Provider Video Visit Documentation Coding and Billing as of 4/3/20

Video visit Billing General Principals

- New patient billing based solely on time-based coding with Medical Decision Making (MDM) supporting level chosen
- Established patient billing based on either time-based coding or standard E+M coding focusing on history and MDM since physical exam limited
- MDM is therefore key component for all

Time Based E/M Coding

- **Documenting Time is *required* for New Patients seen via video visit**
  - **Necessary elements of documentation:**
    - Duration of the encounter in the record
    - State that over 50% the time was spent on counseling and/or coordination of care.(FACE TO FACE TIME) (This rule is in the process of disappearing for some payers)
    - Nature of the counseling and/ or coordination of care must be specifically documented.
    - Absolutely essential to record the time spent.
    - Chief Complaint/Reason for visit, is required : documentation should support medical necessity.
    - NO **SPECIFIC** DOCUMENTATION REQUIREMENTS FOR HISTORY, PHYSICIAL EXAM *AND* MEDICAL DECISION MAKING.

Time Based E/M Coding

New Patient Visit code	Visit time	Minimum counseling time	Established patient visit code	Visit time	Minimum counseling time
99201	10 min	>5 min	99211	5 min	>2.5 min
99202	20 min	>10 min	99212	10 min	>5 min
99203	30 min	>15 min	99213	15 min	>7.5 min
99204	45 min	>22.5 min	99214	25 min	>12.5 min
99205	60 min	>30 min	99215	40 min	>20 min

Medical Decision Making – (MDM)

Medical Decision Making is the **key component** for telemedicine video visits.

There are three components to medical decision making:

1. Number of diagnoses or management options
2. Amount and/or complexity of data to be reviewed
3. Risk of complications

Assessment and Plan

- For each encounter an assessment, clinical impression, or diagnosis should be documented.
- For a presenting problem with an established diagnosis, the record should reflect whether the problem is
  1. Improved, well-controlled, resolving, or resolved; **OR**
  2. Inadequately controlled, worsening or failing to change as expected
- Having a differential diagnosis increases complexity
- Document treatment options and risks and benefits
- Summarize any pertinent old records, hospital records reviewed Just stating reviewed is not enough.

Risk of Complications

- Document Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making. *e.g. Patient with abscess and Diabetes, Strep throat with Diabetes and A fib on coumadin*

- Document If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter *e.g. Cath needed due to positive stress test*

- Document If a surgical or invasive procedure is performed at the time of the E/M encounter *e.g. Abscess I And D*

Risk of Complications

- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented. *e.g. referral for Cholecystectomy to Surgery asap*

- Renewing and/or changing medications and handing out drug samples are considered prescription drug management.

Tips

In order for CMS to make the payment, documentation submitted must indicate how the provider is treating, managing or addressing the chronic conditions

Language Samples:	
Assessment	Plan
Stable Improved Tolerating Meds Deteriorating Uncontrolled	Monitor D/C Meds Continue Current Meds Refuses Treatment Refer
Example of Acceptable Language	
Ex: Diabetes type 2, stable well controlled on meds Ex: COPD Stable on Advair	

Assessment & Plan/Medical Decision Making (MDM) Example

Acceptable Example

MEDICAL DECISION MAKING:

Patient presents to the office today for 6 month follow up to review lab work and ongoing care of hypertension, atrial fib, hyperlipidemia, and vitamin d deficiency. Labs reviewed with patient and questions answered.

1. Vitamin D deficiency: Vitamin D level 81. Continue current supplementation. Will check Vitamin D level with next blood draw.
2. Hyperlipidemia: Lipid panel on 10/23/2018 revealed LDL 82; HDL 91; Triglycerides 59. Liver function currently intact. Continue statin therapy. Will check lipid panel with next blood draw.
3. Hypertension: BP today in office excellent at 111/72. GFR 65; BUN 20; Creatinine 0.8. Continue current medication regimen.
4. Chronic A fib: Rate controlled. Anticoagulated with Eliquis. Denies issues with falls. Continue following with cardiology.
5. Severe lumbar osteopenia: According to 7/14/2016 DEXA scan, lumbar spine with no osteopenia or osteoporosis. Left and right hip osteopenia. Will discontinue Fosamax for now. Will repeat DEXA. Continue supplementation.

Follow up in 6 months with blood work. Call office for new/worsening conditions. Denies need for refills of medications today.