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AMGA CMO Council: Triage, Patient Management, Telephone Visits, Provider Compensation

This summary is based on a discussion via AMGA's Chief Medical Officer Council listserv as of March 17, 2020. For more information about the CMO Council, please click [here](#).

Question: *Has anyone worked through the question about which patients should we defer chronic disease care during COVID? This population, especially the older individuals in this cohort, are the folks who most need social distancing for prevention of infection. We can create a list of conditions (diabetes, CHF, COPD, etc.) and criteria, but to save time, wanted to see if anyone else had done that work yet.*

Multiple Groups Are Using This Approach

- Conduct routine visits telephonically until a robust telemedicine solution is stood up. Defer AWW, preventive, and other visits for 60 days. Contact patients ahead of time and convert as many as possible—only see people in the office who absolutely need essential care based on the provider's recommendation.

Messaging to Staff (Examples)

Practices continue to be open for now, and team members and clinicians will work from the office, not from home.

Practices should be making every effort to utilize telephonic care methods:

- Delivering trans-telephonic care now includes routine "clerical/administrative" care, such as medication reconciliation and refills, and routine follow up visits. All telephonic visits should be documented in the EHR, an updated tip sheet will be forthcoming. Physicians are empowered to use their clinical judgement on a patient-by-patient basis. Practices should:
 - Reschedule wellness visits and routine "well" visits for 60 days out
 - Proactively contact patients to perform these telephonic visits where appropriate
 - Document telephonic encounters in the EHR using a tip sheet

- Delay/defer all elective routine testing for 60 days, only pursue if patients are symptomatic or there is potential of adverse impact on patient health, using best clinical judgment.
- If patient has mild to moderate symptoms of illness
 - Attempt to manage ill patients at home with supportive measures and standard precautions.
 - Perform daily check-ins with telephone encounter documentation.
- A telehealth solution is under development and will start rolling out mid-week.

For patients being seen, to minimize the risk of further spread of the disease in our practices:

- Patients should be contacted and pre-screened prior to their appointment for symptoms of illness.
- Patients arriving at the practices need to be screened to ascertain if a patient is physically ill **before they enter the office/waiting room**. All sick patients get a surgical mask prior to entering the practice.
- Where at all possible, patients should be seen individually without an accompanying family member. Accompanying family members should be kept out of the waiting room, if possible (in their private vehicle, for example). When not possible, please try to limit the number of accompanying individuals to no more than one (1) into the practice.
- In the waiting room, practices will need to communicate and enforce social distancing.
- A team member must disinfect the chairs in the practice waiting room routinely during the day.

Regarding the scheduling and/or cancellation of elective surgeries and procedures

- Each hospital president is coming up with a plan for drawdowns of procedures. Communications to physicians of these changes will be conducted by relevant chairs or hospital leadership.

Please remain vigilant on the conservative use of personal protective equipment (PPE), there is a critical shortage of these resources!

Finally, please make every effort to project and remain calm as we work through this incredibly stressful situation together. Stay disciplined and project both confidence and compassion toward your patients and each other, as you always do. We will overcome this challenge together.

Management of Visits for High-Risk Patients

- Risk factors for severe COVID illness are not yet clear, although older patients (60+) and those with chronic medical conditions (heart disease, lung disease, diabetes, immunocompromised) may be at higher risk for severe illness. CDC and DHHS are recommending alternative modes beyond face-face appointments for these patients.
- Core is advising for all Core practices, the below be followed for the above higher-risk patients with appointments, or looking to schedule appointments, for the next 30 days.
 - **Defer appointment:** appointments that are routine, not acute, and require in-person evaluation (Ex: physical exam, routine follow-up of stable chronic medical conditions, group visits)
 - **Conduct by phone:** Appointments that are routine, not acute, and do not require in person evaluation (Ex: medication follow-up, medication refill, Medicare wellness visit)
 - **Keep appointment:** Appointments that are not routine, require in-person evaluation, and deferring the appointment may result in patient risk/harm (Ex: same-day sick, pediatric patient < 4yo requiring vaccines, 10yo vaccine boosters)

NOTE: The triage of appointments is at provider discretion only.

* Please contact your medical director/practice director if you need guidance.

* Though patient volume may decrease, all providers are required to remain at the clinic for their usual schedules unless directed otherwise by management.

* Core labs are open and all patients are being screened upon entry.

How to Conduct Telephonic Visits

1. Patient must meet the above criteria for a telephonic visit
2. Patient MUST be checked in. If the patient is not checked in, the note will not trigger for coding.
3. Telephonic visits cannot be related to an E&M encounter in previous 7 days, nor one that leads to E&M in next 24 hours. This should not be for acute issues.
4. Visits need to be timed according to below:
 - a. 99441: 5-10 minutes
 - b. 99442: 11-20 minutes
 - c. 99443: 21-30 minutes
5. Master Documentation should include full details of the phone call, as well as duration. It should state, "As a means of avoiding spread of coronavirus, this visit is being conducted by telephone".

Regarding Payment

We are submitting for office virtual visits and telephone visits—adding in a clause that says we are doing them due to the COVID situation and medical hardship.

Government Responses Regarding Telemedicine

- [Medicare Telemedicine Health Care Provider Fact Sheet](#)
- [Medicare Telehealth FAQs](#)

Question: *How are you addressing physician/provider compensation during the next 60 days? We have discussed an approach, but are concerned about significant pushback based on the finances of it, as our providers are in an RVU-based compensation model.*

Approaches

- We have decided to guarantee at 90% of their annualized 2019 compensation if the provider is on production-based pay. We have no other choice.
- Thinking of keeping track of hours and paying an hourly rate when we pull docs into other work.
- Our docs manning our RN/MD/DO hotline are being paid hourly for weekend shifts.
- Our clinicians are in a wRVU model. We will figure it out. We are thinking we will be reimbursed somehow for these telephonic visits. We have had a model for Epic ambulatory roll-out that we held clinicians harmless for wRVU—paid them at 90 day wRVU run rate prior to rollout if their wRVUs were lower for 90 days after rollout. We may go back to that.