MODULE 1:
OVERVIEW - WHAT IS TELEHEALTH

Telehealth

- Administration
- Consumer Education
- Public Health
- Health Professionals Education
- Regional Health Information Sharing
- Evaluation & Research
- Homeland Security

Telemedicine
OBJECTIVES

• After completing this course, you should be able to:
  – Define telehealth and its various delivery modalities
  – Describe aspects of telehealth licensing and interstate compact rules
  – Describe Emory Healthcare’s Telehealth policy
  – All of Emory’s telemedicine materials, policies, documents, and other items may be found at https://emory.sharepoint.com/sites/EHCTelehealth
  – Please let your administrator know if you wish to have access to this site, and they can request it for you by working with the EHC Telehealth Team
WHAT IS TELEHEALTH?

• **Telehealth** is providing care at a distance utilizing medical and related data transferred via audio, video, and/or other types of telecommunications technology to provide or support clinical and non-clinical services (e.g., education, administration, public health)

• **Telemedicine** refers specifically to remote clinical services

• These are the four most common telehealth **modalities**:

  - Live Video-conferencing
  - Store and Forward
  - Remote Patient Monitoring
  - mHealth
GEORGIA’S DEFINITION OF TELEHEALTH

• Telemedicine is the use of medical information exchange from one site to another via electronic communications to improve patient’s health status. It is the use of two-way, real-time interactive communication equipment to exchange the patient information from one site to another via an electronic communication system. This includes audio and video communications equipment.

• Closely associated with telemedicine is the term “telehealth,” which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Telehealth is the use of telecommunications technologies for clinical care (telemedicine), patient teachings and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

WHY TELEMEDICINE?

- Clinical provider shortages
- Misdistribution of providers
- Aging population
- Travel time, cost & hardship
- Language & cultural barriers
- Clinical education
- Disaster relief
- Rural & urban medically underserved populations
- Many others reasons for patients not receiving needed care
TELEHEALTH BENEFITS

- Reduces barriers to access
- Increases efficiency for providers
- Reduces overall health care costs
- Reduces delays in care
- Retains resources locally
- Reduces travel
- Increases patient & provider satisfaction
- Supports improved quality
- Improves health outcomes
- Literature contains numerous other benefits overall & by specialty
TELEHEALTH APPLICATIONS

- Intensive care units
- Inpatient care
- Emergency departments
- Emergency response vehicles
- Skilled nursing services
- Outpatient services
- Screening services
- Chronic disease management
- Patient support groups
- Home monitoring programs
- Clinical provider education
- Patient education
- Interpreter services
- Provider to provider consultation
BASICS - DEFINITIONS

**Originating Site:** Location of a patient at the time the service is provided. Provider must be licensed in the state of the originating site. Examples of originating sites include, but are not limited to:

- Patient's home
- Doctor's office
- Clinic
- Hospital
- School
- Work
- Correctional facility

**Distant Site:** Location of the provider rendering services at the time the service is provided. Examples of distant sites include but are not limited to:

- Provider's home
- Provider's office
- Clinic
- Hospital
TYPES OF CONNECTIVITY

- POTS: Plain Old Telephone System
- ISDN: Integrated Services Digital Network
  - Digital Phone Line
- IP: Internet Protocol
  - T1, DSL, Cable, ISDN can all transmit IP Information
  - Public vs. Virtual Private
  - Quality of Service
- Wireless
  - Minimum 3G
- Microwave & Satellite
LIVE VIDEO CONFERENCING (SYNCHRONOUS)

• **Live Video Conferencing:** Synchronous, real-time, two way consult between a patient (possibly with medical provider present) and a provider at a distant site

• **Technology:** Videoconferencing equipment, specially adapted diagnostic equipment, often referred to as peripherals, such as a USB Digital stethoscope

• **Example use cases:**
  – Telestroke visits where the patient is located in the ED and the Neurologist is remoting in from their home office when on call
  – Telepsychiatry & other mental/behavioral health applications where the patient is located in the ED and an evaluation could be done remotely with a psychiatrist to reduce the length of stay
LIVE VIDEO CONFERENCING (SYNCHRONOUS)

• Effective & flexible in many situations & locations
• Equipment needed: camera, monitor/viewing screen, microphone & speaker, codec, peripherals (e.g., electronic stethoscope)
• Desired features
  – Pan tilt zoom camera
  – Far end camera control &/or automatic camera movement
  – Quality lens optics, high-resolution
  – Automatic color balance & automatic gain
  – Picture in picture
  – Full duplex audio
**STORE AND FORWARD (ASYNCHRONOUS)**

- **Store and Forward**: Asynchronous, delayed transfer of diagnostic images, video and other data from one site to another in preparation for a consult or for direct consultation when face-to-face not necessary
- **Technology**: Digital camera, computer, radiology PACS, pathology whole slide imager, digital retinal imager
- **Example use cases**:
  - Radiology, pathology, dermatology, ophthalmology
  - Teledermatology: Primary Care Provider takes a digital photo of a patient’s skin condition and sends the image via secure platform to a dermatologist for review and determination of treatment if needed
REMOTE PATIENT MONITORING

- **Remote Patient Monitoring**: The use of a specific technology to enable monitoring of patients outside of traditional clinic settings to improve care and potentially reduce cost by providing the proper interventions at the right time.

- **Examples include**:
  - Glucose monitoring for diabetes patients
  - Daily weights for heart failure patients
  - Bluetooth blood pressure monitors for hypertension
  - Monitoring of chronic conditions
**MHEALTH**

- **mHealth**: The use of mobile phone and other wireless technology applications to monitor a user’s health and provide education
- **Example use case:**
  - Apple Health app can integrate with a patient's electronic health record, allowing users to access their health data on their iPhone or iPad
LICENSING

• Georgia requires that physicians providing services via telemedicine to patients located in Georgia must be licensed in Georgia.

• In general, the provider must be licensed in the state of the originating site (patient’s location)
  – Please note that during states of emergency (COVID19 pandemic), emergency licenses are available in multiple states.
  – These are easy to obtain and allow the practice of medicine in that state (including telemedicine).
  – Please see the out-of-state licensing folder on https://emory.sharepoint.com/sites/EHCTelehealth.

• Certain organizations like the Indian Health Service and the VA allow providers to practice across state lines within the organization.

• Georgia is a member of the Nurse Licensure Compact (NLC)
  – The compact allows nurses “to have one multistate license, with the ability to practice in person or via telehealth in both their home state and other eNLC states.”

• Georgia has adopted the Federation of State Medical Boards (FSMB)’s Interstate Medical Licensure Compact (IMLC)
  – Physicians can apply for a telemedicine license to practice in states that are members of the IMLC.
IMLC - COMPACT STATES

• The Interstate Medical Licensure Compact offers a new, voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states
• The IMLC mission is to increase access to health care for patients in underserved or rural areas and allowing them to more easily connect with medical experts through the use of telemedicine technologies
• While making it easier for physicians to obtain licenses to practice in multiple states, the Compact also strengthens public protection by enhancing the ability of states to share investigative and disciplinary information
• Physicians can treat across state lines if both states are in the IMLC

Source: https://imlcc.org/
IMLC - ELIGIBILITY REQUIREMENTS

- You must hold a **full, unrestricted medical license** in a Compact Member State that is available to serve as an SPL (State of Principal Licensure) **AND at least one** of the below must apply:
  - Your **primary residence** is in the SPL (State of Principal Licensure)
  - At least **25% of your practice** of medicine occurs in the SPL
  - Your **employer** is located in the SPL
  - You use the SPL as your **state of residence for U.S. federal income tax purposes**
Visit [https://www.imlcc.org/](https://www.imlcc.org/) for the most updated information on participating states.
**IMLC - COSTS**

- Application process is outlined in detail at [https://imlcc.org/](https://imlcc.org/)
- Application cost is **$700.00 fee PLUS the cost of each license(s)**

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EMERGENCY TELEMEDICINE LICENSING

• During COVID-19 pandemic, states varied in their allowance of medical practice in their state by practitioners licensed in other states but not in the state in question
• Many states set up emergency licensure pathways
• States contiguous to GA who have these pathways are:
  – North Carolina (click here to fill out the form for the temporary license)
  – South Carolina (click here to fill out the form for the temporary license)
  – Tennessee (click here to fill out the form for the temporary license)
  – Alabama (click here to fill out the form for the temporary license)
• Florida has considerations that limit ability to practice which Emory is working through
• You CANNOT practice telemedicine in any state in which you are not licensed
LICENSING FOR OTHER PROVIDERS

• The Enhanced Nurse Licensure Compact (eNLC) allows RNs, LPNs, and LVNs to practice in other eNLC states, including the entire southeast
• PAs & dieticians will need to get licensed in each state individually to practice across state lines
• Other providers (e.g., PT, OT, SLP, PhD, MSW) should check with their local Board to verify telehealth practice requirements and regulations

Source: https://sos.ga.gov/index.php/licensing/plb/45/nurse_licensure_compact
EMORY’S TELEHEALTH POLICY

• Telehealth **use case development** must be done in partnership with the Emory telehealth team (ehctelehealth@emoryhealthcare.org)
• Emory Healthcare’s **primary platform** for telehealth is provided by Zoom
• Alternative, **approved, HIPAA compliant platforms** can be used in certain circumstances
• During the COVID-19 pandemic, HIPAA compliance restrictions were relaxed but this is likely to revert, such that platforms must be HIPAA compliant
• Handling of **PHI and ePHI** must still follow current policies
  – Do not **capture or communicate** PHI using unsecured devices or platforms (phones, personal email, etc.)
  – Do not **store** PHI on unsecured devices or platforms
TELEMEDICINE PRIVACY COMMUNICATION

• The use of telemedicine provides flexibility for how and when we treat patients, but it also removes the built-in privacy protections that a private exam room offers. While we should always be vigilant in maintaining patient privacy, it is even more important to focus on privacy during a telemedicine visit.

• **Provider Responsibilities**
  – Conduct the visit in a professional and private location
  – **DO NOT** conduct visits in shared spaces
  – If at home:
    • **DO NOT** have family members around
    • Be in a room with a door that is closed
    • Use headphones if others are within earshot
    • Use a virtual background if possible
    • If you cannot meet these responsibilities, then discuss space alternatives with your administrator
  – Configure waiting room to catch ALL participants (see guide on SharePoint)
  – Use Emory approved HIPAA compliant platforms.
OBJECTIVES

• Following this module, you will be able to:
  – Define Georgia Composite Medical Board requirements for telehealth
  – State the requirements for establishing a patient-provider relationship
  – Describe the compliance requirements for Medicare, Medicaid, and Commercial payers in order to be reimbursed for telehealth
  – Describe the limitations on controlled substance prescribing during telehealth visits
INTRODUCTION

• There are several legal and regulatory aspects to keep in mind when practicing telehealth in the state of Georgia.
• Legislation and its application to telehealth is frequently changing and will require continued monitoring as you develop your telehealth service.
• For current state laws & reimbursement policies see the Georgia section of the Center for Connected Health Policy’s 50-state summary: https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies#
• The Emory Telehealth team will help you stay abreast of new changes, but we appreciate direct feedback from you if/when you become aware of a legislative or regulatory change.
**Georgia State Medical Board Telehealth Requirements**

The Georgia Composite Medical Board (GCMB) requires the following conditions be met:

1. **Establish a valid provider-patient relationship**
2. **Conduct annual in-person follow-up exam**
   - Must make an effort to have the patient seen and examined by a GA licensed practitioner annually
3. **Able to examine the patient using technology or peripherals that are equal or superior to** an examination done personally by a provider within that provider’s standard of care
4. **Regarding the prescription of controlled substances**: The Ryan Haight Online Pharmacy Consumer Protection Act of 2008, which strongly regulated a provider’s ability to prescribe controlled substances. Under the Ryan Haight Act, providers are required to conduct an in-person examination before prescribing or otherwise dispensing controlled substances. The EHC Telehealth team will monitor and provide updates as they are available.
5. **Non-physician providers** must have documented to the GAMB that telehealth is within their scope of practice and competence providing telehealth has been demonstrated
6. Provider must have **access** to patient’s record at time of the consult, **document** in patient’s record, and **provide** a copy of the visit record to referring provider if necessary
7. Provider must provide **credentials, emergency contact information, and appropriate follow-up instructions** to the patient
8. **Telehealth treatment and/or consults must be done by Georgia licensed practitioners**

[https://medicalboard.Georgia.gov/](https://medicalboard.Georgia.gov/)
ESTABLISHING A PATIENT-PROVIDER RELATIONSHIP FOR A TELEHEALTH PATIENT (REQUIREMENT 3 OF THE STATUTE)

At least one of these conditions must be met to establish a patient-provider relationship:

- Provider has **personally seen and examined patient** (in-person) and provides **ongoing** intermittent care by electronic or other such means.
- Providing medical care by electronic or other such means **at the request** of physician, PA, or APP licensed in GA who has **personally seen and examined** the patient.
- Providing medical care by electronic or other such means **at the request** of a Public Health Nurse, a Public School Nurse, the Dept. of Family and Children’s Services, law enforcement, community mental health center or through established child advocacy center for the protection of a minor.
- Provider is able to examine the patient using **technology or peripherals that are equal or superior** to an examination done personally by a provider within that provider’s **standard of care**.
WHAT IF THE PATIENT THAT I AM SEEING IS A NEW PATIENT TO ME OR MY PRACTICE GROUP?

- You are allowed to establish a patient-provider relationship with patients that are **NEW** to you or your practice.
- You must be able to examine the patient with technology **or** peripherals that are equal to or superior to an in-person examination.
- If you identify that you cannot perform appropriate medical decision making without examination elements that can only be conducted in person, you should **bring the patient in** as soon as feasible to finalize your examination and proceed with medical decision making.
- You would only **submit one bill** for the combined visit, on the day that you were able to complete your assessment.
TELEHEALTH CONTROLLED SUBSTANCE GUIDELINES

- **Prescribing controlled substances** via telehealth is governed by state law (in addition to the Ryan Haight Act\(^1\))
- Controlled substances **should not** be prescribed based solely on a telehealth consult
- As of January 2020, Georgia state law **bans** prescribing controlled substances, such as narcotics, benzodiazepines, or even antiepileptic drugs like pregabalin that are in schedule III-V, via telehealth; **except**, stimulants for the treatment of ADHD
- On call or covering providers may prescribe up to a 30 day supply of dangerous medications (**not controlled substances**) and when a documented emergency exists
- Must have a current DEA registration in the state where the **patient is located** prior to prescribing controlled substances via telemedicine
- **State and Federal waivers and executive orders** allow prescribing of controlled substances based on a telemedicine visit during a state of emergency or disaster or pandemic

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In response to the COVID-19 pandemic, GCMB removes prescription restrictions and allows prescribing of Schedule II-V drugs. All of the following conditions must be met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice.
- The telemedicine communication is conducted using an audio-visual, real time, two-way interactive communication system.
- The practitioner is acting within federal and state law.

Read the DEA's ruling here: https://www.deadiversion.usdoj.gov/coronavirus.html

The Georgia DEA registered practitioner may issue a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy.
• The Board’s rules regarding prescribing controlled substances for chronic pain require a clinical visit at least every ninety (90) days (See Section (f) below). This can be waived and the clinical visit be at least once per year if the doctor determines there is a substantial hardship and documents such hardship in the patient's record or if the morphine equivalent daily dose (“MEDD”) is 30 mg or less.

• Practitioners should be sure to document the COVID-19 Pandemic/Public Health Emergency as the hardship basis for waiving the 90 day in-person visit, which should be conducted via telemedicine at least every 90 days and then at least an annual in-person visit.

• When prescribing a Schedule II or III controlled substance for 90 (ninety) consecutive days or greater for the treatment of chronic pain arising from conditions that are not terminal or patients who are not in a nursing home or hospice, a physician must have a written treatment agreement with the patient and shall require the patient to have a clinical visit at least once every three (3) months, while treating for pain, to evaluate the patient's response to treatment, compliance with the therapeutic regimen and any new condition that may have developed and be masked by the use of Schedule II or III controlled substances.
PRESCRIBING OF CONTROLLED SUBSTANCES ACROSS STATE LINES – DURING THE PUBLIC HEALTH EMERGENCY

• The DEA allowed prescription of controlled substances across state lines during the COVID19 crisis without obtaining a DEA registration in the state where the patient is located and in compliance with the DEA waiver.
• However, please be aware that State Boards also have jurisdiction over the practice of medicine in their state, including the prescription of controlled substances.
• It is recommended that clinicians obtain emergency licenses during the pandemic in states in which their patients are located to comply with appropriate state laws regarding the practice of medicine and specifically the prescription of controlled substances for patients in the state in question.
REIMBURSEMENT FOR TELEHEALTH

- Each payer has **different requirements** for telehealth claims and reimbursement.
- Providers **should be aware of** all Medicare, Medicaid, and Commercial requirements in order to ensure that telehealth visits are reimbursed.
- For **current state laws & reimbursement policies** see the Georgia section of the Center for Connected Health Policy’s 50-state summary [here](https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies#).
- Emory’s Office of Compliance and Patient Financial Services have teamed up to provide updates on telehealth reimbursement especially during the COVID19 crisis. It can be found [here](https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies#).
MEDICARE (PRE-COVID19)

• Prior to the health emergency, Medicare only reimbursed for patients who satisfied specific location designations, for certain types of healthcare professionals, and certain types of facilities; otherwise the visit was not eligible for reimbursement.

• Patients could sign an Advance Beneficiary Notice of Noncoverage (ABN) during intake and agree that they will be responsible for paying any uncovered fees in the event telehealth services are not reimbursable.

• Telehealth regulations are updated yearly and are available in November of each calendar year after the proposed rule is finalized.

• https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth
MEDICARE REIMBURSEMENT (PRE COVID-19)

- Medicare reimbursement has been traditionally utilized to solve for access challenges related to patients that receive care at a facility that is in:
  - A county outside of a Metropolitan Statistical Area (MSA)
  - OR
  - A Health Professional Shortage Area (HPSA) located in a rural census tract

- The Health Resources and Services Administration (HRSA) determines HPSAs, and the Census Bureau determines MSAs. You can access HRSA’s Medicare Telehealth Payment Eligibility Analyzer to determine a potential originating site’s eligibility for Medicare telehealth payment.
**ELIGIBLE LOCATIONS FOR A MEDICARE TELEHEALTH VISIT (PRE COVID-19)**

- Offices of a Physician or Practitioner
- Hospitals
- Critical Access Hospitals
- Community Mental Health Centers
- Skilled Nursing Facilities
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-Based or Critical Access Hospital (CAH)-Based Renal Dialysis Centers (including satellites)
- Renal Dialysis Facilities
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis
- Mobile Stroke Units
- Homes of patients receiving therapy for controlled substance use. Providers still not able to prescribe controlled substance
MEDICAID (PRE-COVID19)

- Medicaid reimburses for telehealth visit as long as a documented consent to telemedicine is obtained for every visit during intake.
- Documentation must be maintained where the patient is seen and where the provider is located.
- Like Medicare, Georgia’s Medicaid program restricts where the patient and provider can be located during the telemedicine visit.
- Both the patient and the provider will need to be at one of the eligible sites during the visit for GA Medicaid to cover it.
ELIGIBLE SITES FOR MEDICAID COVERAGE (PRE COVID-19)

• Provider Offices
• Hospitals
• CAH based renal Dialysis Centers
• Rural Health Clinics (RHC)
• Federally Qualified Health Centers (FQHC)
• Skilled nursing facilities
• Emergency Medical Services Ambulances
• School-based clinics
• Pharmacies
• County Boards of Health
• As of January 2020, home sites are not normally covered
COVID19 EFFECT ON MEDICARE REIMBURSEMENT

• Because of COVID19, many payers, led by Medicare, relaxed restrictions on originating site and ability to be reimbursed.
• Specifically, a patient's home is now an accepted originating site.
• Providers can now see patients when the patient initiates the telemedicine visit from their home *(Medicare wants the usual site of service or 02)*
• Billing for routine E/M visits requires only the addition of a “95-modifier” to the appropriate CPT code, which can be done in the electronic medical record.
• Providers can also now bill for telephonic visits in which they perform medical evaluation and management, and which last > 5 minutes.
• Billing for telephone visits requires use of the following CPT codes:
  – 99441: telephonic visit 5-10 minutes
  – 99442: telephonic visit 11-20 minutes
  – 99443: telephonic visit 21 minutes or more
COMMERCIAL

• Currently commercial payers **generally follow CMS guidelines** at minimum for most instances of Telehealth

• Commercial payers **can be less restrictive** than CMS, so opportunities exist for more reimbursable services

• SB 118 modifies the Georgia Telehealth Act to include **payment parity** for services delivered using telehealth in eligible sites

• **In response to the COVID-19 pandemic**, many commercial payers are extending their coverage of telemedicine visits
MODULE 3: TELEHEALTH VISIT PROCESSES

PRE-VISIT

Screening/Patient selection → Scheduling → Pre-visit period

VISIT

Pre-provider → Provider → Post-provider

POST-VISIT
OBJECTIVES

• Following this module you will be able to:
  – Describe the stages of a telehealth encounter
  – Determine the optimal set-up for your technical equipment
INTRO

• Once you have addressed operational and regulatory aspects of Telehealth, the final step will be to master the **delivery of a quality telehealth visit**

• These **skills** are learned by repetition and by making sure you **prepare properly** for each telehealth visit so you can be positioned to deliver **quality care** to your patients

• Requirements for **store and forward** applications include use of high-quality appropriately evaluated technology (e.g., digital camera, peripheral devices) & image/data acquisition **protocols** (e.g., proper views/angles and number of images for given conditions)

• **Real time** encounters require not only technology considerations but also “webservice manner” skills

• All telemedicine encounters require **clear communication skills**, both written and oral
**TELEHEALTH ENCOUNTERS**

- All Telehealth encounter can be organized into three parts:
  - **Pre visit**
    - Technical setup
    - Encounter preparation (including consent if required)
  - **Visit**
    - Introduction
    - Conducting the visit
    - Ending the visit
  - **Post visit**
    - Documentation
    - Follow-up with providers & patient as necessary
    - Billing
Pre-Visit
**PRE VISIT - TECHNICAL SETUP (REAL TIME)**

**Camera**
- Placement should be above subject
- Position camera to estimate gaze and make it appear that subject is looking at the person on the other end while looking forward at the monitor

**Microphone and Speakers**
- Make sure device is powered
- Test microphone
- Test speakers
PRE VISIT - ENCOUNTER PREPARATION

- Ensure location is **quiet, private, and professional**
- Providers (and if possible patients) should be located in front of a **neutral background** for maximum visibility
  - Provider should wear colors that are camera friendly (**light blue** is ideal; do not wear white lab coats, bright/multi-colored patterns)
- Do not sit in front of a light source to prevent backlighting - **indirect light** is preferred
- Have access to patient’s **Electronic Medical Record** readily available
- **Review** any patient information pertinent to the visit
The use of telemedicine provides flexibility for how and when we treat patients, but it also removes the built-in privacy protections that a private exam room offers. While we should always be vigilant in maintaining patient privacy, it is even more important to focus on privacy during a telemedicine visit.

**Provider Responsibilities**

- Conduct the visit in a professional and private location
- **DO NOT** conduct visits in shared spaces
- If at home:
  - **DO NOT** have family members around
  - Be in a room with a door that is closed
  - Use headphones if others are within earshot
  - Use a virtual background if possible
  - If you cannot meet these responsibilities, then discuss space alternatives with your administrator
- Configure waiting room to catch ALL participants (see guide on SharePoint)
- Use Emory approved HIPAA compliant platforms.
Visit
INTRODUCTION

• Introduce yourself
  – Share your specialty
  – Share where you are located
    • Include that you are the only one who can see and hear them and that they are not being recorded
  – Summarize the conditions & limitations of telemedicine
  – Note possible need to end encounter & refer to in-person if necessary (e.g., emergency room)
  – Explain back-up plans in case the connection is lost
  – Ask patient to indicate if anyone else is in the room with them
• Share appropriate contact info in case your visit gets disconnected
• Instruct patient to call 911 if they are experiencing a medical emergency
• Follow standard documentation/protocols to ensure these items are addressed at the beginning of the visit
CONDUCTING THE VISIT

• **Conduct your assessment**
  – Follow the guidance for a telehealth exam that is specific to your specialty
  – Important to take a thorough history
  – Observing the patient and their surroundings are vital during a telehealth visit

• **Tell a patient** if you need to divert attention away from the patient, look **off-screen** (at the EMR), or excuse yourself from the camera view

• **Documentation** should always follow the requirements for the specialty and appointment type

• Include in documentation the **modality** (e.g., real time, asynchronous, etc.) in which the patient was seen
Some limitations of a telehealth video visit can include:

• Cannot lay hands on or get other relevant information (e.g., smell liquor) about the patient for a physical exam (although with qualified adjunct at patient end information can be relayed)
• May not be able to perform certain diagnostic exams that require patient movement that is potentially out of camera range (e.g., gait, range of motion)
• May not be able to perform labs (e.g., swab for a strep test)
• Video and audio quality may vary depending on devices, equipment & internet service (bandwidth) used
• Limited diagnostic capabilities depending on peripherals (e.g., electronic stethoscope) available on patient end
TELEMEDICINE EXAMINATION

• Emory clinicians have developed appropriate ways to examine patients via telemedicine
• This can be found on the EHC Telehealth website under Operations: (https://emory.sharepoint.com/sites/EHCTelehealth/SitePages/Telemedicine-Visit.aspx?csf=1&web=1&e=8auQC0)
TELEMEDICINE EXAMINATION BY VIDEO:
LIST OF EXAM COMPONENTS THAT CAN BE DONE BY DIRECT VISUAL INSPECTION

- **Vital signs**: Any vital sign obtained on the patient would need to be accurately measured. For the note, one could document:
  - Patient reported temperature:
  - Patient reported weight:
  - Patient reported Height:
  - Patient reported pulse:
  - Respiratory rate:
  - Heart rate (smart watch):

- The clinician should use their judgement in whether or not to factor these into clinical decision making

- **General appearance** of the patient, mental status, level of distress, speech pattern, pain level, etc
TELEMEDICINE EXAMINATION BY VIDEO:
LIST OF EXAM COMPONENTS THAT CAN BE DONE BY DIRECT VISUAL INSPECTION

- **Eyes**: Conjunctiva, Pupil equality (difficult to test direct and consensual reactivity without direct light); Extraocular muscles; Asymmetry; Lid ptosis; Proptosis, exophthalmos; scleral show, ectropion, entropion
- **ENT**: oral mucosa, pharyngeal erythema, facial lesions, bruising, abrasions, hearing
- **Neck**: Obvious thyromegaly or mass; range of motion; tenderness (patient’s own palpation)
- **Lungs**: labored or non-labored respiration, symmetrical expansion
- **Cardiovascular**: JVD at 90 degrees; Edema (have patient gently press on lower legs to see if pitting present or not); smart watch heart rate or ECG strip; reproduce maneuvers for heart failure including orthopnea (shortness of breath on laying down) or bendopnea (shortness of breath when bending over)
- **Abdominal**: Self administered rebound tenderness; Distension, visible herniation
- **Musculoskeletal**: edema, bruising, range of motion, complex motor functions for strength
- **Feet**: assessment of nails, sensation (self directed with pin / paperclip), direct observation for lesions
- **Breast**: Symmetry, nipple position, nipple inversion, swelling, induration
- **Cutaneous**: Skin color, turgor (patient can pinch), presence of lesions/rash, ecchymosis, erythema, appearance of surgical wounds (incisions, sutures/staples), superficial necrosis, swelling, capillary refill (self-administered), nail beds
TELEMEDICINE EXAMINATION BY VIDEO:
LIST OF EXAM COMPONENTS THAT CAN BE DONE BY DIRECT VISUAL INSPECTION

• **Screening Neuro exam:**
  - Cranial nerves: pupils equal; EOM's intact; face has equal sensation to patient touch; face shows equal motor function; patient notes hearing equal in both ears; patient can perform lingual (la la), labial (ba ba) and guttural (ka ka) sounds normally; tongue is midline, fasciculation assessment
  - Assess symmetry appearing motor strength (can have patient lift heavy items, squat on one or both legs, do push-up, walk on heels and toes, or do complex motor tasks
  - Assess drift, no tremor
  - Fine finger movements assessment for dysmetria, or hand assessment for dysmetria
  - Sensory assessment with light touch (symmetry) or pin/paperclip
  - Romberg assessment
  - Gait and station, including tandem gait
  - Finger to nose possible (have patient touch their nose then touch the camera)

• **Psych:** full mental status examination
COMMON CONDITIONS AMENABLE TO TELEMEDICINE

Common Diagnoses capable of being made via telehealth include, but not limited to:
- Sinusitis, URI, cough, sore throat
- Conjunctivitis
- UTI, cystitis and painful urination
- Cellulitis
- Rashes/abrasions/lacerations
- Insect or animal bites
- Sprains/strains

Other common conditions:
- Behavioral health
- Chronic conditions and follow up
- Medication questions
ENDING THE VISIT

• **Recap** the visit and provide **follow-up** instructions
  – Verify the patient’s pharmacy to route the prescription
  – Review treatment plan
  – Discuss follow-up plan
  – Educate if necessary
• Invite the patient to end the visit first to ensure they are finished talking
• Complete Documentation
Post Visit
POST VISIT - CODING

• Patient Financial Services (PFS) has enacted several changes to streamline the coding process for providers and ensure that charges are coded according to each payors specifications.
  – Document the modality of telemedicine that was used for the appointment (audio-only telephone, A/V synchronous interaction, etc.)
  – Use the CPT codes corresponding to the services that were performed and add the 95 modifier
  – For hospital based clinics, make sure to use the version of the CPT code that doesn't include a facility fee.
• Your coding education team will be consulted when setting up a new telehealth offering
POST VISIT - CODING

• Billing for routine E/M visits requires only the addition of a “95-modifier” to the appropriate CPT code, which can be done in the electronic medical record.

• Billing for telephone visits requires documenting time and use of the following CPT codes:
  – 99441: telephonic visit 5-10 minutes
  – 99442: telephonic visit 11-20 minutes
  – 99443: telephonic visit 21 minutes or more
POST VISIT DOCUMENTATION (DURING COVID-19)

• All telemedicine encounters must include special documentation in the visit note. The primary aspects that must be recorded are:
  – A/V or audio-only connection was used for the visit
  – The location of the patient on the day of service
  – Verbal consent received from the patient
  – Visit occurred during COVID-19 pandemic
POST VISIT DOCUMENTATION EXAMPLE (DURING COVID-19)

• Below is a recommended template to use. Documentation should take place in your typical E/M note. (DO NOT USE A TEL NOTE)

This is a telehealth visit that was performed with the originating site at PATIENT LOCATION and the distant site at Emory Healthcare, Atlanta, GA [Might need to edit based on your location]. Verbal consent to participate in video visit was obtained. This particular visit occurred during the 2020 COVID19 outbreak. I discussed with the patient the nature of our telehealth visits, that:

1. I would evaluate the patient and recommend diagnostics and treatments based on my assessment
2. Our sessions are not being recorded and that personal health information is protected
3. Our team would provide follow up care in person if/when the patient needs