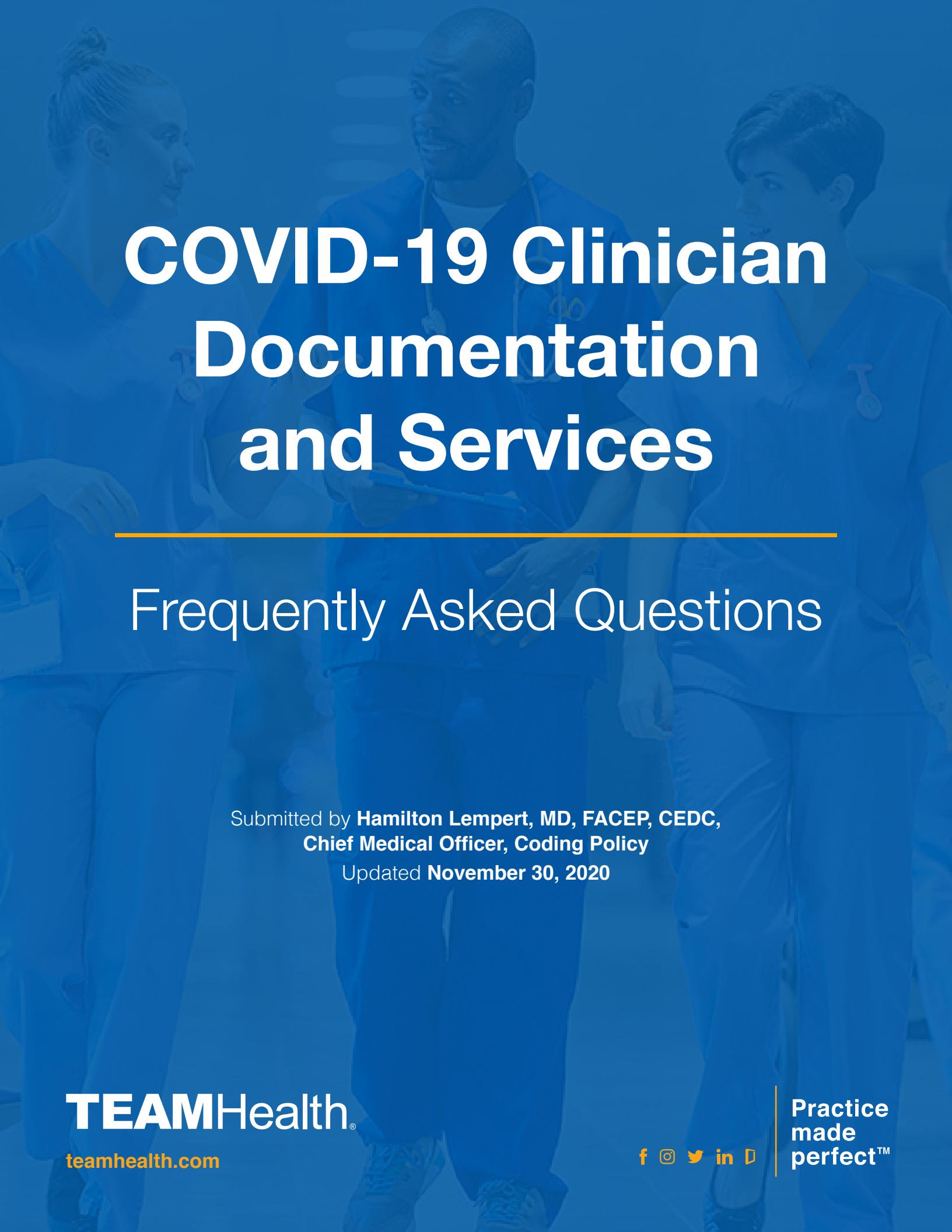

COVID-19 Clinician Documentation and Services

Frequently Asked Questions

Submitted by **Hamilton Lempert, MD, FACEP, CEDC,**
Chief Medical Officer, Coding Policy

Updated **November 30, 2020**

TEAMHealth®
teamhealth.com

Practice made perfect™

During the COVID-19 pandemic, many questions have arisen regarding documentation and services. Below are some frequently asked questions to serve as a resource for TeamHealth clinicians.

The rules are changing so fast. What should I do?

- First and always, take good care of the patient, the family, your staff and yourself.
- Document what you do, how you do it (in person face-to-face, audio/video [telemedicine], audio only [telecommunication]), and where you and the patient were located.
- Be as complete as possible with your History, Physical Exam and Medical Decision Making.
- Document the total time spent on taking care of the patient. If more than 50% of the total time was spent providing "counseling and/or coordination of care," document this fact and the total amount of time spent on the visit. Be sure to include details of the counseling and/or care coordination.

I am unable to enter the patient's room and can only communicate with audio. Is this OK?

- Unfortunately the answer to whether this is a billable situation is currently in flux. Some payers have stated that audio communication alone does not count as telemedicine, while others say it does. Others have indicated that if the clinician and the patient are in the same location, this would be considered a regular, non-telemedicine visit.
- If at all possible, perform and document some sort of face-to-face interaction with the patient, either through the window, door or video. If this is not possible, document the interaction you had, knowing it may or may not be billable.
- Document an exam of the affected area. For example, if the patient has shortness of breath, then comment if they have labored breathing or not. You can document physical findings by video or even audio communication.
- For subsequent visits, there is a requirement to complete two out of three key elements (History, Physical Exam and Medical Decision Making). We require Medical Decision Making to be one of the two. If you cannot perform a Physical Exam with sufficient detail, the service may still be billable with a sufficiently documented subsequent History. A subsequent History requires a defined number of History of Present Illness (HPI) elements and Review of System (ROS) elements. Past Family and Social History (PFSH) is not required for subsequent visits. It is also possible to count time as the determining factor if more than 50% of the time is spent in counseling and/or coordination of care. Documentation must include the total amount of time spent and details of the counseling and/or coordination of care.

I am evaluating patients who are physically in the ED via video technology while I am at the nurse's station. Is this considered telemedicine? What is the most appropriate documentation to clarify my use of technology during this time?

- No, this is not telemedicine for Medicare and many other payers. The service described is a regular visit. Telemedicine is when the patient and the clinician are not at the same location. "Same location" is defined similarly to the EMTALA requirements and is considered all buildings connected to or within 250 yards of the main hospital.
- The most appropriate documentation is to include the physical location of the patient, your physical location, the type of technology being used (e.g., audio/video, audio only), consent for services and the service provided. This will allow the coders to identify what is telemedicine and what is not. Some clinicians are stating they are using telemedicine and not stating where the clinician and patient are located, but it appears they were in the same facility. This is confusing as to whether it should be billed as telemedicine or not.

I discharged a patient from the hospital. Can I bill for a follow up phone call?

- An audio phone call to check on a patient post discharge was not billable before the COVID-19 pandemic and is still not billable.
- If you are the patient's primary clinician and would normally see the patient in your office, then an audio/video interaction would be billable and possibly even an audio-only interaction would be billable.

We have assigned a resident to see patients, and the attendings are signing off on the case. Is this OK?

- Supervision rules have not changed for Medicare. Attending physicians must personally evaluate a patient seen by a resident in order to bill using the resident's documentation. This evaluation and management (E/M) service can be completed by telemedicine.
- It is not a Medicare billable service to "sign off" on a resident's chart without the attending having performed some sort of patient evaluation between the patient and the attending.

Are these documentation changes permanent?

- Many of these changes are based on emergency proclamations by governors and the President. Most of these changes will expire when the stated emergency is considered over by those governing bodies.

Our Emergency Department (ED) has created a drive-by COVID-19 testing area. What do I need to document on these patients?

- These can be considered Medical Screening Exams (MSEs). You should document what you normally document in any chart, such as History, Physical Exam (including an exam of the affected area) and Medical Decision Making. Missing any one of these key elements will result in a non-billable chart.

The ED is boarding patients for days, or the ED is being asked to set up and staff a satellite intensive care unit (ICU). What should we document?

- There must be clear documentation that the ED visit has ended, and that the patient has been admitted to the hospital.
- Care for these patients needs to be documented on a daily basis with separate notes for each day of service.
- If you are documenting the care a patient receives while in the ED in a running ED note, it is important to separate each day of service in the ED note so that the E/M service provided on each day can be identified as specific to each day of service.
- You need to let leaders know that this service is being provided so that we can make sure to get the medical records. Non-ED notes are frequently stored differently.

Can we bill for prolonged services?

- Prolonged services can be billed when the clinician has provided extended services beyond that which is normally encompassed in the E/M code. Some payers do not cover this Current Procedural Terminology (CPT) code or do not cover prolonged services in combination with other codes.
- ED codes do not have a time component; therefore, they are not eligible for prolonged services.
- In the outpatient setting, the prolonged care codes require direct face-to-face patient contact. Therefore, the time to don or doff personal protective equipment (PPE) or review medical records is not part of this time.
- In the inpatient setting, these codes include the face-to-face time and the time on the unit/floor, but the time spent on the unit/floor must be spent in services related to the patient. Some payers will only allow time spent face to face with the patient.
- Prolonged services require specific documentation of the prolonged time spent, which is at least 30 minutes beyond the normal time for the service. Documentation should reflect what was done with this extra time.

Is taking care of COVID-19 patients considered critical care? Is donning and doffing PPE considered critical care?

- Critical care is well defined, and that definition has not changed. “A critical illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition.”
- Simply having COVID-19 does not qualify as critical care, but if the patient fulfills the critical care criteria then critical care can be billed.
- Time for critical care is time spent specifically caring for a particular patient. Just like the time putting on a pair of gloves is part of critical care time, so is the donning and doffing of PPE. However, it must be time dedicated to an individual patient.

Advanced practice clinicians (APCs) who are not part of my group have been sent by my facility to help care for patients. Can I supervise them and bill for those services?

- First and foremost, provide good care to the patients. If that includes using APCs from other departments, then by all means accept their help within state supervision and scope of practice rules. However, realize that those services might not be credited to you or billable by your group.
- Your group cannot bill for services provided by non-affiliated clinicians. Performing a shared visit with a non-affiliated APC cannot be billed by your group.
- In order for an affiliated clinician to bill for services performed, either solely or in conjunction with a non-affiliated APC, the affiliated clinician must fully perform and document their own E/M service without relying on the services or documentation provided by the non-affiliated APC. In order for services by non-affiliated APCs to be billable, there must be business agreements, insurance credentialing and malpractice arrangements. This can be done on a pre-planning basis but is virtually impossible after the fact.

The literature is considered current as of November 30, 2020, and changing frequently; this document is provided for informational and educational purposes; it is not intended to replace clinical judgement, information from relevant professional societies or any information from the Centers for Disease Control and Prevention or the World Health Organization.