

BUSINESS TRACK

From Visit to Value: Connecting Telehealth Documentation, Coding, and Reimbursement



Introduction by:
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SEPTEMBER 1
2:15PM-3:00PM

REGENCY BALLROOM F

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From Visit to Value: Connecting Telehealth Documentation, Coding, (Billing) and Reimbursement

Tuesday, September 1, 2026

2:15pm – 3:00pm

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The Flow

Clinical
Encounter

Documentation

Coding

Compliance

Claim

Payment

Learning Objectives

- Identify the documentation elements that support accurate telehealth coding
- Distinguish clinical, coding, compliance and payer requirements
- Recognize common points of failure between the encounter and the claim
- Apply a practical framework for evaluating a telehealth encounter before billing
- Use real-world scenarios to identify opportunities for stronger workflow design

Where could telehealth revenue fall apart? Anywhere!

- The clinician performs the service, but the note does not support the code
- The note supports the code, but the wrong POS or modifier is reported
- The service is correctly billed, but the billing provider/entity is not configured correctly
- The claim is technically clean, but the payer applies a different coverage or contractual rule
- The organization discovers the problem only after a denial, audit, or payment variance

Documentation

Does the Record Tell the Story?

- What problem(s) were evaluated or managed?
- What did the clinician actually do?
- What information was reviewed, analyzed or interpreted?
- What decisions were made and why?
- Does the documentation support the selected code without relying on assumptions?
- Are telehealth-specific elements documented when required by policy or payer?

Example: 'Good Visit, Weak Note'

- Scenario: Patient with worsening symptoms has a 25-minute video visit
- Provider reviews prior records, evaluates medication response, changes treatment and establishes follow-up
- The note says only: “Follow-up for condition. Continue management.”
- Clinical reality: meaningful assessment and management occurred
- Billing problem: the record may not demonstrate the work necessary to support the selected service
- Discussion: What should the clinician document prospectively, not after the fact?

Coding

Translating the Encounter

- Select the code for the service performed and documented
- For E/M services, determine whether the level is supported by MDM or time, as applicable
- Apply relevant diagnosis codes
- Evaluate the telehealth billing construct: POS, modifier, payer rules and billing entity
- Separate CPT coding rules from payer-specific reimbursement rules

Place of Service is Important

- POS demonstrates where the patient received the service
- For Medicare professional telehealth claims in 2026:
 - POS 10 = patient in the home and pays at the non-facility rate
 - POS 02 = telehealth provided other than in the home and pays at the facility rate
- A correct CPT code paired with an inappropriate POS can produce denial, payment variance or incorrect reporting
- Key question: Where was the patient physically located when the service was furnished?

Example: Same Video Visits, but Different Billing Constructs

- Patient A: at home: one set of telehealth/POS considerations
- Patient B: physically located in an acute-care facility: potentially different facility, professional and payer considerations
- Patient C: in an outpatient clinic with a remote practitioner: different workflow again
- The video technology is identical. The billing environment is not
- Remember: “Telehealth” describes how the service was delivered; it does not answer every billing question

Compliance

Was the Encounter Permissible?

- Patient location and practitioner location
- Licensure and scope of practice
- Credentialing and privileging (where applicable)
- Provider enrollment and reassignment
- Consent requirements
- Supervision / incident-to requirements when applicable
- Payer-specific telehealth conditions
- Documentation that demonstrates compliance

Example: 'The Visit Happened, so Can We Bill It?'

- A physician conducts a follow-up video visit with a patient who is temporarily outside the physician's state.
- The clinician can technically connect with the patient and documents the encounter
- Question 1: Is the clinician legally authorized to practice where the patient is located?
- Question 2: Does the payer recognize the service under those circumstances?
- Question 3: Does the organization have a workflow that identifies location before the visit?
- The compliance issue may exist before coding ever begins

Reimbursement

The Correct Code does not Guarantee Payment

- Medicare, Medicaid and commercial payers may apply different requirements
- For CY 2026, CMS streamlined the Medicare Telehealth Services List and permanently removed frequency limits for subsequent inpatient visits, subsequent nursing-facility visits and critical-care consultations
- Contract language can differ from national coding guidance
- Professional and institutional claims may follow different payment methodologies
- A service can be medically necessary and correctly coded yet still deny
- Denial analysis should identify the upstream workflow failure—not simply correct the claim

Professional vs. Facility: Who Is Billing for What?

- Professional fee: reflects the practitioner's service and follows professional claim rules
- Facility claim: depends on the facility's resources, setting, benefit category and payment methodology, not merely the fact that video was used
- The same clinical encounter can generate different billing considerations for the professional and facility sides
- A professional telehealth rule does not automatically create or support a facility charge
- Build the workflow around the billing entity, patient setting and service being reported

Case Study 1: Clinically Appropriate, Poorly Supported

- Video visit: established patient with worsening chronic condition
- Provider reviews recent labs and prior notes, adjusts medication and orders additional testing
- Claim is submitted at a higher E/M level
- Audit question: Can the reviewer reconstruct the medical decision-making from the note?
- Build-on discussion: What documentation is missing? What can or and/or cannot be inferred?

Case Study 2: Documentation Supports It, Billing Does Not

- The note supports the service and medical necessity
- The patient was at home
- The claim uses the correct CPT but the wrong POS for the payer's telehealth construct
- Result: denial or unexpected payment
- Build-on discussion: Where should the edit occur—clinician workflow, charge capture, coding, claim scrubber or payer configuration?

Case Study 3: The Hidden Enrollment Problem

- Provider performs telehealth services appropriately
- Documentation and coding are correct
- Claim denies because the billing provider/TIN/NPI configuration does not match payer enrollment
- This is not a documentation problem
- This is not a coding problem
- It is a revenue-cycle configuration problem that surfaced as a claim denial

A Practical Pre-Bill Review

1. Who performed the service?
2. Where was the patient located?
3. Where was the practitioner located?
4. What service was performed?
5. Does the documentation support the service?
6. What CPT/HCPCS code best represents it?
7. What POS, modifier and payer-specific requirements apply?
8. Is the billing provider/entity correctly enrolled and configured?

Build the Workflow Backward From the Claim

What must be billed?

What must be coded?

What must be documented?

What must the clinician do?

What must the system capture?

- Revenue-cycle requirements should inform clinical workflow design and not applied afterward
- Every required claim element should have a defined source in the workflow

Where Organizations Can Strengthen the Process

- Standardize telehealth documentation expectations
- Build patient-location and practitioner-location checks into workflow
- Create payer-specific billing matrices where necessary
- Align EHR build, charge capture and claim edits
- Monitor denials by root cause—not just by CPT code
- Audit the entire encounter-to-claim pathway periodically
- Educate clinicians on documentation without turning them into coders

The Audit Question: Can You Connect the Dots?

- Clinical record: What happened?
 - Coding: How is it represented?
 - Compliance: Was it permissible?
 - Claim: Was it submitted correctly?
 - Payment: Did the payer reimburse it as expected?
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- If one link is weak, the entire chain can fail

Closing Takeaways

- Telehealth reimbursement is an end-to-end process
- Documentation is the foundation, but documentation alone does not guarantee payment
- Coding accuracy requires understanding the underlying clinical service and the billing environment
- Compliance questions often begin before the clinician joins the visit
- Denials are often symptoms of workflow design problems
- The strongest telehealth programs align clinical, operational, compliance and revenue-cycle teams

Discussion / Q&A

- Where does your organization's telehealth revenue cycle most often break?
- Which requirements create the greatest disconnect between clinicians and billing?
- What is one workflow change that could prevent a denial before the claim is submitted?