

# REVENUE CYCLE UPDATE

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## Achieving Balance Integrity

*In the Age of Consumerism, you need to exhaust all other payment options before the bill goes out*

By Jesse Ford, CEO

Many years ago, on a flight home from Washington, D.C., I struck up a conversation with a fellow passenger who was heading home with her young son, a boy filled with joy and energy, who has bouncing around his seat like any other child his age. The difference was that he was blind, though you couldn't tell how or even if this disability was impacting his life.

Nevertheless, the mother slowly revealed the financial burden that caring for her son demanded. It had made her an advocate; she had been in Washington to seek funding for new services for the blind. One of the most revealing stories she shared was about a medical bill she received for more than \$100,000 for her son's care.

Huge bills like that can be accurate, but I also know that such a large balance often reflects a claim error. Financial assistance was not going to help her enough, and she needed to continue to take her child to the hospital for treatment. She had commercial insurance, but her share of the cost was going to bankrupt her family.

The mother spent hours negotiating with her insurer, speaking with financial counselors and the billing office. I imagined how much energy that probably took and was not surprised that nobody she spoke to would or could help her. Amazingly, one day she happened upon

the right person, who routed the claim to someone who examined it and contacted the coding department. As it turned out, the services were wrongly coded, so the insurer denied coverage. Documentation supported the use of alternative codes appropriate for the services, so the provider rebilled the claim and was paid by the insurer.

Not everyone is as lucky as my seatmate. This kind of error and its aftermath – savings wiped out and medical debt mounting – is what we at Salud consciously and diligently strive to avoid when we code, bill, and follow up with insurers and patients. Salud has coined the term "balance integrity" to describe the importance of ensuring that patients are billed accurately, but we take it further: We aim to bill patients accurately only up to their financial means and only after we have exhausted every possibility of an insurer paying for the services.

Consumerism demands these changes. People are seeing the cost of employer-sponsored and individual coverage rise, especially out-of-pocket maximums. A recent Urban Institute analysis of census data says at least 3 million Americans have already lost job-based coverage from the pandemic, and a separate analysis from Avalere Health predicts some 12 million will lose coverage by the end of this year.

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As cost pressures rise, consumers are looking more closely at medical bills and wondering why healthcare costs so much. This is why regulatory changes aimed at surprise medical bills and price transparency loom on the near horizon.

Balance integrity requires accurate balances. Our definition of an accurate balance is that it matches the insurance explanation of benefits, and the balance does not include anything caused by a billing error. Providers must ensure that claims have been coded accurately, and that each field on a claim form, including modifiers, has been filled in appropriately.

When a provider makes an error, it can expect insurers to deny a portion or the entire claim with a denial that can be complex and easily shifted to a patient to resolve with their insurance. For a large academic medical center, 25% of our accounts have been denied, many with reasons such as "duplicate," "non-covered," "coding (error)" or "not medically necessary." Providers' payer follow-up staff need to advocate on behalf of patients and ensure that they solve challenging denials instead of transferring the problem to a patient to solve.

Balance integrity means we evaluate and take into account a patient's ability to pay. For the indigent or people with deductibles and co-pays beyond their means, providers should try to advocate on behalf of the patient with financial assistance, including charity write-offs, discounts, payment plans and perhaps a zero-interest credit card.

If there isn't someone else who could be billed for services, balance integrity demands we assist patients with finding alternative insurance coverage, such as Medicaid, COBRA or liability insurance.

Balance integrity results in higher payments because most patients do not pay balances that they cannot afford, and insurers tend to pay more than patients. The industry should embrace price transparency rather than trying to sandbag it. If we truly want to be service-oriented, we need to do what's right for the patient by ensuring that nobody facing a healthcare crisis should also confront the shock of a huge healthcare bill they should not have to think about, much less try to pay.



*Jesse Ford is President and CEO of Salud Revenue Partners*

## SALUD ONLINE

### Webinar: Key Steps to Close the Financial Gap in 2021

With operational revenue still depressed, experts from Lumina Health Partners and Salud Revenue Partners joined forces to provide practical tips for righting the fiscal ship over the crucial next few months.

[Watch.](#) [Download slides.](#)

### STAFF SPOTLIGHT



#### Jessica Varkonyi

As we continue our dedication to quality, we remain focused on employee development.

In August, Jessica Varkonyi joined Salud as an instructional designer, a role which will enhance this focus through the creation of effective and engaging training for our team.

Jessica's expertise lies in instructional systems design, a process which considers training and education systematically. In her role, she will collaborate with knowledge experts to identify the skills and information our employees need to know to operate at the highest level. She will assist us in determining the best ways to teach these skills by considering delivery methods, teaching strategies, and learning theory. In addition, Jessica will develop instructional materials and media and will help put an assessment and evaluation plan in place to ensure our training program is effective.

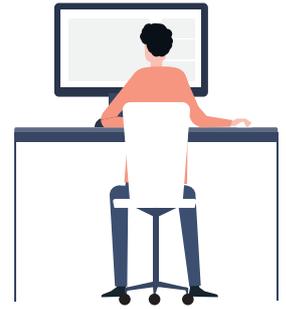
Prior to joining Salud, Jessica spent 13 years in administrative roles at Ivy Tech Community College in our headquarter city of Lafayette, Indiana, most recently as the Assistant Director of Administration in the Chancellor's Office. In this position, she worked to support campus operations and was responsible for maintaining campus policies and procedures. She served as a member of the chancellor's cabinet and acted as a liaison between the campus leadership team and various college stakeholders, including the board of trustees.

In addition to her employment at Ivy Tech, Jessica served as a lecturer in English at Purdue University and Indiana University East, where she designed and taught undergraduate composition courses. Across institutions, she worked with highly diverse groups of students both online and in the classroom. Her teaching experience highlighted the importance of developing instruction within different learning contexts and heightened her interest in instructional design.

Jessica holds bachelor's and master's degrees in English from Indiana University East and is currently pursuing her doctorate in Instructional Systems Technology from Indiana University.

## CODING CORNER

# RPM caution: Remote monitoring can boost care quality and revenue, but watch out for coding and documentation regs that may curb some enthusiasm



By Jennifer Swindle

Much attention has been paid to the explosion of telehealth technology and services during the pandemic. It is viewed as one of the bright spots in an otherwise bleak year in the business of healthcare. Mostly, the action has been in telehealth visits – doctors discussing care with patients over whatever communication devices they have, including phones. Most observers think an expansion of telehealth is here to stay, but it is going to be more regulated post pandemic.

Another aspect of virtual care, remote patient monitoring (RPM), may turn out to have a more significant long-term impact on patient care and revenue than telehealth. RPM, also called remote physiological monitoring, is the collection and/or analysis of data to help manage a treatment plan related to a chronic and/or acute health illness. It uses digital technologies to monitor, capture, and transmit vitals such as blood pressure, weight, heart rate, and blood sugar levels from patients to providers for assessment, recommendations and instructions.

### Revenue enhancer

Thanks to an overhaul of CPT codes for 2020, RPM became one of the more lucrative Medicare care management programs even before the pandemic. The vast majority of RPM services are now billed under four CPT codes: 99453, 99454, 99457 and 99458. There is a small payment for initial patient enrollment into an RPM program, and then a monthly base payment for management of the device and patient readings. Finally, there is an optional service for each 20 minutes of care management – which can be provided by clinical staff – up to 60 minutes total. When added together, each RPM patient can earn a practice up to around \$210 per month, according to McKinsey & Co. projections.

CMS has proposed further changes to these services for 2021, so when the current public health emergency ends, it is important to understand that you need to meet new coding requirements.

As with all services, medical necessity is crucial for coverage of RPM. It is also required that the provider obtain permission from the patient prior to providing RPM services; this patient consent must be documented in the medical record. The consent can be obtained on the same date as RPM services are provided.

The proposed rule for 2021 does clarify that RPM services can be provided to patients with acute conditions; chronic conditions are not required.

### Who can provide RPM

Although the public health emergency waiver allows RPM for new patients, this will not be true once the emergency has ended, so only established patients can be monitored. RPM must be ordered and billed by the physician and/or other qualified healthcare professional (a provider with the ability to bill Evaluation & Management services, such as physician assistant, nurse practitioner, clinical nurse specialist; not ancillary staff).

There is some difference in what type of provider may furnish the service, as the 99091 can only be provided by the physician or other qualified healthcare professional; however, services for codes 99457-99458 can be provided by ancillary clinical staff as well, under the general supervision of the physician. The proposed rule also allows services for codes 99453-99454 to be provided by supervised clinical staff as well. RPM is not considered a diagnostic service, so it cannot be provided by an independent diagnostic testing facility.

One big change, which is at variance from most guidance on time-based codes, is the time for

## Remote patient monitoring codes and descriptions, 2021 proposed

CPT Code	Description
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring), digitally stored and/or transmitted by the patient and/or caregiver to the physician or other healthcare professional qualified by education, training, licensure/ regulation (when applicable), requiring a minimum of 30 minutes of time each 30 days.
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial setup and patient education on use of equipment.
99454	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
99457	Remote physiologic monitoring treatment management services. Clinical staff/ physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes.
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes.

interactive communication. Historically, CMS has been clear that the time-based requirements consist of a combination of interactive communication, monitoring and management of the patient's care plan, which is consistent with the code descriptors. In the proposed policy clarification, CMS has taken a different approach to the time component and is only considering the "interactive communication time."

CMS stated that for purposes of CPT codes 99457 and 99458, interactive communication must total at least 20 minutes over the course of the calendar month for 99457; an additional 20 minutes of interactive communication is needed to report 99458. The interactive communication must have a real-time, synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission. The documentation throughout the month must support the time spent to achieve the right coding, but also must separately capture how much of the time was interactive communication, based on this requirement.

This CMS' interpretation would appear to mean that the practitioner and clinical staff must use the RPM, analyze the data, assess it, update the care plan accordingly, and also spend at least 20 minutes talking on the phone or via video with each monitored patient each month. For example, if a doctor spent 50 minutes overall during the month in providing RPM services, but only 17 minutes of that time was actually interactive communication, RPM services could not be reported. If you have been capturing the total time of all services

to arrive at your time and codes, this would certainly have a negative impact on how to code, as the time of monitoring and updating the treatment plan would not support the time component of the service. It is anticipated that this change will be one of the most challenged during the comment period.

It also should be noted that under the rule, CPT codes 99453-99454 could not be reported more than once during a 30-day period. Also, monitoring must occur over at least 16 days to be reported. The proposed rule also seems to suggest that 99457-99458 cannot be billed until after the initial 30-day period of monitoring.

All eyes will be on the final rule. Remote patient monitoring is a way for providers to use clinical staff to remotely monitor patients and improve revenue, but complying with these new regulations will not be as easy as it may have appeared during the pandemic.



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