UMTRC Virtual Office Hours

Informed Consent and Documentation Requirements for Telehealth
According to Section 2, Title 16 of the Indiana Administrative Code:

IC 16-41-6-2  Informed consent; court ordered examinations

Sec. 2. (a) As used in this section, "informed consent" means authorization for physical examination, made without undue inducement or any form of force, fraud, constraint, deceit, duress, or coercion after the following:

(1) A fair explanation of the examination, including the purpose, potential uses, limitations, and the fair meaning of the examination results.
(2) A fair explanation of the procedures to be followed, including the following:
   (A) The voluntary nature of the examination.
   (B) The right to withdraw consent to the examination process at any time.
   (C) The right to anonymity to the extent provided by law with respect to participation in the examination and disclosure of examination results.
   (D) The right to confidential treatment to the extent provided by law of information identifying the subject of the examination and the results of the examination.
Indiana: Documentation Standards

Per Indiana Medicaid:

“Documentation must be maintained at the distant and originating locations to substantiate the services provided. Documentation must indicate that the services were rendered via telemedicine and must clearly identify the location of the distant and originating sites. All other IHCP documentation guidelines apply for services rendered via telemedicine, such as chart notes and start and stop times. Documentation must be available for postpayment review. Providers should always give the member the choice between a traditional clinical encounter versus a telemedicine visit. Appropriate consent from the member must be obtained by the originating site and documentation maintained at both the distant and originating sites. Providers must have written protocols for circumstances when the member requires a hands-on visit with the provider.”
Illinois: Informed Consent

- Per the Illinois HFS:
  - “The patient must verbally consent to receive virtual check-in services.” *(20 March 2020)*
- Per **20 ICLS 301/30-5**:

  (ff) At the point of admission for services, licensed organizations must obtain written informed consent, as defined in Section 1-10 and in administrative rule, from each client, patient, or legal guardian.

(Source: P.A. 99-143, eff. 7-27-15; 100-759, eff. 1-1-19.)
Per Section 112.30, Title 59 of the Illinois Administrative Code:

d) Informed consent
Informed consent is defined as permission for a procedure freely granted by a person or persons authorized by law to give consent to services and treatment plans, i.e., the recipient, guardian (if the recipient is under guardianship) or parent (if the recipient is under age 18). Informed consent is based on the full disclosure to the authorized person of the information required to make the decision intelligently, including a description of the procedure, the possible benefits and the risks and the alternative(s) to the procedure.
Illinois: Documentation Standards

Per Section 140.403, Title 89 of the Illinois Administrative Code:

(d) Record Requirements for Telehealth Services

1) Medical records documenting the telehealth services provided must be maintained by the originating and distant sites and shall include, but not be limited to, the following:

A) The records required in Section 140.28: Section 140.28, Title 89

B) The name and license number of the licensed health care professional or other licensed clinician present with the patient at the originating site;

C) The name and license number of the provider at the distant site and, if the service involves telepsychiatry, documentation that the physician has completed an approved general psychiatry residency program or an approved child and adolescent psychiatry residency program;

D) The locations of the originating and distant sites;

E) The date and the beginning and ending times of the telehealth service, and

F) The medical necessity for the telehealth service.

2) When the originating site is an encounter clinic, records from the distant site must also be maintained.

3) Appropriate steps must be taken by the originating and distant site staff to assure patient confidentiality, based on technical advances in compliance with all federal and state privacy and confidentiality laws.

4) The type of interactive telecommunication system utilized at the originating and distant sites shall be documented.

5) The billing records related to the use of the telecommunication system shall be maintained as provided in Section 140.28.
Per Ch. 333, Act 359, Sec. 16284 of the Michigan Compiled Laws:

333.16284 Telehealth service; consent required; exception.

Sec. 16284.

Except as otherwise provided in this section, a health professional shall not provide a telehealth service without directly or indirectly obtaining consent for treatment. This section does not apply to a health professional who is providing a telehealth service to an inmate who is under the jurisdiction of the department of corrections and is housed in a correctional facility.
Michigan: Documentation Standards

- Per Ch. 333, Act 481, Sec. 16213 of the Michigan Compiled Laws:

333.16213 Retention of records.

Sec. 16213.

(1) An individual licensed under this article shall keep and maintain a record for each patient for whom he or she has provided medical services, including a full and complete record of tests and examinations performed, observations made, and treatments provided. Unless a longer retention period is otherwise required under federal or state laws or regulations or by generally accepted standards of medical practice, a licensee shall keep and retain each record for a minimum of 7 years from the date of service to which the record pertains. The records shall be maintained in such a manner as to protect their integrity, to ensure their confidentiality and proper use, and to ensure their accessibility and availability to each patient or his or her authorized representative as required by law. A licensee may destroy a record that is less than 7 years old only if both of the following are satisfied:

- Additionally, please see pages 51-56 of the Michigan Medicaid Provider Manual.
Ohio: Informed Consent

Per Title 23, Ch. 2317.54 of the Ohio Administrative Code:

Written consent to a surgical or medical procedure or course of procedures shall, to the extent that it fulfills all the requirements in divisions (A), (B), and (C) of this section, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, or that the person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written. Except as herein provided, no evidence shall be admissible to impeach, modify, or limit the authorization for performance of the procedure or procedures set forth in such written consent.

(A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, and, except in emergency situations, sets forth the names of the physicians who shall perform the intended surgical procedures.

(B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

(C) The consent is signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, minority, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances, including either of the following:
Ohio: Informed Consent, cont’d

- Per Executive Order 2020-01D:
  - “Providers must document their use of telemedicine and meet minimal standards of care.”

- Per Ch. 4731-32-03 of the Administrative Code:

**4731-32-03 Standard of care.**

In order to practice within the minimal standards of care when recommending treatment with medical marijuana, a physician shall comply with all of the following requirements:

(A) The physician shall establish and maintain a bona fide physician-patient relationship with the patient for the provision of medical services that is established in an in-person visit that complies with this rule and for which there is an expectation that the physician will provide care to the patient on an ongoing basis.

(B) The physician shall create and maintain a medical record that documents the provision of medical services. The documentation shall include all of the following:

1. Patient’s name and date or dates of office visits or treatments;
2. A description of the patient’s current medical condition;
3. Documented assessment of the patient’s medical history, including relevant prescription history and any history of substance use disorder;
4. Documented review of any available relevant diagnostic test results;
5. Documented review of prior treatment and the patient’s response to the treatment;
6. Documented review of the patient’s current medication to identify possible drug interactions, including benzodiazepines and opioids.
7. Documented review that standard medical treatment has been attempted or considered. If standard medical treatment is not attempted, the physician must document the reasons that standard medical treatment is not appropriate for this patient;
8. Based on evidence or behavioral indications of addiction or drug abuse, the physician may obtain a drug screen on the patient. It is within the physician’s discretion to decide the nature of the screen and which type of drug to be screened;
9. The physician’s performance of a physical examination relevant to the patient’s current medical condition;
10. The physician’s diagnosis of the patient’s medical condition; and
Ohio: Documentation Standards

Per Ch. 5150-1-18 of the Ohio Administrative Code:

(2) The practitioner site must have access to the medical records of the patient at the time of service and is responsible for maintaining documentation in accordance with paragraph (C)(1) of this rule for the health care service delivered through the use of telehealth.

(C) Requirements and Responsibilities.

(1) All services provided via telehealth shall be provided in accordance with all state and federal laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 C.F.R. part 2 (as in effect on January 1, 2019).
Ohio: Documentation Standards, cont’d

Per Ch. 3701-83-11 of the Ohio Administrative Code:

**3701-83-11 General medical records requirements.**

(A) Each HCF shall maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient’s needs, assessments, and services rendered. Each medical record shall be legible and readily accessible to staff for use in the ordinary course of treatment.

(B) Each HCF shall not disclose individual medical records except as provided by state and federal laws and regulations.

(C) Each HCF shall systematically review the records for conformance with acceptable standards of practice and the requirements of Chapter 3701-83 of the Administrative Code.

(D) Each HCF shall maintain an adequate medical record keeping system and take appropriate measures to protect medical records against theft, loss, destruction, and unauthorized use.

(E) Each HCF shall have policies and procedures to ensure the confidentiality of patient medical records.

(F) Each HCF shall maintain medical records as necessary to verify the information and reports required by statute or regulation for at least six years from the date of discharge.
Since CMS has temporarily suspended HIPAA sanctions for providing telehealth on non-encrypted software, your platform is up to you. When it comes to obtaining consent, **verbal consent is fine during this state of emergency**, but it must be documented pursuant to the codes in your state. Functionally, what you should do is read an optimized consent form to the patient while screen sharing a .pdf or image file.

Sample [Informed Consent for Telehealth Consultation form](#)
Additional Resources and Contact

- **COVID-19 Resources**
- **Telehealth FAQs**
- “Starting a Telemedicine Program During the COVID-19 Pandemic” [webinar recording](#)
- **Technology toolkits**
- **Other resources**
- Monthly newsletter and [updates](#)

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