



DEPARTMENT OF THE ARMY
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND
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FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF

OTSG/MEDCOM Policy Memo 08-053

MCHO-CL-C

18 DEC 2008

Expires 18 December 2010

MEMORANDUM FOR Commanders, MEDCOM Regional Medical Commands

SUBJECT: Use of Telehealth in AMEDD Table of Distribution and Allowances (TDA) Facilities

1. References:

a. Department of Defense (DoD) Directive 6025.18, Privacy of Individually Identifiable Health Information in DoD Health Care Programs, 19 Dec 02.

b. DoD 6025.18-R, DoD Health Information Privacy Regulation, 24 Jan 03.

c. Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines, Version 2, Unified Biostatistical Utility, Mar 08, http://www.tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm.

d. HQDA Letter 25-02-1, US Army Wireless Local Area Networks (LAN) and Wireless Portable Electronic Devices (PED) Policy, 15 Apr 02.

e. Army Regulation (AR) 40-66, Medical Records Administration and Health Care Documentation, 17 Jun 08.

f. AR 40-68, Clinical Quality Management, 26 Feb 04.

g. MEDCOM Regulation 25-1, Information Management, 15 Jun 05.

h. OTSG/MEDCOM Policy Memo 07-009, 28 Mar 07, subject: Use of Army Knowledge On-line Email in Support of Electronic Telehealth Medical Consultation by Deployed Providers.

2. Purpose: To state the policy for use of Telehealth services within Army Medical Department TDA medical treatment facilities (MTFs).

*This policy supersedes OTSG/MEDCOM Policy 06-020, 13 Sep 06, subject: Use of Telehealth in AMEDD TDA Facilities

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3. Definitions:

a. Telehealth, a subset of e-Health, is a business process that utilizes information technologies and telecommunications infrastructure to distribute electronic health information, health services, and health education between providers and/or providers and patients to facilitate the delivery of healthcare services at a distance.

b. Teleconsultation, a subset of Telehealth, is the use of information and telecommunications technologies to transmit electronic medical information and associated or stand-alone digital images in a store-forward or asynchronous fashion over a secure connection between healthcare providers for the purpose of obtaining an expert opinion or diagnostic support regarding the care of a patient.

(1) In the process of teleconsultation, the remote Consultant does not interact directly with the patient. The Consultant prepares and transmits comments, recommendations or an official interpretation back to the referring provider for their review and consideration.

(2) A teleconsultation can be accomplished using web-based technologies, or under special circumstances, using email systems (reference 1.h). In the future, it is anticipated that this functionality will be enabled in the DoD electronic medical record.

(3) A teleconsultation is not a telephone consultation between providers or a traditional patient referral whereby patient care is transferred to the Consultant.

4. Proponent: The proponent for this policy is the Health Policy and Services Directorate.

5. Responsibilities:

a. Regional Medical Commands (RMC) Staff and MTF Command Staffs are responsible for the administration and implementation of Telehealth AMEDD Policy.

b. RMC and MTF Command Staffs and designated Telehealth functional proponents are responsible for developing and implementing Telehealth services based on a Business Case Analysis (BCA).

c. MTF healthcare providers are responsible for maintaining appropriate medical standards when using Telehealth to deliver healthcare services to beneficiaries.

d. US Army Medical Information Technology Center, as the MEDCOM Information Technology (IT) Service Provider, is responsible for the architecture, engineering, and integration of IT based on Telehealth requirements.

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6. Policy:

a. Telehealth will be utilized when it augments, expands, or enhances the delivery of healthcare services across the Military Health System (MHS).

b. The analysis of Telehealth application will follow BCA practices and procedures to select clinical services and to monitor future performance metrics.

c. Non-research based uses of Telehealth will be brought through the process defined in reference 1.g. above.

d. When Telehealth is utilized by an RMC and/or MTF, Commanders will ensure that:

(1) Healthcare and administrative personnel are trained, knowledgeable, and have the capacity to use Telehealth as part of their clinical practice, where appropriate.

(2) Performance metrics are collected to support the BCA and reported to the MTF and RMC Quality Management Committees.

(3) The MTF conducts annual reviews of all Telehealth programs as part of their Balanced Score Card requirement.

e. Telehealth capabilities can be used for Resource Sharing Agreements between Veterans Affairs/DoD and academic universities whenever it is supported by the BCA. However, before Telehealth services are exchanged, a formal written agreement is required.

7. Procedures:

a. Medical Documentation.

(1) Telehealth encounters should be documented and archived within the DoD electronic medical record and utilizing paper-based records or other alternative information systems in cases where the electronic health record is not available or does not permit the provider to fully document a store-forward encounter—both data and digital images. (As the DoD electronic medical record development progresses, the ultimate goal will be to document the Telehealth encounter in that system).

(2) Medical information generated from Telehealth will be part of the medical record in the facility rendering the service to the patient (reference 1.c.). Workload credit associated with the medical record documentation will belong to the facilities providing the service. The Annex contains an example.

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(3) Tele-radiology will use standard report forms and archive images in Picture Archiving and Communications Systems.

b. Credentialing and Privileging.

(1) AR 40-68, Clinical Quality Management (reference 1.f.) and standards of The Joint Commission (TJC) will be supported in all Telehealth programs.

(2) When Telehealth performance metrics exceed TJC standards, AR 40-68 guidelines must be followed.

(3) Providers who write orders or direct care, treatment, or services via Telehealth must be privileged at both facilities--the one providing and the one receiving the service. This may be accomplished by use of the Interfacility Credentials Transfer Brief (ICTB) along with a copy of the provider's delineation of privileges. The MTF receiving the service should privilege the provider only for the Telehealth services the MTF receives. Types of services requiring privileges include all clinical video-conferencing services and any other direct provider-patient interactions.

(4) Providers who provide official reading and interpretation of images, tracings, or specimens do not require privileges at the receiving facility. In such cases, the facility must obtain and maintain a copy of the ICTB and delineation of privileges from the provider's home MTF, but need not privilege the provider. Examples of these types of services include, but are not limited to, tele-radiology (except mammography which has additional requirements), tele-pathology, tele-echocardiography, and tele-dermatology.

(5) These credentialing and privileging requirements do not apply when the receiving facility is deployed to a Theater of operations.

c. Workload Accounting and Coding.

(1) Guidance for Telehealth workload accounting and coding was first approved by the Unified Biostatistical Utility Office at Health Affairs in Jul 06 and briefed to MTFs. It is recommended that MTFs refer to reference 1.b., Sections 8.4 and 8.5 for official Telehealth coding guidelines.

(2) The Telehealth service and any applicable modifier will be coded at the remote site where the Consultant resides. Telehealth encounters will be identified either with an asynchronous encounter code (e.g., 99242 GQ) or a real-time interactive encounter code (e.g., 99242 GT).

(3) Specific coding instructions. See Annex for a sample coding scenario.

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(a) Currently, use of the "GT" modifier with a Telehealth procedure code signifies that real-time communication between the remote clinician has taken place with the patient present and participating in the Telehealth visit.

(b) By using the "GQ" modifier, the remote clinician certifies that an asynchronous medical record was collected and transmitted to them, or shared via AHLTA, at their distant site from an eligible originating site when the Telehealth services were furnished.

(c) When a provider at a distant site provides an interpretation and report of diagnostic study (e.g., laboratory test or radiograph), the service is reported with the -26 modifier for the professional component of the procedure. In this instance, the originating site would report the procedures with the "TC" modifier (technical component).

d. Informed Consent for Telehealth

(1) When direct healthcare is provided to a US military patient or non-US military patient using Telehealth in an asynchronous or store-forward modality (e.g., Tele-dermatology, Tele-ophthalmology, etc.) or via video-teleconferencing, written informed consent should be obtained and documented on Optional Form (OF) 522 (Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures).

(2) While there is no standard AMEDD informed consent for Telehealth, it is recommended that the following types of information be relayed to the patient about the process of any Telehealth service:

(a) That details of the medical history and current condition, including protected health information (PHI), as that term is defined in reference 1.b., may be used by, or shared with, military healthcare providers to facilitate the Telehealth service.

(b) That records resulting from examination and care via a Telemedicine Clinic or as the result of a teleconsultation will become part of the patient's military medical record and will be protected as required by the Health Insurance Portability and Accountability Act (HIPAA).

(c) The security measures which have been taken to ensure that patient-related PHI are protected during electronic transmission and not accessed by unauthorized users, including the use of a private network and an encryption tool.

(d) The likely differences between receiving care delivered using Telehealth versus face-to-face care.

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(e) The benefits and risks of using Telehealth in the patient's situation, the likely benefits and risks associated with the alternatives to Telehealth to deliver care in the patient's situation.

(f) Providers need to tell patients that they are free to choose between a Telehealth service and those that do not use Telehealth.

(3) Video-taped encounter.

(a) Telehealth encounters that utilize video-conferencing technologies involving direct patient care (excludes pathology or radiology) will be recorded only after appropriate written informed consent is obtained from the patient. In most cases, the only reason to consider recording the episode of healthcare would be to capture information that has compelling educational value.

(b) Written informed consent is not required if the taping is for the documentation of negligence or abuse.

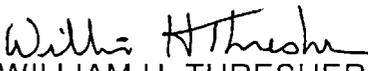
(c) Consent will be recorded on an OF 522 or a state-mandated consent form in accordance with AR 40-66, paragraphs 3-3q.

(d) Information Security. HIPAA requirements dictate the standards for all electronic patient information, to include those of Telehealth. Guidance on HIPAA standards can be obtained from the RMC or MTF Command official representatives.

(e) Regulatory Compliance. The MHS is a covered entity as defined by HIPAA of 1996 and such Telehealth programs must comply with HIPAA Transactions and Code Set Identifier, Privacy and Security Standards as they evolve per reference 1.a.

8. The point of contact for this policy memorandum is COL Ron Poropatich, Medical Informatics Consultant to The Surgeon General at 301-619-7967 or email ron.poropatich@amedd.army.mil. The USAMRMC Telemedicine and Advanced Technology Research Center will serve as the management center for all AMEDD Telehealth issues.

FOR THE COMMANDER:


WILLIAM H. THRESHER
Chief of Staff

ANNEX

TELEHEALTH CODING

Per Reference 1.b., the following types of providers are authorized to code for Telehealth encounters:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Clinical psychologist*
- Clinical social worker*

*Clinical psychologists and clinical social workers cannot code for psychotherapy services that include medical E&M services. These practitioners may not use the following CPT codes: 90805, 90807, and 90809.

SAMPLE CODING SCENARIO FOR TELE-NEUROSURGERY ENCOUNTER

New Visit to Telemedicine Clinic for Primary Care Diagnosis and Treatment Referral

Referral Site Provider: Physician Assistant

The patient is a 28-year old male active duty service member who presents with chronic low back pain and radiculopathy into the posterior aspect of his left lower extremity. Pain started acutely when service member bent over to tie his shoe four months ago. Since that time, he has noticed the development of weakness in the left lower extremity. This service member has tried medications, including narcotics, without relief of symptoms. He has not had a trial of physical therapy. The service member is currently unable to do 19D MOS duties.

E&M Code: 99205 - Office/Outpatient Visit, New (complex patient to examine)

Additional Procedure Code: 96150 (include appropriate modifiers)

Documentation to support "Severity of Illness":

- Comprehensive history (HPI, PMH and ROS)
- Comprehensive neurological physical exam
- High-Complexity medical decision making

Include nature of presenting illness, coordination-of-care (at least 30 min), counseling, and time.

Neurosurgeon VTC Consultation for Telemedicine PA Consult Referral

Consult Site Provider: Neurosurgeon Assistant **Referral Site Provider: Physician**

(Same patient as before)

Six weeks later, the patient has failed to improve with conservative measures and is presented to the neurosurgeon over video-teleconferencing system (VTC) for surgical consideration.

Neurosurgeon E&M Code: 99245 - Office Consultation with "GT" modifier

Physician Assistant E&M Code: 99212 – Office/Outpatient Visit, Est. with "GT" modifier

Documentation to support "Decision on Surgery" (both providers document visit):

- Comprehensive history (HPI, PMH and ROS)
- Comprehensive neurological physical exam performed by PA in full-view of neurosurgeon over VTC
- High-complexity medical decision making for surgery decision

Include nature of presenting illness; coordination-of-care (includes documenting prior PA-to-Neurosurgeon patient evaluation and treatment plan); and a consultation report to the referring (PA) provider via DoD electronic medical record by the neurosurgeon.