May 11, 2020 | Volume 34, Issue 19

Part B News
partbnews.com
COLLECT EVERY DOLLAR YOUR PRACTICE DESERVES

In this issue

DecisionHealth
a Simplify Compliance brand

Practice management

Whether reopening now or later, communicate to patients with rules and compassion

Keeping patients informed is always a good idea — especially so when you're closed in a pandemic shutdown or emerging from one. Be sure you not only let your patients know you're still there for them, but also specifically how you'll be there for them in the future.

Despite studies that show dedicated patient communications help improve care and increase visits, many practices don't do much with them, or only consider them when they need to improve collection of patient payments (*PBN 10/11/18*, *5/2/19*).

But if anything calls for you to step up communications, it's the COVID-19 pandemic, especially now that many practices, perhaps including yours, contemplate reopening after weeks of reduced or interrupted service as states begin emerging from lockdown (*PBN 4/30/20*).

"I can personally say I don't think providers have been good about communicating," Jeanette Ball, RN, Client Solution Executive at CTG in Buffalo, N.Y. "They're not used to thinking of themselves as a business. We get emails from airlines and banks saying, 'We're taking care of you.' I'd like to hear something like that from my provider."

And patients are hungry for that information. Karen Dennis of KSD Public & Media Relations in Hollywood, Fla., says one of her clients, an infertility clinic in south Florida, saw the open rate on its emails increase from 31% to 40% during

Adopt new therapy payment modifiers

Starting January 1, therapy service claims must be submitted with new payment modifiers when therapy assistants provide a certain level of service. Practices must understand how and when these modifiers should be appended now, because in less than two years, the modifiers will carry payment adjustments. Get all the details during the webinar **Stay Up to Date and Compliant on Coding Changes for Therapy Services** on May 19. Learn more: *https://codingbooks.com/ympda051920*.

the shutdown. "That is significant for a database of 5,000 patients," Dennis says.

"I'd like to think of COVID-19 as an opportunity to provide services to patients even if they do not come to the office, even if they do not have an examination, and even if they don't have any medical issues," says Neal H. Baum, M.D., medical advisor to Vanguard Communications in Denver, Colo. "I would provide them with the reassurance that I can still provide them with care via telemedicine if they're quarantined and are unable to come to the office or don't want to go to an emergency room or an urgent care center."

For all practices

Whether you're calling them in or waving from a distance, communications experts remind you to adopt or maintain good patient message hygiene. While the telehealth waivers CMS recently issued make less-than-perfect security acceptable for online medical encounters, they do not completely overrule HIPAA law (*PBN 4/16/20*). Your ordinary patient communications still can't expose protected health information (PHI) via insecure media like email or postcards.

- **Do the basics.** Jon Dinchak, senior product manager for AdvancedMD in South Jordan, Utah, says you should follow at least elementary customer messaging best practices. "Make sure you have the most up-to-date contact information. Give your patients the ability to opt out if they don't want to receive messages," Dinchak advises. "Know the right channel: Email is best for longer messages. Use text and voicemail for quick, short, emergency-type messaging."
- **Keep updated.** Now it's more important than ever to have policies immediately and accurately updated on your website and anywhere else patients may find them, says Giselle Bardwell, head of health care at Chatmeter in San Diego. "Patients must be able to easily find information about where to receive care nearby, including updated hours, location changes, ongoing telemedicine services, if and where to receive elective procedures and so on," Bardwell says. "It is critical that health organizations prioritize keeping this information updated in search engines, where we know more than two out of three consumers start their mobile health research."

And when you update, do it across all media, Bardwell urges. That's critical for the performance of your search engine optimization (SEO) and your ability to attract patients to your web presence. "Consistent information across the entire local ecosystem — local directories, review sites, etc. — is considered by Google to determine importance, relevance, prominence and proximity for local listings rankings," Bardwell explains. "Meaning, if the business name, address, phone number, hours, description, etc., matches across multiple sites, including the business website, then Google gains more trust that it is the correct

Simplify Compliance
Learn, Comply, Succeed

SUBSCRIBER INFORMATION

Have questions on a story? Call or email us.

***PART B NEWS* TEAM**

Maria Tsigas, x6023
Product Director, Information, Print Subscription Products and Services
mtsigas@decisionhealth.com

Marci Geipe, x6022
Senior Manager, Product and Content
mgeipe@simplifycompliance.com

Steven Andrews, x3171
Managing Editor, Coding
sandrews@hcpro.com

Richard Scott, 267-758-2404
Associate Content Manager
rscott@decisionhealth.com

Roy Edroso, x6031
Editor
redroso@decisionhealth.com

Jim Dresbach, x5031
Editor
jdresbach@decisionhealth.com

Medical Practice & Hospital community!

www.facebook.com/DecisionHealthPAC
www.twitter.com/DH_MedPractice
www.linkedin.com/groups/12003710

SUBSCRIPTIONS
Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email: customer@decisionhealth.com

DECISIONHEALTH PLEDGE OF INDEPENDENCE:
Part B News works for only you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. For nearly three decades, we've been independently watching out for the financial health of health care providers and we'll be there for you and your peers for decades to come.

CONNECT WITH US
Visit us online at: www.partbnews.com.

CEUS
Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email *customer@decisionhealth.com.*

ADVERTISING
To inquire about advertising in *Part B News,* call 1-855-CALL-DH1.

DecisionHealth
a Simplify Compliance brand

Part B News® is a registered trademark of DecisionHealth. Part B News is published 48 times/year by DecisionHealth, 100 Winners Circle, Suite 300, Brentwood, TN 37027. ISSN 0893-8121. *pbncustomer@decisionhealth.com* Price: $647/year.

information and will rank it accordingly. Therefore, just updating on one's own site will not get the job done."

- **Give them content.** All practices should offer robust health and safety messages via their websites and other media to give patients something to remember them by when they're separated. Ron King, CEO of Vanguard Communications, recommends keeping a blog and letting patients know when it's updated. "The biggest names in health care — from Mayo to Cleveland Clinic to the National Institutes of Health — have been blogging for a long time," he says. "Why not do as the big boys?"

"I would also share with them some good book titles and videos that are health-related," Baum says. "I would share some healthy recipes that are nutritious yet tasty. If they are experiencing loneliness, I or a member of my staff would offer them a 'no charge' teleconference just to let them know the practice cares about them." Ultimately, an outreach strategy intertwines with good patient care. "The bottom line is that COVID-19 is not a time to feel isolated and depressed," Baum says.

Messages for reopening practices

- **Calm their fears.** Many patients will be eager to come back; others will be nervous as, despite the reopening your state allows, COVID-19 is far from eradicated. You are advised to assure your patients that you're doing everything possible to reduce the risk of infection, says James Brown, CEO of Smart Communications in New York. That may include "details on what practitioners are doing to keep patients safe, how they're maintaining social distancing guidelines — such as closing or limiting waiting room access — and the steps they're taking to provide responsible treatment options during the pandemic," Brown conveys.
- **Give quick, relevant messages.** One way to underline the immediate relevance of your efforts to reduce risk is by making full use of digital communications channels such as texting, which "can help providers ensure messages reach patients in an efficient, timely manner and, ultimately, help allay any initial apprehensions about in-person visits," Brown adds.
- **Tailor reopening messages to different groups.** Ball suggests you "risk stratify your panel by age and condition and develop appropriate strategies" to communicate to each patient demo based on their anticipated needs. For young patients, for example, you may lean on services such a STD testing: "They haven't been able to have that," Ball says. "You can't do it by telehealth or in the emergency room." For the chronically ill, on the other hand, "you want a very personal approach," she says. "I'd give them a phone call at minimum. Use all your communication options — emails, texts, even letters. Have it come from a member of their care team — Bill who works with Dr. Smith, for example."

Messages for closed or half-open practices

- **Be there, virtually.** Patients want to know you're there, even if they can't be. "If you have email addresses, use them," suggests Deb Gordon, author of *The Health Care Consumer's Manifesto*. "If you have particularly vulnerable patients or patients you're concerned about, reach out by phone. Let them know you just want to check on them and make sure they're doing OK. Answer questions and just listen to their concerns."

"Right now, many consumers have gotten the message to stay home," Gordon adds. "But some people who are sick or have acute issues actually do need medical attention. Help people understand when it is time to seek care and how to do so safely. Being proactive in this regard can help prevent bad health outcomes".

- **Make sure they can use telehealth.** Practices and patents have flocked to telehealth during the shutdown weeks, and it's generally accepted that it'll remain a big part of American medicine for a long time to come. So it's important to make sure that patients can use it. That includes those who may be avoiding it because, despite all CMS' efforts to make it easy, they haven't made the transition.

"One thing we learned about telehealth was the struggle some patients had with the technology," Ball says.

You might offer to guide your patients through whatever platform you're using — or engage a third-party support service to do so. "One client has a service where, the day before a telehealth appointment, they call the patient and walk through the process, making sure the connection works and showing them how to use the platform," Ball notes. — *Roy Edroso* (*redroso@decisionhealth.com*) ■

Practice management

How one Pennsylvania primary care practice is planning its comeback

Hatboro Medical Associates in Hatboro, Pa., has been around since the 1950s, serving as "a pillar of the community," says Harris B. Cohen, M.D., a family medicine physician with the practice. It's also in Montgomery County near Philadelphia, one of the "red" zones in Governor Tom Wolf's reopening plan, and has had no physical appointments since the state started its lockdown on April 1.

But Cohen and his crew are taking advantage of the slowdown to plan for their reemergence — they hope by June 1. Here's what he told Part B News:

Dr. Cohen: We'll move to a "hybrid" reopening [live and telehealth]. That would involve several things. We'll get the word out through Facebook, EHR email blasts, etc. The goal is to communicate [that] we are open to people who are comfortable with coming in.

I envision starting with well visits: acute issues without COVID signs. Rashes, diabetic checks, gout, chest pain, etc. We'll do a lot of phone triage — anyone with COVID signs we'll keep as televisits — and the doctors will take on more of the triage from the nursing staff.

The waiting room is a thing of the past! We'll have them check in from their vehicle. We'll send a text when we're ready for them to come in, and we will room them directly after taking their temperature.

We'll have rules: No one comes in with you except if you need them for interpretation or frailty. We'll check temps when they come in with no-touch thermometers. [We'll do] a full wipe-down between visits, per CDC recommendations. Where we had nebulizers for our COPD and asthma patents, now we'll have inhalers with spacers — chambers that click on the mouth of the inhaler to chamberize it so it doesn't get aerosolized. And we'll need sufficient PPE, mask and gown protection. Patients will have to bring their own masks. We'll be in scrubs for a long time as well.

I see possibly in the future split visits — with well visits in the morning and sick visits in the afternoon, including respiratory complaints.

[For patient communications:] We'll want to keep the information simple: Wear a mask. Leave people at home. Call from the car, etc. More than anything, call the office. We have to talk them though this to find out whether they're safe or not. — *Roy Edroso* (*redroso@decisionhealth.com*)

Coronavirus

CMS cements fresh round of COVID waivers, upping payments, expanding telehealth

A second wave of policy and payment changes that CMS released April 30 is reshaping — yet again — how the medical community can conduct care during the COVID-19 crisis and, critically, how much providers can expect to get paid.

In a wide-ranging update to policy guidance that CMS is touting as a "second round of sweeping changes," the agency seeks to further expand COVID care, ramp up diagnostic testing and again loosen restrictions on which types of providers can deliver vital services like telehealth during this unprecedented emergency.

Take stock of some of the key updates below.

Telephone services get a raise

A pay boost for telephone E/M services — approaching nearly a 200% rise in reimbursement — will give new meaning to the phrase "phoning it in" for practices that have provided and reported telephone E/M services (**99441-99443**) during the COVID-19 public health emergency (PHE).

As part of the drive to encourage the use of non-face-to-face services during the PHE, CMS will "increase payments for these services from a range of about $14-$41 to about $46-$110," CMS said. The updated payments are similar to those for established office visit codes **99212-99214**.

Better still, the update is retroactive to March 1, so practices that have been reporting these services won't miss out.

The move is similar to steps taken by states like Maryland that allow providers to report office E/M services conducted by audio-only means.

CMS notes that some patients can't or won't use a real-time audio/video connection that is required for a telehealth office visit. However, it appears that you will still need to report a telephone code for Medicare services. The codes will be added to the telehealth list, CMS states.

If this news makes your doctors and non-physician practitioners take a fresh look at telephone services, crack open your 2020 CPT manual and educate staff about the codes'

(continued on p. 6)

Benchmark of the week

COVID-hit providers increased patient messaging 37-fold in early crisis response

A major patient communication vendor's records show a massive spike in provider-to-patient interactions during the early days of America's COVID-19 shutdown — an indicator of the importance of appropriate patient messaging in handling the COVID crisis (*see story, p. 1*).

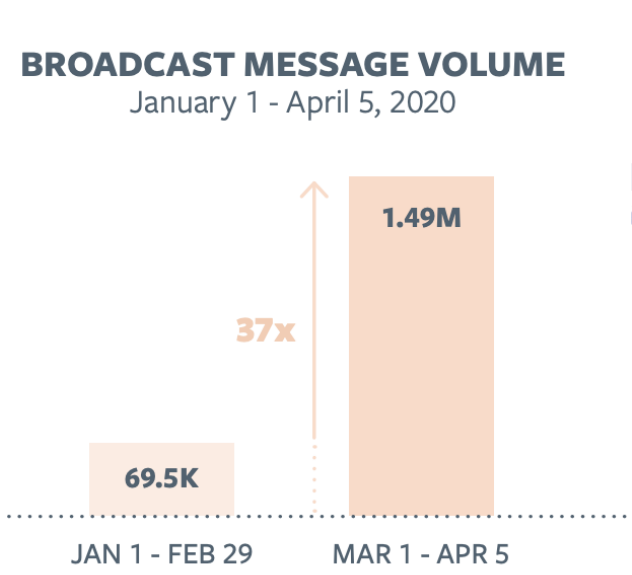
Luma Health, a San Francisco-based patient engagement platform provider, reports in an analysis of its clients' messaging that providers on their platform "increased patient communication via broadcast messages 37 times over, broadcasting more than a million messages to patients" in the fewer than five weeks between March 1 and April 5. The biggest spike took place the week of March 16 as the federal government and many states began ramping up COVID-19 response. This compares with message volume of less than 70,000 in January and February 2020.

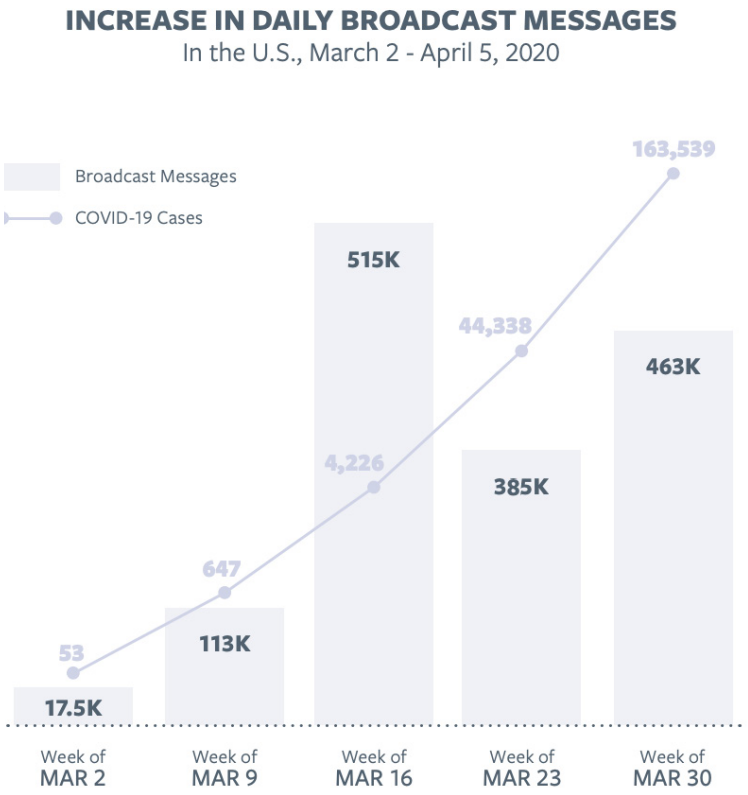
Luma further reports a 108% increase in provider appointment cancellations during March, with "appointments for non-urgent care — such as wellness visits, preventive screenings, and elective surgeries … rapidly deferred due to concerns about exposure risks in health care settings." The three specialties hardest hit were cosmetic surgery (365% increase in cancellations), physical therapy (170%) and radiology (121%).

Among the cancellation messages, about two-thirds were blanket cancellations "that essentially said, we're shut down, don't come in,'" while a third were more along the lines of, "We think we'll be closing, stay in touch, wash your hands if you come in," says Aditya Bansod, co-founder and chief technology officer of Luma.

California had by far the biggest surge in patient communications in the early days of the U.S. infection crisis, increasing messaging on the Luma platform from 2,263 in late January to 206,000 at the end of March. "Washington State was first to close down, but the Bay Area [of California] was the first place after that to close down, and shortly thereafter all California followed suit," Bansod says. "That turned the dial up to 11. Clinical behavior was mimicking [government] behavior, which is why you see that cancellation trend."

Luma's analysis is based on 5.7 million patient data interactions from its base of approximately 300,000 health care professionals. – *Roy Edroso* (*redroso@decisionhealth.com*)





Source: Luma Health study: www.lumahealth.io/wp-content/uploads/2020/04/COVID19_DataReport_April2020_FINAL.pdf
Used with permission.

(continued from p. 4)

requirements. For example, the phone call can't be related to a recent E/M service or lead to an in-person visit.

In addition, the codes are based on the time the clinician devotes to medical discussion. Make sure they're keeping close track of their time your practice doesn't experience an outbreak of over- or undercoding.

Telephone E/M services

Here's a list of the currently covered telephone E/M services, which are set to see significant increases to their associated payment levels:

- 99441 (Telephone E/M service by a physician or other qualified health care professional 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; 5-10 minutes of medical discussion).
- 99442 (… ; 11-20 minutes of medical discussion).
- 99443 (… ; 21-30 minutes of medical discussion).

Expanded diagnostic testing options

- **Non-physician practitioners (NPP) can order COVID-19 tests — if state scope of practice allows.** CMS says it is waiving its requirement for a written order from the treating physician or other practitioner for Medicare patients to obtain COVID-19 or related lab tests. Instead, during the public health emergency (PHE), the tests may be covered when ordered by "any health care professional authorized to do so under state law," the agency said.

"To help ensure that Medicare beneficiaries have broad access to testing related to COVID-19, a written practitioner's order is no longer required for the COVID-19 test for Medicare payment purposes," CMS said.

CMS will also pay for tests conducted on homebound patients and in drive-through locations such as parking lots.

Providers as well as hospitals can bill and be paid separately for tests subsequent to patient assessment for COVID-19 and lab sample collection. Also, CMS will cover some antibody tests and some FDA-authorized at-home tests conducted by beneficiaries. Heretofore, CMS had authorized code **U0001** for CDC-authorized tests, **U0002** for non-CDC-authorized tests and the nasal probe test code **87635**, which pay approximately $36, $51 and $51 dollars, respectively. CMS says it is now adding the antibody test codes **86328** and **86769**, lab test codes **U0003** and **U0004** and patient-collected test codes **C9803**, **99211**, and **G2023** and **G2024**.

Outpatient departments can retain rates

- **Some off-campus provider-based outpatient departments can apply for a temporary pay boost.** Off-campus provider-based departments (PBDs) in recent years have seen their reimbursement reduced as it was based on physician fee schedule payment rates. Under the latest CMS expansion, some PBDs will be allowed to apply for a temporary exception so they can be paid based on hospital outpatient prospective payment system (OPPS) facility rates. CMS says it also will allow hospitals to relocate outpatient departments to more than one off-campus location or to partially relocate to off-campus sites.

More telehealth updates

- **CMS will now allow physical and occupational therapists to bill telehealth therapy codes.** This is an expansion from the March 31 interim final rule, which added numerous therapy codes, including evaluations and re-evaluations, to the list of payable telehealth codes but barred therapists from billing for telehealth services. CMS now will allow PTs, OTs and speech language pathologists to provide care via telehealth. In addition, CMS says it will allow Medicare reimbursement for therapy assistants who provide "maintenance therapy services" in the outpatient setting. "This frees up physical and occupational therapists to perform other important services and improve beneficiary access," CMS states.
- **Expect additional telehealth services to hit the master list. CMS already approved dozens of additional services to be eligible for telehealth during the PHE.** With a tweak to how it decides which services are eligible, you can expect to see more come online. "CMS is changing its process during the emergency, and will add new telehealth services on a sub-regulatory basis, considering requests by practitioners now learning to use telehealth as broadly as possible," says CMS. "This will speed up the process of adding services." — *DecisionHealth staff (rscott@decisionhealth.com)* ■

Coronavirus

4 coding scenarios to help you report COVID-19 encounters, follow-up care and more

You don't need a positive test result to report COVID-19 with ICD-10-CM code **U07.1**. Doctors may use their medical judgment to conclude that the patient has COVID-19. However, if the doctor uses terms such as "suspected" or "probable," you should instead code based on the reason for the encounter, such as fever or suspected exposure to COVID-19.

- Use these tips, gathered from the HCPro/Propel Advisory Services webinar, **COVID-19 Diagnosis Coding and Documentation: Are You Capturing the Correct Code?**, on April 23 to train staff and speed your coding.

The webinar was presented by Shannon McCall, RHIA, CCS, CCS-P, CPC, CEMC, CRC, CCDS, CCDS-O, director of HIM and coding for HCPro, and Laurie Prescott, RN, MSN, CCDS, CDIP, CRC, CDI education director of HCPro. HCPro is a division of SimplifyCompliance, DecisionHealth's parent company.

The webinar also featured a long frequently asked question session that consisted of answers to questions that McCall has received about coding the disease. Review the following four questions to help yourself navigate COVID-19 testing and coding.

Question: *The patient's test results came back negative after the provider documented COVID as a confirmed diagnosis. How should we code this?*

Answer: "When that happens, the answer really should be that the provider should be queried if the COVID-19 [test] comes back and the test results say its negative," McCall said. Providers should be given the opportunity to reconsider the diagnosis, but as long as the provider feels the patient has COVID-19, it should be documented as such.

"There are times where the provider's going to look at the test result and say, 'No, I still feel that this patient is COVID-positive,'" Prescott observed. "You want to go back for that clarification because there's conflicting information in the chart. But do encourage your physicians, if they strongly believe the patient is COVID-19 positive based on the patient's history, presentation and response to treatment … to put that in in the chart," Prescott said. If they provide that strong documentation, you'll be able to report U07.1, Prescott noted.

Question: *What codes would be appropriate for a patient who has symptoms due to suspected exposure to COVID-19?*

Answer: You should code the signs and symptoms, such as fever with additional code **Z20.828** (Contact with and [suspected] exposure to other viral communicable diseases), McCall said.

"It is best to wait for lab tests," but if the patient is presenting and the physician can give you the definitive diagnosis, use U07.1, Prescott added.

Question: *What should be coded for a patient being seen in follow up for a resolved COVID patient?*

Answer: According to the most recent AHA Coding Clinic, you should use the generic follow-up code **Z09** (Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm), and history code **Z86.19** (Personal history of other infectious and parasitic diseases), McCall said.

Based on this guidance, McCalll recommended Z86.19 for patients with a history of COVID-19 because there are no ICD-10-CM codes for personal history of COVID-19 or viral infection.

Question: *Is there a list of acceptable terms that, if documented as positive or confirmed, can be coded as COVID-19? Is it required for the provider to specifically document the patient is positive for COVID-19?*

Answer: "I've never seen a comprehensive list of terms," McCall said, adding that the coder should query the physician if there is any doubt.

"Number one, if you have the test results, make sure they're on the record," Prescott said. And be leery of charts that state the patient has coronavirus "because coronavirus doesn't necessarily mean COVID-19," Prescott warned. Coders should educate providers about the required documentation, and remind them that while they may know they mean COVID-19, it needs to be clear in the chart. A practice may need to agree on language. Remember: "No one is going to argue with 'Positive COVID-19'," in a chart, Prescott noted. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

Physician payments

Capture payments for uninsured COVID patients, but act fast to get a slice

Providers now have a way to capture reimbursement for the treatment of uninsured patients during the COVID-19 emergency. But bear in mind that funds are limited, and you'll have to wade through various registration steps to get set up.

Starting May 6, HHS will start accepting claims for encounters dating back to Feb. 4. HHS promises an expedited turnaround time, with payments doled out to providers as soon as mid-May.

The COVID-19 Uninsured Program Portal, where you can register and submit claims, is an outgrowth of the Families First Coronavirus Response Act (FFCRA) and the Paycheck Protection Program and Health Care Enhancement Act, each of which designated $1 billion for the treatment of uninsured patients. Additional funding is allocated by the Coronavirus Aid, Relief and Economic Security (CARES) Act.

In general, the steps involved in obtaining payments for uninsured encounters will follow this framework:

- **Enroll as a provider participant.** You'll do this through a system administered by UnitedHealthcare, the contractor working with HHS to distribute the Provider Relief Funds. To get started, you will need to use or create an Optum ID account. You can find more details about the Optum ID account here: *https://coviduninsuredclaim.linkhealth.com/get-started.html*.
- **Set up Optum Pay.** This will create a direct deposit mechanism by which you can gain payments. Note that the process can take a week or longer to get into place.
- **Add your provider roster.** Note that only one person per TIN can serve as the program administrator, so you'll want to coordinate your efforts across your organization. This designated person "must agree to make their name and email address available to others within their organization for coordination of provider and patient rosters," HHS says. "This will involve accessing temporary member IDs from the program portal and sharing across their organization as needed." Note: The verification process for the provider roster can take up to three days to complete.
- **Add your patient roster.** You'll need to show that you've confirmed the patient's uninsured status. Specifically, you must have "verified that the patient does not have coverage such as individual, employer-sponsored, Medicare or Medicaid coverage, and no other payer will reimburse you for COVID-19 testing and/or care for that patient," HHS stipulates.
- **Submit claims for reimbursement.** Starting May 6, you can begin submitting claims for professional and facility services.

HHS says it will pay claims at a rate on par with Medicare payments. Note that eligible claims must involve a patient with a COVID-19 diagnosis. — *Richard Scott* (*rscott@decisionhealth.com*) ■

RESOURCES:

- CARES Act Provider Relief Fund: www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html
- HRSA COVID-19 Uninsured Payment Portal: https://coviduninsuredclaim.linkhealth.com/