Telehealth Implementation and Documentation

The following responses were collected from this question posted on the listserv: **"What does appropriate documentation look like (when I can't cover all body systems)? Does anyone have any tools/how to on working through a telehealth visit as a provider? Or even any advice?"**

1. See link to "Managing a telephone encounter – five tips for effective communication": https://www.aafp.org/journals/fpm/blogs/inpractice/entry/telephone_visit_tips.html
   See link to additional AAFP. 10 communication tips for physician phone visits during COVID-19: https://www.aafp.org/journals/fpm/blogs/inpractice/entry/telephone_visit_tips_2.html

   This is what we sent to our providers:

   - A couple of best practices regarding phone visits: (From Family Practice Management)
     1. Speak slowly, clearly, and don't use medical jargon.
     2. Listen actively. Don't be afraid to ask patients to clarify what they said.
     3. Develop rapport. Make sure to take a few minutes at the beginning of the phone call developing rapport, just as you would in person.
     4. Give each call your full attention. It may seem obvious, but resist doing anything else while you are on the phone. Don't check email or text!
     5. Be clear about the plan. At the end of the call, review what you discussed and establish what will happen after the call. Send a patient plan by snail mail or through portal.
   - Some specifics to us for your phone visits. Remember that you can address lots of quality measures during a phone visit.
     - Your MA should be administering a PHQ-9 if they have not had one this year.
     - Your MA should be asking about smoking, using the smoking encounter plan, and this is definitely something that you can address on a phone call.
     - You can send Cologuard in the mail to patients if they are due for colon cancer screening. Remember when you order this it is sent directly to their house! Lots of patients are bored at home so they have time to do this! 😁
     - You can counsel regarding BMI, utilizing the most recent BMI number.
     - You can ask patients with diabetes about their last eye exam, and make sure that the results are in the chart. If they are not, the MAs can call for results.
     - For patients with high blood pressure, encourage them to check their blood pressure at home. If they don't have a BP cuff, prescribe one. If their insurance doesn't cover it, we have cuffs that your MA can send to the patient in the mail.
     - For kids, you can still counsel regarding diet and exercise and document appropriately.

2. I have attached our Telehealth resources packet. In terms of documentation: a full ROS can be taken via telehealth, but exam is necessarily limited. Time-based coding may be used. Providers should be documenting time on telehealth visits. Be sure to document things that you are able to assess, general appearance, quality of voice, skin appearance, any maneuvers you may ask the patient to perform for assessment, patient-reported vitals, etc. See attached "PHC Telehealth Implementation Resource Packet"

3. **VIRTUAL VISIT NOTE - ROUTINE CARE**

   Clinical Summary:
   ***

   Assessment & Plan:
   **

   Encounter Diagnoses & Associated Orders
   No diagnosis found.

   Attestation:
   The {PATIENT/SURROGATE:3467} participated in the virtual visit. Identity was verified by name and {identityconfirmation:3463}. Verbal consent for the visit was provided. I spent {Numbers 1-30:3464} minutes in direct personal communication during this virtual visit.

4. For a telehealth visit, you need to document the actual time the provider visits starts and stops. You also need to document the total PROVIDER time (not MA or other staff) spent on the visit. So, if you spend 5 minutes before the visit reviewing labs, other diagnostics, consult notes, discharge summaries, etc. you would include that. There needs to be documentation that the visit is telehealth, and why, and should document the location of the patient and provider. It can be a brief quick-text such as "*I am seeing this patient today virtually using HIPAA-compliant videoconferencing technology. The patient has previously provided full consent to use this technology and understands the risks and benefits of proceeding. I am seeing the patient today from my office in CITY, STATE, and from their home located within STATE."* We also make a statement that this is to reduce the risk to patient and provider during the COVID-19 pandemic.

   In terms of clinical documentation, you simply document as you otherwise would. Put in your history, med list, PMH, FH, ROS, etc. as you obtain it. For exam, document to the extent you can by phone or video. You can document the degree of distress, the quality of their respirations, etc. We have a form that allows us to document the patients REPORTED BP, P, TEMP, WEIGHT, O2 SAT, and some of our patients have been very prepared with this info. I've documented range of motion, swelling, and bruising as well as patient-documented location of tenderness for an acute minor orthopedic injury, extent of swelling and redness for a cutaneous injury.

   Coding is the same as always, if you bill based on Hx/Exam/MDM. But, for CMS, we can use time primarily for telehealth during this emergency. Here is a table from a coding information site that lists the EM codes and appropriate time. Remember, this is total provider time. If you spend time after hanging up to place orders, send patient instructions by portal or mail, create and sent Rx's, all of that is included. CMS has adjusted the total typical time for each office EM telehealth code to account for pre-evaluation time, intra-service time, and immediate post-service time. We have used CPT typical time as below to document time spent with the patient, including counseling and coordination of care. The CMS typical times listed below include the

pre- and immediate post-visit time. These are to be used during the declared public-health emergency. (Source: https://codingintel.com/wp-content/uploads/2020/03/2020-03-30CMS-1744-IFCWEBPOSTINGMASTER03-30-20FINAL508c.pdf)

Document the total face-to-face and non-face-to-face for all activities by the billing practitioner related to the visit.

	CPT typical time	CMS typical time
New patient		
99201	10	17
99202	20	22
99203	30	29
99204	45	45
99205	60	67

Code	CPT typical time	CMS typical time
Established patient		
99212	10	16
99213	15	23
99214	25	40
99215	40	55

We have developed a form in our EMR (Centricity) that makes documentation of the telehealth specific elements easily. There is a check-box for means of communication and the video platform if used. There are boxes to check at the start and end of the visit to document those times, as well as a box to either document the elapsed time as the total time for the visit. We can edit that to document the TOTAL provider time as needed. There is also a box to document that consent for telehealth visit was obtained, and drop-down menus to document provider location, patient location, and who participated in the visit if more than the patient.

**Reminder: Responses shared over the MWCN listserv are meant to be informational and reflective of what other health centers may be doing. It is recommended that you check federal and state regulations before implementing new practices.*