2021 EVALUATION AND MANAGEMENT GUIDELINES

2021 E/M CHANGES

- Medicare adopted the new CPT® E/M changes effective 1/1/2021. Additional revisions were made effective 1/1/2023.
  - There is no required level of history or exam for all evaluation and management codes. Providers need to document a medically necessary history and physical as deemed appropriate by the provider. A chief complaint is still required.
  - Several E/M codes have been deleted since the implementation.
  - The level of service may be coded based on documented time or overall medical decision making – whichever is most advantageous to the provider.

2021 E/M CHANGES

"Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (eg, by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of office or other outpatient services."

2021 E/M CHANGES

Coding Based on Time

- Time is defined as total time spent, including non-face-to-face work done on that day and will no longer require time to be dominated by counseling.

2021 E/M CHANGES

- Total time on the date of the encounter:
  - For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff).
  - Physician/other qualified health care professional time includes the following activities, when performed:
    - preparing to see the patient (eg, review of tests)
    - obtaining and/or reviewing separately obtained history
    - performing a medically appropriate examination and/or evaluation
    - counseling and educating the patient/family/caregiver
    - ordering medications, tests, or procedures
    - referring and communicating with other health care professionals (when not separately reported)
    - documenting clinical information in the electronic or other health record
    - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
    - care coordination (not separately reported)

2021 E/M CHANGES

- Prolonged Service for Use with CPT 99205 & 99215
  - CPT® and CMS do not agree on the use of the new prolonged service code used with 99215 or 99205.
  - CPT® has created 99417 to be used when the total time spent on the day of the encounter exceeds the lower limit of the time range by a minimum of 15 minutes.
  - CMS has created G2212 to be used when the total time spent on the day of the encounter exceeds the upper limit of the time range by a minimum of 15 minutes.
  - Add additional units for each 15-minute increment above the upper limit of the time range.
  - The 8-minute rule does not apply.

CPT®

CPT Codes – New Patient	Total Time Required for Reporting
99205	60-74 minutes
99205x1 and 99417x1	75-89 minutes
99205x1 and 99417x2	90-104 minutes
99205x1 and 99417x3	105-120 minutes

CPT Codes – Established Patient	Total Time Required for Reporting
99215	40-54 minutes
99215x1 and 99417x1	55-69 minutes
99215x1 and 99417x2	70-84 minutes
99215x1 and 99417x3	85-99 minutes

CMS

CPT/HCPCS Codes – New Patient	Total Time Required for Reporting
99205	60-74 minutes
99205x1 and G2212x1	89-103 minutes
99205x1 and G2212x2	104-118 minutes
99205x1 and G2212x3	119-133 minutes

CPT/HCPCS Codes – Established Patient	Total Time Required for Reporting
99215	40-54 minutes
99215x1 and G2212x1	69-83 minutes
99215x1 and G2212x2	84-98 minutes
99215x1 and G2212x3	99-114 minutes

CODE THIS!

I SPENT A TOTAL OF 40 MINUTES ON THIS PATIENT ENCOUNTER TODAY. 10 MINUTES WAS SPENT IN PREPARATION FOR THE ENCOUNTER REVIEWING PREVIOUS LAB RESULTS, HOSPITAL NOTES FROM ABC HOSPITAL AND THE PATIENT'S MEDICATION LIST. 20 MINUTES WAS SPENT FACE TO FACE WITH THE PATIENT. 10 MINUTES WAS SPENT WRITING ORDERS AND DOCUMENTATION TODAY.

Established Patient

A. 99212
B. 99213
C. 99214
D. 99215

New Patient

A. 99202
B. 99203
C. 99204
D. 99205

AND THE ANSWER IS…

Established Patient

D. 99215

New Patient

C. 99203

2021 E/M CHANGES

Coding Based on Medical Decision Making

- There are new definitions within MDM
- The MDM calculation is similar to, but not identical to, the 1995/1997 MDM calculation.
- CPT® is providing numerous definitions to clarify terms in the current guidelines, such as "chronic illness with exacerbation", "progression or side effects of treatment", and "drug therapy requiring intensive monitoring for toxicity."

MEDICAL DECISION-MAKING COMPARISON

95/97 MDM

- Number of Diagnoses or Management Options
- Amount and/or Complexity of Data to be Reviewed
- Risk of Complications and/or Morbidity or Mortality

2021 MDM

- Number and Complexity of Problems Addressed at the Encounter
- Amount and/or Complexity of Data to be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management

2021 E/M CHANGES

- Medical decision making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.
- There are the four levels of medical decision making
  - Straightforward
  - Low
  - Moderate
  - High
- There are three elements of medical decision making
- To qualify for a particular level of medical decision making, two of the three elements for that level of medical decision making must be met or exceeded.

2021 E/M CHANGES

- Element 1 - The number and complexity of problem(s) that are addressed during the encounter.
  - A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.
  - A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service.
  - This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.
  - Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service.
  - Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

2021 E/M CHANGES

Minimal problem

A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211).

Examples may include blood pressure checks or weight checks performed under physician orders.

2021 E/M CHANGES

Self-limited or minor problem

A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Example may be common cold.

2021 E/M CHANGES

Stable, chronic illness

A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). 'Stable' for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function.

For example: a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant.

Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia.

2021 E/M CHANGES

Acute, uncomplicated illness or injury

A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness.

Examples may include cystitis, allergic rhinitis, or a simple sprain.

2021 E/M CHANGES

Chronic illness with exacerbation, progression, or side effects of treatment

A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.

Example may be asymptomatic, uncontrolled hypertension, DMII with hyperglycemia,

2021 E/M CHANGES

Undiagnosed new problem with uncertain prognosis

A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

An example may be a lump in the breast, or unknown cause of abdominal pain.

2021 E/M CHANGES

Acute illness with systemic symptoms

An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for 'self-limited or minor' or 'acute, uncomplicated.' Systemic symptoms may not be general, but may be single system.

Examples may include pyelonephritis, pneumonitis, or colitis.

2021 E/M CHANGES

Acute, complicated injury

An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.

Examples may include a laceration to forehead with brief loss of consciousness, or an open fracture.

2021 E/M CHANGES

Chronic illness with severe exacerbation, progression, or side effects of treatment

The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

Examples may include Type II Diabetes with HgbA1c of 16.0, Hypertensive crisis – severe elevation in blood pressure typically equal to or greater than 180/120.

2021 E/M CHANGES

Acute or chronic illness or injury that poses a threat to life or bodily function

An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

Examples may include COVID-19 with O2 saturation of 90%, MI, stroke.

CLASSIFY THE CONDITION!

1. Minimal
2. Self limited or minor
3. Stable, chronic illness
4. Acute, uncomplicated illness or injury
5. Chronic illness with exacerbation, progression or side effects of treatment.
6. Undiagnosed new problem with uncertain prognosis
7. Acute, complicated injury
8. Chronic illness with severe exacerbation, progression or side effects of treatment.
9. Acute or chronic illness or injury that poses a threat to life or bodily function

A. Breast lump
B. Laceration to forehead with brief loss of consciousness.
C. Blood pressure check
D. Type II Diabetes with HgbA1c of 7.0
E. Type II Diabetes with HgbA1c of 16.0
F. Sprained ankle
G. Asymptomatic, uncontrolled hypertension
H. Common cold
I. COVID-19 with O2 saturation of 90%

AND THE ANSWERS ARE…

1. Minimal
   C. Blood Pressure check
2. Self limited or minor
   H. Common Cold
3. Stable, chronic illness
   D. Type II Diabetes at goal with HgbA1c of 7.0
4. Acute, uncomplicated illness or injury
   F. Sprained ankle
5. Chronic illness with exacerbation, progression or side effects of treatment
   G. Asymptomatic, uncontrolled hypertension
6. Undiagnosed new problem with uncertain prognosis
   A. Breast lump
7. Acute, complicated injury
   B. Laceration to forehead with brief loss of consciousness
8. Chronic illness with severe exacerbation, progression or side effects of treatment
   E. Type II Diabetes with HgbA1c of 16.0
9. Acute or chronic illness or injury that poses a threat to life or bodily function –
   I. COVID-19 with O2 saturation of 90%

2021 E/M CHANGES

- Element 2 - The amount and/or complexity of data to be reviewed and analyzed.
  - This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter.
  - This includes information obtained from multiple sources or interprofessional communications that are not separately reported.
  - It includes interpretation of tests that are not separately reported. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter.
    - Data is divided into three categories:
      - Tests, documents, orders, or independent historian(s). (Each unique test, order or document is counted to meet a threshold number)
      - Independent interpretation of tests.
      - Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source

Note: Reviewing of tests previously ordered are not counted separately

2021 E/M CHANGES

- *Test*: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.
- *External:* External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.
- *External physician or other qualified healthcare professional*: An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency.

2021 E/M CHANGES

- *Independent historian(s):* An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.
- *Independent Interpretation:* The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented, but need not conform to the usual standards of a complete report for the test.
- *Appropriate source:* For the purpose of the Discussion of Management data element, an appropriate source includes professionals who are not health care professionals, but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

2021 E/M CHANGES

- Element 3 - The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment (s). This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family.
  - For example, a decision about hospitalization includes consideration of alternative levels of care.
  - Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

2021 E/M CHANGES

- *Morbidity*: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.
- *Social determinants of health*: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

2021 E/M CHANGES

- *Risk*: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration.
  - For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk.
  - Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty.
  - Trained clinicians apply common language usage meanings to terms such as 'high', 'medium', 'low', or 'minimal' risk and do not require quantification for these definitions, (though quantification may be provided when evidence-based medicine has established probabilities).
  - For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.
  - Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

2021 E/M CHANGES

- *Drug therapy requiring intensive monitoring for toxicity*: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death.
  - The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy.
  - The monitoring should be that which is generally accepted practice for the agent, but may be patient specific in some cases.
  - Intensive monitoring may be long-term or short term.
    - Long-term intensive monitoring is not less than quarterly.
    - The monitoring may be by a lab test, a physiologic test or imaging.
    - Monitoring by history or examination does not qualify.
    - The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient.
      - Examples may include monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis.
      - Examples of monitoring that does not qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold.

IN SUMMARY

- The new guidelines only apply to all Evaluation and Management services
- A chief complaint is required for every encounter
- A medically appropriate history and exam should be documented
- Coding based on time is counted as the time spent on the day of the encounter, including non-face-to-face time
  - Document actual time spent and not just a range of time
- New Prolonged Service codes added by CPT and CMS
  - CPT® has created 99417 to be used when the total time spent on the day of the encounter exceeds the lower limit of the time range by a minimum of 15 minutes.
  - CMS has created G2212 to be used when the total time spent on the day of the encounter exceeds the upper limit of the time range by a minimum of 15 minutes.
  - Add additional units for each 15-minute increment above the upper limit of the time range.

MRN: 100
Chief Complaint: Abdominal pain

SUBJECTIVE:
HPI: 27 yo female with complaints of R lower quadrant pain and pressure for the past 3 weeks. She has developed intermittent nausea that comes and goes throughout the day – it will wake her up at night. She rates the pain as 7/10.

Review of Systems:
Respiratory: No shortness of breath, dyspnea on exertion, cough, or hemoptysis
Gastrointestinal: Nausea, vomiting, diarrhea, and constipation

OBJECTIVE:
BP: 130/80, T: 98.6, P: 88 bpm, R: 16, Wt: 219 lbs, Ht: 5' 5" BMI: 36.22 LMP: 2 weeks ago
Constitutional: Healthy, NAD
Gastrointestinal: Abdomen soft, suprapubic, and lower right quadrant tenderness noted. BS normal. No masses, organomegaly.
Genitourinary: Normal external genitalia without lesions. Normal vagina and vulva, normal cervix without lesions or tenderness. Uterus normal size, anteverted, adnexa normal in size without tenderness.

Assessment/Plan:
1. Abdominal Pain – RLQ
   Neisseria gonorrhoeae PCR, Chlamydia trach PCR, Wet Prep, CBC with Platelets, TSH, BMP, US transvaginal and transabdominal. HCG. Ibuprofen 200 mg every 4-6 hours as needed for pain.
2. RTC – 1 week or sooner if symptoms worsen. Due for annual well woman exam with pap

2021 Documentation Guidelines

History and Exam – problem focused/medically appropriate

Number and Complexity of Problems Addressed – Moderate
(1 undiagnosed new problem with uncertain prognosis)

Amount and/or Complexity of Data to be Reviewed/Analyzed – Moderate
(Category 1: 3+ labs ordered, imaging ordered)

Risk of complications and/or Morbidity or Mortality of Patient Management – Low
(Ibuprofen ordered)

MDM: Moderate

This encounter supports 99214 based on overall risk.

MRN 200
Chief Complaint: Back pain

SUBJECTIVE:
HPI: 24 yo male with back pain. He states the pain started earlier this year when he hit his right low back/buttock while snowmobiling. He was evaluated in the ER a few days later. He has had continued pain since that time. He points to pain right over the SI joint on the right and notes pain and occasional numbness radiating down the L3 nerve distribution. He denies any previous injury to this area. He has tried ice, heat and ibuprofen with little to no relief.

Review of Systems:
Musculoskeletal: As above
Neurologic: As above

OBJECTIVE:
BP: 122/78, T: 98.6, P: 68 bpm, R: 12, Wt: 170 lbs, Ht: 5' 8" BMI: 25.85
Constitutional: Healthy, NAD
Musculoskeletal: Pain over SI joint on right, straight leg raise positive on right
Neurologic: Patellar reflexes equal bilaterally

Assessment/Plan:
1. Sacroiliitis: Prednisone 20 mg tablet, Zanaflex, 4 mg tablet, Norco 5-325 mg. PT referral
2. RTC as needed. Patient is told no refills are to be given.

2021 Documentation Guidelines

History and Exam – problem focused/medically appropriate

Number and Complexity of Problems Addressed – Low
(1 acute, uncomplicated illness or injury)

Amount and/or Complexity of Data to be Reviewed/Analyzed – None

Risk of complications and/or Morbidity or Mortality of Patient Management – Moderate
(Prescription Medication Management)

MDM: Low

This encounter supports 99213 based on overall risk.

MRN: 300
Chief Complaint: Eye Pain

SUBJECTIVE:
HPI: 13 yo female with complains of redness, with discharge and mattering in bilateral eyes for the last 2 days. No prior ophthalmological history and pertinent history of eye trauma. No change in visual acuity, no photophobia, no severe eye pain.

OBJECTIVE:
Constitutional: Appears well, NAD, vitals are normal
Eyes: bilateral eyes with findings typical of conjunctivitis. Conjunctival erythema present and discharge present. Lids normal, no evidence of cellulitis. The corneas are clear and fundi normal. PERRL. Visual acuity grossly normal. Fluorscein stain negative

Assessment/Plan:
1. Conjunctivitis – Gentamycin Opth drops as directed
2. RTC as needed or if symptoms worsen.

2021 Documentation Guidelines

History and Exam – problem focused/medically appropriate

Number and Complexity of Problems Addressed – Low
(1 acute, uncomplicated illness or injury)

Amount and/or Complexity of Data to be Reviewed/Analyzed – None

Risk of complications and/or Morbidity or Mortality of Patient Management – Moderate
(Prescription Medication Management)

MDM: Low

This encounter supports 99213 based on overall risk.

MRN: 400

Chief Complaint: Diabetes Follow-up

SUBJECTIVE:

HPI: 43 yo m presents for DM follow-up. Last HgbA1c was 12.5. Currently on Metformin. Pt denies polydipsia, polyuria, fatigue. Pt currently tests glucose in the morning. Review of glucose log shows consistent elevated readings. Pt states he does not exercise regularly but does watch his intake of carbohydrates. Still drinks 1-2 sodas per day. Has not seen dietary in 3 years.

Objective: NAD

Remainder of exam deferred.

Assessment and Plan:

1. DMII, uncontrolled, with hyperglycemia
   - Continue Metformin
   - HgbA1c, Lipid Panel and BMP ordered
   - Referral to Dietary

2. Time: I spent 15 minutes in pre-, and post-encounter work. I spent an additional 30 minutes with the patient discussing diet, exercise and potential need to add insulin. Total time spent: 45 mins.

2021 Documentation Guidelines

History and Exam – problem focused/medically appropriate

Number and Complexity of Problems Addressed – Moderate
(One or more chronic illnesses with exacerbation, progression, or side effects of treatment)

Amount and/or Complexity of Data to be Reviewed/Analyzed – Moderate
(Category 1: 3 labs ordered)

Risk of complications and/or Morbidity or Mortality of Patient Management – Moderate
(Prescription Medication Management)

MDM: Moderate

This encounter supports 99214 based on overall risk.

Time: 45 Minutes

This encounter supports 99215 based on overall time spent on this encounter

2021 E/M CHANGES

MDM Grid

https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

2023 CPT EM Code and Guideline Changes

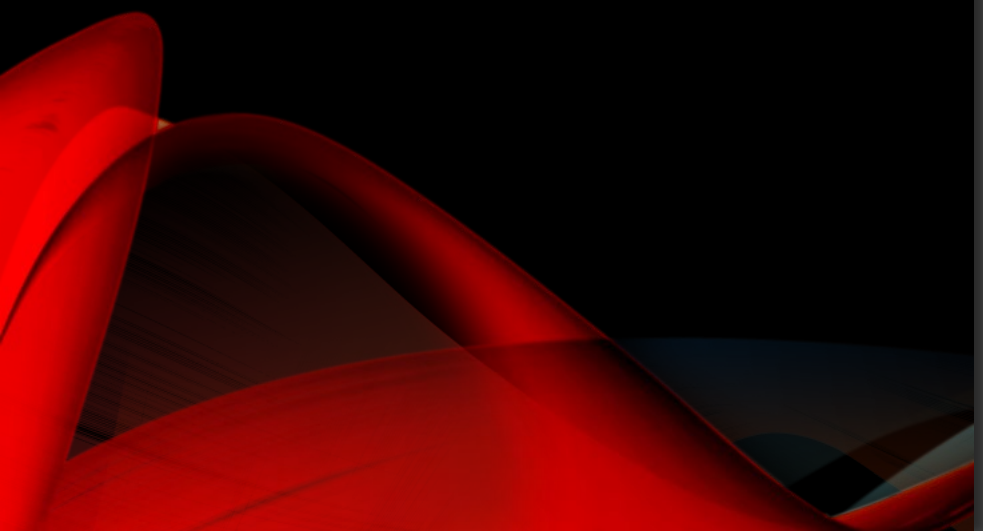
https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

TELEMEDICINE

- Medicare allows for audio-visual or audio only services to be rendered to patients.
- Use the appropriate EM code 99202-99215 based on either MDM or time.
- Append Modifier 95 for Audio-Visual services.
- Append Modifier 93 for Audio-Only services.
- See list of approved services allowed by Medicare.

https://www.cms.gov/medicare/coverage/telehealth/list-services

TELEMEDICINE



- Medicare allows for psychotherapy to be performed by behavioral health clinicians.
- Use the appropriate psychotherapy code based on either documentation or time spent.
- Append Modifier 95 for Audio-Visual psychotherapy services.
- Append Modifier 93 for Audio-Only psychotherapy services.
- Psychotherapy sessions less than 16 minutes are not billable.
  - If a PHQ-9, GAD-7, Columbia, etc. assessment(s) were performed, these may be coded separately for psychotherapy sessions not meeting the 16-minute threshold.

TELEMEDICINE - MEDICAID

Iowa

https://hhs.iowa.gov/media/13025/download?inline

Nebraska

https://dhhs.ne.gov/Medicaid%20State%20Plan/Attachment%204.19b%20Item%202d%20-%20Indian%20Health%20Service%20and%20Tribal%20health%20facilities;%20telehealth.pdf

TELEMEDICINE - MEDICAID

North Dakota

https://www.hhs.nd.gov/sites/default/files/documents/medicaid-policies/telehealth.pdf

https://www.hhs.nd.gov/sites/default/files/documents/medicaid-policies/indian-health-services-and-tribal-health-programs.pdf

South Dakota

https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/IHS_and_Tribal_638_Facilities.pdf

https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/Telemedicine.pdf

TELEMEDICINE DOCUMENTATION GUIDELINES

- The following elements must be documented:
  - Location of Patient
    - If the patient is in their home – use POS 10
    - If the patient is in the clinic – use POS 02
  - Location of Provider
  - Type of Telemedicine Rendered (A/V, Audio-only)
  - Patient Consent to Telemedicine Service

THANK YOU!

Christine A. Pfeifer, MHA, CPC
cpfeifer@mcmanis-monsalve.com