THE UNIVERSITY OF CHICAGO | UChicago Medicine | Office of Corporate Compliance

# COVID-19 FAQ's - Telehealth Provider Billing & Documentation (MD, APN, PA)

Updated Feb 7th, 2021

**To access the most current version of this document, click here to go to the Policies & Guidances page. For other Telemedicine Billing Questions contact: Telemedicine.BillingQuestion@uchospitals.edu . For Compliance questions or concerns contact: compliance@bsd.uchicago.edu.**

**Table of Contents**



## OVERVIEW

**Q1. What are the various types of Outpatient telehealth visits available for practitioners who may normally report an E/M (i.e. MD, APN, PA)?**

Below is an overview of each type of service* along with documentation tips to support billing:

| | |
|---|---|
| **E-visits (MyChart)**<br>**Online Portal** | 99421: 5-10 minutes<br>99422: 11-20 minutes<br>99423: 21 or more minutes |
| **Telephone**<br>**or Brief Virtual Check-in** | 99441: 5-10 minutes<br>99442: 11-20 minutes<br>99443: 21-30 minutes<br>Claim may be updated per payor (i.e. Medicaid G2012: 5-10 minutes of discussion) |
| **Telehealth Video Visits**<br>**(via Zoom, FaceTime, Skype, etc)** | Billed/treated as in-person visit i.e.<br>Outpatient New 99202-99215<br>Outpatient Established 99211-99215 |

*For Usage By: Professionals who may report Evaluation & Management services, such as an MD, APN, or PA. For questions related to other practitioner types email Telemedicine.BillingQuestion@uchospitals.edu.

- **Telehealth E&M (Video Visits):** Use of an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. NEW OR ESTABLISHED
    - Visit conducted via 2-way interactive audio-visual platform (i.e. Zoom)
    - May use Time or Medical Decision Making for leveling Outpatient E/M

  **Documentation:** To allow flexibility in leveling, it is recommended you document the time associated with the E/M. Please also continue to document extent of any history, exam, and/or medical decision making you were able to perform. See "Video Visits, Time, & MDM".

- **E-Visits (My Chart):** Patient-initiated communications using My Chart online patient portal that occurs over a 7-day period with permanent storage in record. NEW OR ESTABLISHED
    - Patient must initiate inquiry/interaction via My Chart (may educate pt. on availability)
    - Patient must have an annual consent on file, or may verbally consent at time of service
    - Reported for cumulative time needed to evaluate, assess, and manage the patient including:
        - Ordering tests, Rx generation, subsequent communication (i.e. email, online, telephone)
    - Frequency: Reported only once in a 7-day period
    - Limitation: Not reported if online patient request is related to an E/M within the previous 7 days, or is within the global period of a procedure

  **Documentation: Time spent must be documented**; notate any patient verbal consent

- **Telephone Only/Virtual Check-Ins**: a brief communication technology-based service that uses audio-only real-time telephone interactions ***or*** synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. NEW OR ESTABLISHED
    - Visit conducted via telephone only (may educate pt. on availability)
    - Patient must have an annual consent on file, or may verbally consent at time of service
    - Limitation: Not reported if stemming from an E/M within the previous 7 days, and may not lead to an E/M or procedure within the next 24 hours or soonest available appointment.

  **Documentation: Time spent must be documented**; notate any patient verbal consent

**Q2. What are the various types of communication technologies that can be used for telehealth?**

Zoom is the preferred platform at UCM for telehealth visits with patients. In cases where the patient is unable to use Zoom or doesn't have a phone with video capability, telephone may be used. MyChart is also a platform through which patient/physician interaction can occur. Note, the type of technology used will dictate the type of codes the service can be billed with. For example, Medicare Telehealth Services must use a device with audio/video capabilities. For details specific to telehealth codes, see the OCC COVID-19 Provider Billing Tip Sheet under Quick Links.

## TELEPHONE COMMUNICATION

**Q3. If I return a patient's call (not on my schedule), can I bill for the telephone encounter since I was told to place all telephone encounters on my schedule?**

Depending on the scenario, it may be possible to document and bill for a telephone E&M (99441-99443) service. Keep in mind a provider should only bill for telephone (or video) E&M services when that call/video replaces an in-person office visit. If the discussion or reason for call is not a replacement in-office visit, it is not considered a billable service.

**Q4. Does the time for telephone calls include coordination of care?**

No, telephone visits are time spent with the billing provider in medical discussion solely on the actual call. In contrast, when performing a Video Visit – all time spent by the billing provider on the calendar day can be included.

## COORDINATION OF CARE & COUNSELING (NEW)

**Q5. Why is the "More or Less" than 50% of time spent in counseling and/or coordination of care statement present? How should a provider determine when to select "More or Less"?**

When the provider and patient are "onsite", the visit is not considered telehealth and thus the E/M may be leveled either by 1) the key elements (History, Exam, and MDM) or 2) by time if Counseling and/or Coordination of Care dominate more than 50% of the encounter. Please note that for Outpatient services delivered "onsite", leveling by time spent in Counseling and/or Coordination of Care may only include face-to-face time spent with the patient counseling and coordinating care; non face-to-face coordination activities may not be factored into the time. For Inpatient services only, time spent Counseling or Coordinating Care may also include time spent on non face-to-face activities such as reviewing records & tests, arranging for further services, communicating with other professionals and the patient through written reports or telephone contact, and discussing the patient with the family without the patient present.

When determining whether to select "More/Less than 50% of time spent in counseling/coordination of care", consider the following:

1. The total length of time of the E/M visit (i.e. 40 minutes)

2. Whether your efforts are considered Coordination of Care or Counseling as defined in the context of CMS guidance below:
   - Coordination of Care = "Coordination of care is communication with other clinicians or agencies regarding the nature of the patient's condition and the needs of the patient and family." Continued…

- Counseling = "Counseling of a patient is defined as discussion with a patient or related party concerning one or more of the following areas":
  - Diagnostic results, impressions, and/or recommended diagnostic studies
  - Prognosis
  - Risks and benefits of management (treatment) options
  - Instructions for management (treatment) and/or follow-up
  - Importance of compliance with chosen management (treatment) options
  - Risk factor reduction

3. Whether More or Less than 50% of the total length of visit time was spent on Coordination of Care or Counseling activities defined above:
   - ***LESS THAN 50%:*** If the majority of your time is spent in "medical care" (obtaining history, performing exam and medical decision making), then you would select "less than 50% of time was spent in counseling and coordination of care."

   - ***MORE THAN 50%:*** Was more than 50% of that time spent in counseling and/or coordination of care as defined above? If so, be sure to include a detailed description of the counseling provided and type of coordination in the note.

## VIDEO VISITS, TIME & MDM

**Q6. What components should be used to level outpatient Evaluation & Management codes provided via Video Visits?**

On an interim basis during the PHE, CMS is allowing outpatient E/M level selection, when furnished via telehealth, to be based on Medical Decision Making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter. CMS is also removing any requirements for documenting History and/or Physical exam in the medical record, for the purposes of assigning a level of service. This policy is similar to the policy that will apply to all office/outpatient E/M's beginning in 2021 per the CY 2020 PFS final rule.

Note: This does not prevent providers from documenting any history or exam elements pertinent to the care of the patient.

**Deciding Time vs. Medical Decision Making (MDM):**

- **TIME** is based only on the billing providers' work related to the E/M on the same day, including F2F (video) time with patient, coordination of care, chart review, ordering of studies, etc. (does not include resident time).
- **MDM** accounts for the components of medical decision making documented by the resident and/or billing provider.

**Q7. How can I bill a level of service (LOS) for a video visit when I am unable to perform a physical exam?**

On an interim basis during the PHE, CMS is allowing providers to determine level of service based on the CY2021 guidelines, which include time or medical decision making (MDM). A comprehensive physical exam is not required for billing.

**Q8. How can we do an examination on a patient through the internet or via video? Can we use elements of the exam that you assess through direct observation despite not being "hands on"? How does this impact the CPT level selected?**

For examinations - Providers should document any visual exam components they can personally see and or observe through the audio and/or visual interaction. Additionally, according to NGS, a patient may self-report constitutional exam items, such as height, weight, and temperature.

Alternatively, History and Exam are not required for leveling of outpatient E/M visits during the public health emergency, Time or Medical decision can be used for calculating service levels. For Inpatient services, time based coding requirements may be used.

**Q9. For video visits, when should I consider billing based on time versus History, Exam, MDM (Medical Decision Making) or Medical Decision Making alone?**

- **TIME** is based only the billing providers' work related to the E/M on the same day, including F2F (video) time with patient, coordination of care, chart review, ordering of studies, etc.
- **MDM** accounts for the components of medical decision making documented by the resident and/or billing provider. MDM tools are at the end of this document. MDM is leveled based on data reviewed, diagnostic work up, number of problems addressed, and overall complexity/risk.
- **HISTORY, EXAM, Medical Decision Making** includes work up and documentation by the resident and billing provider for all three E/M components.

**Q10. For Outpatient Services, what constitutes total time for a time-based encounter with and without resident involvement (for both video and telephone)?**

**Telephone Only (99441-99443):**

- **Non Primary Care Exception**: Count only billing providers' time spent in medical discussion with patient or representative.
- **Primary Care Exception (PCE):** Count TP or Resident's individual or concurrent time spent in medical discussion with patient or representative on the phone call.
    - For example, Resident on call for 20 minutes; TP joins in last 5 minutes, of the 20-minute call. Total time is 20 minutes. TP bills 99442. (continued next page)

**Video Visit (99201 – 99205/ 99211-99215)**

- **Non Primary Care Exception:** Count only the billing providers work related to the E/M on the same day, including F2F (video) time with patient, coordination of care, chart review, ordering of studies, etc.
- **Primary Care Exception (PCE):** Count TP and Resident' individual or concurrent time on the call. - May also count time related to coordination of care, chart review, ordering of studies, on the same day of the E/M service.
    - For example, Resident spends 20 minutes on Video call and discusses case immediately afterwards with TP. Resident spends another 20 minutes on the day of the E/M coordinating care and ordering labs. Total time is 40 minutes. TP bills 99203.

**Q11. How do we document level of medical complexity if billing under MDM rather than time for video visits? What elements need to be documented in the note?**

Documentation for medical decision making should include the presenting problem(s), diagnostic procedure(s) ordered or reviewed, review of records, discussion with other providers, risk level and management/treatment Plan. See MDM tool at the end of this document for instructions on level of service selection.

**Q12. If billing a consult for video telehealth, is there the same requirement of documenting sending a consult letter or routing note to the referring provider?** UPDATED

Yes, the requirements for consultations are unchanged – there must be a request from a referring provider, the consulting provider renders an opinion, and the consultant provides a written response back to the referring provider. Consultations must also still be leveled using the three key components, History, Exam, and Medical Decision Making. Coding by time is only allowed when greater than 50% of the total face-to-face visit is dominated by Counseling and Coordination of Care.

**Q13. When performing a video visit, can I bill for an annual wellness exam (primary care and/or OBGYN)? Which code should I use?**

CMS has included the Annual Wellness Visit (initial and subsequent, G0438-G0439) on the list of approved telehealth services. Additionally, the AWV has now been approved on an interim basis, to be conducted as an audio-only service (via telephone only). The services to be included in an Initial or Subsequent AWV may be found here: CMS MLN Annual Wellness Visits

**Q14. For a video encounter, can we bill an LOS not from the ExpressLane but attach a 95 modifier?**

There are specific CPT codes that qualify for telehealth billing under the Interim Final Rule. If a provider is interested in billing for a code not on the ExpressLane list, please use HELP99 with a comment to indicate what service is being requested. Revenue Cycle will review the request and determine if the service qualifies under the revised telehealth regulations.

**Q15. When we see patients by Video at either DCAM or River East, does the hospital also get reimbursement from insurance providers for the facility fee or just professional fee?**

River East is considered a Physician Office place of service and therefore a hospital facility fee is not applicable. However, this is allowed for DCAM which is a hospital outpatient provider based department setting.

**Q16. If patient does not want to use their camera during the zoom visit does that make it into a telephone visit, considering they are logged into Zoom but chose not to turn the camera on?**

If the provider and patient do not complete the entirety of the visit using video/camera, it is considered a telephone E&M (99441-99443). Do not select video visits if video is not used during the whole encounter.

**Q17. If the patient was registered as telephone visit on my EPIC clinic schedule but I change it to video by using Doximity and bill as video visit, will the billing department know that it was a video visit since the EPIC schedule will not match what is documented in the note?**

Select a Video Visit and ensure clinical documentation reflects how the visit was performed. When releasing telehealth claims, coding staff will also review the charge to confirm the correct code (video vs. telephone).

## PRIMARY CARE EXCEPTION

**Q18. Who can use primary care exceptions? How do we apply primary care exceptions to video-based encounters?**

In general, primary care exception typically applies to residency programs within: General Internal Medicine, General Pediatrics, Family Practice, Geriatrics, and Obstetrics/ Gynecology. Please check with your section administrator for question regarding your department.

Under the original requirements (pre Public Health Emergency), residents working under the primary care exception (PCE) could see patients without the attending having a face to face encounter for low & mid-level E&M services (99201-99203, 99211-99213). The attending is present in clinic, immediately available, and is supervising no more than 4 residents during the clinic session. However, during the PHE, The Interim Final Rule allows residents to independently see patients under the PCE for all OP E&M levels (99201-99205, 99211-99215). (continued next page)

The other requirements still apply – including that the teaching physician must have no other responsibilities at the time, and must review the patient's medical history, physical examination, diagnosis, and record of tests and therapies with each resident. CMS has clarified that for Primary Care Exception services, that the teaching physician can provide the necessary direction, management and review of the resident's services using interactive audio/video real-time communications technology. Thus the teaching physician has to be immediately available to provide direct supervision via video, but does not need to be present via video during the resident's performance of the service.

**Q19. For a video visit using the Primary Care Exception, do we use the amount of time that the resident or the attending spent on that calendar day for billing?**

For Primary Care Exception clinics only, the residents time may be used toward Billing, as long as all of the other Primary Care Exception rules are met.

**Q20. Using the Primary Care Exception (PCE) can discussing the case "immediately" mean that the attending can discuss all patients at the end of a resident or fellows' clinic, or must you discuss each one right after each appointment?**

The requirement prior to the PHE that an Attending providing PCE supervision must review the care furnished by the residents during, or immediately after each visit has not changed. Therefore, waiting until the end of a clinic day to discuss all patients does not meet PCE guidelines. The review during or immediately following the visit must include: a review of the patient's medical history and diagnosis, the resident's findings on physical examination, and the treatment plan.

## RESIDENTS, SUPERVISION, SPLIT SHARED

**Q21. Are we allowed to do split-share billing with APPs?**

CMS has not issued any guidance in the context of Split/Shared billing during the public health emergency (PHE). Based on existing rules and the requirement for participation in at least one of the three components (History, Exam and Medical Decision Making), the billing providers involvement in medical decision making continues to be the primary contributing factor for selecting the billing level.

**Q22. How do we incorporate APPs helping with MD clinic into the billing?**

There is no formal guidance on split shared billing.

**Q23. How do we incorporate residents into non-PCE clinic billing – is using their time or MDM allowed?**

In the non-PCE clinics, when conducting a video visit, you can only count the teaching physician's time on the video visit, and the teaching physician's time on non-face to face work (i.e., coordination of care, chart review, ordering of studies, etc.). Alternatively, documentation and contribution in medical decision making (MDM) by the resident with supervision of the teaching physician may be used to select the appropriate

level of service for a video visit. When conducting a telephone encounter in non-PCE, only the teaching physician's time spent in medical discussion with patient or representative on the phone call may be counted.

**Q24. On an outpatient telephone encounter that a resident performs, can the teaching physician attest to the visit and bill?**

Except for Primary Care Exception services, telephone visits performed by residents, without the attending participating in the telephone call with the patient are not billable services. Providers should select no charge [900] and use the attestation statement below accordingly. Revenue Cycle will monitor for coverage updates. If a provider, however does participate in all or part of the call with the resident, please note that only the attending time may be used for purposes of billing. Use **".ATTTELEHEALTHOUTPT",** then select "*ATTTELEHEALTH_TEACHING_PHYSICIAN*" from list.

**Q25. Have teaching physician "physical presence" requirements been relaxed for the COVID-19 emergency in terms of billing for outpatient based telehealth?**

Per the Interim Final Rule, CMS requires direct supervision of the Resident which is satisfied by the teaching physician being present during the key and critical portions of the service by video (e.g., Zoom) or phone for audio-only services. It is up to the teaching physician whether they feel it is appropriate to exercise this flexibility. Note that this flexibility does not apply to surgical, high risk, or other complex procedures including anesthesia services. The teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. This also applies to the teaching anesthesiologists. For Primary Care Exception clinic visits, the rules vary, please see the Primary Care Exception section for specifics.

**Q26. Since resident supervision may be met via audio-visual presence for outpatient telehealth, can the audio/visual interaction be done *after* the resident sees the patient?**

No, at this time CMS requires that the attending be present during the key and critical portions of the service for billing.

**Q27. As an Attending, if a resident or fellow sees the patient but I still review the data and make the plan jointly, can I bill for Inpatient rounding services with the ".ATTESTNOTINROOMINP" attestation?**

No, if you're not personally seeing the patient at the bedside, via telephone, or via interactive telecommunication (i.e. Zoom video), you should select ".ATTESTNOTINROOMINP" and select the "No Charge [900]" code. However, note that Revenue Cycle will hold cases with this attestation until further guidance from CMS is provided. If, however the inpatient is seen via Video or you communicate via telephone, please see Q27 for Inpatient billing scenarios.

**Q28. When and how should the updated attestation statement for the Inpatient Setting ".ATTTELEHEALTHINPT" be used, including when Housestaff is involved…and when is an Inpatient service billable using this attestation?**

When "**.ATTTELEHEALTHINPT"** is selected for attestation, the provider will be able to choose between the two SmartText options listed below. Use these when the attending does not have a face-to-face encounter with the patient; billable and non-billable scenarios are outlined below.

- *"ATTTELEHEALTH_IP_Provider" I {DID/DID NOT} participate in key portions of the encounter via [Video/Telephone].*

- *"ATTELEHEALTH_IP_TEACHING_PHYSICIAN" I {DID/DID NOT} participate in the key portions of the encounter performed via {Video/Telephone}. After discussion with Dr. ***. I agree with the house staff's note {as written / with exception:20717}.*

- **BILLABLE:** If you were not at the bedside but participated in one of the below ways, then select the appropriate Inpatient E/M Code for the service and specialty. Document the service based on the information available to you, including medical decision making, diagnoses, and time spent on the service**. Inpatient encounters may be leveled solely by time only when original time based requirements are met and documented (i.e. 50% or more time spent on counseling or coordination of care); otherwise use normal Hx, Exam, MDM leveling.**
  - ON CAMPUS:
    - Zoom Video = Select corresponding level of service from below Inpatient E/M table*
    - Audio Discussion Only = Select corresponding level of service from below table*
  - OFF CAMPUS:
    - Zoom Video = Select corresponding level of service from below Inpatient E/M table*
    - Audio Discussion Only = Use Telephone E/M 99441-99443
      - 99441: 5-10 min of medical discussion
      - 99442: 11-20 min of medical discussion
      - 99443: 21-30 min of medical discussion

* The below table lists the most common Inpatient codes but do not represent all Inpatient services:

| Inpatient E/M Codes (Use Hx, Exam, and MDM or Time only when Counseling + Coord over > 50% of encounter**) | | Inpatient Consultations (Use Hx, Exam, and MDM or Time only when Counseling + Coord over > 50% of encounter**) | |
|---|---|---|---|
| Initial 30 min [99221] | Sub 15 min[99231] | 20 min [99251] | 80 min [99254] |
| Initial 50 min [99222] | Sub 25 min [99232] | 40 min [99252] | 110 min [99255] |
| Initial 70 min [99223] | Sub 35 min [99233] | 55 min [99253] | |
| **See Original Time Based Coding Req. for Time | | | |

- **NOT BILLABLE:** If you were not at the bedside, or did not see the patient via telephone or via Video (Zoom), then Select "No Charge [900]". Please still document the medical decision making, diagnoses, and time spent on the service. Revenue Cycle will hold these charges until further guidance from CMS is provided on these scenarios. For more information, please see Provider Billing Tip Sheet.

**Q29. If I am next to my resident while they are making and performing a telephone call, does that count as my billable time?**

In non-Primary Care Exception clinics, if you are able to hear both the patient and the resident on the telephone call, then you can count that as billable time. For Primary Care Exception clinics only, the resident's time may be used toward Billing, as long as all of the other Primary Care Exception rules concerning supervision are met.

## OTHER QUESTIONS & VISIT TYPES

**Q30. Does the global period for video visits still apply just as they would in person?**

Yes. There have been no changes to the requirements for global periods.

**Q31. Can a provider bill chronic care management using telehealth? If so, are there modifiers that should be used?**

Chronic care management is not considered telehealth defined by CMS, however you may communicate via telephone as needed to carry out management activities. Chronic Care Management services were designed to be non-face-to-face, billed once a month for the coordination of a patient's chronic care. If communication occurs by telephone or email to complete any of the month's coordination activities, this is allowed. No telehealth modifiers are required.

Finally, please follow your departments documentation and billing process for Chronic Care Management, as there are multiple criteria, limitations, and consideration for providing and billing these services to patients.

**Q32. Can a provider bill transitional care management using telehealth?**

Yes, transitional care management codes 99495-99496 for newly discharged Inpatients are on Medicare's list of allowed telehealth services. Initial contact must be made with the patient within 2 business days and can be done by telephone. The face-to-face visit required within either 14 or 7 days, may be done via Video Visit (i.e. Zoom).

- **99495** Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period **Face-to-face visit, within 14 calendar days of discharge**
- **99496** Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period **Face-to-face visit, within 7 calendar days of discharge**

**Q33. Are providers able to perform the Medicare Initial Preventive Physical Exam (IPPE – G0402) via telehealth during the emergency?**

No, at this time the IPPE must be performed face-to-face to bill Medicare. Providers should consider delaying the IPPE until normal face-to-face services are able to resume.

**Q34. Are providers able to perform the Medicare Annual Wellness Visit (AWV – G0438 & G0439) during the emergency?**

Yes, however due to the numerous specific requirements we only recommend departments who previously conducted Annual Wellness Visits perform them during the health emergency. Note that the visit should be conducted via audio/video technology (i.e. Zoom video); see Q11 for more information and a link to AWV billing information.

**Q35. Does the hospital bill a hospital portion of postop visits that are within the global period – can we do telemedicine visits for these?**

You can perform the professional post-op service virtually, but they must still be billed as a postoperative visit (99024). At this time a hospital cannot bill a corresponding facility fee since 99024 is not on the CMS Telehealth List.

**Q36. The attestation statement that we are asked to use (.ATTTELEHEALTH, etc) has a sentence about time. If we use MDM for billing should we still include time spent in the attestation statement?**

When you select the level based on MDM, it is optional to document time spent on the visit.

## SCHEDULING & APPOINTMENTS

**Q37. Do I need to preferentially schedule video visits at POS11 (Physician Office, non-hospital) sites when possible?**

Video and telephone visits should be scheduled onto existing provider schedules. If a provider has existing templates at offsite locations (such as River East, Orland Park, South Loop), telemedicine visits may be scheduled into these locations.

**Q38. What happens if someone forgets to arrive the patient, can we document and bill and then have someone arrive them later?**

Services that are performed should be documented. Revenue Cycle and UCM IT are still reviewing the impact of arriving a scheduled appointment after the service is completed. The standard workflow is for scheduled services to be arrived prior to the service being performed.

**Q39. Should clinics be going back and creating an appointment for previous telephone/video encounters that did not follow the new workflow?**

Not at this time. Revenue Cycle and UCM IT are reviewing the Epic options to create billing encounters for previous telephone/video encounters that did not follow the new workflow. All areas are asked to follow the new standard work for scheduling and arriving video and telephone visits.

## VERBAL CONSENTS

**Q40. What is the consent process for telehealth type encounters?**

Below are the general steps for Verbal Consent for telehealth:

1. *Verify the patient's identity*: verify identify by confirming patient's name and DOB. If the patient is a minor or does not have the capacity to provide consent, ensure the parent or authorized representative is able to remain present for the entirety of the visit or key portions, as appropriate

2. *Discuss & Document informed consent*: discuss informed consent with the patient, including any risks relative to the nature of the visit. Ask if the patient has any questions. Document any questions asked and that informed consent to proceed with the video visit was obtained from the patient.

3. *Obtain consents for treatment, if recommended during visit*: as applicable obtain any necessary consents for treatment according to the verbal consent process outlined in the question below.

**Q41. Where written consent forms were previously required for certain treatments & service; how do we appropriately obtain a verbal informed consent instead?**

In lieu of written consent, you may obtain the verbal consent of the patient by communicating all elements of informed consent to the patient or their representative. Explain why written consent is not being obtained and that "Verbal Consent from Patient" will be written on the consent form, along with the patient's last name.

Add the completed form to the patient's medical record. If the patient requests a copy, a blank copy of the consent may be provided to the patient or their rep and does NOT need to be returned to the provider or staff member.

**For Telemedicine Billing Questions Contact: Telemedicine.BillingQuestion@uchospitals.edu**

ATTESTATION STATEMENTS

**Instructions: 1) Choose either Outpatient or Inpatient Attestation 2) Choose SmartText specific to situation.**

## OUTPATIENT = .ATTTELEHEALTHOUTPT

| Outpatient Selections | Core Statement | Video Selected | Telephone Selected |
|---|---|---|---|
| **ATTTELEHEALTH_TEACHING_PHYSICIAN**<br>For Attending/APP Supervising Housestaff | I {DID/DID NOT} participate in the key portions of the encounter performed via {Video/Telephone}. After discussion with Dr. ***. I agree with the house staff's note {as written / with exception:20717}. | *I spent a total of *** minutes in care of this patient on [DATE PATIENT WAS SEEN BY ME:22094524] . {More/Less} than 50% of time was spent in counseling and/or coordination of care . I {was/was not} onsite.* | *I spent *** minutes on the telephone with the patient on the date of this encounter. I [was/was not] onsite.* |
| **ATTTELEHEALTH_PCE_TEACHING_PHYSICIAN**<br>For Attending/APP Supervising PCE Housestaff | I discussed this encounter with Dr. ***, which included a review of the patient's medical history, diagnosis and treatment plan. I agree with the assessment and plan {as written/with exception:20717}. The encounter was conducted via {Video/Telephone}. | | |
| **ATTTELEHEALTH_PROVIDER**<br>For Attending/APP Alone **&**<br>Housestaff (use prior to routing to Attending) | The {PATIENT/SURROGATE:935} participated in the encounter via {Video/Telephone}. Identity was verified by name and {identityconfirmation:931}. Verbal consent for the visit was provided. | *I spent a total of *** minutes in care of this patient on [DATE PATIENT WAS SEEN BY ME:22094524] . {More/Less} than 50% of time was spent in counseling and/or coordination of care . I {was/was not} onsite.* | |

## INPATIENT = .ATTTELEHEALTHINPT

| Inpatient Selections | Core Statement | Video Selected | Telephone Selected |
|---|---|---|---|
| **ATTTELEHEALTH_IP_PROVIDER**<br>For Attending/NPP without supervision of Housestaff | I {DID/DID NOT} participate in key portions of the encounter via [Video/Telephone]. | *I spent a total of *** minutes in care of this patient on [DATE PATIENT WAS SEEN BY ME:22094524] . {More/Less} than 50% of time was spent in counseling and/or coordination of care . I {was/was not} onsite.* | *I spent *** minutes on the telephone with the patient on the date of this encounter. I spent a total of *** minutes in care of this patient on [DATE PATIENT WAS SEEN BY ME:22094524] . *** minutes were spent in counseling and/or coordination of care. I [was/was not] onsite.* |
| **ATTTELEHEALTH_IP_TEACHING_PROVIDER**<br>For Attending/NPP supervising housestaff | I {DID/DID NOT} participate in the key portions of the encounter performed via {Video/Telephone}. After discussion with Dr. ***. I agree with the house staff's note {as written / with exception:20717}. | | |

MDM Table (99202-99215 only)

**Instruction:** To qualify for a particular type of Medical Decision Making, criteria from at least two of three categories must be satisfied to select the level of MDM (i.e. High, Moderate, Low, etc.)

## Step 1: Calculate Number & Complexity of Problems

| Element | • 1 self-limited or minor problem<br>*(runs a prescribed course, is transient in nature, and is not likely to permanently alter health status)* | • 2 or more self-limited or minor problem<br>• 1 stable chronic illness *(ie, well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia)*<br>• 1 acute, uncomplicated illness or injury *(i.e. cystitis, allergic rhinitis, or a simple sprain)* | • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment *(requires supportive care or attention to side effects, but not hospitalization)*<br>• 2 or more stable chronic illnesses<br>• 1 undiagnosed new problem with uncertain prognosis<br>• 1 acute illness with systemic symptoms *(ie, pyelonephritis, pneumonitis, or colitis)*<br>• 1 acute complicated injury *(ie, head injury with brief loss of consciousness)* | • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment *(significant risk of morbidity; may require hospitalization)*<br>• 1 acute or chronic illness or injury that poses a threat to life or bodily function, i.e.:<br>* *acute myocardial infarction,*<br>* *pulmonary embolus,*<br>* *severe respiratory distress*<br>* *progressive severe rheumatoid arthritis*<br>* *psychiatric illness with potential threat to self or others*<br>* *Peritonitis*<br>* *acute renal failure*<br>* *abrupt change in neurologic status* |
|---|---|---|---|---|
| **Complexity Level** | **Minimal** | **Low** | **Moderate** | **High** |

## Step 2: Calculate Amount and/or Complexity of Data to be Reviewed and Analyzed

| **Complexity Level**<br>Must meet category requirements specified here → | **Minimal**<br>MINIMAL OR NO DATA | **Limited**<br>MEET CATEGORY 1 BELOW | **Moderate**<br>MEET 1 OF 3 CATEGORIES BELOW | **Extensive**<br>MEET 2 OF 3 CATEGORIES BELOW |
|---|---|---|---|---|
| **CATEGORY 1**<br>**1.** Review of prior external note(s) from each unique source*<br>**2.** Review of the result(s) of each unique test*;<br>**3.** Ordering of each unique test* (order of test includes review of results)<br>**4.** Assessment requiring an Independent historian<br>*Each unique test, order, or document may be counted | | **Category 1:** Meet any combination of 2 from items 1-3<br>**Or**<br>Meet item 4 (independent historian) | **Category 1:** Meet any combination of 3 from items 1-4 | **Category 1:** Meet any combination of 3 from items 1-4 |
| **CATEGORY 2:** independent interpretation of tests—*performed by another physician/other qualified healthcare professional (not separately reported)* | | | **Category 2:** Independent interpretation of test | **Category 2:** Independent interpretation of test |
| **CATEGORY 3:** Discussion of management or test interpretation—*with external physician/other qualified health care professional/ appropriate source (not separately reported)* | | | **Category 3:** Discussion mgmt., or test interpretation (external) | **Category 3:** Discussion mgmt., or test interpretation (external) |

**Step 3: Calculate Risk of Complications and/or Morbidity or Mortality of Patient Management Decisions Made at the Visit Associated with the Patient's Problems, the Diagnostic Procedure(s), and Treatment(s)** Select the risk level associated with the patient's problems, diagnostic procedures and treatments

| **Description** | Minimal risk of morbidity from additional diagnostic testing or treatment<br>Examples only<br>• Rest<br>• Gargles<br>• Elastic bandages<br>• Superficial dressings | Low risk of morbidity from additional diagnostic testing or treatment<br>Examples only<br>• OTC drugs<br>• Minor surgery w/no identified risk factors<br>• Physical/Occ therapy | Examples only<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health | Examples only<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to deescalate care because of poor prognosis |
|---|---|---|---|---|
| **Risk Level** | **Minimal** | **Low** | **Moderate** | **High** |

**Step 4: Calculating Level of Medical Decision Making** - Select the corresponding complexity level below that was calculated for Elements 1-3. To qualify for a particular level of medical decision making, two of the three elements for that level of decision making must be met or exceeded. If a column has 2 or 3 selections, draw a line down the column and select the code. Otherwise, draw a line down the column with the center selection and select the code.

| **ELEMENTS** | **COMPLEXITY LEVEL** | | | | |
|---|---|---|---|---|---|
| 1. Number and Complexity of Problems Addressed | N/A | Minimal | Low | Moderate | High |
| 2. Amount and/or Complexity of Data to be Reviewed and Analyzed | N/A | Minimal or None | Limited | Moderate | Extensive |
| 3. Risk of Complications and/or Morbidity or Mortality of Patient Management | N/A | Minimal Risk | Low Risk | Moderate Risk | High Risk |
| **LEVEL of MDM** | **N/A**<br>**99211** | **Straightforward**<br>**99202 (New)**<br>**99212 (Est)** | **Low**<br>**99203 (New)**<br>**99213 (Est)** | **Moderate**<br>**99204 (New)**<br>**99214 (Est)** | **High**<br>**99205 (New)**<br>**99215 (Est)** |