NCDHHS
NC Medicaid
Division of Health Benefits

NC DHB

SPECIAL BULLETIN COVID-19 #9: Telehealth Provisions - Clinical Policy Modification

Friday, March 20, 2020

Effective March 23, 2020, NC Medicaid is temporarily modifying its Telemedicine and Telepsychiatry Clinical Coverage Policy (/providers/clinical-coverage-policies/telemedicine-and-telepsychiatry-clinical-coverage-policies) to better enable the delivery of remote care to Medicaid members. These temporary changes will be retroactive to March 10, 2020, and will end the earlier of the cancellation of the North Carolina state of emergency declaration or when this policy is rescinded. In particular, this Medicaid Bulletin reinforces notable changes including payment parity for telehealth, expanding eligible telehealth technologies, expanding eligible provider types, expanding the list of eligible originating and distant sites, and eliminating the need for prior authorization and referrals (other than what is necessary to meet the standard of care as detailed below). Additionally, this policy modification allows Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) to serve as distant sites. Specific guidance related to billing and coding is detailed in "Temporary Modifications to Attachment A," below.

Providers can bill for allowed services as described in this Medicaid Bulletin beginning March 23, 2020, for dates of service on or after March 10, 2020. NC Medicaid will continue to release telehealth policy provisions and will continue to evaluate this policy throughout the state of emergency period.
There are three telehealth modalities referenced within this policy bulletin, defined as:

- Telemedicine: Telemedicine is the use of two-way real-time interactive audio and video to provide and support health care when participants are in different physical locations.
- Telepsychiatry: Telepsychiatry is the use of two-way real–time interactive audio and video to provide and support psychiatric care when participants are in different physical locations.
- Virtual Patient Communication: Virtual Patient Communication is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a patient or a provider and another provider. Covered virtual patient communication services include telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., 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).

Telemedicine and Telepsychiatry Services

Coverage and Payment Parity: Consistent with its existing policy, telemedicine and telepsychiatry have coverage and payment parity with in-person care. Medicaid and NC Health Choice will continue to cover and reimburse all telemedicine interactions at a rate that is equal to in-person care as long as they meet the standard of care and are conducted over a secure HIPAA-compliant technology with live audio and video capabilities.
The following are policy modifications related to telemedicine and telepsychiatry:

- Eligible Technologies
  - NC Medicaid has eliminated the restriction that telemedicine and telepsychiatry services cannot be conducted via “video cell phone interactions.” These services can now be delivered via any HIPAA-compliant, secure technology with audio and video capabilities, including (but not limited to) smart phones, tablets and computers.
    - In addition, the Office of Civil Rights (OCR) at Health and Human Services (HHS) recently issued guidance noting that “covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency.”
- Service Sites
  - Originating Site: There are no restrictions on originating sites (formerly known as spoke sites). Originating sites may include health care facilities, school-based health centers, community sites, the home or wherever the patient may be located.
  - Distant Site: There are no restrictions on distant sites (formerly known as hub sites). Distant sites may be wherever the provider may be located. Providers must ensure that

patient privacy is protected (e.g., 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 should follow the coding and billing guidelines in "Temporary Modifications to Attachment A" below.

- Providers
  - Referring Providers: There are no longer any requirements related to referring providers.
  - Eligible Providers: NC Medicaid has expanded the list of eligible distant site telemedicine and telepsychiatry providers to include clinical pharmacists, licensed clinical social workers (LCSWs), licensed clinical mental health counselors (LCMHCs), licensed marriage and family therapists (LMFTs), licensed clinical addiction specialists (LCASs) and licensed psychological associates (LPAs). Further guidance regarding additional eligible provider types is forthcoming.
- Authorization, Referrals and In-Person Examinations
  - Patients are not required to obtain prior authorization or have an initial in-person examination prior to receiving telemedicine or telepsychiatry services; however, when establishing a new relationship with a patient via either telemedicine or telepsychiatry, the provider must meet the prevailing standard of care and complete all appropriate exam requirements and documentation dictated by E/M coding guidelines.

Virtual Patient Communication Services

On March 13, 2020, NC Medicaid issued new guidance (/blog/2020/03/13/special-bulletin-covid-19-2-general-guidance-and-policy-modifications)and codes for the delivery of virtual patient communication services, defined earlier. Two additional sets of codes will be added March 23, 2020, for online digital evaluation and management and for interprofessional consultations as follows.

Online Digital E/M Codes

- **99421** – Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- **99422** – Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- **99423** – Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Online digital E/M services require physician or other qualified health care professional (QHP) evaluation, assessment and management of the patient. These services are not for the non-evaluative electronic communication of test results, scheduling of appointments or other communication that does not include E/M. Patients initiate online digital E/M services through HIPAA-compliant, secure platforms such as electronic health record (EHR) portals, secure email or other digital application.

See “Temporary Modifications to Attachment A” for additional coding and billing guidance.

Interprofessional Consultations (QHP to MD)

- **99446** - Interprofessional telephone/internet/electronic health records assessment and management service provided by a consultative physician, including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review.
- **99447** - Interprofessional telephone/internet/electronic health records assessment and management service provided by a consultative physician, including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review.
- **99448** - Interprofessional telephone/internet/electronic health records assessment and management service provided by a consultative physician, including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review.
- **99449** - Interprofessional telephone/internet/electronic health records assessment and management service provided by a consultative physician, including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review.

Temporary Modifications to Attachment A: Claims-Related Information

Effective March 23, 2020, through the conclusion of the State of Emergency related to COVID-19, NC Medicaid is temporarily modifying Attachment A of its Telemedicine and Telepsychiatry Clinical Coverage Policy 1-H to better enable the delivery of remote care to Medicaid beneficiaries. 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 and NC Health Choice:

A. Claim Type
Professional (CMS-1500/837P transaction)
Institutional (UB-04/837I transaction)

B. International Classification of Diseases and Related Health Problems, Tenth Revision, 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, telepsychiatry and select virtual patient communication 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 (https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center) .

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

The following new and established patient **office or other outpatient service** and **office and inpatient consultation codes**, when provided via telemedicine or telepsychiatry, may be billed by physicians, nurse practitioners (including psychiatric), physician assistants, advanced practice midwives and clinical pharmacist practitioners.

Codes

99201	99213	99245
99202	99214	99251
99203	99215	99252
99204	99241	99253
99205	99242	99254
99211	99243	99255
99212	99244	T1015(+)

The following **online digital evaluation and management** codes may be billed by physicians, physician assistants, nurse practitioners, advance practice midwives, FQHCs, FQHC Look-Alikes and RHCs.

Codes
99421+
99422+
99423+

The following **telephonic evaluation and management** and **virtual patient communication** codes may be billed by physicians, physician assistants, nurse practitioners and advance practice midwives.

Codes	
99441	G0071+
99442	G2012
99443	

The following **interprofessional assessment and management** codes may be billed by physicians only.

Codes	
99446	99449
99447	
99448	

The following **psychiatric diagnostic evaluation and psychotherapy** codes, when provided by telepsychiatry, may be billed by licensed clinical addiction specialists, licensed clinical mental health and professional counselors, psychologists, licensed clinical social workers, licensed marriage and family therapists, physicians, psychiatric nurse practitioners.

Codes		
90791	90833	90837
90792	90834	90838
90832	90836	T1015-HI +

The following **telephone assessment and management** codes may be billed by licensed clinical addiction specialists, licensed clinical addiction specialist associates, licensed mental health and professional counselors, licensed mental health and professional counselor associates, licensed psychologists, licensed psychological associates, licensed clinical social workers, licensed clinical social worker associates, licensed marriage and family therapists and licensed marriage and family therapist associates.

Codes
98966
98967
98968

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. Refer to Subsection 6.3 for list of providers.

HCPCS code T1023 can be billed only by diagnostic assessment agencies for screening / evaluation to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter (1 unit = 1 event). T1023 (1 unit)

is billed for the date that the total assessment is completed by the agency that employs the providers of service.

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.

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 is not appropriate for services performed telephonically or through email or patient portal.

Modifier CR (catastrophe/disaster related) must be appended to all claims for CPT and HCPCS codes listed in this policy to relax frequency limitations defined in code definitions.

E. Billing Unit

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

F. Place of Service

Telehealth and telepsychiatry claims should be filed with place of service 02 (telehealth).

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at https://medicaid.ncdhhs.gov/ (https://medicaid.ncdhhs.gov/).

For NC Health Choice refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html (http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html) .

H. Reimbursement

Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/ (https://medicaid.ncdhhs.gov/).
When the GT modifier is appended to a code billed for professional services, the service is paid at 100% of 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) unless otherwise noted in this policy.

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