MEDICARE QUALITY COMMITTEE

Special Webinar Meeting: Covid-19 **March 18, 2020**

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Treating the FutureSM

About this Presentation

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- On **Wednesday, March 18,** The NEQCA Medicare Quality Committee met to discuss Telehealth, Coding Guidelines and an update from Dr. Ben Kruskal, NEQCA Medical Director on COVID-19 and what practices can be doing.

- *Disclaimer:* The information in this presentation is relevant as of 3/18/20. The situation, however, is changing rapidly. To ensure you have the latest information on COVID-19, use the resources below:
  - Global & national impact, including countries of concern: Centers for Disease Control
  - Situation in Massachusetts: Massachusetts Department of Public Health
  - COVID-19 Resource Center: Infectious Diseases Society of America
  - Travel restrictions: U.S. State Department

AGENDA

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Introduction	*Ben Kruskal, MD*
Telehealth Update	*Lisa Reed*
Telehealth Coding Guidelines	*Pratiksha Patel, MD*
Discussion and general questions	*Ben Kruskal, MD*

COVID-19 AND YOUR PRACTICE: WHAT CAN YOU DO?

- **Ben Kruskal, MD**, *NEQCA Medical Director*

Topics and priorities

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- **Take care of patients first**
  - Typical priorities like quality metrics, MWOV, etc set aside while we deal with the crisis; will made whatever adjustments are necessary, either within NEQCA or by negotiation with payers
  - Everyone will be in the same boat (metrics are all compared to market)
- NEQCA Central can share our experience with staff issues like
  - Remote work for non-clinical staff
  - Sick time; child care; reducing workforce
- Social distancing; what we should all do outside of our work lives
- *Practice survival: Nate Gagne*

- **What you can do for your patients amidst this crisis**

COVID-19: WHAT IS IT AND WHY SHOULD YOU CARE?

- Covid-19 is the illness caused by a novel strain of coronavirus, a family of respiratory viruses that have been recognized for decades
  - There have been known human coronaviruses causing typical minor URIs which have been recognized for decades
  - The first serious human coronaviral pathogen was SARS, which caused a very serious outbreak of lower respiratory illness in 2002-3 originating in Hong Kong, spreading to the surrounding areas of East Asia and other areas around the world, with an especially large concentration in Toronto

Covid-19: clinical

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- The virus which causes Covid-19 is moderately closely related to the SARS virus and is called Human-SARS-CoV-2
- Incubation period avg 5 d (range 2-14 d) till sx onset
- Transmission 0-2 d before sx onset; not known how long transmission might continue after sx onset
- Sxs: fever 80% (around 40% fever at presentation), cough, SOB, URI sx
  - GI sx rare
  - Bilat pneumonia similar to other virals, ARDS common
- Severe disease/mortality increases with age starting around 50
  - Under 50: 0.5%; 50s: 1.5%; 60s: 4%; 70s: 8%; 80+: 16%
  - Also chronic diseases, notably DM, COPD, CAD, HTN (illness vs rx?)
- Illness rare in children; severe illness and death very rare in kids and young adults

Social distancing/#flattenthecurve

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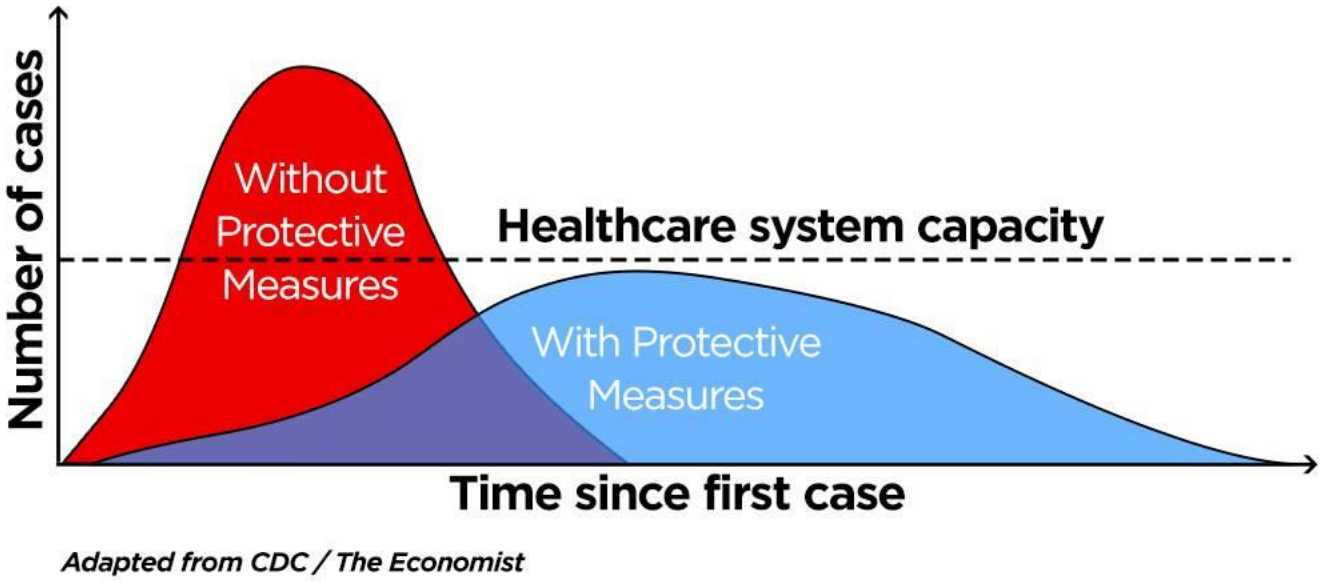

COVID-19: WHAT CAN YOUR PRACTICE DO?

- Save your patient unnecessary trips to the ER and potential exposures there and along the way
- Make sure that the right patients DO go for Covid-19 testing
- Make sure that the right patients DO go to the ER
- Decrease anxiety in your patients and staff by giving them accurate information
- Protect yourself and your staff from exposure with good triage, (and understanding of what personal protective equipment (PPE) is needed and how to use it when available)

Assessing practice readiness

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- **Supplies/PPE (Personal protective equipment)**
  - **Surgical masks** (N95 only needed for nebulizer treatments)
  - Gowns
  - Gloves
  - Eye protection
- **Knowledge**
  - Triage protocol
  - How to get patients tested
  - Telehealth visits?
- **Messaging**
  - Outgoing recorded message/hold message
  - Patient portal message/Website
  - Sign on door
- **Consider cross-coverage in case of illness or volume**

What can you do without PPE?

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- What do you do if you don't have, or run out?
  - Can't see patients with respiratory symptoms
  - **Good phone triage (Covid and other)**
  - **Telehealth visits (Covid and other)**
    - Respiratory illness: Can't listen to lungs, but can listen grossly, observe (gross breath sounds, breathlessness while talking, RR, respiratory effort, color)
    - For anything else that doesn't require a physical exam, reduce incidental/unexpected exposures
  - **See patients with <u>non-respiratory non-deferrable acute symptoms/injuries</u>. Keep what's not serious out of the ER!**

Phone triage for Covid-19

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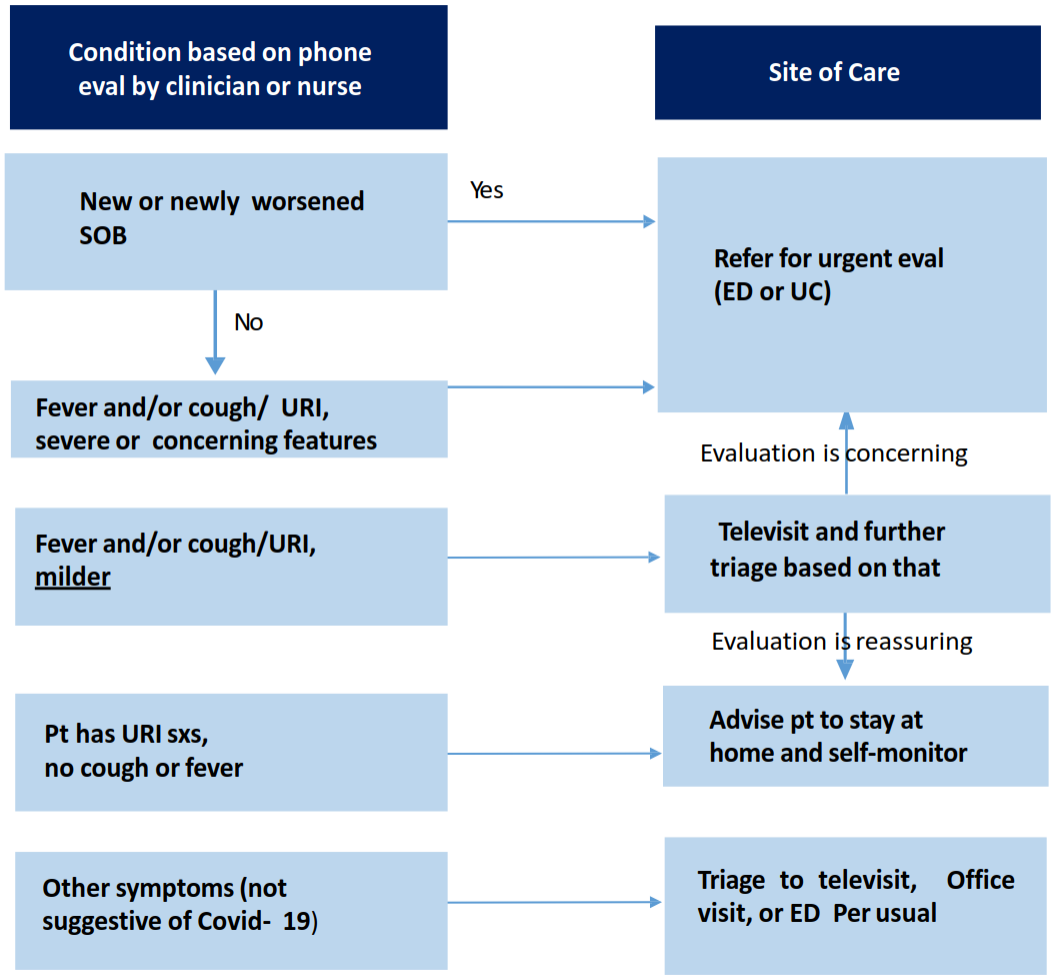
COVID-19 ADULT PRIMARY CARE PHONE TRIAGE

B. Kruskal, MD 3/18/2020 after Circle Health



Telehealth

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- Wellforce has worked with the vendor we use for Urgent Care televisits to allow our practices to get up and running quickly
- Easy solution using tech most of us already have available (laptop or desktop with webcam, iPhone, iPad)
- State mandate to payers for the duration of the crisis allow telehealth and mandates payment at equivalent level to face to face with no patient liability at all (no copay or coinsurance, no deductible); payers will make physicians whole for this
- Multiple platforms available; HHS now allows use of non-HIPAA compliant technology (FaceTime, Skype, etc) for the duration of the crisis
- Our performance improvement team will be helping practices that are interested get started within days

Testing: not very available

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- Limitations in supply of testing kits themselves, and some necessary additional reagents AND the swabs
- NO strategic stockpile reserve available, at either state or Federal levels
- None internationally (crisis everywhere!)

- Managing without test results
  - Doesn't affect clinical management
  - Might be useful to prevent some exposures, but as Covid-19 becomes more prevalent, more and more people will have had unrecognized exposures anyway

Testing criteria: 1

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PATIENTS IN CATEGORIES 1-6 SHOULD BE TESTED THROUGH THE MASSACHUSETTS STATE PUBLIC HEALTH LABORATORY		
EPIDEMIOLOGIC OR OCCUPATIONAL RISK[1]		CLINICAL FEATURES[2]
CATEGORY 1 Healthcare providers and EMTs who have worked in direct clinical care while symptomatic	**AND**	Fever **or** signs/symptoms of respiratory illness • even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. • Influenza should be ruled out prior to testing for COVID-19
CATEGORY 2 Close contacts of confirmed COVID-19 cases who were present in congregate settings (example: school) while symptomatic **AND** who had close contact with numerous others • Being in a public setting while symptomatic but without prolonged close contact to others does NOT meet this criteria	**AND**	Fever **or** signs/symptoms of lower respiratory illness (e.g. cough, shortness of breath) • Influenza should be ruled out prior to testing for COVID-19
CATEGORY 3 Hospitalized patients with fever and **severe** acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization **and without alternative explanation** (negative results on a respiratory viral panel, other infectious disease testing as appropriate). A compatible exposure history (travel or contact with a confirmed case) is not required.		Clinical features that may increase suspicion of COVID-19 include: • infiltrative process on chest x-ray (e.g., bilateral infiltrates consistent with viral pneumonitis). • bilateral ground-glass opacities on chest CT unexplained lymphocytopenia or thrombocytopenia

Testing: 2

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CATEGORY 4 Clusters of acute respiratory illness in congregate settings (e.g., Long-term care facilities, shelters, prisons)		3 or more individuals with fever **and** signs/symptoms of a lower respiratory illness (e.g., cough, shortness of breath, pneumonia) • Minimally, influenza should be ruled out prior to testing for COVID-19 • Negative results from a respiratory viral panel are preferred
CATEGORY 5 Close contacts of confirmed COVID-19 cases who were NOT present in congregate settings (example: school) while symptomatic **AND** close contacts are largely restricted to household members	**AND**	Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough, shortness of breath, pneumonia) • Minimally, influenza should be ruled out prior to testing for COVID-19 • Negative results from a respiratory viral panel are preferred
CATEGORY 6 People with a history of travel from an international geographic area designated for Level 3 travel restrictions within 14 days of symptom onset. For current locations: https://wwwnc.cdc.gov/travel/notices)		Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough, shortness of breath, pneumonia) **AND** hospitalization not required • Minimally, influenza should be ruled out prior to testing for COVID-19 • Negative results from a respiratory viral panel are preferred

Testing: 3

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PATIENTS IN CATEGORIES 7 AND 8 SHOULD BE TESTED THROUGH COMMERCIAL LABORATORIES AND SPECIMENS SHOULD NOT BE SENT TO THE MASSACHUSETTS STATE PUBLIC HEALTH LABORATORY		
CATEGORY 7 People with a history of travel from an international geographic area designated for Level 3 travel restrictions OR to a location within the United States that has known community transmission within 14 days of symptom onset For current locations with Level 3 travel restrictions: https://wwwnc.cdc.gov/travel/notices) Locations within the United States with known community transmission as of March 12, 2020 include: Seattle/King County Washington, Westchester County, New York, and Solano County, California		Fever OR mild to moderate respiratory illness NOT meeting the criteria listed above
CATEGORY 8 Other symptomatic individuals for whom knowledge of COVID-19 infection is medically indicated including older individuals and those with co-morbidities		Fever OR mild to moderate respiratory illness

VIRTUAL VISIT OPTIONS

- **Lisa Reed**, *VP Performance Management*

Outline

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- Recent regulatory changes and options in view of Covid Pandemic
- Potential Options for NEQCA practices and their pros/cons
- Additional resources

Recent Temporary and Emergency Massachusetts Regulatory Changes: March 15

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- Governor Baker executed an *Order Expanding Access To Telehealth Services And To Protect Health Care Providers* requiring the state's Group Insurance Commission (GIC), all Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations (Carriers) regulated by the Division of Insurance (Division) to
  - allow all in-network providers to deliver clinically appropriate, medically necessary covered services to members **via telehealth and mandating reimbursement for such services**.

Recent Temporary and Emergency Federal Regulatory Changes: March 17

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- CMS under 1135 waiver expanded telehealth services for Medicare beneficiaries
- The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) (the agency responsible for enforcing HIPAA) sent a notice of Enforcement Discretion for telehealth remote communications
  - Effective immediately, OCR will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency for all patients
- Under this Notice, covered health care providers may use popular applications that allow for video chats, including
  - Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules
  - Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications
- Under this Notice, however, Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers

TELEHEALTH CODING GUIDELINES

- **Pratiksha Patel, MD**, *NEQCA Medical Director*

Telehealth billing codes

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- **Telehealth Visits**
  - **Synchronous audio/visual visit** between a patient and clinician for evaluation and management (E&M).
  - **CPT Code 99201-99205** (POS 02 for Telehealth, Modifier 95 (Commercial Payers)) – Office or other outpatient visit for the evaluation and management of a new patient
  - **CPT Code 99210-99215** (POS 02 for Telehealth, Modifier 95 (Commercial Payers)) – Office or other outpatient visit for the evaluation and management of an established patient
  - *A list of all available codes for telehealth services can be found on the CMS website.

Online Digital visits

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- **Online Digital Visits**
  - Digital visits and/or brief check-in services furnished using communication technology that are employed to evaluate whether or not an office visit is warranted (**via patient portal, smartphone**).
  - **CPT Code 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
  - **CPT Code 99422 –** 11-20 minutes
  - **CPT Code 99423 –** 21 or more minutes

GENERAL DISCUSSION AND QUESTIONS

- **Ben Kruskal, MD**, *NEQCA Medical Director*

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