Documenting Meaningful Use for Telehealth Visits
Frequently Asked Questions

Updated: May 21, 2020

1. **Does the CMS definition of an office visit include telehealth under the DC Medicaid Promoting Interoperability/EHR Incentive Program (formally known as Meaningful Use)?**
   - Yes, the CMS definition of an office visit under Promoting Interoperability/ Meaningful Use includes telehealth visits. For additional information, please see ***Reference 1***.

2. **When calculating my DC Medicaid patient volume, can I include telehealth visits?**
   - Yes, you can include telehealth visits as part of your 30% DC Medicaid patient volume threshold if the patient is an active DC Medicaid enrollee. For additional Information, please see ***Reference 2*****.**

3. **Do Meaningful Use objectives and measures still count when conducting telehealth visits?**
   - Yes, you will receive credit if you perform and document the actions related to Meaningful Use objectives and measures for telehealth visits in your certified EHR technology.
   - Please Note: With some EHRs, you must use an office visit progress note (and not a telephone note) to be able to document your Meaningful Use objectives and measures. Contact your eHealthDC TA Specialist for additional information.

4. **What are the advantages to using my EHR's built-in telehealth module?**
   - Your built-in certified electronic health record technology's (CEHRT) telehealth module is usually linked to your CEHRT's patient portal; please confirm this with your EHR vendor. By using your built-in telehealth module, you can get credit for the following Meaningful Use objectives and measures:
     - **Patient Portal Access**: when patients log into the patient portal to initiate a telehealth visit;
     - **Patient Education:** when the provider sends patient education through the portal during or after the patient's telehealth visit;
     - **Secure Messaging**: when the practice sends or responds to secure messages through the patient portal (example: responding to patients' clinical advice questions, medication refill requests, etc.);
     - **View, Download, Transmit:** when a patient logs into the portal to check their lab results, diagnosis and medical records; and
     - **Patient Generated Data:** when a patient fills out questionnaires through the patient portal before their visit or connects their health devices (Apple watch, Fitbit, etc.) to their patient portal.

   For additional questions about your EHR's built-in telehealth module, please contact your eHealthDC TA Specialist.

5. **Can I still receive the same advantages if my practice uses a third-party telehealth module?**
   - Yes, you can still meet your Meaningful Use objectives and measures when using a third-party telehealth module, in conjunction with using your CEHRT functionalities.

   *Please note that most third-party telehealth modules do not contain CEHRT functionalities; as a result, eHealthDC still encourages you to use your CEHRT functionality for the tasks listed in Question 4. In addition, is best practice to send the third-party telehealth visit link and information through the portal using your CEHRT secure messaging module

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References:

Reference 1:

"For the EHR Incentive Programs, an office visit includes separate, billable encounters that result from evaluation and management services provided to the patient.

While CMS does not specify a range of E&M billing codes to which this exclusion applies, we define office visits as:

1. *Concurrent care or transfer of care visits*
2. *Consultant visits*, or*
3. *Prolonged Physician Service without Direct (Face-To-Face)* ***Patient Contact (telehealth).***

**A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider." CMS Meaningful Use Specialist Tip sheet June 2014*

Reference 2:

"FAQ #7535

Q. The Promoting Interoperability Programs Stage 1 Rule stated that, in order for a Medicaid encounter to count towards the patient volume of an eligible provider, Medicaid had to either pay for all or part of the service, or pay all or part of the premium, deductible or coinsurance for that encounter. The Stage 2 Rule now states that the Medicaid encounter can be counted towards patient volume if the patient is enrolled in the state's Medicaid program (either through the state's fee-for-service programs or the state's Medicaid managed care programs) at the time of service without the requirement of Medicaid payment liability. How will this change affect patient volume calculations for Medicaid eligible providers?

A. Importantly, this change affecting the Medicaid patient volume calculation is applicable to all eligible providers, regardless of the stage of the Medicaid Promoting Interoperability Program they are participating in. Billable services provided by an eligible provider to a patient enrolled in Medicaid would count toward meeting the minimum Medicaid patient volume thresholds. Examples of Medicaid encounters under this expanded definition that could be newly eligible might include: behavioral health

services, HIV/AIDS treatment, or other services that might not be billed to Medicaid/managed care for privacy reasons, but where the provider has a mechanism to verify eligibility. **Also, services to a Medicaid-enrolled patient that might not have been reimbursed by Medicaid (or a Medicaid managed care organization) may now be included in the Medicaid patient volume calculation (e.g., oral health services, immunization, vaccination and women's health services, , telemedicine/telehealth, etc.).** Providers who are not currently enrolled with their state Medicaid agency who might be newly eligible for the incentive payments due to these changes should note that they are not necessarily required to fully enroll with Medicaid in order to receive the payment. In some instances, it may now be appropriate to include services denied by Medicaid in calculating patient volume. It will be appropriate to review denial reasons. If Medicaid denied the service for timely filing or because another payer's payment exceeded the potential Medicaid payment, it would be appropriate to include that encounter in the calculation. If Medicaid denied payment for the service because the beneficiary has exceeded service limits established by the Medicaid program, it would be appropriate to include that encounter in the calculation. If Medicaid denied the service because the patient was ineligible for Medicaid at the time of service, it would not be appropriate to include that encounter in the calculation. Further guidance regarding this change will be distributed to the states as appropriate." CMS FAQ#7535