DOWNLOAD PDF SECTION 1. INITIAL PATIENT ENCOUNTER

Chapter 1 : Evaluation and Management Coding - E&M Coding

When the orthopedist rechecks the patient and reduces the fracture the next day, the patient is receiving initial active treatment for this fracture. That is, this is the first encounter at which the patient receives definitive care (the ER was able to apply comfort care only).

This depends on whether or not the organization uses coders. If so, CMS provides the following guidance: A joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. To ensure that you are using the best codes, communication with the coder and potentially the billing department is essential. Consider reviewing charts as a team so that you all can agree that the documentation is complete and proper codes are used for submission of the claim. What should I know up front to be successful with coding? You should note that code construction and guidance can change from body system to body system, from condition to condition, and from inpatient setting to outpatient setting, to name a few examples. For outpatient settings, there is additional specific guidance for both hospital-based on private outpatient clinics. What are the basic steps to use in selecting the codes? Locate the term that best identifies the diagnosis or reason for visit in the Alphabetical Index. Always start you search with the Alphabetical Index to help ensure that you are looking up the correct code that most accurately reflects the condition. Verify the code to the greatest level of specificity in the Tabular Index. Once you have identified the appropriate 3-digit code in the alphabetical index, use that code to search in the Tabular Index. Never begin searching initially in the Tabular List as this will lead to coding errors. The files are titled "Index. Yes, use the number of codes needed to adequately describe the patient. Pay close attention to notes included with the codes; some codes cannot be used with other codes. There are codes for Right, Left, or Unspecified. If the problem is bilateral, do I choose Unspecified or use 2 codes for both Right and Left? This is a good example of the need to follow the guidance for each specific code. Do not assume that the instructions for one code will apply elsewhere. Some codes indicate right, left, and bilateral. Some indicate right and left but not bilateral, so if the condition affects the right and left you would use both. For some codes, such as torticollis, you might think a side would be appropriate but the code does not provide that option. Below is an example of very specific instructions for a condition: Codes from category I69, Sequelae of cerebrovascular disease, that specify hemiplegia, hemiparesis, and monoplegia identify whether the dominant or nondominant side is affected. Should the affected side be documented but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows: For ambidextrous patients, the default should be dominant. If the left side is affected, the default is nondominant. If the right side is affected, the default is dominant. Can I use ICD 10 codes to report signs and symptoms? Yes, signs and symptoms, and even "unspecified" codes, are at times not only acceptable but necessary. Code each encounter to the level of certainty known for that encounter. Your coding needs to be as complete as you can make it based on confirmed information that you identify during the visit. You may use codes for signs or symptoms pertinent to the physical therapy services you provided--codes that the physician may not have included. If I suspect my patient has a condition, such as a herniated disc, but he or she has had no imaging, do I code for what I suspect? No, you code to the level you can confirm. If a herniated disc is not confirmed, you cannot code that one is present. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded. List additional codes that describe any coexisting conditions. APTA is aware of the many questions about the first-listed diagnosis for patients receiving outpatient physical therapist services. The Cooperating Parties agree that with the transition to ICD it is important that all health care providers code consistently. APTA recognizes that payers have not been consistent with instructions on the first-listed diagnosis, and physical therapists may not have been coding according to the guidelines above. Can the ICD code change throughout the episode of care? Yes, if the

diagnosis becomes more definitive or additional diagnoses develop then add the appropriate ICD code. Also add codes for identified signs and symptoms if they were not initially included as part of the diagnostic codes. Is there a Medicare list of ICD codes that would qualify for an automatic therapy cap exception based upon clinical condition or complexity? There is no longer a list of specific ICD-9 codes that would qualify for an exception to the therapy cap. The beneficiary may qualify for the cap exceptions at any time during the episode when covered services that are documented as medically necessary exceed the therapy caps. All requests for exception are in the form of a KX modifier added to claim lines. It is important that the documentation indicate that there is a need for continued skilled therapy. You can use the automatic exceptions process for any diagnosis for which you can justify services exceeding the cap. Do PTs need to submit documentation for automatic exceptions from the therapy cap? No specific documentation is submitted for automatic process exceptions. Medicare beneficiaries will be automatically accepted from the therapy cap, and you will not be required to submit documentation for an exception, if the beneficiary meets the criteria for an automatic exception. You are responsible for consulting guidance in the Medicare manuals and in the professional literature to determine if the beneficiary qualifies. If claims are selected for medical review via an Additional Documentation Request ADR , you must submit documentation justifying the services. If medical records are requested for review, you may include, at your discretion, a summary that specifically addresses the justification for therapy cap exception. Aftercare Codes What are aftercare codes, and when do I use them? Aftercare visit codes Z codes cover situations in which the initial treatment of a disease has been performed or the injury or disease has been removed, and the patient requires continued care during the healing or recovery phase or for the long-term consequences of the disease. Do not use the aftercare Z code if treatment is directed at a current, acute disease. Use the diagnosis code in these cases. Also, do not use the aftercare Z codes for aftercare for injuries that are still present. For aftercare following an injury, assign the acute injury code with the appropriate 7th character for subsequent encounter. Page 95 For injuries, the appropriate 7th characters identify subsequent care with the diagnosis code. Use the acute injury code with the appropriate 7th character for subsequent encounter eg "D". To avoid payment delays or denials, check with your payers for their requirements on the use of aftercare codes. Patient is seen by the PT after a total knee replacement to remove osteoarthritis in the right knee. Encounter for fitting and adjustment of external prosthetic device. Orthopedic aftercare Excludes 1: Encounter for other orthopedic aftercare Z Encounter for other postprocedural aftercare Excludes1: Encounter for attention to dressings, sutures and drains Excludes1: Encounter for change or removal of nonsurgical wound dressing; Encounter for change or removal of wound dressing NOS Z Encounter for aftercare following organ transplant Z ICD added the code extensions 7th character for injuries and external causes to identify the encounter: The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The code extension to identify encounter must always be in the seventh position of the data field, so if a code that requires a 7th character does not have a 6 characters, use a placeholder X to fill in the empty character s. Do all codes have 7 characters? Codes with 3 characters are included in ICDCM as the heading of a category of codes that may be further subdivided by the use of fourth-sixth characters, which provide greater detail. Codes for injury or trauma generally have a 7th code. In addition, it is used in the Obstetrics, Musculoskeletal, and External Cause chapters. Use a 3-character code only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable. How and when do I use the 7th character? When the patient is receiving active treatment for the condition Examples: For encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase Examples: Complications or conditions that arise as a direct result of a condition Example: This is typically a second code. The presenting complication is listed first. The common fracture extensions include greater detail: When do I use an X as a placeholder? Some ICD categories indicate there is an applicable 7th character. The applicable 7th character is then required for all codes within the category, unless the notes in the Tabular List instruct otherwise. The 7th character must always be in the 7th character position. If a code that requires a 7th character is fewer than 6 characters 3, 4, or 5 characters , use a placeholder X to fill in the empty characters. When submitting a claim for the first physical therapy encounter with the patient,

should I use the "initial encounter" 7th character?

Chapter 2 : Understanding When to Use the New Patient E/M Codes -- FPM

The nurse practitioner shall disclose to the patient at the initial encounter that he is a licensed nurse practitioner. Any party to a practice agreement shall disclose, upon request of a patient or his legal representative, the name of the patient care team physician and information regarding how to contact the patient care team physician.

This lecture simplifies that complex process by having practitioners answer a series of specific questions necessary to define the correct group of care codes used in their initial hospital evaluation. These are the codes providers use to bill for such services as hospital, clinic and nursing home visits. Once the correct group of codes has been determined, the level of service "low, medium or high" can then be defined. This lectures will focus on choosing the correct group of codes, not the right coding level within a chosen group. I am a practicing hospitalist with over a decade of clinical experience at a large community hospital. I have written dozens of medical billing and coding lectures over the years. While some of these lectures are several years old, their information remains highly relevant today. They can and should all be used under the correct circumstance. By understanding the possible groups of codes, the questions that must be asked will make more sense. I approach the process by defining whether the provider is the attending physician or the consultant, as the choice of codes are quite variable between these two groups. Hospital inpatient initial care: Hospital inpatient discharge codes: These questions are detailed below. As you continue to read, refer to this flow chart for quick reference. Does my patient meet criteria for billing critical care? Am I the attending physician or am I a consultant on the case? Does my documentation support the code I am supposed to use? Does the code I chose appropriately describe the level of service provided? Was my discharge encounter more or less than eight hours after the original face-to-face encounter on the same date or did I only provide one face-to-face encounter for admission and discharge? Have I seen the patient in the last three years? Has anyone in my group of the same specialty seen the patient in the last three years? Does the patient have Medicare or other insurance that does not recognize consultation codes? Before I begin the discussion, I think it is important to define the difference between when the order for admission was written and when the physician or NPP provided their first face-to-face encounter. The date of the admission order has no relevance on Medicare Part B physician billing. What matters is when the physician provided the medically necessary and reasonable face-to-face encounter. This is an important point of clarification when trying to define the appropriateness of using the same day admission and discharge codes for inpatient or observation services. In the Medicare Part B environment, the time of an "admission" to the hospital is not a physician payment issue. The "admission" time and date are necessary for the hospital billing, but not for the physician billing. Refer to the decision tree flow diagram above for a big picture view of this section. Does my documentation meet the threshold for critical care? Choose critical care codes and or Critical care codes can be used on admission and on follow up hospital care. There is no limit to the number of times they can be used on any one patient in the hospital, but documentation should support their use. Critical care codes can be used at any site of care. Patients do not have to be in the ICU to use these codes. Likewise, being in the ICU does not mean a patient qualifies for using critical care codes either. Go to question 2. Does my documentation support use of hospital inpatient initial care codes , , ? Go to question 3. Choose from the inpatient hospital subsequent care code group , , Another document supports this concept as well. If documentation does not support use of these inpatient subsequent care codes, I recommend getting intense coding education as you will have provided your service for free. There are no alternative codes to consider. Was my face-to-face discharge encounter date different than my face-to-face admission calendar date? Choose from the inpatient hospital initial care codes NO, my admission and discharge face-to-face encounters or encounter if the patient was seen just one time occurred on the same calendar date. Go to question 4: Did I discharge the patient less than 8 hours from my first face-to-face encounter or provide only one face-to-face encounter for admission and discharge? Some resources suggest the physician can instead choose the discharge code or if only one face-to-face encounter was provided and the service was consistent with a discharge encounter. There is some discrepancy in resources from CMS and Medicare carriers in this scenario. Read the discussion below: CMS discussed this in

section They say to use the initial encounter admission codes. However, this Medicare carrier says you could consider billing for the discharge instead. The physician could bill an initial inpatient visit or a discharge management summary based on the service documented. The combination admit and discharge procedures codes are not appropriate since the patient was an inpatient for less than 8 hours. This is not precedent. It has happened before such as the prolonged service codes. There appears to be contradictory information between CMS documents and the Medicare carrier resource above. If documentation does not support these codes, go to question 2. Answering question 4 is important when providing hand-offs from night shift hospitalist admissions to day shift hospitalists who may or may not discharge the patient. Knowing how long the patient has spend in the hospital is important to prevent denial of payment. Some physicians may choose to round last on these special situation patients if they think they will initiate discharge orders. NO, my patient was discharged greater than 8 hour from admission on the same calendar date: Go to question 5. Did I or my partners in combination with me provide two face-to-face encounters at least eight hours apart on the same calendar date? Choose from the hospital admit and discharge same day inpatient or observation care codes This is a bundled care code. If two physicians from the same group and specialty each provide one of the face-to-face encounters, only one provider should submit the code from the care group NO, two face-to-face encounters were not provided: As I stated above, I do believe the discharge codes or apply. See the discussion above on question 1. Does my documentation support use of hospital observation initial care codes , , ? Choose from the hospital observation subsequent care code group , , See the discussion in question 2 above to understand why this group of codes is appropriate. Choose from the observation hospital initial care codes Physicians who admit and discharge patients who spend less than 8 hours in the hospital should not submit same day admit discharge codes I discussed the use of the options for using the discharge code in this case above in the attending section under question 4. I do not recommend it. See that discussion to better understand the reasoning. See the discussion above at question 5. This code should only apply for discharge services on dates different than the admission face-to-face encounter. Same day admission and discharge codes are reserved for the attending physician or NPP only. Does my patient have Medicare? Medicare no longer recognizes hospital inpatient consultation codes. Go to question 4. Choose from the inpatient hospital subsequent care codes These codes are used as initial care codes when documentation does not support the use of the initial care codes When you find out, choose yes or no in question 4. Does my documentation support the use of hospital inpatient consult care codes ? Choose from the inpatient hospital consult care codes This is the only alternative group of codes from which to choose from. If the documentation does not support the inpatient hospital consult codes, then the subsequent care codes should be used instead. If documentation does not support the use of the subsequent care codes, I recommend the physician seek intensive coding education as no other codes are available. That means they provided their service here for free. Being a consultant on an observation case is the most difficult of the coding scenarios I have detailed above. Remember, office or outpatient consultation codes are no longer recognized by CMS but may be recognized by other third party payers. Medicare no longer recognizes outpatient and office consult codes. Go to question 7.

Chapter 3 : P.L. , c (S SS/SCS/SCS) CC

During an initial patient encounter, you note that her acute anxiety appears to be affecting your ability to help her learn more about her disease process. To overcome this problem, you would consider all of the following, except.

As used in P. Unless specifically prohibited or limited by federal or State law, a health care provider who establishes a proper provider-patient relationship with a patient may remotely provide health care services to a patient through the use of telemedicine. A health care provider may also engage in telehealth as may be necessary to support and facilitate the provision of health care services to patients. Any health care provider who uses telemedicine or engages in telehealth while providing health care services to a patient, shall: The contact information shall enable the patient to contact the health care provider, or a substitute health care provider authorized to act on behalf of the provider who provided services, for at least 72 hours following the provision of services. In the case of a subsequent telemedicine or telehealth encounter conducted pursuant to an ongoing provider-patient relationship, the provider may review the information prior to initiating contact with the patient or contemporaneously with the telemedicine or telehealth encounter. For patients without a primary care provider or other health care provider of record, the health care provider engaging in telemedicine or telehealth may advise the patient to contact a primary care provider, and, upon request by the patient, assist the patient with locating a primary care provider or other in-person medical assistance that, to the extent possible, is located within reasonable proximity to the patient. The health care provider engaging in telemedicine or telehealth shall also refer the patient to appropriate follow up care where necessary, including making appropriate referrals for emergency or complimentary care, if needed. Consent may be oral, written, or digital in nature, provided that the chosen method of consent is deemed appropriate under the standard of care. If telemedicine or telehealth services would not be consistent with this standard of care, the health care provider shall direct the patient to seek in-person care. Unless the provider has established a proper provider-patient relationship with the patient, a provider shall not issue a prescription to a patient based solely on the responses provided in an online questionnaire. The prescription of Schedule II controlled dangerous substances through the use of telemedicine or telehealth shall be authorized only after an initial in-person examination of the patient, as provided by regulation, and a subsequent in-person visit with the patient shall be required every three months for the duration of time that the patient is being prescribed the Schedule II controlled dangerous substance. A mental health screener, screening service, or screening psychiatrist subject to the provisions of P. A health care provider who engages in telemedicine or telehealth, as authorized by P. A health care provider shall not be subject to any professional disciplinary action under Title 45 of the Revised Statutes solely on the basis that the provider engaged in telemedicine or telehealth pursuant to P. Such rules and regulations shall, at a minimum: Any health care provider who engages in telemedicine or telehealth shall ensure that a proper provider-patient relationship is established. The establishment of a proper provider-patient relationship shall include, but shall not be limited to: The provider shall make this determination prior to each unique patient encounter. Telemedicine or telehealth may be practiced without a proper provider-patient relationship, as defined in subsection a. Each telemedicine or telehealth organization operating in the State shall annually register with the Department of Health. Each telemedicine or telehealth organization operating in the State shall submit an annual report to the Department of Health in a manner as determined by the commissioner. The annual report shall include de-identified encounter data including, but not limited to: The commissioner may require the reporting of any additional information as the commissioner deems necessary and appropriate, subject to all applicable State and federal laws, rules, and regulations for recordkeeping and privacy. Commencing six months after the effective date of P. The Department of Health shall compile the information provided in the reports submitted by telemedicine and telehealth organizations pursuant to subsection b. The department shall annually share the Statewide data with the Department of Human Services, the Department of Banking and Insurance, the Telemedicine and Telehealth Review Commission established pursuant to section 5 of P. The department shall also transmit a report to the Legislature and the Telemedicine and Telehealth Review Commission that includes: A telemedicine or telehealth organization that fails to

register with the Department of Health pursuant to subsection a. Six months after the effective date of P. The commission shall consist of seven members, as follows: The public members shall be health care professionals with a background in the provision of health care services using telemedicine and telehealth. The public members shall serve at the pleasure of the appointing authority, and vacancies in the membership shall be filled in the same manner as the original appointments. Members of the commission shall serve without compensation but may be reimbursed for necessary travel expenses incurred in the performance of their duties within the limits of funds made available for that purpose. The members shall select a chairperson and a vice chairperson from among the members. The chairperson may appoint a secretary, who need not be a member of the commission. The Department of Health shall provide staff and administrative support to the commission. The commission shall meet at least twice a year and at such other times as the chairperson may require. The commission shall be entitled to call to its assistance and avail itself of the services of the employees of any State, county, or municipal department, board, bureau, commission, or agency as it may require and as may be available for its purposes. The commission shall report its findings and recommendations to the Governor, the Commissioner of Health, the State boards or other entities that, pursuant to Title 45 of the Revised Statutes, are responsible for the licensure, certification, or registration of health care providers in the State who provide health care services using telemedicine or telehealth pursuant to P. The commission shall expire upon submission of its report. If any provision of P. The State Medicaid and NJ FamilyCare programs shall provide coverage and payment for health care services delivered to a benefits recipient through telemedicine or telehealth, on the same basis as, and at a provider reimbursement rate that does not exceed the provider reimbursement rate that is applicable, when the services are delivered through in-person contact and consultation in New Jersey. Reimbursement payments under this section may be provided either to the individual practitioner who delivered the reimbursable services, or to the agency, facility, or organization that employs the individual practitioner who delivered the reimbursable services, as appropriate. The State Medicaid and NJ FamilyCare programs may limit coverage to services that are delivered by participating health care providers, but may not charge any deductible, copayment, or coinsurance for a health care service, delivered through telemedicine or telehealth, in an amount that exceeds the deductible, copayment, or coinsurance amount that is applicable to an in-person consultation. Nothing in this section shall be construed to: As used in this section: A carrier that offers a health benefits plan in this State shall provide coverage and payment for health care services delivered to a covered person through telemedicine or telehealth, on the same basis as, and at a provider reimbursement rate that does not exceed the provider reimbursement rate that is applicable, when the services are delivered through in-person contact and consultation in New Jersey. The State Health Benefits Commission shall ensure that every contract purchased thereby, which provides hospital and medical expense benefits, additionally provides coverage and payment for health care services delivered to a covered person through telemedicine or telehealth, on the same basis as, and at a provider reimbursement rate that does not exceed the provider reimbursement rate that is applicable, when the services are delivered through in-person contact and consultation in New Jersey. STATEMENT This Senate floor substitute authorizes health care providers, including, but not limited to, licensed physicians, nurses, nurse practitioners, psychologists, psychiatrists, psychoanalysts, clinical social workers, physician assistants, professional counselors, respiratory therapists, speech pathologists, audiologists, and optometrists, to remotely provide health care services to patients through the use of telemedicine and telehealth. Specifically, a health care provider will be permitted to remotely provide health care services to a patient through the use of telemedicine, and will be permitted to engage in telehealth as may be necessary to support and facilitate the provision of health care services to patients. The substitute bill requires any health care provider who uses telemedicine or engages in telehealth while providing health care services to a patient to: The bill requires telemedicine services to be provided using interactive, real-time, two-way communication technologies. A health care provider engaging in telemedicine or telehealth will be required to review the medical history and any medical records provided by the patient. In the case of an initial encounter with the patient, the provider is to conduct the review before initiating contact with the patient; in the case of a subsequent encounter pursuant to an ongoing provider-patient relationship, the provider may conduct the review prior to initiating contact or

contemporaneously with the telemedicine or telehealth encounter. Health care providers will not be subject to any professional disciplinary action under Title 45 of the Revised Statutes solely on the basis that the provider engaged in telemedicine or telehealth pursuant to the substitute bill. For patients without a primary care provider or other health care provider of record, the health care provider engaging in telemedicine or telehealth may advise the patient to contact a primary care provider, and, upon request by the patient, may assist the patient with locating a primary care provider or other in-person medical assistance that, to the extent possible, is located within reasonable proximity to the patient. The health care provider engaging in telemedicine or telehealth will also be required to refer the patient to appropriate follow up care where necessary, including making appropriate referrals for emergency or complimentary care, if needed. Health care providers providing health care services using telemedicine or telehealth will be subject to the same standard of care or practice standards as are applicable to in-person settings. If telemedicine services would not be consistent with this standard of care, the health care provider is to direct the patient to seek in-person care. Similarly, diagnosis, treatment, and consultation recommendations made through the use of telemedicine or telehealth, including the issuance of a prescription based on a telemedicine encounter, are to be held to the same standard of care or practice standards as are applicable to in-person settings. A provider may not issue a prescription to a patient based solely on the responses provided in an online questionnaire, unless the provider has established a proper provider-patient relationship with the patient. Schedule II controlled dangerous substances may be prescribed through the use of telemedicine only after the provider conducts an initial in-person examination of the patient. Subsequent in-person visits with the patient will be required every three months for the duration of time that the patient is being prescribed the Schedule II controlled dangerous substance. The substitute bill provides that mental health screeners, screening services, and screening psychiatrists subject to the provisions of P. Professional licensing and certification boards will be required to adopt rules and regulations, which will be applicable to the health care providers under their respective jurisdictions, in order to implement the provisions of the bill and facilitate the provision of telemedicine and telehealth services. The rules and regulations are to, at a minimum: The rules and regulations may not include any provision requiring an initial in-person visit with a patient before providing services using telemedicine or telehealth. In order to engage in telemedicine or telehealth, a health care provider will be required to establish a proper patient-provider relationship with the patient. Establishing this relationship includes, but is not be limited to: Telemedicine may be practiced without establishing a proper provider-patient relationship during informal consultations without compensation; during episodic consultations by a medical specialist located in another jurisdiction; when a health care provider furnishes medical assistance in response to an emergency or disaster, provided that there is no charge for the medical assistance; and when a substitute health care provider acting on behalf of an absent health care provider in the same specialty provides health care services on an on-call or cross-coverage basis, provided that the absent health care provider has designated the substitute provider as an on-call provider or cross-coverage service provider. The substitute bill requires each telemedicine or telehealth organization operating in the State to annually register with the Department of Health DOH and to submit an annual report to DOH in a manner as determined by the commissioner. A telemedicine or telehealth organization that fails to register or that fails to submit the annual report will be subject to disciplinary action. Commencing six months after the effective date of the bill, the annual report submitted by telemedicine and telehealth organizations is to additionally, include, for each telemedicine or telehealth encounter: DOH will be required to share the reported information with the Legislature, the Department of Human Services, the Department of Banking and Insurance, the Telemedicine and Telehealth Review Commission established under the bill, and the appropriate boards and entities that license or certify professionals who provide health care services in the State using telemedicine or telehealth. Additionally, DOH will be required to compile the reported information to generate Statewide data concerning telemedicine and telehealth services provided in New Jersey, and report the Statewide data to the Legislature and the Telemedicine and Telehealth Review Commission on an annual basis. The report is to include an analysis of each rule and regulation adopted by State boards and entities responsible for the licensure or certification of health care providers using telemedicine and telehealth, and an assessment of the effect that the provision of health care services using

telemedicine and telehealth is having in New Jersey on health care delivery, health care outcomes, population health, and in-person health care services provided in facility-based and office-based settings. Six months after the effective date of the substitute bill, the Telemedicine and Telehealth Review Commission will be established in DOH. The commission will be required to review the information reported by telemedicine and telehealth organizations and make recommendations for such executive, legislative, regulatory, administrative, and other actions as may be necessary and appropriate to promote and improve the quality, efficiency, and effectiveness of telemedicine and telehealth services provided in New Jersey. The commission will consist of seven members: The public members are to be health care professionals with a background in the provision of health care services using telemedicine and telehealth. The public members will serve at the pleasure of the appointing authority, and vacancies in the membership shall be filled in the same manner as the original appointments. Members of the commission will serve without compensation but may be reimbursed for necessary travel expenses incurred in the performance of their duties within the limits of funds made available for that purpose. The commission will meet at least twice a year and at such other times as the chairperson may require. The commission will be entitled to call to its assistance and avail itself of the services of the employees of any State, county, or municipal department, board, bureau, commission, or agency as it may require and as may be available for its purposes. The commission will be required to report its findings and recommendations to the Governor, the Commissioner of Health, the State boards or other entities which are responsible for the licensure, certification, or registration of health care providers in the State who provide health care services using telemedicine or telehealth, and the Legislature no later than two years after the date the commission first meets, and will expire upon submission of the report. Reimbursement payments may be made to the individual practitioner who delivered the reimbursable services, or to the telemedicine or telehealth organization that employs the practitioner. Each such carrier or insurance provider will be authorized to charge a deductible, copayment, or coinsurance for a health care service delivered through telemedicine or telehealth, provided that the amount charged does not exceed the charge for an in-person consultation. Where applicable, each carrier or insurance provider will be limited in its ability to impose annual or lifetime dollar maximum amounts on the coverage of services provided through telemedicine. Nothing in the substitute bill will prohibit a carrier or other insurance provider from providing coverage only for services deemed to be medically necessary, and nothing will allow a carrier or other insurance provider to coerce a covered person to use telehealth or telemedicine in lieu of receiving an in-person service.

Chapter 4 : P.L. , c CC (S SS/SCS/SCS)

As used in P. Unless specifically prohibited or limited by federal or State law, a health care provider who establishes a proper provider-patient relationship with a patient may remotely provide health care services to a patient through the use of telemedicine. A health care provider may also engage in telehealth as may be necessary to support and facilitate the provision of health care services to patients. Any health care provider who uses telemedicine or engages in telehealth while providing health care services to a patient, shall: The contact information shall enable the patient to contact the health care provider, or a substitute health care provider authorized to act on behalf of the provider who provided services, for at least 72 hours following the provision of services. In the case of a subsequent telemedicine or telehealth encounter conducted pursuant to an ongoing provider-patient relationship, the provider may review the information prior to initiating contact with the patient or contemporaneously with the telemedicine or telehealth encounter. For patients without a primary care provider or other health care provider of record, the health care provider engaging in telemedicine or telehealth may advise the patient to contact a primary care provider, and, upon request by the patient, assist the patient with locating a primary care provider or other in-person medical assistance that, to the extent possible, is located within reasonable proximity to the patient. The health care provider engaging in telemedicine or telehealth shall also refer the patient to appropriate follow up care where necessary, including making appropriate referrals for emergency or complimentary care, if needed. Consent may be oral, written, or digital in nature, provided that the chosen method of consent is deemed appropriate under the standard of care. If telemedicine or telehealth services would not be consistent with this standard of care, the health care provider shall direct the patient to seek in-person care. Unless the provider has established a proper provider-patient relationship with the patient, a provider shall not issue a prescription to a patient based solely on the responses provided in an online questionnaire. The prescription of Schedule II controlled dangerous substances through the use of telemedicine or telehealth shall be authorized only after an initial in-person examination of the patient, as provided by regulation, and a subsequent in-person visit with the patient shall be required every three months for the duration of time that the patient is being prescribed the Schedule II controlled dangerous substance. A mental health screener, screening service, or screening psychiatrist subject to the provisions of P. A health care provider who engages in telemedicine or telehealth, as authorized by P. A health care provider shall not be subject to any professional disciplinary action under Title 45 of the Revised Statutes solely on the basis that the provider engaged in telemedicine or telehealth pursuant to P. Such rules and regulations shall, at a minimum: Any health care provider who engages in telemedicine or telehealth shall ensure that a proper provider-patient relationship is established. The establishment of a proper provider-patient relationship shall include, but shall not be limited to: The provider shall make this determination prior to each unique patient encounter. Telemedicine or telehealth may be practiced without a proper provider-patient relationship, as defined in subsection a. Each telemedicine or telehealth organization operating in the State shall annually register with the Department of Health. Each telemedicine or telehealth organization operating in the State shall submit an annual report to the Department of Health in a manner as determined by the commissioner. The annual report shall include de-identified encounter data including, but not limited to: The commissioner may require the reporting of any additional information as the commissioner deems necessary and appropriate, subject to all applicable State and federal laws, rules, and regulations for recordkeeping and privacy. Commencing six months after the effective date of P. The Department of Health shall compile the information provided in the reports submitted by telemedicine and telehealth organizations pursuant to subsection b. The department shall annually share the Statewide data with the Department of Human Services, the Department of Banking and Insurance, the Telemedicine and Telehealth Review Commission established pursuant to section 5 of P. The department shall also transmit a report to the Legislature and the Telemedicine

and Telehealth Review Commission that includes: A telemedicine or telehealth organization that fails to register with the Department of Health pursuant to subsection a. Six months after the effective date of P. The commission shall consist of seven members, as follows: The public members shall be health care professionals with a background in the provision of health care services using telemedicine and telehealth. The public members shall serve at the pleasure of the appointing authority, and vacancies in the membership shall be filled in the same manner as the original appointments. Members of the commission shall serve without compensation but may be reimbursed for necessary travel expenses incurred in the performance of their duties within the limits of funds made available for that purpose. The members shall select a chairperson and a vice chairperson from among the members. The chairperson may appoint a secretary, who need not be a member of the commission. The Department of Health shall provide staff and administrative support to the commission. The commission shall meet at least twice a year and at such other times as the chairperson may require. The commission shall be entitled to call to its assistance and avail itself of the services of the employees of any State, county, or municipal department, board, bureau, commission, or agency as it may require and as may be available for its purposes. The commission shall report its findings and recommendations to the Governor, the Commissioner of Health, the State boards or other entities that, pursuant to Title 45 of the Revised Statutes, are responsible for the licensure, certification, or registration of health care providers in the State who provide health care services using telemedicine or telehealth pursuant to P. The commission shall expire upon submission of its report. If any provision of P. The State Medicaid and NJ FamilyCare programs shall provide coverage and payment for health care services delivered to a benefits recipient through telemedicine or telehealth, on the same basis as, and at a provider reimbursement rate that does not exceed the provider reimbursement rate that is applicable, when the services are delivered through in-person contact and consultation in New Jersey. Reimbursement payments under this section may be provided either to the individual practitioner who delivered the reimbursable services, or to the agency, facility, or organization that employs the individual practitioner who delivered the reimbursable services, as appropriate. The State Medicaid and NJ FamilyCare programs may limit coverage to services that are delivered by participating health care providers, but may not charge any deductible, copayment, or coinsurance for a health care service, delivered through telemedicine or telehealth, in an amount that exceeds the deductible, copayment, or coinsurance amount that is applicable to an in-person consultation. Nothing in this section shall be construed to: As used in this section: A carrier that offers a health benefits plan in this State shall provide coverage and payment for health care services delivered to a covered person through telemedicine or telehealth, on the same basis as, and at a provider reimbursement rate that does not exceed the provider reimbursement rate that is applicable, when the services are delivered through in-person contact and consultation in New Jersey. The State Health Benefits Commission shall ensure that every contract purchased thereby, which provides hospital and medical expense benefits, additionally provides coverage and payment for health care services delivered to a covered person through telemedicine or telehealth, on the same basis as, and at a provider reimbursement rate that does not exceed the provider reimbursement rate that is applicable, when the services are delivered through in-person contact and consultation in New Jersey.

Chapter 5 : CPTÂ® Admission Codes For Initial Inpatient & Observation Hospital H&P.

Patient-Physician Relationships The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentallya moral activity that arises from the imperative to care for patients and to alleviate.

Chapter 6 : Encounter Forms -- FPM Toolbox

initial comprehensive preventive medicine evaluation and management of an individual, age 7 with an age appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient.

Chapter 7 : FAQ: Understanding ICD (ICDCM)

one (1) prescription for an opioid to a patient per encounter. (2) If a healthcare practitioner treats a patient with more than a three-day supply of an opioid, the healthcare practitioner may treat the patient with no more.