CMS TELEHEALTH GUIDANCE

NY MEDICAID EHR INCENTIVE PROGRAM

As the result of the COVID-19 emergency, many NYC providers have expanded their telehealth services. Providers who plan to attest to Meaningful Use (MU) for Payment Year (PY) 2020 should consider the Centers for Medicare and Medicaid Services' (CMS) guidance on telehealth visits when calculating their Meaningful Use performance and Medicaid Patient Volume (MPV) .

OFFICE VISITS

- **Since the beginning of the Medicaid EHR Incentive Program, telemedicine/telehealth services have been included in the CMS definition of an "office visit."**
  - From the 2010 CMS Final Rule:

    "An office visit is defined as any billable visit that includes: (1) Concurrent care or transfer of care visits, (2) Consultant visits and (3) **Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health**)."

    Reference for applicable section of rule

    The same definition was included in the 2012 CMS proposed rule and final rule
  - From the 2015 CMS Proposed Rule:

    "Office visits. The denominators of the measures that reference "office visits" may be limited to only those patients whose records are maintained using CEHRT. An office visit is defined as any billable visit that includes the following:

    - Concurrent or transfer of care visits,
    - Consultant visits, or
    - **Prolonged physician service without direct, face-to-face patient contact (for example, telehealth)."**

    Reference for applicable section of the rule
  - **How this applies to Stage 3:**

    Objective 5 measure 1 and 2 exclusions

    Objective 6 measures 1, 2 , and 3 exclusions

    Where the provider has "no office visits during the EHR reporting period."

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PATIENTS SEEN BY THE EP

- **In 2012, the CMS definition of 'patients seen by the EP' included telemedicine/ telehealth services in the context of measure/objective denominators.**
  - From 2012 CMS Final Rule:

    "In the proposed rule, we stated that the term "unique patient" means that if a patient is seen or admitted more than once during the EHR reporting period, the patient only counts once in the denominator. Patients seen or admitted only once during the EHR reporting period will count once in the denominator. A patient is seen by the EP when the EP has an actual physical encounter with the patient in which they render any service to the patient**. A patient seen through telemedicine will also still count as a patient "seen by the EP"."**

    Reference for applicable section of the rule
  - **How this applies to Stage 3:**

    Objective 5 measure 1 and measure 2

    Objective 6 measures 1, 2, and 3

    Where the denominator is "the number of unique patients seen by the EP during the EHR reporting period."

- **In 2015, CMS added more specific telehealth inclusion for Meaningful Use Objective 4: Computerized Provider Order Entry Objective.**
  - From 2015 CMS Final Rule:

    "Finally, we believe that **a circumstance involving tele-health or remote communication may be included in the numerator** as long as the order entry otherwise meets the requirements of the objective and measures."

    Reference for applicable section of the rule
  - **How this applies to Stage 3**

    Objective 4 Measures 1, 2, and 3 when medication, lab, and diagnostic imaging orders are created during a telehealth encounter.

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MPV CALCULATION

- **After CMS expanded the definition in 2011, telemedicine/telehealth encounters were included in the calculation of MPV.**
- **From CMS 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.)....**