Telehealth for Primary Care

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Co-Host, The Curbsiders
Scheduled Telehealth

Schedule a telehealth in two weeks to follow-up.
Scheduled Telehealth

- **Consent is required for Telehealth**
- **With Video-Teleconferencing**
  - 9921X-GT/95
    - GT Modifier for “Real-Time” (not required per CMS)
    - 95 Modifier if not doing site-to-site (i.e. directly with the end-user and not a remote telehealth site)
- **Without Video-Teleconferencing**
  - Limited to the G2012 HCPCS or 9944X CPT Codes
    - Reimbursed (CMS): G2012
    - Not Reimbursed (CMS): 9944X

**Rules applied for Telehealth:**
- No E&M for same issue in the next 24-hours
- No E&M for same issue in last 7 days
# Knowledge food… for your brain hole!

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
<th>Time (min)</th>
<th>wRVU Value</th>
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<td>$0.00</td>
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<tr>
<td>G2012</td>
<td>&gt;5</td>
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<td>$12.96</td>
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**NOTE:** DHA does not recommend usage of G2012.

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
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<td>99215-GT/95</td>
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<td>2.11</td>
<td>$147.76</td>
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</table>

**NOTE:** DHA does not recommend usage of G2012.
Remote Specialist Telehealth
I don’t know what to do...

Knowledge food… for your brain hole!
Remote Telehealth Model

Knowledge food… for your brain hole!

I wonder what’s going on with...

PRIMARY CARE OFFICE

PATIENT

Q3014

OK!

Recommendations...

SPECIALIST OFFICE

9920X with either GT (Q3014) or 95
Inter-Professional Telehealth
(Ideal for Primary Care)

Model that allows for “true” closed loop communications with PCM.

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Inter-professional 1-2-3-4 Telehealth Model

1. Patient engages with PCM (Tele/F2F)
2. PCM sends referral to Specialist (Tele)
3. Specialist responds directly to PCM (Tele)
4. PCM re-engages with patient (Tele/F2F)
Inter-professional 1-2-3-4
Telehealth Model

STEP 1 – Patient to PCM

- Patient, parent, guardian initiated
- Must have established relationship
- Can be face-to-face or telehealth
  - Rules apply for Telehealth:
    - No E&M for same issue in the next 24-hours
    - No E&M for same issue in last 7 days
- Billed as service type
  - F2F: 9921X
  - Tele: 9921X-95, 9944X, or G2012
STEP 2 – PCM to Specialist

- PCM contacts specialist (can be electronic or within EHR)
- At this point, the consult is included in the bundled E&M for Step 1.
STEP 3 – Specialist to PCM

- Specialist may determine that the patient either (a) does not need a F2F or (b) can provide recommendations remotely to the PCM.
- Recommendations documented in EHR; PCM could be identified as a Co-Signer for the Encounter for closed-loop communications.
STEP 3 – Specialist to PCM

- E&M Code Depends on method of closed loop communication:

  - Specialist:
    - Verbal and written report: 9944X
    - Written report only: 99451

  - PCM:
    - Preparing consult and/or communicating with consultant: 99452

<table>
<thead>
<tr>
<th>CPT Code</th>
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<td>99447</td>
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<td>99448</td>
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<td>99451</td>
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<td>99452</td>
<td>&gt;16</td>
<td>1.04</td>
<td>$37.48</td>
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STEP 3 – Specialist to PCM

- If specialist documents a report only, a 99451 would be documented and the PCM could be identified as the co-signer. If the PCM spent >15 minutes preparing the consult and reviewing this report, they could separately bill a 99452.
STEP 3 – Specialist to PCM

• If specialist discussed the consult over the phone or via electronic communications, a 99446-99449 could be billed by the specialist and the PCM could separately bill a 99452, assuming >15 minutes is spent preparing the consult and communicating with the specialist.
STEP 4 – PCM to Patient

- May be scheduled after Step 3 (F2F, Tele) to review consult results

- Can be face-to-face or telehealth
  - Rules still apply for Telehealth:
    - No E&M for same issue in the next 24-hours
    - No E&M for same issue in last 7 days

- Billed as service type
  - F2F: 9921X
  - Tele: 9921X-95, 9944X, or G2012
Inter-professional 1-2-3-4 Telehealth Model

1. Patient engages with PCM (Tele/F2F)
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Chronic Care Management
Chronic Care Management

• NOTE: 99491 is new as of 11/2018 and explicitly states that this is >30 minutes of physician or qualified healthcare provider time; therefore, you cannot use 99489 with 99491

• Aside from 99491, CCM Time includes any clinical staff as long as it directly involves the patient’s care and includes RNs, LVNs, MAs, etc.

• Can be billed “incident to”

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time (min)</th>
<th>wRVU Value</th>
<th>tRVU (Non-Fac)</th>
<th>$$$ (Non-Fac)</th>
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<td>2.33</td>
<td>$83.97</td>
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Chronic Care Management

- Non-Billed Encounters
  - Bill as “99499,” but document appropriate clinical time spent on the patient’s care.

- Billed Encounters:
  - Add up total clinical time during the calendar month and bill for total time during the final clinical encounter.
Transitional Care Management
Transitional Care Management

• PCM is notified of a hospital discharge for one of their patients. In response to this notification, the provider reaches out to the patient and/or caregiver within **two business days**. Face-to-face within 7 days (99496) or 14 days (99495) is required.

• May be billed by a specialist with whom the patient has a hospital follow-up scheduled (i.e. CHF patient scheduled to see their cardiologist).

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>MDM</th>
<th>wRVU Value</th>
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<tr>
<td>99495</td>
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<td>99496</td>
<td>High</td>
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Remote Monitoring
Remote Monitoring

QUALIFIED HEALTHCARE OFFICE
(PCM OR SPECIALIST)

PATIENT

REMOTE MONITORING OFFICE

Knowledge food… for your brain hole!
Remote Monitoring

- Codes:
  - 99453: Initial set-up, patient education
  - 99454: Initial device set-up, programming alerts, etc.
  - 99457: Billed CY (>20 minutes)
- Not Recommended:
  - 99091: Billed 30-day period (>30 minutes)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time (min)</th>
<th>tRVU Value</th>
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<td>99091</td>
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<td>1.62</td>
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Productivity Example

Reimbursement Per Patient

- Case Study: Each patient has (a) annual follow-up, (b) routine follow-up every six months, (c) been enrolled in Chronic Care Management (CCM), and (d) remote tele-monitoring.

<table>
<thead>
<tr>
<th>Encounter</th>
<th>CPT/HCPCS</th>
<th>Units (Per year)</th>
<th>wRVU</th>
<th>tRVU (Non-Fac)</th>
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<td>1.50</td>
<td>3.28</td>
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<td>Routine Follow-up</td>
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<td>3.00</td>
<td>6.12</td>
<td>$220.56</td>
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<td>Chronic Care Mgmt</td>
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<td>$505.99</td>
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<td>TOTAL</td>
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<td>19.14</td>
<td>40.60</td>
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- Total annual reimbursement as high as $1,463.21 per patient. For 600 patients, this equates to $877,926 and a ridiculous 11,484 work RVUs, indicating the workload of approximately two and a half FTEs with just 600 patients!
MA2 does initial remote monitoring (RM) data collection for six (6) patients per hour (10 minutes each) and documents this in the chronic care management (CCM) notes for each of the RNs for patients scheduled next week. Up to 180 patients are prepped each week.

Each RN is assigned 200 patients. RNs (1/2/3) provide CCM (20 minutes) and close out the RM note (additional 10 minutes).

MD/DO works with MA1 to see nine (9) scheduled patients. All flex time can be used for walk-ins.

Template requires 17 patient care days per month (200-210 days per year). Last two business days each month wouldn’t have scheduled patients, but would be used for panel management and to sign/close out CCM/RM notes that month.

Monthly Productivity (0 no-shows): $73,498.14 / 2,039.40 tRVU