**COVID-19**

**Telehealth Documentation & Billing FAQs**

**Definitions**

**Telehealth Visit** – a two-way, real-time interactive communication between a patient and a provider at a distant site through telecommunications equipment that includes, at a minimum, audio and visual equipment.

**Performing provider** – the physician, nurse practitioner or other recognized billable provider who is providing the telehealth service.

**Distant site** - the site where the provider is physically located at the time of service.

**Originating site** – the site where the patient is physically located at the time of service. *During the COVID-19 outbreak, the originating site can be the patient’s home.*

**Licensure**

Under normal circumstances providers must be licensed in the state where the patient is physically located (originating site) in order to perform a telehealth service. *During the COVID-19 outbreak, this licensure requirement is waived and providers may practice across state lines as long as they have a similar license in one state.*

**Documentation of Services**

Telemedicine notes should be kept in the same manner as face-to-face visit notes. We must comply with all standards, including the need for assessment, informed consent, details of service performed and authentication of record entries.

Resident Supervision rules are the same as those for in-person services.

The provider will bill using the regular E/M codes (99201-99215). The documentation requirements are the same as those for in-person visits. The following information should be included at a minimum:

* Date of Service
* Confirmation of telehealth consent
* Provider Location
* Patient Location
* Person Assisting at Originating Site

*When provider or patient is at their home, the following attestation is to be included:*

*Patient and/or provider is at home due to the national state of emergency issued by the government for the coronavirus situation. (A macro has been created for this,* ***//z\_tele\_home****)*

* Chief Complaint
* HPI
* Appropriate History Information
* Exam

*If the provider at the originating site is assisting in the examination, the performing (distant site) provider should state the areas examined as assessed by the assistant and include his/her own observations as appropriate.*

* Impression and Plan
* Signature

*Remember that the exam may not be as thorough as a face-to-face exam and nothing should be documented that would not be practical in a telehealth setting. It is usually best to base the E/M code on time.*

*In order to bill based on time the following attestation is required:*

***More than 50% of this \_\_\_(fill in total minutes of face-to-face visit)\_\_\_ minute visit was spent in counseling and/or coordination of care detailed as follows: (give brief summary of content of counseling/coordination of care).***

*Example: More than 50% of this 30 minute visit was spent in counseling with the patient/parents about the onset of Type I Diabetes, management of disease with goals and reasonable expectations set. Appointments were confirmed with dietitian and diabetic educator.*

*In this case, you would bill for a 30-minute visit.*

Times for various types of services are listed below:

New Patients: 99201 10 min Clinic Consultations: 99241 15 min

 99202 20 min 99242 30 min

 99203 30 min 99243 40 min

 99204 45 min 99244 60 min

 99205 60 min 99245 80 min

Established Patients: 99211 5 min

 99212 10 min

 99213 15 min

 99214 25 min

 99215 40 min

**Prolonged Service**

If the time spent with the patient via electronic visit is longer than the times listed with each visit above, prolonged service codes may be billed in addition to the E/M code.

Code 99354 (first hour) – can be billed once 31 minutes of additional time has been documented. Code 99355 (each additional 30 min) is billed in addition to the E/M code and 99354 when 76 minutes or more has been documented over and above the time associated with the E/M code reported.

**Incident-to Billing**

* Supervising Physician has to be in the same physical location as the non-physician provider who is rendering the service.
* All incident-to criteria must be met:
1. Patient must be established with practice and/or supervising provider
2. Problem addressed must be established (new problems do not meet criteria)
3. Supervising physician must state in his/her plan of care the need for follow-up/incident-to service with non-physician provider.

For official CMS guidance, please visit this site: <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet?inf_contact_key=a7c5904f717ac9230f8a20f03ae91e7f680f8914173f9191b1c0223e68310bb1>

**Please note:** This information is being constantly updated and changed and we will keep you abreast of pertinent changes as we receive them.

**Billing for Telephone Calls**

*We are now able to bill for telephone calls as long as they meet CMS criteria and are documented appropriately.*

We have one code to be used for telephone calls made to patients by the staff and three codes to be used by billable providers. These codes are time-based which means the length of the call must be documented in the note. Each code has exclusions and it is important that we not bill telephone calls that are excluded.

*Mississippi Medicaid and Arkansas Medicaid do not reimburse for any telephone calls.*

**Code 98966 – telephone call to patient by a staff member**

**Code Description:**

Telephone assessment and management service provided by *a qualified non-physician health care professional* to an *established* patient, parent, or guardian *not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment;* 5-10 minutes of medical discussion

*Code 98966 cannot be billed more frequently than once every 7 days.*

*Code 98966 cannot be billed during the same time frame that complex chronic care management services are being billed (99487-99489) or during same time frame as transitional care management services are being billed (99495-99496).*

**Exclusions (conditions that are NOT billable):**

* Call initiated by the qualified health care professional (must be initiated by patient/guardian)
* Calls during the postoperative period of a procedure
* Decision to see the patient at the next available urgent care appointment
* Decision to see the patient within 24 hours of the call
* Calls made on same date physician bills a telephone call
* Calls made to monitor INR
* Calls to give routine lab results

**Codes 99441 – 99443 – telephone call to patient by physician or billable provider**

**Code Description:**

Telephone evaluation and management service by a *physician or other qualified health care professional who may report evaluation and management services* provided to an *established patient,* parent, or guardian *not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment;*

99441: 5-10 minutes of medical discussion

99442: 11-20 minutes of medical discussion

99443: 21-30 minutes of medical discussion

*These codes can only be reported for an established patient and are not billable if the call results in the patient coming in for a face-to-face service within the next 24 hours (or next available urgent visit). These calls are also not billable if they refer to an E/M service performed within the last seven days.*

*These codes* ***CAN*** *be reported for related E/M services provided within the postoperative period of a completed procedure.*

*Codes 99441-99443 cannot be billed more frequently than once every 7 days.*

*These codes cannot be billed during the same time frame as the following services:*

* *care plan oversight services (99339-99340)*
* *supervision of home health, hospice or nursing facility services (99374-99380)*
* *complex chronic care management services (99487-99489)*
* *transitional care management services (99495-99496)*
* *patient/caregiver training for home INR monitoring (93792)*
* *anticoagulant management (93793)*

*These codes cannot be reported for calls made on same date staff member bills for a telephone call.*

If you are not sure if a “phone call” should be billed as an office visit in some circumstances, enter the CPT code for a phone call. These all hit edits and the coders will screen them and convert necessary visits to E&M charges when applicable.

**Documentation of Services**

All telephone calls should be documented in the medical record. The following information, at a minimum, is required for billable telephone notes:

* Date of Service
* Name of person spoken to and their relationship to the patient
* Notation that patient consented to the service being held via telephone
* For calls *made by staff*, evidence that patient requested the service
* Chief Complaint or Reason for Telephone Call
* Relevant history, background and/or results
* Assessment and Plan
* Total time spent on medical discussion
* Signature of staff member or provider