UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
AUDIT & ADVISORY SERVICES

Telehealth Review
Project #21-055

May 2021

UCSF
University of California
San Francisco

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May 7, 2021

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SUBJECT: Telehealth Review

As a planned internal audit for Fiscal Year 2021, Audit and Advisory Services ("A&AS") conducted a review of telehealth. The purpose of this review was to assess the controls and processes for virtual care including regulatory compliance and reimbursement.

Our services were performed in accordance with the applicable International Standards for the Professional Practice of Internal Auditing as prescribed by the Institute of Internal Auditors (the "IIA Standards").

Our review was completed and the preliminary draft report was provided to department management in March 2021. Management provided their final comments and responses to our observations in May 2021. The observations and corrective actions have been discussed and agreed upon with department management and it is management's responsibility to implement the corrective actions stated in the report. In accordance with the University of California audit policy, A&AS will periodically follow up to confirm that the agreed upon management corrective actions are completed within the dates specified in the final report.

This report is intended solely for the information and internal use of UCSF management and the Ethics, Compliance and Audit Board, and is not intended to be and should not be used by any other person or entity.

Sincerely,

Irene McGlynn
Chief Audit Officer
UCSF Audit and Advisory Services

EXECUTIVE SUMMARY

I. BACKGROUND

As a planned audit for Fiscal Year 2021, Audit & Advisory Services (A&AS) conducted a review of telehealth. Telehealth encompasses a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Through telehealth, providers can serve patients who are geographically disparate from them, and who might otherwise lack access to certain providers or services. During Fiscal Year 2021, 502 UCSF Health departments adopted telehealth; these departments conducted approximately half a million video visits during this period. The rapid expansion of telehealth was spurred on by the pandemic. Medicare implemented waivers of multiple requirements in response to the declaration of a Public Health Emergency (PHE), such as allowing for reimbursement for video visits from additional originating sites and for additional services. Centers for Medicare & Medicaid Services (CMS) has announced that this regulatory change will remain in place until the end of the calendar year in which the PHE ends.

The UCSF Telehealth Resource Center (TRC) was established in 2014 and serves as a support to clinics interested in providing care via telehealth. The TRC provides guidance to clinics to ensure telehealth is effective, compliant, and reimbursable. The TRC assists clinics with videos and tip sheets for providers, patients, practice managers, and clinic staff to ensure the following: (1) telehealth video visits are operating effectively; (2) visits are documented and billed appropriately for reimbursement; (3) direction on how to use Zoom; (4) guidance on recommended workflows for video visits; and (5) direction on how to schedule video visits with patients and if needed include interpreters.

II. AUDIT PURPOSE AND SCOPE

The purpose of this review was to assess the controls and processes for virtual care including regulatory compliance and reimbursement. Procedures performed as part of the review include: (1) interviewing department personnel and conducting walkthroughs of the four clinics (Rheumatology, Neurology, Women's Primary Care and General Medicine); (2) reviewed the applicable policies governing telehealth; (3) selected a sample of the four clinics to ensure providers are not charging more than twenty-four hours in a day; (4) validated that the Terms and Conditions of Financial Responsibility were in place at time of visit (TACO); (5) reviewed encounters for proper usage of DOT phrases when video visits fail; (6) reviewed Compliance Bulletin for proper guidance of telehealth billing during the PHE; (7) analyzed the TRC's monitoring reports over telehealth for effectiveness; (8) performed data analytics over telehealth denials; (9) reviewed industry best practice to ensure telehealth is effective and equip to adapt to the changes in laws and regulations; and (10) inquire with clinics on how they validate patient's identity.

Work performed was limited to the specific activities and procedures described above. As such, this report is not intended to, nor can it be relied upon to provide an assessment of compliance beyond those areas specifically reviewed. Fieldwork was completed in February 2021.

III. SUMMARY

Based on the work performed, controls and processes for virtual care appear to be adequate. The TRC monitors the effectiveness of telehealth by reviewing no-shows, patient satisfaction, and failed video visits. Additionally, the TRC offers support and guidance to the clinics from scheduling a telehealth visit to billing the visit for reimbursement and compliance. Opportunities for enhanced internal controls and processes were identified relating to policies and procedures, training, and compliance.

The specific observations from this review are listed below.

1. The Telehealth Policy has a checklist with program elements that serve as prerequisites for clinics prior to commencing telehealth services; this checklist must be completed and signed/approved by the Director of Telehealth, and Director of MGBS—a practice that is currently not being executed by the clinics.
2. The Patient Identification Policy does not address patients' identity verification for telehealth, and clinics' practices for identity verification are inconsistent.
3. Providers were not documenting patients' location to ensure compliance with federal and state laws and licensing requirements prior to the PHE.
4. Several of the Terms and Conditions of Financial Responsibility (TACO) had expired and were not re-obtained by the time of the visit.
5. Incorrect billing can occur when a video visit fails and it turns into a call.
6. The Billable Telephone Visits APEX Tip Sheet has incorrect guidance that allows for billing of resident's time, leading to the potential for non-compliant billing.
7. Patients who do not have MyChart cannot immediately view their after-visit summary, which may lead to delay in the patients' starting to follow a treatment plan.

Additionally, three opportunities for improvement were identified, including developing a plan for telehealth training updates post-pandemic (when waivers expire and rules and regulations become more stringent), monitoring key performance indicators for effective management of telehealth, and providing clarification to the patient on the difference between an integrated visit versus a non-integrated visit.

IV. OBSERVATIONS AND MANAGEMENT CORRECTIVE ACTIONS ("MCAs")

<table>
<tr><th>No.</th><th>Observation</th><th>Risk/Effect</th><th>Recommendation</th><th>MCA</th></tr>
<tr><td>1</td><td>The Telehealth Policy has a checklist with program elements that serve as prerequisites for clinics prior to commencing telehealth services; this checklist must be completed and signed/approved by the Director of Telehealth, and Director of MGBS—a practice that is currently not being executed by the clinics.

None of the four clinics (Rheumatology, Neurology, Women's Primary Care and General Medicine) included in this review were aware of the Telehealth Policy and its requirements. The policy was enacted in September of 2014, with nine key program elements that are currently required of the clinics, including:
(1) establishing a process to monitor the provision of telehealth consults;
(2) identifying a Telehealth Champion;
(3) identifying a process to measure the effectiveness of telehealth consults;
(4) identifying and documenting clinical workflows;
(5) establishing Inclusion/Exclusion Criteria for clinical selection of patients and that is documented and followed;
(6) performing encounters in a location that ensures the patient's privacy and confidentiality and that follow a written protocol;
(7) having any provider who will perform telehealth encounters receiving training regarding program processes and requirements;
(8) ensuring providers are credentialed for the appropriate originating site, as applicable; and
(9) ensuring billing staff at appropriate site(s) have received training regarding billing and coding for telehealth encounters, including allowable procedures, site originating fees, and transmission fees, for each payor.
These policy elements provide guidance to clinics prior to commencing telehealth programs and set expectations for a successful implementation. These nine elements have not been reviewed to ensure they reflect the current expectations and practice of telehealth.</td><td>Without an updated policy, the TRC cannot provide guidance, and ensure relevant controls or prerequisite steps are in placed prior to the clinics commencing telehealth services.</td><td>The TRC should review the Telehealth Policy and update it to ensure all checklists and requirements are relevant to clinics for a successful implementation of the telehealth program.</td><td>Action: Update Telehealth Policy

Responsible Party: Director, Telehealth Programs

Target Date: January 31, 2022</td></tr>
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No.	Observation	Risk/Effect	Recommendation	MCA
2	***The Patient Identification Policy does not address patients' identity verification for telehealth, and clinics' practices for identity verification are inconsistent.*** The Patient Identification Policy establishes a consistent method for ensuring the accuracy of patient identification in the provision of care; however, it was last updated in August 2014 and it does not address the patients' identity verification for telehealth. Review of the four clinics in scope identified inconsistent practices being followed for patient identification; for example, one clinic will ask for name and date of birth, while another clinic will ask for address on file. While historically telehealth visits were conducted for existing patients, the waiver to allow new patient visits to be conducted via telehealth increases the need to verify identities of patients who had not previously been seen by the clinic or provider.	By not having telehealth included in the policy around patients' identity verification, UCSF risks inconsistent verification practices between clinics and reduced ability to identify potential identity theft.	The TRC should work with Patient Safety and Quality Services to update the Patient Identification Policy to address the verification of patients' identity for telehealth.	**Action:** Meet with Patient Safety and Quality Services to discuss updates to Patient Identification Policy (Policy 6.04.08) **Responsible Party:** Director, Telehealth Programs **Target Date:** June 30, 2021
3	***Providers were not documenting patients' location to ensure compliance with federal and state laws and licensing requirements prior to the PHE.*** Review of a sample of fifty-three encounters for the period prior to the PHE was conducted to evaluate providers' propensity to adhere to proper documentation under the more rigid regulations that may return to being enforced when the PHE ends. In the sample, the following was noted: • Forty-eight instances in which providers were not documenting the patients' location. ○ Of the forty-eight instances in which providers were not documenting the patients' location, thirteen were Medicare patients. Per review of the billing in APeX, UCSF Health made adjustments and did not bill for the thirteen Medicare patients, with the assumption that they were at home for their telehealth visit, which at the time was ineligible for billing per CMS guidelines. Given the increase in volume of telehealth, this may not be a financially sustainable practice post PHE.[1]	By not documenting the patient's location, providers cannot ensure compliance with state laws and licensing. Without an update to the smart phrase to include verification of the patient's location,	The TRC should communicate in training to clinics, and in its newsletter, the importance of documenting the patient's location post PHE.	**Action:** Monitor regulatory changes regarding state licensure and Medicare reimbursement, and update billing policies and procedures as appropriate. The TRC communication will be disseminated via our Newsletter, as well as to FPRMO via email.

[1] During the PHE, CMS does allow the patient to be anywhere, including home.

No.	Observation	Risk/Effect	Recommendation	MCA
	• Five instances where the provider had to copy and paste the question about location from outside of APeX and into the encounter notes. • Eight instances where the provider used the smart phrase to attest that, prior to initiating the consultation, they obtained informed verbal consent and answered all questions about the telehealth interaction; however, the smart phrase does not address what questions were asked, including whether the location was determined to be appropriate. Providers should document a patient's location in order to demonstrate compliance with federal and state laws and licensing requirements, including those below: • Medicare Conditions of Participation regulations (§ 482.22) and Joint Commission Medical Staff Standards (MS.13.01.01) state that the individual distant-site physician or practitioner must hold a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located. • Federal regulations (42 CFR § 410.78 (b)(1)) states, "Physician or practitioner at the distant site must be licensed to furnish the service under State law." • The Medicare Claims Processing Manual (Chapter 12, § 190.6.1) states, "By coding and billing the GT modifier with a covered telehealth procedure code, the distant-site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished." • The Medical Board of California requires that "Physicians using telehealth technologies to provide care to patients located in California must be licensed in California." The Telehealth SmartPhrase was updated in January 2021 to specify whether the provider was located in a UCSF clinical facility or not in a UCSF clinical facility, but the update did not address the location of the patient.	providers may not be able to substantiate that the patient's location was appropriate for state laws and licensing.	The TRC should assist in updating the smart phrase to include language around verifying the patient's location post PHE.	TRC will work with clinical providers and Clinical Systems to implement change, if any. **Responsible Party:** Director, Telehealth Programs **Target Date:** March 31, 2022
4	***Several of the Terms and Conditions of Financial Responsibility (TACO) had expired and were not re-obtained by the time of the visit.***	Without the TACO being in placed at time	The TRC should communicate to the clinics the importance	**Action:** Remind clinics via the TRC Newsletter that the

No.	Observation	Risk/Effect	Recommendation	MCA
	Eleven out of sixty telehealth visits had an expired TACO at the time of the visit, and the TACO was not obtained during that visit. The TACO is an agreement to accept financial responsibility for services rendered; it also outlines medical consent to treatment, and consent to be treated or observed by residents, interns, medical students under the supervision of the attending physician. The TACO needs to be obtained annually.	of visit, patients may not be financially liable for the cost of the visit.	of obtaining the TACO by the time of the visit.	TACOS can be made available to patients and signed remotely as part of eCheck-in. **Responsible Party:** Director, Telehealth Programs **Target Date:** June 30, 2021
5	***Incorrect billing can occur when a video visit fails and it turns into a call.*** Two out of sixty telehealth visits were overbilled as a result of the provider not using the correct DOT phrase for failed video visits. A DOT phrase or SmartPhrase allow a Provider to type a few characters that automatically expand to a longer phrase or paragraph. Coders rely on the correct DOT phrase to bill; in the absence of the correct DOT phrase for failed video visits, they were incorrectly billed as video visits.	By not using the correct DOT phrase when a video visit fails, coders may overbill the visit.	The TRC should train the clinics and communicate in its newsletter, the importance of using the correct DOT phrase when a video visit fails and it turns into a call.	**Action:** Improve provider tools in APeX for documenting visit type transition from video to phone call. **Responsible Party:** Director, Telehealth Programs **Target Date:** June 30, 2021
6	***The Billable Telephone Visits APEX Tip Sheet has incorrect guidance that allows for billing of resident's time, leading to the potential for non-compliant billing.*** The APeX Training team provided the Billable Telephone Visits APeX Tip Sheet that states, "Telephone visits are billed based on time spent by the Provider, including time spent by residents/ACGME fellows." This guidance may lead to incorrect billing, since billing for residents/ACGME fellows is not	Without correct billing guidance, UCSF risks being noncompliant with reimbursement regulation.	The TRC should collaborate with the APEX team and the Office of Healthcare Compliance to get this tip sheet corrected and communicate the updated tip sheet to all clinics.	**Action:** Update tip sheet, route to Compliance for approval, then back to Clinical Systems Training for publication.

No.	Observation	Risk/Effect	Recommendation	MCA
	generally allowed, with the only exception being for primary care. Medicare pays for residents' services through Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments; therefore, these services may not be billed or paid under the Medicare Physician Fee Schedule. One of sixty telehealth visits, which turned into a call conducted by a Resident, was incorrectly billed based on the Resident's time.			**Responsible Party:** Director, Telehealth Programs **Target Date:** June 30, 2021
7	***Patients who do not have MyChart cannot immediately view their after-visit summary, which may lead to delay in the patients' starting to follow a treatment plan.*** During the walkthrough, it was mentioned that the ability to give patients documents, such as their after-visit summary, was limited. If the patient is in MyChart, they can view the document there, if the patient is not in MyChart, the provider would have to print it out and mail it to the patient.	Without access to important documents, patients' care can be compromised.	The TRC should consider educating providers and patients on using Instant Activation in MyChart to get pertinent documentation.	**Action:** Remind clinics via the TRC newsletter that patients who are not active on MyChart should be offered Instant Activation. **Responsible Party:** Director, Telehealth Programs **Target Date:** June 30, 2021

V. OPPORTUNITIES FOR IMPROVEMENTS

No.	Observation	Risk/Effect	Recommendation
1	***During the PHE, the federal and state government issued numerous waivers for telehealth, which will expire once the PHE ends. A plan to address expiration of waivers should be developed.*** The federal government issued 150 waivers during the PHE. These waivers affect a wide range of subject matters, from provider screening and enrollment to HIPAA privacy. These waivers will eventually expire, and clinics may have to abide by more stringent rules and regulations. Many clinics commenced telehealth services during the PHE, where they only experienced lenient rules and regulations as a result of	Without a training update for post-pandemic, the TRC cannot ensure the clinics' compliance to more stringent rules and regulations.	The TRC should develop a plan for telehealth training updates post-pandemic, when waivers expire and rules and regulations become more stringent.

No.	Observation	Risk/Effect	Recommendation
	waivers; these clinics will lack the experience of complying with more rigid rules and requirements under pre-PHE times.		
2	***Although patient's satisfaction is being tracked, the TRC should consider monitoring patients' wait time and surveying providers and staff for feedback.*** The Annals of Internal Medicine suggests monitoring over patients' wait time and surveying providers and staff for feedback as a way to determine effectiveness, utility, and unmet needs of virtual care for patients, providers, and staff. Additionally, as video visits generate more ancillary communication demand, monitor the triage system for incoming visits to ensure that providers are not overloaded.	By not monitoring patients' wait time and surveying key stakeholders in the telehealth process, the TRC may miss opportunities to improve patient's experience, and the telehealth process.	The TRC should consider monitoring patients' wait time, and surveying providers, and staff routinely for satisfaction, utility, and unmet needs, including suggestions for program reorientation and program development.
3	***The TRC should consider providing clarification to the patient on what is required of them in order to have a visit under an integrated visit versus a non-integrated visit.*** For integrated visits, the Zoom meeting occurs in APEX, and the patient has to complete e-check-in via MyChart before their visit can start. For non-integrated visits, the Zoom meeting occurs outside of APEX and the patient can complete the e-check-in, but it is not a required step to have their visit. Different clinics are in different stages of integration. Patients may be confused when going from a non-integrated clinic to an integrated clinic, or if they do not have MyChart activated prior to an integrated clinic visit. Currently, integrated visits are limited, but there are plans for expansion going forward. There is a training video produced by the TRC that speaks to the e-check-in process, but it requires the patient to have MyChart activated.	Without clarification to the patient on the difference between an integrated visit versus a non-integrated visit, patients may be confused with what is required of them in order to start their visit.	The TRC should work with the MyChart team to implement clarification on what the patient needs to do in an integrated visit versus a non-integrated visit.