability to bill on behalf of provider
- Compliance
  - Audit trail of work done
  - Recordings of communications
  - HITRUST, SOC2, HIPAA
  - Audit of RPM services by health care law firm

Chronic Care Management

According to AMA,

“Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient’s condition, care plan, and prognosis”

These codes are geared toward primary care physicians (PCPs) but can be billed by any physician or qualified healthcare professional who fulfills the code requirements.

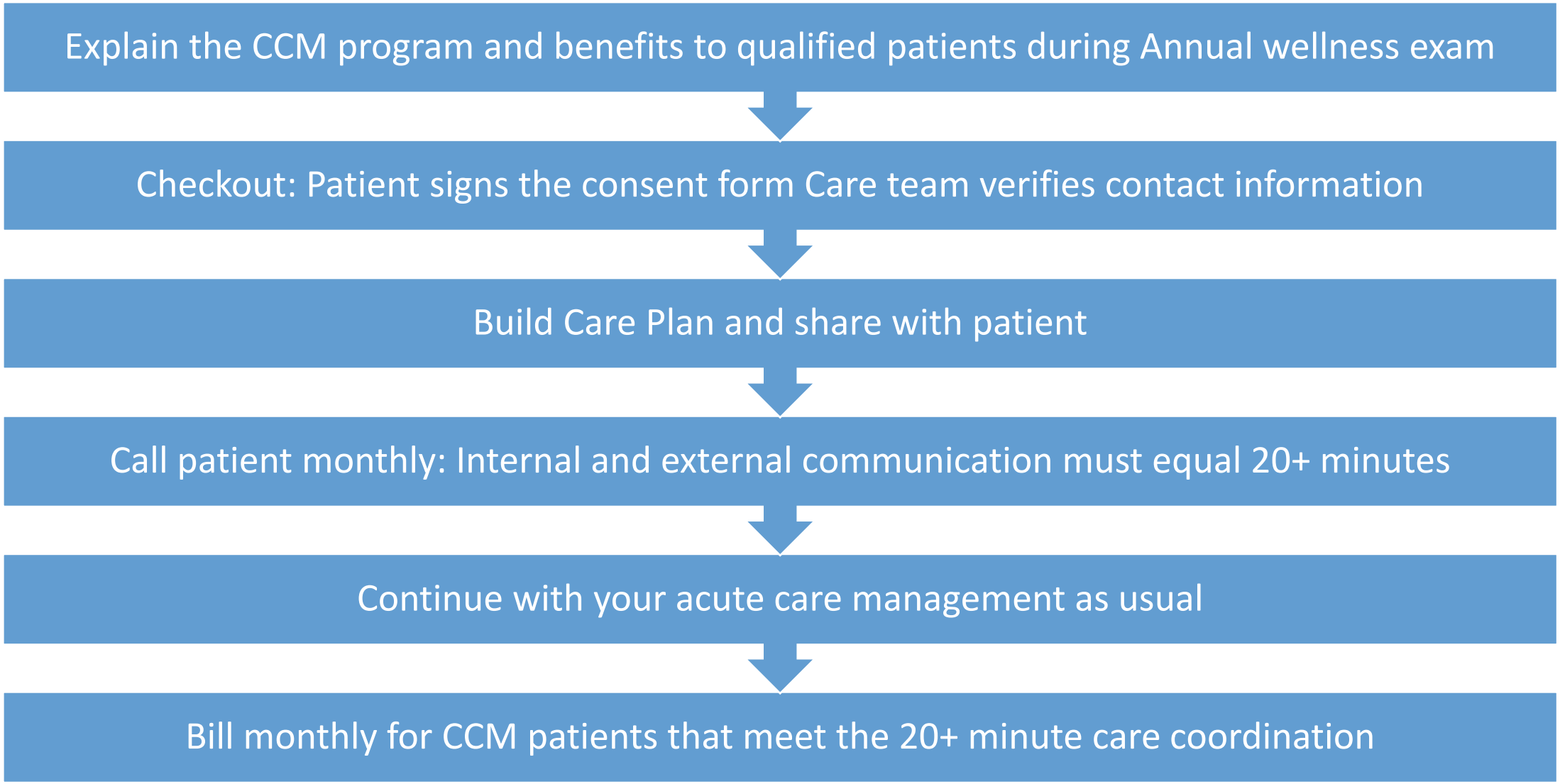
Requirements Overview

- Applies to Medicare Fee-for-Service Program
- Beneficiaries with 2 or more chronic conditions
- 20 minutes of qualifying time
- Only one practitioner can bill per month
- Transitional Care Management, Care Plan Oversight and certain ESRD services payments cannot be billed the same month

CCM BILLING REQUIREMENTS

- Recorded Patient consent
- Establish patient-provider relationship to provide RPM service
- Use of a medical device defined by the FDA
- Ordered by a physician or other qualified healthcare professional
- Treatment management services are to be provided b by physician / staff / other qualified healthcare professional (subject to state law scope of practice and supervision requirements)
- Wireless data sync for evaluation
- Patient must have one or more acute or chronic conditions

Workflow for Chronic Care Management



ENROLL PATIENTS

- FOCUS on COPD, CHF, CKD, Diabetes, etc
- For patients not seen within 1 year: needs initiating face-to-face visit with the billing practitioner
- How can you do this?
- Annual Wellness visits (AWV) and Initial Preventive Physical Exam (IPPE) are two popular means of introduction into CCM for patients who are eligible.
- G0438 initial visit ($164)- For new first-time patients who have been enrolled with Medicare for more than one year.
- Yearly revenue for new patients =($164 x 100)= $16400

ENROLL PATIENTS

- G0439 subsequent visit ($109)- For returning patients who have had the AWV before
- A patient is only eligible for a subsequent visit a year after the initial visit.
- Yearly revenue for returning or 2nd year patients =($109 x 100) = $10900
- As a starting point for new patients, one can use either CPT Code 99490 or 99491.
- CPT 9940 requires the least amount of minutes, and would be the code used to bill new chronic care patients who are at the beginning stages of their diseases.
- Note: Except complex CPT Codes, no other CPT codes in CCM can be billed more than once, or in the same month as each other.

ENROLL PATIENTS

- CPT 99490 ($42 for non-facility/ $32 for facility) “Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. Assumes 15 minutes of work by the billing practitioner per month.” Yearly revenue = ($42x12x100) = $50400
- If the patient needs more time that spans beyond 30 minutes, then CPT 99491 should be used. It is reimbursed at double the rate because 30 minutes of time is allocated to the patient by either the doctor or other qualified healthcare professional, as opposed to the 15 minutes in CPT 99491.
- Also notice, there is no mention of clinical staff in CPT 99491. This is because all of the 30 minutes of work is expected to be provided by the physician or qualified health professional.
- Whereas for CPT 99490, the 20 minutes of time can be performed by clinical staff, but must be directed by the physician or qualified healthcare professional. It does say 15 minutes of work should be performed by the billing practitioner, but this 15 minutes are a part of the 20 minutes of directed work

ENROLL PATIENTS

- CPT 99491($84 for non-facility and facility) “Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month.” Yearly revenue= ($84x12x100) = $100800
- Needs of the patient and the subsequent minutes of care recorded in the EMR system per month should dictate what CPT code is used, there is also scope of strategizing.
- It comes down to whether you have clinical staff at your disposal and if you want to use them.
- If you do, then you can train them to do the monthly outreach electronically and use CPT 99490.
- If physicians or qualified healthcare professionals were to involve themselves, then CPT 99491 would be preferred. Yes, it would take away valuable time, but that is why there is higher compensation.

TABLE 1. SUMMARY OF 2017 CCM CODING CHANGES

BILLING CODE	PAYMENT (NON-FACILITY RATE)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
CCM (CPT 99490)	$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised, or monitored	Ongoing oversight, direction, and management Assumes 15 minutes of work
Complex CCM (CPT 99487)	$94	60 minutes	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 26 minutes of work
Complex CCM Add-On (CPT 99489, use with 99487)	$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 13 minutes of work
CCM Initiating Visit*	$44-$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

*(Annual Wellness Visit [AWV], Initial Preventive Physical Examination [IPPE], Transitional Care Management [TCM], or Other Qualifying Face-to-Face Evaluation and Management [E/M])

Challenges with CCM

- Practice/provider/team education
- Obtaining consent from patients
- Co-pay related to non face-to-face encounter
- Recording/Tracking time for all encounters
- Calculation if better to bill CPO or CCM or TCM

DRIVING ENGAGEMENT

- Partner with patients at multiple touchpoints- patient portal announcements, front-desk reminder, TV screens throughout office, email newsletter reminders
- Leveraging talking points about how this will benefit patients
- Set clear expectations- to ensure repeat use and success of the program long term
- Costs- the value of paying for service (e.g., more focused visit)
- Logistical- strong Wi-Fi connection, private environment, ability for doctor to see them clearly

IMPROVING PATIENT SATISFACTION

- Videoconference for adherence to clinical recommendations
- Asking the right (focused, dynamic, interactive) questions
- Tech Access
- Language Barriers
- Age/Tech savviness
- Informing caregivers

IMPLEMENTATION

Announce Telehealth Launch and Availability

- Timing: Go-live date; Quarterly, Before/after visits; New patient; Plan to message the same patient about three times about telehealth before engagement
- Messaging: Showcase benefits including increased convenience; increased access to specialized care not locally available; decreased time and money spent getting to care; use cases; evidence; appropriate uses; where to sign up
- Channels: In-person; Office collateral; Email newsletter; Patient portal; Website; Social media

IMPLEMENTATION

Educate Patient about Using Telehealth

- Timing: Once visit is scheduled
- Messaging: How to download the app or platform; learn more about the telehealth process; what to expect; payment/billing practices; FAQs
- Channels: Email; Phone

IMPLEMENTATION

Telehealth Visit Reminder

- Timing: Day of visit; 15 minutes before visit
- Messaging: Walk through check-in process; provide link to meeting
- Channels: Email; Text

IMPLEMENTATION

Follow-up Care

- Timing: After visit
- Messaging: Collect patient satisfaction feedback; schedule any necessary follow-up care
- Channels: In telehealth platform; Email; Text

IMPLEMENTATION

Scaling Announcements

- Timing: Quarterly
- Messaging: New use cases and/or capabilities of telehealth solution
- Channels: Website; Social media; Patient portal; Email; Text

Revenue

- RPM
  - $150+/ month
  - With RPM reimbursement codes
- CCM
  - $175+/ month
  - For 40 minutes of work monthly, 20 minutes of general supervision and 20 minutes of direct supervision

RPM vs CCM

	Remote Physiologic Monitoring	Chronic Care Management
Patient Eligibility	1+ chronic conditions	2+ chronic conditions
Reimbursement	Approx $116/month	Approx $42/month
Staff Requirement	Physicians, QHP, Clinical Staff	Physicians and QHP
Monitoring	20 minutes/month	20-60 minutes/month
Availability	-	24/7 Access must be provided
Billing	Calendar Month	Calendar Month