Digital E/M Visits

It’s 2020. Your patients know they can use the portal to have their concerns addressed – and avoid an office visit. Shouldn’t you get paid for the care you provide when managing patients in an online setting? Now you can.

Eligibility Requirements

- Established patient (has received care in the past 3 years)
- Patients must initiate the contact, like they would with other Evaluation & Management (E/M) services, in a digital format (such as through the patient portal)
- Problems addressed in digital E/M visits must be unrelated to any E/M service provided in past 7 days
- Problems addressed in a digital E/M visit must require a clinical decision that typically would have required an office-based E/M visit
- Digital E/M visits may not be billed during surgical global period or during the same period covered by a Virtual Check-In (G2012)

Digital E/M vs Digital Assessment

Medicare has created 2 levels of digital visits:

- those that would typically be provided by physicians and non-physician providers (NPP). These services are billed using CPT codes 99421-99423, which describe digital visits that replace an office-based E/M visit.
- those that would be delivered by qualified healthcare providers (QHP), such as Physical Therapists, Social Workers, and Dieticians, who cannot bill for E/M visits. These services are billed using HCPCS codes G2061-G2063, which describe digital visits that include assessments by QHP.

Whether billing digital E/M visits or digital assessments, clinical staff time does not count towards the cumulative time for billing purposes.
7 Days of Services

- Time spent by the provider, NPP, or QHP over the course of 7 days can count towards the total time calculation.
- The 7-day period begins when the healthcare provider personally reviews the patient-initiated inquiry.
- Digital E/M and Digital Assessments can be billed once every 7 days.
- In addition to reviewing the initial patient inquiry, actions counting towards the cumulative service time can include:
  - Review of patient records or data relevant to the problem
  - Provider interaction with other clinical staff focused on the patient’s problem
  - Developing a management plan, including generating prescriptions, ordering tests, and following up with the patient
  - Follow-up with patients may occur through the same digital medium, another digital platform, or telephone
- Consent for services must include notification of cost-sharing obligations; documented verbal consent meets requirements. Once obtained and documented, a single consent can cover services for entire year. Consent may be obtained by auxiliary personnel under general supervision.
- Documentation should be similar to what would typically be documented for an E/M visit or QHP assessment, using addendums to amend the documentation over the 7 day period.
- Documentation of the digital communication, such as the patient inquiry and provider responses, should be placed in the Electronic Medical Record (EMR).
- If a face-to-face visit occurs within 7 days of the initiation of the digital visit, a separate digital visit cannot be billed. However, the cumulative time spent or complexity of medical decision-making that occurred during the 7-day period can count selecting the level of service for the face-to-face visit.
- Services must be provided on a HIPAA compliant platform*, such as a patient portal, secure email, or other digital applications.

Billing Tips

- Both E/M Digital Visits (99421 - 99423) and Digital Assessments (G2061 - G2063) may be billed the same day in fee-for-service settings, using the -25 modifier.
- Digital E/M or Assessment Visits can be billed the same month as Chronic Care Management, Transitional Care Management, and Principal Care Management.
- When requirements for Digital E/M Visits (99421-99423) are met in Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) settings, G0071 may be billed.
- During the National Public Health Emergency, providers may waive cost sharing for this service.

Suggested Citation: