

**UNIVERSITY OF CALIFORNIA, DAVIS  
AUDIT AND MANAGEMENT ADVISORY SERVICES**

**UC Davis Health  
Video and Telephone Visits  
Audit & Management Advisory Services Project #22-16**

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## Video and Telephone Visits

### AMAS Project #22-16

#### MANAGEMENT SUMMARY

##### Background

As part of the fiscal year (FY) 2022 audit plan, AMAS reviewed video and telephone visits conducted at UC Davis Health.

Video visits are commonly defined as synchronous audiovisual interactions between provider and patient who are in different physical locations. It is one modality in addition to telephone for providing patient care that falls under the larger umbrella of “telehealth” services. Telehealth provides access to care for patients who are geographically distant from their provider, or who are unable to access certain providers or services easily, such as those living in rural communities or those with limited transportation options.

In 2000, UC Davis Health’s executive leadership approved establishment of the Center for Health and Technology as a formal center with a broad mission to advance technology-enabled care, education, research, and training.

Presently, most patients at UC Davis Health join video visits with their providers through the ExtendedCare application. A limited number of departments utilize a HIPAA-compliant version of Zoom for certain video visits. Patients connect via smartphone, tablet, or computer in a synchronous video call with their provider.

The Secretary of the United States Department of Health and Human Services declared a public health emergency (PHE) for the entirety of the United States on January 31, 2020 in response to the COVID-19 pandemic. In response, the Centers for Medicare and Medicaid Services (CMS) expanded Medicare’s coverage for telehealth services, removed geographic restrictions on coverage and expanded the types of services covered. Health and Human Services also expanded the list of allowable, non-public facing applications for the delivery of video visit services during the PHE.

As a result of the PHE, UC Davis Health saw a rapid expansion in patients accessing video and telephone visit services, and provided an average of approximately 16,000 video and telephone visits per month between April 2020 and June 2021.

	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021
Telephone Visits Attended <sup>1</sup>	12,345	6,520	9,071	10,060	6,942
Video Visits Attended	48,929	33,800	39,461	42,712	33,078

<sup>1</sup> Data retrieved from “Daily Attended Telehealth Visits” dashboard.

**Purpose and Scope**

The purpose of this audit was to assess the controls and processes for synchronous video and telephone visits including billing, compliance with federal regulations and UC policy, and information security where relevant.<sup>2</sup>

In order to accomplish these objectives, we interviewed relevant management and staff; analyzed billing and scheduling data and dashboards; reviewed applicable policies, guidance and regulations governing video visits; reviewed purchasing agreements and security policies for video visit platforms; and viewed dashboards used by staff for tracking and troubleshooting technical issues with video visits.

The timeframe under review was FY 2021. Our scope was limited to outpatient provider-to-patient visits and did not include provider-to-provider visits. Our scope was also limited to scheduled, video and telephone visits. We did not review endpoint security for this project; this was the subject of a FY 2021 audit (AMAS Project #21-38).

**Conclusion**

We were able to verify that centrally managed video visit platforms are monitored for technological failures and follow-up support is provided to users.

We also conclude that there is no easily accessible centralized repository for telehealth guidance, policies or procedures at UC Davis Health; provider documentation lacks support to confirm the appropriate facility fee was billed; and billing of facility fees was inconsistent.

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<sup>2</sup> Synchronous telemedicine requires the presence of both parties at the same time and a communication link between them that allows a real-time interaction to take place. Asynchronous telemedicine involves communication that is not live.

**Observations, Recommendations, and Management Corrective Actions****A. Telehealth Facility Fees**

**UC Davis Health is not maximizing collection of facility fees for video and telephone visits at hospital-based outpatient clinics.**

Prior to the PHE, hospital-based outpatient clinics at UCDH were able to bill Medicare a fee for the use of its facility, effectively reimbursing for administrative costs in addition to the professional fees that are billed for services performed by a provider. During the PHE, CMS issued guidance that allows healthcare providers to charge Medicare patients a facility fee for telehealth visits as if the patient's home were a hospital-based clinic, provided that:

- 1) The healthcare provider has documented its election to treat patient homes as hospital-based clinics, and
- 2) Provider's documentation of each encounter indicates the location of the provider and the patient.

There are two types of facilities fees that may then be charged for a video visit: A Use of Facility Fee is appropriate when the provider is physically located within a hospital-based clinic but the patient is remote; and an Originating Site Fee, which is reimbursed at a lower rate than the Use of a Facility Fee, and is appropriate when a provider and patient are both in remote locations.

**A.1 Hospital-based designation**

We were advised that UC Davis Health had elected not to extend the hospital-based designation to patients' homes, and that facility fee charges should not be applied to video visits.

We however identified patient encounters that were charged an Originating Site Fee (5,908 encounters) or Use of Facility Fee (498 encounters) from January to September 2021.

Without documenting the election, UC Davis Health would not be eligible for reimbursement by Medicare for a Use of Facility Fee or Originating Site Fee. After documenting the election, UC Davis Health could be reimbursed either 40% of the Outpatient Prospective Payment System or for the Originating Site Fee, depending on the patient and provider documented locations.

**A.2 Provider Documentation**

In order for UCDH to charge a facility fee for a video visit, providers must document the patient's and provider's locations. None of the providers' notes in our sample included a statement indicating the specific locations of patient and provider.

This is likely due to providers' frequent use of a standardized Epic Smart Phrase,<sup>3</sup> which is a useful notation shortcut if properly configured, but in this case appears to contain insufficient information.

Any charges on a patient account that cannot be supported by provider documentation are subject to review and may require action, which increases the cost of reimbursement to UC Davis Health.

### **Recommendations**

1. UCDH Compliance Department, in coordination with Revenue Services, should review provider documentation for telephone and video visits and take necessary actions to remedy any billing errors observed.
2. Ambulatory Administration Leadership, Compliance/Legal Leadership and Finance Leadership should make a determination regarding extending the hospital-based designation to patients' homes.
  - a. If leadership decides that such an extension will be made, it should be formally documented and relevant processes should be communicated to necessary entities.
  - b. If leadership decides that the extension will not be made, that too should be formally documented and communicated, along with the implementation of appropriate EPIC charging and/or claim edits to correct future charging practices.
3. To ensure that future documentation is sufficient to satisfy telehealth billing requirements, Health Information Management (HIM) and Professional Billing Group (PBG) should communicate to providers that they are expected to document their physical locations. This may be facilitated by creating new or editing existing Smart Phrases in Epic.

### **Management Corrective Actions**

- 1) For those accounts charged a telehealth facility fee, Compliance Department will determine whether documentation supports the charge and initiate appropriate action by June 30, 2022.
- 2) Leadership will make a determination regarding extending the clinic locations to the patient's home.
  - a. If a determination is made to extend the clinic locations, executive leadership will formally document the decision and communicate to the necessary entities by June 30, 2022.

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<sup>3</sup> Excerpt from the SmartPhrase "... telehealth video connection between my location and patient's location. The patient's location was confirmed during this visit."

- b. If a determination is made to not extend the clinic locations, the decision will be communicated and the appropriate edits to the CDM, will be completed by June 30, 2022.
- 3) By March 31, 2022, HIM and PBG will communicate to providers the expectation to document the physical location for themselves and their patients. Additional tools, such as Smart Phrases, will also be considered.

## **B. Telehealth Guidance**

### **There is no centralized repository for telehealth guidance.**

CHT and Ambulatory Care have developed and maintained telehealth guidance and policies. In April 2020, during the declared PHE, CHT developed and distributed additional guidance. This included direction regarding documentation and acceptable platforms for conducting telehealth appointments. CHT has made other informal guidance available on the UCDHS intranet, such as information regarding documentation requirements for telehealth appointments. However, there is no centralized repository of telehealth guidance materials. As a result, providers and other relevant parties cannot easily access guidance over requirements for video visits or methods to enforce security practices, including allowable platforms (or an exception process for use of non-approved platforms), training requirements, or defined mechanisms for measuring the effectiveness of telehealth.

### **Recommendation**

The Center for Health and Technology, in coordination with other relevant stakeholders, including Ambulatory Services, should compile relevant telehealth policies, procedures and guidance in a centralized easily accessible location.

### **Management Corrective Action**

- 1) By June 30, 2022, the Center for Health and Technology, along with leadership and representatives from Ambulatory Services, IT, Compliance, Health Information Management, Revenue Services, and other relevant stakeholders, will compile telehealth guidance and make it available to staff and providers.

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