



Telemedicine Documentation Guidance during the COVID-19 Pandemic

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The purpose of this document is to provide clinicians with guidance documenting telemedicine and telecommunication services to all patients – not just COVID-19 patients – in all service lines during the COVID-19 pandemic.

Changing rules

- In light of the COVID-19 pandemic, Centers for Medicare and Medicaid Services (CMS) announced that certain restrictions for providing telemedicine services are being lifted.
- Other payers are modifying rules too.
- Unfortunately, this is not a coordinated effort; therefore, clear, specific guidance is difficult.
- This document will provide broad instructions on documentation requirements.

Defining telemedicine and lifting restrictions

- Telemedicine is a service provided on a communication platform that supports both audio and video two-way synchronous communication when the clinician and the patient are in different locations.
- There are several telecommunication services that are different from telemedicine. Telecommunication differs from telemedicine in that telecommunication is without synchronous audio/visual two-way communication. These codes are time based and require the time spent providing service to be documented in the medical record.
 - The following two services must be initiated by the patient and there cannot be an Evaluation and Management (E/M) service in the preceding seven days or in the subsequent 24 hours.
 - Telephone communication is when audio only two-way synchronous communication is available.
 - Internet is when communication is not synchronous and over the internet, such as email.
 - Telephone consultation can be provided to another clinician but requires that there have been no E/M service by the consultant within the past 14 days or within the next 14 days, and there must be documentation of a verbal and written report back to the consulting clinician.
 - In summary, you cannot replace an E/M visit with a telephone call.
- Many telemedicine restrictions have been lifted while many others have not.
 - Service requirements are still in place. For example:
 - E/M services still require a face-to-face evaluation. This can be done from a window or a door or over telemedicine. Some payers are accepting audio only as an E/M visit, but this is variable. For example, for hospital medicine sub visits, if there is no face to face documented then no service can be billed.
 - Documentation requirements of History, Physical Exam and Medical Decision Making have not changed.
 - Physical Exam of the affected body part/system is still required. For example, if a patient complains of shortness of breath, there must be an exam of the respiratory system.
 - Supervision rules have not changed but can be performed by telemedicine.
 - Attending physicians must personally evaluate a patient seen by a resident in order to bill for the resident's services. This E/M service can be done by telemedicine but not by telecommunication.
 - Advanced practice clinicians (APCs) must be supervised per current site and state-specific supervision rules and practice within their scope of practice.
 - EMTALA-required Medical Screening Exams (MSEs) can be performed by telemedicine but not telecommunication.
 - Frequency limitations on hospital and nursing home visits by telemedicine have been lifted.
 - Initial hospital/nursing home, discharge hospital/nursing home, emergency department (ED) and critical care E/M services can now be completed by telemedicine for Medicare.
- What is/is not telemedicine and telecommunication:
 - When the clinician and the patient are in the same location, this is not telemedicine or telecommunication. It is important to document the location of the patient and clinician so services can be billed appropriately.
 - For example, the following are not telemedicine or telecommunication and should be billed as regular visits.
 - The clinician uses synchronous audio/visual communication to perform an E/M service when both the clinician and patient are in the ED but in different rooms, or the clinician is in the ED and the patient is in the parking lot.
 - The clinician uses audio without visual communication when in the nurse's station and the patient is in a hospital room and the clinician documents a face-to-face encounter with the patient in addition to the telephone call. Without the face to face interaction, telephone calls by many payers are not billable, while some are allowing it. It is best to document what services are being provided and how they are being provided.

Documenting the service provided – and how it was provided

- Document if the service was provided via technology with synchronous audio/video or by audio alone.
- Document where the patient is physically located and where you, the clinician, are physically located.
- Document “Care provided by telemedicine/telecommunication during the COVID-19 pandemic.”
- Document specific consent for telemedicine: “Consent for telemedicine/telecommunication obtained from the patient (guardian) by: _____” and state either the facility or you.
- Document the History, Physical Exam and Medical Decision Making as you would for a face-to-face service.
- Document nursing findings (if relevant) in the History of Present Illness (HPI) and not in the Physical Exam section of the note. Example: “HPI: The patient presents with two days of shortness of breath. The nurse reports the patient is wheezing bilaterally with moderate air movement.”
- Document Physical Exam elements consistent with a telemedicine visit. These may be limited due to the inability to auscultate or palpate; however, your ability to observe and use the nursing resources within the patient’s room can still allow you to evaluate key systems. Examples include:
 - Cardiovascular: “The patient’s capillary refill is observed to be greater than three seconds and she has peri-oral cyanosis.”
 - Lungs: “The patient has moderate respiratory distress, is using accessory muscles and speaking in three-word sentences.”
 - Abdomen: “The patient’s abdomen is distended, and she winces when the nurse pushes on her belly.”
- Document the amount of time you spent providing services. This is a requirement of some telemedicine and all telecommunication codes.
- 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. Include details of the counseling and/or care coordination.
- For Emergency Medicine clinicians – it is possible the office/outpatient code sets will have to be used.
 - This means that each patient should have a Past Medical, Family and Social history obtained and documented.
 - This is more than is normally required for regular ED visits but fits nicely into good medical care. Inquiring about a patient’s respiratory history, family members who may or may not be ill and recent travel history is very pertinent to this current pandemic.

Registering patients and documenting medical records

- When setting up telemedicine services, ensure patients are properly registered and a medical record is created.
- Document your E/M service in the appropriate medical record.

Providing telemedicine services

The use of telemedicine as a tool to provide clinical care is first and foremost a clinical decision. There are some conditions or symptoms where telemedicine may not be an appropriate substitute for care by a physically present clinician.

- Before providing telemedicine, approval must be obtained by your operational leadership.
- There are many rules regarding the provision of telemedicine services. For more information, please refer to the [Telemedicine Toolkit on the COVID-19 Zenith channel](#) for each specific service line.

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.