healthfirst
Health Insurance for New Yorkers

Documentation and Coding: Telehealth Services

Healthfirst is dedicated to providing you with resources and tools to help you accurately capture telehealth services and to ensure timely payment while also improving the quality of care of our members.

The Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services during the Coronavirus: Type COVID-19 Public Health Emergency (PHE). This change allows members to receive a wider range of services from you without having to travel to a healthcare facility, in addition to practicing social distancing to reduce the risk of COVID-19 transmission. New York State has similarly expanded access under Medicaid, Health and Recovery Plans, Child Health Plus, Essential Plans, Qualified Health Plans, and commercial plans.

Due to the increased use of telehealth, we are sharing the information below to help you code accurately for telehealth services, as outlined by **CMS**.

CMS Medicare Telehealth Policy

On an interim basis, CMS is revising its policy to specify that the office/outpatient Evaluation and Management (E/M) level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record. This policy applies only to office/outpatient visits furnished via Medicare telehealth, and only during the PHE for the COVID-19 pandemic. For more information, see pages **136-137.**

E/M Services

E/M services are a category of CPT codes used when billing for a patient's visit. You should select codes that best represent the services furnished during the visit, ensuring that the clinical documentation supports the level of service reported to Healthfirst.

- **Patient Type:** For purposes of billing for E/M services, patients are identified as either new or established, depending on previous encounters with the provider.
- **New Patient:** An individual who, within the previous three years, did not receive any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice.
- **Established Patient:** An individual who, within the previous three years, received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice.

Documentation Requirements for E/M Services for New Patients* (99201–99205)

1. Medical decision-making (MDM)
2. Patient consent
   - The patient must verbally consent to receive telehealth services.

Documentation Requirements for E/M Services for Established Patients* (99212–99215)

1. Medical decision-making (MDM)
2. Patient consent
   - The patient must verbally consent to receive telehealth services.

**For office or other outpatient visit*

E/M Based on Time

For encounters that involve extensive counseling, coding based on time offers the best opportunity for thorough documentation of the services. Only the time spent by the primary provider (physician, physician assistant, nurse practitioner, etc.) can be considered in determining the level of service. CPT states that counseling involves a discussion with the patient or family. It says further that encounters with parties who have assumed responsibility for the patient can be used to calculate the face-to-face time. This might include not just family members, but foster parents, legal guardians, and the like.

If the level of service is reported based on counseling and/or coordination of care, **you should document the start and stop time as well as the total length of time of the encounter and time spent counseling. In addition, the record should describe the counseling and/or activities to coordinate care.**