50 State Medicaid Statute Survey

PART III
February 2011
Disclaimer

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Information contained in this report is current up to the date listed on the report. Note that the information is subject to change following action taken by a state’s legislature, state agencies, state medical boards, or other applicable state government agency or body. CTeL will make every effort to provide the most current information.

The views and opinions expressed in the forgoing publication are solely those of the author and do not necessarily represent the views and opinion of the Center for Telehealth & eHealth Law, its Board Directors, or its staff.

Methodology

This information in this report was compiled by contacting the Medicaid offices in all 50 states asking them:

1) If their state policy reimburses for Telehealth.
2) If their state policy reimburses for Telehomecare.

If the office responded in the affirmative, CTeL requested reimbursement documents to explain their state policy.

CTeL expresses appreciation to the State Medicaid offices for their cooperation.
Acknowledgements

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Originally from New England, Lydia graduated cum laude from Tufts University in 2008. During college, she held internships in the Washington offices of former Congressman Thomas Allen (D-ME) and the late Senator Edward Kennedy (D-MA). In her spare time, Lydia volunteers as a tutor for Horton’s Kids, a non-profit organization that works with at-risk youth in the Anacostia neighborhood.

Crystal LaMothe is a graduate from Stevenson University, and is currently pursuing a Master’s degree at Bowie State University in Maryland. Her diverse contributions to the health community include her serving as a volunteer with MedStar Washington Hospital Center; and working in-depth on projects for the Center for Telehealth & e-Health Law involving Medicare and Medicaid reimbursement, and White Papers.

Furthermore, Crystal’s prior encounters of remote communities within various Caribbean Islands has proven to be a driving force in her desire to see patrons within and across our borders gain access to telemedical services.

Chris Rieser is a legislative assistant in the Washington, D.C., office of Drinker Biddle & Reath. He has been with the firm since July of 2010. Chris works with a range of non-profit and for-profit health care clients providing both government relations and policy research services. He works on a variety of policy areas in the health care arena, including telehealth, medical devices, Medicare reimbursement and grassroots patient advocacy.

Chris graduated from the Georgetown Public Policy Institute with a Masters of Public Policy in May, 2010.
Welcome To CTeL

The Center for Telehealth & e-Health Law (CTeL) was founded in 1995 to overcome the legal and regulatory barriers to the utilization of telehealth and related e-health services. CTeL, formerly known as the Center for Telemedicine Law, was created under the vision and leadership of a number of individuals and organizations, including Dr. Yadin David, Bob Waters, the Mayo Foundation, the Cleveland Clinic, the Midwest Rural Telemedicine Consortium, and the Texas Children’s Hospital.

CTeL has established itself as a leader in the telehealth community and is known for its ability to compile and analyze complex legal, regulatory and public policy information. CTeL provides vital support to the community by providing critical analysis and information on legal and regulatory issues on topics such as reimbursement, licensure, telecommunications, FDA regulations, privacy, and accreditation.

For additional information about the Center for Telehealth & e-Health Law, please feel free to contact us at:

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Please Note:
- The following ten states do not provide information regarding the coverage of telemedicine: Connecticut, Delaware, Iowa, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, Ohio, and Rhode Island.
- The District of Columbia does not provide information regarding the coverage of telemedicine.
Oklahoma’s state Medicaid program (SoonerCare) does provide reimbursement for telemedicine services. Reimbursement is limited to consultations, office visits, individual psychotherapy, psychiatric diagnostic interview examinations and testing, mental health assessments, and pharmacological management. SoonerCare also covers store-and-forward, however, the state is currently in the process of revising the policy.

In the area of tele-home care and remote monitoring services, Oklahoma does not reimburse for tele-home care services.
317:30-3-27. Telemedicine
(a) Applicability and scope. The purpose of this Section is to implement telemedicine policy that improves access to health care services by enabling the provision of medical specialty care in rural or underserved areas to meet the needs of members and providers alike, while complying with all applicable federal and state statutes and regulations. Telemedicine services are not an expansion of SoonerCare covered services but an option for the delivery of certain covered services. SoonerCare views telemedicine no differently than an office visit or outpatient consultation. However, if there are technological difficulties in performing an objective through medical assessment or problems in member's understanding of telemedicine, hands-on-assessment and/or care must be provided for the member. Quality of health care must be maintained regardless of the mode of delivery.

(b) Definitions. The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) "Certified or licensed health care professional" means an individual who has successfully completed a prescribed program of study in any variety of health fields and who has obtained an Oklahoma state license or certificate indicating his or her competence to practice in that field.

(2) "Distant site" means the site where the specialty physician/practitioner providing the professional service is located at the time the service is provided via audio/video telecommunications.

(3) "Interactive telecommunications" means multimedia communications equipment that includes, at a minimum, audio/video equipment permitting two-way, real-time or near real-time service or consultation between the member and the practitioner.

(4) "Originating site" means the location of the SoonerCare member at the time the service is being performed by a contracted provider via audio/video telecommunications.

(5) "Rural area" means a county with a population of less than 50,000 people.

(6) "Store and forward" means the asynchronous transmission of medical information to be reviewed at a later time. A camera or similar device records (stores) an image(s) that is then sent (forwarded) via telecommunications media to another location for later viewing. The sending of x-rays, computed tomography scans, or magnetic resonance images are common store and forward
applications. The original image may be recorded and/or forwarded in digital or analog format and may include video "clips" such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

(7) "Telehealth" means the use of telecommunication technologies for clinical care (telemedicine), patient teaching and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

(8) "Telemedicine" means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the real-time or near real-time and in the physical presence of the member.

(9) "Telemedicine network" means a network infrastructure, consisting of computer systems, software and communications equipment to support telemedicine services.

(10) "Underserved area" means an area that meets the definition of a medically underserved area (MUA) or medically underserved population (MUP) by the U.S. Department of Health and Human Services (HHS).

(c) Coverage. SoonerCare coverage for telemedicine technology is limited to consultations, office visits, individual psychotherapy, psychiatric diagnostic interview examinations and testing, mental health assessments and pharmacologic management.

(1) An interactive telecommunications system is required as a condition of coverage.

(2) Coverage for telemedicine services is limited to members in rural areas, underserved areas, or geographic areas where there is a lack of medical/psychiatric/mental health expertise locally.

(3) Office and outpatient visits that are conducted via telemedicine are counted toward the applicable benefit limits for these services.

(4) Authorized originating sites are:

(A) The office of a physician or practitioner;
(B) A hospital;
(C) A school;
(D) An outpatient behavioral health clinic;
(E) A critical access hospital;
(F) A rural health clinic (RHC);
(G) A federally qualified health center (FQHC); or
(H) An Indian Health Service facility, a Tribal health facility or an Urban Indian clinic (I/T/U).

(5) Authorized distant site specialty physicians and practitioners providers are contracted:

(A) Physicians;
(B) Advanced Registered Nurse Practitioners;
(C) Physicians Assistants;
(D) Genetic Counselors;
(E) Licensed Behavioral Health Professionals; and
(F) Dieticians; and
(G) I/T/U’s with specialty service providers as listed in (A)
through (F) above.

(d) **Non-covered services.** Non-covered services include:
1. Telephone conversation;
2. Electronic mail message; and
3. Facsimile.

(e) **Store and forward technology.** SoonerCare covers store and forward technology for applications in which, under conventional health care delivery, the medical service does not require face-to-face contact between the member and the provider. Examples include teleradiology, telepathology, fetal monitor strips, as well as physician interpretation of electrocardiogram and electroencephalogram readings that are transmitted electronically. SoonerCare does not consider these services telemedicine as defined by OHCA and will not reimburse an originating site fee for these services.

(f) **Conditions.** The following conditions apply to all services rendered via telemedicine.
1. Interactive audio and video telecommunication must be used, permitting real-time communication between the distant site physician or practitioner and the SoonerCare member. As a condition of payment the member must be present and participating in the telemedicine visit.
2. Only telemedicine services provided utilizing an OHCA approved network are eligible for reimbursement.
3. For SoonerCare reimbursement, telemedicine connections to rural areas must be located within Oklahoma and the health providers must be licensed in Oklahoma or practice at an I/T/U.
4. The telemedicine equipment and transmission speed must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telemedicine visit need to be trained in the use of the telemedicine equipment and competent in its operation.
5. An appropriate certified or licensed health care professional at the originating site is required to present the member to the physician or practitioner at the distant site and remain available as clinically appropriate.
6. The health care practitioner must obtain written consent from the SoonerCare member that states they agree to participate in the telemedicine-based office visit. The consent form must include a description of the risks, benefits and consequences of telemedicine and be included in the member's medical record.
7. If the member is a minor child, a parent/guardian must
present the minor child for telemedicine services unless otherwise exempted by State or Federal law. The parent/guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.

8. The member retains the right to withdraw at any time.
9. All existing confidentiality protections apply.
10. The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.
11. There will be no dissemination of any member images or information to other entities without written consent from the member.

(g) **Reimbursement.**

1. A facility fee will be paid to the originating site when the appropriate telemedicine facility fee code is used.
   
   A) Hospital outpatient: When the originating site is a hospital outpatient department, payment for the originating site facility fee will be paid according to the SoonerCare fee schedule.
   
   B) Hospital inpatient: For hospital inpatients, payment for the originating site facility fee will be paid outside the Diagnostic Related Group (DRG) payment.
   
   C) FQHCs and RHCs: The originating site facility fee for telemedicine services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee is paid separately from the center or clinic all-inclusive rate.
   
   D) Facilities of the Indian Health Service, tribal facilities or Urban Indian Clinics: When an I/T/U serves as the originating site, the originating site facility fee is reimbursed outside the OMB rate.
   
   E) Physicians'/practitioners' offices: When the originating site is a physician's office, the originating site facility fee will be paid according to the SoonerCare fee schedule. If a provider from the originating site performs a separately identifiable service for the member on the same day as telemedicine, documentation for both services must be clearly and separately identified in the member's medical record.

2. Services provided by telemedicine must be billed with the appropriate modifier. Only the portion of the telemedicine service rendered from the distant site is billed with the modifier.

3. If the technical component of an X-ray, ultrasound or electrocardiogram is performed at the originating site during a telemedicine transmission, the technical component and a telemedicine facility fee are billed by the originating site. The professional component of the procedure and the appropriate visit code are billed by the distant site.

4. Post payment review may result in adjustments to payment
when a telemedicine modifier is billed inappropriately or not billed when appropriate.
(5) The cost of telemedicine equipment and transmission is not reimbursable by SoonerCare.

(h) Documentation.
(1) Documentation must be maintained at the originating and the distant locations to substantiate the services provided.
(2) Documentation must indicate the services were rendered via telemedicine, the location of the originating and distant sites, and which OHCA approved network was used.
(3) All other SoonerCare documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:
   (A) Chart notes;
   (B) Start and stop times;
   (C) Service provider's credentials; and
   (D) Provider's signature.

(i) Telemedicine network standards. In order to be an approved telemedicine network, an applicant must be contracted with the OHCA and meet certain technical and privacy standards stated within the contract in order to ensure the highest quality of care.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1091. Definition of I/T/U services
(a) As described in Title 42 of the Code of Federal Regulations (CFR) 136.11(a), the I/T/U services may include hospital and medical care, dental care, public health nursing and preventive care (including immunizations), and health examination of special groups such as school children.
(b) Further, Title 42 CFR 136.11(c) allows that the scope and availability of I/T/U services will depend upon the resources of the facility.
(c) I/T/U services may be covered when furnished to a patient at the clinic or other location, including a mobile clinic, or the patient's place of residence.
(d) I/T/U outpatient encounters include but are not limited to:
   (1) Physicians' services and supplies incidental to a physician's services;
   (2) Within limitations as to the specific services furnished, a doctor of dentistry or oral surgery, a doctor of optometry, or a doctor of podiatry [Refer to Section 1861(r) of the Act for specific limitations];
   (3) The services of a resident as defined in OAC 317:25-7-5(4) who meets the requirements for payment under SoonerCare and the supplies incidental to a resident's services;
(4) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;
(5) Services and supplies incidental to the services of APNs and PAs (including services furnished by certified nurse midwives);
(6) Public health nursing services include but are not limited to services in the following areas:
  (A) Phlebotomy;
  (B) Wound care;
  (C) Public health education;
  (D) Administration of immunizations;
  (E) Administration of medication;
  (F) Child health screenings meeting (EPSDT) criteria;
  (G) Prenatal, newborn and postpartum assessments, including case management services for first time mothers; and
  (H) General health assessments and management of conditions such as tuberculosis, diabetes and hypertension.
(7) Visiting nurse services to the homebound;
(8) Behavioral health professional services and services and supplies incidental to the services of LBHPs; and
(9) Dental services.
317:30-5-11. Psychiatric services

(a) Payment is made for procedure codes listed in the Psychiatry Series section of the most recent edition of the CPT codes American Medical Association Current Procedural Terminology codebook. The codes in this service range are accepted services within the Medicaid SoonerCare program for children and adults with the following exceptions:

1. Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.
2. Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.
3. Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.
4. Unlisted psychiatric service or procedure.

(b) All services must be medically necessary and appropriate and include a DSM Diagnostic and Statistical Manual (DSM) multi axial diagnosis completed for all five axes from the most recent version of the DSM.

(c) Services in the psychiatry series of the CPT manual must be provided by a board eligible or board certified psychiatrist or a physician, physician assistant, or nurse practitioner with additional training that demonstrates the knowledge to conduct the service performed. Documentation of training for physicians who are not board eligible or board certified psychiatrists should be submitted to the Medical Director of the OHCA. For general physicians (M.D. or D.O.), payment is made for the appropriate medical procedure code(s) and not for psychiatric procedure codes.

(d) No services in the psychiatry series of the CPT manual may be provided via telemedicine or other electronic medium, with the exception of "pharmacologic management". Pharmacological management may be performed via telemedicine under the following circumstances:

1. A healthcare professional with knowledge of the patient must accompany and attend the patient during the performance of the service.
2. The psychiatrist performing the service or in the case of a group practice or agency, another psychiatrist within that practice or agency must have seen the patient receiving the service during either a psychiatric exam or previous pharmacologic management session or other face-to-face psychiatric service.
3. The patient must understand the procedure including the technologic aspects of the process and agree, in writing, to having his/her pharmacological management session via electronic equipment.

(e) The telecommunications equipment must provide clear images of the psychiatrist to the patient. The psychiatrist must have a clear visual field to effectively evaluate the physical condition of the patient, including but not limited to extrapyramidal symptoms, injuries and
changes in weight. Audio reception must be sufficient for the patient and physician to clearly hear one another's conversation.
OREGON

Oregon’s state Medicaid program provides reimbursement for telemedicine services. Coverage is extended towards patient consultation utilizing videoconferencing, and patient consultation using telephone and online or electronic mail, provided that billed services comply with the practice guidelines set forth by the Health Service Commission (HSC).

In the area of tele-home care and remote monitoring services, Oregon does not cover home telehealth services.
410-130-0610 Telemedicine

(1) For the purposes of this rule, telemedicine is defined as the use of medical information, exchanged from one site to another, via telephonic or electronic communications, to improve a patient’s health status.

(2) Provider Requirements:
(a) The referring and evaluating practitioner must be licensed to practice medicine within the state of Oregon or within the contiguous area of Oregon and must be enrolled as a Division of Medical Assistance Programs (Division) provider.
(b) Providers billing for covered telemedicine services are responsible for the following:
(A) Complying with HIPAA and/or DHS Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records. Examples of applicable Department of Human Services (Department) Confidentiality and Privacy Rules include: OAR 407-120-0170, 410-120-1360, and 410-120-1380, and OAR 410 Division 14. Examples of federal and state privacy and security laws that may apply include HIPAA, if applicable and 42 CFR Part 2, if applicable and ORS 646A.600 to 646A.628 (Oregon Consumer Identity Theft Protection Act);
(B) Obtaining and maintaining technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA and/or Department Privacy and Confidentiality Rules described in subsection (A).
(C) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized persons.
(D) Complying with the relevant Health Service Commission (HSC) practice guideline for telephone and email consultation.
(E) Maintaining clinical and financial documentation related to telemedicine services as required in OAR 410-120-1360.

(3) Coverage for telemedicine services:
(a) The telemedicine definition encompasses different types of programs, services and delivery mechanisms for medically appropriate covered services within the patient’s benefit package.
(b) Patient consultations using telephone and online or electronic mail (Email) are covered when billed services comply with the practice guidelines set forth by the Health Service Commission (HSC) and the applicable HSC approved CPT code requirements, delivered consistent with the HSC practice guideline.
(c) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a medical practitioner located in a distant site and the client being evaluated and located in an originating site, is covered when billed services comply with the Billing requirements stated in (5).
(d) Telephonic codes may be used in lieu of videoconferencing codes, if
videoconferencing equipment is not available.
(4) Telephone and E-mail billing requirements: Use the E/M code authorized in the HSC practice guideline.
(5) Videoconferencing billing requirements:
   (a) Only the transmission site (where the patient is located) may bill for the transmission:
       (A) Bill the transmission with Q3014;
       (B) The referring practitioner may bill an E/M code only if a separately identifiable visit is performed. The visit must meet all of the criteria of the E/M code billed.
       (C) The referring provider is not required to be present with the client at the originating site.
   (b) The evaluating practitioner at the distant site may bill for the evaluation, but not for the transmission (Q3014): 410-130-0610 Page 3
       (A) Bill the most appropriate E/M code for the evaluation;
       (B) Add modifier GT to the E/M code to designate that the evaluation was made by a synchronous (live and interactive) transmission.
(6) Other forms of telecommunications, such as telephone calls, images transmitted via facsimile machines and electronic mail are services not covered:
   (a) When those forms are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access, or
   (b) When those forms and specific services are not specifically allowed per the Health Service Prioritized List and Practice Guideline.
Stat. Auth.: ORS 404.110, 409.050, 414.065
Stats. Implemented: ORS 414.065
7-01-08
7-1-10 (Hk)
Pennsylvania’s state Medicaid program (Pennsylvania Medical Assistance Program) does reimburse maternal fetal medicine specialists and psychiatrists when rendering services using telecommunication technology.

In the area of tele-home care and remote monitoring services, Pennsylvania does reimburse for tele-home health status measuring, monitoring of chronic conditions, and activity and sensor monitoring.
PURPOSE

The purpose of this bulletin is to notify providers that, effective December 1, 2007, the Medical Assistance (MA) Program is adding a telehealth technology procedure code and an informational modifier to the MA Program Fee Schedule and issuing an updated MA Program Fee Schedule for consultations performed using telecommunication technology.

SCOPE

This bulletin applies to physicians, certified registered nurse practitioners (CRNP), and certified nurse midwives (CNM) that are enrolled in the MA Program fee-for-service (FFS) delivery system. Providers rendering services under the managed care delivery system should address any payment related questions to the appropriate managed care organization.

BACKGROUND

The Department of Public Welfare (Department) recognizes that MA recipients may have limited access to consultations with maternal fetal medicine specialists and psychiatrists which may inhibit them from receiving timely diagnosis, treatment and monitoring. While face-to-face consultations with the patient are preferred whenever possible, there are instances where this is not possible due to a shortage of providers, rural access issues, or the patient’s particular condition or disability. In these instances, telehealth, which is the use of electronic communication equipment for the delivery of medical services, has been found to be an effective tool in increasing patient access to specialists and mental health providers, improving quality of care, and promoting better communication and coordination among providers.

The National Committee for Quality Assurance reported in its “State of Health Care Quality 2007” that early, effective prenatal care can identify mothers at risk of delivering a preterm infant and provide medical and educational interventions that may prevent poor pregnancy outcomes. One appropriate intervention may be increased access to maternal

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap
fetal medicine specialists. However, there are fewer than 100 maternal fetal medicine specialists currently practicing within the Commonwealth. The Department anticipates that, in cases of a high-risk pregnancy, where a woman presents with factor(s) that may place either the woman or the baby at high risk, increased practitioner and recipient access to consultations with maternal fetal medicine specialists will further improve birth outcomes and reduce neonatal intensive care unit admissions, as well as, reduce costs related to poor birth outcomes to the MA Program.

Additionally, the Department has reviewed the prescribing patterns of providers in the MA FFS delivery system and found that 33% of all pharmacy costs in the MA FFS delivery system are for psychotropic medications and that the majority of these psychotropic medications are not prescribed by psychiatrists. The Department also found that communication with providers regarding their prescribing patterns was associated with improved provider adherence to best practice prescribing standards and improved clinical outcomes of patients. The Department anticipates that increased MA provider and MA recipient access to consultations with psychiatrists will reduce the unnecessary utilization of services, support improved treatment adherence to accepted best practice standards, improve overall health outcomes and reduce the cost of care to the MA Program.

DISCUSSION

Effective December 1, 2007, the Department will provide payment for consultations to MA recipients when rendered using telecommunication technology, including video conferencing and telephone, by enrolled maternal fetal medicine specialists, related to high risk obstetrical care, and psychiatrists, related to psychopharmacology.

The consultation will be initiated during the course of an office visit by the physician, CRNP, or CNM contacting the maternal fetal medicine specialist or psychiatrist for consultation with the recipient. The maternal fetal medicine specialist or psychiatrist will then conduct the consultation with the recipient during the office visit. The consultation must be rendered directly to the recipient with the participation of the referring provider.

Providers should fully document the specific telecommunication technology used to render the consultation, whether by video conferencing or telephone, and the reason the consultation was conducted using telecommunication technology, and not face-to-face, in the MA recipient’s medical record, in accordance with MA regulations at 55 Pa.Code § 1101.51 relating to ongoing responsibilities of providers.

Providers are reminded that services should be rendered face-to-face whenever practical and appropriate. Some situations providers may consider when determining if
the use of telecommunication technology to provide a consultation is practical and appropriate include, but are not limited to, the recipient’s medical condition would deem it dangerous to travel, the recipient must travel beyond the travel limits of 60 minutes in a rural area or 30 minutes in an urban area, or there are no available openings with a maternal fetal medicine specialist or psychiatrist located within the travel limits within a timeframe appropriate to treat the recipient’s condition.

**PROCEDURE**

Effective December 1, 2007, the MA Program is adding the telehealth technology procedure code Q3014 and the informational modifier GT to the MA Program Fee Schedule for consultations related to high risk obstetrical care and psychopharmacology that are rendered using telecommunication technology, including video conferencing and telephone.

Physicians, CRNPs, and CNMs enrolled in the MA Program may bill using office visit procedure codes 99213, 99214, and 99215 and appropriate pricing modifiers with the GT informational modifier in conjunction with the telehealth originating site facility procedure code Q3014 and GT informational modifier in order to be paid for the technology service.

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Maternal fetal medicine specialists and psychiatrists enrolled in the MA Program may bill for a consultation rendered using telecommunication technology using procedure codes 99241, 99242, 99243, 99244 and 99245 with the GT informational modifier and other appropriate modifiers.

The procedure codes and code descriptions, provider types and specialties that may bill for the services, modifiers, fees, and limits for consultations related to high risk obstetrical care and psychopharmacology that are rendered using telecommunication technology are shown on the attached fee schedule.

**Please note:** Providers rendering services to MA recipients participating in the Healthy Beginnings Plus (HBP) program will continue to bill using the appropriate trimester package procedure codes and modifiers. When the recipient chooses to disenroll from participation in HBP services or the provider disenrolls as a HBP provider, the provider may bill for the individual MA service that is provided.

*Provider File Requirements*
Maternal fetal medicine specialists who are currently enrolled in the MA Program and wish to render consultations using telecommunication technology must request the addition of the special indicator code 0GT to their MA provider file in order to bill and be paid for consultations rendered using telecommunication technology. Maternal fetal medicine specialists who do not update their provider file to include the 0GT special indicator will not be paid for consultations they render using telecommunication technology. Referring providers and psychiatrists do not need to request an update to their provider files.

Maternal fetal medicine specialists must submit a “Maternal Fetal Medicine Specialist Telehealth Information Request Form” to the Enrollment Division to have the special indicator code 0GT added to their files. A copy of the form is attached to this bulletin. The form will be available on the Department’s website at: http://www.dpw.state.pa.us/omap/promise/enroll/omappromiseenroll.asp. Maternal fetal medicine specialists may also obtain the form by contacting MA Provider Enrollment at 1-800-537-8862, or by writing to:

    DPW Enrollment Unit
    P.O. Box 8045
    Harrisburg, PA 17105

Attachments:
1) Medical Assistance Program Fee Schedule for Consultations Performed Using Telecommunication Technology
2) Maternal Fetal Medicine Specialist Telehealth Information Request Form
AGING PROGRAM DIRECTIVE

SUBJECT: TELECARE SERVICE DEFINITIONS AND STANDARDS

TO: EXECUTIVE STAFF OFFICE OF LONG-TERM LIVING
AAA DIRECTORS PA DEPARTMENT OF AGING
HCBS PROVIDERS

FROM: John Michael Hall Jennifer Burnett
Secretary Deputy Secretary
Pennsylvania Department of Aging Office of Long-Term Living

PURPOSE: The purpose of this Aging Program Directive (APD) is to provide guidance on TeleCare services under the Aging Waiver and Options program.

SCOPE: This APD is directed to all Area Agencies on Aging (AAAs) and AAA staff responsible for the authorization and oversight of TeleCare services and applies to all providers of TeleCare services seeking to enroll or are enrolled as approved Aging Waiver providers and/or contracted AAA service providers.

BACKGROUND: In early 2007, several stakeholders put forth the idea that Pennsylvania actively pursue the delivery of technology supported services. Often referred to as telemedicine or telehealth nationally, supportive services through the use of technology are recognized as TeleCare. By September 2007, a demonstration project was announced and the TeleCare service standards were introduced to the AAA network.

The demonstration project allowed for several new services to be incorporated under the heading of TeleCare and incorporated the freestanding service of Personal Emergency Response System (PERS) along with Health Status Measuring and Monitoring and Quality of Life Technology, i.e., Activity Sensor Monitoring and Medication Dispensing and Monitoring. Over the past year, input from the AAAs and providers has been collected and used to refine this service definition and standard.
DISCUSSION: TeleCare is a model of service that employs technology with services to empower people with chronic conditions to remain independent. TeleCare integrates social and healthcare services with technology to sustain and promote quality of life and reduce unnecessary institutionalization. By utilizing in-home technology, Pennsylvania will have more options to assist and support individuals so that they can remain in their own homes. TeleCare complements home and community based services by facilitating timely and equitable resource allocation based on participant needs and improvement to quality of life.

TeleCare services are to be utilized for participants where there is a demonstrated need for the services and it has been determined that the services are not covered under Medicare or other third party resources. In instances where Medicare or other third party payer services are in place, TeleCare services will not be approved by the case manager and AAA nursing staff. TeleCare services are to be provided in an efficient manner, preventing duplication of services, unnecessary costs and unnecessary administrative tasks.

The participant’s home must be evaluated by the service provider to ensure that there is an adequate living environment with sufficient utilities to meet the manufacturer’s specifications for TeleCare equipment. TeleCare Services that are web-based must be HIPAA compliant. The documentation collected from the use of TeleCare services must be available to the AAA and Office of Long-Term Living (OLTL) upon request from the provider. All reports and data must be maintained by the provider and made available for at least 3 years past removal of the equipment. Providers shall assure that individuals providing services meet Medicare qualifications and standards; and that equipment meets all manufacturers’ qualifications and standards for the appropriate type of TeleCare services.

Participant service plans including TeleCare services must adhere to Pennsylvania Department of Aging, Office of Long-Term Living policies for Service plan review as outlined in APD # 06-01-03. TeleCare services are not to be used as a one time emergency service. The Older Adults Protective Services Act, the Department of Aging’s APD# 09-01-01, Incident Reporting Policy and Neglect of a Care Dependent Person are all applicable to recipients of this service.

The following types of services are included under the umbrella of TeleCare services.

**Health Status Measuring and Monitoring:** Using wireless technology or a phone line, this service includes electronic communication between the participant and healthcare provider that focuses on collecting health related data, i.e., vital signs information such as pulse and blood pressure that assists the healthcare provider in assessing the participant’s condition, and providing education and consultation.

**Activity and Sensor Monitoring:** This service employs sensor-based technology on a 24 hour/7 day basis by remotely monitoring and passively
tracking participants’ daily routines and may report on the following: wake up
times, overnight bathroom usage, bathroom falls, medication usage, meal
preparation and room temperature.

**Medication Dispensing and Monitoring:** This service assists participants by
dispensing and monitoring medication compliance. A remote monitoring system
is personally pre-programmed for each participant to dispense and monitor
compliance and notifies the provider or family caregiver of missed doses or non-
compliance with medication therapy.

**ELIGIBILITY**

To qualify for TeleCare services, the participant must be clinically eligible for
nursing facility care (NFCE). In addition, the Department will consider the
following factors when authorizing TeleCare services:

The participant presents with two or more of the following conditions/situations
for **Health Status Measuring and Monitoring Service, Activity and Sensor
Monitoring Service and Medication Dispensing and Monitoring Services**:

- Hospitalization in the past year;
- Medical Diagnosis of depression or other mental health issues;
- Use of the emergency room in the last year;
- Poor adherence with physician’s orders or medications;
- Formal or informal support systems are limited or absent;
- History of falls within the last six months that resulted in an injury;
- Lives alone or is at home alone for extended periods of time;
- Service access challenges.

The participant is sufficiently cognitively intact and able to physically operate the
equipment (i.e., able to see the monitor or put on the blood pressure cuff) *OR*
has a caregiver willing and able to assist with the equipment, unless the service
does not require active participation of the participant.

The participant’s home will be evaluated by the service provider to ensure that
the TeleCare equipment works properly. Adequate utilities to meet the
manufacturer’s specifications for equipment and the living situation/environment
must allow for adequate adaptation of the equipment. Home adaptations are not
included as part of this service.

A determination is made that there is a demonstrated need for the services and it
has been determined that the requested services are not duplicate covered
benefit services under Medicare or other third party resources.

If additional services are recommended due to changes identified by this
monitoring in the participant’s condition, the case manager must be informed and
services approved in consultation with the AAA nurse. When the change in
condition requires a skilled level of care, the home health agency (HHA) provider
should access Medicare and other third party payers for the services and notify
the AAA of the participant’s Medicare eligibility.
If the participant’s condition changes and requires skilled services covered by Medicare, the Waiver/OPTIONS program will no longer authorize the use of TeleCare. However under the Waiver/OPTIONS program, if reimbursement is on a monthly basis, the equipment should remain for that 30-day period. It is at the discretion of the provider to leave the equipment in place for the Medicare benefit period, however it cannot be charged to the Waiver/Options program during this period. It is at the discretion of the provider to remove or keep the equipment in the participant’s home after the month’s reimbursement is over.

**NOTE:** TeleCare service is dependent on the home environment having such basic equipment such as electric and telephone service. It is not meant to provide home modifications or to provide payment for technology such as Internet access, upgrade telephone access, etc. to adapt the home environment. Home modifications can be requested as a separate service under the Options and Aging Waiver programs as needed.

### SERVICE DESCRIPTIONS

**HEALTH STATUS MEASURING AND MONITORING SERVICE**

Health Status Measuring and Monitoring Service may be beneficial to participants with chronic medical conditions such as congestive heart failure, diabetes or pulmonary disease. Examples of Health Status Measuring and Monitoring Service may include, but are not limited to, weight, oxygen saturation measurements (pulse oximetry), and vital sign monitoring. Providers of Aging Waiver and Options program funded Health Status Measuring and Monitoring Services must be Medicare Certified HHAs enrolled in the Medical Assistance program. Any peripheral equipment must be capable of interfacing with Health Status Measuring and Monitoring Service equipment. Health Status Measuring and Monitoring equipment must be UL listed/certified or have 501 (k) clearance and/or must verify compliance for UL listing standards. A primary physician, physician assistant or nurse practitioner must order Health Status Measuring and Monitoring Service.

**The reimbursement fee for this service will include:**

- A one time fee at installation that covers both the cost of installation and removal of equipment;
- Daily rental of the equipment that will include repair and replacement of malfunctioning equipment;
- Training of the participant and/or their representative in the use of the equipment;
- Monitoring service activities by trained and qualified home health agency staff;
- Documentation of appropriate intervention based on information/data collected;
- Remote teaching and coaching provided as necessary to the participant and/or their representative;
• Ongoing provision of web-based data collection for each individual, as appropriate. This includes response to participant self-testing, as well as manufacturer’s specified testing, self-auditing and quality control;
• Health Status Measuring and Monitoring activity by the provider’s registered nurse;
• One monthly face-to-face visit by a registered nurse is included in the fee should the data collected from the health status monitoring warrant a visit. Should additional visits by a registered nurse need to occur during the month, those visits will be paid at the current Options/Waiver rates with AAA nurse approval. If data shows a potential emergency, the provider may dispatch a nurse without consultation with the AAA. However, by the next business day, the AAA nurse must be contacted for retroactive approval.

Roles and Responsibilities of the Area Agency on Aging (AAA)

• The AAA will determine the need for service based on the completion of the Care Management Instrument (CMI) and applying the eligibility guidelines for TeleCare services;
• The AAA nurse will review the CMI and all other pertinent information, including but not limited to, information obtained by contacting the participant’s health care providers to assure the appropriateness of the service;
• The AAA will ensure that the HHA has secured a primary physician, physician assistant or nurse practitioner order for the service;
• The AAA nurse and the case manager supervisor will review and approve the recommendation for the service;
• If there is a question regarding the need for the service, the AAA nurse should perform a face-to-face review to assess any concerns, e.g., to determine if the participant would benefit from Telecare service and/or is capable of properly using the system;
• The AAA nurse assists in the development of the service plan that includes this service;
• The AAA will follow OLTL guidelines for Service Plan Review Process;
• The AAA will coordinate the service plan with the HHA;
• The case manager will investigate the damage or misuse of the equipment with the participant/representative and provider to determine the continued use of the service;
• The AAA decision to discontinue the service shall be based on review of the participant’s need(s) and information from the HHA. The AAA will provide the HHA written documentation with justification for removal of the equipment and notice to participants regarding their appeal rights.
Roles and Responsibilities of the Provider

- Be a Medicare Certified HHA enrolled in the Medical Assistance Program that is an enrolled waiver provider or contracted Options provider;
- Develop and implement a service plan including the type, mode, and frequency of the service;
- Provide teaching and training to the participant and/or representative on the use, maintenance and safety of the equipment and how the service operates within the confines of the service plan;
- Ensure that all equipment is UL listed/certified or have 501(k) clearance and must document this compliance with the AAA;
- If additional services are recommended due to changes in the participant’s condition, the case manager must be informed and services approved in consultation with the AAA nurse;
- Maintain clinical documentation of all service activities, data and all participant contacts;
- Remotely monitor, track and review the data collected and respond with interventions applicable to the type of technology in the home;
- Coordinate participant’s current service plan with the AAA service plan;
- Coordinate/communicate with the AAA regarding the service plan and recommendation for service when the service plan is updated/modified, or at a minimum of at least every 60 days;
- Maintain an up to date event notification system, i.e., a system that provides information on changes in participant care;
- Update equipment when necessary, at no cost, as technology improves performance in the delivery of the service;
- Provide data and documentation to a designated individual upon request, i.e., individual/representative, case manager, OLTL staff or State Medicaid staff;
- Disconnect/remove the equipment from the participant’s residence within the same month of notification of discontinuance by the Case manager;
- Repair or replace malfunctioning equipment within 24 hours of notification or identification. Events beyond the control of the provider, i.e., natural disaster or unforeseen circumstances, may delay or impact the repair or replacement of equipment in this timeframe. The AAA must receive a report detailing the issue and the disposition of the repair or replacement. Payment for repairs and replacement of equipment is the responsibility of the provider.
- Provide an **Informed Consent Form** to the participant that at a minimum states:
  - Right to accept, deny, or terminate the use of the TeleCare services;
  - Benefits and purpose of the services;
  - Risks associated with the use of the equipment;
  - Extent to which data will be collected, reviewed, shared and stored;
  - Assurance of confidentiality;
No charge will be assigned by the provider to waiver participants and options participants will be responsible for only the AAA cost share;

- Subject to review and approval by the AAAs;

- Information associated with the maintenance and repair procedures for the equipment and call-in number for questions regarding operation of the equipment;
  - Review all data collection of peripheral devices (blood pressure, weight, glucometer readings, etc.) and follow-up with appropriate interventions;
  - Ensure that the Health Status Measuring and Monitoring Service is ordered by a primary physician, physician assistant or nurse practitioner and the order must:
    - Be obtained by the HHA prior to service authorization;
    - Include the specific nursing and/or therapeutic service required;
    - Reflect the client's medical condition as it relates to the special medical eligibility requirements;
    - Be obtained every 60 days for continuation of service.

**Provider Standards for Health Status Measuring and Monitoring Service:**

The provider in the delivery of services must:

- Install, maintain services, and ensure that the equipment is in proper working order;
- Deliver and install equipment and start service within 3 working days of receipt of the service order and notify the case manager of the equipment installation;
- Provide oversight of the system/equipment;
- Have a system in place for notification of emergency events to designated individuals;
- Ensure that individuals providing service meet provider qualifications under Medicare and Medicaid;
- Service data collected must be available at least 90% of the time to AAAs and participants/representatives when web-based systems are used;
- Provide direct participant contact employees training;
- Verify that all employees completing installation are adequately trained;
- Use and have on file, written staff training materials and procedures for services;
- Have a licensed registered nurse or licensed practical nurse evaluating participant data collected from the equipment and monitoring the service.

**Health Status Measuring and Monitoring Service Reporting:**

- Reporting includes documentation and service plan requirements, data analysis with tracking and trending and any other state and federal
requirements (e.g. communicable diseases, abuse and neglect, incident reporting, etc.). The AAA and OLTL will monitor the provider of services regarding compliance with reporting standards.

- Provider must document delivered services tracking and trending reports specified by OLTL.

**ACTIVITY AND SENSOR MONITORING SERVICE**

A service that employs sensor based technology on a 24/7 day basis by remotely tracking the participant’s activities of daily living. These activities may include, but are not limited to, various activities in the house and environmental temperature monitoring. Data is then transmitted to the caregiver and/or healthcare provider depending on the activity and sensor monitoring system employed. Activity and Sensor Monitoring Service equipment must be UL listed/certified. Providers of Aging Waiver and Options funded Activity and Sensor Monitoring Services can be provided by an enrolled Home Health Agency, Durable Medical Equipment (DME), Personal Care/Homemaker, Pharmacy or Hospital provider.

The AAA will authorize the use of Activity and Sensor Monitoring Services when other methods such as informal caregivers and other technology have been considered with documentation about how ineffective other methods or interventions would be for individual safety and monitoring.

**The reimbursement fee for this service will include:**

- A one time fee at installation that covers both the cost of installation and removal of equipment;
- Monthly rental of the equipment that will include repair and replacement of malfunctioning equipment;
- Training of the participant and/or their representative in the use of the equipment;
- Monitoring service activities by trained and qualified agency staff;
- Documentation of appropriate intervention based on information/data collected;
- Remote teaching and coaching provided as necessary to the participant and/or their representative;
- Ongoing provision of web-based data collection for each individual, as appropriate. This shall include response to participant self-testing, as well as manufacturer’s specified testing, self-auditing and quality control;
- Included in the monthly fee is the provision of a personal emergency response system (PERS) that is required in conjunction with this service. PERS is subject to all of the current requirements under the Options and Aging Waiver services definitions.

**Roles and Responsibilities of the Area Agency on Aging (AAA):**
A physician’s order is not necessary for this service. The remaining roles and responsibilities are the same as those stated for Health Status Monitoring and Measuring Service.

**Roles and Responsibilities for Activity and Sensor Monitoring Providers:**

The provider must:

- Be a Medicare Certified Home Health Agency (HHA), Durable Medical Equipment (DME), Personal Care/Homemaker, Pharmacy or Hospital that is an enrolled waiver provider or contracted Options provider;
- Develop and implement a service plan including the type, mode, and frequency of the service;
- Provide teaching and training to the participant and/or representative on the use, maintenance and safety of the equipment and how the service operates within the confines of the service plan;
- Ensure that all equipment is UL listed/certified or have 501K clearance and must document this compliance with the AAA;
- Notify the case manager if data collected indicates a change in the participant’s condition and additional home health services are being recommended;
- Maintain clinical documentation of all service activities, data and all participant contacts;
- Remotely monitor, track and review the data collected and respond with interventions applicable to the type of technology in the home;
- Coordinate participant’s current service plan with the AAA service plan;
- Coordinate/communicate with the AAA regarding the service plan and recommendation for service when the service plan is updated/modified or at a minimum of at least every 60 days;
- Maintain an up to date event notification system, i.e., a system that provides information on changes in participant care;
- Update equipment when necessary, at no cost, as technology improves performance in the delivery of the service;
- Provide data and documentation to designated individual upon request, i.e., individual/representative, case manager, OLTL staff or State Medicaid staff;
- Disconnect/remove the equipment from the participant’s residence within the same month of notification of discontinuance by the Case manager;
- Repair or replace malfunctioning equipment within 48 hours of notification or identification. Events beyond the control, i.e., natural disaster or unforeseen circumstances, of the provider may delay or impact the repair or replacement of equipment in this timeframe. The AAA must receive a report detailing the issue and the disposition of the repair or replacement. Payment for repairs and replacement of equipment is the responsibility of the provider;
- Provide an **Informed Consent Form** to the participant that at a minimum states:
• Right to accept, deny, or terminate the use of the TeleCare services;
• Benefits and purpose of the services;
• Risks associated with the use of the equipment;
• Extent to which data will be collected, reviewed, shared and stored;
• Assurance of confidentiality;
• No charge will be assigned by the provider to waiver participants and Options participants will be responsible for AAA cost share;
• Subject to review and approval by the AAAs;
• Information associated with the maintenance and repair procedures for the equipment and call-in number for questions regarding operation of the equipment.

**Provider Standards for Activity and Sensor Monitoring Service:**

- Same as Health Status Measuring and Monitoring service with exception that an RN does not have to monitor this service.

**Activity and Sensor Monitoring Service Reporting:**

- Same as Health Status Measuring and Monitoring service.

**MEDICATION DISPENSING AND MONITORING SERVICES**

Remote Medication Dispensing and Monitoring is pre-programmed based on the needs of the participant to dispense and monitor medication compliance. A system will be in place to notify the provider or caregiver of missed doses or non-compliance with medication administration. This service may be used with individuals that demonstrate a cognitive deficit, need assistance with medication, and have demonstrated and documented past non-compliance with medication administration.

Medication Dispensing and Monitoring Service equipment must be UL listed/certified. The provider agency shall assure that all equipment meets service standards. Providers of Aging Waiver and Options funded Medication Dispensing and Monitoring Services can be provided by an enrolled Home Health Agency, Durable Medical Equipment (DME), Personal Care/Homemaker, Pharmacy or Hospital provider.

The use of Medication Dispensing and Monitoring Services will be authorized by the AAA when all other methods, such as: pharmacy filled blister packs/pillboxes and informal caregivers have been considered with documentation about how ineffective other methods would be for individual safety and monitoring.

**NOTE:** If the Aging Waiver/Options participant only requires a medication dispenser unit and no monitoring services; the
dispensing unit should be purchased and/or rented under special equipment and supplies. In this instance, the medication dispensing and monitoring service should not be authorized.

The reimbursement fee will include:

- Same as Activity and Sensor Monitoring service.

Roles and Responsibilities of the Area Agency on Aging (AAA):

- A physician’s order is not necessary for this service. The remaining roles and responsibilities are the same as those stated for Health Status Monitoring and Measuring Service.

Roles and Responsibilities for Medication Dispensing and Monitoring Service Providers:

- Same as Activity and Sensor Monitoring service.

Provider Standards for Medication Dispensing and Monitoring Service:

- Same as Activity and Sensor Monitoring service.

Medication Dispensing and Monitoring Reporting:

- Same as Health Status Measuring and Monitoring service.

**NOTE:** All other medical equipment and supplies that will be of value to the individual to maintain them safely in the home can be purchased using medical equipment and supplies in the Aging Waiver and Options services.
## Waiver TeleCare Services

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<th>PROCEDURE CODE</th>
<th>PROC TYPE</th>
<th>SPEC CODE</th>
<th>POS</th>
<th>DEFINITION</th>
<th>FEE</th>
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<td><strong>Remote Monitoring</strong> participant’s Health Status by a Home Health Agency for individuals with <strong>chronic conditions</strong>.&lt;br&gt;Daily rental includes use, repair, replacement, and training of equipment, documentation, remote teaching and coaching, and one monthly RN Visit if warranted. Service must be ordered by a physician, physician assistant, or nurse practitioner&lt;br&gt;Daily Fee</td>
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## OPTIONS TeleCare Services

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<td>Remote Monitoring participant’s Health Status by a Home Health Agency for individuals with <em>chronic conditions</em>.&lt;br&gt;Daily rental includes use, repair, replacement, and training of equipment, documentation, remote teaching and coaching, and one monthly RN Visit if warranted.&lt;br&gt;Service must be ordered by a physician, physician assistant, or nurse practitioner&lt;br&gt;Daily Fee</td>
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<td><strong>MEDICATION DISPENSING AND MONITORING</strong></td>
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South Carolina's state Medicaid program does provide reimbursement for real-time telepsychiatry services.

In the area of tele-home care and remote monitoring services, South Carolina recently began covering home remote monitoring services for home and community-based waiver participants. These patients must meet certain health status requirements including hospitalizations in the past year and the ability to use telemonitoring equipment in order to qualify for the program.
SECTION 2
Policies and Procedures

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PROGRAM SERVICES

Supplies (Cont’d.)

99070 – Supplies and Materials
99071 – Educational Supplies

This supply list is not all-inclusive. Some supply codes specific to certain specialties may be listed in those sections.

Telepsychiatry

Telepsychiatry is defined as live, real-time, two-way interaction via a telecommunication system between a psychiatrist and a patient for the purpose of assessment, evaluation, or provision of therapy and counseling. Telepsychiatry does not include teleassistive medical services, which do not require a psychiatrist to directly visualize a patient. Telepsychiatric counseling based on stored and forwarded communications is not reimbursable under these guidelines. Telepsychiatry must be an interactive patient encounter that meets the criteria for psychiatric service as outlined in the Physician’s Current Procedural Terminology (CPT) descriptor.

Requirements for Participation:

- The psychiatrist must be licensed, enrolled with South Carolina Medicaid, and practicing medicine within the South Carolina Medical Service Area.

- The participating health care providers must have received training in proper use of, and limitations of, telemedicine equipment.

- The patient’s attending physician, nurse practitioner, or nurse midwife must request services prior to conducting telepsychiatric therapy. The request must be documented in the patient’s records.

- The attending health care provider must be requesting the opinion or advice of a psychiatrist regarding treatment or therapy of a patient with a specific mental condition.

- The patient’s attending health care provider or other trained medical personnel such as a physician’s assistant, nurse practitioner, or registered nurse must be present with the patient during the performance of the telepsychiatry session.

- The psychiatrist’s findings and recommendations must be documented in writing in the format normally used for recording treatment and therapy in medical records and included in the patient’s medical record at the patient’s location.
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Telepsychiatry (Cont’d.)

- The use of video conferencing for direct patient management by a remote physician in the absence of attending health care providers is not acceptable.

Reimbursement:

Providers will submit charges for telepsychiatric services on the CMS-1500 claim form. The referring physician will submit a form using the usual E/M encounter codes with a modifier “TM” to indicate the service as a telemedicine encounter. The psychiatric physician will also submit a claim form using the psychiatric codes with a modifier “TM.”

There is no additional reimbursement for telemedicine equipment.

Unusual Travel

Procedure code 99082 is compensable only when a patient must be transported to a medical facility and is accompanied by a physician because there is no other recourse available based on the necessary medical skills and expertise required for the patient's condition. Documentation must be submitted with the claim. Coverage and reimbursement will be determined on a claim-by-claim basis.

Unlisted Services or Procedures

A service or procedure may be provided that is not listed in the CPT. When reporting such a service; the appropriate “unlisted” procedure code may be used to indicate the service, identifying it by special report.

Appropriate records to justify the use of the unlisted code, the complexity of the service, and the charge must accompany the unlisted procedures. The reimbursement will be directly related to the support documentation submitted with the claim. To ensure proper interpretation and payment, a complete description of the performed service is required.

Procedures that are considered an integral part of an examination should not be charged separately (i.e., simple vision test, blood pressure check, ophthalmoscopy, otoscopy). Charges for these services in addition to an E/M visit will be denied.

Non-Covered Services

CPT procedure codes 99075, 99078, 99080, and 99090 indicating medical testimony, special reports for insurance, educational services for groups, and data analysis are non-compensable by Medicaid.

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) are provided to support primary medical care in patients who exhibit risk factors that directly impact their medical status. These services are designed to help the physician maximize the patient’s treatment benefits and outcomes by supplementing routine medical care.
APPENDIX A-

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
TELEMONITORING SERVICE

A. **Objectives**

The objectives of the Telemonitoring service are to maintain and promote the health status of Medicaid home and community-based waiver participants through medical telemonitoring of body weight, blood pressure, oxygen saturation, blood glucose levels, and basic heart rate information.

B. **Conditions of Participation - Providers**

1. Providers must have equipment that records at a minimum the participant’s body weight, blood pressure, oxygen saturation, blood glucose levels, and basic heart rate information. All agencies must also have nursing personnel and health care professionals able to carry out the duties of the service described below.

2. Providers must agree to participate in all components of the Care Call monitoring and payment system and have the capability to receive and respond to authorizations for service in an electronic format.

3. Providers must have at least one (1) year of experience or otherwise demonstrate competency in the provision of this service.

C. **Conditions of Participation – Community Choices Waiver Participants**

Community Choices waiver participants must meet the following criteria in order to be considered for the telemonitoring service:

- Have a primary diagnosis of Insulin Dependent Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, and/or Congestive Heart Failure; and
- Have a history of at least two hospitalizations and/or emergency room visits in the past 12 months; and
- Have a primary care physician that approves the use of the telemonitoring service and is solely responsible for receiving and acting upon the information received via the telemonitoring service; and
- Be capable of using the telemonitoring equipment and transmitting the necessary data or have an individual available to them that is capable of utilizing the telemonitoring equipment and transmitting data to the telemonitoring provider.
At a minimum, CLTC shall perform a re-assessment of the telemonitoring service need at re-evaluation of level of care. The re-assessment by CLTC shall be done to assess whether or not any of the above conditions have changed and to assess the continuing need for the service.

D. Description of Services to be Provided

1. The Unit of Service is one (1) day of direct telemonitoring provided to/for a participant in the participant’s place of residence.

2. Home telemonitoring equipment must record, at a minimum, body weight, blood pressure, oxygen saturation, blood glucose, and basic heart rate information. The data must be transmitted electronically, and any transmission costs shall be incurred by the provider of the telemonitoring service. Medical professionals shall receive the data and determine if readings are within normal limits based upon guidelines provided by the physician.

3. The daily reimbursement rate for the telemonitoring service is inclusive of monitoring of data, charting data from the monthly monitoring, visits or calls made to the home to follow up with participants and/or caregiver, phone calls made to primary care physician(s) that are necessary while the participant is receiving the telemonitoring service, all installation of the equipment in the home, and training on the equipment’s use and care while it is in the participant’s home. This also includes equipment removal when the service is no longer authorized for the participant.

4. The Provider shall provide the telemonitoring service seven (7) days per week for all authorized time periods.

E. Staffing

The Provider must provide all of the following (some, but not all of which, may be provided through subcontracts):

1. A. A registered nurse (RN) who meets the following requirements:
   
   a. Currently licensed by the S.C. State Board of Nursing or by a state that participates in the Nursing Compact.
   
   b. At least one (1) year of experience as a RN in public health, hospital or long term care nursing.
   
   c. Capable of evaluating and monitoring vital signs and physiological data transmitted from the participant’s residence.
d. Able to assume responsibility for monitoring and training participants and/or caregivers in the use of telemonitoring equipment.

e. Able to use the Care Call IVR system.

B. Technicians that install telemonitoring equipment must meet the following requirements:

a. Qualified as a technician to install telemonitoring equipment.

b. Capable of evaluating whether or not the telemonitoring equipment is functioning properly.

c. Able to assume responsibility for training participants and/or caregivers in the use of telemonitoring equipment.

d. Able to use the Care Call IVR system.

2. Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. Copies of this policy are available upon request.

3. A criminal background check is required for all potential employees to include employees who shall provide direct care to CLTC participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). At a minimum, the criminal background check must include statewide data. Potential employees with felony convictions within the last ten (10) years cannot provide services to CLTC participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to CLTC participants under the following circumstances:

- Participant/responsible party must be notified of the RN or technician’s criminal background
- Documentation signed by the participant/responsible party acknowledging awareness of the criminal background and agreement to have the RN or technician provide care must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the Provider’s discretion.

Hiring of employees with misdemeanor convictions shall be at the Provider’s discretion.
4. Personnel folders: Individual records shall be maintained to document that each member of the staff has met the above requirements.

F. Conduct of Service

The Provider must maintain documentation showing that it has complied with the requirements of this section.

1. Participants and/or caregivers shall choose among qualified providers of the telemonitoring service. Once a provider has been chosen by the participant and/or caregiver, the telemonitoring provider shall receive a referral that will have information on the participant's condition. Telemonitoring providers must accept or decline referrals from CLTC within two (2) working days. Failure to respond shall result in the loss of the referral.

2. If the referral is accepted, the Provider shall obtain the physician's authorization for the telemonitoring service. The Provider shall notify the Case Manager when it has received the signed physician authorization for telemonitoring form. A blank copy of the physician authorization form can be obtained on our website.

3. The Provider shall initiate telemonitoring services on the date negotiated with the Case Manager and indicated on the Medicaid Home and Community-Based waiver service authorization. The Case Manager must be notified if services are not initiated on that date. Services provided prior to the service authorization date are not reimbursable.

4. The Case Manager shall authorize telemonitoring services by designating the amount, frequency and duration of service for participants in accordance with the participant's Service Plan. The Service Plan shall be developed utilizing the telemedicine assessment criteria and in consultation with the participant and others involved in the participant's care. The Case Manager must update the Service Plan yearly, or more frequently as needed, and send to the Provider.

5. The Case Manager shall notify the Provider immediately if services to a participant are to be terminated. However, the Provider should refer to the language in the Community Long Term Care Services Provider Manual in section 1, General Information and Administration, regarding the Provider's responsibility in checking the participant's Medicaid eligibility status.

6. The Provider shall install the equipment in the home and train the participant and/or caregiver in the use of the telemonitoring equipment. The installation and training must be done by a trained technician and/or RN knowledgeable of the equipment and able to address issues that may arise during training.
and in the installation of the product. The daily monitoring fee is inclusive of installation and training.

7. As part of the conduct of service, telemonitoring must be provided by an RN (or physician) who meets the requirements as stated in the scope and shall:

a. Be responsible for daily medical telemonitoring of body weight, blood pressure, blood glucose levels, and basic heart rate information. Each day when the physiological data is conveyed, the nurse shall analyze and interpret the data. If the data continues to remain within normal limits, information shall be conveyed at least quarterly, or more often if requested by the primary care physician accepting responsibility for the telemonitoring information. The telemonitoring agency and primary care physician accepting responsibility for the data shall maintain a written protocol that indicates the manner in which data shall be shared in the event of emergencies or other medical complications that arise during the monitoring service.

b. Call the participant at least monthly to determine if the participant and/or caregiver are utilizing the equipment correctly and that the equipment continues to operate appropriately.

8. The Provider shall notify the Case Manager in the event the Provider becomes aware of any of the following situations:

- Participant is institutionalized, dies or moves out of the service area.
- Participant no longer wishes to receive telemonitoring services.
- Knowledge of the participant’s Medicaid ineligibility or potential ineligibility.
- Participant is not able to utilize the telemonitoring equipment any longer.

9. Telemonitoring equipment located in the participant’s home must, at a minimum, be a FDA Class II Hospital grade medical device that includes a computer/monitor that is programmable for a variety of disease states and for rate and frequency. The equipment must have a digital scale that measures accurately to at least 400 lbs that is adaptable to fit a glucometer and a blood pressure cuff. All installed equipment must be able to measure, at a minimum, blood pressure, heart rate, oxygen saturation, blood glucose, body weight. Telephones, facsimile machines, and electronic mail systems do not alone meet the requirements of the definition of telemonitoring, but may be utilized as a component of the telemonitoring system. All data must be transmitted electronically and any fees or costs associated with the transmission are the sole responsibility of the Provider. The maintenance,
repair and/or replacement of any damaged telemonitoring equipment are the Provider’s sole responsibility and are not a reimbursable Medicaid service. Major telemonitoring equipment failures which affect the ability to transmit or receive data must be repaired within two (2) working days. Any failure in the individual components of a telemonitoring system such as adaptability with a glucose monitor will need to be corrected within one week of discovering the problem associated with the additional equipment.

10. The Provider must maintain an individual participant record which documents the following items:

a. Documentation that telemonitoring services were initiated on the date negotiated with the Case Manager and indicated on the Medicaid authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the Service Provision Form/Authorization.

b. The written protocol for notifying the primary care physician of all telemonitoring services.

c. The Provider shall maintain a record keeping system which documents:

1. The delivery of services in accordance with the CLTC Service Plan. Monitoring sheets that are reviewed and signed, by the RN, must be filed in the participant’s record within two (2) weeks of service delivery.

d. Documentation that a participant phone call has been made on at least a monthly basis to determine that the participant and/or caregiver are utilizing the equipment correctly and that the equipment continues to operate appropriately.

e. In the event services cannot be provided as authorized, the Provider must maintain documentation of the reason(s) why services were not completed as specified by the Service Provision Form/Authorization.

F. Administrative Requirements

1. The Provider must inform CLTC of the Provider’s organizational structure including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The Provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.
2. The Provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. The Provider agency shall acquire and maintain, for the duration of the contract, liability, insurance and worker’s compensation insurance as provided in Article IX, Section D of the Contract. The Provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The Provider shall develop and maintain a Policy and Procedure Manual that describes how activities shall be performed in accordance with the terms of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body and personnel and shall be made available to SCDHHS upon request.

6. The Provider must comply with Article IX, Section AA of the Contract regarding safety precautions. The Provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

7. The Provider shall ensure that key agency staff are accessible in person, by phone, or by beeper during compliance review audits conducted by SCDHHS and/or its agents.

8. The Provider shall ensure that its office is open and staffed by qualified personnel during the hours of 10:00 am to 4:00 pm., Monday through Friday. Outside of these hours, the Provider agency must be available by telephone during normal business hours, 8:30 am to 5:00 pm, Monday through Friday. The Provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

Written 10/14/09
South Dakota’s state Medicaid program does reimburse for telemedicine services. Reimbursements are limited to consultation services; follow-up office visits for established patients, and pharmacological management services. Coverage of telemedicine consultations is treated like any other consultation service as defined in the Physician’s Current Procedural Terminology (CPT). Additionally, telepsychiatric services are reimbursed and are limited pharmacological management procedure code 90862.

In the area of tele-home care and remote monitoring services, South Dakota does not cover home telehealth services.
SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM

PROFESSIONAL SERVICES MANUAL
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TELEMEDICINE CONSULTATION SERVICES

Telemedicine is the real time or near real time two-way transfer of medical data and information between two medical entities.

Medical data exchange can take the form of multiple formats: text, graphics, still images, audio, and video. The information/data exchange can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through so-called “store and forward” applications such as electronic mail, fax, or phone-mail.

Telemedicine services provided to eligible South Dakota Medical Assistance Program recipients are limited to consultation services; follow-up office visits for established patients, and pharmacological management services. Coverage of telemedicine consultations is treated like any other consultation service as defined in the Physician’s Current Procedural Terminology (CPT).

When an attending physician requests an opinion or advice regarding evaluation and/or management of a specific problem from another physician or appropriate source, the consultant may bill the appropriate evaluation/management code for the service to the Medical Assistance Program.

Appropriate CPT codes for these consultation services are within the CPT range of 99241-99275. When billing the Medical Assistance Program for telemedicine consultations the addition of the procedure code modifier “GQ”, or “GT” is required. The “GQ” modifier denotes asynchronous telecommunications system. The “GT” signifies interactive audio and video telecommunications systems.

The Medical Assistance Program also reimburses telemedicine technology services for follow-up visits of established patients. Specifically, reimbursement for follow-up visits for established patients delivered via telemedicine are limited to CPT evaluation and management procedure code range 99211-99215. Additionally, telepsychiatric services are reimbursed and are limited to pharmacological management procedure code 90862.

The reimbursement for the cost incurred from the use of the telemedicine network is included in the Medical Assistance Program’s payment for the evaluation/management code submitted by the requesting physician. It is not appropriate to bill the Medical Assistance Program for telemedicine network costs under any additional CPT code.

HYPERBARIC OXYGEN THERAPY

**REQUIREMENTS – ARSD § 67:16:02:05.08**

Hyperbaric oxygen therapy is a modality in which the entire body is placed in a chamber and exposed to oxygen under increased atmospheric pressure. The department must authorize hyperbaric oxygen therapy before it is provided. Hyperbaric oxygen therapy is limited to outpatient services for treatment of the following conditions:

1. Acute carbon monoxide intoxication;
2. Decompression illness;
3. Gas embolism;
4. Gas gangrene;
5. Acute traumatic peripheral ischemia. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life threatened;
6. Crush injuries and suturing of severed limbs. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
7. Meleney ulcers. Any other type of cutaneous ulcer is not covered;
TENNESSEE

Upon the release of the 50 State Medicaid Statute Survey, CTeL remains to receive a response from the Tennessee Medicaid Office (TennCare) regarding their reimbursement policy for telehealth or telehome health services.
TEXAS

Texas’s state Medicaid program does provide reimbursement for telemedicine services at the same level that it does for in-person visits and has done so since 1998. Over the years, the range of telehealth services that are reimbursable has grown and the program has been continually refined. In the past few years, the use of telehealth has increased among Medicaid providers.

In the area of tele-home care and remote monitoring services, Texas does not currently provide reimbursement. However, a bill has been introduced for the current Texas legislative session that would allow for home telemonitoring services through a licensed home health agency.
6.3.65 Telemedicine Services

Telemedicine is defined as the practice of health-care delivery by a provider who is located at a site other than the site where the client is located. Telemedicine requires the use of advanced telecommunications technology and is used for the purposes of evaluation, diagnosis, consultation, or treatment.

Only those services that involve direct face-to-face interactive video communication between the client and the distant-site provider constitute a telemedicine interactive video consultation. Telephone conversations, chart reviews, electronic mail messages, and facsimile transmissions alone do not constitute a telemedicine interactive video consultation and will not be reimbursed as telemedicine services.

Use of telemedicine services within ICF-MR State Schools is subject to the policy established by DSHS and the Texas Department of Aging and Disability Services (DADS) established policies.

The provider requesting the telemedicine service must maintain medical record documentation indicating the medical necessity for the service. The referring provider is responsible for contacting the distant-site provider and arranging for the telemedicine service. In the absence of a referring provider, the distant-site provider is responsible for arranging the telemedicine service.

More than one medically necessary telemedicine service may be reimbursed for the same date of service and place of service, if the services are billed by physicians of different specialties. Documentation for a service provided via telemedicine must be the same as for a comparable in-person service.

Providers may not disclose any medical information revealed by the client or discovered by the physician in connection with the treatment of the client via telemedicine without proper authorization from the patient.
Utah Medicaid does provide reimbursement for specific telemedicine services. Coverage includes the treatment for special health care needs children, restricted to those residing in rural areas, and mental health consultations.

In the area of tele-home care and remote monitoring services, Utah Medicaid reimburses for diabetic monitoring and education.
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a miscellaneous code for billing medical supplies or equipment available from a medical supplier.

a. The Utah Medicaid Program covers medical supplies and equipment under four conditions: (1) the supplies and equipment are medically necessary; (2) they are ordered by a physician; (3) they meet the standards stated in policy and the Medical Supplies List, and they are within the limits specified; and (4) they are on the Medical Supplies List included with this manual. Coverage requirements are described in the Utah Medicaid Provider Manual for Medical Supplies. A copy of this manual may be obtained by contacting Medicaid Information.

(1) Medical necessity does not include use primarily for hygiene, education, exercise, convenience, cosmetic purposes, or comfort. The physician's order must list each item required, a medical necessity, and be signed and dated by the physician or other licensed medical practitioner. An item simply marked on a preprinted multiple item order sheet is not acceptable.

b. The Child Health Evaluation and Care (CHEC) Program may approve medical supplies and medical equipment which are medically necessary for children less than 21 years of age. For specific information, please refer to the Utah Medicaid Provider Manual for Child Health Evaluation and Care (CHEC) Program Services. A copy of this manual is available on the Internet through a link on the Medicaid Provider's Guide http://health.utah.gov/medicaid/provhtml/provider.html, or contact Medicaid Information.

29. Medicaid restricts hemophilia blood factors to a single provider. The purpose is to provide a uniform hemophilia case management support program to the patient and patient's physician and to achieve economies in the purchase of blood factor through a sole source contract. Medicaid will reimburse only the sole source provider for hemophilia case management, blood factors VII, VIII and IX. No other provider will be paid for blood factors VII, VIII or IX supplied. Medicaid clients who choose not to participate in the Medicaid Hemophilia program must make their own arrangements for procurement and payment of the blood factor.

The contract affects only the procurement and management of the prescribed blood factor. The patient's physician continues to be responsible to develop a plan of care and to prescribe the blood factor. The contract with the sole source provider specifies the provider must work closely with the patient's Primary Care Provider physician or managed care plan.

Managed care plans which contract with Medicaid continue to be responsible for hemophilia-related services such as physical therapy, lab work, unrelated nursing care, and physician services.

As of October 2000, the sole source provider is University Hospital Home Infusion Services. Please direct questions concerning hemophilia case management and blood factors VII, VIII and IX to this provider: (801) 466-7016.

30. Telemedicine or telehealth services are an additional method of delivering health care to patients in underserved rural areas. Medicaid views telemedicine no differently than an office visit or outpatient consultation. However, if there are technological difficulties in performing
an objective thorough medical assessment, or problems in patient understanding or acceptance of telemedicine, hands-on-assessment and/or care must be provided for the patient. Quality of health care must be maintained regardless of the mode of delivery.

For Medicaid reimbursement, University of Utah telehealth connections to rural areas must be located within Utah, and health providers must be licensed in Utah.

Definitions

Telemedicine or telehealth is a technological method of providing an auditory and visual connection between the consultant at a remote site and the patient who is assisted by a Health Department clinician at the rural Health Department clinic.

Authorized providers: The University of Utah telehealth site will provide access for physician and dietitian consultation. Health care providers are limited to physicians and dietitians during the beginning of the Children’s Special Health Care Needs pilot project. Other specialty areas may be added later as the project continues.

Covered Services

Medically necessary diagnostic and therapeutic services, appropriate for the adequate diagnosis or treatment of some Special Health Care Needs Children, are covered services. The services include initial physician consultation, confirmatory consultations, and follow up consults. The service and codes will be limited to those which might be appropriate for evaluation and consultation without hands-on-care.

Limitations

• For Medicaid and the Special Health Care Needs Children project purposes, health care delivery through telehealth is only relevant for Special Health Care Need’s Children residing in rural areas. It provides the child with access to a health provider specialist in an urban area without travel from the rural area. Health Department clinics in Milford, Price, and Richfield with telehealth connections to the University of Utah telehealth site are eligible for inclusion in the project.

• Providers are limited to physicians and dietitians working through the University of Utah telehealth site as participants in the Special Health Care Needs Child project. Each health provider must have a Medicaid provider number.

• Providers will ensure that the legal guardian of the Special Health Care Needs Child signs a consent to authorize the child’s participation in the telehealth project. Without signed consent, the child is not eligible to participate in telehealth.

Billing/Payment

Bill on a CMS-1500 (08/05) Claim form.

All payments will be made to the Bureau of Children with Special Health Care Needs in the Division of Community and Family Health Services, Department of Health.

No payments will be made for telehealth transmission expense or facility charge.
Codes

Codes which may be used by telemedicine physician consultants:

- 99201-99205 - initial outpatient consultations
- 99211-99215 - outpatient established patient

Codes which may be used for dietician consultation:

1. S9470 dietician nutritional counseling. This is a new code which specifically describes dietician education and consultation for Special Health Care Needs Child during the telehealth project. Dietician consultation for the family will average four per year.

Modifier

GT Each dietician and physician provider consultant must add the GT modifier to indicate the service was provided through telehealth. This modifier is required to monitor and evaluate the financial impact of this project.

Non-Covered Modifiers

GQ This modifier is used for transmission of data such as radiology or electrocardiogram. This is not a covered service for the Medicaid Telehealth Special Health Care Needs Child project.

31. Diabetes Self-Management Training


Patient Preauthorization

A newly diagnosed patient with Type I, Type II, or gestational diabetes or a patient previously diagnosed with Type I or Type II diabetes, is eligible to receive diabetes self management training through Medicaid when:

1. The physician provides a referral for the patient who has never had a diabetes self management training course. The course is limited to 10 sessions. Services are billed under code S9455.

2. The patient completed the diabetes training at least 12 months ago, and the physician refers the patient for a specified number of refresher diabetes training sessions because:
   - The patient has progressed in diabetes illness to require further management training or the patient has indications they are noncompliant with treatment.
   - Patient has complications of diabetes requiring two or more visits to the emergency room during the last six months or a hospital admission related to diabetes within the last year.

3. These services must meet the requirements of the ADA courses. Use solely for glucose monitoring or nutritional counseling is not covered through this program.

At preauthorization the following patient information should be provided:
# SECTION 2

Mental Health Centers

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1. GENERAL POLICY

1 - 1 Authority

Rehabilitative mental health services are provided under the authority of 42 CFR 440.130, Diagnostic, Screening, Preventive, and Rehabilitative Services. Under this authority, services may be provided in settings other than the mental health center, as appropriate, with the exception of an inpatient hospital.

1 - 2 Qualified Mental Health Providers

Rehabilitative mental health services are covered benefits when provided by or through a mental health center under contract with or directly operated by a local county mental health authority.

Children in State Custody

For the provision of outpatient services to children in state custody, mental health centers may follow this provider manual. However, children in state custody must have more frequent reviews of their treatment plans. The review schedule for children in state custody is outlined in Chapter 1 - 8, Periodic Review of the Treatment Plan.

1 - 3 Definitions (Updated 4/1/11)

**Children in Foster Care:** Means children and youth under the statutory responsibility of the Utah Department of Human Services identified as such in the Medicaid eligibility (eREP) system.

**Habilitation Services:** Typically means interventions for the purpose of helping individuals acquire new functional abilities whereas rehabilitative services are for the purpose of restoring functional losses. (See Rehabilitative Services definition below.)

**Medically Necessary Services:** means any mental health service that is necessary to diagnose, correct or ameliorate a mental illness or condition, or prevent deterioration of that mental illness or condition or development of additional health problems and there is no other equally effective course of treatment available or suitable that is more conservative or substantially less costly.

**Non-Traditional Medicaid Plan:** means the reduced benefits plan provided to Medicaid-eligible adults age 19 through age 64 who:

1) Are not blind, disabled, or pregnant;

2) Are in a Medically Needy aid category and are not blind, disabled, or pregnant; or

3) Are in a Transitional Medicaid aid category.

Non-Traditional Medicaid Plan enrollees are in Utah’s Section 1115 Primary Care Network Demonstration Program. These individuals’ Medicaid cards specify they are enrolled in the Non-Traditional Medicaid Plan. Services covered under this reduced benefit plan are similar to the Traditional Medicaid Plan with some limitations and exclusions.
1) Services for conditions without manifest mental health diagnoses (i.e., conditions that do not warrant a mental health diagnosis);

2) Hypnosis, occupational or recreational therapy;

3) Office calls in conjunction with medication management for repetitive therapeutic injections; and

4) Psychiatric diagnostic interview examination for legal purposes only (e.g., for custodial or visitation rights, etc.).

**Psychiatric diagnostic interview examination** means a face-to-face evaluation with the client to determine the existence, nature and extent of a mental illness or disorder for the purpose of identifying the client’s need for mental health services, with interpretation and report. The evaluation includes a history, mental status and a disposition. It may also include communication with family or other sources and ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants will be seen in lieu of the client.

**Interactive psychiatric diagnostic interview examination**- This service is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a client who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language and includes physical devices, play equipment, language interpreter, or other mechanisms of non-verbal communication to aid in the examination.

If it is determined services are medically necessary an individual identified in Chapter 1-5, paragraph A, must develop an individualized treatment plan. (See Chapter 1-7, Treatment Plan.)

Psychiatric diagnostic interview examinations may also be provided in a tele-health setting to rural clients where distance and travel time create difficulty with access. See ‘Limits’ section below.

**Who:**

1. In accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure.

2. When evaluations are conducted only for the purpose of determining need for medication prescription, these evaluations may be conducted by:

   a. licensed physician and surgeon or osteopathic physician regardless of specialty;

   b. licensed APRN regardless of specialty;

   c. licensed APRN intern regardless of specialty under the supervision of a licensed APRN regardless of specialty or a licensed physician and surgeon or osteopathic physician regardless of specialty; or
d. other medical practitioner licensed under state law when acting within the scope of his/her license (e.g., licensed physician assistants when practicing within their scope of practice and under the delegation of services agreement required by their practice act).

Record: Documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. report of psychiatric diagnostic interview examination findings that includes:
   a. history and mental status (mental status report may be based on formal assessment or on observations from the evaluation process); and
   b. disposition, including diagnosis(es), recommended mental health services, and other recommended services as appropriate; and
6. signature and licensure or credentials of individual who rendered the service.

Unit: 90801 – Psychiatric Diagnostic Interview Examination - per 15 minutes

90802 –Interactive Psychiatric Diagnostic Interview Examination - per 15 minutes

When billing or reporting these procedure codes, follow these rounding rules for converting actual time to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 57 minutes of service equals 4 units;

58 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Limits: 1. The periodic reevaluation of the client’s treatment plan by an individual identified in paragraph A of Chapter 1-5 may be billed only if the reevaluation conducted includes a face-to-face interview with the client and the elements of this service are met.

2. Psychiatric diagnostic interview examinations provided in a tele-health setting are limited to clients residing in rural areas of Utah and are limited to evaluations conducted to determine need for medication prescription.

3. When a psychiatric diagnostic interview examination is provided in a tele-health setting, only this subcontracted service may be billed. The time spent by a mental health center
case manager or other mental health professional to assist the client during the service provided in the tele-health setting may not also be billed.

2 - 3 Mental Health Assessment by a Non-Mental Health Therapist

Mental health assessment by a non-mental health therapist means individuals listed below participating as part of a multi-disciplinary team in the psychiatric diagnostic interview examination process and in the periodic reevaluation/review of the treatment plan by gathering psychosocial data, including basic historical, social, functional, psychiatric, developmental, or other information, through face-to-face contacts with the client. Additional psycho-social information may be collected through face-to-face or telephonic interviews with family/guardians or other informants as necessary. Also see #1 in ‘Limits’ section below.

Who:

1. The following individuals when under the supervision of a licensed mental health therapist identified in Chapter 1-5, paragraph A.1:
   a. licensed social service worker or individual working toward licensure as a social service worker;
   b. licensed registered nurse; or
   c. licensed practical nurse.

2. Registered nursing student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph B.3.

Although one of these individuals may assist in the evaluation or reevaluation process by gathering the psychosocial data as directed by the supervisor, under state law, an individual identified in the ‘Who’ section of Chapter 2-2 must conduct the psychiatric diagnostic interview examination or the reevaluation /treatment plan review. (See Chapter 1-8, Periodic Review of the Treatment Plan.) These individuals may also participate as part of the multi-disciplinary team in the development of the treatment plan, but they may not independently diagnose or prescribe treatment. Individuals identified in the ‘Who’ section of Chapter 2-2, based on their evaluation of the client, must diagnose and prescribe treatment.

Record: Documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. summary of psychosocial findings; and
6. signature and licensure or credentials of individual who rendered the service.

Unit: H0031 - Mental Health Assessment by a Non-Mental Health Therapist -- per 15 minutes
When billing or reporting this procedure code, follow these rounding rules for converting actual time to the specified number of units:

Less than 8 minutes equals 0 units;
8 minutes through 22 minutes of service equals 1 unit;
23 minutes through 37 minutes of service equals 2 units;
38 minutes through 52 minutes of service equals 3 units;
53 minutes through 57 minutes of service equals 4 units;
68 minutes through 82 minutes of service equals 5 units;
83 minutes through 97 minutes of service equals 6 units;
98 minutes through 112 minutes of service equals 7 units; and
113 minutes through 127 minutes of service equals 8 units, etc.

Limits: This service is meant to accompany the psychiatric diagnostic interview examination or the reevaluation/periodic review of the treatment plan. Therefore, it should be billed only if a psychiatric diagnostic interview examination or a reevaluation/treatment plan review is also provided.

However, if the psychiatric diagnostic interview examination or the reevaluation/treatment plan review is not conducted after this assessment is performed, this assessment may be billed if:

(1) all of the documentation requirements in the ‘Record’ section are met; and
(2) the reason for non-completion of the psychiatric diagnostic interview examination or the reevaluation/treatment plan review is documented.

2.4 Psychological Testing

Psychological testing means a face-to-face evaluation to determine the existence, nature and extent of a mental illness or disorder using psychological tests appropriate to the client’s needs, including psychometric, diagnostic, projective, or standardized IQ tests, with interpretation and report.

Who: 1. licensed physician and surgeon, or osteopathic physician engaged in the practice of mental health therapy;

2. licensed psychologist qualified to engage in the practice of mental health therapy;

3. certified psychology resident under the supervision of a licensed psychologist qualified to engage in the practice of mental health therapy;

4. psychology student enrolled in a predoctoral education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph A.3.a; or.

5. an individual exempted from licensure in accordance with Chapter 1-5, paragraph A.3.b, employed as a psychologist by a state, county or municipal agency or other
political subdivision of the state prior to July 1, 1981, and who subsequently has
maintained employment as a psychologist in the same state, county, or municipal
agency or other political subdivision while engaged in the performance of his/her
official duties for that agency or political subdivision. [See Title 58-61-307(2)(h).]

Record: Documentation must include:

1. date(s) and actual time(s) of testing (time may be rounded to the nearest five minute
   interval);
2. duration of the testing;
3. setting in which the testing was rendered;
4. specific service rendered;
5. signature and licensure or credentials of individual who rendered the service; and
6. written test reports which include:
   a. brief history
   b. tests administered;
   c. test scores;
   d. evaluation of test results;
   e. current functioning of the examinee;
   f. diagnoses;
   g. prognosis; and
   h. specific treatment recommendations for mental health services, and other
      recommended services as appropriate.

Unit:  

96101 - Psychological Testing - includes psychodiagnostic assessment of personality,
psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI, with
interpretation and report - per hour

96105 - Assessment of Aphasia - includes assessment of expressive and receptive speech
and language function, language comprehension, speech production ability, reading spelling,
writing, e.g., Boston Diagnostic Aphasia Examination, with interpretation and report - per
hour

96110 - Developmental Testing: limited - e.g., Developmental Screening Test II, Early
Language Milestone Screen, with interpretation and report - per hour

96111 - Developmental Testing: extended - includes assessment of motor, language, social,
adaptive and/or cognitive functioning by standardized developmental instruments, e.g.,
Bayley Scales of Infant Development, with interpretation and report - per hour

96116 - Neurobehavioral Status Exam - Clinical assessment of thinking, reasoning and
judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language
functions, planning, with interpretation and report - per hour

96118 - Neuropsychological Testing Battery - e.g., Halstead-Reitan, Luria, WAIS-R, with
interpretation and report - per hour
When billing or reporting these procedure codes, follow these rounding rules for converting actual time to the specified number of units:

Less than 30 minutes equals 0 units;
30 minutes through 89 minutes of service equals 1 unit;
90 minutes through 149 minutes of service equals 2 units;
150 minutes through 209 minutes of service equals 3 units; and
210 minutes through 269 minutes of service equals 4 units; etc.

Limits: None.

Individual psychotherapy means face-to-face interventions with an individual client. Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the client and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development so that the client may be restored to his/her best possible functional level.

Individual psychotherapy includes insight oriented, behavior modifying and/or supportive psychotherapy, and interactive psychotherapy.

Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.

Interactive psychotherapy is typically furnished to children. It involves the use of physical aids or devices, play equipment, language interpreter, or other mechanisms of non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a client who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.

Individual Psychotherapy with Medical Evaluation and Management Services

Some clients receive psychotherapy only and others receive psychotherapy and medical evaluation and management services from a prescriber identified below. These evaluation and management services involve a variety of responsibilities unique to the medical management of psychiatric patients, such as medical diagnostic evaluation (e.g., evaluation of comorbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations.

Individual psychotherapy/interactive psychotherapy or individual psychotherapy/interactive psychotherapy with medical evaluation and management services may also be provided in a tele-health
setting to rural clients where distance and travel time create difficulty with access. See ‘Limits’ section below.

**Who:**

A. **Individual Psychotherapy/Interactive Psychotherapy**

   In accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or an individual exempted from licensure.

B. **Individual Psychotherapy/Interactive Psychotherapy with Medical Evaluation and Management Services**

   1. licensed physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;
   2. licensed APRN with psychiatric mental health nursing specialty certification;
   3. licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification;
   4. licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification; or
   5. APRN student specializing in psychiatric mental health nursing enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph A.3.a.

**Record:** Documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. treatment goal(s);
6. clinical note that documents:
   a. the psychotherapeutic approach used to produce therapeutic change as described in the service definition above (i.e., insight oriented, behavior modifying and/or supportive psychotherapy for the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination to provide therapeutic change);
b. the focus of the psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, and encouragement of personality growth and development);

c. the client’s progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers;

7. for individual psychotherapy with medical evaluation and management services, if applicable, a medication order or copy of the prescription signed by the prescribing practitioner; and

8. signature and licensure or credentials of individual who rendered the service.

Unit: Individual Psychotherapy - Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility

90804 - approximately 20 to 30 minutes
90806 - approximately 45 to 50 minutes
90808 - approximately 75 to 80 minutes

Individual Psychotherapy – Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility with medical evaluation and management services

90805 – approximately 20 to 30 minutes
90807 – approximately 45 to 50 minutes
90809 – approximately 75 to 80 minutes

Interactive Individual Psychotherapy - using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility

90810 - approximately 20 to 30 minutes
90812 - approximately 45 to 50 minutes
90814 - approximately 75 to 80 minutes

Interactive Individual Psychotherapy - using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility with medical evaluation and management services

90811 - approximately 20 to 30 minutes
90813 - approximately 45 to 50 minutes
90815 - approximately 75 to 80 minutes

When billing or reporting these procedure codes, follow these rounding rules for converting actual time to the specified service provided:

Less than 10 minutes, equal 0 units;
10-37 minutes, use the applicable procedure code with a 20-30 minute time frame;

38-62 minutes, use the applicable procedure code with a 45-50 minute time frame; and

63 or more minutes, use the applicable procedure code with a 75-80 minute time frame.

Note: In accordance with Chapter 1-12, if for example, two separate individual psychotherapy sessions are provided in a day and each independently meets the time specifications for billing the services, both services may be billed.

If both services independently meet the time specifications for the same CPT code (e.g., two services are provided and each service meets specifications for 90804), the two services may be billed, either on separate lines of the same claim with one unit per line, or on one line of the claim with two units representing the two services.

However, if each service independently meets time specifications for different CPT codes (e.g., one service meets the time specifications for 90804 and the other service meets the time specifications for 90806), each service must be billed separately.

**Limits:**

1. The periodic reevaluation of the client’s treatment plan may be billed under individual psychotherapy/interactive psychotherapy or individual psychotherapy/interactive psychotherapy with medical evaluation and management services only if the reevaluation is conducted during a face-to-face session with the client.

2. Individual psychotherapy, interactive psychotherapy or individual psychotherapy/interactive psychotherapy with medical evaluation and management services provided in a tele-health setting are limited to clients residing in rural areas of Utah.

3. When individual psychotherapy, interactive psychotherapy or individual psychotherapy/interactive psychotherapy with medical evaluation and management services is provided in a tele-health setting, only this subcontracted service may be billed. The time spent by a mental health center case manager or other mental health professional to assist the client during the service provided in the tele-health setting may not also be billed.

**Family psychotherapy**

Family psychotherapy with patient present means, in accordance with the definition of psychotherapy in Chapter 2-5 and as specified below, face-to-face interventions with family members and the identified client with the goal of treating the client’s condition and improving the interaction between the client and family members so that the client may be restored to their best possible functional level.

Family psychotherapy without patient present means, in accordance with the definition of psychotherapy in Chapter 2-5 and as specified below, face-to-face interventions with family member(s) without the identified client present with the goal of treating the client’s condition and improving the interaction between the client and family member(s) so that the client may be restored to their best possible functional level.

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the client and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.
Who: In accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure.

Record: Documentation must include:
1. date and actual time of the service (time may be rounded to the nearest five minute interval);
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. treatment goal(s);
6. clinical note that documents;
   a. the psychotherapeutic approach used to produce therapeutic change as described in the service definition above (i.e., insight oriented, behavior modifying and/or supportive psychotherapy for the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination to provide therapeutic change);
   b. the focus of the family psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, and encouragement of personality growth and development);
   c. the client's progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
7. signature and licensure or credentials of individual who rendered the service.

Unit: 90847 - Family Psychotherapy - with patient present - per 15 minutes
90846 - Family Psychotherapy - without patient present - per 15 minutes

When billing or reporting these procedure codes, follow these rounding rules for converting actual time to the specified number of units:

Less than 8 minutes equals 0 units;
8 minutes through 22 minutes of service equals 1 unit;
23 minutes through 37 minutes of service equals 2 units;
38 minutes through 52 minutes of service equals 3 units;
53 minutes through 57 minutes of service equals 4 units;
68 minutes through 82 minutes of service equals 5 units;
83 minutes through 97 minutes of service equals 6 units;
98 minutes through 112 minutes of service equals 7 units; and
113 minutes through 127 minutes of service equals 8 units, etc.

Limits: The periodic reevaluation of the client’s treatment plan may be billed under family psychotherapy only if the reevaluation is conducted during a face-to-face session.

2-3 Group Psychotherapy

Group psychotherapy means, in accordance with the definition of psychotherapy in Chapter 2-5 and as specified below, face-to-face interventions with two or more clients in a group setting so that the clients may be restored to their best possible functional level. Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the client and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or changes maladaptive patterns of behavior, and encourage personality growth and development.

Like individual psychotherapy, group psychotherapy includes interactive group psychotherapy. It also includes multiple family group psychotherapy.

Services are based on measurable treatment goals identified in each client’s individual treatment plan.

Who: In accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or an individual exempted from licensure.

Record: Documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. treatment goal(s);
6. per session clinical note that documents:
   a. the psychotherapeutic approach used to produce therapeutic change as described in the service definition above (i.e., insight oriented, behavior modifying and/or supportive psychotherapy for the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination to provide therapeutic change);
   b. the focus of the group psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, and encouragement of personality growth and development);
c. the client’s progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

7. signature and licensure or credentials of individual who rendered the service.

Unit:

90853 - Group Psychotherapy - per 15 minutes per Medicaid client
90857 - Interactive Group Psychotherapy - per 15 minutes per Medicaid client
90849 - Multiple-Family Group Psychotherapy - per 15 minutes per Medicaid client

When billing or reporting these procedure codes, follow these rounding rules for converting actual time to the specified number of units:

Less than 8 minutes equals 0 units;
8 minutes through 22 minutes of service equals 1 unit;
23 minutes through 37 minutes of service equals 2 units;
38 minutes through 52 minutes of service equals 3 units;
53 minutes through 57 minutes of service equals 4 units;
68 minutes through 82 minutes of service equals 5 units;
83 minutes through 97 minutes of service equals 6 units;
98 minutes through 112 minutes of service equals 7 units; and
113 minutes through 127 minutes of service equals 8 units, etc.

Limits:

1. Effective July 1, 2010, psychotherapy groups (90853 and 90857) are limited to twelve clients in attendance unless a co-leader is present; then psychotherapy groups may not exceed 16 clients in attendance.

2. Multiple family psychotherapy groups (90849) are limited to ten families in attendance.

3. Co-leaders must meet the provider qualifications outlined in the ‘Who’ section above.

Pharmacologic management means, when provided by a qualified prescriber identified in the ‘Who’ section below, a face-to-face service that includes prescription, use and review of the client’s medication(s) and medication regimen, and providing appropriate information regarding the medication(s) and medication regimen, and administering as appropriate, and with no more than minimal medical psychotherapy. If more than minimal medical psychotherapy is provided, see Chapter 2-5, individual psychotherapy/interactive psychotherapy with medical evaluation and management services. The review of the client’s medication(s) and medication regimen includes dosage, effect the medication(s) is having on the client’s symptoms, and side effects. The provision of appropriate information should address directions for proper and safe usage. The service also may include assessing and monitoring the client’s other health issues that are either directly related to the behavioral health disorder or to its treatment (e.g., diabetes, cardiac and/or blood pressure issues, weight gain, etc.).
When provided by a qualified nurse identified in the 'Who' section below, pharmacologic management means a face-to-face service that includes review/monitoring of the client's medication(s) and medication regimen, and providing appropriate information regarding the medication(s) and medication regimen, and administering as appropriate. The review of the client’s medication(s) and medication regimen includes dosage, effect the medication(s) is having on the client’s symptoms, and side effects. The provision of appropriate information should address directions for proper and safe usage. The service also may include assessing and monitoring the client’s other health issues that are either directly related to the behavioral health disorder or to its treatment (e.g., diabetes, cardiac and/or blood pressure issues, weight gain, etc.).

Pharmacologic management services may also be provided in a tele-health setting to rural clients where distance and travel time create difficulty with access. See 'Limits' section below.

**Who:**

Qualified Prescribers

1. licensed physician and surgeon or osteopathic physician regardless of specialty;
2. licensed APRN regardless of specialty;
3. licensed APRN intern regardless of specialty under the supervision of a licensed APRN regardless of specialty or licensed physician and surgeon or osteopathic physician regardless of specialty;
4. APRN student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter I-5, paragraph A.3.a; or
5. other medical practitioner licensed under state law who can perform the activities defined above when acting within the scope of his/her license (e.g., licensed physician assistants when practicing within their scope of practice and under the delegation of services agreement required by their practice act).

Qualified Nurses

1. licensed registered nurse; or registered nursing student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter I-5, paragraph B.3; or
2. licensed practical nurse under the supervision of a licensed physician and surgeon or osteopathic physician, a licensed APRN, a licensed physician assistant or a licensed registered nurse.

**Record:** Documentation must include

1. as appropriate, medication order or copy of the prescription signed by the prescribing practitioner;
2. date and actual time of service (time may be rounded to the nearest five minute interval);
3. duration of the service;
4. setting in which the service was rendered;
5. specific service rendered;
6. treatment goal(s);
7. note that documents:
   a. the condition for which medication is needed (required for prescribers only);
   b. medication(s) prescribed or used;
   c. dosage;
   d. results of the review;
   e. summary of the information provided;
   f. if medications are administered, documentation of the medication(s) and method of administration;
   g. if applicable, a summary of the assessment and monitoring of other health issues;
   h. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
8. signature and licensure or credentials of individual who rendered the service.

Unit: 90862 - Pharmacologic Management by prescriber - per encounter
90862 with TD modifier - Pharmacologic Management by nurse - per encounter

When billing or reporting this procedure code/modifier, bill or report 1 unit regardless of the length of the service. Service is based on an encounter.

Note: In accordance with Chapter 1-12, if the same pharmacologic management service is provided more than once in a day, the services may be billed on separate lines of a claim with one unit per line, or on one line of the claim with the total number of units corresponding to the number of services provided (e.g., if two pharmacologic management by prescriber services are provided, each service would be billed on the same claim on separate lines with one unit per line, or on the same line with two units).

Limits:
1. Pharmacologic management services provided in a tele-health setting are limited to clients residing in rural areas of Utah and to services of a qualified prescriber.
2. When pharmacologic management is provided in a tele-health setting, only this subcontracted service may be billed. The time spent by a mental health center case manager or other mental health professional to assist the client during the service provided in the tele-health setting may not also be billed.
3. Distributing medications (i.e., handling, setting out or handing medications to clients) is not a covered service and may not be billed to Medicaid.
4. Solely administering medications (i.e., giving an injection only) is not a covered service and may not be billed to Medicaid.
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# SECTION 2  
## HOME HEALTH AGENCIES

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**ATTACHMENTS:**  
- Home Health Agency: Medicaid Surety Bond  
- Private Duty Nursing Acuity Grid – October 2009  
- Skilled Nursing Needs Form – January 2010
1 GENERAL POLICY

Home Health services are a benefit of the Utah Medicaid Program as described in this Section. Home health services are medically necessary, part-time, intermittent health care services provided to eligible persons in their place of residence when the home is the most appropriate and cost effective setting consistent with the client’s medical need, and when the medical need can be safely met in the home through one of two nursing skill levels with support from family care givers.

Home Health Agencies requesting services should encourage and identify how much help is available from the family to supplement the agency assistance. There is no age limitation for home health care. Support and assistance from family members is essential in order to maintain home health service for some clients at a level that is realistically appropriate and cost effective. Family members who have physical and/or medical limitations which could affect their ability to participate in supplementing agency services can provide a statement from their primary care physician identifying the limitations. The medical statement(s) will be considered in the evaluation of care needs.

Home health services must be based on a physician’s order and a plan of care. The home health care provided must require the skills of technical or professional personnel such as a registered nurse (R.N.), licensed practical nurse (L.P.N.), trained home health aide, physical therapist, or speech pathologist. Service is limited to one visit per day.

The goals of home health care are to minimize the effects of disability or pain; promote, maintain or protect health; and prevent premature or inappropriate institutionalization while allowing the patient to live at home in personal dignity and independence. The home health agency should effectively coordinate all patient care services to meet the medical, nursing and related health needs of the patient in the home. When a skilled home health nurse is authorized to provide a service, such as the recertification visit or caring for a wound vac, other medically necessary services must be provided at the same time, including, but not limited to providing caregiver training, completing the nursing assessment to access for condition changes, medication box fill, and changing an IV dressing. Additional visits will not be authorized for services which could be provided during other visits.

Two levels of nursing care are provided through home health with support from family care givers:

First, a highly skilled level of care where the severity of illness and intensity of service are such that the attendance of a family or professional care giver is necessary on a consistent basis; specialized equipment is required to support activities of daily living; and the ability to function outside of the home is severely limited by medical needs, treatment, supportive equipment and the need for physical assistance.

Second, a supportive maintenance level of care where the patient demonstrates permanent limitations or significant disability due to illness or injury, requiring minimal assistance, use of specialized equipment, assistance with activities of daily living, observation, teaching and follow-up. Care needs are relatively stable, supportive in nature, and long term. The client is capable of leaving home to attend school, sheltered workshops, work, or receive necessary medical care after assistance from the care giver to get out of bed, bathe, dress and get into a wheelchair or other conveyance. Assistance may be needed to reverse the process at night. Specialized transportation is required for the patient to travel outside of the home — handicap bus or van, or taxi. If the patient drives himself or demonstrates the ability to move about independently, the medical need and home health service should be in question. The typical client requiring this level of service is generally the paraplegic or quadriplegic individual. However, this level of care can also apply to clients with medical needs.
related to degenerative neurological diseases; newly diagnosed diabetics; acute, high risk diabetic complications; and those with multi-system problems requiring a skilled service or acute monitoring.

All home health service must be supervised by a registered nurse employed by an approved, certified home health agency. Nursing service and all approved therapy services must be provided by the appropriate licensed professional.

Legal References: Sections 1102, 1842, 1861, 1862, 1870 and 1871 of the Social Security Act; 42 Code of Federal Regulations, Part 484 and 440.70.

1 - 1 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a Managed Care Plan, or Prepaid Mental Health Plan (PMHP), must receive all health care services, including medical supplies, through that plan. Refer to SECTION 1, Chapter 5, Verifying Eligibility, for information about how to verify a client’s enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1, Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of Managed Care Plans and PMHPs, with which Medicaid has a contract to provide health care services, is included as an attachment to the provider manual. Please note that Medicaid staff makes every effort to provide complete and accurate information on all inquiries as to a client’s enrollment in a managed care plan. Because eligibility information as to what plan the patient must use is available to providers, a “fee for service” claim will not be paid even when information is given in error by Medicaid staff.

1 - 2 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Billing

Home health services may be billed electronically or on paper using the UB-04 or CMS-1500 (08/05) claim format. Use the procedure codes listed in Chapter 6. Billing methods are covered in SECTION 1 of this manual, Chapter 11 - 9. Medicaid encourages electronic billing. Mistakes can be corrected immediately, and your claim is processed without delays. Electronic claims may be submitted until 5:00 PM on Thursday for processing that week.
A break in service coverage of four days or more must be discussed with the Medicaid Prior Authorization Unit Staff. When a break in service occurs, the provider must provide the necessary information so that an adjustment can be made to the authorization of service. When the client returns to Home Health Service, the provider must again contact the Medicaid reviewer to reopen the service.

4 - 6 Rural Area Home Health Travel Enhancement

Effective May 1, 2001, Medicaid will provide enhancements to the home health reimbursement rate when travel distances to provide service are extensive. The enhancement is available only in rural counties where round-trip travel distances from the care giver's base of operations are in excess of 50 miles. The client and the care giver must reside in the same or an adjacent rural county. Rural counties are defined as counties other than Weber, Davis, Salt Lake, and Utah counties. For the enhanced rate for round trip travel of 50 miles or more, see Utah State Plan, attachment 4.19-B, Home Health Services.

Effective October 1, 2003, To receive the rural home health travel enhancement, home health agencies must file the claim using the applicable, approved service code listed in Chapter 6 with a modifier “TN”. For example, code T1030 with a modifier “TN”. For dates of service prior to October 1, 2003, a “22” modifier must be used with the applicable, approved service code.

Y0458 was used to provide the differential for San Juan. HIPAA requirements require closure of code Y0458. Beginning October 1, 2003, providers authorized for the San Juan differential must place the TN modifier on each line of the claim along with the appropriate home health care service code. Beginning April 1, 2004, an enhancement factor is applied to home health services rendered for residents living in San Juan or Grand County. This enhancement is irrespective of the distances traveled and is in lieu of the rural area exceptions provided for other rural counties. A “TN” modifier should not be used to report services for San Juan or Grand County.

4 - 7 Telehealth Skilled Nurse Pilot Project for Patients in Rural; Areas

Medicaid implemented a telehealth home care project effective January 1, 2000. The project is an additional, complimentary method to provide patient medical monitoring and education and to increase medical care compliance of home health care patients in rural areas. The project allows delivery of a percentage of home health care visits through Telehealth to patients who meet selection criteria. Criteria are: Patient lives in identified rural areas; meets diabetes eligibility requirements; is home bound and requires two or more home care nursing visits per week; and agrees to participate in Telehealth home care services. Refer to Selection Criteria below for details.

After one year, a cost benefit analysis will be completed to determine whether the project should continue. Any change to the program will be announced in a Medicaid Information Bulletin.

Definition of Telehealth

Telehealth or Telemedicine is a technological method of providing auditory and visual connection between the skilled home health care nurse at a Telehealth site and the patient living in a rural Utah area.

Authorized providers
All interested home health care agencies serving rural areas may participate in the pilot project. Home health care visits are authorized through utilization management, typically 10-12 visits are authorized. A percentage (20-30%) of skilled nurse home health care visits may be authorized for provision through Telehealth.

Selection Criteria

*Diabetes patient* eligible for participation in Telehealth must be able to **physically use** Telemedicine equipment including: ability to follow directions, push two colored buttons, hear and see, apply the blood pressure cuff or stethoscope appropriately, and **want to participate** in the Telehealth project. When the patient is unable to use Telemedicine equipment, the patient may be included in the pilot project if there is a full time care giver consistently available who wishes to assist the patient with Telehealth.

Diabetes patient condition indicates to prior authorization staff that hands on assessment is probably not required, and/or the home health care nurse determines that the patient does not meet severity of illness or have complicating conditions which might limit patient inclusion in the study. The appropriateness of delivering adequate education and/or monitoring will depend on the equipment available. The **skilled nurse must determine if patient care needs and quality of care delivery** will be met through the use of the Telehealth mode of delivery.

Covered Services

After Utilization Management preauthorization, the following services are covered for Telehealth home care patients:

- monitoring for compliance in taking medications, foot condition/assessment of wounds or inflamed areas, blood glucose monitoring
- education which may include a review in knowledge of the disease process, diet or nutritional counseling,
- exercise and activity, diet/activity adjustment in illness/stress, medication, and glucometer use evaluation.

Home health care has a four-hour limit for all education purposes, which may include some diabetes training.

2 **Limitations**

- Centers for Medicaid and Medicare Service (CMS) rules for Medicaid/Medicare do not allow reimbursement for Telemedicine equipment or Telemedicine transmission costs.
- The State would not anticipate a bill nor approve payment for a patient initiated anxiety call to the home health agency. Spot checks related to patient anxiety calls are not considered a home health care visit by Utah Medicaid.
- Medicaid eligibility for home health care is limited to home bound patients. Home bound status must be documented by the home health agency. Telehealth home care visits are limited to patients living in rural areas of Utah. Patients residing on the Wasatch Front are not eligible for inclusion in the study. Wasatch front patients have access to home health care through their managed care plan provider.
- The State would not expect Telehealth home care to become the exclusive means of delivering home health care; it is viewed as an enhancement to traditional home health care for rural or remote areas of Utah.
- RN visits are covered for Telehealth home care reimbursement.
The home health agency will provide home health agency staff with extensive training and practice in how to use Telehealth technology. The Telehealth participating patients will receive an explanation of the purpose of Telehealth home care, adequate training in the use of Telehealth equipment and will sign a consent to participate in Telehealth. Medicaid will not reimburse for home health agency staff or patient training in Telehealth equipment use.

- The home health care nurse and the participating home health agency will address staff and patient concerns about privacy and confidentiality.
- The state requires the patient have a desire to participate in the home health care project. The home health agency must not discriminate against patients who do not wish to participate in Telehealth home care.

Billing and Payment

Bill on a CMS-1500 (08/05) claim form. No payments will be made for Telehealth transmission expense or facility charge. Reimbursement for Telehealth home care visits will be discounted from the charge for the home health visit delivered by traditional methods.

Codes

The following code changes are required due to HIPAA requirements:

- **T1002** 15 minutes or one unit of Telehealth home care RN time, limit 2 units per date of service
- **S9470** 30 minutes of Telehealth home care dietary counseling provided by a registered dietician. The modifiers GT and TG must be submitted with the code S9470 for this service.

Modifiers

**Covered**

GT - Each skilled nurse Telehealth home care visit must indicate the service was provided through Telehealth by adding the GT modifier. This modifier is required to monitor and evaluate the financial impact of this project.

**Non-Covered**

GQ – telehealth data via asynchoronous telecommunications systems is the code used for transmission of telehealth data such as radiology or electrocardiogram. This is not a covered service for the Medicaid Telehealth home health care project.

4 – 8 Private Duty Nursing

Private duty nursing is an optional program which is covered within the Home Health Program. Private duty nursing service may be indicated to prevent prolonged institutionalization in children under 21 who are medically needy and categorically eligible for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Child Health Evaluation and Care (CHEC) program.

Eligibility and Access requirements

1. The patient must meet EPSDT eligibility requirements for being under age 21, categorically needy and medically needy.
2. The patient must require more than four continuous skilled nursing hours of care per day.
3. The patient must have a written physician order establishing the need for private duty nursing service.
VERMONT

Vermont’s state Medicaid program does reimburse for telemedicine services for the following providers and sites: community mental health clinics, designated agencies, federally qualified health centers, rural health clinics, physicians, and naturopathic physicians. Providers are reimbursed using the standard Medicaid reimbursement methodology. Patient sites are reimbursed a facility fee which is 80% of the standard Medicare fee.

In the area of tele-home care and remote monitoring services, Vermont does not reimburse for telehealth.
METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

25. Telemedicine

Telemedicine is defined as the practice of health care delivery by a provider who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, consultation, or treatment that requires the use of advanced telecommunications technology. Telephone conversations, chart reviews, electronic mail messages, and facsimile transmissions are not considered telemedicine.

The distant site provider uses telemedicine to provide a service to the patient at the patient site.

The applicable provider types are as follows:
1. Community Mental Health Clinics
2. Designated Agencies
3. Federally Qualified Health Centers
4. Rural Health Clinics
5. Physicians
6. Naturopathic Physicians

Qualifying distant site providers are reimbursed in accordance with the standard Medicaid reimbursement methodology.

Qualifying patient sites are reimbursed a facility fee. The fee is set at 80% of Medicare and is effective for services on or after 7/01/10; all rates are published at http://ovha.vermont.gov/providers. Payment is made at the lower of the actual charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.
VIRGINIA

Virginia’s state Medicaid program does reimburse for telehealth services provided by a broad range of practitioners including physicians, nurse practitioners, nurse midwives, clinical nurse specialists, clinical psychologists, and licensed professional counselors. The most recent addition to the list of covered services tele-ophthalmology care as of December 2010.

In the area of tele-home care and remote monitoring services, Virginia does not reimburse for home telehealth services.
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CHAPTER IV

COVERED SERVICES AND LIMITATIONS
Providers MUST put the Clinical Laboratory Improvement Amendment (CLIA) number of the physician office laboratory (POL) performing the service in Block 19 (Reserved for Local Use) of the CMS-1500 (08-05) claim form, as mandated by the Health Care Financing Administration.

Should the situation arise when multiple physician office laboratories are used for services for the same recipient, file a separate claim form listing the services that each laboratory performed and their applicable CLIA certificate number.

For example, if Physician Office Laboratory A performs CPT code 88150, and Physician Office Laboratory B performs CPT code 81000, and medical services are also performed on the same recipient, submit a separate claim for CPT 88150 since the CLIA number will be different than for the physician office laboratory performing CPT 81000. The medical services can be billed on either claim since the CLIA number is not applicable for medical services.

A claim will be denied if one or all of the following conditions exist:

- There is no CLIA number on the claim, and the billing is for a laboratory service.
- The CLIA number that is on the claim is invalid.
- The CLIA number is valid, but the provider is billing Medicaid for a service that is outside of the scope of the laboratory’s CLIA certificate (e.g., the lab holds a Certificate of Waiver, and the provider is billing for a Physician Performed Microscopy Procedure).
- The services that are being billed were rendered outside of the effective dates of the CLIA certificate.

Providers who currently submit claims electronically should contact their service centers to have their software updated. The CLIA number must be put in the FA0 Record, Claim Service Line Record, in field number 34.0 (CLIA ID NO).

- Medicaid requires that the services, as defined in the CPT Manual, be billed using the appropriate panel code and not the code for the individual components. For codes 80046-80076, if all of the components are completed, the provider must bill using the panel code that best defines the panel.
- Whenever four or more components of a hemogram are performed, the appropriate hemogram CPT/HCPCS code must be used (85025-85027). The appropriate CPT/HCPCS codes are to be used when specimens are tested using automated or manual equipment.
- If fewer than four components of a hemogram are performed, bill for them using the appropriate individual CPT/HCPCS codes.

**Telemedicine Services:**
DMAS reimburses for telemedicine services under limited circumstances. Telemedicine is the real-time or near-real-time exchange of information for diagnosing and treating medical conditions. Telemedicine utilizes audio/video connections linking medical practitioners in one locality with medical practitioners in another locality. DMAS recognizes telemedicine as a means for delivering some covered Medicaid services. Physicians, nurse practitioners, nurse midwives, clinical nurse specialists, clinical psychologists, clinical social workers, and licensed professional counselors enrolled with DMAS may participate for selected services. Federal and state laws and regulations apply which prohibit any of these providers from participating in telemedicine. The telemedicine services described here are for Medicaid recipients with fee-for-service or Medallion coverage.

The telemedicine equipment and transmission speed must be technically sufficient to support the service billed to DMAS. Staff involved in the telemedicine encounter need to be trained in the used of the telemedicine equipment and competent in the operation of it. Patient records at the hub and spoke sites are to document the telemedicine encounter consistent with the service documentation described in Chapter II of the DMAS provider manuals. The documentation is to specifically reference telemedicine as the means for conducting the medical service. Other coverage described in this provider manual is applicable including the information on claims processing.

Some medical professional associations have protocols for conducting telemedicine. Practitioners billing DMAS for telemedicine are encouraged to follow those protocols so long as they are consistent with DMAS coverage. All telemedicine activities are to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended and all other applicable state and federal laws and regulations.

Providers enrolled with DMAS and intending to bill telemedicine services must first notify DMAS. This is a one-time activity and needs to occur at least 10 days in advance of the telemedicine service date. The following information is to be provided:

- Specific services to be billed,
- Provider names and Medicaid provider numbers, including any information about multiple practitioner settings,
- Specific geographic locations where telemedicine will be conducted,
- General description of telemedicine equipment and transmission,
- The name and title of the principal point of contact with email and telephone number, and
- Any other information to enhance the understanding of the telemedicine services to be billed.

For telemedicine billing codes, refer to Chapter V of the Physician Manual. This information and any questions that you may have can be emailed to DMAS at: Vatelmed@dmas.state.va.us.

Non-Covered Services

The following laboratory and radiology services are specifically EXCLUDED from coverage and payment:
Tests performed on a routine basis but not medically indicated by the patient's symptoms.

Laboratory test professional component (CPT/HCPCS procedure modifier "26") for procedures performed in the physician's office, outpatient hospital, or in the independent laboratory. Payment for supervision and interpretation is included in the full procedure payment.

Sensitivity studies when a culture shows no growth or urine cultures with contaminant growth (10^3 or less). Payment will only be made for the culture.

Radiology procedure professional component (CPT/HCPCS procedure modifier “26”) is used only when billing for interpretation and reporting of x-ray. The technical component (HCPCS/CPT procedure modifier “TC”) is used when billing for the use of the radiology equipment.

Procedures Covered for a Pathologist or Laboratory Outside the Physician's Office

Payment for the following tests will be made only to a pathologist, a hospital laboratory, or a participating laboratory. Specimens for the tests listed below may also be sent to the State Laboratory:

- **86171** Complement fixation tests, each antigen
- **87116** Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); any source, isolation only
- **87118** Culture, mycobacteria; definitive identification of each organism
- **87250** Virus identification; inoculation of embryonated eggs or small animal, includes observation and dissection

**Pap Smears**

Screening Pap smears shall be covered annually for females consistent with the guidelines published by the American Cancer Society. Medicaid guidelines do not allow preventive care visits for anyone age 21 or over. The use of any preventive evaluation and management (E&M) CPT code for this age group will be denied as a non-covered service.

Therefore, if you want to submit a claim for a visit and the reason for the visit was to receive a yearly pap smear you may use the following guidelines for billing Medicaid.

- Use the E&M code that will reflect the level of care given during the visit plus the administration of the pap smear.
- Documentation to support the level of care provided must appear in the patient’s medical records.
- Use either a preventive ICD-9 diagnosis code or a diagnosis code for any presenting problem found in the process of examination.
- Additional guidelines may be found in the current CPT manual “Evaluation and Management (E/M) Services Guidelines.”

**Screening Mammography**
WASHINGTON

Washington’s state Medicaid program does reimburse for the following services when provided through telemedicine: consultations in office or other outpatient visits, psychiatric intake and assessment, individual psychotherapy, and pharmacologic management.

In the area of tele-home care and remote monitoring services, the Medicaid program for the state of Washington does reimburse for tele-home care. The Department pays for one telemedicine interaction per eligible client per day based on the ordering licensed practitioner’s home health plan of care. Home health monitoring is not covered as tele-health. The Department does not pay for the purchase, rental, repair, or maintenance of telemedicine equipment and associated costs of operation of telemedicine equipment.
About This Publication

This publication supersedes all previous Department Physician-Related Services Billing Instructions published by the Medicaid Purchasing Administration, Washington State Department of Social and Health Services.

**Note:** The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **10/01/2010**.

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How Can I Get Department/MPA Provider Documents?

To download and print Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at [http://hrsa.dshs.wa.gov](http://hrsa.dshs.wa.gov) (click the *Billing Instructions and Numbered Memorandum* link).
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When billing, primary physicians must put their NPI in field 33 of the CMS-1500 Claim Form. When billing, the consulting physician, other than the primary physician, must put the following on the CMS-1500 Claim Form:

- The primary physician name or clinic name and NPI the referring provider field of the HIPAA transaction (field 17 and 17a of the CMS-1500); and
- The consulting physician’s performing NPI (PIN#) in the servicing provider field of the HIPAA transaction (field 24k of the CMS-1500) and group NPI (GRP#) in the pay-to provider number field of the HIPAA transaction (field 33 of the CMS-1500).

If not related to hospice care, when billing electronically, enter “Not related to hospice care” in the claim notes field of the HIPAA transaction.

Domiciliary, Rest Home, or Custodial Care Services

CPT codes 99304-99318 are not appropriate E&M codes for use in place of service 13 (Assisted Living) or 14 (Group Home). Providers must use CPT codes 99324-99328 or 99334-99337 for E&M services provided to clients in these settings.

Home Evaluation and Management

The Department pays for Home Evaluation and Management (CPT codes 99341-99350) only when services are provided in place of service 12 (home).

Telehealth

What is telehealth?

Telehealth is when a health care practitioner uses interactive real-time audio and video telecommunications to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.

Using telehealth when it is medically necessary enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telehealth allows Department clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.
The following services are **not** covered as telehealth:

- Email, telephone, and facsimile transmissions;
- Installation or maintenance of any telecommunication devices or systems;
- Home health monitoring; or
- “Store and forward” telecommunication based services. (Store and forward is the asynchronous transmission of medical information to be reviewed at a later time by the physician or practitioner at the distant site).

**Who is eligible for telehealth?**

Fee-for-service clients are eligible for medically necessary covered health care services delivered via telehealth. The referring provider is responsible for determining and documenting that telehealth is medically necessary. As a condition of payment, the client must be present and participating in the telehealth visit.

The Department will not pay separately for telehealth services for clients enrolled in a managed care plan. Clients enrolled in a Department managed care plan are identified as such in ProviderOne. Managed care enrollees must have all services arranged and provided by their primary care providers (PCP). Contact the managed care plan regarding whether or not the plan will authorize telehealth coverage. It is not mandatory that the plan pay for telehealth.

**When does the Department cover telehealth?**

The Department covers telehealth through the fee-for-service program when it is used to substitute for a face-to-face, “hands on” encounter for only those services specifically listed in this section.

**Originating Site (Location of Client)**

**What is an “originating site”?**

An originating site is the physical location of the eligible Department client at the time the professional service is provided by a physician or practitioner through telehealth. Approved originating sites are:

- The office of a physician or practitioner;
- A hospital;
- A critical access hospital;
- A rural health clinic (RHC); and
- A federally qualified health center (FQHC).
Is the originating site paid for telehealth?

Yes. The originating site is paid a facility fee per completed transmission.

How does the originating site bill the Department for the facility fee?

- **Hospital Outpatient**: When the originating site is a hospital outpatient department, payment for the originating site facility fee will be paid according to the maximum allowable fee schedule. To receive payment for the facility fee, outpatient hospital providers must bill revenue code 0789 on the same line as HCPCS code Q3014.

- **Hospital Inpatient**: When the originating site is an inpatient hospital, there is no payment to the originating site for the facility fee.

- **Critical Access Hospitals**: When the originating site is a critical access hospital outpatient department, payment is separate from the cost-based payment methodology. To receive payment for the facility fee, critical access hospitals must bill revenue code 0789 on the same line as HCPCS code Q3014.

- **FQHCs and RHCs**: When the originating site is an FQHC or RHC, bill for the facility fee using HCPCS code Q3014. This is not considered an FQHC or RHC service and is not paid as an encounter, and is not reconciled in the monthly gross adjustment process.

- **Physicians’ Offices**: When the originating site is a physician’s office, bill for the facility fee using HCPCS code Q3014.

If a provider from the originating site performs a separately identifiable service for the client on the same day as telehealth, documentation for both services must be clearly and separately identified in the client’s medical record.

**Distant Site (Location of Consultant)**

What is a “distant site”?

A distant site is the physical location of the physician or practitioner providing the professional service to an eligible Department client through telehealth.

Who is eligible to be paid for telehealth services at a distant site?

The Department pays the following provider types for telehealth services provided within their scope of practice to eligible Department clients:

- Physicians (including Psychiatrists); and
- Advanced Registered Nurse Practitioners (ARNPs).
What services are covered using telehealth?

Only the following services are covered using telehealth:

- Consultations (CPT codes 99241–99245 and 99251-99255);
- Office or other outpatient visits (CPT 99201-99215);
- Psychiatric intake and assessment (CPT code 90801);
- Individual psychotherapy (CPT codes 90804-90809); and
- Pharmacologic management (CPT codes 90862).

**Note**: Refer to other sections of these billing instructions for specific policies and limitation on these CPT codes.

How does the distant site bill the Department for the services delivered through telehealth?

The payment amount for the professional service provided through telehealth by the provider at the distant site is equal to the current fee schedule amount for the service provided.

Use the appropriate CPT codes **with modifier GT** (via interactive audio and video telecommunications system) when submitting claims to the Department for payment.
Health and Recovery Services Administration (HRSA)

Home Health Services (Acute Care Services)
Billing Instructions
ProviderOne Readiness Edition

[WAC 388-551-2000 through 2220]
About This Publication

This publication supersedes all previous Department/HRSA *Home Health Services Billing Instructions* published by the Health and Recovery Services Administration, Washington State Department of Social and Health Services.

**Note:** The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: 05/09/2010.

2010 Revision History

This publication has been revised by:

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<th>Subject</th>
<th>Issue Date</th>
<th>Pages Affected</th>
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How Can I Get Department/HRSA Provider Documents?

To download and print Department/HRSA provider numbered memos and billing instructions, go to the Department/HRSA website at [http://hrsa.dshs.wa.gov](http://hrsa.dshs.wa.gov) (click the *Billing Instructions and Numbered Memorandum* link).

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**Telemedicine**

[Refer to WAC 388-551-2125]

**What Is Covered?**

**Effective for dates of service on and after January 1, 2010,** the Department will cover home health services delivered through telemedicine (see below):

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<th>Revenue Code</th>
<th>Maximum Allowable Fee</th>
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<tr>
<td>0559</td>
<td>$77.00</td>
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**Who Is Eligible?**

The Department covers the delivery of home health services through telemedicine for clients who have been diagnosed with an unstable condition who may be at risk for hospitalization or a more costly level of care. The client must have a diagnosis(es) where there is a high risk of sudden change in medical condition which could compromise health outcomes.

**What Does the Department Pay for?**

The Department pays for one telemedicine interaction, per eligible client, per day based on the ordering licensed practitioner’s home health plan of care.

**Requirements for Payment**

To receive payment for the delivery of home health services through telemedicine, the services must involve:

- A documented assessment, identified problem, and evaluation which includes:
  - Assessment and monitoring of clinical data including, but not limited to, vital signs, pain levels and other biometric measures specified in the plan of care. Also includes assessment of response to previous changes in the plan of care; and
  - Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care; and

- Implementation of a documented management plan through one or more of the following:
  - Education regarding medication management as appropriate, based on the findings from the telemedicine encounter;
Education regarding other interventions as appropriate to both the patient and the caregiver;

Management and evaluation of the plan of care including changes in visit frequency or the addition of other skilled services;

Coordination of care with the ordering licensed provider regarding findings from the telemedicine encounter;

Coordination and referral to other medical providers as needed; and

Referral to the emergency room as needed.

What Does the Department Not Pay for?

The Department does not pay for the purchase, rental, repair, or maintenance of telemedicine equipment and associated costs of operation of telemedicine equipment.

Prior Authorization

The Department does not require prior authorization for the delivery of home health services through telemedicine.

What Is Not Covered? [Refer to WAC 388-551-2130]

The Department does not cover the following home health services under the Home Health program, unless otherwise specified:

1. Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in placed through the Department of Social and Health Services, Aging and Disabilities Services Administration (ADSA) or Division of Developmental Disabilities (DDD).

   The Department may consider requests for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for ADSA or DDD to implement a long-term care skilled nursing plan or specialized therapy plan; and
On a case-by-case basis, the Department may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until an ADSA or DDD long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in these billing instructions and other published WACs. Fax Department forms 13-847 and 13-756 with requests to: 1-360-586-1471.

**Home Health Agencies**

- The client must have a stable, chronic skilled nursing need.
- The client’s skilled nursing need cannot be met in the community (e.g., the client is unable to access outpatient services in the community);
- The home health provider must contact the Department and request coverage through the home health program;

**The Department will first** contact the client’s ADSA or DDD case manager to see if long-term care skilled nursing services are accessible in the community or through ADSA or DDD.

If there are no other options, the Department will send a notification letter to the client, Home Health agency, and case manager notifying them that the chronic, long-term care skilled nursing visits will be reimbursed through the Department for a limited time until a long-term care plan is in place.

**See LTC Skilled Nursing Needs flow chart on next page**
WEST VIRGINIA

West Virginia’s state Medicaid program does reimburse for telemedicine services. The state Medicaid manual specifies that Medicaid coverage of teleconsultations is limited to members in non-metropolitan statistical professional shortage areas as defined by CMS and also requires the referring provider to be located in a non-metropolitan area.

In the area of tele-home care and remote monitoring services, West Virginia does not reimburse for home health.
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**DISCLAIMER:** This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.
519.4.7 WV MEDICAID MUST PAY PROVIDER OF SERVICE

The provider of a service to WV Medicaid-eligible members must bill directly to the WV Medicaid Program for the service. If certain criteria are met, payment may be made to the employer of the provider. (e.g., Payment may be made to the employer of the practitioner if the practitioner is required, as a condition of employment, to turn over his fees to the employer or to the facility in which the service is provided if the practitioner has a contract under which the facility submits the claim.) Information regarding group enrollment may be obtained from the Provider Enrollment Unit.

519.5 SERVICE DESCRIPTIONS IN OTHER MANUALS

Various medical services that may complement or augment the Practitioner Services described in this chapter may be rendered to WV Medicaid members by enrolled WV Medicaid providers. The policies and procedures covering the provision of those services may be found in the appropriate Chapters as listed below:

- Chapter 504: Chiropractic Services
- Chapter 505: Dental Services
- Chapter 506: Durable Medical Equipment
- Chapter 508: Home Health
- Chapter 510: Hospital Services
- Chapter 512: Laboratory & Radiology
- Chapter 515: Occupational/Physical Therapy
- Chapter 518: Pharmacy Services
- Chapter 520: Podiatry Services
- Chapter 524: Transportation
- Chapter 525: Vision Services

Policies and procedures regarding Organ Transplant Services are found in Chapter 510 of the Hospital Services Manual.

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six month period. The member may receive consultations from different physicians within the same six month period, regardless of whether the physicians provide the same or different levels of service, unless the consultants are in the same group practice or partnership. WV Medicaid covers follow-up consultations (CPT 99261-99263) with no service limitation other than billing with other consultation codes or hospital/office visits.

Consultations are disallowed if and of the following criteria are met:

- They are provided in conjunction with other services furnished by the same physician on the same date to the same member, such as office visits, home visits, or hospital visits,
- They are provided by a surgeon immediately prior to the procedure and resulted in the initial decision to perform surgery with the use of modifier 57,
- When billed by a member of the same group and specialty as the physician performing the surgery.

Gathering of the member’s medical history and/or performance of a physical examination prior to a member’s admission for surgery is the responsibility of the admitting/operating surgeon under the global surgical package. This may not be billed as a consultation.

Pre-operative evaluations for anesthesia are not considered to be consultations and may not be billed as consultations. Payment for these evaluations is included in the fee for the administration of the anesthesia.

When the consultant assumes responsibility for the management of a portion or all of the member’s care subsequent to the consultation, then consultation codes are no longer appropriate. There is a difference between consultations and referrals. See Section 519.7.4 for information on referrals.

519.7.5.1 SECOND OPINIONS FOR ELECTIVE SURGERY

Second opinions (Confirmatory consultations) are covered for elective/non-emergency surgery. The second opinion concept is to be a member oriented service that allows an individual member to make better informed decisions about a physician’s recommendation on the need for surgery. However, a physician may also request a second opinion.

The consulting physician must document the type of surgery, the name of the member or physician requesting the second opinion, and must bill an appropriate confirmatory consultation procedure code.

519.7.5.2 TELEHEALTH SERVICES

A teleconsultation is an interactive member encounter that meets specific criteria. This service requires the use of “interactive telecommunications systems” defined as multimedia communication equipment that involves at least audio and video equipment that permits two-way consultation among the member, consultant and referring provider. Telephones, facsimile machines, and electronic mail systems do not qualify as interactive telecommunication systems. WV Medicaid covers teleconsultations subject to the following criteria:

- The consultation must involve real time consultation as appropriate for the member’s medical needs and as needed to provide information to and at the direction of the consulting physician.
- Medicaid coverage of teleconsultations is limited to members in non-metropolitan statistical professional shortage areas as defined by CMS. The referring provider must be located in the non-metropolitan area.
- The referring provider may bill for an office, outpatient, or inpatient E&M service that precedes the consultation and for other Medicaid-covered services the consultant orders, or for services unrelated to the medical problem for which the consultation was requested. However, the referring provider may not bill for a second visit for activities provided during the teleconsultation.
- The consultant must be in control of the member's medical examination, with the referring provider participating, as needed, to complete the examination. The member must be present in real time, and telecommunication technology must allow the consultant to conduct a medical examination of the member.
- The consultant's findings must be documented in a written report given to the referring physician.
- Payment for a teleconsultation does not include any separate reimbursement for telephone line charges or facility fees, and a member may not be billed any amount for these charges/fees.
- Separate payment is not made for the review and interpretation of medical records.
- Medicaid coverage is limited to professional consultations that meet the criteria specified for consultation service in the CPT Manual. Covered services include initial follow-up or confirming consultations in hospitals, outpatient facilities, or medical offices, that is: CPT 99241-99245, 99251-99255, 99261-99263, and 99271-99275. These are subject to the same service limits discussed in the consultation section of this chapter, Section 519.7.5.

Modifier GT must be used with the proper consultation code in order for a physician to bill for a teleconsultation.

**519.7.6 NURSING FACILITY VISITS**

WV Medicaid covers one nursing facility visit per 30 days when made by the member's primary care physician. The appropriate E&M code (CPT 99301-99313) must be used to bill for the visit. WV Medicaid does not reimburse a nursing facility visit if the same physician provides another E&M visit to the same member on the same date of service.

WV Medicaid does not cover daily, weekly, or routine nursing facility visits. Emergency treatment provided within the 30-day cycle will be considered for payment based on using the appropriate nursing facility procedure code with documentation of the emergency nature of the visit.

Specialists called by an attending physician must bill the code appropriate for their services, such as a procedure code for a consultation or minor surgery. The service must be provided based on a specific request of the primary care physician. **Standing orders are not acceptable.**

Nursing discharge orders, CPT 99315 – 99316, are not covered by WV Medicaid.

There is no coverage for nurse practitioner visits.

**519.7.7 CARE PLAN OVERSIGHT SERVICES**

Care plan oversight (CPO) consists of physician supervision of members under either home health or hospice care when the member requires complex or multidisciplinary care modalities with ongoing physician involvement. WV Medicaid provides payment for only one CPO service per calendar month, per member, per provider. CPT 99375 and 99378 are the only procedure codes that may be used to bill CPO services. CPO coverage is subject to the following rules:

- The member must be receiving medically necessary home health services or hospice care.
- The physician who bills for CPO services must be the same physician who signed the home health or hospice plan of care.
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Appendix 1: Eligibility Categories for MHC Enrollment
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DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.
CHAPTER 527 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MOUNTAIN HEALTH CHOICES

The following codes must be utilized for billing services:

For in-office dietician services:

97802  Medical nutrition therapy; initial assessment and intervention, individual, face to face with the member; each 15 minutes for a maximum of 4 units or 1 hour.
97803  Medical nutrition therapy; re-assessment and intervention, face to face with the member; each 15 minutes for a maximum of 12 units, or 3 hours.

For in-office exercise physiologists:

S9449  Weight management classes, non-physician provider, per session, for a maximum of 3 sessions for both adults and children.

For facility based fitness centers/certified trainer services:

S9451  Exercise classes, non-physician provider, per session for a maximum of 36 sessions. A session is considered to be 1 hour.

Telehealth Services

Because not all facilities have exercise physiologists and dieticians available on a daily basis, a single site model will not always present a feasible option. For example, rural clinics have fitness facilities and the medical and ancillary staff for oversight, but they lack a dietician or exercise physiologist. Rural clinics may partner with a single site provider to utilize their professional services in a coordinated effort to provide the services necessary. Scheduled appointments are then set up and video teleconferencing is used to deliver services to the member with at minimum a nurse present with the member during the consultation.

Q3014 originating site facility fee can be used with Modifier GT to be used for interactive audio and video telecommunications can be used. However, comparable services may be rendered through the use of telehealth technology and/or a hybrid of “hands-on” and telehealth services.

Refer to Chapter 519, Practitioner Services, for additional policy information

527.30.6  BARIATRIC SURGICAL PROCEDURES

The West Virginia Medicaid Program covers bariatric surgery procedures for those who have enrolled in the Enhanced Plan, who are in the appropriate eligibility categories for MHC, and subject to the following conditions.

527.30.6.1  MEDICAL NECESSITY REVIEW AND PRIOR AUTHORIZATION

The member’s primary care physician or the bariatric surgeon may initiate the medical necessity review and prior authorization by submitting a request to BMS’ s Utilization Management Contractor (UMC), along with all

Department of Health and Human Resources

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January 30, 2009

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.
Wisconsin's state Medicaid program reimburses for a wide range of health services provided via telemedicine as long as the provider is licensed in-state. The covered services include mental health and substance abuse treatment, care provided by physician assistants, nurse midwives, nurse practitioners, and services to patients in rural health clinics.

In the area of tele-home care and remote monitoring services, Wisconsin’s Family Care waiver program covers some telehealth services provided in the home.
Covered and Noncovered Services: Covered Services and Requirements

Telemedicine

Information for DOS (dates of service) before January 1, 2009, is available.

Telemedicine services (also known as "Telehealth") are services provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between a member (i.e., the originating site) and a Medicaid-certified provider at a remote location (i.e., distant site). The services must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face contact. Telemedicine services do not include telephone conversations or Internet-based communication between providers or between providers and members.

All applicable HIPAA (Health Information Portability and Accountability Act of 1996) confidentiality requirements apply to telemedicine encounters.

Reimbursable Telemedicine Services

The following additional individual providers are reimbursed for selected telemedicine-based services:

- Physicians and physician clinics.
- RHCs (rural health clinics).
- FQHCs (federally qualified health centers).
- Physician assistants.
- Nurse practitioners.
- Nurse midwives.
- Psychiatrists in private practice.
- Ph.D. psychologists in private practice.

These providers may be reimbursed, as appropriate, for the following services provided through telemedicine:

- Office or other outpatient services (CPT (Current Procedural Terminology) procedure codes 99201-99205, 99211-99215).
- Office or other outpatient consultations (CPT codes 99241-99245).
- Initial inpatient consultations (CPT codes 99251-99255).
- Outpatient mental health services (CPT codes 90801-90849, 90862, 90875, 90876, and 90887).
- Health and behavior assessment/intervention (CPT codes 96150-96152, 96154-96155).
- ESRD (end-stage renal disease)-related services (CPT codes 90951-90952, 90954-90958, 90960-90961).
- Outpatient substance abuse services (HCPCS codes H0022, H0047, T1006).

Reimbursement for these services is subject to the same restrictions as face-to-face contacts (e.g., POS (place of service), allowable providers, multiple service limitations, PA (prior authorization)).

Claims for services performed via telemedicine must include HCPCS modifier "GT" (via interactive audio and video telecommunication systems) with the appropriate procedure code and must be submitted on the 837P (837 Health Care Claim: Professional) transaction or 1500 Health Insurance Claim Form paper claim form. Reimbursement is the same for these services whether they are performed face-to-face or through telemedicine.
Only one eligible provider may be reimbursed per member per DOS (dates of service) for a service provided through telemedicine unless it is medically necessary for the participation of more than one provider. Justification for the participation of the additional provider must be included in the member's medical record.

Separate services provided by separate specialists for the same member at different times on the same DOS may be reimbursed separately.

**Services Provided by Ancillary Providers**

Claims for services provided through telemedicine by ancillary providers should continue to be submitted under the supervising physician's NPI (National Provider Identifier) using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT code for the service performed. These services must be provided under the direct on-site supervision of a physician and documented in the same manner as face-to-face services. Coverage is limited to procedure codes 99211 or 99212, as appropriate.

**Federally Qualified Health Centers and Rural Health Clinics**

Telemedicine may be reported as an encounter on the cost settlement report for both RHCs and FQHCs when both of the following are true.

- The RHC or FQHC is the distant site.
- The member is an established patient of the RHC or FQHC at the time of the telemedicine service.

**Members Located in Nursing Homes**

Claims for telemedicine services where the originating site is a nursing home should be submitted with the appropriate level office visit or consultation procedure code.

**Out-of-State Providers**

Out-of-state providers, except border-status providers, are required to obtain PA before delivering telemedicine-based services to Wisconsin Medicaid members.

**Documentation Requirements**

All telemedicine services must be thoroughly documented in the member's medical record in the same way as if it were performed as a face-to-face service.

**Eligible Members**

All members are eligible to receive services through telemedicine. Providers may not require the use of telemedicine as a condition of treating the member. Providers should develop their own methods of informed consent verifying that the member agrees to receive services via telemedicine.

**Telemedicine and Enhanced Reimbursement**

Providers may receive enhanced reimbursement for pediatric services (services for members 18 years of age and under) and HPSA (Health Professional Shortage Area)-eligible services performed via telemedicine in the same manner as face-to-face contacts. As with face-to-face visits, HPSA-enhanced reimbursement is allowed when either the member resides in or the provider is located in a HPSA-eligible ZIP code. Providers may submit claims for services performed through telemedicine that qualify for pediatric or HPSA-enhanced reimbursement with both modifier "GT" and the applicable pediatric or HPSA modifier.

**Originating Site Facility Fee**
An originating site may be reimbursed a facility fee. The originating site is a facility at which the member is located during the telemedicine-based service. It may be a physician’s office, a hospital outpatient department, an inpatient facility, or any other appropriate POS with the requisite equipment and staffing necessary to facilitate a telemedicine service. The originating site may not be an emergency room.

Note: The originating site facility fee is not an RHC/FQHC service and, therefore, may not be reported as an encounter on the cost report. Any reimbursement for the originating site facility fee must be reported as a deductive value on the cost report.

**Claim Submission**

The originating site is required to submit claims for the facility fee with HCPCS code Q3014 (Telehealth originating site facility fee). These claims must be submitted on an 837P transaction or a 1500 Health Insurance Claim Form with a POS code appropriate to where the service was provided.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>School</td>
</tr>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
</tr>
<tr>
<td>05</td>
<td>Indian Health Service Free-Standing Facility</td>
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<tr>
<td>06</td>
<td>Indian Health Service Provider-Based Facility</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 Free-Standing Facility</td>
</tr>
<tr>
<td>08</td>
<td>Tribal 638 Provider-Based Facility</td>
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<tr>
<td>11</td>
<td>Office</td>
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<tr>
<td>12</td>
<td>Home</td>
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<tr>
<td>13</td>
<td>Assisted Living Facility</td>
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<tr>
<td>14</td>
<td>Group Home</td>
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<tr>
<td>15</td>
<td>Mobile Unit</td>
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<td>20</td>
<td>Urgent Care Facility</td>
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<td>21</td>
<td>Inpatient Hospital</td>
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<tr>
<td>22</td>
<td>Outpatient Hospital</td>
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<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
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<tr>
<td>25</td>
<td>Birthing Center</td>
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<tr>
<td>26</td>
<td>Military Treatment Center</td>
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<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
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<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>49</td>
<td>Independent Clinic</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility Partial Hospitalization</td>
</tr>
</tbody>
</table>
### Community Mental Health Center
### Facilities for Developmental Disabilities
### Residential Substance Abuse Treatment Facility
### Psychiatric Residential Treatment Center
### Nonresidential Substance Abuse Treatment Facility
### Mass Immunization Center
### Comprehensive Inpatient Rehabilitation Facility
### Comprehensive Outpatient Rehabilitation Facility
### End-Stage Renal Disease Treatment Facility
### Public Health Clinic
### Rural Health Clinic
### Other Place of Service

**Outpatient Hospital Reimbursement**

Wisconsin Medicaid will reimburse outpatient hospitals only the facility fee (Q3014) for the service. Wisconsin Medicaid will not separately reimburse an outpatient hospital the rate-per-visit for that member unless other covered outpatient hospital services are also provided beyond those included in the telemedicine service on the same DOS. Professional services provided in the outpatient hospital are separately reimbursable.

**Store and Forward Services**

"Store and forward" services are not separately reimbursable which are the asynchronous transmission of medical information to be reviewed at a later time by a physician or nurse practitioner at the distant site.
Wyoming’s state Medicaid program (EqualityCare) does reimburse for multiple types of telemedicine services performed in real time. This coverage began in mid-2007.

In the area of tele-home care and remote monitoring services, Wyoming does not reimburse for telehealth services provided in a patient’s home.
EqualityCare

EqualityCare is the name chosen by the Wyoming Department of Health for its Medicaid Program. This name reflects our state’s great history as the “Equality State” as well as promoting equality in healthcare benefits and services.

Overview

Thank you for your willingness to serve clients of the EqualityCare Program and other medical assistance programs administered by the Office of Healthcare Financing. EqualityCare has incorporated the former General Manual, CMS-1500 Covered Services Module and CMS-1500 Billing Module into one CMS-1500 manual. This manual supersedes all prior versions.

Rule References

Providers must be familiar with all current rules and regulations governing the EqualityCare Program. Provider manuals are to assist providers with billing EqualityCare; they do not contain all Medicaid rules and regulations. Rule citations in the text are only a reference tool. They are not a summary of the entire rule. In the event that the manual conflicts with a rule, the rule prevails.

Revised June 2010
6.24 Telehealth

Telehealth is an electronic real time synchronous audio-visual contact between a patient and healthcare practitioner relating to the healthcare diagnosis or treatment of the patient. The patient is in one location, called the hub site, with specialized equipment including a video camera and monitor, and with a referring/presenting provider. The healthcare practitioner, or consulting provider, is at another location, called the spoke site, with specialized equipment. The practitioner and patient interact as if they were having a face-to-face service. Each site will be able to bill for their own services as long as they are an enrolled EqualityCare provider (this includes out-of-state EqualityCare providers).

6.24.1 Covered Services

The acceptable hub sites for EqualityCare covered telehealth are the following:

- Physician office
- Psychologist office
- Nurse practitioner office
- Critical access hospital
- Rural health clinic
- Federal qualified health center (FQHC)
- Hospital (as defined by Medicare, including general acute care hospitals and acute psychiatric hospitals)
- Community Mental Health or Substance Abuse Centers
- Nursing Facilities

For EqualityCare payment to occur, interactive audio and video telecommunications must be used permitting real-time communication between the distant site physician or practitioner and the patient with sufficient quality to assure the accuracy of the assessment, diagnosis, and visible evaluation of symptoms and potential medication side effects. All interactive video telecommunication must comply with HIPAA patient privacy regulations at the site where the patient is located, the site where the consultant is located, and in the transmission process. If distortions in the transmission make adequate diagnosis and assessment improbable and a presenter at the site where the patient is located is unavailable to assist, the visit must be halted and rescheduled. It is not appropriate to bill for portions of the evaluation unless the exam was actually performed by the billing provider.
6.24.1.1 Non-Covered Services

Telehealth does not include a telephone conversation, electronic mail message (email), or facsimile transmission (fax) between a healthcare practitioner and a patient.

6.24.1.2 Billing Requirements

In order to obtain EqualityCare reimbursement for services delivered through telehealth technology, the following standards must be observed:

- The healthcare practitioner who has ultimate authority over the care of the primary diagnosis of the patient must obtain an Informed Consent for Telehealth Consultations Form (Section 6.24.1.3, Informed Consent for Telehealth Consultations Form) from the patient or the patient’s legal representative. This should be maintained in the patient’s permanent record.
- The services must be medically necessary and follow generally accepted standards of care.
- The service must be a service covered by EqualityCare.
- Claims must be made according to EqualityCare billing instructions.
- The same procedure codes and rates apply as for services delivered in person.
- Quality assurance/improvement activities relative to telehealth delivered services need to be identified, documented, and monitored.
- Providers need to develop and document evaluation processes and patient outcomes related to the telehealth program, visits, provider access, and patient satisfaction.
- All service providers are required to develop and maintain written documentation in the form of progress notes the same as is originated during an in-person visit or consultation with the exception that the mode of communication (i.e. teleconference) should be noted.
- EqualityCare will not reimburse for the use or upgrade of technology, for transmission charges, for charges of an attendant who instructs a patient on the use of the equipment or supervises/monitors a patient during the telehealth encounter, or for consultations between professionals.

NOTE: If the patient and/or legal guardian indicate at any point that he/she wants to stop using the technology, the service should cease immediately and an alternative appointment set up.
<table>
<thead>
<tr>
<th>CPT-4 and HCPCS Level II Codes</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241 - 99255</td>
<td>GT</td>
<td>Consultations</td>
</tr>
<tr>
<td>99201 – 99215</td>
<td>GT</td>
<td>Office or other outpatient visits</td>
</tr>
<tr>
<td>90804 – 90809</td>
<td>GT</td>
<td>Individual psychotherapy</td>
</tr>
<tr>
<td>90862</td>
<td>GT</td>
<td>Pharmacologic management</td>
</tr>
<tr>
<td>90801</td>
<td>GT</td>
<td>Psychiatric diagnostic interview examination</td>
</tr>
<tr>
<td>96116</td>
<td>GT</td>
<td>Neurobehavioral status exam</td>
</tr>
<tr>
<td>G0308, G0309, G0311, G3012, G0314, G0315, G0317, and G0318</td>
<td>GT</td>
<td>End stage renal disease related services</td>
</tr>
<tr>
<td>G0270, 97802, 97803</td>
<td>GT</td>
<td>Individual medical nutrition therapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GT</td>
<td>Telehealth Service</td>
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</table>

<table>
<thead>
<tr>
<th>HCPCS Level II Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3014</td>
<td>Telehealth originating site facility fee</td>
</tr>
</tbody>
</table>

For accurate listing of codes, refer to the fee schedule on the EqualityCare website (Section 2.2, Quick Website Reference).
6.24.1.3 Wyoming Telehealth Network

Informed Consent for Telehealth Consultations

Healthcare services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as “telemedicine” or “telehealth”, this means that I may be evaluated and treated by a healthcare provider or specialist from a different location. Since this is different than the type of consultation with which I am familiar, I understand and agree to the following:

1. The consulting healthcare provider or specialist will be at a different location from me. A physician or other healthcare provider (“presenting practitioner”) will be at my location with me to assist in the consultation.

2. The presenting practitioner may transmit or share electronically details of my medical history, examinations, x-rays, tests, photographs or other images with the specialist who is at a different location.

3. Details of my medical history, examinations, x-rays, and tests will be discussed with the specialist who is at a different location.

4. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the consultant and presenting practitioner. I will give my verbal permission prior to additional personnel being present.

5. Video recordings may be taken of the telehealth consultation, after I have given my written permission prior to recording. Video recordings and other data, including x-rays, images, and photos maybe kept, viewed, and used for purposes including teaching, training, technical, scientific, research, or administrative purposes.

6. The physician or healthcare provider for whom the on-site examination or treatment is performed will keep a record of the consultation in my medical record.

Noting all the above, I understand that my participation in the process described (called “telemedicine” or “telehealth”) is voluntary and constitutes a waiver of the usual right to physician-patient privacy and may possibly increase the risk of disclosure of my medical data.

I further understand that I have the right to:

1. Refuse the telehealth consultation, or stop participation in the telehealth consultation at any time.

2. Limit any physical examination proposed during the telehealth consultation.

3. Request that the presenting practitioner refrain from transmitting my information if I make the request before the information is transmitted.

4. Request that nonmedical personnel leave the room(s) at any time.

5. Request that all personnel leave the room(s) to allow a private consultation with the off-site specialist(s)

I acknowledge that the healthcare providers involved have explained the consultations in a satisfactory manner and that all questions that I have asked about the consultations have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

Patient signature:_____________________________________Date:________________________________________
Patient Representative signature:_________________________Date:_______________________________________
Witness signature:____________________________________ Date:_______________________________________

Patient name:__________________________________________________________________________________
Primary Care Provider or Case Manager:______________________________________________________________
Location:_____________________________________________________________________________________

Please place in patient’s record
9.14.2 Genetic Testing

Procedure Codes: 83891 and 88385-88386

9.14.2.1 Covered Services

EqualityCare covers genetic testing under the following conditions:

- There is reasonable expectation based on family history, risk factors, or symptomatology that a genetically inherited condition exists; and
- Test results will influence decisions concerning disease treatment or prevention; and
- Genetic testing of children might confirm current symptomatology or predict adult onset diseases and findings might result in medical benefit to the child or as the child reaches adulthood.

9.14.2.2 Billing Requirements

- The physician’s letter justifying the genetic testing must be attached to the claim. The letter must document the necessity for the genetic testing by meeting the covered service conditions mentioned above.
- No prior authorization is required

NOTE: Post payment claim review will be conducted.

9.15 Physician and Nurse Practitioner Services

The following mid-level practitioners are able to bill for services provided in a physician or nurse practitioner’s office, under their direct supervision, using the physician’s EqualityCare provider number:

- Physician Assistant - Physician Assistants may enroll individually, but can only receive payment for Medicare crossovers.
- Licensed Master’s Level Counselors.

9.15.1 Covered Services

EqualityCare covers almost all services provided by practitioners, including limited preventative care. This section provides covered services information that applies specifically to services performed by physicians, mid-level practitioners, independent labs, independent imaging facilities, and independent diagnostic testing facilities including:

- Abortion
- Anesthesia Services
- Dermatology