Manual Title	Chapter	Page
Telehealth Services Supplement		
Chapter Subject	Page Revision Date	
	TBD	

TELEHEALTH SERVICES

Telehealth Services 1

Definitions 1

Reimbursable Telehealth Services 2

Reimbursement and Billing for Telehealth Services 3

Originating Site Fee 4

Service Limitations ..... 4~~5~~

Provider Requirements ..... 4~~5~~

Documentation Requirements 5

Member Choice and Education ..... 5~~6~~

Telehealth Equipment and Technology 6

Definitions

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.

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.

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.

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).

Distant Site

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

Reimbursable Telehealth Services

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

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 CPT or HCPCS code, as defined by the American Medical Association (AMA);
- 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; and
- Services delivered via telehealth meet all applicable state laws, regulations and licensure requirements on the practice of telehealth.

In order to be reimbursed for services using telehealth that are provided to MCO-enrolled individuals, 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/#/cccplus and https://www.dmas.virginia.gov/#/med4.

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

Telemedicine

- Services delivered via telemedicine must be provided with the same standard of care as services provided in person.
- Telemedicine must not be used when face-to-face 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 visit, the telemedicine 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, in-person services to meet the needs of the individual. In this circumstance, the Provider shall be reimbursed only for services successfully delivered.

Reimbursement and Billing for Telehealth Services

Telemedicine

Distant site Providers must include the modifier **GT** on claims for services delivered via telemedicine.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location in which a telehealth service would *have normally been provided*, had interactions occurred in person. For example, if the member would have come to a private office to receive the service outside of a telehealth modality, a POS 11 would be applied. Providers should **not** use POS 02 on telehealth claims, even though this POS is referred to as "telehealth" for other payers. Place of service codes can be found at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

Store-and-Forward

Distant site Providers must include the modifier **GQ**.
Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location where the distant site provider is located at the time that the service is rendered.

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 both of 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); 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.

All telehealth modalities

The only procedure code an originating site Provider may bill is Q3014.
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"). The use of these codes is currently not applicable for services administered by Magellan.
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 site and bill under the encounter rate. When an FQHC or RHC serves as the originating site, the originating site fee is paid separately from the center or clinic all-inclusive rate.

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 versus 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 networks 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 Managed Care Organizations (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 a face-to-face encounter for professional medical services.

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

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	• At least one in-person visit per trimester for the purposes of evaluation, testing, and assessment of risk in the prenatal period.	• 59400, 59510, 59410, 59515, 59425, 59426, 59430 • 96156, 96158, 96159a
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 • 92227, 92228; 26 if applicable; GQ modifier if store and forward
Speech Language Therapy/Audiology		• 92507†, 92508†
Diagnosis, analysis cochlear implant function		• 92601-92604, 95974
Cardiography interpretation and report		• 93010
Echocardiography		• 93307, 93308, 93320, 93321, 93325
Genetic Counseling		• 96040

* Select services authorized for store-and-forward noted in Code(s) column of Table 1~~Table 1~~. See Table 2~~Table 2~~ for services related to mental health and Substance Use Disorders.
** See

Table 3~~Table 3~~ for further information.
† 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)
Maternal Mental Health Screening		• 96127, 96160††, 96161††
Physical therapy / Occupational therapy		• 97110†, 97112†, 97150† • 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 • 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 clinical team. Restricted to outpatient respiratory therapy.	• 99503, 94664
Education for Diabetes, Smoking, Diet		• G0108, 97802, 97803
Early Intervention	• Must have family member/caregiver, trained facilitator, or member of the clinical team physically present with member during visit.	• T2022 • 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~~Table 1~~. See Table 2~~Table 2~~ for services related to mental health and Substance Use Disorders.
** See

Table 3~~Table 3~~ for further information.
† 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)
	• Initial service visit (G* codes) must be in-person with trained facilitator, or 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.	

* Select services authorized for store-and-forward noted in Code(s) column of Table 1~~Table 1~~. See Table 2~~Table 2~~ for services related to mental health and Substance Use Disorders.
** See

Table 3~~Table 3~~ for further information.
† 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
Clinicians shall use their clinical judgment to determine the appropriateness for the delivery of services via telehealth considering the needs and presentation of individual.

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Diagnostic Evaluations		• 90791-90792
Psychotherapy		• 90832-90837
Pharmacologic counseling		• 90863
Psychotherapy w/E&M svc		• 90833-90838
Family/Couples Psychotherapy		• 90845-90847
Group Therapy		• 90853
Prolonged Service, in office or outpatient setting		• 99354-99357
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 • 96164-96165 • 96167-96168 • 96170-96171
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
OTP/OBOT Specific Services	*Initial prescriber assessment for	• H0004, H0005, H0014*, G9012

Service(s)	Telemedicine-specific Service Limitations	Code(s)
	buprenorphine induction allowed via telehealth during the Public Health Emergency.	
SUD Case Management		• H0006
Mental Health Case Management Services		• H0023
IACCT Initial Assessment		• 90889 HK
Crisis Intervention		• H0036
Assertive Community Treatment		• H0040
Psychosocial Rehabilitation		• H2017
Intensive In-Home Services		• H2012
Therapeutic Day Treatment		• H2016
Behavioral Therapy Program		• H2033
Foster Care Case Management		• T1016
Peer Recovery Support Services (PRSS)		• H0024, H0025, S9445, T1012
Mental Health Partial Hospitalization Program		• H0035
Mental Health Intensive Outpatient Program		• S9480
SUD Partial Hospitalization		• S0201
SUD Intensive Outpatient		• H0015

Table 3. 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