 Telehealth Enhances Patient Care, But Is Hampered by Regulations, Research Suggests

The set-up costs can impede the success of telemedicine initiatives at Medicare practices.

With healthcare technologies coming at you left and right, it’s easy to get bogged down. But telemedicine is one area of healthcare that can really improve patient care and your fiscal reserves, yet it’s not being utilized as much as it could be.

CMS wants to change that.

**Definition:** Medicare.gov classifies telemedicine as “medical or other health services given to a patient using a communication system (like a computer, phone [with two-way visual capabilities], or television) by a practitioner in a location different than the patient’s.” For more CMS clarity check out www.medicare.gov/glossary/t.htm.

Telehealth and telemedicine are often grouped together, but telemedicine focuses specifically on clinical services for patients while telehealth also covers non-clinical services like medical training, physician-to-physician consultation, public health initiatives, and education.

**Can Telemedicine Make a Difference?**

**Framework:** A report issued by the United States Government Accountability Office (GAO) on July 20, 2017 highlights that telehealth has the potential to invigorate patient-provider relations, but that only a small percentage of Medicare providers are actually using the technology.

“An analysis of Medicare claims data by the Medicare Payment Advisory Commission shows that about 68,000 Medicare beneficiaries — 0.2 percent of Medicare Part B fee-for-service beneficiaries — accessed services using telehealth,” said the GAO research. The analysis showed that the majority of services were for evaluation and management (E/M) and psychiatric care. “Behavioral health clinicians, including psychiatrists, made up 62 percent of providers at distant sites,” the study pointed out.

**Advantage:** The GAO study, which asked a selection of Medicare providers the pros and cons of telehealth, mentions that most practitioners agree that there are many benefits of using two-way video technology. It “alleviates provider shortages...
and increases convenience to [Medicare] patients,” the analysis noted.

“Telehealth can help providers deliver important medical services where they are needed most, and remove barriers of time, distance, and provider scarcities,” reminds Lee Horner, president of telehealth at Stratus Video in Clearwater, Florida. “The use of telehealth helps increase patients’ ability to access timely care while reducing the inconvenience of extensive or expensive travel.”

Caveat: For some Medicare providers, the culmination of setting up telehealth products and infrastructure, including training and ensuring that patients also have access to the materials needed, thwarted the success of telemedicine, the GAO commentary suggested. “Officials from the selected associations also reported several potential barriers to the use of telehealth in Medicare, including payment, coverage restrictions, and infrastructure requirements,” the report stated. Other associates questioned on telehealth also maintained that providers had to contend with greater restrictions for Medicare reimbursement versus being paid by private payers for the services rendered.

Scenario: Wi-Fi problems, hardware breakdowns, server issues, and other technical components sometimes get in the way of the telehealth interactions. In one example, the study noted that “officials from one provider association and both of the selected patient associations described access to sufficiently reliable broadband internet service as a barrier to telehealth use.”

Here’s Why You Should Consider It

Despite a few shortcomings outlined in the GAO analysis for Medicare providers, CMS remains committed to telehealth and will continue to invest in the technology, the study alluded. “Our report found that as of April 2017, CMS was supporting eight models and demonstrations that have the potential to expand the use of telehealth in Medicare,” the GAO said. “In these models and demonstrations, CMS has waived certain Medicare telehealth requirements or restrictions, such as requirements for the locations and facility types where beneficiaries can receive telehealth services.”

Federal input: And for a second year in a row, CMS proposed new code options and reduced billing measures in its Medicare Physician Fee Schedule for CY 2018, out last month (see specifics on pg. 59). “The proposed changes appear to reflect that CMS recognizes that telehealth can help healthcare providers deliver more efficient and effective care,” determines Horner. “By lessening restrictions and adding more code options, CMS is supporting greater adoption and utilization of telehealth by healthcare providers and ensuring that the healthcare industry is positioning for the future.”

Remember: Telemedicine is not only helpful for rural and underserved populations, where there might be provider shortages; it is also beneficial to patients in urban environments to manage care, particularly to assist homebound patients with chronic diseases, through transitional care from one healthcare venue to another, and between coordinating physicians.

“Telehealth usage in coordinating transitional care and managing chronic diseases can reduce staff’s windshield time, improve productivity, and increase the number (and frequency) of patients being ‘seen’ via virtual visits,” explains Horner. “When investing in telehealth, practices should consider an ROI which we refer to as a ‘return on impact’ — meaning, understanding the impact telehealth will have on the timing and quality of care delivered.”

Take a look at Horner’s suggestions for ways that telehealth measures can improve and positively impact your practice care and bottom line:

1. Time-to-consult fulfillment: Benchmark time duration between consult request and provider response versus less dynamic, non-video platforms such as in-person or telephone consults.

2. Diagnostic accuracy: Measure diagnostic accuracy to ensure that your platform both promotes efficiency and consistently helps providers recognize and resolve presenting conditions.

3. Readmissions rate: Measure readmissions rate to evaluate how post-discharge programs are preventing penalties, keeping patients at home, identifying when interventions are needed, avoiding care escalation, and freeing up bed space.

4. Patient adherence to treatment plan: Track patients’ adherence to treatment to demonstrate
5. Staff utilization: Measure the redistribution of staff, the load-balance resources across entire systems, and increase in patients reached with less strain on specialist resources.

6. Downstream referrals: Track revenue from downstream treatment of appropriately transferred patients and/or subsequent use of other in-network services.

(Continued on next page)

Take a Look at New Proposed Options for Telehealth in CY 2018

Behavioral health gets a boost with new code proposals promoting telemedicine.

With the rise and necessity of telehealth, CMS pushes forward, adding more coding choices and refining problem areas.

Background: Last year for CY 2017, CMS invested in telehealth with codes for End-Stage Renal Disease (ESRD)-related services for dialysis, advanced care planning, and critical care consultation. Here is an overview of what CMS added for the current year and is available now:

- **CPT® code 90967**: (End-stage renal disease [ESRD] related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age).
- **CPT® code 99497**: (Advance care planning including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member[s], and/or surrogate).
- **CPT® code +99498**: (… each additional 30 minutes [List separately in addition to code for primary procedure]).
- **HCPCS code G0508**: (Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth).
- **HCPCS code G0509**: (Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth).

**CY 2018 proposed updates and revisions:** And in last month’s Federal Register release of the proposed Medicare Physician Fee Schedule (MPFS) for CY 2018, CMS continued its support of this important care option with a selection of diverse codes supporting behavioral health and chronic care management, as well as a suggestion that it might do away with a particularly frustrating modifier requirement.


“CMS has again proposed to expand the list of covered telehealth services, including adding coverage for Health Risk Assessments, care planning for chronic care management, and psychotherapy for crisis services provided via telehealth,” notes attorney Benjamin Fee, Esq. of Dorsey and Whitney LLP in the Des Moines, Iowa office.

Here are the specifics CMS mentioned in the proposed MPFS for CY 2018 fact sheet:

- **HCPCS code G0296**: (Visit to determine low dose computed tomography [LDCT] eligibility);
- **CPT® code 90785**: (Interactive Complexity);
- **CPT® codes 96160 and 96161**: (Health Risk Assessment);
- **HCPCS code G0506**: (Care Planning for Chronic Care Management); and
- **CPT® codes 90839 and 90840**: (Psychotherapy for Crisis).

**Modifier change:** The updates also push to drop the need for the “telehealth modifier for professional claims” starting in 2018. “Anytime a billing requirement is removed it is positive, one less regulation to potentially ‘trip over,’” says Vinod Gidwani, founder and president of Currence Inc. in Skokie, Illinois. “Telemedicine will continue to expand and its potential to bend the cost curve is one of the positive innovations taking place in healthcare.”

**Note:** “The lessening of restrictions, plus the addition of more code options, is an encouraging sign that CMS understands the transformative role of telehealth in healthcare,” says Lee Horner, president of telehealth at Stratus Video in Clearwater, Florida. “Telehealth is vital to achieving the triple aim in healthcare — improving the patient experience of care, improving population health, and reducing the cost of care.”

7. **Existing patient retention rates:** Track patient satisfaction and loyalty from added ability to access care on-demand.

8. **Staff attitudes and perceptions:** Measure staff’s rate of adoption and utilization of the platform, as well as feedback on how the platform enhances workflows/processes.


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**Revenue Booster**

**Don’t Let These Common HIT Gaffes Impact Your Revenue**

**Tip:** Incorrect coding caused by faulty EHRs happens and will cost you.

If your practice is plugging along successfully, but your revenue is still in a slump, take a look at your health IT situation. Outdated systems, lack of training, improper coding, nefarious third-party associates, and lax protocols lead to audits and breaches — and get in the way of your fiscal viability.

Stay on Top of Coding Updates

Even though ICD-10 has been around for years now, some practices are still finding it difficult to adapt and implement the annual changes. ICD-10 enhances documentation, making it easier for providers to convey the diagnosis, procedure, and treatment more thoroughly to coders. But, despite the benefits garnered from its use that simplify the claims process, some practices are failing at the implementation.

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Unfortunately, you must follow these pesky ICD-10 updates — the alterations, the clarifications, and the rulings —sometimes weekly, to ensure that your practice is in the loop. Keeping an eye on the new wording, the extra digits, and so much more is a lot for some providers and their coders to handle.

**Manage the means:** If coding changes have got you flummoxed, try adding some quick tools to your staff resources. Invest in ICD-10 code books as well as CPT® and HCPCS help guides too, follow online coder alerts, utilize practice management and EHR programs that offer updates in real time, and, most importantly, make your staff aware that understanding the changes is crucial to the practice’s livelihood.

Make Sure Your Notes and Your Codes Match

Even though Medicare keeps trying to make it easier with tools like its National Correct Coding Initiative (NCCI), coding problems are the bane of the healthcare industry. Whether your incomplete notes are a cause for concern or the coding books and software your staff use are from the Dark Ages, it’s time to fix the problem.

**Consider this:** If the auditors come calling, do your notes justify what you’ve billed? Insufficient documentation ranks first, followed closely by a lack of medical necessity and improper coding, as the top reasons that Part B payers deem claims improper, according to past Medicare Fee-for-Service Improper Payments Reports.

**Quick fix:** Embracing technology and all the services available now really can eradicate many of these issues. The upfront cost is worth the long-term gain — mobile EHRs, dictation software, a trained and certified staff,
and crisp, new coding resources will put your practice back on track — but make sure that you and your staff know how to properly utilize the technologies.

**Beware:** “The cut-and-paste function allows providers to enter relevant information into a patient’s medical record more efficiently, which saves time on typing and leaves more time for patient care,” explains attorney **Michaela D. Poizner** of Baker, Donelson, Bearman, Caldwell & Berkowitz in Nashville, Tennessee.

“But providers have to be careful that they don’t accidentally copy inaccurate information into a patient’s record,” Poizner says. Misuse of the copy/paste function can lead to erroneous health records, redundancy, upcoding, and even false claims.

**Hire and Employ Qualified Staff and Vetted Vendors**

Whether you outsource your IT, coding, or billing — or hire people to do these jobs in-house — you can no longer ignore the necessity of hiring certified staff or engaging reputable business associates.

**Remember:** A highly trained staff can focus on what matters most — patient care. Training needs to be ongoing versus an annual event because the rules, regulations, updates, and laws that are pervasive in healthcare today don’t come out annually; they change daily. Communication and a willingness to invest in education are the hallmarks of successful practices.

**Review outsourcers:** Ensure your office doesn’t get caught up in a mess by checking out the backgrounds of the third-party billers and HIT vendors you utilize.

“Practices that use third-party billers should meet with them and review how claims are coded and submitted,” suggests **John E. Morrone, Esq.** a partner at Frier Levitt Attorneys at Law in New York. “Many practices do not realize that they are ultimately responsible for claims coded and submitted on their behalf.”

And the same goes for your IT business associates. “Not all cloud vendors are alike. It is more nuanced than that,” says **Kurt J. Long,** founder and CEO of FairWarning, Inc in Clearwater, Florida. “Look for third-party evidence when choosing a cloud vendor for your EHR — a good-looking website does not equate to a mature product or adequate security.”

**Assess, Analyze, and Manage Your Health IT**

A successful practice is like a well-oiled machine, and with the right tools and parts can easily avoid common practice pitfalls.

With all the advancements in mobile technology, practice management software, and EHRs over the last few years, it’s easy to keep up-to-date with CMS, ICD-10, HIT trends, and initiatives. A knowledgeable healthcare IT firm, which understands coding, HIPAA, and compliance, can evaluate what your needs are and adapt to your budget.

**Tip:** A missed software patch, an EHR glitch that upcodes a service, or engaging with a cloud-service provider without a business associate agreement (BAA) can all land you in hot water with the feds if a violation occurs. Checks and balances keep the healthcare industry honest from top to bottom. Annual audits, both internal and external, are necessary to see where you and your staff are succeeding and failing. This needs to be at the top of your checklist, especially in regard to coding errors, CEHRT implementation and management, and HIPAA compliance issues. □

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**Toolkit**

**Check Out the New HHS-OCR Breach Reporting Tool**

With violations on the rise, the feds’ offering simplifies disclosure.

As the number of large-scale HIPAA breaches is around 175 with more added daily, both providers and consumers need easier access for reporting and accessing information. A new online portal that is easy-to-use, updated, and focused on the largest impacts over the last 24 months helps to refine data for research and disclosure.

*(Continued on next page)*
“HHS heard from the public that we needed to focus more on the most recent breaches and clarify when entities have taken action to resolve the issues that might have led to their breaches,” said HHS Secretary Tom Price, MD, in a press release. “To that end, we have taken steps to make this website, which features only larger breaches, a more positive, relevant source of information for concerned consumers.”

Remember These Specifics on the Who, How, When, and Why of Breach Disclosure

If you uncover a HIPAA breach in your office, this is what you need to remember when reporting the violation to the HHS Office for Civil Rights (OCR).

Breaches that include more than 500 individuals:

» “A covered entity must notify the secretary of the breach without unreasonable delay and in no case later than 60 calendar days from the discovery of the breach,” the HHS Breach Notification guidance says.
» You must file the breach notification electronically, and all information on the forms must be complete and comprehensive regarding the breach.
» You must notify the media of the breach.
» You must alert affected individuals to the loss of their protected health information (PHI).

Breaches that include fewer than 500 individuals:

» The covered entity must alert the HHS secretary of the breach within 60 days of the calendar year in which the breach occurred.
» You must file the breach notification electronically, but you can submit the breach notifications on the same day — even if they occur on different days and concern different issues.
» You must alert individuals affected by the breach.

Here’s How the New Option Will Help with the Process

The revamped HIPAA Breach Reporting Tool (HBRT) allows for greater transparency for provider contacts, hospitals, and consumers. The streamlined website shows only the largest breaches from the last 24 months, archiving older breaches from past years and detailing their resolutions on the site, the release says.

A consumer help section addresses patients’ concerns about lost PHI with links on how to rectify and verify information as well.

The HBRT still includes mainstays from its original 2009 format mandated in the Health Information Technology for Economic and Clinical Health (HITECH) Act. The following categories are part of each breach description on the HBRT, OCR notes:

» name of the entity;
» state where the entity is located;
» number of individuals affected by the breach;
» date of the breach;
» type of breach (e.g., hacking/IT incident, theft, loss, unauthorized access/disclosure); and
» location of the breached information (e.g., laptop, paper records, desktop computer).

Federal take: “The HBRT provides health care organizations and consumers with the ability to more easily review breaches reported to OCR,” said Roger Severino, Director of the OCR. “Furthermore, greater access to timely information strengthens consumer trust and transparency — qualities central to the Administration’s focus on a more innovative and effective government.”


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Help Patients Access Their PHI with a New Form From AHIMA

Plus: Technology overload can impact healthcare in a negative way.

Patients with access to their protected health information (PHI) are more invested in their care and more willing to abide by doctors’ orders. However, despite the best intentions, it can be challenging for patients to request and gain that important information.

The American Health Information Management Association (AHIMA) created a new form for providers to “streamline the process when patients request their PHI under HIPAA and comply with the timeframe and fees set out by the Office for Civil Rights’ (OCR) guidance of 2016,” says AHIMA’s “Advocacy and Policy Efforts” section on its website.

The AHIMA form is free, and it’s easy to read, download, and use. It offers detailed reasoning with HHS and OCR links that explain why you must follow certain HIPAA protocols (i.e. 30-day timeframe for delivery of PHI to patient) when patients request their medical records. The form can be “customized by providers and organizations to capture the data you need as well as organizational contact information,” the AHIMA guidance notes.

Resource: For a link to the AHIMA information and patient request form, visit http://www.ahima.org/about/advocacy/efforts.

In other news …

Cyber criminals continue to make their mark with ransomware attacks, taking down healthcare systems on a daily basis and exposing patients’, providers’, and hospitals’ privacy and security. And with HIPAA compliance repeatedly compromised as thousands of individuals’ ePHI is lost or manipulated, patients’ care and treatment (as well as practices’ livelihoods) are at risk.

In the July issue of the OCR’s Cybersecurity Newsletter, the federal organization focuses on the increase of ransomware attacks and how the rise in mobile hardware and health IT might be to blame.

“The healthcare sector’s risk landscape continues to grow with the increasing number of interconnected, ‘smart’ devices of all types, the increased use of interconnected medical record and billing systems, and the increased use of applications and cloud computing,” notes the July Cybersecurity Newsletter. The release also addresses the perennial question of who should be trained on HIPAA protocols and how often, particularly with the avalanche of breaches caused by malware and social engineers pummeling the nation’s healthcare industry.

Reminder: The newsletter guidance advises covered entities and their associates to remember the HIPAA Security Rule and its requirements that necessitate implemented training programs with updates for all staff members. “Note the emphasis on all members of the workforce, because all workforce members can either be guardians of the entity’s PHI or can, knowingly or unknowingly, be the cause of HIPAA violations or data breaches,” indicates the OCR.

The Cybersecurity Newsletter also offers insight into how often training should take place and how you should document it. Consider these questions as you organize your HIPAA compliance training:

» Are you analyzing your risks and using that data to plan the timeliness of your practice HIPAA education? Do you need to revisit your assessments and checklists weekly, monthly, or annually?
» Does your practice IT manager or third-party vendor update you and your staff on the most recent threats and how to combat them?
» What resources do you utilize now in your training? Do you need to upgrade and increase the materials to better manage your cybersecurity?
» Are you documenting the assessments, analysis, management, and training?

Tip: If you are audited after a breach, the first thing the OCR will ask is for written details of your HIPAA plan and staff training. Prepare now to avoid problems after a breach happens.

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