Telehealth

PURPOSE

Telehealth is the use of telecommunications and information technology to provide access to physical, mental, and behavioral health care across distance.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll with ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the Automated Voice Response System (AVRS) by dialing 1.877.328.7098.

Refer to the Member Eligibility Manual for additional information regarding eligibility including information regarding limited coverage categories.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

All qualified telehealth services must:

- Meet the same standard of care as in-person care;
- Be medically appropriate and necessary, with supporting documentation included in the patient's clinical medical record;
- Be provided with secure and appropriate equipment to ensure confidentiality and quality in the delivery of the service. The service must be provided using a

HIPAA-compliant platform; and
- Health care professionals must follow CPT® coding guidelines for each section below.
- A telecommunications system may include two-way, real-time, audio-only communication technology for any Medicaid telehealth service furnished to a member in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system. However, the patient is not capable of, or does not consent to, the use of video technology. The reason for audio-only must be documented in the medical record for the service. Use the Procedure Code Look-up Tool to verify if a service can be rendered audio-only.

SYNCHRONOUS AUDIO-VIDEO AND AUDIO-ONLY TELEHEALTH SERVICES

Synchronous audio-video Outpatient E/M services

CPT® 98000-98007

- Do not report CPT® E/M services 99202-99215 when the service was performed via telehealth.
  - The only exception is for claims that Medicare has processed as the primary payer. Medicare does not recognize CPT® 98000-98015 and requires them to be billed under regular E/M codes.

Synchronous audio-only E/M services

CPT® 98008-98015

The Procedure Code Look-up Tool should be utilized to verify if specific codes can be delivered via telehealth. Examples include, but are not limited to, the following:

- 1915i Services;
- Behavioral Health Services;
- Diabetes Self-Management and Training;
- ESRD Services;
- Medical Nutrition Therapy;
- Medication Therapy Management (MTM) Services;
- Occupational Therapy Services;
- Physical Therapy Services;
- Speech Language Pathology Services;
- Smoking Cessation;
- Substance Use Disorder Services; and
- Telehealth consultations: Emergency Department or Inpatient Care.

ONLINE DIGITAL EVALUATION AND MANAGEMENT SERVICES
CPT® 99421-99423

Cumulative online digital evaluation and management (E/M) services occurring within seven days beginning with the health care professional's review of the patient-generated inquiry. Included services not separately billable:

- For the same or a related problem within seven days of a previous E/M service;
- Related to a surgical procedure occurring within the postoperative period of a previously completed procedure;
- Any subsequent online communication that does not include a separately reported E/M service; and
- E/M services related to the patient's inquiry provided by qualified health care professionals in the same group practice.

Separate reimbursement may be allowed for:

- Online digital inquiries initiated for a new problem within seven days of a previous online digital E/M service.

Do not report this service if:

- It is decided that the patient will be seen within 24 hours or at the next available urgent visit appointment;
- There is an E/M service for the same or a similar problem within the previous seven days; or
- The patient is within a postoperative period and related to the surgical procedure.

Permanent documentation storage (electronic or hard copy) of the encounter is required.

INTERPROFESSIONAL TELEPHONE/INTERNET/ELECTRONIC HEALTH RECORD ASSESSMENT AND MANAGEMENT SERVICES

This service allows treating providers to consult with a specialist to assist the treating provider in diagnosis and/or management of a patient's health condition without requiring the patient to have face-to-face contact with the specialist. Specialists bill their consultation time with these codes. These services are limited to four per member per year.

COVERED SERVICES & LIMITS

CPT ® Code	Code Description	Limits/Service Requirements
99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, 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.	Cannot be billed more than once per 7 days per patient.
99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, 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.	Cannot be billed more than once per 7 days per patient.
99451	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.	Cannot be billed more than once per 7 days per patient.
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.	Cannot be billed more than once per 14 days per patient. Requires a minimum service time of 16 minutes.

Service requirements:

- Both the treating practitioner and the consultant must be enrolled in ND Medicaid.
- Consultations must be:
    - directly related to the patient's diagnosis and treatment;
    - for the patient's direct benefit; and
    - documented.
- Review of patient records and reports is included in this service.

Treating practitioners and consultants must follow all state and federal privacy laws regarding patient privacy and the exchange of patient information.

Do not report this service if:

- Direct specialty care is clinically indicated;
- Consultant has seen the patient in a face-to-face encounter in the last 14 days;
- The consultation leads to a transfer of care or other face-to-face service within the next 14 days or the next available appointment date of the consultant; or
- Greater than 50% of the service time is devoted to data review and/or analysis (for codes 99446-99449 only).

INDIAN HEALTH SERVICES AND TRIBAL HEALTH PROGRAMS

Telehealth services provided by an Indian Health Service (IHS) facility or a Tribal Health Program functioning as the distant site are reimbursed at the All-Inclusive Rate (AIR), regardless of whether the originating site is outside the "four walls" of the facility or clinic. Revenue code 0780 should only be reported along with Q3014 when the IHS or Tribal Health Program is the originating site.

FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Revenue code 0780 should only be reported along with Q3014 when the FQHC is the originating site. When providing telehealth services to patients located in their homes or another facility, FQHCs and RHCs should continue to bill the revenue codes listed in the FQHC and RHC policies, along with the CPT® or HCPCS code for the service rendered, appended with modifier GT or 95.

SERVICE AUTHORIZATION REQUIREMENTS

Service authorization is required for interprofessional consultations exceeding the 4 per calendar year limit. SFN 481 must be utilized to request additional services.

NON-COVERED SERVICES

GENERAL NON-COVERED SERVICES

The Noncovered Services Policy contains a general list of services that are not covered by North Dakota Medicaid.

Telehealth services that are not covered include:

Type of Noncovered Service	CPT®/HCPCS Code
Store and forward	G2010
Virtual check-in	98016
Interprofessional telephone/internet/electronic health record assessment and management services	99446, 99499
Digital Assessment and Management Services	98970-98972

DOCUMENTATION REQUIREMENTS

GENERAL REQUIREMENTS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the Provider Requirements Policy.

TELEHEALTH DOCUMENTATION

Originating site documentation is required for originating sites that are eligible for reimbursement. North Dakota Medicaid does not require documentation to be maintained for originating sites that are not eligible for reimbursement. The originating site must document the physical location of the recipient and provider at the time the services were provided. The originating site must also document if a nurse or other healthcare professionals were present and provided any services, such as checking vitals.

The distant site must document the physical location of the recipient and provider at the time the services were provided. The distant site provider must follow the documentation requirements in the Provider Requirements Policy.

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The Third Party Liability Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.
Payment will be made only to the distant health care professional during the telehealth session. No payment is allowed to a professional at the originating site if their sole purpose is the presentation of the patient to the professional at the distant site.

Payment will be made to the originating site as a facility fee only in the following places of service: office, inpatient hospital, outpatient hospital, or skilled nursing facility/nursing facility. There is no additional payment for equipment, technicians, or other technology or personnel utilized in the performance of the telehealth service.

CLAIM FORM

Telehealth services can be billed on a professional CMS 1500 / 837P or institutional CMS UB04/837I claim. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual webpage.

CLAIM REQUIREMENTS

PROFESSIONAL CLAIMS

Modifier	93	Synchronous telehealth service rendered via telephone or other real-time interactive audio-only telecommunication system.
HCPCS Code(s)	Q3014	Telehealth originating site facility fee (If applicable. Cannot be billed if patient is outside of the healthcare facility, or for digital health services).
Place of Service	02	Telehealth provided in a location other than the patient's home.
	10	Telehealth provided in patient's home.

INSTITUTIONAL CLAIMS

Applicable Revenue Codes(s)	780	Telehealth – facility charges related to the use of telehealth.
HCPCS Code(s)	Q3014*	Telehealth originating site facility fee (If applicable. Cannot be billed if patient is outside of the healthcare facility, or for digital health services).
Applicable Modifier(s)	GT or 95	Via interactive audio and video telecommunication systems. Billed by performing health careprofessional for real-time interaction between the professional and the patient who is located at a distant site from the reporting professional. Modifiers are not required for Medicare primary claims.
	93	Synchronous telehealth service rendered via telephone or other real-time interactive audio-only telecommunications system.

** HCPCS Code Q3014 must be billed in conjunction with Revenue Code 780 to indicate the originating site facility fee.*

DEFINITIONS

Digital Health - consists of online digital evaluation and management (E/M) services[1] which are patient-initiated services with health care professionals. These are not real-

[1] Physicians and other qualified professionals whose scope of practice include E/M services may bill for E/M digital health visits. These professionals include physicians, nurse practitioners, physician assistants, and optometrists.

time services. Patients initiate services through HIPAA-compliant secure platforms which allow digital communication with the healthcare professional. Online digital evaluation and management services are for established patients only. These services do not include non-evaluative electronic communications of test results, scheduling of appointments, or other communication that does not include evaluation and management.

Distant Site - the location of the health care professional.

Originating Site - the location of the patient.

Synchronous Telehealth - two-way, real-time interactive communication between a patient and their health care provider using technology such as interactive video/television, audio/visual secure online digital portals, and videoconferencing. Synchronous telehealth involves two collaborating sites: an “originating site” and a “distant site.” The patient is located at the originating site, and the health care professional is located at the distant site.

Audio-Only Telephone Services - can be delivered by using older-style “flip” phones or traditional “land-line” phones that only support audio-based communication. Only certain services are covered using audio-only telephone services.

Telehealth - an umbrella term that includes digital health and synchronous two-way real-time interactive audio/visual services. It does not include store-and-forward services.

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

RELATED POLICIES

Federally Qualified Health Centers
Rural Health Clinics
Indian Health Service and Tribal Health Programs

FREQUENTLY ASKED QUESTIONS

Q: An originating site is located in North Dakota, but the distant site is an enrolled provider located out of state. Does the distant site provider need an out-of-state prior authorization?
A: No, the distant site provider does not need an out-of-state service authorization for services delivered via telemedicine. If the service otherwise requires service authorization, the provider is still required to obtain service authorization prior to providing the service.
Q: Can a home be an originating site?
A: Yes, a home can be an originating site, but it is not eligible for reimbursement for Q3014.

CONTACT

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SUMMARY OF POLICY UPDATES

January 2024

Section	Update
Audio only Telephone and E/M Services	policies combined
Noncovered service	Virtual check in code

May 2025

Section	Update
Covered Services	Added link to Procedure Code Look-up Tool
Audio Only	Added link to Procedure Code Look-up Tool

October 2025

Section	Update
	Format changes throughout.