COVID-19 FAQ's Provider Billing & Documentation
MD, APN, PA
Version: 4/14/20

Overview
Telephone Communication
Video Visits, Time & MDM
Primary Care Exception
Residents, Supervision, Split Shared
Other
Scheduling & Appointments
MDM Tools

OVERVIEW
Q1. What are the various types of Outpatient telehealth visits available for practitioners who may normally report an E/M?

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

<table>
<thead>
<tr>
<th>Patients at home interacting with Provider via Communication Based Technologies or Telehealth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E-visits (MyChart)</strong> Online Portal</td>
</tr>
<tr>
<td>99421: 5-10 minutes</td>
</tr>
<tr>
<td>99422: 11-20 minutes</td>
</tr>
<tr>
<td>99423: 21 or more minutes</td>
</tr>
<tr>
<td><strong>Telephone or Brief Virtual Check-in</strong></td>
</tr>
<tr>
<td>99441: 5-10 minutes</td>
</tr>
<tr>
<td>99442: 11-20 minutes</td>
</tr>
<tr>
<td>99443: 21-30 minutes</td>
</tr>
<tr>
<td><strong>Telehealth Video Visits</strong> (via Zoom, FaceTime, Skype, etc)</td>
</tr>
<tr>
<td>Billed/treated as in-person visit, i.e.:</td>
</tr>
<tr>
<td>Outpatient New: 99201-99205</td>
</tr>
<tr>
<td>Outpatient Est: 99211-99215</td>
</tr>
</tbody>
</table>

*For Usage By: Professionals who may report Evaluation & Management services, such as an MD, APN, or PA. For questions related to other practitioners see the OCC COVID-19 Newsletter

- **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
• **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 Q8 & Q9 for more guidance.

**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?**

Yes, you can document a telephone encounter and bill for a telephone E&M (99441-99443) service.

**VIDEO VISITS, TIME & MDM**

**Q4. What components should be used to level outpatient Evaluation & Management codes provided via Video Visits?**

On an interim basis, CMS is allowing that outpatient E/M level selection when furnished via telehealth can be based on 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 regarding documentation of History and/or Physical exam in the medical record. 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 that this does not prevent you from documenting any history or exam elements you were able to obtain or think are important to note. Even if these elements are not used in the selection of your level, history and exam elements can still assist in supporting medical necessity and establish patient course of care.

**Q5. How can I bill for a higher LOS for a video visit when I am unable to do a physical exam?**

CMS is allowing providers to determine their level of service based on the CY2021 guidelines, which include time or medical decision making. A comprehensive physical exam is not required.

**Q6. 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 examination the provider should document any visual exam components they can personally see and or observe or notate through the audio and/or visual interaction. Additionally, according to a call with NGS, a patient may self-report to their ability constitutional items like height, weight, and temperature.

History and Exam will no longer be required for leveling during the emergency, now Time or Medical decision making may be used.

However, if you would like to or need to still use history and exam elements for leveling, the level of CPT service selected and the supporting documentation should be sufficient to meet the key components and requirements of the service. Otherwise, use the lowest level that meets the required components of the service.
Q7. When should I think about billing based upon time versus Hx/Ex/MDM?

When history and/ exam are limited or counseling & coordination of care dominates the service. Two MDM tools are at the end of this document. MDM is determined based on data points, problem points, and complexity/risk.

Q8. 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, and management options selected.

Q9. What constitutes total time for a time-based encounter with and without resident involvement (for both video and telephone)?

All activity performed by the billing provider on same day of service as the telephone or video encounter.

Q10. 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?

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.

Q11. 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. The services to be included in an AWV may be found here: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7079.pdf.

Q12. 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.

PRIMARY CARE EXCEPTION

Q13. Who can use primary care exceptions? How do we apply primary care exceptions to video-based encounters?

Under the original terms, residents working in a primary care clinic under the primary care exception (PCE) can 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. The Interim Final Rule allows residents under the PCE to see all OP E&M levels (99201-99205, 99211-99215) without the attending having a face to face encounter. The other rules still apply - no more than 4 residents per attending during the clinic session, and the teaching physician has to be immediately available (although direct supervision may be met via video or in-person).

RESIDENTS, SUPERVISION, SPLIT SHARED

Q14. Are we allowed to do split-share billing with APPs?

CMS hasn’t specifically addressed Split/shared in a facility setting, but if we apply the general waivers - then both APN and attending will need to see/speak to the patient. Each provider needs to document their contributions, and sign their note.
Q15. On an outpatient telephone encounter that a resident performs, can the teaching physician attest to the visit and bill?

It is unclear at this time whether telephone visits performed by residents, without the attending are billable services as CMS’s expansion of the teaching physician rule has only been extended to video visits and requires the attending to be available/participate by video.

In the interim, providers should select a Telephone E/M from the 99441-99443 series and use the attestation statement below accordingly. Revenue Cycle will hold claims pending coverage updates.

- “.ATTTELHEALTHHOUSESTAFF”: I was immediately available during all aspects of the telemedicine encounter and after discussion with Dr. ***. I agree with the house staff’s note (as written / with exception:20717). I personally {DID / DID NOT:92163} speak to the {PATIENT, PARENT, LEGAL GUARDIAN:952} during this encounter. I spent *** minutes in the coordination of the patient's care

Q16. Have teaching physician “physical presence” requirements been relaxed for the COVID-19 emergency in terms of billing for outpatient based telehealth via Video Visits?

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 services by video (e.g., Zoom). Under the Primary Care Exception, CMS will pay for CPT 99201-99215 when a resident furnishes telemedicine services under the direct supervision of the teaching physician by video (e.g., Zoom).

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.

Q17. 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 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. Please see Q20 for more guidance.

Q18. When and how should the new attestation statement “.ATTESTNOTINROOMINP” be used and when is a service billable using this attestation?

The statement “.ATTESTNOTINROOMINP” outlined below should be used when the attending does not have a face-to-face encounter with the patient. Note that you must indicate whether or not you were present via video (i.e. Zoom).

“.ATTESTNOTINROOMINP” I spent *** minutes in the coordination of the patient’s care on {DATE PATIENT WAS SEEN BY ME:22094524}. I {DID / DID NOT:92163} participate in key portions of the encounter via video.

- **BILLABLE**: If you were not at the bedside but participated virtually via video (i.e. Zoom), then select the appropriate Inpatient Initial, Subsequent, or Consultation codes based on time based requirements. Please document the medical decision making, diagnoses, and time spent on the service to support the charge.

- **NOT BILLABLE**: If you were not at the bedside but participated via telephone or via conversations on the floor or unit, then Select No Charge. 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.
**Q19.** 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.

**Q20.** Can a provider bill chronic care management using telehealth? If so, are there modifiers that should be used?

No, chronic care management is not applicable to the concept of telehealth but you may communicate via telephone as needed to carry out management activities. Chronic Care Management services are already intended to be non-face-to-face services billed once a month for the coordination of a patient’s chronic care. If you need to communicate by telephone or email to complete any of the month’s coordination activities, this is allowed due to the non-face-to-face nature of the service. No modifiers are required specific to telehealth as the service is not applicable as a true telehealth service.

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.

**Q21.** Can a provider bill transitional care management using telehealth?

Yes, transitional care management codes 99495-99496 for newly discharged Inpatients as outlined below 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**

**SCHEDULING & APPOINTMENTS**

**Q22.** 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.

**Q23.** 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.

**Q24.** 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.

For questions, contact the Office of Corporate Compliance at compliance@bsd.uchicago.edu.
**Instruction:** See “Grid B” below or link to AMA for guidance by CPT code: **AMA’s MDM Grid**

<table>
<thead>
<tr>
<th><strong>GRID A</strong></th>
<th><strong>HISTORY</strong></th>
<th><strong>EXAM</strong></th>
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<tr>
<td>(C) COMPREHENSIVE</td>
<td>YES</td>
<td>4+</td>
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<tr>
<td>(D) DETAILED</td>
<td>YES</td>
<td>4+</td>
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<tr>
<td>(E) EXPANDED</td>
<td>YES</td>
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<td>(F) PROBLEM FOCUSED</td>
<td>YES</td>
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**GRID B**

<table>
<thead>
<tr>
<th><strong>DECISION MAKING - 1 OF 3</strong></th>
<th><strong>DATA POINTS</strong></th>
<th><strong>PROBLEM POINTS</strong></th>
<th><strong>RISK CLASSIFICATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(H) HIGH</td>
<td>4</td>
<td>4</td>
<td>High</td>
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<tr>
<td>(M) MODERATE</td>
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<td>Mod</td>
</tr>
<tr>
<td>(L) LOW</td>
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<td>2</td>
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<tr>
<td>(S) Straightforward</td>
<td>0 to 1</td>
<td>0 to 1</td>
<td>minimal</td>
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**DATA POINTS**
- Lab tests *
- Radiology *
- Medicare tests *
- Independent Visualization
- Additional Data
  - Old records
  - Hx from others
  - Discuss w/ other healthcare provider

**PROBLEM POINTS**
- New Problem
- Established Problem
- Worsening

**RISK CLASSIFICATIONS**
- Chronic illness w/ severe exacerbation, progression or side effects of treatment
- Acute problem poses a threat to life
- Abrupt change in neurologic status (eg, seizure, TIA, weakness, sensory loss)
- Parenteral controlled substances, drug therapy requiring intensive monitoring for toxicity
- DNR/DNI decision
- Chronic illness w/ mild exacerbation, progression or side effects of treatment
- 2 or more stable chronic problems
- Undiagnosed new problem w/ uncertain prognosis
- Prescription drug management, IV fluids w/additive

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**1995 E & M GUIDELINES**

**INPATIENT**

**ADMISSION – 3 OF 3**

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<tr>
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<td>C</td>
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**NEW, INITIAL INPT & OUTPT CONSULT – 3 OF 3**

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**SUBSEQUENT DAY – 2 OF 3**

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**RETURN – 2 OF 3**

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<tbody>
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<td>Minimal problem that may not require presence of physician</td>
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Refer to “Grid A” for history & exam definitions, to “Grid B” for decision making definitions.