

## TELEMEDICINE AUDIO/VISUAL – DOCUMENTATION FOR CPT CODE 99212

CPT 99212 is an office or other outpatient visit for the evaluation and management (E&M) of an established patient. This code can also be used for Telemedicine Services under certain circumstances. History and decision making should be the main focus of these visits. Documentation requirements for a telehealth service are the same as for a face to face encounter. Best practice suggests that documentation should also include a statement that the service was provided through telehealth, both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service. The patient must consent to the visit.

**\*When billed as a Telemedicine Service use the place of service code “02” and append modifier “GT”. Medicare Part B does not require the GT modifier. Documentation should also include both patient and provider location and identified as telehealth service.**

### Two out of the Three following key components are required:

- A problem focused history
- A problem focused examination
- A medical decision making straightforward

### Problem Focused History includes all of the following components:

- A chief complaint
- A brief history of the present illness (1-3 HPI elements).  
Elements include location, quality, severity, timing, context, modifying factors or associated signs or symptoms.
- A PFSH or ROS is **not** required.

### Problem Focused Exam includes the following 2 options:

- An examination of 1 – 5 bullets in 1 or more areas or systems for '97 Guidelines.
- **OR** review of 1 body area or system for '95 Guidelines.

### Straightforward Medical Decision Making – meets or exceeds 2 out of 3 of the following components:

- Number of diagnoses or treatment options  $\leq$  1 problem points
- Amount and complexity of data to be reviewed  $\leq$  1 data points
- Assessment of risk (complications, morbidity, mortality) = minimal

### Time used as the sole component and basis for 99212:

The provider may document that out of the total time of 10 minutes or more, over 50% of the encounter time was spent face-to-face counseling and/or coordinating care. Documentation must be specifically noted regarding some of the following details:

- Prognosis
- Differential Diagnosis
- Risks and Benefits of Treatment
- Instructions
- Compliance
- Discussion with Another Health Care Provider

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of service of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.



### **Telehealth Coding Example 99212**

Patient is located in Connecticut. Patient [other participant] participated in telehealth visit. This provider is part of the telehealth program and is conducting this visit in office or another appropriate site within Connecticut. For this visit, the physician and patient were present via interactive audio & video telecommunications system that permits real-time communication. Patient consent for telemedicine visit was obtained.

**Chief complaint:** Patient has lower back strain.

**History:** 55 y.o. male with 3-week history of chronic lower back pain. Pain is dull and intermittent. Wife reports pt has found relief with 800 mg Ibuprofen. No chest pain, shortness of breath or abdominal pain at rest. Using Ibuprofen with stable improvement in symptoms. Patient reports pain started after extensive walk in park.

**Examination:**

Musk/Skeletal-Normal range of motion

Neuro-Normal Gait

**Assessment and Plan:**

Patient experiencing gradual recovery. Current treatment of rest and Ibuprofen as needed. Follow as needed.

Signed and Dated *Dr John Smith-Jones, MD 3/15/2020*

## TELEMEDICINE AUDIO/VISUAL - DOCUMENTATION FOR CPT CODE 99213

CPT 99213 is an office or other outpatient visit for the evaluation and management (E&M) of an established patient. This code can also be used for Telemedicine Services under certain circumstances. **History** and **decision making** should be the main focus of these visits. Documentation requirements for a telehealth service are the same as for a face to face encounter. Best practice suggests that documentation should also include a statement that the service was provided through telehealth, both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service. The patient must consent to the visit.

**\*When billed as a Telemedicine Service use the place of service code "02" and append modifier "GT". Medicare Part B does not require the GT modifier. Provider's documentation should include both patient and provider location and identified as telehealth services.**

### Two out of the Three following key components are required:

- An expanded problem focused history
- An expanded problem focused examination
- A medical decision making of low complexity

### Expanded Problem Focused History includes all of the following components:

- A chief complaint
- A brief history of the present illness (1-3 HPI elements).  
Elements include location, quality, severity, timing, context, modifying factors or associated signs or symptoms.
- It does **not** need any of the 3 elements of either Past, Family or Social Histories.
- A review of 1 system.

### Expanded Problem Focused Exam includes the following 2 options:

- An examination of 6 bullets in 1 or more areas or systems for '97 Guidelines.
- **OR** review of 2-7 body areas or systems (check list type **without** any expansion of documentation of findings) for '95 Guidelines.

### Low Complexity Medical Decision Making – meets or exceeds 2 out of 3 of the following components:

- Number of diagnoses or treatment options = 2 problem points
- Amount and complexity of data to be reviewed = 2 data points
- Assessment of risk (complications, morbidity, mortality) = Low

### Time used as the sole component and basis for 99213:

The provider may document that out of the total time of 15 minutes or more, over 50% of the encounter time was spent face-to-face counseling and/or coordinating care. Documentation must be specifically noted regarding some of the following details:

- Prognosis
- Differential Diagnosis
- Risks and Benefits of Treatment
- Instructions
- Compliance
- Discussion with Another Health Care Provider



### Telehealth Coding Example 99213

Patient is located in Connecticut. Patient [other participant] participated in telehealth visit. This provider is part of the telehealth program and is conducting this visit in office or another appropriate site within Connecticut. For this visit, the physician and patient were present via interactive audio & video telecommunications system that permits real-time communication. Patient consent for telemedicine visit was obtained.

**Chief complaint:** Patient has cough x 3 days

**History:** 55 y.o. male with 3-day history of worsening cough. Cough is moderately severe, no expectoration. Wife reports pt was “up all night” coughing. No chest pain, reports mild shortness of breath when climbing stairs. Using dextromethorphan cough syrup with no improvement in symptoms. No travel or other evidence of community exposure to coronavirus.

**Examination:**

**Respiration** 20

**Temperature** P.O. temp 99.0 by patient

**General appearance of patient** Well-developed patient appearing unwell, fatigued, dressed in night clothes

Exam- 95 Guideline	Exam- 97 Guideline
Ears, Nose, Mouth, Throat	Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Chest	Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)

**Assessment and Plan:**

Patient cough for 3 days reportedly getting worse, mild fever. Current treatment of rest, cough syrup and fluids modestly effective. Prescription for benzonatate (Tessalon Perles) 100 mg three times daily as needed for cough #30. Pt instructed to contact 911 for difficulty breathing, chest pain, stridor, perioral cyanosis. Pt counseled to contact office in 2 days to report on symptoms and reassess need for inhalers or steroids.

Signed and Dated *Dr. John Smith-Jones, MD 3/15/2020*

## TELEMEDICINE AUDIO/VISUAL – DOCUMENTATION FOR CPT CODE 99214

CPT 99214 is an office or other outpatient visit for the evaluation and management (E&M) of an established patient. This code can also be used for Telemedicine Services under certain circumstances. History and decision making should be the main focus of these visits. Documentation requirements for a telehealth service are the same as for a face to face encounter. Best practice suggests that documentation should also include a statement that the service was provided through telehealth, both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service. The patient must consent to the visit.

**\*When billed as a Telemedicine Service use the place of service code “02” and append modifier “GT”. Medicare Part B does not require the GT modifier. Documentation should also include both patient and provider location and identified as telemedicine service.**

### Two out of the Three following key components are required:

- A detailed history
- A detailed examination
- A medical decision making of moderate complexity

### Detailed History includes all of the following components:

- A chief complaint
- An extended history of present illness (4 or more HPI elements or the status of 3 chronic conditions). Elements include location, quality, severity, timing, context, modifying factors or associated signs or symptoms.
- At least 1 of the 3 elements of either Past, Family or Social Histories.
- A review of 2-9 systems (noting the pertinent positives and the statement “all other systems Negative”).

### Detailed Exam includes the following 2 options:

- An examination of 12 bullets in 2 or more area or systems **OR** 2 bullets in 6 or more body areas or systems for '97 Guidelines.
- **OR** An examination of 2-7 areas or systems with expanded documentation of the normal/abnormal areas, requires more than checklists for the '95 guidelines.

### Moderate Medical Decision Making includes at least 2 of the following components:

- Number of diagnoses or treatment options = 3 problem points
- Amount and complexity of data to be reviewed = 3 data points
- Assessment of risk (complications, morbidity and mortality) = Moderate

### Time used as the sole component and basis for 99214:

The provider may document that out of the total time of 25 minutes or more, over 50% of the encounter time was spent face-to-face counseling and/or coordinating care. Documentation must be specifically noted regarding some of the following details:

- Prognosis
- Differential Diagnosis
- Risks and Benefits of Treatment
- Instructions
- Compliance
- Discussion with Another Health Care Provider

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of service of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.



### Telehealth Coding Example 99214 Time-Based Coding

Patient is located in Connecticut. Patient [other participant] participated in telehealth visit. This provider is part of the telehealth program and is conducting this visit in office or another appropriate site within Connecticut. For this visit, the physician and patient were present via interactive audio & video telecommunications system that permits real-time communication. Patient consent for telemedicine visit was obtained.

**Chief complaint:** Patient has worsening cough x 3 days, febrile.

**History:** 55 y.o. male with 3-day history of rapidly worsening cough. Cough is severe, no expectoration. Wife reports pt was “up all night” coughing. No chest pain, reports shortness of breath at rest. Using dextromethorphan cough syrup with no improvement in symptoms. Had dinner with business client last week in New Rochelle, NY.

**Examination:**

**Respiration** 26

**Temperature** P.O. temp 102.2 by patient.

**General appearance of patient** Well-developed patient appearing unwell: shivering, fatigued, somnolent, and difficult to rouse. Dressed in sweatshirt.

Exam- 95 Guideline	Exam- 97 Guideline
Ears, Nose, Mouth, Throat	Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Chest	Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)

**Assessment and Plan:**

Patient cough for 3 days rapidly worsening, with fever and shortness of breath. Concerning for COVID-19 exposure due to symptoms and recent visit to NY. Contacted COVID hotline, in agreement pt in need of transport to ED. Instructed patients wife to call 911 and inform the ambulance of possible COVID risk. Contacted ED to relay concerns regarding COVID exposure and patient’s arrival by ambulance. While waiting for the ambulance, I counseled wife on need for self-quarantine until patient testing complete.

Spent a total of 30 minutes assessing patient, more than 50% of the time was related to counseling and coordination of care.

Signed and Dated *Dr. John Smith-Jones, MD 3/15/2020*