

TELEHEALTH

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

POLICY DEFINITIONS

Digital Health consists of online digital evaluation and management (E/M) services¹ which are patient-initiated services with health care professionals. These are not real-time services. Patients initiate services through HIPAA-compliant secure platforms which allow digital communication with the health care professional. Online digital evaluation and management services are for established patients only. These services do not include nonevaluative electronic communications of test results, scheduling of appointments, or other communication that does not include evaluation and management.

Distant Site is the location of the health care professional.

Originating Site is the location of the patient.

Synchronous Telehealth is 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 a traditional “land-line” phones that only support audio-based communication. Only certain services are covered using audio-only telephone services (see linked list of covered services below).

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

COVERED SERVICES

Use the [Procedure Code Look-up Tool](#) to identify services covered via Telehealth.

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.

REQUIREMENTS

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 via 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.
- Use appropriate coding as noted in the following tables. Health care professionals must follow CPT®/HCPCS coding guidelines.

DIGITAL HEALTH EVALUATION AND MANAGEMENT SERVICES

Cumulative online digital evaluation and management (E/M) services occurring within a seven-day period 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.
- 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.

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

AUDIO ONLY TELEPHONE E/M SERVICES

Services must be initiated by an established patient or guardian of the established patient.

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.

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,

- The patient is within a postoperative period and related to the surgical procedure.

INTERPROFESSIONAL TELEPHONE/INTERNET/ELECTRONIC HEALTH RECORD CONSULTATIONS

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 for their consultation time with these codes.

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	Cannot be billed more than once per 7 days per patient.

	health care professional, 5 minutes or more of medical consultative time.	
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 North Dakota Medicaid.
- Consultations must be:
 - directly related to the patient's diagnosis and treatment and
 - for the patient's direct benefit.
 These must be 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 next available appointment date of the consultant.
- Greater than 50% of the service time is devoted to data review and/or analysis (for codes 99446-99449 only).

Limits

Members are limited to four Interprofessional consultations per year. Service authorizations are required to exceed this limit.

SERVICE AUTHORIZATION

Service authorization is required for interprofessional consultations exceeding the 4 per calendar year limit.

BILLING AND REIMBURSEMENT**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 care professional 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.*

PAYMENT LIMITATIONS

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.

Payment is made for services provided by licensed professionals enrolled with ND Medicaid within their licensed scope of practice only. All service limits set by ND Medicaid apply to telehealth services.

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.

Refer to the [FQHC](#) and [RHC](#) policies for the revenue codes to bill for the various services.

OUT OF STATE SERVICES

See [Out of State Services policy](#).

NONCOVERED SERVICES

Services that are not covered include:

Type of Noncovered Service	CPT®/HCPCS Code
Store and forward	G2010
Virtual check-in	98016
Digital Assessment and Management Services	98970-98972

REFERENCE CITATIONS

42 CFR 410.78 - Telehealth services

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.78>

Telehealth coverage from Medicaid.gov

<https://www.medicaid.gov/medicaid/benefits/telemed/index.html>

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