25 YEARS
1995-2020

AAWC®

Association for the Advancement of Wound Care®

The AAWC is the preeminent multidisciplinary membership society whose mission is to promote excellence in education, clinical practice, public policy and research focused on the care of patients with and at-risk for wounds.

Contact us:
info@aawconline.org
www.aawconline.org

The webinar will begin in a few moments…

- During the webinar comments or questions are appreciated
  - Type your question into the Q & A box
  - I will share the question or comment with the other attendees
- A short evaluation will appear on your screen when we finish
  - Please fill it out as we value your input and insight
- If you have recommendations or suggestions, please email info@aawconline.org

Best Practices in Telemedicine- Wound Care

Kara S. Couch MS, CRNP, CWCN-AP
Secretary, AAWC

Elaine H. Song MD, PhD, MBA
Co-Chair, Website Committee, AAWC

March 31, 2020

Objectives:

Review the new CMS policy changes related to telemedicine and wound care
Discuss how to conduct a thorough virtual visit
Share templates for triaging patients and documenting a telemedicine visit.

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All information regarding regulatory guidance is subject to change during this fluid situation.

Please note the date that the information was accessed under each hyperlink.

Regulatory Issues

ALLIANCE OF WOUND CARE STAKEHOLDERS
POWER THROUGH COLLECTIVE ADVOCACY

Statement from the Alliance of Wound Care Stakeholders (March 20, 2020)

Wound Care is an Essential – Not Elective – Service that Prevents Hospital Admissions and ED Visits Among a Fragile Cohort of Patients at High-Risk of COVID-19

The rapidly evolving COVID-19 pandemic in the United States has hospitals and acute care facilities changing standard operating procedures to prepare for the expected influx of infected patients. As a result, services, procedures, and surgeries that are deemed "non-essential" are being shut down immediately, without thorough consideration of the ramifications.

Hospital outpatient-based wound care departments have been placed in the non-essential group by many hospitals. The Alliance of Wound Care Stakeholders is concerned that this decision will result in ***unintended negative consequences*** that will cause a gradual influx of patients to the emergency department (ED). Nonhealing wounds, left untreated and unmanaged, can result in significant medical issues including infection, sepsis, the need for limb amputation, and even death. As a result, many procedures provided by wound clinics are **essential** – *not elective* – to protect the health of patients and prevent an escalation of their disease.

Individuals with chronic wounds (diabetic foot ulcers, pressure ulcers, venous ulcers, arterial ulcers, etc.) commonly have other chronic conditions – typically type 2 diabetes, hypertension, venous insufficiency, peripheral arterial disease, and/or chronic kidney disease. This cohort of fragile patients is high risk if they develop COVID-19, but are also high risk for increased morbidity and mortality – loss of limb or life - if their access to wound care is abruptly discontinued.

Address the COVID-19 pandemic while avoiding unintended consequences for wound patients:

Across the country, wound care providers are working to ensure that the health of our patients is protected during the COVID-19 crisis. We are adopting aggressive infection control and social distancing precautionary measures at our sites and with our staff. While wound care providers are working to limit clinic visits and move as many patients as practical to telehealth, office visits or home health follow-up where appropriate, wound clinics must be able to provide those urgently needed wound care procedures that are infection-sparing, limb-saving and life-saving. These procedures are essential, not "elective," and ultimately will reduce wound patients' potential for needing other hospital services such as operative intervention or amputation, which require prolonged hospitalization.

Our position is at this time:

Leave clinics open to manage complex wounds in clinically complex medical patients who are at risk for limb loss, hospital admission, amputation or infections. Hospital administrations should take into consideration input from providers when making these decisions, and deploy appropriate triage criteria when reducing essential clincal services. Enabling continuity of care for these wound patients will improve outcomes while unburdening emergency departments, operating rooms, hospital staff and hospital beds for the COVID-19 crisis. Keeping these patients out of the ED and out of hospital beds can in turn limit exposures and curb COVID-19 infection among this fragile population.

The Alliance has created a task force to help wound clinics and health systems address the evolving realities of the COVID-19 pandemic while avoiding unintended consequences for wound patients. Recommendations will be circulated shortly and can be obtained directly by contacting the Alliance.

The Alliance of Wound Care Stakeholders is a nonprofit multidisciplinary trade association of physician specialty societies and clinical and patient associations, whose mission is to promote evidence-based quality care and access to products and services for people with chronic wounds through advocacy and educational outreach in the regulatory, legislative and public arenas. Contact: marcia@woundcarestakeholders.org, 301.530.7846, www.woundcarestakeholders.org

https://www.woundcarestakeholders.org/advocacy/submitted-comments/alliance-position-statement-covid-19-unintended-consequences
Accessed online 3/29/20

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Accessed online: 3/29/20

New Regulations- 3/30/20

- Nurse Practitioners are now allowed to certify/re-certify home health services.- CARES Act (effective 3/28/20)
- Allow simultaneous visits for telehealth and home health on same day (NAHC)
  - CMS will allow the home health agency to visit for the wound care if it is on the HH POC. If the physician wants to conduct a visit as well, CMS did not have a problem with that as long as the HH personnel are not acting as auxiliary staff to the wound clinic. To be clear the simultaneous "visit" can only occur if the patient is a HH patient and the wound is part of the HH POC.

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
Accessed online 3/31/20

Homebound Status- 3/30/20

•Homebound Definition: A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19. As a result, if a beneficiary is homebound due to COVID-19 and needs skilled services, an HHA can provide those services under the Medicare Home Health benefit.

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
Accessed online 3/31/20

DMEPOS

- CMS is waiving signature and proof of delivery requirements for Part B drugs and Durable Medical Equipment when a signature cannot be obtained because of the inability to collect signatures. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19.
- Where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, DME Medicare Administrative Contractors have the flexibility to waive replacements requirements under Medicare such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency
- Prior Authorization in DMEPOS: CMS is pausing the national Medicare Prior Authorization program for certain DMEPOS items.

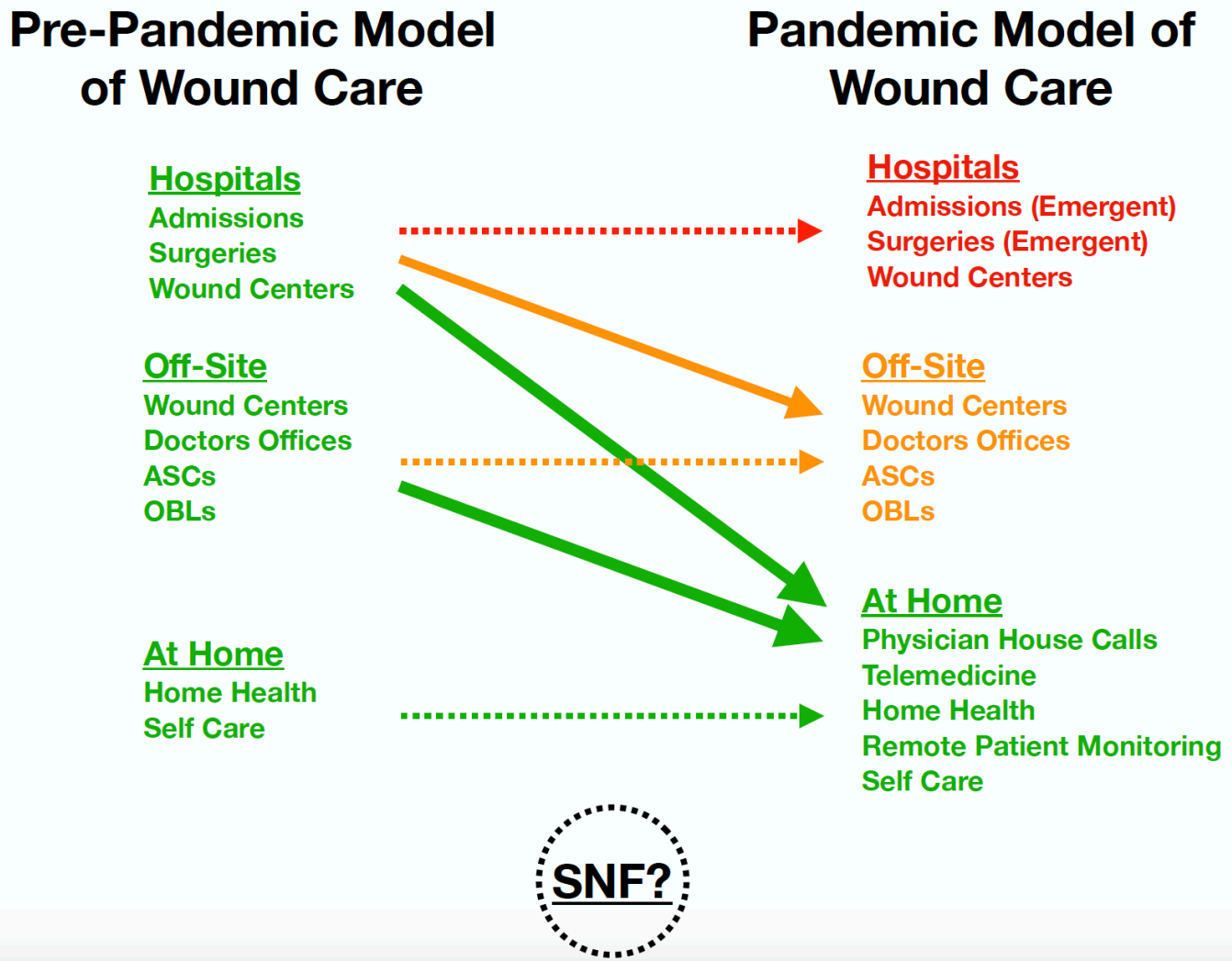
https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
Accessed online 3/31/20

Physician Services- 3/30/20

- CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.
- Direct physician supervision is no longer required for non-surgical extended duration therapeutic services provided in hospital outpatient departments and critical access hospitals. Instead, a physician can provide a general level of supervision for these services so that a physician is no longer required to be immediately available in the office suite
- To the extent that a National Coverage Determination (NCD) or Local Coverage Determination (LCD) would otherwise require a face-to-face visit for evaluations and assessments, clinicians would not have to meet those requirements during the public health emergency.

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
Accessed online 3/31/20

SETTING & UTILIZATION SHIFT



Credit: Lee C. Rogers DPM

SHIFT IN STANDARDS OF CARE

Pre-Pandemic Model of Wound Care

Healing At All Costs

Evaluation
- Face-to-Face Specialist(s) Evaluation
- Infection Assessment/Labs/Imaging
- Vascular Assessment/Studies
- Diabetes/Nutrition/Biopsy

Procedures
- Regular Surgical/Sharp Debridement
- Invasive Vascular Diagnostics
- Revascularization for most impairments
- Surgical resection of infection
- Surgical closure of wounds
- Surgical offloading
- CTPs

Treatments
- Total contact casts
- NPWT
- Offloading devices
- Compression dressings/pumps
- Advanced Surgical Dressings
- Rx treatments

Follow Up
- Weekly or every 2 weeks

Pandemic Model of Wound Care

Prevention of Hospitalization/ Reduced Utilization (Management of Wounds)

Triage
Determine which patients need to be seen in which setting and when to escalate

Evaluation
- Face-to-Face Doctor's Office, In Home, Telemedicine
- Infection Assessment (<Labs/<Imaging)
- Vascular Assessment (<Studies)

Procedures
- Change of site of service
- Reduction in procedures (and fewer definitive)
- Infections treated as an outpatient
- Greater tolerance for ischemia
- Greater tolerance for ischemia

Treatments
- Change of site of service
- Greater tolerance for longer healing times
- Greater emphasis on:
  - Advanced Surgical Dressings
  - Home health care
  - Alternative methods of debridement

Follow Up
- Based on Triage

Credit: Lee C. Rogers DPM

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Patient Triage

	Conditions	Site of Care	Urgency
Critical (0.25% of patients with diabetes)	- IDSA Severe and some Moderate infections - Gas gangrene - SIRS/Sepsis - Acute limb-threatening ischemia	Hospital	Priority 1 *Urgent*
Serious (0.75% of patients with diabetes)	- IDSA Mild and some Moderate infections (including osteomyelitis) - Chronic limb-threatening ischemia (CLTI) - Dry gangrene - Worsening foot ulcers - Active Charcot foot	Outpatient Clinic Office-based Lab Surgery Center Podiatrist Office	Priority 2
Guarded (3% of patients with diabetes)	- Improving foot ulcer - Inactive Charcot foot (not yet in stable footwear)	Podiatrist Office Home Telemedicine	Priority 3
Stable (94% of patients with diabetes)	- Uncomplicated venous leg ulcer - Recently healed foot ulcer - Inactive Charcot foot (in stable footwear) - Healed amputation - Diabetic foot risk assessments	Home Telemedicine	Priority 4

Lee C. Rogers,Lawrence A. Lavery,Warren S. Joseph,David G. Armstrong, (2020) All Feet On Deck—The Role of Podiatry During the COVID-19 Pandemic: *Preventing hospitalizations in an overburdened healthcare system, reducing amputation and death in people with diabetes*. Journal of the American Podiatric Medical Association In-Press.

Level 1-			
Infection			
Postop patients			
Level 2-			
Higher risk if we don't see them as normal			
Level 3-			
Stable			
Can be pushed out 3-4 weeks safely			
Has good home care options/home health			

GW Wound Healing and Limb Preservation Center Triage Model: Created 3/18/20

High Risk Patients

Patients who must be seen

- Patients who are at high risk for infection
- Patients who have necrotic tissue and are actively undergoing serial debridement
- Patients who do not have reliable wound care at home- socioeconomic issues
- Postop patients
- Patients being treated with CTP/TCC/NPWT
- Patients in compression with high drainage
  - Patients in compression with low drainage and stable wraps may consider extending visits to every 2 weeks

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Telemedicine Coding/Coverage Guidelines

Consider your payer mix

- Info on Medicare/Medicaid coding and payment to follow
- Do not assume private payers are the same
- AMA website has updates:

https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice

Accessed online 3/29/20

Summary of Medicare Telemedicine Services

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
Accessed online 3/29/20

Type of Service	Description	HCPCS/ E&M Codes	Relationship with Provider
Medicare Telehealth Visit	Visit between a provider and a patient using a telecommunication system	99201-5 99211-5	New or Established Patients
Virtual Check-In	Brief (5-10 minute) check-in with the provider by telephone or other telecommunications device to decide if an office visit is needed. Or an evaluation of recorded video or images from a patient	G2012 G2010	Established Patient
E-Visit	Communication between a patient and provider through an online patient portal	99421-3 G2061-3	Established Patient
Remote Patient Monitoring	Remote monitoring of a physiologic parameter (i.e. foot skin temperature)	99453-4,7	Established Patient

Lee C. Rogers,Lawrence A. Lavery,Warren S. Joseph,David G. Armstrong, (2020) All Feet On Deck—The Role of Podiatry During the COVID-19 Pandemic: *Preventing hospitalizations in an overburdened healthcare system, reducing amputation and death in people with diabetes*. Journal of the American Podiatric Medical Association In-Press.

General Provider Telehealth and Telemedicine Tool Kit

Table of Contents

https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf
Accessed online 3/29/20

https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf
Accessed online: 3/29/20

Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth

This document is intended to assist states in understanding policy options for paying Medicaid providers that use telehealth technology to deliver services. The overview and sample state plan language apply to Medicaid fee-for-service payments and additional considerations may be warranted for states interested in offering telehealth within other delivery systems. CMS encourages states to consider telehealth options as a flexibility in combating the COVID-19 pandemic and increasing access to care.

1. Use CPT 99202-99215 for Medicare Part B and Medicare Advantage patients when these services are provided remotely as long as the Public Health Emergency lasts. Some private payers have made the same allowance. Check private payer policies for details.

On March 17, CMS announced that providers can submit CPT 99201–99215 when providing these services remotely. The provider can be in any location and the patient can be in any location. Since that announcement, some private payers have followed suit.

- Must use a communication tool that has interactive audio and video
- Communication tool must allow real time communication
- Providers are permitted to reduce or waive cost-sharing for these services if they wish
- Typical HIPAA guidance does not apply to these services as long as providers are providing these services in good faith
- No modifiers needed
- Use Place of Service "02"
- These will be paid at facility rate
- This waiver is in place as long as the Public Health Emergency lasts
- Postoperative global periods apply
- Document a progress note just like one would do when this service is provided face-to-face. This interaction is an E/M service and the same documentation requirements apply. The level is selected based on the 1995 or 1997 CMS guidelines for Evaluation and Management services.

https://www.apma.org/emremote Accessed online 3/29/20

2. Use G2012 when a virtual check-in is provided to a Medicare Part B or Medicare Advantage patient using telephone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission.

- G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health-care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
- Can be any type of telecommunication tool, including telephone
- CANNOT relate to any service in the last seven days
- CANNOT result in patient coming in within the next 24 hours or soonest available appointment
- Can only be used for established patients.

New 3/31/20- can be used for NEW Patients

- No modifiers needed

https://www.apma.org/emremote Accessed online 3/29/20

3. Telephone E/M

- This interaction is an E/M service and documentation must support an E/M just like any other E/M type. Must have history, as much of an evaluation as possible, and some form of medical management
- Explained in the first half of this webinar
- Must be an established patient
- Must be initiated by established patient or the patient's guardian
- Provider may educate patients about this option
- Not reimbursed by Medicare and some other payers
- CANNOT report if call results in decision to see patient within 24 hours or next available urgent appointment
- CANNOT report if call refers to E/M service performed by same provider within previous seven days
- CANNOT report if call refers to a problem for which a patient is in a global period
- CANNOT report if provider performed a Telephone E/M or Online Digital E/M for same patient for same problem in the last seven days
- CANNOT report if the call is part of Home Care Oversight Services, Care Plan Oversight Services, Home/Outpatient INR Monitoring, ~~Complex Care Management Services, or Transitional Care Management Services~~
  - **CPT 99441: Telephone evaluation and management service by a physician or other qualified health-care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion**
  - **CPT 99442: ; 11–20 minutes of medical discussion**
  - **CPT 99443: ; 21–30 minutes of medical discussion**

https://www.apma.org/emremote Accessed online 3/29/20

4. Online Digital E/M Services

- This interaction is an E/M service and documentation must support an E/M just like any other E/M type. Must have history, as much of an evaluation as possible, and some form of medical management
- Explained in the second half of this webinar (starting at 9:50)
- Examples of "Digital" platforms:
  - HIPAA-compliant EHR
  - HIPAA-compliant email
  - HIPAA-compliant text
  - Other HIPAA-compliant two-way digital communication
- Must be an established patient
- Must be initiated by established patient via a digital platform
- Provider may educate patients about this option
- Not reimbursed by Medicare and some other payers

https://www.apma.org/emremote Accessed online 3/29/20

- CANNOT report if service refers to a problem for which a patient is in a global period
- CANNOT report if service is initiated within seven days of any E/M for same problem.
- CANNOT report if performed on same day as in-person E/M service
- CANNOT report if service is part of Home Care Oversight Services, Care Plan Oversight Services, Home/Outpatient INR Monitoring, Complex Care Management Services, or Transitional Care Management Services
- Time spent is cumulative time over seven days starting with review of the request
- Can only report once per seven day period
- Time includes:
  - Review of inquiry
  - Review of patient records
  - Interaction with other staff
  - Development of management plan
  - Rx
  - Ordering tests
  - Communication with patient
- Add time if multiple providers in same practice perform this service for same patient over same seven day period
- If within **seven**days of the initiation of an online digital E/M service, a separately reported E/M visit occurs, then the provider work devoted to the online digital E/M service is incorporated into the separately reported E/M visit
- **CPT 99421: Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes**
- **CPT 99422: ; 11–20 minutes**
- **CPT 99423: ; 21 or more minutes**

https://www.apma.org/emremote Accessed online 3/29/20

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Documentation Templates

Consideration of telemedicine visits

- Do you have a Business Associate Agreement?
- Do you have a way to document patient consent for telehealth visit? This must be obtained at each encounter.
- How are you integrating to your EHR?
- Are you HIPPA compliant?
- What can you do if you patients can't telemed?
- Environment for the visit (i.e. what's behind you?), Be dressed professionally

Pearls

- Plan to document in your current EHR as much as possible
- Obtain consent from the patient for a telehealth visit and document in the medical record. Label visit as **TELEHEALTH During COVID19 National Emergency** at the top of your note
- Work out how patients can send images/videos securely
- The patient should have an object of reference to be placed close to the wound (i.e. a quarter)
- Ensure the patient has good lighting
- Test audio/video at the beginning of each visit
- Check your liability insurance to ensure telemedicine is covered

Housekeeping Details

- ID yourself and purpose of the call to check on the patient and their wound. Will take approx. 5 minutes with RN/admin, then provider. Explain about basic telemedicine and future appointments scripting.
- Obtain verbal consent for the encounter and document it in the note.
- Do they have access to a smartphone?

  If so, what is the number? (patient must provide)
- Do you have a back-up phone number or secondary contact if we cannot reach you?

  If no smartphone do they have access to a computer with internet + camera
- What is the email address? (patient must provide)

Questions for Telephone Visit--General

First, ask the basics (and screen for COVID19):
-How are they feeling?
-Any signs/symptoms of resp illness or GI illness?
-Fevers/chills?
How are your blood sugars running?
-Any new or increased pain?
-What's new since we last spoke?
-Any changes in medications?
-Have you had a telemedicine visit with your PCP?

Questions for Telephone Visit- Wound Focused

-Who is doing their wound care and how often

-Do you have supplies? Were they delivered? What do you have?

-Can the patient visualize the wound – If not is there someone there who can assist them (family, aide, HHRN), Do they have a mirror?

How is wound doing:

Is there drainage, how much, has it increased or decreased? What color is the drainage? is there an odor or smell?

Is there redness or swelling?

-Is there undermining or tunneling? (Patients may not understand this)

-Is it firm around the wound?

-What colors are in the wound bed (i.e. red/yellow/black), what are the percentages?

-New areas of wound since we last spoke?

Questions for Telephone Visit- Plan

- Create wound care plan with dressings that last longer than 1 day (consider AWD that have debridement properties)

– Send wound care instructions to patient email vs PDF and scan.

- Consider giving instructions for a “rescue dressing” (provider)

- Consider emailing the dakins/acetic acid recipe and teaching videos

- If you need additional dressing supplies, DO NOT GO TO AN URGENT CARE OR ED. Contact the office immediately for further instructions.

- You may require an in person evaluation. This will be discussed and determined during the telemedicine appointment.

- You will receive a call back to schedule your next appointment in clinic or telemedicine.
- Give Instructions on when to come to the ED/Clinic

Options for Telemed Visits (audio and video)

- FaceTime
- Zoom
- Doxy.Me
- Skype
- Messenger
- Google Hangout
- Wound Reference

- NOT ALLOWED: Tiktok, FaceBook Live, twitch (nothing front facing)

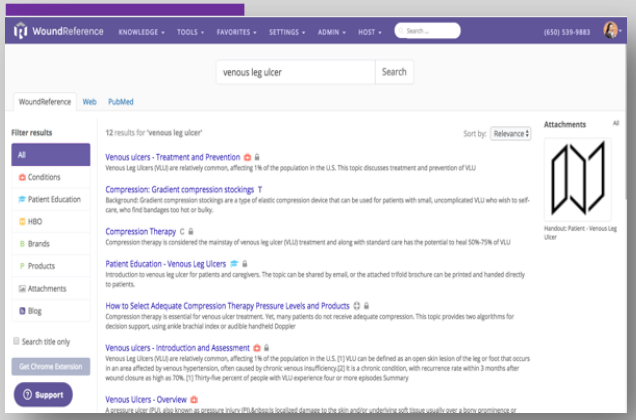
Wound Reference TeleHealth Tool

Elaine Song MD, PhD, MBA

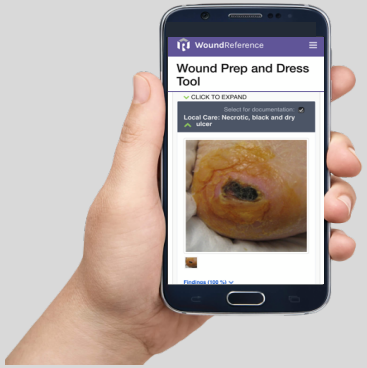
What is WoundReference?

WoundReference is a clinical decision support and telemedicine platform for wound care and hyperbaric clinicians at the point-of-care

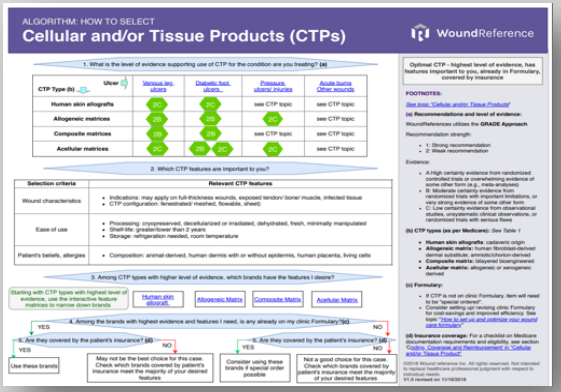
In addition to several resources, WoundReference includes a HIPAA compliant telemedicine tool



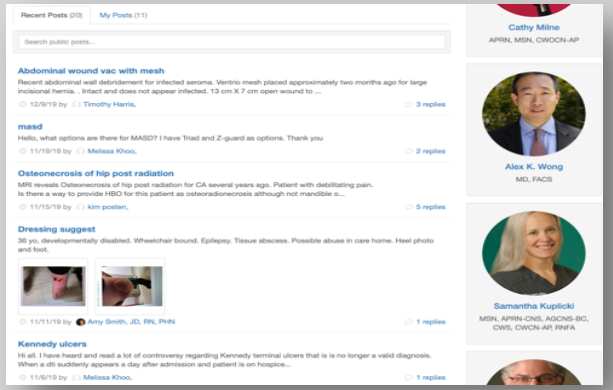
MY Power Search



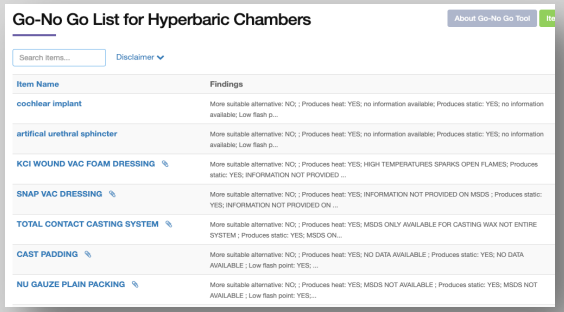
Prep and Dress Tool



Wound Care and HBOT Knowledge Base (CME/CE)



Curbside Consult



HBOT Risk Assessment Tool (Go No-go)

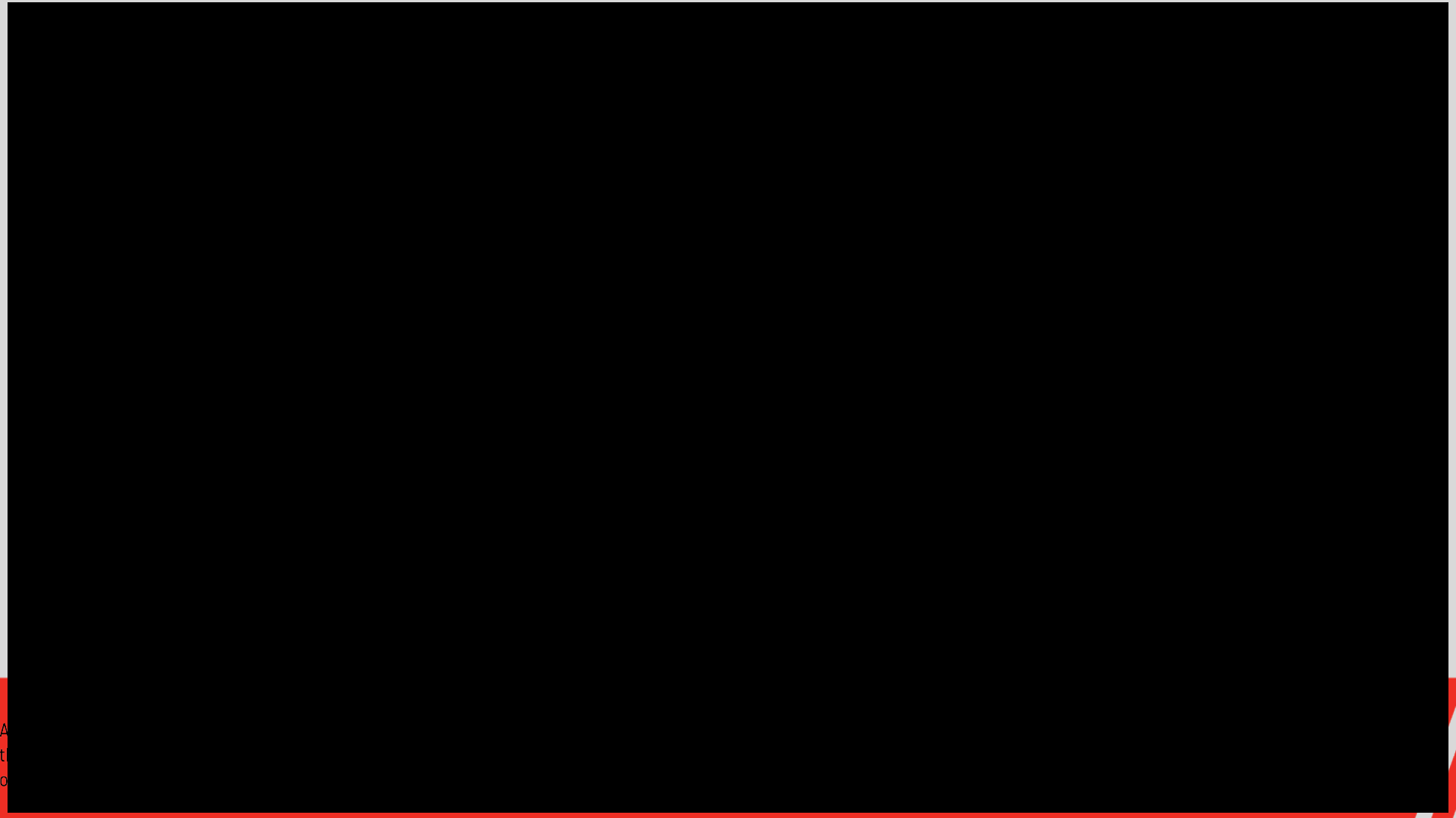
TeleVisit Tool

AAWC® Association for the Advancement of Wound Care

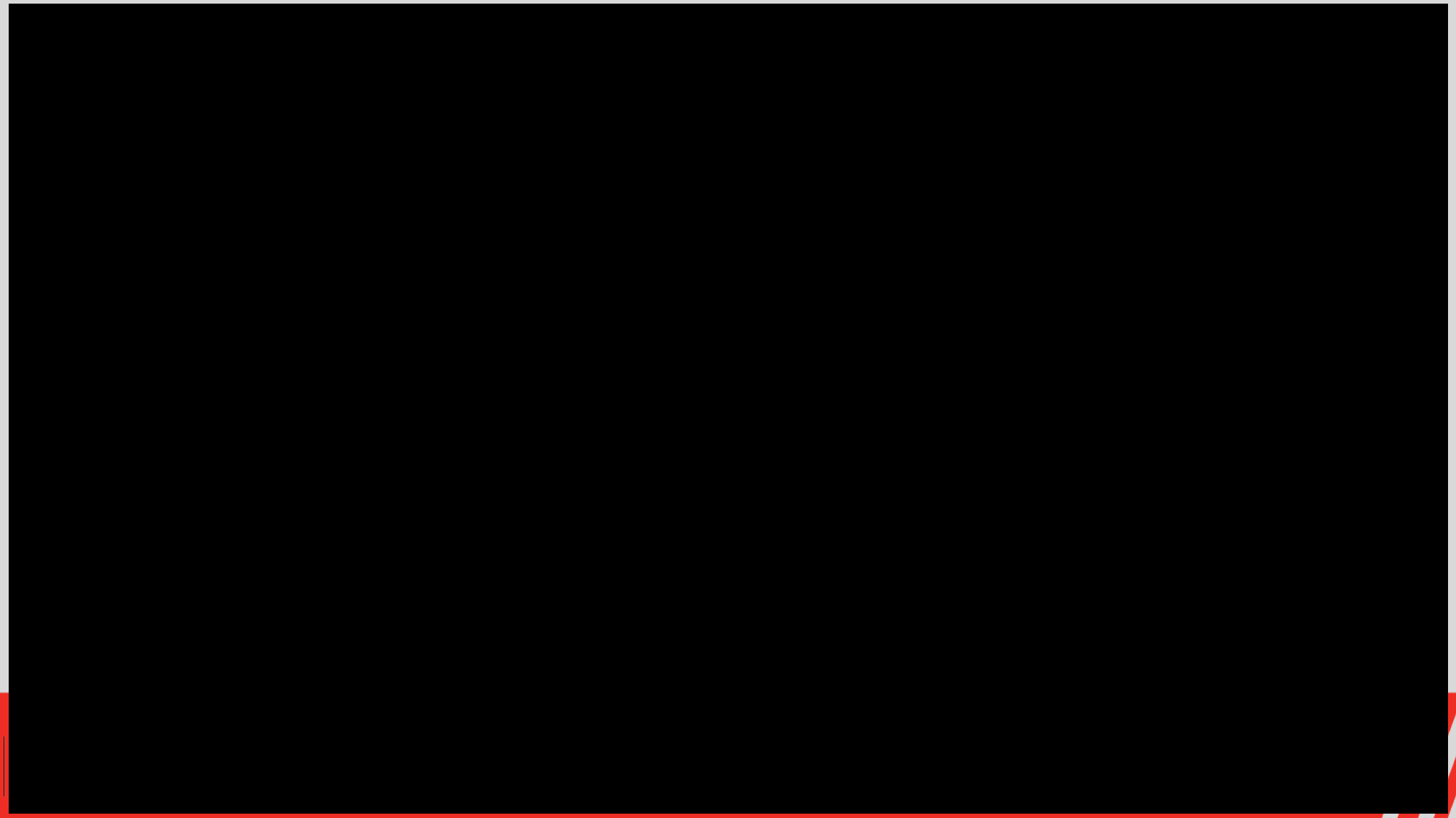
What are ideal characteristics of a telemedicine app?

- ✓ HIPAA compliant
- ✓ Audio and video (real-time communication)
- ✓ No downloads needed
- ✓ Patients do not need an account
- ✓ Works on desktops, tablets and mobile
- ✓ Audit trail, documentation templates to meet CMS telemedicine CPT requirements (Premium Edition)

WoundReference Offers Free Use of the TeleVisit Tool Video Chat Edition



WoundReference Free TeleVisit Tool Video Chat Edition



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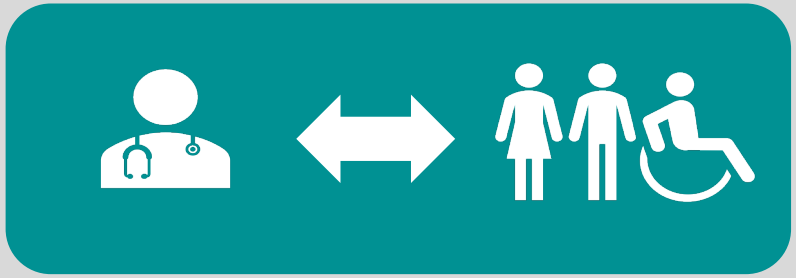
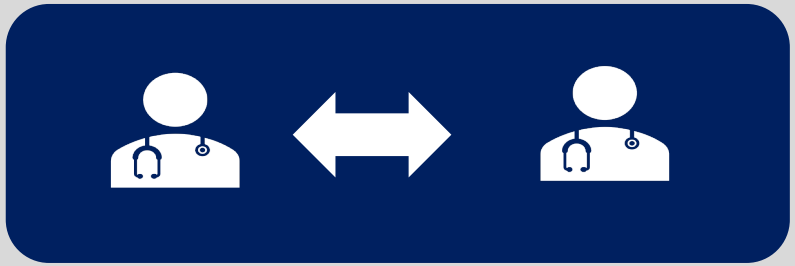
How can clinicians utilize telemedicine in wound care?

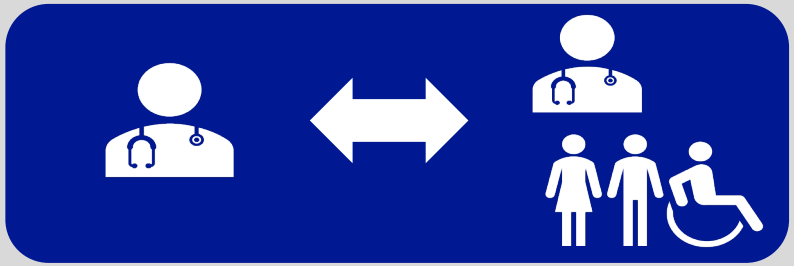
Provider to Patient



Provider to Provider



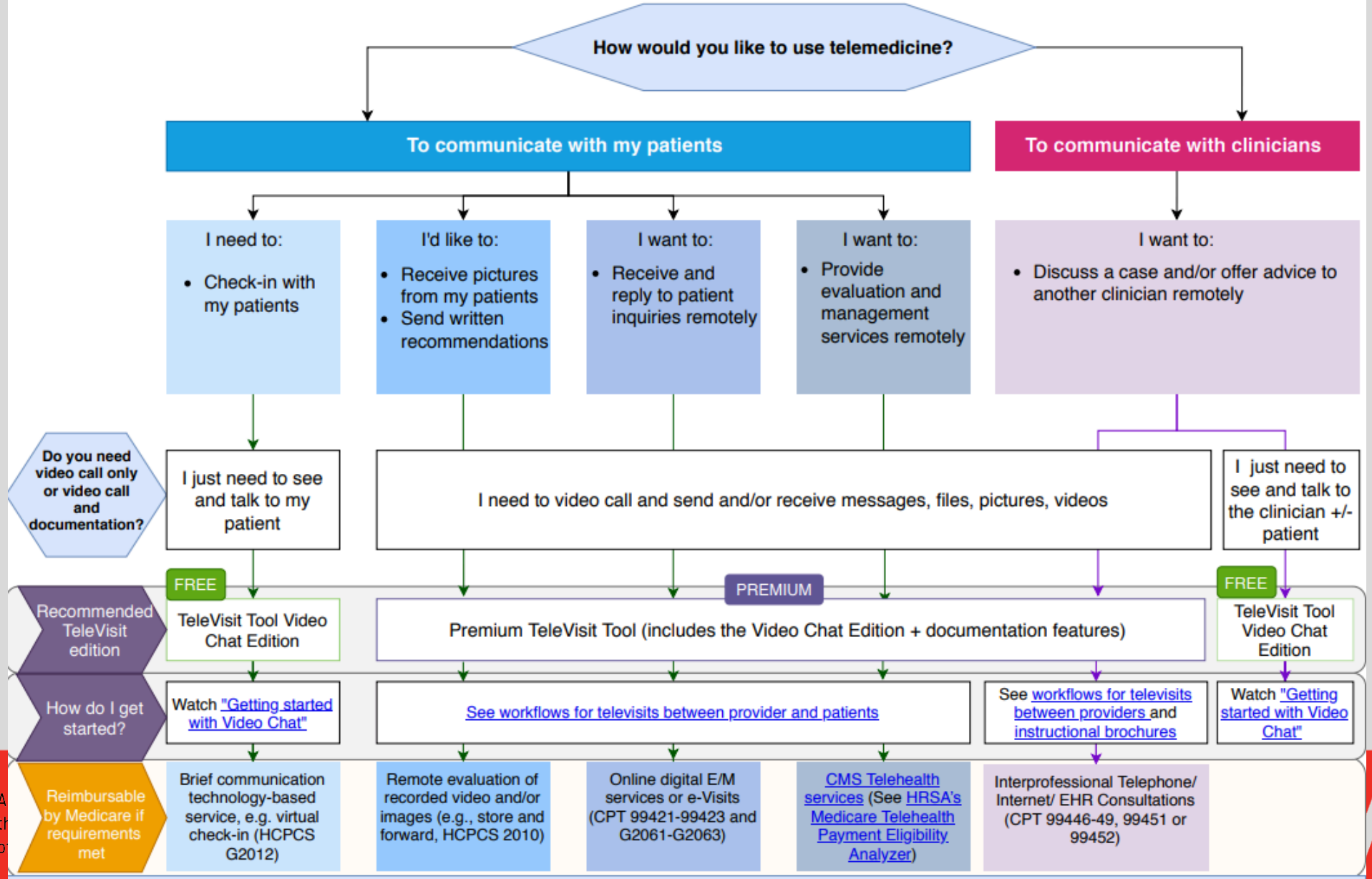
Provider to Provider + Patient



ALGORITHM:

The Wound Telemedicine Wizard

WoundReference



See topic "Reimbursement for Telemedicine Services in Wound Care"

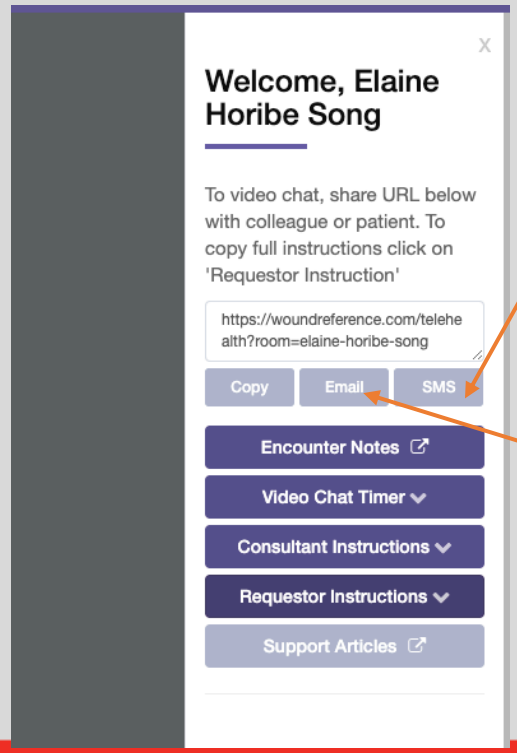
Demo: Patient to provider telemedicine encounter

How can I provide telemedicine services to my patients? (includes documentation – Premium Edition)

6 STEPS

Step 1. Schedule a televisit appointment

1. Patient requests televisit appointment
2. Office/clinician sends the patient a link to the clinician's private virtual room via email or text message (SMS)

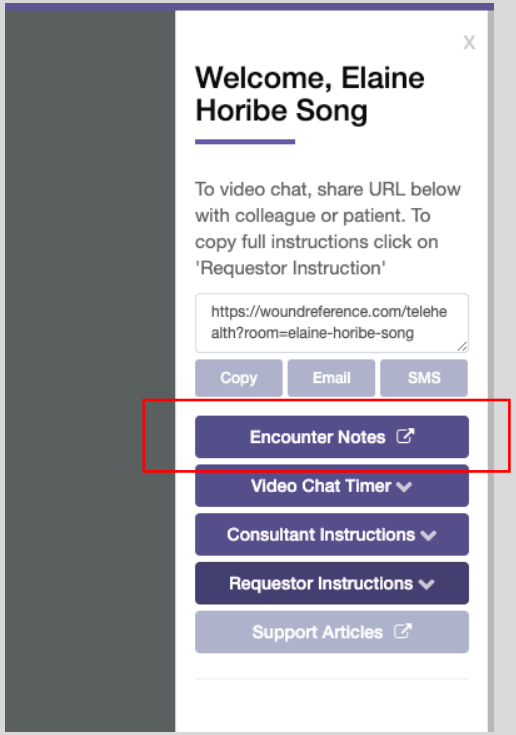


Click to send link to private room via SMS

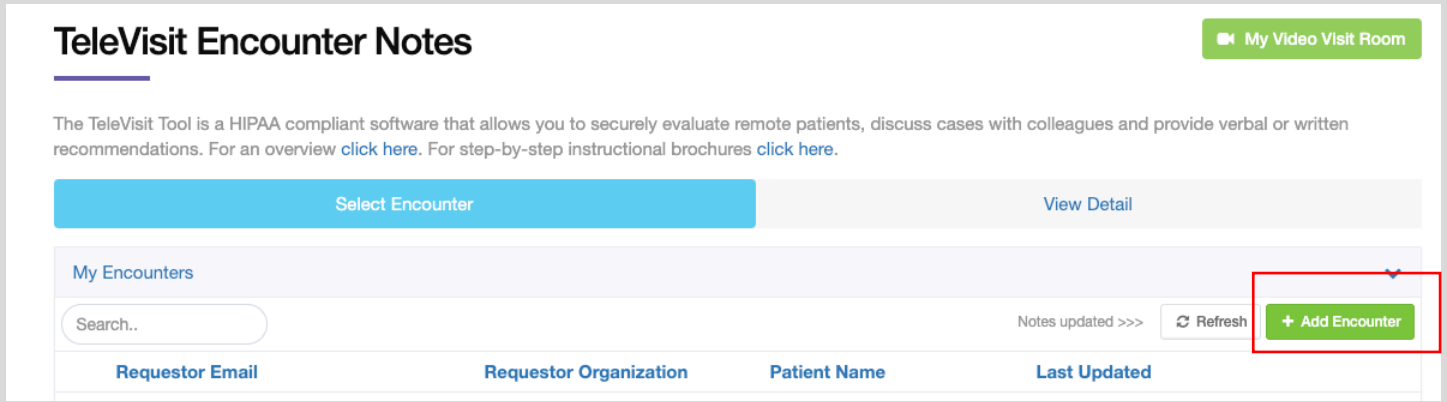
Click to send link to private room via email

Step 2. Prepare for the encounter (optional, if documenting on the TeleVisit Tool)

1. Go to the TeleVisit Tool, click on “Encounter Notes”

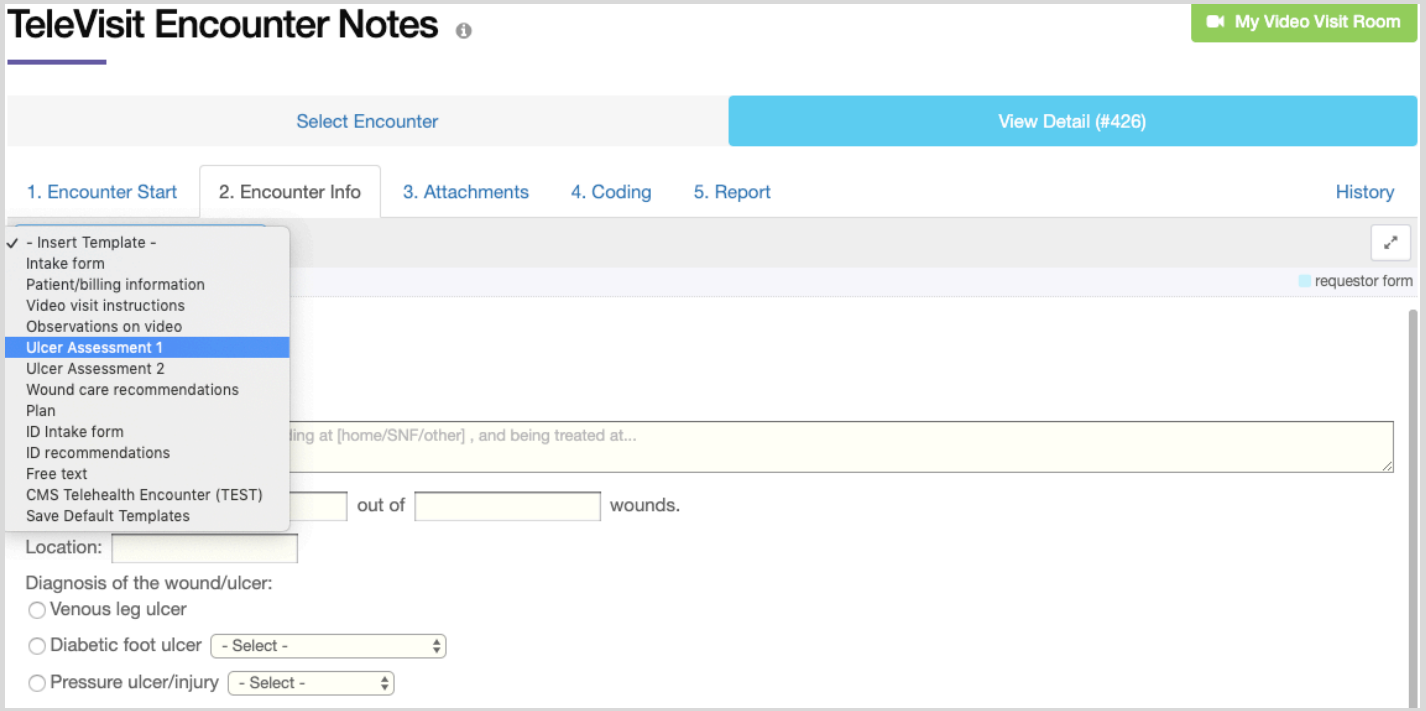


2. Create an encounter for your patient ahead of the video call. Enter patient name and email



Step 2. Prepare for the encounter (optional, if documenting on the TeleVisit Tool)

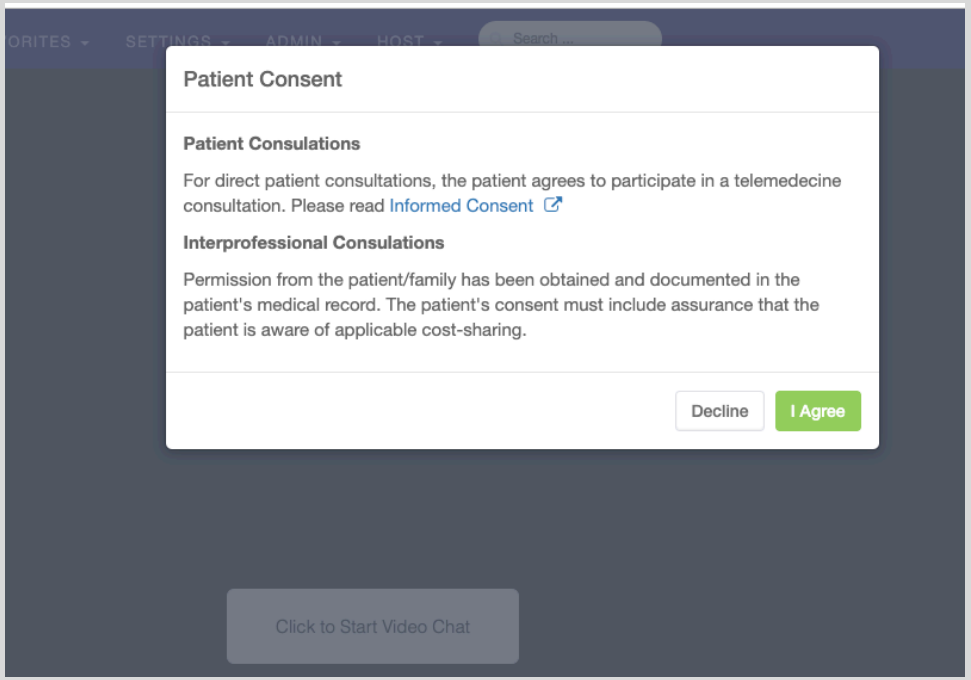
3. Add desired documentation template



Step 3. Video call with patient

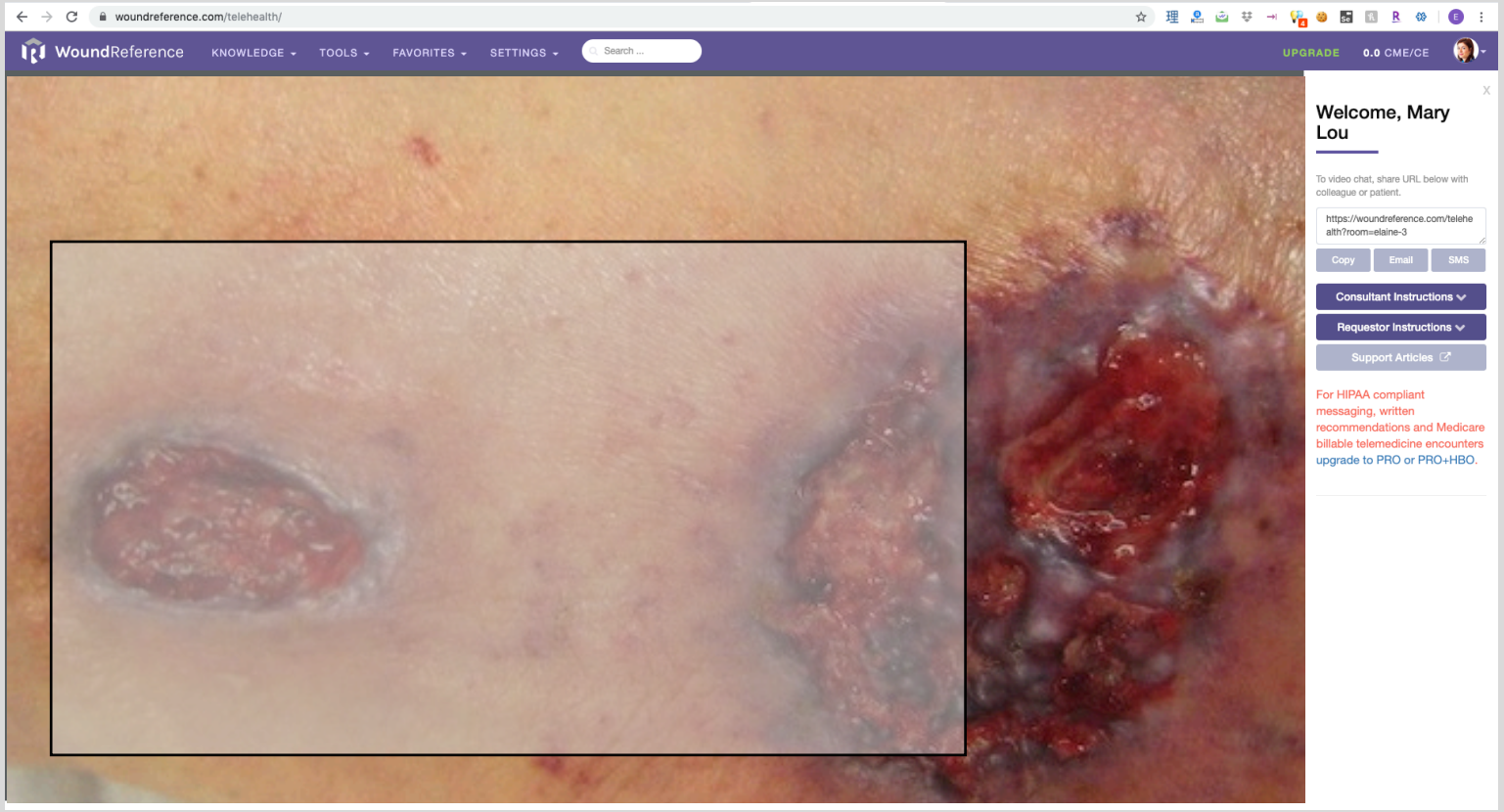
1. Time spent on verbal discussion automatically tracked and logged
2. Patient is prompted to provide consent to telemedicine service before initiating video call

Patient view >>

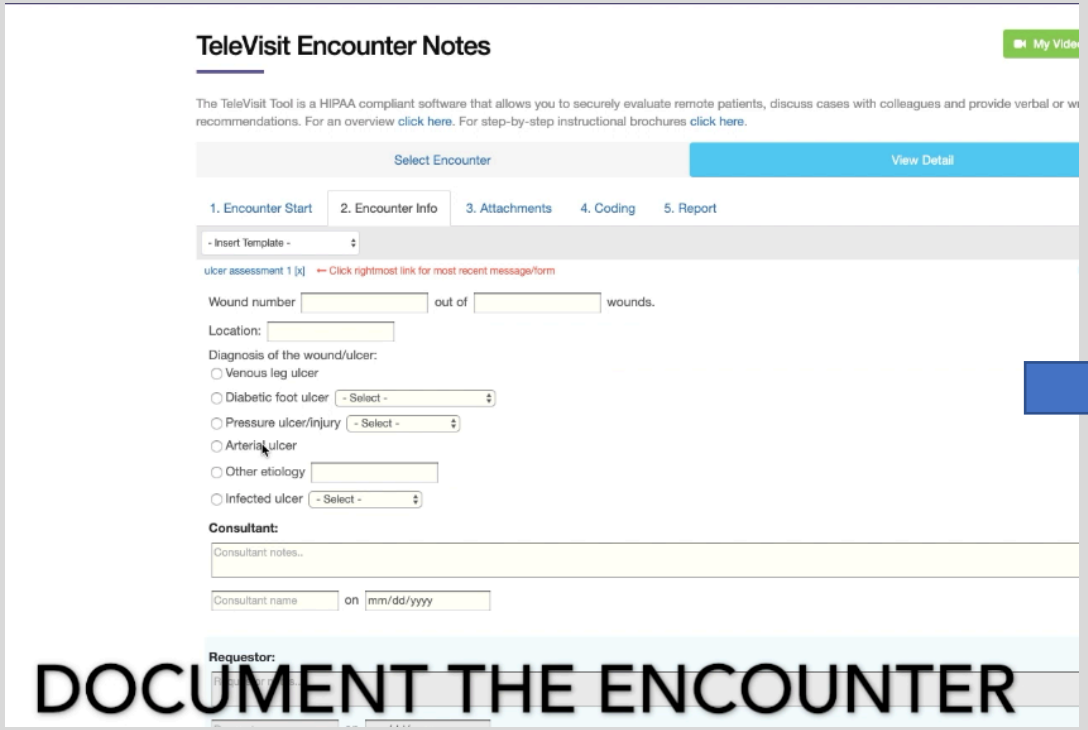


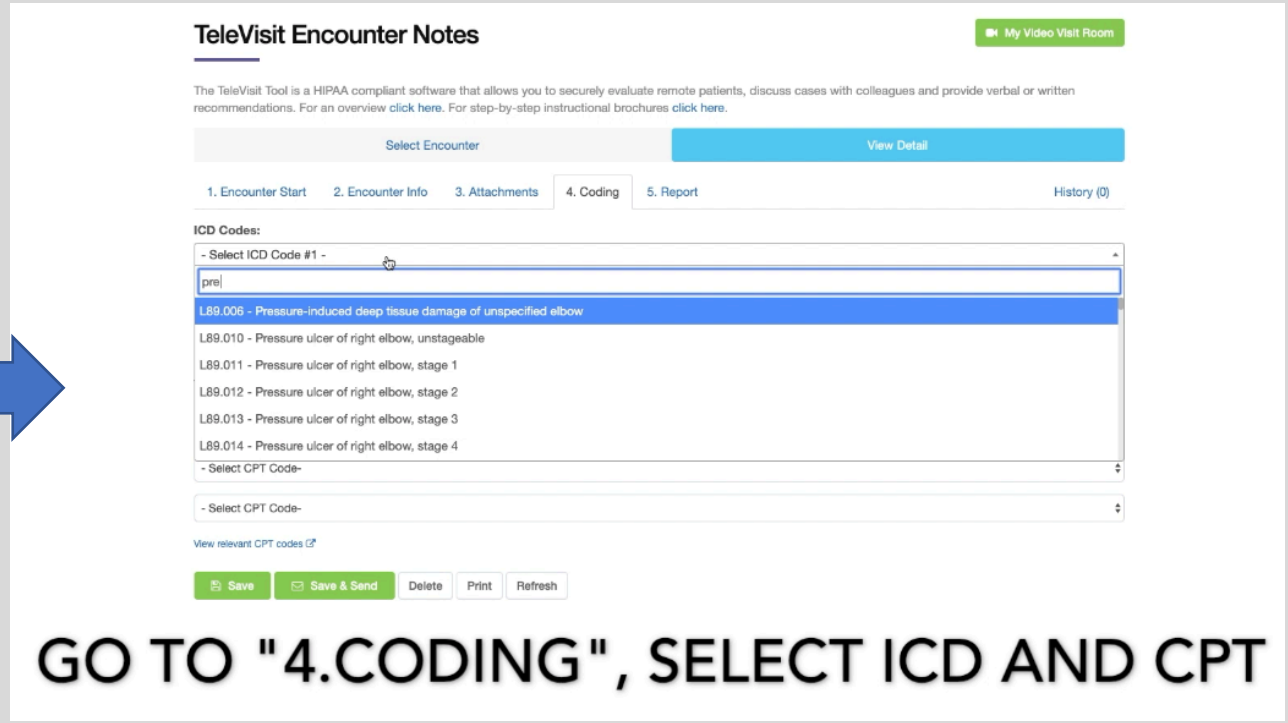
Step 3. Video call with patient

3. During the video call, get screenshots of the ulcer or documents that the patient shares with you

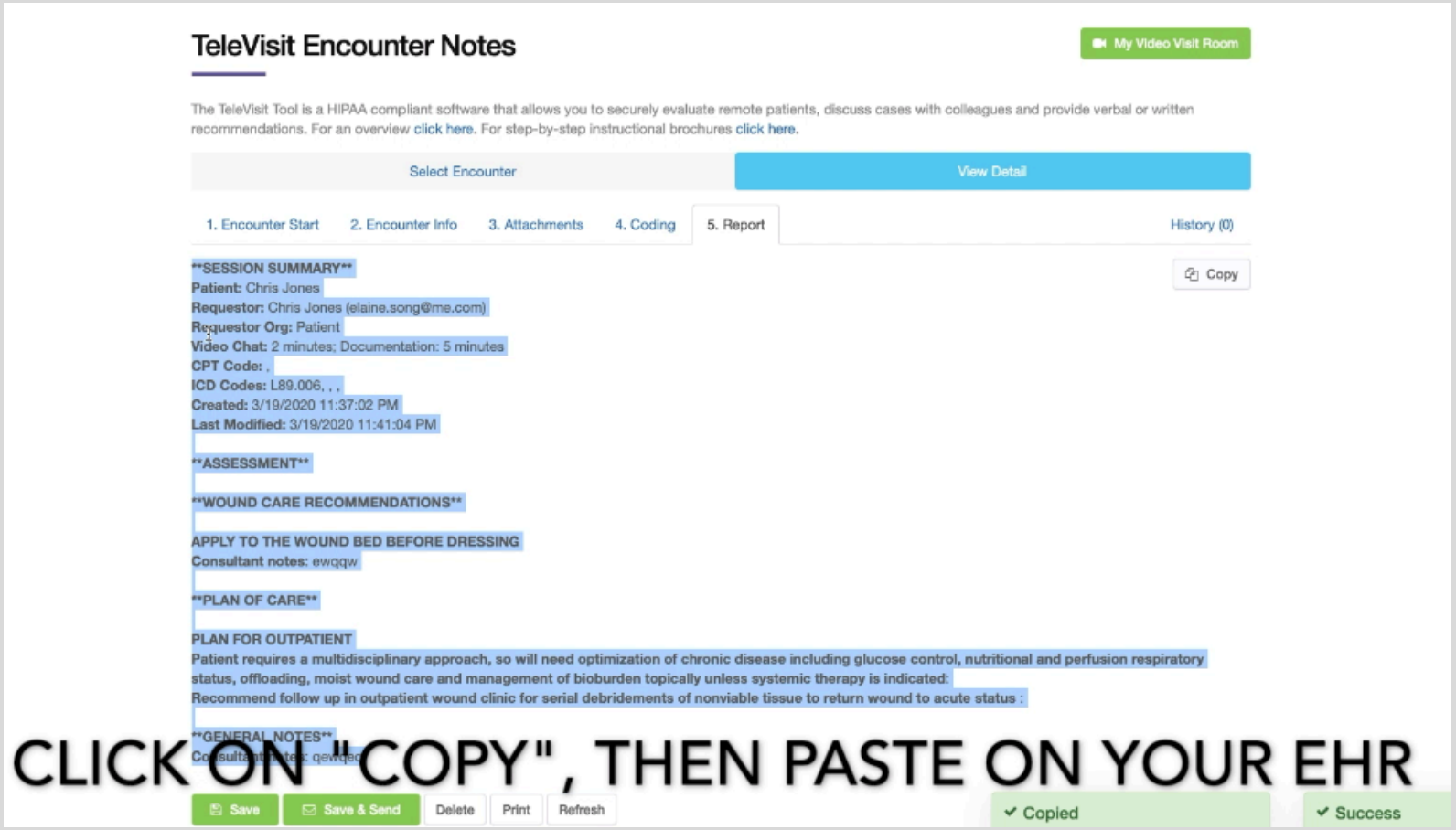


Step 4. Document encounter, add ICD and CPT codes



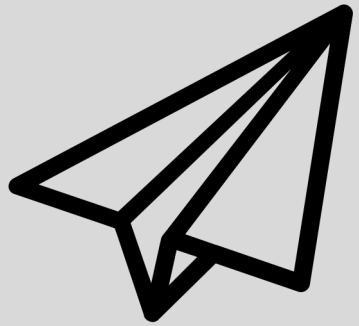


Step 5. Finalize encounter, transfer to EHR



Step 6. Send summary to patient or clinician (optional)

1. TeleVisit Tool sends link via email to HIPAA compliant area where patient/ clinician can access summary (serves as online patient portal)



Virtual visit template if documenting manually

Clinicians may want to use Free TeleVisit Tool Video Chat edition and document encounter manually, directly on own EHR

Gerontology Virtual Visit Progress Note Example

Encounter date 03/19/20 (auto generated)

This service was provided through Telemedicine, using audio/video [***insert modality] due to contact precautions during COVID 19 time period
Provider*** and provider location***
Patient location***

The patient ***gave informed consent for the use of Telemedicine for this visit. The patient understands the risks and benefits of the virtual visit medium. The patient should weigh the advantages such as improved access or convenience against the risks posed by the audio/video communication medium or the limited physical examination.

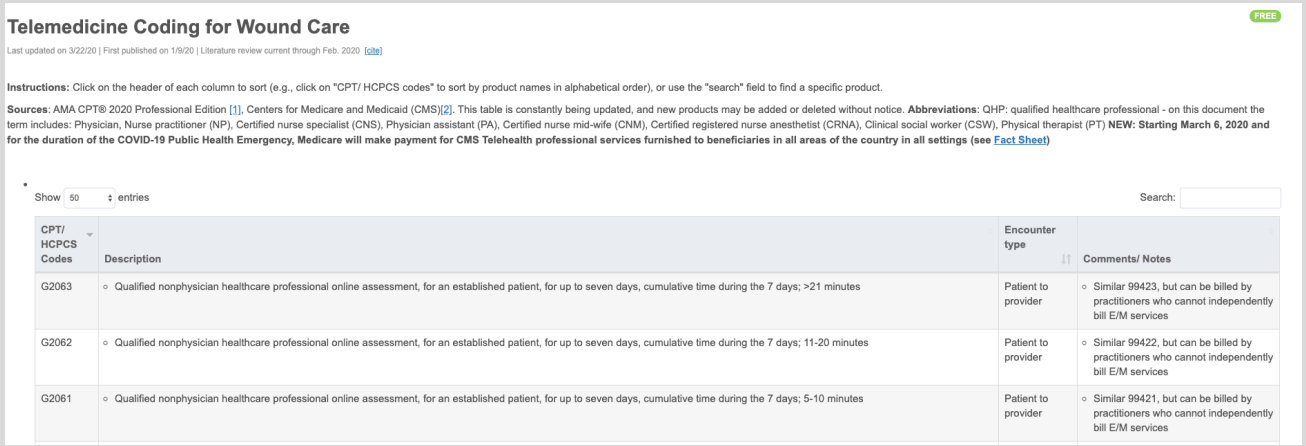
CC:
HPI:
ROS (smartblock)
PMH
Home Medications
Allergies

OBJECTIVE:
General:
awake, alert, no acute distress
no psychomotor agitation, non-diaphoretic
Head:
atraumatic, normocephalic, no lesions visualized
Eyes:
No redness, discharge, swelling, or lesions
Nose:
No redness, swelling, visible discharge, or deformity
Skin:
no lesions, wounds, erythema, or cyanosis noted on face or hands
Cardiopulmonary:
no increased respiratory effort, speaking in clear sentences, I:E ratio WNL
Neuro:
Cranial nerves grossly normal
speech normal rate and rhythm
orientation arrived to appointment on time with no prompting
moved both upper extremities equally
Gait ***if performed
Psych:
well groomed, pleasant, cooperative
Attention and concentration focused and appropriate
Thought process appropriate
Speech normal rate and rhythm, Affect appropriate, Insight and judgement appropriate

DATA Reviewed:
@ASSESSPLAN@ (problem list and associated orders generate)

Total Audio/Video Face to Face Time: *** minutes.

***Billing Reminders: Encounter must include video AND audio. CPT codes for follow ups with 99213, 99214, 99215 with POS 02 (Medicare) or modifier 95 (commercial insurance). Code based on time or complexity as you would use for a regular office visit.



Telemedicine Coding for Wound Care

FREE

Last updated on 3/22/20 | First published on 1/9/20 | Literature review current through Feb. 2020 [cite]

Instructions: Click on the header of each column to sort (e.g., click on "CPT/ HCPCS codes" to sort by product names in alphabetical order), or use the "search" field to find a specific product.

Sources: AMA CPT® 2020 Professional Edition [1], Centers for Medicare and Medicaid (CMS)[2]. This table is constantly being updated, and new products may be added or deleted without notice. **Abbreviations**: QHP: qualified healthcare professional - on this document the term includes: Physician, Nurse practitioner (NP), Certified nurse specialist (CNS), Physician assistant (PA), Certified nurse mid-wife (CNM), Certified registered nurse anesthetist (CRNA), Clinical social worker (CSW), Physical therapist (PT) **NEW: Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for CMS Telehealth professional services furnished to beneficiaries in all areas of the country in all settings (see Fact Sheet)**

Show 50 entries Search:

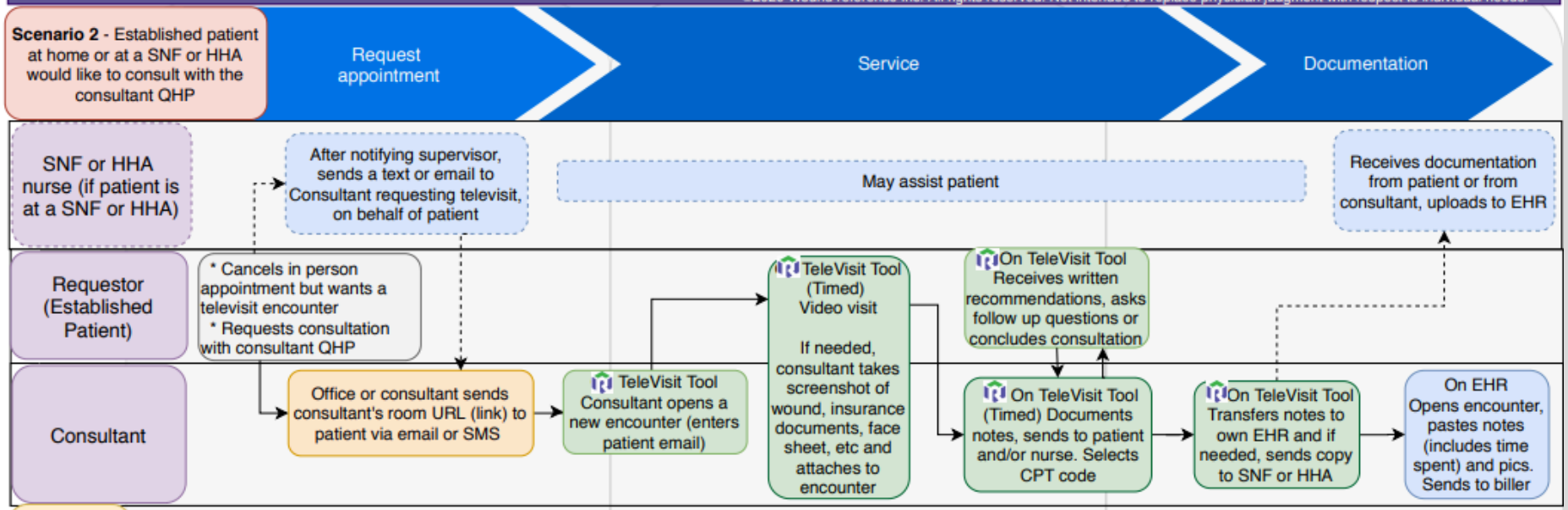
CPT/ HCPCS Codes	Description	Encounter type	Comments/ Notes
G2063	◦ Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; >21 minutes	Patient to provider	◦ Similar 99423, but can be billed by practitioners who cannot independently bill E/M services
G2062	◦ Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes	Patient to provider	◦ Similar 99422, but can be billed by practitioners who cannot independently bill E/M services
G2061	◦ Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes	Patient to provider	◦ Similar 99421, but can be billed by practitioners who cannot independently bill E/M services

https://woundreference.com/app/topic?id=cpt-codes

Video Visit Workflow: Scenario 2 Simplified

WoundReference

Billable telemedicine encounters between consulting qualified healthcare professional (QHP) and patients



Billable Services and restrictions/ requirements per CMS/ AMA

1) "Virtual Check-in" : Brief Communication Technology-based Service

CMS guidelines consider brief communication technology-based service, e.g., virtual check-in, by a Physician or Other Qualified Health Care Professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion reported with HCPCS code G2012 eligible for reimbursement according to the CMS Physician Fee Schedule (PFS).

2) "Online digital E/M" : Online Digital Evaluation and Management Services

CMS Physician Fee Schedule (PFS) guidelines consider online digital evaluation and management services (99421-99423 and G2061-G2063) eligible for reimbursement. These codes must be reported according to the guidelines as outlined by the AMA in CPT.

Patients
* Established
* Patient initiates request through HIPAA compliant platform

Billing practitioners
* 99421-99423: Providers who can bill for E/M services
* G2061-G2063: Qualified nonphysician healthcare professional (e.g. eg, speech-language pathologists, physical therapists, occupational therapists, social workers, dietitians)

Frequency and time
* Can be reported once per seven days for the same patient and same problem or related problem
* If another E/M occurs in this period, work devoted to the online digital E/M is incorporated into the other E/M

Service

* Time-based codes. Minimum of 5 minutes
* Includes review of the initial inquiry, review of patient records or data pertinent to assessment of the patient's problem, personal physician or other QHP interaction with clinical staff focused on the patient's problem, development of management plans, including physician- or other QHP generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email, or other digitally supported communication, which does not otherwise represent a separately reported E/M service.

3) "CMS Telehealth services

* Usually, geographical restrictions apply. See HRSA's Medicare Telehealth Payment Eligibility Analyzer
* These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits
* Interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient is needed.

NEW: Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings. Any QHP can bill for telehealth services regardless of state licensure. Patients can be at home. For new or established patients.
See "MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET"

WoundReference's benefits vs. other methods

- HIPAA compliant
- Time Tracker for billing purposes
- Documentation template to meet payor's requirements

The steps described on this presentation are illustrated on this workflow.

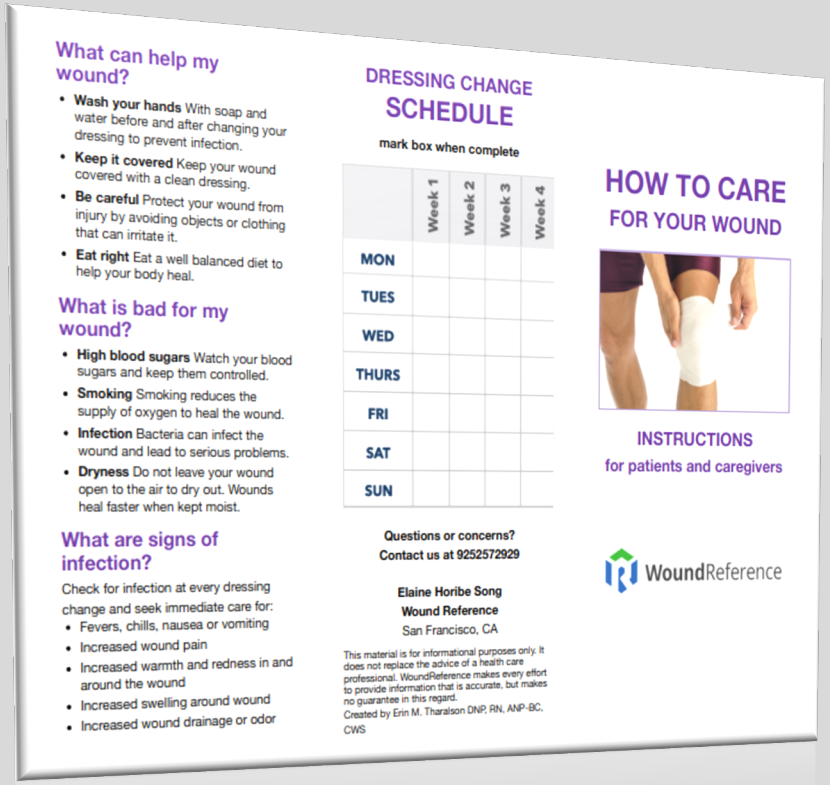
For a PDF with higher resolution, see section 'Step 7. Designing the Workflow' on topic "Telemedicine/ Televisit Implementation Playbook - Part 2"

Teaching patients how to change dressings at home

Dressing Change Brochure Editor

FREE TOOL

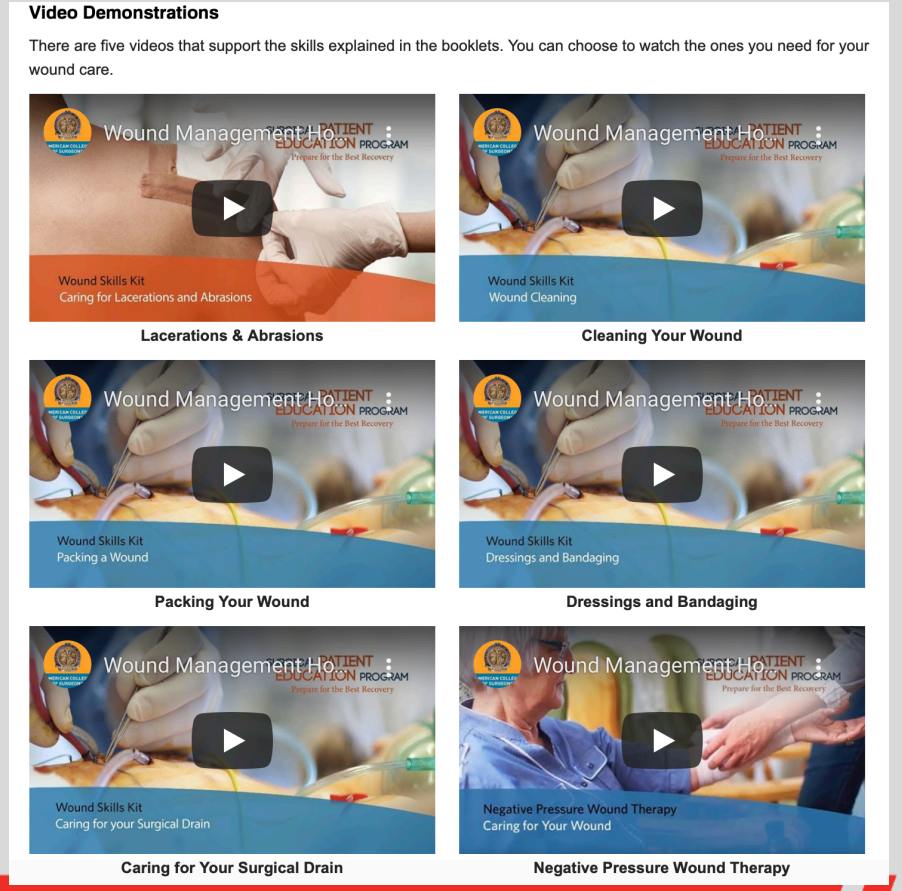
https://woundreference.com/pated?id=0



Email for copies of the materials provided

esong@woundreference.com

Additional Home Resources- American College of Surgeons



https://www.facs.org/education/patient-education/skills-programs/wound-care
Accessed online March 30, 2020

Web Resources

- https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice
- https://www.apma.org/emremote
- https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf
- https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
- https://www.cms.gov/files/document/covid-dme.pdf
- https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
- https://www.facs.org/education/patient-education/skills-programs/wound-care
- http://woundreference.com

25 YEARS
1995-2020

AAWC® | Association for the Advancement of Wound Care®

Wednesday, April 8 at 8 PM EST
COVID-19 Summary Report Update
Presented by William Tettelbach MD, FACP, FIDSA, FUHM, CWS

Topics for this discussion include…

- Guidelines
- How this is affecting out and in patient
- Symptoms
- How we are managing in clinics
- Let’s get creative and resourceful

Thank you!

Questions?