

Unique Aspects for a Sleep Medicine Telemedicine Video Visit Note:

Teamwork is important for an optimally functioning clinic. While the clinician may be responsible for some of the work below; clinic staff may complete others, including items like informed consent.

1. Confirm patient location (address/state of patient)
2. Confirmation that the patient is on the call (along with other caregivers if present)
3. Confirmation of an appropriate location and timing of visit
4. A statement of the type of visit: (Audio-visual/ phone, synchronous/non-synchronous).
5. Visit initiated by patient or clinician?
6. Time spent in direct communication with patient (Ex: face-to-face if video visit or conversation if telephone visit).
7. Informed Consent for a telemedicine visit (privacy concerns, billing) based on local/regional policies

NEW TELEMEDICINE VISIT

Date of service:	
Referring provider:	

Telemedicine Specifics

Identity Confirmed?	<input type="radio"/> Yes <input type="radio"/> No
Patient Location	
Agreed to Telemedicine Visit	<input type="radio"/> Yes <input type="radio"/> No
Who Initiated Visit	<input type="radio"/> Clinician <input type="radio"/> Patient
Type of Visit	<input type="radio"/> AV <input type="radio"/> Phone Only <input type="radio"/> Non-synchronous
Provider Location	

HISTORY OF PRESENT ILLNESS

Reason for Visit:

OSA Evaluation

Snoring	Frequency	<input type="radio"/> Occasional <input type="radio"/> Frequent <input type="radio"/> Nightly
	Volume	<input type="radio"/> Soft <input type="radio"/> Med <input type="radio"/> Loud
	Length of Time	___ years
	Snort Arousals	<input type="radio"/> Yes <input type="radio"/> No
	Worsening Factors	<input type="radio"/> Alcohol <input type="radio"/> Position
Apneas	Apneas Witnessed	<input type="radio"/> Yes <input type="radio"/> No
	Gasping/Choking arousals	<input type="radio"/> Yes <input type="radio"/> No

Nocturnal Heartburn	<input type="radio"/> Yes <input type="radio"/> No
Nocturia (Frequency)	___ times/night
Morning Dry Mouth	<input type="radio"/> Yes <input type="radio"/> No
Morning Headache	<input type="radio"/> Yes <input type="radio"/> No
Family History of OSA	<input type="radio"/> Yes <input type="radio"/> No
Weight Changes	<input type="radio"/> Up <input type="radio"/> Down <input type="radio"/> None
Prior Sleep Studies	<input type="radio"/> Yes <input type="radio"/> No
Prior OSA Treatments (if any)	

Daytime Sleepiness

EDS Present	<input type="radio"/> Yes <input type="radio"/> No
Sleepy vs. Fatigue	<input type="radio"/> Sleepiness <input type="radio"/> Fatigue <input type="radio"/> Both
Length of Time for Symptom	
Triggering Factors	<input type="radio"/> Illness <input type="radio"/> Vaccine <input type="radio"/> Medication <input type="radio"/> Other
Time of Day	<input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Evening
Present During Workday	<input type="radio"/> Yes <input type="radio"/> No
Safety Concerns	<input type="radio"/> Yes <input type="radio"/> No
Prior Sleep Studies	<input type="radio"/> Yes <input type="radio"/> No

Drowsy Driving

Drowsy Driving	<input type="radio"/> Yes <input type="radio"/> No
Near Miss MVC	<input type="radio"/> Yes <input type="radio"/> No
Motor Vehicle Collisions (MVC) Due to Sleepiness	<input type="radio"/> Yes <input type="radio"/> No
Countermeasures Used	<input type="radio"/> Caffeine <input type="radio"/> Windows <input type="radio"/> Music <input type="radio"/> Other

Narcolepsy Symptoms

Sleep Paralysis	<input type="radio"/> Yes <input type="radio"/> No
Hypnopompic/Hypnagogic Hallucinations	<input type="radio"/> Yes <input type="radio"/> No
Cataplexy (trigger, body part(s) affected, frequency)	<input type="radio"/> Yes <input type="radio"/> No Explanation:

Prior Sleepiness Treatments (if any):	
OTC (including caffeine) and Prescriptions	

Insomnia

Insomnia Present	<input type="radio"/> Yes <input type="radio"/> No ___ mos./yrs.
Pattern	<input type="radio"/> Falling asleep <input type="radio"/> Staying asleep <input type="radio"/> Early morning awakening
Number of Nights Per Week	___ nights/wk
Triggers: (e.g. stress, work, family)	
Previous Treatments	
Current Insomnia Medications (if any) with Timing of Medication	
Anxiety Around Sleep	<input type="radio"/> Yes <input type="radio"/> No
Clock-Watching	<input type="radio"/> Yes <input type="radio"/> No
Disruptive Environmental/Bedroom Stimuli	<input type="radio"/> Yes <input type="radio"/> No

Sleep Schedule

Preferred Circadian Timing	<input type="radio"/> Morning Lark <input type="radio"/> Night Owl
Work Schedule	<input type="radio"/> Stable <input type="radio"/> Shift-stable <input type="radio"/> Shift-multiple <input type="radio"/> Frequent Travel
Pre-Bedtime Routine	
Time into Bed	
Time Lights Out	
Estimated Sleep Latency (minutes)	
Estimated Sleep Maintenance (Number of awakenings/triggers/return to sleep)	
Wake Time	
Estimated Total Sleep Time	

	Out Of Bed Time	
NAPS	Naps	<input type="radio"/> Yes <input type="radio"/> No
	If yes, are they planned	<input type="radio"/> Yes <input type="radio"/> No
	Timing	<input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Evening
	Estimated Total Daily Napping Time	
	Other	
	Weekend/Vacation Sleep Schedule	

RLS

URGE	Urge to Move	<input type="radio"/> Yes <input type="radio"/> No
	Worse with Rest	<input type="radio"/> Yes <input type="radio"/> No
	Gets Better with Activities	<input type="radio"/> Yes <input type="radio"/> No
	Worse in Evening	<input type="radio"/> Yes <input type="radio"/> No
	Frequency	
	Severity	
	Time of Symptom Onset	
	Symptom Location	
	Associated Medical History (neuropathy, iron deficiency, anemia)	
	Triggers	<input type="radio"/> Pregnancy <input type="radio"/> Caffeine <input type="radio"/> Tobacco <input type="radio"/> Alcohol <input type="radio"/> Non-sleep Medications
	Previous Treatments	

Parasomnias

Are Parasomnias Present	<input type="radio"/> Yes <input type="radio"/> No
Onset (months/years)	___ mos./yrs.
Time of Night	
Childhood Parasomnias	<input type="radio"/> Yes <input type="radio"/> No

Sleep-walking	Dangerous Behaviors	
	Safety/Countermeasures	
	Dream Enactment/Recall	<input type="radio"/> Yes <input type="radio"/> No
	Sleep Talking	<input type="radio"/> Yes <input type="radio"/> No
	Triggers	<input type="radio"/> Alcohol <input type="radio"/> Sleep-deprivation <input type="radio"/> Medications <input type="radio"/> Others

PAST MEDICAL HISTORY

Family History	OSA	<input type="radio"/> Yes <input type="radio"/> No
	RLS	<input type="radio"/> Yes <input type="radio"/> No
	Insomnia	<input type="radio"/> Yes <input type="radio"/> No
	Central Disorder of Sleepiness	<input type="radio"/> Yes <input type="radio"/> No
	Other Sleep Disorder	<input type="radio"/> Yes <input type="radio"/> No
Social History	Alcohol	<input type="radio"/> Yes <input type="radio"/> No
	Nicotine	<input type="radio"/> Yes <input type="radio"/> No
	Recreational Drugs	<input type="radio"/> Yes <input type="radio"/> No
	Caffeine	<input type="radio"/> Yes <input type="radio"/> No
	Opioids	<input type="radio"/> Yes <input type="radio"/> No

REVIEW OF SYSTEMS

SYSTEM	SYMPTOM	STATUS
Constitutional	Fever	<input type="radio"/> Yes <input type="radio"/> No
	Night sweats	<input type="radio"/> Yes <input type="radio"/> No
Eyes	Dry eyes	<input type="radio"/> Yes <input type="radio"/> No
Ears, Nose, Throat	Difficulty breathing through nose	<input type="radio"/> Yes <input type="radio"/> No
	Grind or clench teeth	<input type="radio"/> Yes <input type="radio"/> No
Cardiovascular	Racing heart beat	<input type="radio"/> Yes <input type="radio"/> No
	Chest pain	<input type="radio"/> Yes <input type="radio"/> No
Genitourinary	Nocturnal urination	<input type="radio"/> Yes <input type="radio"/> No

Respiratory	Chronic cough	<input type="radio"/> Yes <input type="radio"/> No
	Shortness of breath	<input type="radio"/> Yes <input type="radio"/> No
Gastrointestinal	Heartburn	<input type="radio"/> Yes <input type="radio"/> No
Musculoskeletal	Joint pain	<input type="radio"/> Yes <input type="radio"/> No
Psychiatric	Nightmares	<input type="radio"/> Yes <input type="radio"/> No
	Depression	<input type="radio"/> Yes <input type="radio"/> No
	Anxiety	<input type="radio"/> Yes <input type="radio"/> No
Neurological	Memory loss	<input type="radio"/> Yes <input type="radio"/> No
	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Endocrine	Hot flashes	<input type="radio"/> Yes <input type="radio"/> No

EXAM*

Appearance	Awake	<input type="radio"/> Yes <input type="radio"/> No
	Distress	<input type="radio"/> Yes <input type="radio"/> No
	Sleepy	<input type="radio"/> Yes <input type="radio"/> No
Eyes	Clarity	<input type="radio"/> Clear <input type="radio"/> Redness <input type="radio"/> Irritation
	Lids	<input type="radio"/> Normal <input type="radio"/> Droopy
Ear/Nose/Throat	Mallampati Airway Class	<input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> VI
	Hard Palate	<input type="radio"/> Low <input type="radio"/> Moderate <input type="radio"/> High
	Soft Palate	<input type="radio"/> Short <input type="radio"/> Moderate <input type="radio"/> Long
	Uvula	<input type="radio"/> Small <input type="radio"/> Medium <input type="radio"/> Large
	Tonsils	<input type="radio"/> Class 1 <input type="radio"/> Class 2 <input type="radio"/> Class 3 <input type="radio"/> Class 4
	Tongue	<input type="radio"/> Scalloped <input type="radio"/> Non-scalloped <input type="radio"/> Small <input type="radio"/> Moderate <input type="radio"/> Large
Dental	Molar Occlusion	
	Bite/Jet	
	Gnathic Status	<input type="radio"/> Retrognathia <input type="radio"/> Orthognathia <input type="radio"/> Prognathia
Neck	Symmetric	<input type="radio"/> Yes <input type="radio"/> No
	Visually Evident Masses	<input type="radio"/> Yes <input type="radio"/> No

Respiratory	Assessment of Effort	
	Respiratory Rate	
	Single Breath Count	
	Wheezing or Stridor	<input type="radio"/> Yes <input type="radio"/> No
Miscellaneous	Digits	<input type="radio"/> Normal <input type="radio"/> Clubbing <input type="radio"/> Cyanosis
	Visible Edema in Upper Extremity or Lower Extremity	<input type="radio"/> Yes <input type="radio"/> No
	Gait	<input type="radio"/> Normal <input type="radio"/> Abnormal
Skin	Evident Lesions on Face	<input type="radio"/> Yes <input type="radio"/> No
	Evident Lesions on Hands	<input type="radio"/> Yes <input type="radio"/> No
Neuro	Extraocular Movements Intact	<input type="radio"/> Yes <input type="radio"/> No
	Facial Motor Exam	<input type="radio"/> Yes <input type="radio"/> No
	Palate Elevates Symmetrically	<input type="radio"/> Yes <input type="radio"/> No
	Tongue	<input type="radio"/> Midline <input type="radio"/> Deviated
	Shoulder Shrug	<input type="radio"/> Symmetric <input type="radio"/> Asymmetric
	Pronator Drift	<input type="radio"/> Yes <input type="radio"/> No
	Alert	<input type="radio"/> Yes <input type="radio"/> No
Psych	Oriented	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
	Affect	<input type="radio"/> Euthymic <input type="radio"/> Depressed <input type="radio"/> Anxious

Evaluation and Management (E/M) Coding

CMS has implemented changes to the office/outpatient Evaluation and Management (E/M) visit codes as of January 1, 2021, in an effort to reduce administrative burden and apply appropriate valuations to each code. More information and educational resources on the E/M changes can be found [here](#).

Telemedicine Coding

Telemedicine is a unique method of interacting with patients yet the process of coding for patients is fairly similar to that of in-person coding. However, there are some subtleties. We would refer you to the [AASM Telemedicine Codes page](#) for more details.

*Exam References: [E/M University Physical Exam](#)

Disclaimer: This document is meant to serve as education from the AASM about aspects of a telemedicine visit in sleep medicine. However, the Telemedicine Presidential Committee recommends speaking with your local coding professional and payers for information specific to your own billing and coding for telemedicine visits.