Integrated Service Lines Observation and Hospital Medicine: Where Does the ED Add Value?

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Disclosure

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Dr. Parker is Chief Coding Officer for HCFS of TeamHealth and President of Team Parker, a coding, compliance and revenue cycle consulting group. All content and opinions are my own.

ACEP Course Description

The ED is the hub of the health care delivery system. Increasingly ED groups are being asked to provide integrated solutions involving outpatient care, Observation care, and Inpatient Hospital Medicine. The successful ED group of the future will be able to add value broadly across the spectrum of care.

Integrated Service Lines: Observation and Hospital Medicine

Develop	Develop strategies to improve patient outcomes for an episode of care. **Hospital at Home.**
Improve	Improve collaboration with other service lines and specialties to improve safety, patient outcomes and optimize reimbursement. **Transitions of Care.**
Incorporate	Incorporate into practice, disease—specific practice guidelines, as opposed to those limited to Emergency Medicine. **Telemedicine and Behavioral Health.**

Hospital at Home

Obj #1: Develop strategies to improve patient outcomes for an episode of care.

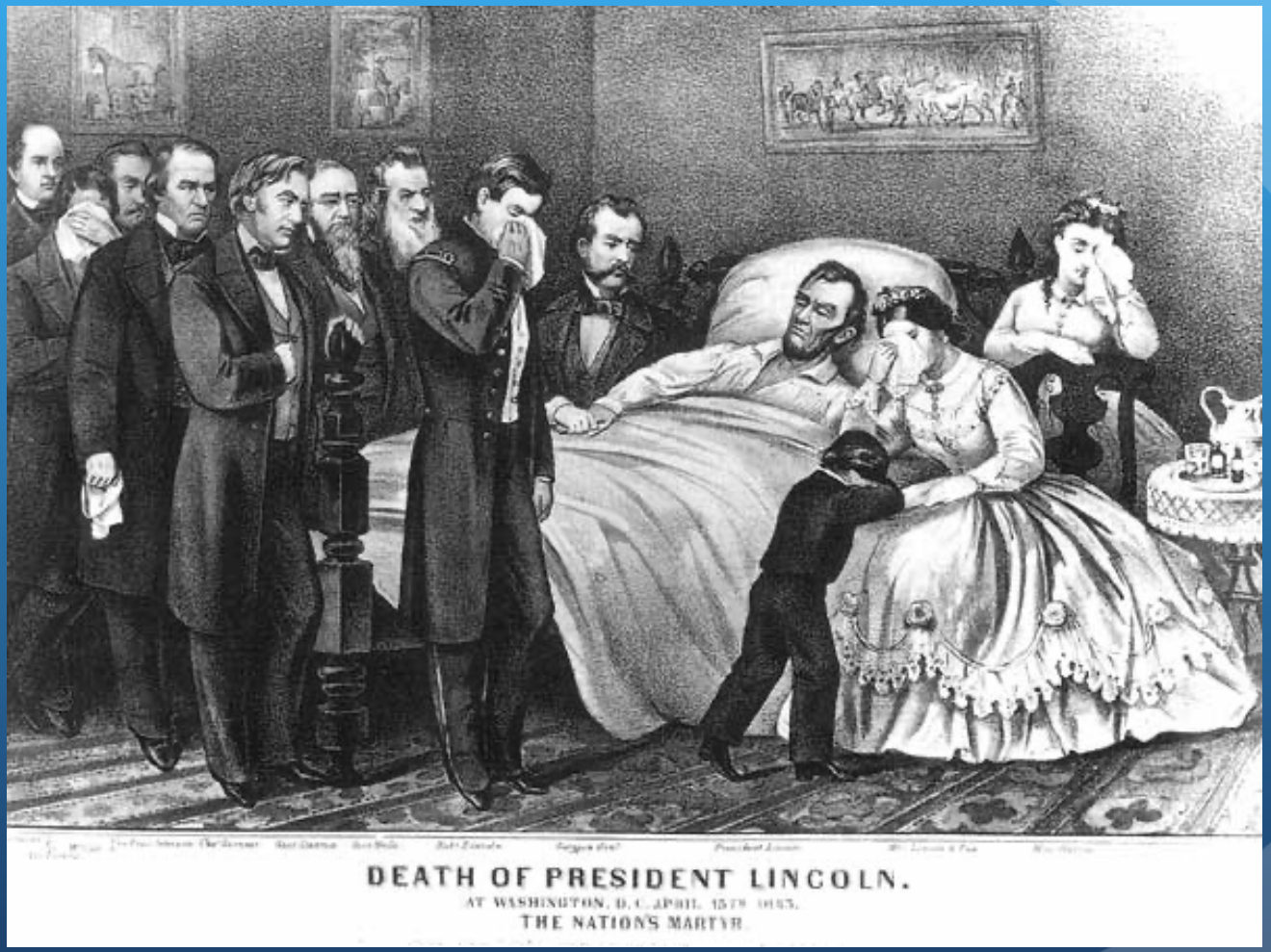
Case Scenario - St. Elsewhere

CC/HPI
82 yo male with hx/o DM, HTN, PVD here with his wife presents c/o redness and swelling to right lower leg for 4 days. Yesterday was seen at urgent care and prescribed antibiotics. He woke up this morning and the redness was worse, and now he may have a fever.
PE
Temp 100.4, normal VS otherwise
RLE: PVD with cellulitis of the lower leg, no lymphedema. NVI distally

Tests:
US doppler negative
CBC has WBC 15k with mild left shift
BMP normal except glucose 280

ED course:
Diabetic with RLE cellulitis with failed outpatient antibiotic and hyperglycemia. Admit for IV antibiotics and glucose control.

Hospital at Home



Hospital at Home

- Studied since the 1970s & pockets of implementation
  - Veterans Administration (VA), other hospital systems
  - CMMI Innovation Awards
- Studies show:
  - Lower re admission rate
  - Lower payer costs
  - Higher patient satisfaction
  - Preferred by patients, payers and hospital's want inpatient bed availability
- Slow to adopt secondary to payers

Sources: Hospital at Home is Not Just for Hospitals, Health Affairs Forefront, May 24, 2022, DOI: 10.1377/forefront.20220520.712735; https://www.johnahartford.org/blog/view/hartford-foundation-and-cmmi-work-together-to-spread-hospital-at-home-model, November 13, 2014

Hospital at Home – American Hospital Association (AHA)

Key Elements

- Referrals
  - Emergency Department
  - Community Paramedicine
  - Specialty
- Best for medium acuity patients who need hospital-level care but stable enough to be safely monitored at home

Source: American Hospital Association Issue Briefing: Creating Value by Bringing Hospital Care Home, December 2020. Accessed December 21, 2022, at https://www.aha.org/hospitalathome

Hospital at Home - AHA

Key Elements

- Examples:
  - Oncology care
  - Post surgical monitoring
  - Conditions with well defined treatment protocols (pneumonia, CHF, COP, diabetes, cellulitis)
  - COVID-19 or non-COVID-19 appropriate
- Connected to care team through in-person visits, video visits, and continuous biometric monitoring

Source: American Hospital Association Issue Briefing: Creating Value by Brining Hospital Care Home, December 2020. Accessed December 21, 2022, at https://www.aha.org/hospitalathome

Hospital at Home - AHA

Key Elements

- Typical services:
  - Diagnostic studies (e.g., ECG, echo, x-rays)
  - Treatments (e.g., oxygen, IVF, IV antibiotics and other meds)
  - Services (e.g., RT, pharmacy, skilled nursing)
- John's Hopkin's best practice (in appendix)

Source: American Hospital Association Issue Briefing: Creating Value by Brining Hospital Care Home, December 2020. Accessed December 21, 2022, at https://www.aha.org/hospitalathome

Hospital at Home – CMS Waiver

Hospital at Home – CMS Acute Hospital Care at Home (AHCaH)

- COVID-19 PHE CMS action:
  - Starting October 1, 2020
  - Hospitals may apply for waiver of §482.23(b) and (b)(1) of the Hospital Conditions of Participation (CoP)
    - CoP that requires nursing services be provided 24/7 and immediate availability of RN
  - Entitled "Acute Hospital Care at Home" (AHCaH)
  - By 12/16/2022, 259 hospitals in 37 states were approved
  - Payment the same as inpatient DRG

Sources: Acute Hospital Care at Home: The CMS Waiver Experience, Clarke, D et al, NEJM Catalyst, December 7, 2021, https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0338; https://qualitynet.cms.gov/acute-hospital-care-at-home, accessed December 22, 2022.

Hospital at Home – CMS Acute Hospital Care at Home (AHCaH)

Table 1.

Requirements for Hospital Waiver Approval

Provide or contract for the following services:

- Pharmacy
- Infusion
- Respiratory care including oxygen delivery
- Diagnostics (labs, radiology)
- Monitoring with at least two sets of patient vitals daily
- Transportation
- Food services including meal availability as needed by the patient
- Durable Medical Equipment
- Physical, Occupational, and Speech Therapy
- Social work and care coordination

At least one daily MD/APP, which can be remote after the initial in-person History and Physical Exam performed in the hospital or ED.

At least two in-person daily visits by RN or MIH/CP. If both in-person visits performed by MIH/CP, additional daily remote RN visit to develop a nursing plan.

Sources: Acute Hospital Care at Home: The CMS Waiver Experience, Clarke, D et al, NEJM Catalyst, December 7, 2021, https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0338.

Hospital at Home – CMS Acute Hospital Care at Home (AHCaH)

Table 1.

Requirements for Hospital Waiver Approval

Immediate, on-demand remote audio connection with an AHCaH team member who can immediately connect the appropriate RN or MD.
In-home appropriate emergency personnel response to a patient's home within 30 minutes, if needed.
Only patients in an ED or inpatient hospital are eligible.
Must develop or use patient selection criteria.
Agree to voluntarily provide volume, escalation rate, and unanticipated mortality to CMS.
Establish a local safety committee (like Mortality and Morbidity team) to review reported metrics.
Use of an accepted patient leveling process to ensure patients require an acute level of care.

Abbreviations: APP = advanced practice provider; MIH/CP = Mobile Integrated Healthcare–Community Paramedicine; AHCaH = acute hospital care at home; CMS = U.S. Centers for Medicare & Medicaid Services. Source: The authors

Sources: Acute Hospital Care at Home: The CMS Waiver Experience, Clarke, D et al, NEJM Catalyst, December 7, 2021, https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0338.

Hospital at Home – CMS Acute Hospital Care at Home (AHCaH)

Table 2.

Waiver Design Considerations and Responses

Area of Concern	Actions Taken/Requirements Established
Experience of Institution	Established two levels of waivers: • Expedited Waivers (Tier 1) for experienced programs that had treated at least 25 patients meeting inpatient admission criteria • Detailed Waivers (Tier 2) for all other submitters
Patient Safety	• Hospital guarantees that an appropriate emergency personnel team would be available in a patient's home within 30 minutes. • Community emergency 911 system and emergency paramedics to meet this requirement. • For Tier 2 hospitals, detailed algorithms outlining emergency response processes and personnel were required.
Nursing Oversight	• CMS originally required two in-person RN visits daily, but after further research, this was revised. • As revised, programs were required to provide two in-person visits daily by either an RN or an MIH/CP. • At least one in-person or virtual visit with an RN was required to ensure that each patient received an updated, appropriate nursing care plan daily.

Sources: Acute Hospital Care at Home: The CMS Waiver Experience, Clarke, D et al, NEJM Catalyst, December 7, 2021, https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0338.

Hospital at Home – CMS Acute Hospital Care at Home (AHCaH)

Table 2.

Waiver Design Considerations and Responses

Physician and Advanced Practice Provider Care	• Hospitals were required to conduct the initial History and Physical exam in person. • Patients were required to have either an ED visit or inpatient stay prior to treatment within the waiver. • Subsequent visits could be virtual with a minimum frequency of once daily if the course of the patient progressed as expected. • The intention and expectation was for provider visits to be provided in-person, not exclusively by telemedicine, within the patient home or after a return to the hospital (should it be indicated).
State Issues	• Hospitals were still required to meet any applicable state regulations. • Several states introduced specific waivers to align with the CMS waiver.
Electronic Medical Record	• All documentation required to be done in an electronic medical record accessible to all clinicians/providers/staff and contracted services, including those in the hospital who would need to treat patients in the event of an escalation.

Abbreviations: CMS = U.S. Centers for Medicare & Medicaid Services; MIH/CP = Mobile Integrated Healthcare–Community Paramedicine. Source: The authors

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Tests:
US doppler negative
CBC has WBC 15k with mild left shift
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ED course:
Diabetic with RLE cellulitis with failed outpatient antibiotic and hyperglycemia. **Admit to St. Elsewhere's Acute Hospital Care at Home program** for IV antibiotics and glucose control.

Hospital at Home

Future considerations:

- AHCaH post-PHE
  - Congress passed and the President signed extension of AHCaH waivers through December 31, 2024
- Telehealth post temporary extensions
- Professional fee payment
  - AHCaH for facility only
- CMS decisions will drive private payer

Transitions of Care

Obj #2: Improve collaboration with other service lines and specialties to improve safety, patient outcomes and optimize reimbursement

Outpatient Transitions

Outpatient Transitions

Transitions of Care = Gaps in Care

CPT and CMS creating new code sets and process around transitions within Evaluation and Management(E/M) code sets

Transitions of Care

- CPT E/M* Categories
  - Care Plan Oversight Services
    - Supervision Home Health Agency (99374-99375)
  - Non-Face-to-Face Services
    - Remote Physiologic Monitoring (99091, 99453-99474)
- CPT non-E/M Non-Face-to-Face Nonphysician Services
  - Remote Therapeutic Monitoring (98970-98981)
- CPT Medicine Section
  - Home and Outpatient INR Monitoring Services (93792–93793)

*Evaluation and Management categories (MD/APP only)

Outpatient Transitions – Case Study

74 yo male from an independent living facility presents to the ED after a mechanical fall. Full work up is unremarkable except for a non-displaced pubic rami fracture. Patient wants to go home. Case management is engaged who advises a potential plan of discharge home with PT and Home Health.

Physical therapy assesses for appropriateness for discharge and advises with a walker patient is safe to go home. Given patient's limitations with transportation and mobility he is a candidate for Home Health for PT, monitoring, and safety assessments. Patient agrees. Certification completed.

Outpatient Transitions – CPT E/M Care Plan Oversight Services

Supervision of patient under care of home health agency (99374-99375)

- 30-day period
- Reported separately from other E/M codes
- Only one individual reports per calendar month
- Timed codes
- Requires complex and multi-disciplinary care modalities involving regular record and test analysis, communication with caregivers, and development or revision of care plans by that individual

Outpatient Transitions – CPT E/M Care Plan Oversight Services

Supervision of patient under care of **home health** agency (99374-99375) – CMS

- CMS has own G code series
  - G0179 re-certification (every 60 days)
  - G0180 certification (30 days)
- Requirements for certification/re-certification:
  - Home bound
  - Need skilled services
  - Under the care of a physician/APP with a care plan that is periodically reviewed
  - Initial face-to-face encounter

Outpatient Transitions - Case Study

CC/HPI
32 yo female with no past history presents with cough, SOB, and fever with body aches for 5 days.

PE
Pulse ox 88% on RA otherwise unremarkable

ED course:
Work up shows patient has COVID-19. Steroids given and home oxygen provided. Will buy pulse ox monitor to monitor O2 at home. Patient DC'd home.

Is there a better, safer way?

Outpatient Transitions – CPT E/M Non-Face-to-Face Services

Remote Physiologic Monitoring (RPM) and RPM Treatment Management code sets

- 30-day period
- Report remote physiologic monitoring (e.g. weight, blood pressure, pulse ox, respiratory flow rate, glucose) with FDA approved device
- CPT codes for initiation, education; supplied device; recording, interpretation and patient contact (timed); final physician/APP review at least 30 minutes
- CMS allows for contracting for certain services under General Supervision for clinical staff

Outpatient Transitions – CPT E/M Non-Face-to-Face Services

Remote Therapeutic Monitoring (RTM) Services code set

- New for 2022, CPT and CMS
- Similar design as RPM (e.g. 30-day period, code design etc.) "Remote therapeutic monitoring (eg musculoskeletal system status, respiratory system status, cognitive behavioral therapy, therapy adherence, therapy response) represent the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response." (*2023 CPT)*

Outpatient Transitions – CPT non-E/M Non-Face-to-Face Nonphysician Services

Remote Therapeutic Monitoring (RTM) Services code set

- Ordered by a physician or other qualified healthcare professional (QHP)
- Performed by physician or QHP (not clinical staff)
  - CMS allows for General Supervision for all RTM codes (CY 2023)
  - CMS specifically permits therapists and other QHPs (CY 2022)

Outpatient Transitions – Case Study

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32 yo female with no past history presents with cough, SOB, and fever with body aches for 5 days.

PE
Pulse ox 88% on RA otherwise unremarkable

ED course:
Work up shows patient has COVID-19. Steroids given and home oxygen provided. **RPMVendor is engaged, comes to ED, establishes contact, provides and trains patient on FDA-approved pulse ox monitor for 3-4 weeks of monitoring with Transitions of Care medical team oversight.** Patient DC'd home.

Outpatient Transitions – CPT Medicine Section

Home and Outpatient INR Monitoring Services (93792—93793)

- Includes training on device and subsequent analysis and management
- CMS specifies diseases (e.g., chronic afib, DVT/PE, mechanical heart valves), anticoagulated for 3 months, patient correctly uses device, self testing no more than once a week
- ED and outpatient hospital appropriate POS to start

Outpatient Transitions – Case Study

24 yo female on BCP diagnosed with a DVT in the ED. No other medical problems. Patient provided with anticoagulation bridge to then begin coumadin. Transition of Care team provided training on INR monitoring device and arranged for ongoing management through the TOC team. Patient discharged home.

Transitions of Care Clinic?

- ✓ Home Health
- ✓ RPM
- ✓ RTM
- ✓ INR

Telemedicine and Behavioral Health

Obj #3: Incorporate into practice disease—specific practice guidelines, as opposed to those limited to Emergency Medicine.

Telemedicine

Telemedicine and Behavioral Health - CMS

Consolidated Appropriation Act (CAA) 2021

- Removed the geographic restrictions and added home as an originating site for purposes of diagnosis, evaluation, or treatment of a mental health disorder
- Required:
  - An initiating visit in-person, non-telehealth service within 6 months prior to the initial telehealth service
  - An in-person, non-telehealth visit must be furnished at least every 12 months
- More frequent visits allowed based on clinical needs

Telemedicine and Behavioral Health - CMS

2022 Calendar Year (CY) Physician Fee Schedule (PFS)

In addition to the CAA 2021 guidance:

- Clarified Substance Use Disorder (SUD) is included as Behavioral Health
- Clarified when audio-only may be used
  - If patient is not capable of video technology
  - If patient does not consent to video

Telemedicine and Behavioral Health - CMS

Other practical items:

- An additional Place of Service was added and both re-defined:

  Prior to April 4, 2022

  - POS 2: Telehealth

  Implementation date April 4, 2022

  - POS 2: Telehealth Provided Other than in Patient's Home
  - POS 10: Telehealth Provided in Patient's Home

Telemedicine and Behavioral Health - CMS

Other practical items:

- Difficulty with in-person requirements
  - Waived during the PHE +151 days after
  - CAA 2023, just passed by Congress and signed by the President, extends this waiver through December 31, 2024
- Unclear qualifying ICD-10 codes
- Telehealth and buprenorphine for SUD
  - X-waiver repealed with CAA 2023
  - SAMHSA proposed regulation, comments due 2.14.2023

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Questions

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Appendix

Hospital at Home

Best practice (John's Hopkins):

- Physician confirms meets hospital eligibility criteria
- Hospital at Home team meets with family and family to discuss program and home suitability
- Physician and care team assigned who meets patient at home (physician in person or video)
- Medical supplies transported and delivered

Source: American Hospital Association Issue Briefing: Creating Value by Brining Hospital Care Home, December 2020. Accessed December 21, 2022, at https://www.aha.org/hospitalathome

Hospital at Home

Best practice (John's Hopkins):

- Orders written, health care providers visit and provide services, VS monitored
- Care provider visits daily, physician connects daily in person of via telemedicine
- When patient stabilized and well enough patient is discharged

Source: American Hospital Association Issue Briefing: Creating Value by Brining Hospital Care Home, December 2020. Accessed December 21, 2022, at https://www.aha.org/hospitalathome

Hospital at Home

Best practice (John's Hopkins):

- Barriers (pre-PHE):
  - Payment. Most private payers do not cover hospital-level in home care.
  - Implementation logistics, technically work and investment of time, staff, and money.
  - Demand low with skepticism of quality of care.

Source: American Hospital Association Issue Briefing: Creating Value by Brining Hospital Care Home, December 2020. Accessed December 21, 2022, at https://www.aha.org/hospitalathome