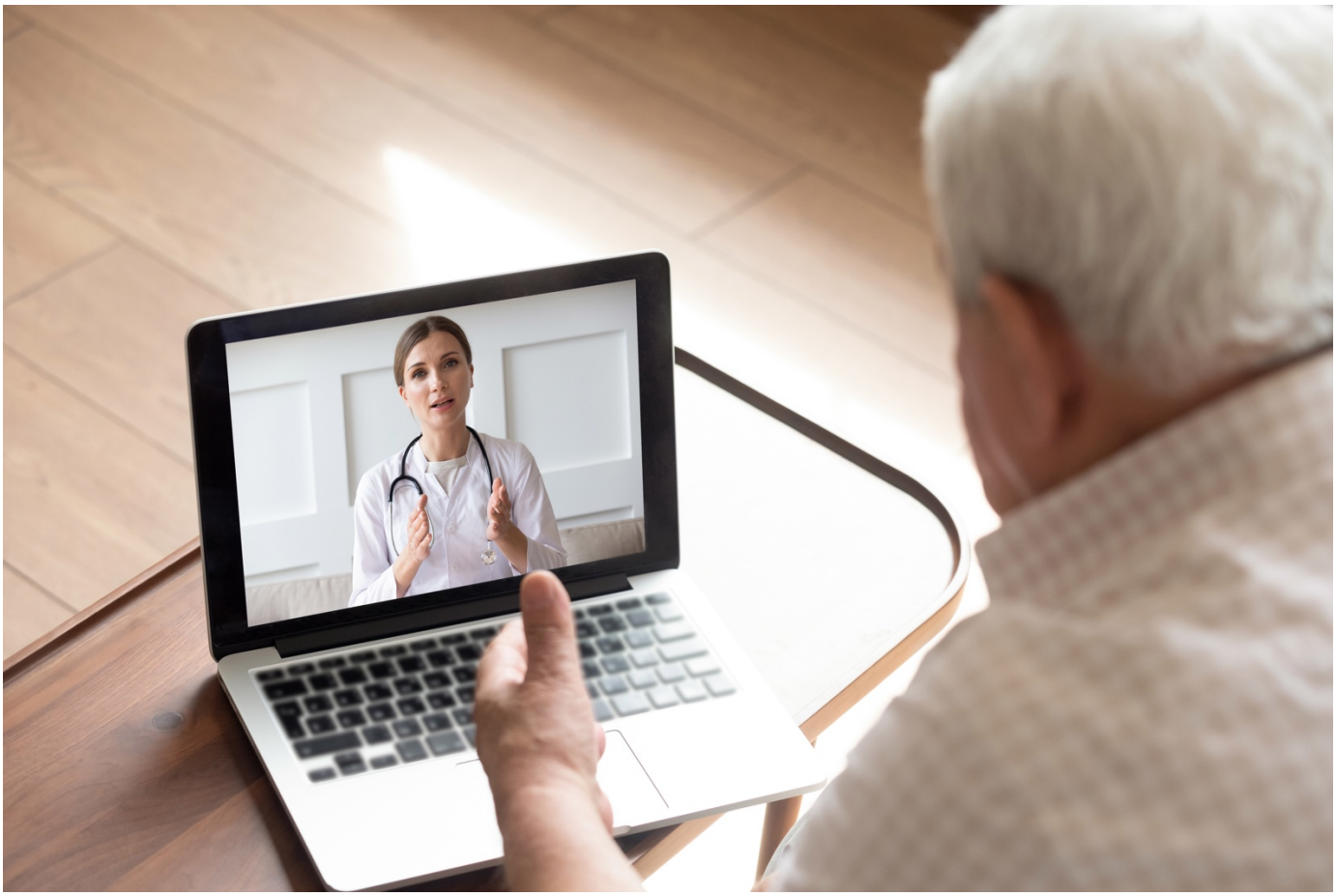
USA HEALTH



USA PROVIDER TELEHEALTH GUIDE

VERSION 1

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TABLE OF CONTENTS

INPATIENT TELEHEALTH

KEY CONTACTS

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INPATIENT VIRTUAL VISITS

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) and CMS have made temporary changes which allow for the use of audio or video communication technology to provide telehealth to patients during the COVID-19 crisis. CMS continues to update guidelines and rules for providers doing inpatient care during the COVID-19 outbreak and as these roll out we will provide updated information.
At this time Medicare has approved telehealth for ED visits, initial and subsequent inpatient visits, discharge day management, critical care services and inpatient neonatal and pediatric critical care. These changes allow services to continue while lowering exposure risk to providers, patients and also helps to preserve PPE. The provider is able to exercise their professional judgement as to when the use of a video device is appropriate for an interview or an examination and visits can be done via zoom or face time. Phones and I-pads have been provided to the ED, COVID unit at University Hospital and Pediatric Unit and PICU at Children's and Women's Hospital. The Licensed Provider (MD, DO, PA, NP) must be able to visualize the patient for these encounters either in the doorway, through a window or using a video device in the same proximity as the patient (not from home or another building or another floor). Video assisted visits can be done for patients with known COVID-19, those who are PUI for COVID-19 or for other medical conditions not related to COVID-19.

The visit does not have to be designated in Cerner as a telehealth or COVID-19 visit but to ensure adequate documentation there should be a statement in the note that a video device was used to assist with the interview or examination.

Statements are being built in Cerner for documentation of video-assisted visit for adult inpatient visits and pediatric inpatient visits and the macros for these statements will be provided ASAP but in the interim these are the statements that can be used:

a) **For adults:** "In order to maintain isolation precautions, a video device was used to assist with this encounter."
b) **For pediatrics:** "The patient or patient's guardian agrees to receive this health care service with the assistance of a video device. In order to maintain isolation precautions, a video device was used to assist with this encounter."

The documentation requirements have not changed for the levels of service but if a video device (including zoom or face time) is used the highest level of service for an initial inpatient or observation visit (99223 or 99220) or consultation (99254 and 99255) cannot be met when video is used as these levels of service require 8 systems for the physical exam. If there are any changes to these rules they will be communicated to the department heads.

The algorithm for inpatient visits during COVID-19 is attached.
It is anticipated that the majority of initial visits in the ED or inpatient setting will be done face-to-face but the decision to use a video assisted device for initial encounters can be made at the provider's discretion.
Initial consults can be done face-to-face or via video assisted device per the consulting provider's discretion.

Follow-up visits can be done face-to-face or with video assisted device at provider's discretion.
For all of the encounters the patient's vitals, labs, imaging, nursing notes and consult notes should be reviewed.

The provider should meet with the nurse to discuss the patient's status.

As a guide, the patient will be seen face to face if one of the following is met:

a) The provider wants to see the patient.
b) The nurse thinks the provider needs to see the patient.
c) The patient requests that the provider see them.

At the conclusion of a video assisted visit the provider should update the family member who is designated as the point of contact with the patient's status and plan and this should be documented in the note.
Link to HHS guidelines: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

REIMBURSEMENT AND CODING CLARIFICATIONS

	Initial Inpatient / Observation Care (Hospital Admit H & P)		
	99221 / 99218 3 of 3	**99222 / 99219** 3 of 3	**99223 / 99220** 3 of 3
History	Chief Complaint 4 or more HPI 2-9 ROS 1 element PFSH	Chief Complaint, 4 or more HPI, 10 or more ROS, Complete PFSH	Chief Complaint, 4 or more HPI, 10 or more ROS, Complete PFSH
Examination	2-7 Systems / Areas (in detail)	8 or more systems	8 or more systems
Medical Decision Making	(Must meet 2 of 3), Minimal diagnoses, Minimal/No Data, Minimal Risk	(Must meet 2 of 3), Multiple diagnoses, Moderate Data, Moderate Risk	(Must meet 2 of 3), extensive diagnoses, extensive data, extensive risk
Time (only relevant if counseling >=50%)	30 minutes	50 minutres	70 minutes

	Subsequent Care (Daily Visits)		
	99231 / 99224 2 of 3	**99232 / 99225** 2 of 3	**99233 / 99226** 2 of 3
History	Interval History, Chief Complaint, 1-3 HPI	Interval History, Chief Complaint, 1-3 HPI, 1 ROS	Interval History, Chief Complaint, 4 or more HPI, 2-9 ROS, Petinent PFSH
Examination	1 system/area	2 - 7 systems/areas	2-7 systems/areas (in more detail)
Medical Decision Making	(Must meet 2 of 3), minimal diagnoses, minimal/no data, minimal risk	(Must meet 2 of 3), Multiple diagnoses, Moderate Data, Moderate Risk	(Must meet 2 of 3), extensive diagnoses, extensive data, extensive risk
Time (only relevant if counseling >=50%)	15 minutes	25 minutes	35 minutes

99231 Usually, the patient is stable, recovering or improving."

99232 "...Usually the patient is responding inadequately to therapy or has developed a minor complication."

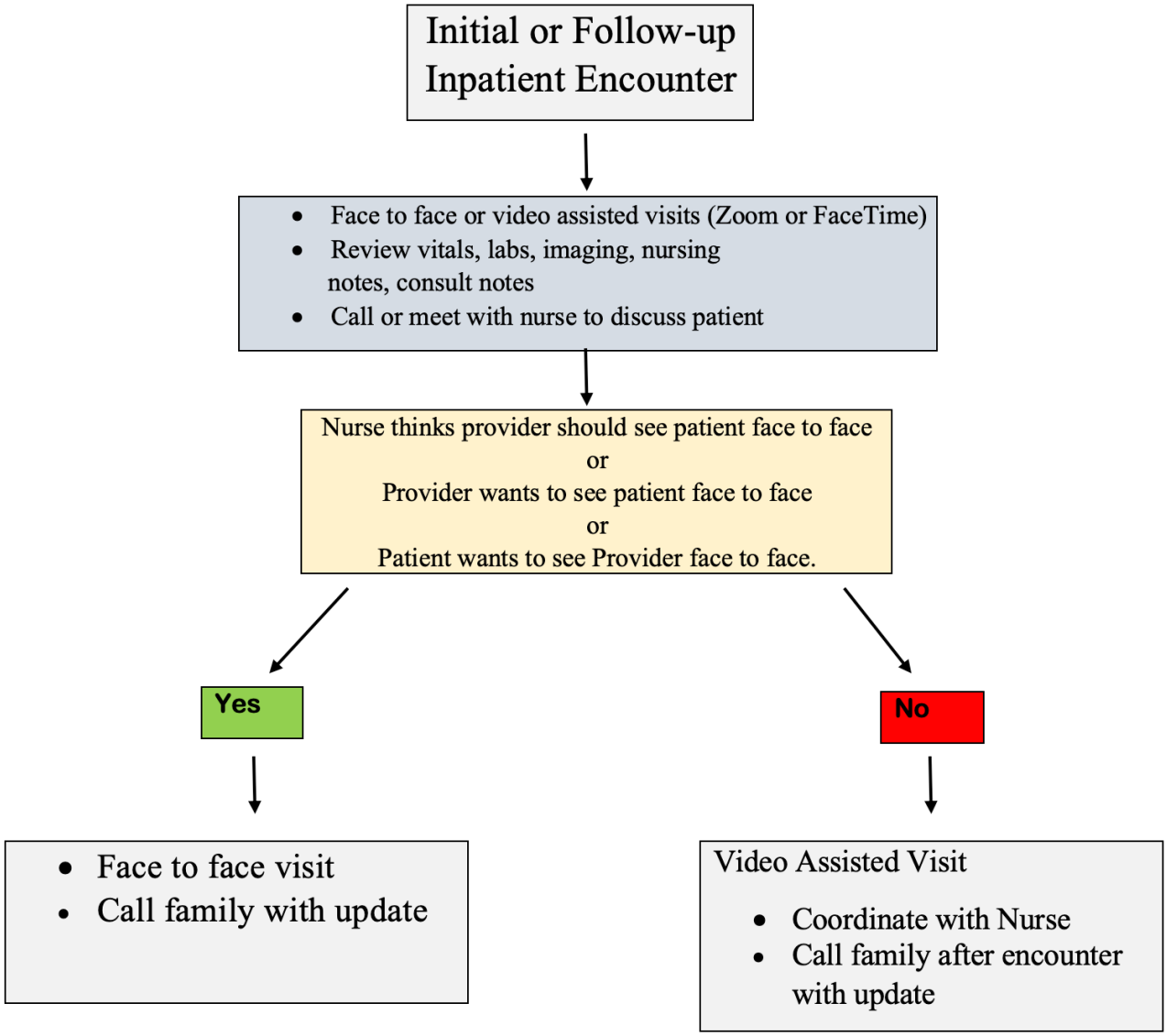
99233 "Usually, the patient is unstable or has developed a significant complication or a significant new problem."

Critical Care: 99291 First Hour (30-74 minutes), 99292 each additional 30 minutes.

	Inpatient Consultations				
	99251 3 of 3	99252 3 of 3	99253 3 of 3	99254 3 of 3	99255 3 of 3
History	Chief Complaint, 1 -3 HPI	Chief Complaint (CC), 1-3 HPI, 1 ROS	CC, 4 or more HPI, 2-9 ROS, Pertinent PFSH	CC, 4 or more HPI, 10 or more ROS, Complete PFSH	CC, 4 or more HPI, 10 or more ROS, Complete PFSH
Examination	1 System / Area	2-7 Systems/ Areas	2-7 Stems/Areas (in more detail)	8 or more systems	8 or more systems
Medical Decision Making	(Must meet 2 of 3), Minimal diagnoses, Minimal/No Data, Minimal Risk	(Must meet 2 of 3), Minimal diagnoses, Minimal/No Data, Minimal Risk	(Must meet 2 of 3), Limited diagnoses, LImited Data, Low Risk	(Must meet 2 of 3), MUltiple diagnoses, Moderate Data, Moderate Risk	(Must meet 2 of 3), Extensive diagnoses, Extensive Data, High Risk
Time (only relevant if counseling >=50%)	20 minutes	40 minutes	55 minutes	80 minutes	110 minutes

* All of the above codes will have -95 modifier added if the Provider is consulting with patient from a different location than the patient's room (via telephone or video device (Zoom or Face Time).

ALGORITHM FOR INPATIENT VISITS DURING COVID-19 CRISIS



RESIDENT SUPERVISION GUIDELINES - INPATIENT

Residents can be used in virtual visits in the same capacity that they are used in face-to-face visits. Essentially, nothing changes except that the patient is on a computer screen rather than sitting in front of you. The resident will interview the patient and discuss assessment/plan with the teaching provider who is on campus and can get to the patient urgently if necessary.

ATTESTATION STATEMENTS - INPATIENT

(NOTE: utilize the below attestation statements to compliment your documentation to thoroughly support the level of reimbursement.

+Adult_inpatient_videoassist

"In order to maintain isolation precautions, a video device was used to assist with this encounter."

+Peds_inpatient_videoassist

"The patient or patient's guardian agrees to receive this health care service with the assistance of a video device. In order to maintain isolation precautions, a video device was used to assist with this encounter."

+attest_virtual:

"The patient or patient's guardian agrees to receive this health care service as a telemedicine service and understand that the health care practitioner documenting this note is located in another location, thereby granting consent for telehealth.

This service was provided via a virtual visit platform. I was present for/performed the above documented history and physical examination of the patient, and formulated the above assessment and plan.

I spent a total of __ minutes with the patient via a virtual platform, of which more than 50% of the time was spent discussing the diagnosis, treatment options, possible lifestyle effects of treatment and coordinating care. The level of intensity provided for evaluation and management is a level __ visit."

+attest_telephone:

"The patient or patient's guardian agrees to receive this health care service as a telephone service and understands that the health care practitioner documenting this note is located in another location. This service was provided via a telephone. I was present for/performed the above documented history and physical examination of the patient, and formulated the above assessment and plan. I spent a total of __ minutes with the patient via the telephone."

AMBULATORY TELEHEALTH

KEY CONTACTS

Primary Contact:
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Secondary Contact:
Spencer Liles, MD, FACS, CMIO Surgical Services, (251) 410-4640, jsliles@health.southalabama.edu

AMBULATORY VIRTUAL VISITS

Telehealth Visit Etiquette

a) *Visits are to be conducted in a private confidential clinical setting, not in shared spaces.*
b) *Wear your white coat (or other professional attire) and have your USA Health name tag displayed.*
c) *Residents are encouraged to be utilized in the virtual visit strategy, but MUST be under direct supervision that meets standard GME supervision rules, including standard attestation.*
d) *At the start of the patient visit, whomever is performing the "virtual check-in process" should verify at least 2 patient identifiers, such as name and DOB, **obtain the patient's verbal consent to proceed with a telehealth visit, and document consent in the physician note.***

MOVE TO AUDIO/VISUAL NOT JUST TELEPHONE CONSULTATIONS – Script can be used

Please use the following introduction with your patient at the start of a Telehealth visit. Please Note- If a telephone consult is performed, the physician will need to perform all aspects of the call, to ensure proper reimbursement.

Telephone visits are only paid as telehealth if the patient does not have access to AV technology. This is why it is important to utilize audiovisual technology.

a) *This is (provider's name), please confirm your name and date of birth (need at least 2 patient identifiers before proceeding with visit).*
b) *This visit is being conducted (note: with or without the benefit of video) due to the restrictions of the COVID-19 pandemic. If it is determined that an in-person physical examination or a higher level of care is indicated or if other diagnostic testing is needed, I will refer you to the appropriate resources.*
c) *Do you understand or have any questions?*
d) *Do you consent to this Telehealth visit?*

REIMBURSEMENT AND CODING CLARIFICATIONS

Telehealth rules have been relaxed during this period of declared emergency to avoid unnecessary exposure. Please follow these guidelines when conducting a virtual/telehealth visit:

a) *New and Established Patient visits can be conducted by telephone (with or without video) or through a USA supported virtual visit platform (audio/visual).*
b) *Every telehealth visit must be documented in the patient's chart, as if it was face to face.*
c) *Use the attestations to document that the visit was conducted by telephone (specify with or without video), and that the patient:*
    1. *consents to be treated remotely by telehealth*
    2. *understands that they will be referred to another level of care if their condition warrants*
d) *Standard of care must still be met. That means for example, if a physical exam (that can't be done remotely) or further testing is indicated to complete care, refer the patient to the appropriate source and arrange for follow-up care.*
e) *Prescriptions, including narcotics can be issues per standard practice for Established patients, however DEA rules require an audio/video visit with a new patient before controlled substances can be prescribed remotely.*

Service Type	Appropriate Use	Guidance for Use	Technology Requirements	Applicable Codes (ACS)
Telemedicine Visit (E & M)	Use for encounters when a virtual visit occurs using both Audio and Visual technology. These encounters should be modified with 95 or GT if IP and provider does not physically interface with patient. For example, the provider stands in doorway, no 95 or GT modifier is needed, but that depends on payer.	New & Established Office Visit/Inpatient Care codes with usual documentation guidelines & systems reviews.	Audio-visual visit is prefered for this type of visit, using Zoom, SnapMD, & FaceTime	99201-99215 (for Outpatient) 99221-99233.95 (For Inpatient) ***** See below***
Virtual Check-in (APPs)	Use for encounters occurring virtually either with image or video, followed by brief medical dicussion 5-10 minutes	1- Remote audio-visual encounter recorded and texted/emailed, submitted by an established patient for provider review. 2- Brief communication, technology based with an established patient for 5-10 minutes of medical discussion.	Audio-visual visit is prefered for this type of visit, using Zoom, SnapMD, & FaceTime	1- G2010 2- G2012
Telephone Visits	Audio service only for established patient. Documentation in the medical record of complaint & treatment	**Telephone encounters may be limited in terms of rendering patient care beyond a Level 3 visit because of limitations in acutally seeing/viewing the patient.** These visits are to be used for evaluation and management services provided to an established patient.	Audio (Telephone)	99441 (5-10 minutes) 99442 (11-20 minutes) 99443 (21-30 minutes)

* The documentation guidelines explicitly state that the physician should use the highest level of risk present when determining the complexity of the medical decision making. For example, an encounter with a patient who presents with one stable chronic illness would amount to a low level of risk. However, if the physician actively manages prescription drug therapy during the encounter, the risk level for the visit qualifies as moderate, because prescription drug management is associated with moderate risk. After you determine the problem points, the data points and the level of risk, you can determine the complexity of the medical decision making. The highest two of three elements determine the overall level of medical decision making.

Encounter Documentation Recommendations

** OBTAIN CONSEN AT THE START OF THE VIDEO ENCOUNTER. REMEMBER TO ATTEST ACCORDINGLY. PLEASE CONSIDER THE DETAILS IN THE TABLE BELOW FOR COMPLETING PATIENT DOCUMENTATION THAT SUPPORTS THE VISIT LEVEL. INCLUDING BRIEFING PHRASES THAT PROVIDE DETAILS ABOUT "HOW" EACH PART OF THE VISIT WAS CONDUCTED WILL SUBSTANTIATE MODERATE & HIGH COMPLEXITY.

Possible choices for E/M code	**Type of History [used to determine proper E/M code]**	**History of Present Illness [HPI]** • the location of the problem • the quality • the severity of the problem • the duration of the problem • the timing of the problem • the context • modifying factors • associated signs and symptoms	**Review of Systems [ROS]** • eyes • ears, nose, throat and mouth • cardiovascular • respiratory • gastrointestinal • genitourinary • musculoskeletal • integumentary • neurological • psychiatric • endocrine • hematologic or lymphatic • allergic or immunologic	**Past Family and/or Social History [PFSH]** • past history • family history • social history
99201 99212	Problem-focused	Brief **(1-3 of the above factors)**	N/A	N/A
99202 99213	Expanded problem-focused	Brief **(1-3 of the above factors)**	Problem-pertinent **(1 of the above systems reviewed)**	N/A
99203 99214	Detailed	Extended **(4 or more of the above factors)**	Extended **(2-9 of the above systems reviewed)**	Pertinent **(1)**
99204 99205 99215	Comprehensive	Extended **(4 or more of the above factors)**	Complete **(10 or more of the above systems reviewed)**	Complete **(2 or 3)**

NON FACE-TO-FACE TELEHEALTH SERVICES GUIDELINES

a) ***Audio/video telehealth visits*** *of any sort are reimbursed comparable to in-office and will be coded, by ACS, according to standard E&M guidelines.*

b) ***Telephone visits (audio only)*** *are paid visits at a lesser rate (need to document the reason why video was not available) and are billed by time so you need to document the duration of the call and ensure that provider is conducting entire telephone visit.*

RESIDENT SUPERVISION GUIDELINES – AMBULATORY

Residents can perform virtual visits in the same capacity that they are used in face-to-face visits. Essentially, nothing changes except that the patient is on a computer screen rather than sitting in front of the provider. The

resident can be sitting next to the teaching physician and interview the patient and discuss assessment/plan as long as they are "supervised" and discuss the plan with the teaching provider.

ATTESTATION STATEMENTS - AMBULATORY

(NOTE: utilize the below attestation statements to compliment your documentation to thoroughly support the level of reimbursement.

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