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| Subject: | Online Digital (e-Visit) Services | | |
| Policy Number: | PO-RE-163v1 | | |
| Effective Date: | 1/1/2025 | Last Approval Date: | 03/16/2026 |

I. Policy Description

This policy outlines Healthfirst’s criteria for reimbursing e-Visits, a form of asynchronous, patient-initiated communication that takes place through a secure, HIPAA-compliant digital platform, most commonly a patient portal.

An e-Visit refers to a non-real-time, text-based clinical interaction between an established patient and a healthcare provider. Unlike video or telephone encounters, e-Visits do not happen in real time; instead, patients submit their health concerns in writing, and providers respond after reviewing the message, typically within a defined time frame. This format allows for clinical evaluation, advice, and follow-up planning without the need for a live consultation.

To be eligible for reimbursement, e-Visits must meet specific Centers for Medicare & Medicaid Services (CMS) and New York State Department of Health (DOH) requirements related to CPT coding, provider eligibility, documentation standards, and appropriate use of technology. Healthfirst supports reimbursement for e-Visits when these criteria are met to ensure clinical integrity, administrative compliance, and patient access to timely care

The information below applies to the following lines of business:

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|--|--|
| • Child Health Plus (CHP) | • Essential Plan (EP) |
| • Integrated Benefit Dual Plan (IB-Dual) | • Managed Long Term Care Plan (MLTCP – Senior Health Partners) |
| • Medicaid Managed Care (MMC) | • Medicaid Advantage Plus/MAP (CompleteCare) |
| • Medicare Advantage HMO | • Qualified Health Plan (QHP) |
| • Medicare PPO | • Personal Wellness Plan (HARP) |

Reimbursement Guidelines

- e-Visits must be initiated by the patient and conducted through a secure digital platform that complies with HIPAA.
- These visits are asynchronous, allowing the provider to respond at a later time.

- The service is billed once per seven-day period, using the last day of communication as the date of service.
- The seven-day (7) timeframe begins when the provider starts reviewing the patient's initial message, which must happen within three business days.
 - For example, if a patient sends a message on Monday, the provider should begin the review no later than Thursday.
- If the e-Visit results in an in-person or synchronous telehealth appointment, the e-Visit should not be billed separately. However, time spent on the initial communication may be applied to the E&M billing.

1. General Conditions for Reimbursement

A. Providers Who Can Independently Bill E&M Services

Eligible provider types include:

- Physicians
- Nurse Practitioners (NPs)
- Midwives

They should use the following CPT code based on the total time spent over seven days:

| CPT Code | Description | Cumulative Time |
|----------|--|--------------------|
| 99421 | Digital E&M for an established patient | 5–10 minutes |
| 99422 | Digital E&M for an established patient | 11–20 minutes |
| 99423 | Digital E&M for an established patient | 21 minutes or more |

B. Providers Not Authorized to Independently Bill E&M Services

These include:

- Licensed Clinical Social Workers (LCSWs)
- Clinical Psychologists
- Speech Language Pathologists (SLPs)
- Physical Therapists (PTs)
- Occupational Therapists (OTs)

They may instead use the following codes:

| CPT Code | Description | Cumulative Time |
|----------|--|--------------------|
| 98970 | Digital assessment and management for an established patient | 5–10 minutes |
| 98971 | Digital assessment and management | 11–20 minutes |
| 98972 | Digital assessment and management | 21 minutes or more |

2. Billing Requirements

- Time billed may include activities like reviewing the patient's message and chart, coordinating with clinical staff, and preparing a written response if these tasks aren't billed separately.
- Only one e-Visit may be billed per seven-day (7) window, even if there are multiple back-and-forth exchanges.
- If the e-Visit stems from a concern related to a recent in-person or telehealth visit (within the past 7 days), then billing for the e-Visit is not permitted.
- When an e-Visit evolves into an in-person or synchronous E&M appointment, skip billing for the e-Visit but include the time in the E&M code.

3. Setting-Specific Rules

- Article 28 clinics (billing under APGs):
 - These clinics can bill for e-Visit CPT codes, but reimbursement goes only to the clinic. Providers may not bill a separate professional component.
- Federally Qualified Health Centers (FQHCs):
 - Under current guidance, FQHCs are not eligible to bill for e-Visits.

4. Patient Consent Requirements

Providers are expected to:

- Obtain and document informed consent (verbal or written) for using digital communication annually.
- Confirm that this consent is on file before each e-Visit takes place.

5. Documentation Expectations

Medical records must include:

- A note confirming that verbal or written consent for telehealth communication was obtained.
- The initial patient communication date and the date the provider began their review.
- A summary of the communication, along with the total time spent during the seven-day period.
- Any relevant clinical decision-making or follow-up actions.

Adjudication and Appeal Process

1. Reimbursement for e-Visit services will be determined based on the provider's scope of services as defined by the provider's contract with Healthfirst.
2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.
4. This policy is a provider resource for understanding Healthfirst’s reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.
5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, “Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process” in this section.*

For any questions or further clarification regarding this policy, providers are encouraged to reach out to their designated contact within our organization

II. Applicable Codes

| Code | Description | Comments |
|-------|--|----------|
| 99421 | Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes | |
| 99422 | Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes | |
| 99423 | Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes | |
| 98970 | Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes | |
| 98971 | Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes | |
| 98972 | Qualified non-physician healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes. | |

III. Definitions

| Term | Meaning |
|-------------------------|--|
| e-Visits | Communications between a patient and their provider through an online patient portal. |
| Synchronous interaction | “Synchronous interaction” means a real-time interaction between a patient and a health care provider located at a distant site |
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IV. Related Policies

| Policy Number | Policy Description |
|---------------|--------------------|
| N/A | N/A |
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Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

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| Medicaid Telehealth Manual |
| Medicare Telemedicine Provider Fact Sheet CMS |

VI. Revision History

| Revision Date | Summary of Changes |
|---------------|--------------------|
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Disclaimer

Healthfirst’s claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst’s coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles,



National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.