**TELEHEALTH SERVICES**



## Definitions

Audio only

The use of real-time telephonic communication that does not include use of video.

Distant Site

The distant site is the location of the Provider rendering the covered service via telehealth.

Originating Site

The originating site is the location of the member at the time the service is rendered, or the site where the asynchronous store-and-forward service originates (i.e., where the data are collected). Examples of originating sites include: medical care facility; Provider's outpatient office; the member's residence or school; or other community location (e.g., place of employment).

Provider

For purposes of this manual supplement, the term "Provider" refers to the billing provider – either a qualified, licensed practitioner of the healing arts or a facility – who is enrolled with DMAS.

Remote Patient Monitoring

Remote Patient Monitoring (RPM) involves the collection and transmission of personal health information from a beneficiary in one location to a provider in a different location

for the purposes of monitoring and management. This includes monitoring of both patient physiologic and therapeutic data.

Store-and-Forward

Store-and-forward means the asynchronous transmission of a member's medical information from an originating site to a health care Provider located at a distant site. A member's medical information may include, but is not limited to, video clips, still images, x-rays, laboratory results, audio clips, and text. The information is reviewed at the Distant Site without the patient present with interpretation or results relayed by the distant site Provider via synchronous or asynchronous communications.

Telehealth

Telehealth means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices. Telehealth includes services delivered in the dental health setting (i.e., teledentistry), and telehealth policies for dentistry are covered in the dental manuals.

Telemedicine

Telemedicine is a means of providing services through the use of two-way, real time interactive electronic communication between the member and the Provider located at a site distant from the member. This electronic communication must include, at a minimum, the use of audio and video equipment. Telemedicine does not include an audio-only telephone.

Virtual Check-In

A Virtual Check-In is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed.

**Reimbursable Telehealth Services**

Attachment A lists covered services that may be reimbursed when provided via telehealth. Specifically:

- Table 1 – Table 3 list Telemedicine services
- Table 4 list Radiology-Related Procedures for Physician Billing Included under Telehealth Coverage (store and forward)
- Table 5 lists Remote Patient Monitoring services
- Table 6 lists Virtual Check-In services

- Table 7 and Table 8 lists audio-only telehealth services

Services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

- The Provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth;
- The service delivered via telehealth meets the procedural definition and components of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as defined by the American Medical Association (AMA), unless otherwise noted in Table 1 – Table 8 in this Supplement;
- The service provided via telehealth meets all state and federal laws regarding confidentiality of health care information and a patient's right to his or her medical information;
- Services delivered via telehealth meet all applicable state laws, regulations and licensure requirements on the practice of telehealth; and
- DMAS deems the service eligible for delivery via telehealth.

In order to be reimbursed for services using telehealth that are provided to Managed Care Organization (MCO)-enrolled members, Providers must follow their respective contract with the MCO. Additional information about the Medicaid MCO programs can be found at https://www.dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/

Additional modality-specific conditions for reimbursement are provided, below.

<u>Telemedicine and Audio-Only Telehealth</u>

- Services delivered via telemedicine or audio-only telehealth must be provided with the same standard of care as services provided in person.
- Telemedicine or audio-only telehealth must not be used when in-person services are medically and/or clinically necessary. The distant Provider is responsible for determining that the service meets all requirements and standards of care. Certain types of services that would not be expected to be appropriately delivered via telemedicine include, but are not limited to, those that: are performed in an operating room or while the patient is under anesthesia; require direct visualization or instrumentation of bodily structures; involve sampling of tissue or insertion/removal of medical devices; and/or otherwise require the in-person presence of the patient for any reason.
- If, after initiating a telemedicine or audio-only telehealth visit, the telemedicine or audio-only telehealth modality is found to be medically and/or clinically inappropriate, or otherwise can no longer meet the requirements stipulated in the "Reimbursable Telehealth Services" section, the Provider shall provide or arrange,

in a timely manner, an alternative to meet the needs of the member. In this circumstance, the Provider shall be reimbursed only for services successfully delivered.

Remote Patient Monitoring

- The Provider must have an established relationship with the member receiving the RPM service, including at least one visit in the last 12 months (which can include the date RPM services are initiated).
- The member receiving the RPM service must fall into one of the following five populations, with duration of initial service authorization in parentheses as per below:
    - High-risk pregnant persons (6 months);
    - Medically complex infants and children under 21 years of age (6 months);
    - Transplant patients (6 months);
    - Patients who have undergone surgery (up to 3 months following the date of surgery);
    - Patients with a chronic or acute health condition who have had two or more hospitalizations or emergency department visits related to such health condition in the previous 12 months when there is evidence that the use of remote patient monitoring is likely to prevent readmission to a hospital or emergency department (6 months)
- All service authorization criteria outlined in the DMAS Form “DMAS-P268” are met prior to billing the following CPT/HCPCS codes:
    - Physiologic Monitoring: 99453, 99454, 99457, 99458, and 99091
    - Therapeutic Monitoring: 98975, 98976, 98977, 98980, and 98981
    - Self-Measured Blood Pressure: 99473, 99474
- Providers must meet the criteria outlined in the DMAS Form “DMAS-P268” and submit their requests to the DMAS service authorization contractor by direct data entry (DDE) via their provider portal. See Appendix D of the *Physician/Practitioner* manual for details on the current service authorization contractor and accessing the provider portal.
- Service authorization requests must be submitted at least 30 days prior to the scheduled date of initiation of services.
- Reauthorizations will be permitted for select services, as appropriate and as per criteria in the DMAS Form “DMAS-P268”.

Virtual Check-In

- Services must be patient-initiated.
- Patients must be established with the provider practice.
- Must not be billed if services originated from a related service provided within the previous 7 days or lead to a service or procedure within the next 24 hours or at the soonest available appointment.

## Reimbursement and Billing for Telehealth Services

Telehealth Place of Service (POS)

Providers must use the place of service code that reflects the originating site:

- POS 02 – used for telehealth services when the originating site is other than the member's home
- POS 10 – used for telehealth services when the originating site is the member's home

Telemedicine and audio-only telehealth

Distant site Providers must include:

- the modifier **GT** on claims for services delivered via telemedicine
- the modifier **93** on claims for services delivered via audio-only telehealth.

CPT codes for activities that are not considered to be essentially in-person services per the CPT Manual do not require telehealth modifiers. Examples include codes used exclusively for audio-only delivery of services (see Table 7 in this supplement below). Refer to the CPT Manual for additional guidance.

Store-and-Forward

Distant site Providers must include the modifier **GQ**.

Remote Patient Monitoring (RPM)

No billing modifier is required on claims for services delivered via RPM.

Devices used to satisfy conditions for CPT 99453 and 99454 must automatically digitally upload patient data (i.e., not self-recorded or reported by patients) and automatically transmit either daily recordings of the beneficiary's physiologic data OR the device must record daily values and transmit an alert if the beneficiary's values fall outside predetermined parameters for 16 days in a 30-day period. Devices used to satisfy conditions for CPT 98975, 98976 and 98977 must be used to monitor data for 16 days in a 30-day period. These codes cannot be used for monitoring of parameters for which more specific codes are available (i.e., CPT 93296, 93264, 94760).

Services billed for using CPT 99457, 99458 and 99091 may involve review of data collected in conjunction with codes CPT 99453, 99454, or physiologic data manually captured and submitted by the patient/caregiver for billing providers to review. Services billed for using CPT 98980 and 98981 may involve review of data collected in conjunction with codes 98975, 98976, 98977, or therapeutic data (including self-

reported data) manually captured and submitted by the patient/caregiver for billing providers to review.

Time requirements associated with CPT 99457, 99458, 98980, 98981, and 99091 can include time spent furnishing care management services, if not billed for under other reported services, as well as time spent on required direct interactive communication. Interactive communication is defined as real-time synchronous, two-way audio interaction. Time spent on a day when the billing provider reports an E/M service (office or other outpatient services) shall not be included. Time counted toward time requirements of other reported services must also not be counted toward the time requirements of the aforementioned codes.

Only providers eligible to bill CMS Evaluation & Management (E&M) services are eligible to bill for RPM services. Clinical staff members—who work under the supervision of the eligible billing provider and are allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who do not individually report that professional service—are allowed to assist in delivery and satisfaction of appropriate RPM service requirements for 99453, 98975, 99457, 99458, 98980, and 98981, but not 99091.

Codes including the provision of RPM devices (99454, 98976, 98977) shall not be billed if patients supply their own device, or have been separately provided relevant durable medical equipment by DMAS.

- An individual provider must not bill for more than one set of RPM services per patient at any given time.

Virtual Check-In

No billing modifier is required on claims for the covered Virtual Check-In codes listed, in Table 6 of Attachment A.

Virtual Check-In services do not require service authorization.

Only physicians and other qualified health care professionals – previously defined by the American Medical Association as being an individual who by education, training, licensure/regulation, and facility privileging (when applicable) performs a professional service within his/her scope of practice and independently reports a professional service – may furnish and bill for Virtual Check-In services.

## Originating Site Fee

Telemedicine

In the event it is medically necessary for a Provider to be present at the originating site at the time a synchronous telehealth service is delivered, said Provider may bill an originating site fee (via procedure code Q3014) when the following conditions are met:

- The Medicaid member is located at a provider office or other location where services can be received (this does not include the member's residence);
- The member and distant site Provider are not located in the same location; and
- The Provider (or the Provider's designee), is affiliated with the provider office or other location where the Medicaid member is located and attends the encounter with the member. The Provider or designee may be present to assist with initiation of the visit but the presence of the Provider or designee in the actual visit shall be determined by a balance of clinical need and member preference or desire for confidentiality.

Originating site fee guidance specific to emergency ambulance transport providers is contained in the Transportation manual (Chapter 5).

All telehealth modalities

Originating site Providers, such as hospitals and nursing homes, submitting UB-04/CMS-1450 claim forms, must include the appropriate telemedicine revenue code of 0780 ("Telemedicine-General") or 0789 ("Telemedicine-Other").

Telehealth services may be included in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Center (IHC) scope of practice, as approved by HRSA and the Commonwealth. If approved, these facilities may serve as the Provider or originating site and bill under the encounter rate. The encounter rate methodology for FQHCs and RHCs is described in 12VAC30-80-25; the encounter rate for IHCs (including Tribal clinics) is the All Inclusive Rate set by Indian Health Services.

## Service Limitations

Unless otherwise noted in Attachment A, limitations for services delivered via telehealth are the same as for those delivered in-person.

## Provider Requirements

All coverage requirements for a particular covered service described in the DMAS Provider Manuals apply regardless of whether the service is delivered via telehealth or in-person.

Providers must maintain a practice at a physical location in the Commonwealth or be able to make appropriate referral of patients to a Provider located in the Commonwealth

in order to ensure an in-person examination of the patient when required by the standard of care.

Providers must meet state licensure, registration or certification requirements per their regulatory board with the Virginia Department of Health Professions to provide services to Virginia residents via telemedicine. Providers shall contact DMAS Provider Enrollment (888-829-5373) or the Medicaid MCOs for more information.

**Documentation Requirements**

Providers delivering services via telehealth must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes. Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. The distant site Provider can bill for covered benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. This documentation should be maintained in the patient's medical record.

When billing for an originating site, the originating site and distant site Providers must maintain documentation at the originating Provider site and the distant Provider site respectively to substantiate the services provided by each. When the originating site is the member's residence or other location that cannot bill for an originating site fee, this requirement only applies to documentation at the distant site.

Utilization reviews of enrolled Providers are conducted by DMAS, the designated contractor or the Medicaid MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the Provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified. Providers should be aware that findings during a utilization review that support failure to appropriately bill for telemedicine services as defined in this policy manual, including use of the GT/GQ modifier, appropriate POS or accurate procedure codes are subject to retractions.

**Member Choice and Education**

Before providing a telehealth service to a member, the Provider shall inform the patient about the use of telehealth and document verbal, electronic or written consent from the patient or legally-authorized representative, for the use of telehealth as an acceptable mode of delivering health care services. This documented consent shall be maintained in the medical record. When obtaining consent, the Provider must provide at least the following information:

- A description of the telehealth service(s);

- That the use of telehealth services is voluntary and that the member may refuse the telehealth service(s) at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of the member's benefits;
- That dissemination, storage, or retention of an identifiable member image or other information from the telehealth service(s) shall comply with federal laws and regulations and Virginia state laws and regulations requiring individual health care data confidentiality;
- That the member has the right to be informed of the parties who will be present at the distant (Provider) site and the originating (member) site during any telemedicine service and has the right to exclude anyone from either site; and
- That the member has the right to object to the videotaping or other recording of a telehealth consultation.

If a Provider, whether at the originating site or distant site, maintains a consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services including the information noted above, this shall meet DMAS's required documentation of patient consent.

**Telehealth Equipment and Technology**

Equipment utilized for telemedicine must be of sufficient audio quality and visual clarity as to be functionally equivalent to in-person encounter for professional medical services.

Equipment utilized for Remote Patient Monitoring must meet the Food and Drug Administration (FDA) definition of a medical device as described in section 201(h) of the Federal, Food, Drug and Cosmetic Act.

Providers must be proficient in the operation and use of any telehealth equipment.

Telehealth encounters must be conducted in a confidential manner, and any information sharing must be consistent with applicable federal and state laws and regulations and DMAS policy. Health Information Portability and Accountability Act of 1996 (HIPAA) confidentiality requirements are applicable to telemedicine encounters.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under HIPAA. Providers shall follow OCR HIPAA rules with the member, including services provided via telehealth. Providers are responsible for ensuring distant communication technologies meet the requirements of the HIPAA rules.

**Attachment A**

Clinicians shall use their clinical judgment to determine the appropriateness of service delivery via telehealth considering the needs and presentation of each individual.

**Table 1. Medicaid-covered medical services authorized for delivery by telemedicine***

| Service(s) | Telemedicine-specific Service Limitations | Code(s) |
|---|---|---|
| Colposcopy | | • 57452, 57454, 57455, 57456, 57460, 57461 |
| Fetal Non-Stress Test | | • 59025 |
| Prenatal and Postpartum Visits | • Synchronous audio-visual delivery is permissible for the prenatal and postpartum services stipulated in CPT 59400, 59410, 59510 and 59515; delivery services for those codes must be completed in person.<br>• Providers should complete at least one in-person visit per trimester for which they bill prenatal services for the purposes of appropriate evaluation, testing, and assessment of risk. | • 59400, 59410, 59425, 59426, 59430, 59510, 59515 |
| Radiology and Radiology-related Procedures | | • 70010-79999 and radiology related procedures as covered by DMAS; GQ modifier if store and forward** |
| Obstetric Ultrasound | | • 76801, 76802, 76805, 76810, 76811-76817 |
| Echocardiography, Fetal | | • 76825, 76826 |
| End Stage Renal Disease | | • 90951 - 90970 |
| Remote Fundoscopy | | • 92250; TC if applicable; GQ modifier if store and forward |

* Select services authorized for store-and-forward noted in Code(s) column of Table 1, see Table 4 for further information. See
Table 2 for services related to mental health and substance use disorders.

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† See the DMAS Rehabilitation provider manual for detailed information on billing using these codes.
†† See the DMAS Baby Care provider manual for detailed information on billing using this code.

**Attachment A**

| Service(s) | Telemedicine-specific Service Limitations | Code(s) |
|---|---|---|
| | | • 92227, 92228; 26 if applicable; GQ modifier if store and forward |
| Speech Language Therapy/Audiology | | • 92507†, 92508† , 92521, 92522, 92523, 92524 |
| Diagnosis, analysis cochlear implant function | | • 92601-92604, 95974 |
| Cardiography interpretation and report | | • 93010 |
| Echocardiography | | • 93307, 93308, 93320, 93321, 93325 |
| Genetic Counseling | | • 96040 |
| Maternal Mental Health Screening | | • 96127, 96160††, 96161†† |
| Physical therapy / Occupational therapy | | • 97110†, 97112†, 97150†<br>• 97530†, S9129† |
| Medical Nutrition Therapy | | • 97804 |
| Evaluation & Management (Office/Outpatient) | | • 99202-99205, 99211-99215; GQ modifier if teledermatology and store and forward |
| Evaluation & Management (Hospital) | | • 99221-99223, 99231-99233; GQ modifier if teledermatology and store and forward |
| Evaluation & Management (Nursing facility) | | • 99304-99306<br>• 99307-99310 |
| Discharge planning (Nursing facility) | | • 99315, 99316 |
| Evaluation & Management (Assisted living facility) | | • 99334, 99335, 99336 |
| Respiratory therapy | • Must have respiratory equipment set up in home and initial in-person visit by a respiratory therapist or member of the | • 99503, 94664 |

* Select services authorized for store-and-forward noted in Code(s) column of Table 1, see Table 4 for further information. See
Table 2 for services related to mental health and substance use disorders.

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† See the DMAS Rehabilitation provider manual for detailed information on billing using these codes.
†† See the DMAS Baby Care provider manual for detailed information on billing using this code.

| Service(s) | Telemedicine-specific Service Limitations | Code(s) |
|---|---|---|
| | clinical team. Restricted to outpatient respiratory therapy. | |
| Education for Diabetes, Smoking, Diet | | • G0108, 97802, 97803 |
| Early Intervention | • Must have family member/caregiver, service coordinator, or member of the clinical team physically present with member during visit.<br>• Initial assessment (T1023) must be in-person with each assessing member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery.<br>• Initial service visit (G* codes) must be in-person with a member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery. | • T2022<br>• w/ or w/o U1: T1023, T1024, T1027, G0151, G0152, G0153, G0495 |

* Select services authorized for store-and-forward noted in Code(s) column of Table 1, see Table 4 for further information. See
Table 2 for services related to mental health and substance use disorders.

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† See the DMAS Rehabilitation provider manual for detailed information on billing using these codes.
†† See the DMAS Baby Care provider manual for detailed information on billing using this code.

**Table 2. Medicaid-covered mental health and substance use disorder services authorized for delivery by telemedicine**

| Service(s) | Telemedicine-specific Service Limitations | Code(s) |
|---|---|---|
| Diagnostic Evaluations | | • 90791-90792 |
| Psychotherapy | | • 90832, 90834, 90837 |
| Psychotherapy for Crisis | | • 90839-90840 |
| Pharmacologic counseling | | • 90863 |
| Psychotherapy w/ E&M svc | | • 90833, 90836, 90838 |
| Psychoanalysis | | • 90845 |
| Family/Couples Psychotherapy | | • 90846-90847 |
| Group Psychotherapy | | • 90853 |
| Prolonged Service, in office or outpatient setting | | • 99417-99418 |
| Psychological testing evaluation | | • 96130, 96131 |
| Neuropsychological testing evaluation | | • 96132, 96133 |
| Psychological or neuropsychological test administration & scoring | | • 96136, 96137, 96138, 96139, 96146 |
| Neurobehavioral Status Exam | | • 96116, 96121 |
| Add-on Interactive Complexity | | • 90785 |
| Health Behavior Assessment | | • 96156 |
| Health Behavior Intervention (Individual, group, family) | | • 96158-96159<br>• 96164-96165<br>• 96167-96168<br>• 96170-96171 |
| Multiple-family group behavior management/modification training | | • 96202 - 96203 |
| Evaluation & Management (Outpatient) | | • 99202-99205, 99211-99215 |
| Evaluation & Management (Inpatient) | | • 99221-99223, 99231-99233 |
| Smoking and tobacco cessation counseling | | • 99406-99407 |
| Alcohol/SA structured screening and brief intervention | | • 99408-99409 |

| Service(s) | Telemedicine-specific Service Limitations | Code(s) |
|---|---|---|
| OTP/OBOT Specific Services | | • H0004, H0005, H0014, G9012 |
| SUD Case Management | | • H0006 |
| Mental Health Case Management Services | | • H0023 |
| IACCT Initial Assessment | | • 90889 HK |
| IACCT Follow-Up Assessment | | • 90889 TS |
| Mental Health Skill Building | | • H0046 |
| Mobile Crisis Response | Assessment and prescreening activities only (See Appendix G to the Mental Health Services Manual) | • H2011 |
| Community Stabilization | Telemedicine-assisted assessment only (See Appendix G to the Mental Health Services Manual) | • S9482 |
| 23-Hour Crisis Stabilization | Psychiatric evaluation only (See Appendix G to the Mental Health Services Manual) | • S9485 |
| Residential Crisis Stabilization | Psychiatric evaluation and individual, group and family therapy only (See Appendix G to the Mental Health Services Manual) | • H2018 |
| Assertive Community Treatment | | • H0040 |
| Psychosocial Rehabilitation (PSR)/ PSR Assessment | | • H2017<br>• H0032 U6 |
| Intensive In-Home Services | | • H2012 |
| Therapeutic Day Treatment | | • H2016 |
| Applied Behavior Analysis (ABA) | 97151 and 97152 may be provided through telemedicine for reassessments only. | • 97151-97158 |
| Multisystemic Therapy (MST) | | • H2033 |
| Functional Family Therapy (FFT) | | • H0036 |
| Foster Care Case Management | | • T1016 |
| Peer Recovery Support Services (PRSS) | | • H0024, H0025, S9445, T1012 |
| Mental Health Partial Hospitalization Program | | • H0035 |

| Service(s) | Telemedicine-specific Service Limitations | Code(s) |
|---|---|---|
| Mental Health Intensive Outpatient Program | | • S9480 |
| SUD Partial Hospitalization Program | | • S0201 |
| SUD Intensive Outpatient Program | | • H0015 |

**Table 3. Medicaid-covered developmental disabilities waiver services authorized for delivery by telemedicine.**

| Service(s) | Telemedicine-specific Service Limitations | Code(s) |
|---|---|---|
| Individual Supported Employment | Up to 10% of services can be billed as telemedicine. The following allowable activities in regulations can be billed via telemedicine:<br>• 12VAC30-122-400. B. 4. (b)<br>• 12VAC30-122-400. B. 4. (c)<br>• 12VAC30-122-400. B. 4. (d)<br>• 12VAC30-122-400. B. 4. (f)<br>• 12VAC30-122-400. B. 4. (g)<br>• 12VAC30-122-400. C. (4) | • H2023 |
| Group Supported Employment | Up to 10% of services can be billed as telemedicine. The following allowable activities in regulations can be billed via telemedicine:<br>• 12VAC30-122-400. B. 4. (b)<br>• 12VAC30-122-400. B. 4. (d)<br>• 12VAC30-122-400. B. 4. (f)<br>• 12VAC30-122-400. B. 4. (g) | • H2024 |
| Workplace Assistance Services | Up to 10% of services can be billed as telemedicine. The following allowable activities in regulations can be billed via telemedicine:<br>• 12VAC30-122-570.B.4. (a.)<br>• 12VAC30-122-570.B.4. (b.) | • H2025 |
| Community Engagement | Up to 10% of services can be billed as telemedicine. The following allowable activities in regulations can be billed via telemedicine:<br>• 12VAC30-122-320. B. 2. a. (ii)<br>• 12VAC30-122-320. B. 2. a. (iii)<br>• 12VAC30-122-320. B. 2. a. (v) | • T2021 Tier 1<br>• T2021 Tier 2<br>• T2021 Tier 3<br>• T2021 Tier 4 |

| Service(s) | Telemedicine-specific Service Limitations | Code(s) |
|---|---|---|
| | • 12VAC30-122-320. B. 2. a. (vi)<br>• 12VAC30-122-320. B. 2. b. (i)<br>• 12VAC30-122-320. B. 2. b. (ii)<br>• 12VAC30-122-320. B. 2. b. (iii)<br>• 12VAC30-122-320. B. 2. b. (iv)<br>• 12VAC30-122-320. B. 2. b. (v)<br>• 12VAC30-122-320. B. 2. b. (vii)<br>• 12VAC30-122-320. B. 2. b. (viii)<br>• 12VAC30-122-320. B. 2. b. (ix)<br>• 12VAC30-122-320. B. 2. b. (x) | |
| Community Coaching | Up to 10% of services can be billed as telemedicine. The following allowable activities in regulations can be billed via telemedicine:<br>• 12VAC30-122-310. B. 1. (a)<br>• 12VAC30-122-310. B. 1. (b)<br>• 12VAC30-122-310. B. (2)<br>• 12VAC30-122-310. B. (3)<br>• 12VAC30-122-310. B. (5) | • T2013 |
| Community Guide | Can be up to 100% of service hours if there is no community integration component | • H2015 |
| Group Day Support | Up to 10% of services can be billed as telemedicine; ratios of up to 7 individuals to one staff are allowable. The following allowable activities in regulations can be billed via telemedicine:<br>• 12VAC30-122-380.B.1. (a)<br>• 12VAC30-122-380.B.1. (c)<br>• 12VAC30-122-380.B.1. (f)<br>• 12VAC30-122-380.B.1. (g)<br>• 12VAC30-122-380.B.1. (h) | • 97150 Tier 1<br>• 97150 Tier 2<br>• 97150 Tier 3<br>• 97150 Tier 4 |
| Peer Mentor Supports | | • H0038 |

| Service(s) | Telemedicine-specific Service Limitations | Code(s) |
|---|---|---|
| Individual and Family Caregiver Training | | • S5111 |
| In-Home Support Services | Up to 20% of services can be billed as telemedicine. The following allowable activities in regulations can be billed via telemedicine:<br>• 12VAC30-122-410. B. (1)<br>• 12VAC30-122-410. B. (3)<br>• 12VAC30-122-410. B. (4)<br>• 12VAC30-122-410. B. (6) | • H2014 (UA, U2, U3) |
| Service Facilitation | Employer Management Training only | • S5109 |
| Therapeutic Consultation | | • 97139<br>• H2017<br>• 97530 |
| Benefits Planning | | • T1023 |

**Table 4. Radiology-Related Procedures for Physician Billing Included under Telehealth Coverage**

| Procedure Title (Reduced Length) | CPT Code |
|---|---|
| Fine needle aspiration; with imaging guidance | 10022 |
| Biopsy of breast; percutaneous, needle core, using image guidance | 19102 |
| Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device | 19103 |
| Preoperative placement of needle localization wire, breast | 19290 |
| Image guided placement, metallic localization clip, percutaneous, breast biopsy/aspiration | 19295 |
| Arthrocentesis, aspiration, and/or injection; major joint or bursa | 20610 |
| Transcatheter occlusion or embolization (eg, for tumor destruction, other) | 37204 |
| Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stage | 47011 |
| Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance | 49083 |
| Electrocardiogram, routine ecg with at least 12 leads; with interpretation | 93000 |
| Electrocardiogram, routine ecg with at least 12 leads; interpretation and report only | 93010 |
| Echocardiography, transthoracic, real-time with image documentation (2d) | 93306 |
| Duplex scan of extremity veins including responses to compression and other | 93970 |
| Duplex scan of extremity veins including responses to compression and other | 93971 |
| Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs | 93975 |
| Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs | 93976 |

**Table 5. Medicaid-covered services authorized for delivery via Remote Patient Monitoring**

| Procedure Title (Reduced Length) | Code |
|---|---|
| Collection & interpretation of physiologic data digitally stored/transmitted 30 min per 30d | 99091 |
| Remote monitoring of physiologic parameter(s); set-up and education on use of equipment | 99453 |
| Remote monitoring of physiologic parameter(s); device(s) supply & daily recording(s) or programmed alert(s) transmission, each 30 days | 99454 |
| Remote physiologic monitoring treatment management services; interactive communication with the patient/caregiver during the month; first 20 minutes | 99457 |
| Each additional 20 minutes | 99458 |
| Remote therapeutic; initial set-up and patient education on use of equipment | 98975 |
| Respiratory system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days | 98976 |
| Musculoskeletal system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days | 98977 |
| Remote therapeutic monitoring treatment management services; interactive communication with the patient or caregiver during the calendar month; first 20 minutes | 98980 |
| Each additional 20 minutes | 98981 |
| Self-measured blood pressure; patient education/training and device calibration | 99473 |
| Self-measured blood pressure; reported 2x daily for 30d w/ clinician review and communication of treatment plan | 99474 |

**Table 6. Virtual Check-In Services**

| Service | Code |
|---|---|
| Virtual check-in, E&M-eligible providers, 5-10 min | G2012 |
| Virtual check-in, non-E&M-eligible providers, 5-10 min | G2251 |
| Virtual check-in, E&M-eligible providers, 11-20 min | G2252 |
| Remote evaluation of recorded video and/or images, E&M-eligible providers | G2010 |
| Remote evaluation of recorded video and/or images, non-E&M-eligible providers | G2250 |

**Table 7. Audio-Only Services(codes do not require 93 modifier)**

| Service | Code |
|---|---|
| Telephone evaluation and management service provided by a physician; 5-10 minutes of medical discussion | 99441 |
| Telephone evaluation and management service provided by a physician; 11-20 minutes of medical discussion | 99442 |
| Telephone evaluation and management service provided by a physician; 21-30 minutes of medical discussion | 99443 |
| Telephone assessment and management service provided by a qualified nonphysician health care professional; 5-10 minutes of medical discussion | 98966 |
| Telephone assessment and management service provided by a qualified nonphysician health care professional; 11-20 minutes of medical discussion | 98967 |
| Telephone assessment and management service provided by a qualified nonphysician health care professional; 21-30 minutes of medical discussion | 98968 |

**Table 8. Medicaid-covered services authorized for delivery by audio-only telehealth (requires 93 modifier)**

| Service | Audio-only Telehealth-specific Service Limitations | Code |
|---|---|---|
| Add-on Interactive Complexity | | 90785 |
| Diagnostic Evaluations | | 90791-90792 |
| Psychotherapy | | 90832, 90834, 90837 |
| Psychotherapy w/ E&M svc | | 90833, 90836, 90838 |
| Psychotherapy for Crisis | | 90839-90840 |
| Psychoanalysis | | 90845 |
| Family Psychotherapy | | 90846-90847 |
| Group Psychotherapy | | 90853 |
| Neurobehavioral Status Exam | | 96116, 96121 |
| Maternal Mental Health Screening | | 96127, 96160*, 96161* |
| Health Behavior Assessment | | 96156 |
| Health Behavior Intervention | | 96158 - 96159 |
| Smoking and tobacco cessation counseling | | 99406 - 99407 |
| Alcohol/SA structured screening and brief intervention | | 99408 - 99409 |
| Mobile Crisis Response | Prescreening activities only (see Appendix G to the Mental Health Services Manual) | H2011 |
| Peer Recovery Support Services (PRSS) | Limited number of units allowed per calendar year – see the Peer Recovery Support Services Supplement to the Mental Health Services and ARTS Manuals | H0024, H0025, S9445, T1012 |

* See the DMAS Baby Care provider manual for detailed information on billing using this code.