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Tomorrow's Doctors, Tomorrow's Cures®

Compliance Officers' Forum Telehealth Webinar

Learn
Serve
Lead

January 12, 2021

A Moderated Discussion by:
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Senior Director and Regulatory Counsel, AAMC

Association of American Medical Colleges

Housekeeping Reminders

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To fully participate, please use WebEx and, optimally, have WebEx call you. If calling in, connect your individualized call-in user ID to properly attach your audio to your WebEx. Call-in only users will not be unmuted.

Today's session will be interactive.

- Comments can be submitted to everyone in the Chat Text box at any point.
- To ask a question, list your Full Name and Institution in the Chat Text box. You will be added to the question queue and called on in appropriate order.
  - When called on to ask your question, unmute yourself by clicking the microphone symbol by your name.

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Mass General Brigham

Telehealth and Compliance:
Collaboration for Sustainable (and Compliant) Success

Lee Schwamm, MD, Vice President for Virtual Care, Mass General Brigham
Kate Connelly, CPA, MBA, Corporate Director, Mass General Brigham Enterprise Risk Management
Rosemary Gottlieb, JD, Senior Legal Counsel, Mass General Brigham

January 12, 2021

Agenda

- Call to Action
- Establishment of Roles and Responsibilities
- Separation of Pandemic and Post-Pandemic Activities
  - Real-time advice in the context of a moving target
  - Standards to facilitate compliance post-PHE
- Establishment of a Proactive Telehealth/Virtual Care Compliance Program
- Risk Areas that Require Assessment

Call to Action

- Define virtual care (telehealth, telemedicine, asynchronous, etc)
- Pre-pandemic virtual care utilization was limited in scope and adoption with mostly internally funded incentives and no/limited reimbursements
- Public Health Emergency (PHE) flexibilities have positioned virtual care as a key enabler to deliver quality patient care that meets STEEEP criteria (though equity has been challenging)
- While we expect these flexibilities to wane post-PHE, we expect demand for virtual care services to continue to increase and differentiate
- In order to achieve our vision of integrating virtual care into our clinical care spectrum, we have committed to investing resources to ensure we understand the regulatory and risk landscape and can support our providers in delivering virtual care appropriately and compliantly.

Establishment of Roles & Responsibilities

- Collaborative effort to establish written roles and responsibilities among key stakeholders to ensure coordinated and productive efforts:
  - Governance –Virtual Care Team determines budget and resource allocations; assists in defining phases in scope to make completion of work manageable with tight timeframes. Dedicated Virtual Care Content Committee integrates key inputs
    - **Legal** – Assists with interpretation of regulatory requirements and coordinates outside counsel assistance as needed
    - **Compliance** – Works with operational owners and subject matter experts to identify existing infrastructure that can be leveraged for virtual care as well as gaps that need to be addressed to achieve compliance post-PHE
    - **Operational** – Leads efforts to determine best strategies to address gaps and establishes timelines for implementation
    - **HIM/Privacy** – Leads efforts to ensure safe and responsible documentation/contact practices

Clarity of roles and responsibilities is critical to ensuring all bases are covered and that productivity and efficiency towards implementation is maximized.

Compliance Efforts to Address Activities During the Pandemic

- Largely driven by regulatory waivers
- Strong presence of legal counsel to assist in identifying and interpreting waivers
- Guidance for providers regarding available flexibilities as well as ongoing risk areas
- Documentation templates to assist with compliance
- Education for providers regarding applicable state licensing requirements
- Monitoring strategies to assess adherence to guidance provided

Overall Goal: Provide access to medically necessary and appropriate care to patients while reducing risk to the institutions and providers.

Compliance Efforts to Address Activities Post-Pandemic

- Anticipation that many regulatory waivers will expire; uncertainty regarding post-PHE reimbursement and other requirements.
- Identification of key areas where standard guidance and workflow is needed to support compliance, especially for non-portal transactions.
- Collaboration with key operational leaders and subject matter experts to assess current infrastructure and identify gaps where additional measures are needed to address telehealth. For example:
  - Patient Access
  - Health Information Management
  - Revenue Cycle
  - Electronic Health Record Operations
  - Quality and Equity
  - Clinical leaders

Compliance Efforts to Address Activities Post-Pandemic (Cont'd)

- Implementation plan that establishes accountability and prioritization to ensure remediation efforts are implemented within time constraints.
- Ultimately a comprehensive guideline, training program and monitoring plan will help support providers achieve compliance in a manner that does not interfere with patient care.

Overarching goal: to make the experience of a Virtual Visit as (or more) seamless for patients and providers as in-person care.

Ongoing Virtual Care Compliance Program

- Utilizing existing infrastructure where appropriate, ensure that a proactive compliance program exists that addresses the unique aspects of Virtual Care:
  - Compliance program oversight, including governance / committee structure
  - Policies and procedures
  - Training regarding to support compliance with standards (as well as CME support)
  - Auditing of individual provider compliance (e.g., documentation, coding, billing)
  - Monitoring of aggregate data
  - Reporting / helpline availability
  - Investigations process to address potential areas of non-compliance
  - Corrective actions and escalation to address non-compliance, if needed

Annual work plan will be established to ensure evolving risk landscape is considered in proactive compliance program efforts.

Risk Areas That Require Assessment

- Provider licensure requirements
- Patient Identity Verification
- Patients located out of state
- Providers Located Out of State
- Prescribing (including PMP requirements)
- Standard of Care / Scope of Practice
- Consent
- HIPAA Privacy / Information Security
- Presence of Third Parties
- Pediatric patients (e.g., COPPA)
- Recording
- Interpreter Services
- Medical Record Documentation
- Data Sharing / Other Treating Providers
- Coding/Billing Compliance
- Supervision
- Duty to Warn
- Duty to Report
- Protocol for Technology Failure
- Emergency Protocol When Acute / Emergency Treatment is Indicated
- Quality Oversight

Each topic / risk area must be addressed within the context of the Virtual Care visit type, patient location, provider location, etc.

Telehealth & Compliance Partnerships

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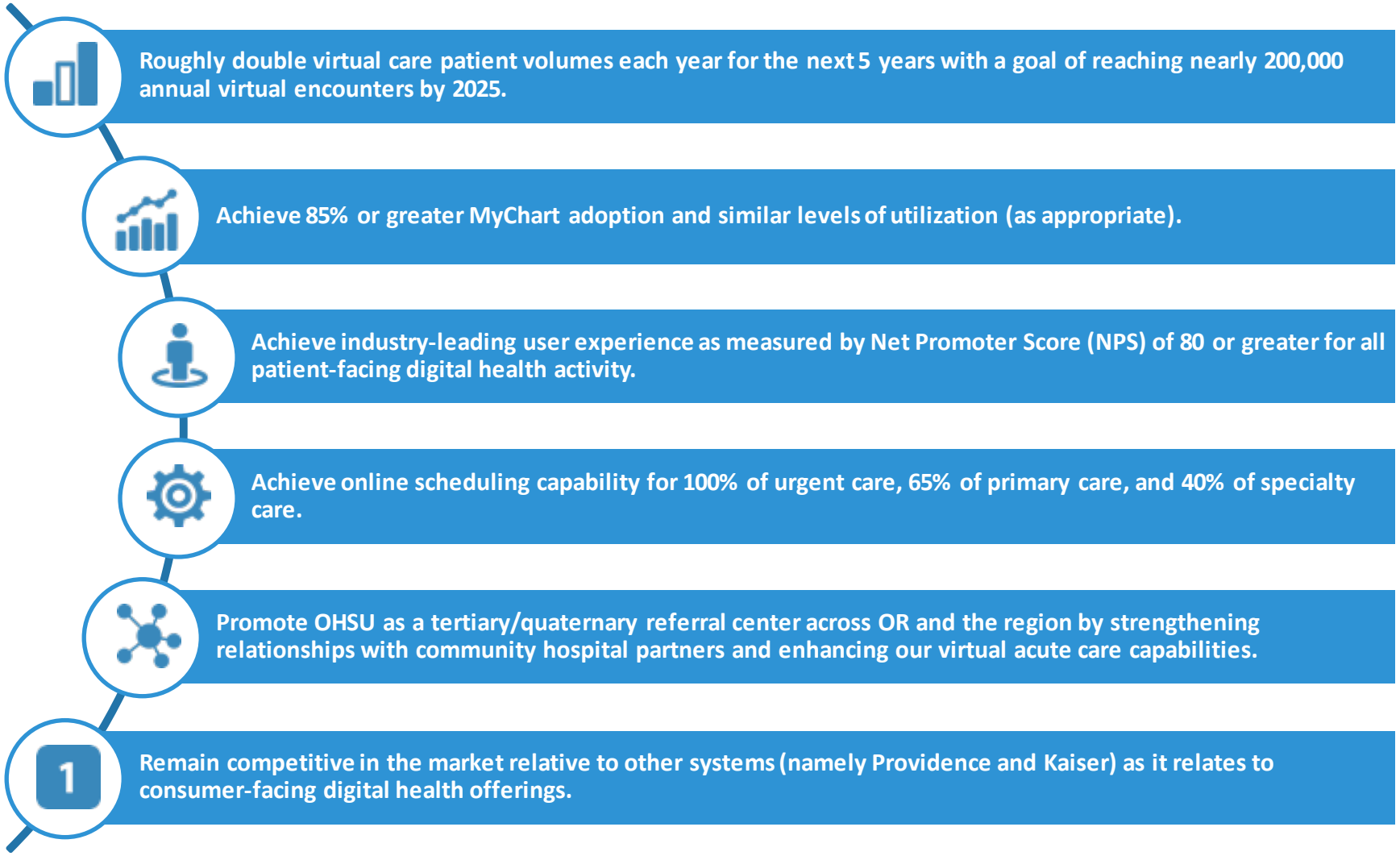
January 12, 2021

Overview

- Office of Digital Health developments
  - ODH goals prior to Covid
  - What happened during Covid
  - Where we go from here…

- Compliance Collaboration
  - Partnerships
  - Collaboration in practice
  - Compliance Information Dissemination
  - Out-of-State licensing

OHSU 2025 Digital Health Ambition



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Digital Health Tools

- Provider to Patient
  - *Synchronous*
    - Telephone visits
    - Video visits
  - *Asynchronous*
    - MyChart messages
    - eVisits
    - Remote Patient Monitoring (RPM)

- Provider to Provider
  - *Synchronous*
    - Phone calls
    - Telemedicine consults
  - *Asynchronous*
    - eConsults

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Office of Digital Health Programs

Comparison of Original Priorities to Work Completed

- FY20/FY21 Priorities
  - **Scaling Existing Ambulatory Telehealth Programs – goal 16000 digital visits**
    - eConsult redesign
    - eConsult expansion within OHSU
    - eConsult external expansion
    - eConsult/eVisits billing
    - eVisit expansion
    - Virtual Visit expansion
    - Remote patient monitoring
  - **Mobile Patient Experience**
    - MyChart Activation and Adoption
    - Online Patient Access (OPA)
  - **Virtual ICU (and eventually Virtual Hospital)**
    - Acute care telemedicine (e.g., virtual consults)

- February-April 2020
  - Ambulatory
    - Virtual Visits: Enabled 1,400 providers across 380 Epic departments, 2 campuses
    - Coronavirus symptom checker and eVisit
    - Telephone visits
  - Inpatient
    - Accelerate VICU/Tele-ICU
    - Remote telemedicine code-99
    - IP phone/video consults
    - Interprofessional telephone consults – replace the "curbside"

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Telehealth Covid Rapid Scale

Team Organization

- COVID19 Baby Tiger Teams formed
- Members from 9 different OHSU depts.
- Resources 100% focused & sequestered
- Daily standups, 7 d/week x 3 weeks

Guidelines

- Leverage existing vendors
- Scale quickly

Total Effort :1500 hours over 3 weeks

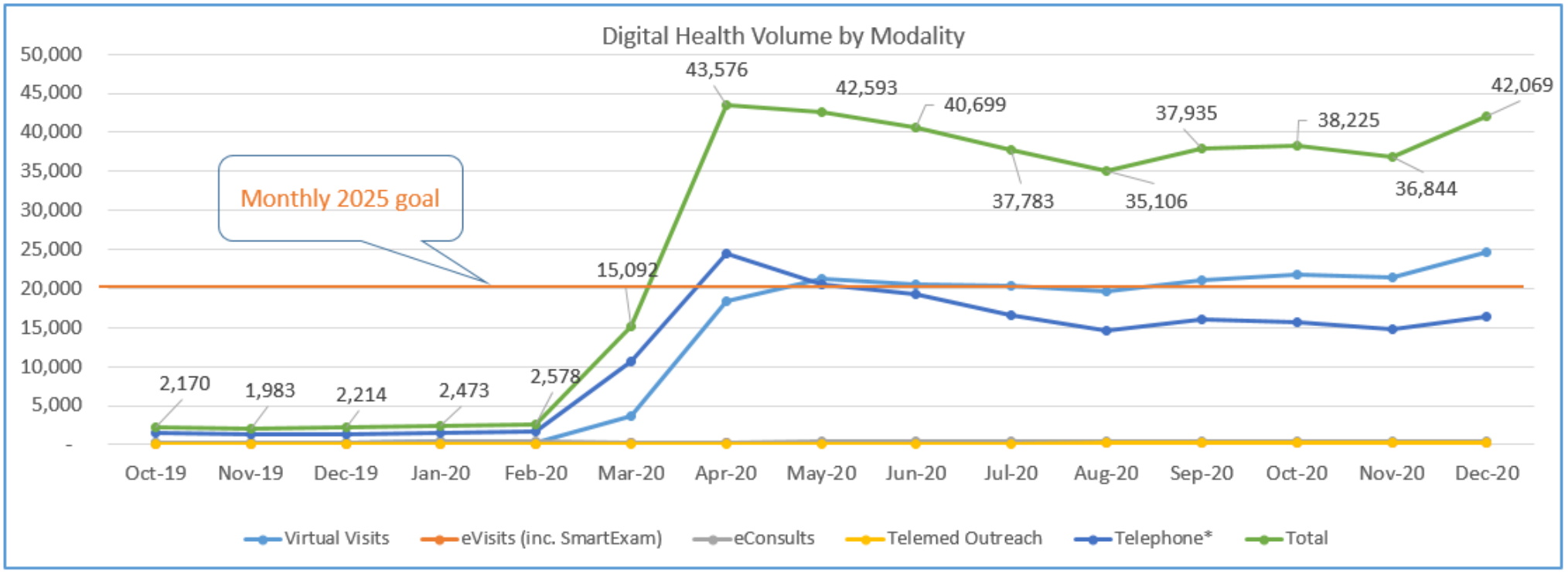
Digital Health Visits by Month

Data includes OHSU and Hillsboro Medical Center

DH Modality	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Virtual Visits	254	235	301	344	300	3,752	18,410	21,251	20,605	20,376	19,716	21,084	21,699	21,339	24,720
eVisits (inc. SmartExam)	69	69	76	94	78	187	242	252	253	293	234	213	246	208	210
eConsults	226	297	279	406	456	319	275	344	393	375	363	373	398	386	396
Telemed Outreach	121	104	143	108	116	142	159	134	132	111	194	211	252	212	259
Telephone*	1,500	1,278	1,415	1,521	1,628	10,692	24,490	20,612	19,316	16,628	14,599	16,054	15,630	14,699	16,484
Total	2,170	1,983	2,214	2,473	2,578	15,092	43,576	42,593	40,699	37,783	35,106	37,935	38,225	36,844	42,069

*Telephone encounters include Perioperative clinic encounters

CY 2020=374,973



FY 21 Office of Digital Health Priorities

- Ambulatory – optimize current tools, external eConsults
  - MyChart adoption and optimization
  - Need to develop formal QA/PI process related to recent expansion
  - Implement MyChart Message Visit billing for prolonged encounters (>5 minutes)
  - Implement Pre-Check-In patient data entry for digital and in-person patients

- Hospital-Based – expand tele-ICU and adoption of current tools
  - Continue to develop VICU

- Communication – improve awareness of both staff and patients

- Strategic – connect to health system councils/priorities
  - Interstate licensing/liability coverage
  - Partner with provider informaticists on development and rollout
  - Evolving reimbursement and compliance guidelines

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Partnerships:

The COVID-19 PHE has provided an opportunity, and a necessity for increased collaboration between several programs and teams across the institution impacted by the various federal and state COVID-19 regulations; including the ever-changing, complex billing and documentation requirements.

Examples of partnerships include:

- Office of Digital Health team
- Revenue Cycle (Including both professional and facility teams)
- Regulatory Affairs
- Clinical teams
- Risk and Legal teams
- Privacy team
- Compliance team
- Clinical Informatics
- Clinical and Administrative Leadership

Compliance Collaboration in Practice:

→Compliance team reviews, interprets, and summarizes regulations, 1135 waivers and ongoing updates to telehealth billing and documentation guidance.

- ✓Including federal and state regulatory review.
- ✓State Medicaid and commercial, third party payer policies.
- ✓Annual rulemaking impact analysis and collaboration on comment submittals.

Compliance Collaboration in Practice:

→ **Examples of collaboration include:**

- ✓ Pro-active communication of regulatory publications to impacted parties.
- ✓ Provide interpretive summary via email with a follow-up video conference to assess impact and assist in planning efforts.
- ✓ Ongoing updates provided via email communications and video-conferencing as needed based on the complexity of the updates.
- ✓ Publish resource documents that include coding, billing and documentation guidance for various digital health services.
- ✓ Participate as a SME in various partner teams to assist in operational efforts.

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Compliance Collaboration in Practice:

→ **Examples of collaboration include *(continued)*:**

- ✓ Partner closely with Revenue Cycle teams on coding and billing requirements for both professional and facility billing, including auditing and monitoring efforts.
- ✓ Educational sessions provided via various venues, including:
  - Daily clinical briefings (both via video-conferencing and daily institution wide email updates)
  - Centralized internal website with tip sheets and resources
  - Centralized COVID incident command/task force
  - Clinical department meetings and digital health listening tour
  - Clinical and Administrative Leadership meetings
  - Coding and billing staff sessions
  - Periodic live Townhalls

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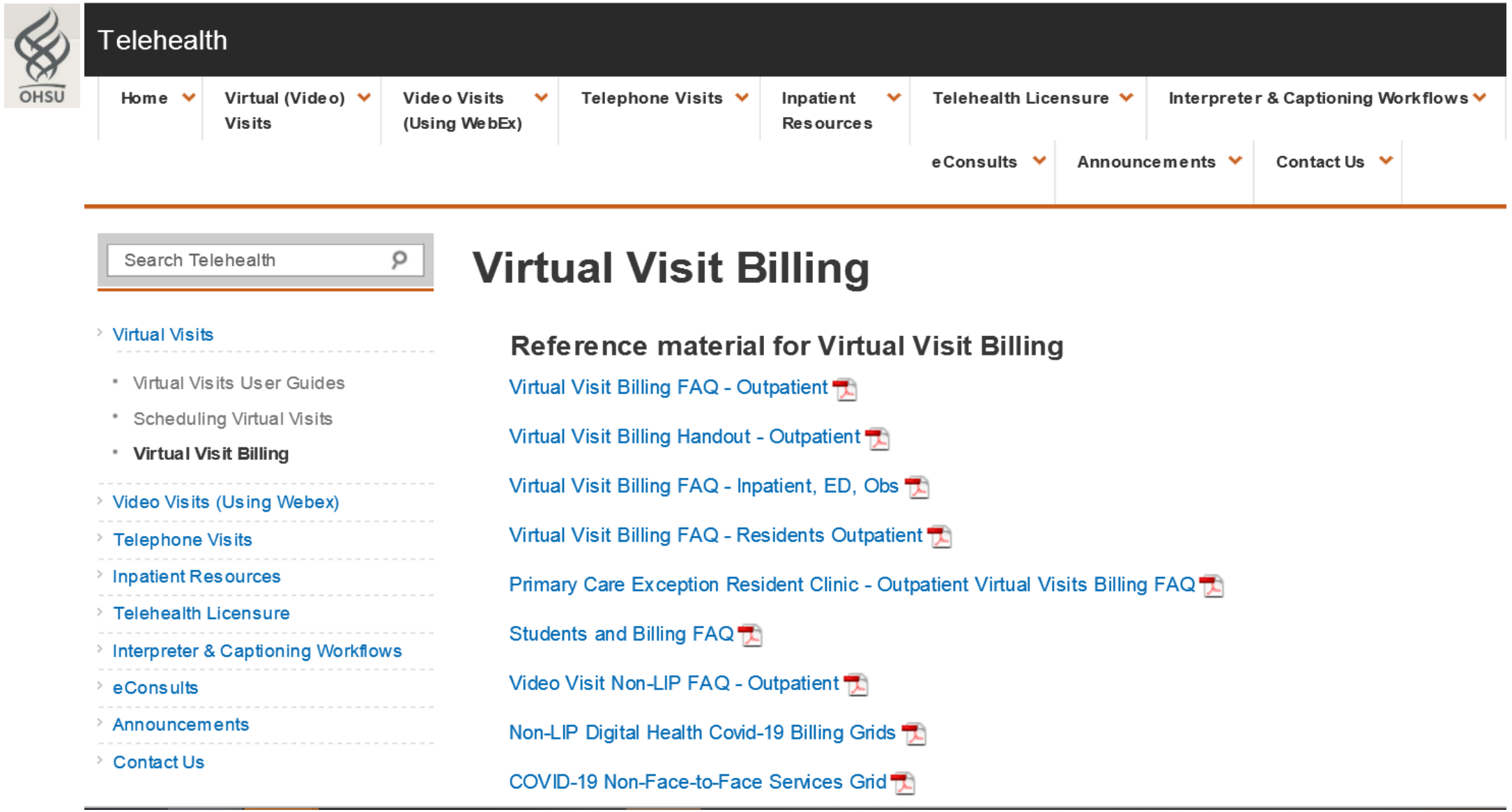
Compliance Collaboration in Practice:



Compliance Collaboration in Practice:

CPT	99441-99443	98966-98968	PREOP, 99024, OBRET, OBINI, OBPP	99201-99205	99211-99215	99221-99223/99231-99233
1/4/2021	*Telephone Call by LIP*	*Telephone Call by Non-LIP*	*Bundled services performed via phone or virtual visit*	*Outpatient Telemedicine Virtual Visit: New Patient*	*Outpatient Telemedicine Virtual Visit: Established Patient*	*Inpatient Telemedicine Video Consult/Visit - For PUI and COVID-19 Patients ONLY during PHE*
Description	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management (E/M) services provided to an established patient, parent, or guardian	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian	PREOP: Pre-operative visit 99024: Post-operative visit OBRET: Prenatal return visit OBINI: Initil prenatal visit OBPP: Post-partum visit	Office or other outpatient visit for the evaluation and management of a new patient	Office or other outpatient visit for the evaluation and management of an established patient	Initial or subsequent hospital care, per day, for the evaluation and management of a patient
Additional Guidance	* 99441: 5-10 minutes * 99442: 11-20 minutes * 99443: 21-30 minutes *Or, service specific CPT code if allowed to be performed via telephone *Can be used for inpatient telephone visits (may be corrected to code G0425-G0427 or G0406-G0408 per payer via the claim rules) • Not originating from a related E/M service provided in past 7 days • Not leading to an E/M service or procedure within the next 24 hours or soonest available appointment. If it does lead to an appointment, 99441-3 is not separately billable. • Do not report these services when performed concurrently with other billable services. • Can be performed in both outpt and inpt settings/POS. • New patients can be billed using these codes as of DOS 3/1/20 for all payors. •Medicare pays for these codes as of 3/1/20.	* 98966: 5-10 minutes * 98967: 11-20 minutes * 98968: 21-30 minutes *OR service specific CPT code if allowed to be performed via telephone *Do NOT bill 98358 for 31+ min. • Not originating from a related service provided in past 7 days • Not leading to a related service within the next 24 hours or soonest available appointment. If it does lead to an appointment, 98966-98968 is not separately billable. • Do not report these services when performed concurrently with other billable services. • Can be performed in both outpt and inpt settings/POS. • New patients can be billed using these codes as of DOS 3/1/20 for all payors. •Medicare pays for these codes now. •For PT/OT/SLP, use GO, GP, GN as appropriate.	These are services that are part of a global package and not typically separately reportable. During the COVID-19 health crisis, these services may be performed via telephone or virtual visit as medically appropriate. Follow the rules associated with each global code and the workflow appropriate for telephone or virtual visit.	*99201: <20 min. *99202: straightforward MDM or 20+ min *99203: low MDM or 30 +min *99204: mod MDM or 45+ min *99205: high MDM or 60+ min • For all payors, including Medicare, select the appropriate LOS. Select GT modifier and Epic will flip it to the correct modifier per payor rules and provider location. • A new patient hasn't been seen for greater than 3 years for a face-to-face visit by a provider/same group practice. • Select the LOS based on MDM or time. For time, you may count all the time you spent on the patient's case on the same calendar day, including non-face-to-face time. You may bill by time even if you do not spend >50% in counseling or coordination of care.	*99211: < 10 min *99212: straightforward MDM or 10+ min *99213: low MDM or 15+ min *99214: mod MDM or 25+ min *99215: high MDM or 40+ min • For all payors, including Medicare, select the appropriate LOS. Select GT modifier and Epic will flip it to the correct modifier per payor rules and provider location. • An established patient has been seen in the last 3 years for a face-to-face visit by a provider/same group practice. • Select the LOS based on MDM or time. For time, you may count all the time you spent on the patient's case on the same calendar day, including non-face-to-face time. You may bill by time even if you do not spend >50% in counseling or coordination of care.	ONLY APPLICABLE FOR PUI OR COVID-19 DIAGNOSED PATIENTS Initial: *99221/G0425: straightforward/low MDM or 30+ min. *99222/G0426: moderate MDM or 50+ min. *99223/G0427: high MDM or 70+ min. Subsequent: *99231/G0406: straightforward/low MDM or 15+ min. *99232/G0407: moderate MDM or 25+ min. *99233/G0408: high MDM or 35+ min. *An initial evaluation can only be billed once per hospital admission, per specialty. • Select the LOS based on E/M components (Hx, Exam and/or MDM) OR time in counseling/coordination of care. •For time, all time you spent on the patient's case can be counted when performed at the patients bedside and unit/floor on the same calendar day when >50% is spent in counseling/coordination of care. Time spent off of the patients unit/floor is not counted. Unable to count resident time or teaching time.
Performing Provider	Licensed Independent Practitioner (MD, NP, PA, CNS, CNM)	Non-Licensed Independent Practitioner (SLP, PT, OT, RD, PhD, PsyD, LCSW)	Licensed Independent Practitioner (MD, NP, PA, CNS, CNM)	Licensed Independent Practitioner (MD, NP, PA, CNS, CNM)	Licensed Independent Practitioner (MD, NP, PA, CNS, CNM)	Licensed Independent Practitioner (MD, NP, PA, CNS, CNM)
Billing Provider	Licensed Independent Practitioner (MD, NP, PA, CNS, CNM)	Non-Licensed Independent Practitioner (SLP, PT, OT, RD, PhD, PsyD, LCSW)	Licensed Independent Practitioner (MD, NP, PA, CNS, CNM)	Licensed Independent Practitioner (MD, NP, PA, CNS, CNM)	Licensed Independent Practitioner (MD, NP, PA, CNS, CNM)	Licensed Independent Practitioner (MD, NP, PA, CNS, CNM)
Place of Service	Follow PBB rules: 11 (clinic), 19 (off campus outpatient hospital), 22 (on campus outpatient hospital), 21 (inpatient)	Follow PBB rules: 11 (clinic), 19 (off campus outpatient hospital), 22 (on campus outpatient hospital), 21 (inpatient)	Follow PBB rules: 11 (clinic), 19 (off campus outpatient hospital), 22 (on campus outpatient hospital)	Follow PBB rules: 11 (clinic), 19 (off campus outpatient hospital), 22 (on campus outpatient hospital)	Follow PBB rules: 11 (clinic), 19 (off campus outpatient hospital), 22 (on campus outpatient hospital)	21 (inpatient hospital)
Category	Non-face-to-face services	Non-face-to-face services	phone: non-face-to-face services virtual visit: telehealth	Telehealth	Telehealth	Telehealth

Out-of-State Licensing:

- ✓ Collaboration on review of out-of-state licensing issues with Telehealth, Legal, Regulatory Affairs and Risk teams.
- ✓ The need to limit in-person care due to COVID-19 quickly increased the need to provide telehealth services “across-state-lines”.
- ✓ The Director of Regulatory Affairs played a vital role in evaluating various state specific laws during the PHE for telehealth services by swiftly creating a user-friendly grid outlining the state laws during the states declared emergency order.
- ✓ Legal, Regulatory Affairs, and Compliance worked closely with the Washington State medical board to obtain temporary licensure during their emergency order for our credentialed providers.

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Thank You

Mass General Brigham

Questions?