CMS is now waiving the video requirement for certain telephone E/M services and allowing providers to bill for these services when conducted via audio-only telephone calls. This change will increase the reimbursement payments for codes 99441, 99442, and 99443. These codes will now be reimbursed at the same rate as if they were conducted in person, in the office/outpatient setting (corresponding to what would be codes 99213-5).

1. **Should you continue to bill telephone codes (99441-3) or should you bill office/outpatient codes (99213-5)?**

You should bill the codes that correspond to the actual encounter taking place. If the service was provided via the telephone, then use 99441-3, and if the service took place in person, then use 99213-5. Even though CMS is reimbursing these codes at the same rate/level, the claim submission should accurately reflect the encounter. Nurse practitioners should use 99441-3 (and not 98966-8, which is reserved for other qualified health care professionals) as NPs are „qualified providers” reporting E/M services, as physicians.

2. **How should these codes be charted / is there any special documentation needed?**

First and foremost, for codes 99441-3, the medical record should document that the encounter took place via an audio-only telephone. Notion in the medical record should also indicate: (1) the patient acknowledged and consented to treatment through use of the audio-only phone; (2) the names/locations of all parties present on the call; (3) the main reason for the call; (4) any relevant history, background, or results; (5) the assessment and next steps; and **most important** (6) the time spent on the phone with the patient. These telephone calls are time-based, so documenting time spent will lead the practitioner to the appropriate code.

Place of service location should be noted as if the encounter took place in-person, even though you will be billing for the telephone call via the telephone codes (POS 11 — “Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.”). No other documentation is needed.

Finally, these codes should not be reported if the provider decides to see the patient within 24 hours or by the next available urgent visit appointment; if the provider performed a related E/M service within the previous seven days; or the call is initiated within a postoperative period.