

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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**NC Medicaid
Telehealth, Virtual
Communications and Remote Patient
Monitoring**

**Medicaid
Clinical Coverage Policy No: 1H
Amended Date: February 15, 2025**

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

1A-24: Diabetes Self-Management Education
1A-34: End-Stage Renal Disease (ESRD) Services
1D-4: Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
1E-5: Obstetrical Services
1E-7: Family Planning Services
1E-6: Pregnancy Medical Home
1-I: Dietary Evaluation and Counseling and Medical Lactation Services
1M-2: Childbirth Education
1M-3: Health and Behavior Intervention
4-A: Dental Services
8-A: Enhanced Mental Health and Substance Abuse Services
8-C: Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
8D-2 Residential Treatment Services
8-F: Research-Based Behavioral Health Treatment (RB-BHT) For Autism Spectrum Disorder (ASD)
8-G: Peer Support Services
8-J: Children's Developmental Service Agencies (CDSAs)
8-P: North Carolina Innovations
10-A Outpatient Specialized Therapies
10-C: Outpatient Specialized Therapies, Local Education Agencies (LEAs)
10-D: Respiratory Therapy Services by Independent Practitioner Provider

1.0 Description of the Procedure, Product, or Service

NC Medicaid has made several key changes to the NC Medicaid Clinical Coverage Policy *1H: Telemedicine and Telepsychiatry* and several other clinical coverage policies to enable expanded coverage of remote physical and behavioral health care to Medicaid beneficiaries. This new Clinical Coverage Policy *1H: Telehealth, Virtual Communications, and Remote Patient Monitoring* builds upon the former policy and replaces it in its entirety. This policy is intended to provide new definitions and overarching guidance related to the delivery of services via telehealth, virtual communications and remote patient monitoring that are not otherwise included in a NC Medicaid program or service-specific clinical coverage policy.

1.1 Definitions

1.1.1 Telehealth

Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.

1.1.2 Virtual Communications

Virtual communications is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a beneficiary or a provider and another provider. As outlined in **Attachment A** and program-specific clinical coverage policies, covered virtual communication services include: telephone conversations (audio only); virtual portal communications (secure messaging); and store and forward (transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation).

1.1.3 Remote Patient Monitoring

Remote Patient Monitoring is the use of digital devices to measure and transmit personal health information from a beneficiary in one location to a provider in a different location. Remote patient monitoring enables providers to collect and analyze information such as vital signs (blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. There are two types of remote patient monitoring addressed within this policy:

- a. Self-Measured and Reported Monitoring: When a beneficiary uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation.
- b. Remote Physiologic Monitoring: When a beneficiary's physiologic data is wirelessly synced from a beneficiary's digital device where it can be evaluated immediately or at a later time by a provider.

1.1.4 Originating Site

The Originating Site is the location in which the beneficiary is located, which may be health care facilities, schools, community sites, the home, or wherever the beneficiary may be at the time they receive services via telehealth, virtual communications, or remote patient monitoring. There are no restrictions on originating sites. Refer to **Section 5.4 below** for information related to originating site facility fees.

1.1.5 Distant Site

The distant site is the location from which the provider furnishes telehealth, virtual communications, or remote patient monitoring services. There are no restrictions on distant sites. Distant sites may be wherever the provider may be located. Provider(s) shall ensure that beneficiary privacy is protected (such as taking calls from private, secure spaces; using headsets).

Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes and Rural Health Centers (RHCs) are considered eligible distant sites and shall follow the coding and billing guidelines in **Attachment A** below.

1.1.6 Established Patient

An Established Patient refers to a beneficiary who has received any professional services (including services via telehealth) from the provider or another provider of the same specialty who belongs to the same group practice within the past three years. Since telehealth services are considered professional services, a beneficiary and provider relationship may be established via telehealth.

1.1.7 New Patient

A New Patient refers to a beneficiary who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid policies)

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise)*.
- b. Provider(s) shall verify each Medicaid beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. Medicaid
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;

- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover services delivered via telehealth, virtual communications, and remote patient monitoring services when the all the following additional criteria are followed before rendering services via telehealth, virtual communications, or remote patient monitoring:

- a. Provider(s) shall ensure that services can be safely and effectively delivered using telehealth, virtual communications, or remote patient monitoring.
- b. Provider(s) shall consider a beneficiary's behavioral, physical and cognitive abilities to participate in services provided using telehealth, virtual communications, or remote patient monitoring.
- c. The beneficiary's safety must be carefully considered for the complexity of the services provided.
- d. In situations where a caregiver or facilitator is necessary to assist with the delivery of services via telehealth, virtual communications, or remote patient monitoring, their ability to assist and their safety must also be considered.
- e. Delivery of services using telehealth, virtual communications, or remote patient monitoring must conform to professional standards of care: ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements, such as Practice Act and Licensing Board rules;
- f. Provider(s) shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this must be documented.
- g. Beneficiaries are not required to seek services through telehealth, virtual communications, or remote patient monitoring, and shall be allowed access to in-person services, if the beneficiary requests;
- h. Provider(s) shall verify the beneficiary's identity using two points of identification before initiating service delivery via telehealth, virtual communications, or remote patient monitoring.
- i. Provider(s) shall ensure that beneficiary privacy and confidentiality is protected to the best of their ability.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.3 Eligible Services and Providers

Telehealth, Virtual Communications, and Remote Patient Monitoring Services Covered in Clinical Coverage Policy 1-H

A range of services may be delivered via telehealth, virtual communication, and remote patient monitoring to Medicaid beneficiaries. All telehealth, virtual communication, and remote monitoring services must be delivered in a manner that is consistent with the quality of care provided in-person.

Each set of eligible services has its own set of eligible provider(s) as defined in **Attachment A** of this policy or *Refer* to <https://medicaid.ncdhhs.gov/> for the related coverage policies.

Eligible services, eligible providers, and related detailed guidance for the following may be found in **Attachment A** below:

3.3.1 Telehealth, including:

- a. office or other outpatient services and office and inpatient consultation codes; and
- b. hybrid telehealth visit with supporting home visit codes.

3.3.2 Virtual communication, including:

- a. online digital evaluation and management codes;
- b. telephonic evaluation and management;
- c. telephonic evaluation and management and virtual communication codes; and
- d. interprofessional assessment and management codes.

3.3.3 Remote patient monitoring, including:

- a. self-measured blood pressure monitoring; and
- b. remote physiologic monitoring.

3.4 Services Covered in Other Program-Specific Clinical Coverage Policies

In addition to the eligible services and providers listed in **Attachment A** of this policy, the policies listed under “Related Clinical Coverage Policies” at the top of this document also include telehealth coverage information, such as telehealth-eligible services and providers. Please refer to those policies for program-specific telehealth guidance.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

None Apply

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Prior Authorization and In-Person Examinations:

Unless otherwise required for a specific service, Medicaid shall not require prior approval for *1H, Telehealth, Virtual Communications and Remote Patient Monitoring*. Prior authorization or an initial in-person examination is not required in order to receive care via telehealth, virtual patient communication, or remote patient monitoring; however, when establishing a new relationship with a patient via these modalities, the provider shall meet the prevailing standard of care and complete all appropriate exam requirements and documentation dictated by relevant CPT or HCPCS coding guidelines.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Eligible Technology

5.3.1 Telehealth

All telehealth services must be provided over a secure HIPAA compliant technology with live audio and video capabilities including (but not limited to) smart phones, tablets and computers.

5.3.2 Virtual Patient Communications

Virtual patient communications must be transmitted between a patient and provider, or between two providers, in a manner that is consistent with the CPT

code definition for those services. Provider(s) shall follow all applicable HIPAA rules.

5.3.3 Remote Patient Monitoring

Remote patient monitoring requires use of a device that is defined by the FDA as a medical device and is in real-time and transmittable. Some forms of remote patient monitoring, such as remote physiologic monitoring (detailed below), require a device that is wirelessly synced where the provider can evaluate the data in real or near-real time. All remote patient monitoring must be conducted in a HIPAA compliant manner, particularly with respect to protecting transmission of patient health data.

5.4 Originating Site Facility Fees

Any Medicaid enrolled provider who provides a beneficiary with access to audio and visual equipment in order to complete a telehealth encounter may bill for a facility fee when their office or facility is the site at which the beneficiary is located when the service is provided, and the distant site provider is at a different physical location.

Skilled nursing facilities (SNF) shall not bill an originating site facility fee when the SNF Medical Director or a beneficiary's attending physician is conducting a telehealth visit.

5.5 Additional Limitations or Requirements

Up to three different consulting providers may be reimbursed for a separately identifiable telehealth service provided to a beneficiary per date of service.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Documentation and Billing Requirements

Provider(s) are expected to send documentation of any telehealth services rendered to a beneficiary's identified primary care provider or medical home within 48 hours of the encounter for medical services (including behavioral health medication management), obtaining required consent when necessary (as per 42 CFR Part 2 for relevant substance use disorder related disclosures). Documentation can be sent by any HIPAA-compliant secure means.

Claims for all telehealth, virtual communication, and remote patient monitoring services must be billed according to the guidance in **Attachment A** below.

8.0 Policy Implementation and History

Previous Policy: Effective November 15, 2020 this version of Clinical Coverage Policy 1-H replaces the previous version of this policy, titled “NC Medicaid Clinical Coverage Policy 1-H: Telemedicine and Telepsychiatry” that was originally published on August 1, 1999 and last amended December 31, 2019; the previous policy is no longer in effect.

Original Effective Date: August 1, 1999

History:

Date	Section Revised	Change
11/15/2020	All sections and attachment(s)	
10/01/2022	5.3.3	Add to end of first sentence “and is in real-time and transmittable”.
10/01/2022	Attachment A C.1	Remove CPT code 99201 from the table. This code was end-dated on 12/31/2020. Added “Family Planning beneficiaries are not eligible for new patient visit via telehealth” at the bottom of the table.
10/01/2022	Attachment A C.3a	Add “self-monitored blood pressure monitoring (SMBPM) requires a device that is wirelessly synced where the provider can evaluate the data in real or near-real time. Monitoring must be conducted on a HIPAA compliant manner particularly with respect to protecting transmission of patient health data”.
03/15/2023	5.5 Additional Limitations or Requirements	Remove “None Apply”. Add: “Up to three different consulting providers may be reimbursed for a separately identifiable telehealth service provided to a beneficiary per date of service.” This line was inadvertently left out of the updated policy during the PHE.
03/15/2023	Attachment C.1	Remove end dated codes, 99241 and 99251 from the table.
06/01/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program’s move to Medicaid. Policy posted 6/1/2023 with an effective date of 4/1/2023.
02/01/2025	Attachment A C.1 Telehealth Services -	Add CPT codes 98000, 98001, 98002, 98003, 98004, 98005, 98006 and 98007 indicating the eligible providers. Has an effective date of 01/01/2025
02/01/2025	Attachment A C.1 Hybrid Telehealth visits	Remove asterisk * sentence at the bottom of the table. The requirement for initial face-to-face visit was removed from CCP 1E-7.
02/01/2025	Attachment A C. 2 Virtual Communication Services	Remove “Telephonic Evaluation and Management and Virtual Communication Codes” code description. Add “Synchronous Audio-Only Codes” in its place.
02/01/2025	Attachment A C. 2 Virtual Communication Services	Remove end-dated codes 99441, 99442, 99443 and G2012.
02/01/2025	Attachment A C. 2 Virtual Communication Services	Add CPT codes 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015 and 98016 indicating the eligible providers. Has an effective date of 01/01/2025.
02/01/2025	Related Clinical Coverage Policies	Add 10-A Outpatient Specialized Therapies

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) may bill for telehealth, virtual communication, and remote patient monitoring services if the service follows core service billing requirements as outlined in clinical coverage policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics. Information concerning Virtual Communication Services provided by FQHCs and RHCs is located here:

<https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center>

Services billable by FQHCs, FQHC Lookalikes and RHCs are identified with a plus sign (+).

C. 1. Telehealth Services

Eligible Services/ Codes	Eligible Providers					
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwives	Clinical Pharmacist Practitioners
Office or Other Outpatient Service and Office and Inpatient Consultation Codes						
99202	X	X	X	X	X	X
99203	X	X	X	X	X	X
99204	X	X	X	X	X	X
99205	X	X	X	X	X	X
99211	X	X	X	X	X	X
99212	X	X	X	X	X	X
99213	X	X	X	X	X	X
99214	X	X	X	X	X	X
99215	X	X	X	X	X	X
99242	X	X	X	X	X	X
99243	X	X	X	X	X	X
99244	X	X	X	X	X	X
99245	X	X	X	X	X	X
99252	X	X	X	X	X	X
99253	X	X	X	X	X	X
99254	X	X	X	X	X	X
99255	X	X	X	X	X	X
98000	X	X	X	X	X	X
98001	X	X	X	X	X	X
98002	X	X	X	X	X	X
98003	X	X	X	X	X	X
98004	X	X	X	X	X	X
98005	X	X	X	X	X	X
98006	X	X	X	X	X	X
98007	X	X	X	X	X	X
Hybrid Telehealth Visit with Supporting Home Visit Codes (see additional guidance below)						
99347	X	X	X	X	X	
99348	X	X	X	X	X	
99349	X	X	X	X	X	
99350	X	X	X	X	X	

Guidance: Hybrid Telehealth with Supporting Home Visit (“Hybrid Model”)

- a. Eligible providers may conduct telehealth visits with a supporting home visit by a delegated staff member (“hybrid model”) with new or established patients, for a range of scenarios including (but not limited to):

1. **Chronic Disease Management:** Providers shall use the home visit codes in this policy with appropriate modifiers.

Perinatal Care: Providers shall only use the home visit codes in this policy with appropriate modifiers if they are not billing the pregnancy global package codes.

Providers billing the pregnancy global package codes shall refer to clinical coverage policy 1E-5, *Obstetrical Services* at <https://medicaid.ncdhhs.gov/>.

2. for billing guidance for this model.
- b. Well-child services are not eligible to be delivered via the hybrid model.
- c. Providers shall choose the most appropriate code based on the complexity of the services provided and document accordingly. If time is used as a determining factor, providers shall choose the code that corresponds with the length of the telehealth visit provided by the eligible provider (not the duration of the home visit performed by the delegated staff person).
- d. The delegated staff person may perform vaccinations in the home as long as they comply with applicable vaccination requirements (e.g., staff person's scope of practice), and may conduct other tests or screenings, as appropriate.
 1. Any vaccinations, tests or screenings conducted in the home should be billed as if they were delivered within the office, without modifiers.
- e. Local Health Departments may also utilize the hybrid model when the telehealth visit is rendered by an eligible provider and may bill the home visit codes listed in table C.1.
- f. FQHCs, FQHC-Lookalikes, and RHCs may utilize this hybrid model but shall not bill the home visit codes in table C.1.; FQHCs, FQHC-Lookalikes and RHCs may bill their core service code (T1015) and an originating site facility fee (Q3014) for hybrid model visits to reflect the additional cost of the delegated staff person attending the beneficiary's home. To be reimbursed for the originating site facility fee, all of the following requirements must be met for each home visit:
 1. The assistance delivered in the home must be given by an appropriately trained delegated staff person.
 2. The fee must be billed for the same day that the home visit is conducted.
 3. HCPCS code Q3014 must be appended with the GT modifier and billed with a place of service '12' to designate that the originating site was the home.
 4. The core service code (T1015) must be billed separately from the originating site facility fee code (Q3014).

C.2. Virtual Communication Services

Eligible Services/ Codes	Eligible Providers				
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwives
Online Digital Evaluation and Management Codes					
99421+	X	X	X	X	X
99422+	X	X	X	X	X
99423+	X	X	X	X	X
Synchronous Audio-Only Codes					
98008	X	X	X	X	X
98009	X	X	X	X	X
98010	X	X	X	X	X
98011	X	X	X	X	X
98012	X	X	X	X	X
98013	X	X	X	X	X

Eligible Services/ Codes	Eligible Providers				
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwives
98014	X	X	X	X	X
98015	X	X	X	X	X
98016	X	X	X	X	X
Interprofessional Assessment and Management Codes					
99446	X				
99447	X				
99448	X				
99449	X				

Services billable by FQHCs, FQHC Lookalikes and RHCs are identified with a plus sign (+).

C.3. Remote Patient Monitoring Services

Eligible Services/ Codes	Eligible Providers					Code-Specific Guidance
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwives	
Self-Measured Blood Pressure Monitoring Codes (see additional guidance below)						
99473+	X	X	X	X	X	Providers may bill once per beneficiary, per device. May be performed remotely. No more than one provider may bill for the same beneficiary.
99474+	X	X	X	X	X	Providers may bill once in a 30-day period if they complete a minimum of 12 readings. No more than one practice may bill for the same beneficiary in the same month.
Remote Physiologic Monitoring Codes (see additional guidance below)						
99453+	X	X	X	X	X	May be billed only once for each episode of care, which begins

Eligible Services/ Codes	Eligible Providers					Code-Specific Guidance
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwives	
						when the RPM is initiated and ends with attainment of targeted treatment goals.
99454+	X	X	X	X	X	May be billed once every 30 days continuously (not calendar month, by contrast with code 99457 below).
99457+	X	X	X	X	X	May be billed for the first twenty minutes of communication with the beneficiary or caregiver in the calendar month, and only once per calendar month per beneficiary.
99458+	X	X	X	X	X	May be billed for each additional twenty minutes of communication with the beneficiary or caregiver in the calendar month

Services billable by FQHCs, FQHC Lookalikes and RHCs are identified with a plus sign (+).

Guidance: Self-Measured Blood Pressure Monitoring (SMBPM)

- a. SMBPM is a beneficiary's regular use of a personal blood pressure monitoring device to assess and record blood pressure across different points in time outside of a clinical setting, typically at home. This service is available for new or established patients. SMBPM require a device that is wirelessly synced where the provider can evaluate the data in real or near-real time. All remote patient monitoring must be conducted in a HIPAA compliant manner, particularly with respect to protecting transmission of patient health data.

Guidance: Remote Physiologic Monitoring (RPM)

- a. **RPM** is the collection and interpretation of an established beneficiary's physiologic data digitally transmitted to the eligible provider. **Codes 99453 and 99454 are used for device set-up, training and supply – the following guidance applies to both of these codes:**
 1. 99453 and 99454 can be used for blood pressure RPM if the device used to measure blood pressure meets RPM requirements. If the beneficiary self-reports blood pressure readings, the provider should instead bill SMBPM codes 99473/99474.
 2. 99453 and 99454 cannot be reported if monitoring is less than 16 days in duration.

3. Providers should not report codes 99453 or 99454 if the services are included in any other codes covered by NC Medicaid for the duration of time of the RPM (for example, continuous glucose monitoring that is covered under code 95250).
- b. **RPM treatment management services** are the use of the RPM results by the eligible provider to manage an established patient's treatment plan. **Codes 99457 and 99458 are used to report RPM treatment management services – the following guidance applies to both of these codes.**
 1. Codes 99457 and 99458 require a live, interactive communication between the beneficiary or caregiver.
 2. Providers may not bill code 99457 or 99458 for interactions of less than 20 minutes.
- c. **For all RPM and RPM treatment management service codes in table C.3:** If the services described by codes 99453, 99454, 99457 or 99458 are provided on the same day a beneficiary presents for an evaluation and management service to the same provider (whether by telehealth or in-person), these services should be considered part of the E/M service and not billed under the RPM code.

C.4. HCPCS Codes

The following HCPCS code can be billed for the Telehealth originating site facility fee by the originating site (the site at which the beneficiary is located): Q3014.

C.5. Revenue Codes

When the originating site is a hospital, the originating site facility fee must be billed with RC780 and Q3014.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

Note: Unlisted procedure codes cannot be used to bill for non-covered services or services for which a provider is not allowed to bill.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

- Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier should not be used for virtual patient communications (including telephonic evaluation and management services) or remote patient monitoring.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Telehealth, virtual communication, and remote patient monitoring claims should be filed with the provider's usual place of service code(s) and not place of service 02 (Telehealth).

Exception: Hybrid telehealth with supporting home visits should be filed with Place of Service (POS) 12 (home).

G. Co-payments

For Medicaid refer to the Medicaid State Plan:

<https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices>

H. Reimbursement

Provider Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

When the GT modifier is appended to a code billed for professional services, the service is paid at the allowed amount of the fee schedule.

1. For hospitals, this is a covered service for both inpatient and outpatient and is part of the normal hospital reimbursement methodology.
2. Reimbursement for these services is subject to the same restrictions as face-to-face contacts (such as; place of service, allowable providers, multiple service limitations, prior authorization).