



# Telehealth Billing Guidelines

**Applies to dates of service on or after November 15,  
2020**

(Updated 2/8/2021 to add pharmacists as eligible providers and patient location modifiers)

# Telehealth Billing Guidelines

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## THE OHIO DEPARTMENT OF MEDICAID

In response to COVID-19, emergency rules 5160-1-21 and 5160-1-21.1 were adopted by the Ohio Department of Medicaid (ODM) and implemented on a temporary basis by Medicaid fee-for-service (FFS), Medicaid Managed Care Plans (MCPs), and MyCare Ohio Plans (MCOPs). Since emergency rules expire after 120 days, ODM filed new rule 5160-1-18 through the regular rule filing process and it will be adopted effective November 15, 2020. This rule enables many telehealth provisions and flexibilities expanded under the emergency rules to continue beyond the expiration date of those rules. These billing guidelines will remain in effect until new rules are adopted by ODM following the public health emergency.

These billing guidelines, pursuant to rule 5160-1-18 of the Ohio Administrative Code (OAC), apply to **fee-for-service claims** submitted by Ohio Medicaid providers and are applicable for dates of service on or after November 15, 2020.

The MCPs and MCOPs cover the same telehealth services as in fee-for-service but may have different billing requirements. For questions about submitting claims for telehealth to the MCPs and MCOPs, providers should contact the plans directly. ODM has posted telehealth guidelines for managed care organizations at <https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans#1910275-covid-19-info>.

**If you are a behavioral health agency certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS),** please refer to the billing guidance found at <https://bh.medicaid.ohio.gov/>.

Specific instructions for the following program areas are contained in this document:

- Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)
- Outpatient Hospitals
- Dental
- Long Term Services and Supports:
  - o Hospice
  - o Private Duty Nursing
  - o State Plan Home Health services
  - o Nursing Facilities
- Pre-Admission Screening and Resident Review (PASRR)

Information and resources concerning ODM's response to COVID-19 will continue to be updated on the ODM website: <https://medicaid.ohio.gov/COVID>

## What is Telehealth?

Under rule 5160-1-18 effective 11/15/2020, the following is considered telehealth:

- The direct delivery of health care services to a patient related to the diagnosis, treatment, and management of a condition.
- Telehealth is the interaction with a patient via synchronous, interactive, real-time electronic communication that includes both audio and video elements; **OR**
- The following activities that are asynchronous or do not have both audio and video elements:
  - Telephone calls
  - Remote patient monitoring
  - Communication with a patient through secure electronic mail or a secure patient portal
- For services rendered by behavioral health providers as defined in rule 5160-27-01 of the Administrative Code, telehealth is further defined in rule 5122-29-31 of the Administrative Code.
- Medicaid covered individuals can access telehealth services wherever they are located. Locations include, but are not limited to:
  - Home
  - School
  - Temporary housing
  - Homeless shelter
  - Nursing Facility
  - Hospital
  - Group home
  - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)

	Practitioner Site	Patient Site
<b>Definition</b>	» Physical location of the treating practitioner when the service was delivered » There is no limitation on practitioner site	» Physical location of the patient when the service was delivered » There is no limitation on patient site
<b>Rendering providers (MITS Provider Type)</b>	» Physician, Psychiatrist, Ophthalmologist (20) » Podiatrist (36) » Psychologist (42) » Physician Assistant (24) » Dentist (30) » Advanced Practice Registered Nurses: <ul style="list-style-type: none"> <li>○ Clinical Nurse Specialist (65)</li> <li>○ Certified Nurse Midwife (71)</li> <li>○ Certified Nurse Practitioner (72)</li> </ul> » Licensed Independent Social Worker (37) » Licensed Independent Chemical Dependency Counselor (54)	» Not applicable

	<ul style="list-style-type: none"> <li>» Licensed Independent Marriage and Family Therapist (52)</li> <li>» Licensed Professional Clinical Counselor (47)</li> <li>» Dietitians (07)</li> <li>» Audiologist (43)</li> <li>» Occupational Therapist (41)</li> <li>» Physical Therapist (39)</li> <li>» Speech-language pathologist (40)</li> <li>» Practitioners who are supervised or cannot practice independently: <ul style="list-style-type: none"> <li>» Supervised practitioners, trainees, residents, and interns as defined in OAC rules 5160-4-05 and 5160-8-05</li> <li>» Occupational therapy assistant</li> <li>» Physical therapist assistant</li> <li>» Speech-language pathology aide</li> <li>» Audiology Aide</li> <li>» Individuals holding a conditional license as described in section 4753.071 of the Revised Code</li> <li>» Registered Nurses (RN) and Licensed Practical Nurses (LPN) working in a hospice or home health setting</li> </ul> </li> <li>» Non-Agency Nurses (38)</li> <li>» Medicaid School Program (MSP) practitioners described in 5160-35 of the Administrative Code (28)</li> <li>» Optometrists (35)</li> <li>» Pharmacists (69) as of 1/17/2021</li> <li>» Other practitioners if specifically authorized in rule under Agency 5160 of the Administrative Code</li> </ul>	
<b>Billing (pay-to) providers (MITS Provider Type)</b>	<ul style="list-style-type: none"> <li>» Rendering practitioners listed above except: <ul style="list-style-type: none"> <li>○ Supervised practitioners defined in 5160-4-05 and 5160-8-05</li> <li>○ Occupational therapy assistant</li> <li>○ Physical therapist assistant</li> <li>○ Speech-language pathology and audiology aides</li> <li>○ Individuals holding a conditional license</li> <li>○ Registered Nurses (RN) and Licensed Practical Nurses (LPN) working in a hospice or home health setting</li> </ul> </li> <li>» Professional Medical Group (21)</li> <li>» Professional Dental Group (31)</li> <li>» Federally Qualified Health Center (12)</li> <li>» Rural Health Clinic (05)</li> <li>» Ambulatory Health Care Clinics (50)</li> <li>» Outpatient Hospitals (01) OPHBH or on behalf of licensed psychologists and independent</li> </ul>	» Not applicable

	<p>practitioners not eligible to separately bill in this setting</p> <ul style="list-style-type: none"> <li>» Psychiatric Hospitals providing OPHBH services (02)</li> <li>» Medicaid School Program Provider (28)</li> <li>» Private Duty or non-Agency Nurses (38)</li> <li>» Pharmacies (70) as of 1/17/2021 (submitted on a professional claim)</li> <li>» Other practitioners if specifically authorized in rule promulgated under Agency 5160 of the Administrative Code</li> </ul>	
<b>Excluded place of service (POS)</b>	<ul style="list-style-type: none"> <li>» Penal facility or Public institution such as jail or prison (09), per federal exclusion</li> <li>» Telehealth (02) will not be accepted unless specified in provider specific billing guidelines</li> </ul>	<ul style="list-style-type: none"> <li>» Not applicable, the patient site can be anywhere.</li> <li>» If applicable, a modifier indicating the patient site location must be reported. See provider specific billing guidelines.</li> </ul>

## Professional Claims

### *When billing for professional services:*

- In most cases, the “GT” modifier is required to identify the service delivery through telehealth. See instructions for your specific program area or provider type for further clarification.
- In most cases, the place of service code reported on the claim must be the location of the practitioner. See instructions for your specific program area or provider type for further clarification.
- Telehealth place of service code 02 will not be accepted unless stated otherwise in provider specific billing guidelines.
- If the patient is at one of the following locations, a specific modifier identifying the type of location is required:
  - o The patient’s home
  - o School
  - o Inpatient hospital
  - o Outpatient hospital
  - o Nursing facility
  - o Intermediate care facility for individuals with an intellectual disability

Professional Claim Submission for Services Delivered via Telehealth*		
<b>Billing provider type</b>	Providers of Professional Services	FQHC and RHC (FFS or claims for wraparound payments)
<b>Claim type</b>	» Professional (Submitted via MITS portal or EDI)	» Professional (Submitted via MITS portal or EDI)
<b>Procedure code</b>	» CPT code for service delivered via telehealth	» First detail line: T1015 encounter code and the appropriate U modifier » Second detail line: procedure code for service delivered via telehealth
<b>Modifier</b>	» GT modifier » Any other required modifiers based on provider contract » Modifier to identify patient location, if applicable	» GT modifier with the procedure code » Any other required modifiers based on provider contract » Modifier to identify patient location, if applicable
<b>Place of service (POS) code</b>	Physical location of the practitioner when the service was delivered	Physical location of the practitioner when the service was delivered

\*Does not apply to crossover claims from Medicare. Provider-submitted crossover claims should be submitted with the information provided by Medicare on the explanation of benefits.

## Institutional Claims

### *Outpatient hospital billing:*

Hospital providers are eligible to bill for telehealth services provided by licensed psychologists and independent practitioners not eligible to separately bill a professional claim. Telehealth services identified in the Appendix to Ohio Administrative Code (OAC) rule 5160-1-18 are covered to the extent they appear on the EAPG covered code list, located on our website:

<https://www.medicaid.ohio.gov/provider/feescheduleandrates>.

To bill outpatient hospital telehealth services, please append modifier “GT” to the procedure code.

If telehealth services are performed as a result of the COVID-19 pandemic, please also append Modifier “CR” – Catastrophe/Disaster to the applicable procedure codes and include Condition Code “DR” – Disaster Related at the header level of the institutional claim.

Outpatient hospital telehealth services will pay according to the Enhanced Ambulatory Patient Grouping (EAPG) pricing methodology as described in OAC rule 5160-2-75.

### ***Outpatient hospital behavioral health services (OPHBH):***

- Hospitals are eligible to provide outpatient behavioral health services via telehealth to the extent they appear on the OPHBH fee schedule on our website:  
<https://www.medicaid.ohio.gov/provider/feescheduleandrates> and are included on the list of allowable telehealth billing codes for community behavioral health providers posted at <https://bh.medicaid.ohio.gov/>.
- To bill OPHBH services performed by telehealth, it remains necessary to append modifier “HE”, along with a practitioner modifier, and any additional pricing modifiers as indicated on the OPHBH fee schedule.
- A mental health/substance abuse diagnosis code is still required to receive OPHBH reimbursement.
- OPHBH telehealth services will pay according to the OPHBH fee schedule.
- Please note: To the extent possible, please include modifier “GT” to indicate it was a telehealth service. If the service provided already requires four modifiers per the OPHBH fee schedule, do not substitute “GT” for one of the required modifiers. List all applicable modifiers from the OPHBH fee schedule first.
- Lastly, please include Condition Code “DR” to indicate that a telehealth service was provided as a result of the COVID19 pandemic.

## **Instructions for Specific Providers and Program Areas**

### **Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) billing:**

- For a covered telehealth service that is also an FQHC or RHC service, the face-to-face requirement is waived, and payment is made in accordance with Chapter 5160-28 of the Administrative Code.
- Medical nutrition therapy and lactation services rendered by eligible FQHC and RHC practitioners will be paid under the PPS.
  - o When these services are rendered by a practitioner not listed in Chapter 5160-28 of the Administrative Code, these services shall be paid through FFS under the clinic provider type 50 (using ODM’s payment schedules).
- Remote patient monitoring will be paid through FFS as a covered non-FQHC/RHC service under the clinic provider type 50 (using ODM’s payment schedules).
- Group therapy will continue to be paid through FFS as a covered non-FQHC/RHC service under the clinic provider type 50 (using ODM’s payment schedules).
- Services under the Specialized Recovery Services (SRS) program are not currently covered FQHC or RHC services.
- When the FQHC or RHC is billing as the practitioner site:
  - o The T1015 encounter code must be reported in the first detail line of the claim with the appropriate U modifier indicating the type of visit.
  - o The next detail line reported on the claim must be the service (procedure code) provided via telehealth. Modifier “GT” must be reported with the procedure code in addition to any

other required modifiers. If there is more than one modifier, the GT modifier should be reported first.

- The place of service code reported on the claim must reflect the physical location of the practitioner.

For more information regarding payment for covered pharmacist services in an FQHC or RHC, please refer to Medicaid Advisory Letter (MAL) number 653 found here:

<https://www.medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/MedicaidPolicy/NonInst/MAL-653.pdf>

## **Dental**

Dentists may provide a limited problem-focused oral exam (CDT D0140) or periodic oral evaluation (D0120) through telehealth during this state of emergency.

- When billing for the procedure on a **professional claim**, providers should use the GT modifier to indicate the service was provided through telehealth. There is no need to report D9995.
- When billing for the procedure on a **dental claim**, providers should include procedure code D9995 to indicate the service was provided through telehealth.
- Dental services **furnished through telehealth at FQHCs** are covered under 5160-1-18 and are paid as covered FQHC dental services.
  - On the first service line of the claim, the provider should report T1015 with the appropriate modifier to identify the type of visit (in this case U2).
  - The procedure code (D0140 or D0120) should be reported in the next detail line of the claim representing the service that was provided along with a GT modifier to identify the service as a telehealth service. There is no need to report D9995.
  - The place of service code should reflect the practitioner's physical location.

## **Hospice**

Hospice services can be provided using telehealth when clinically appropriate. In order to track the services that are provided through telehealth, the appropriate procedure codes below in addition to using the modifier GT must be used on any claims that include at least one telehealth component for that date of service.

- T2042 routine home care
  - Billed one unit per day
- T2043 continuous home care
  - Billed one unit per hour with a minimum of 8 hours per day –



- This type of care consists predominately of nursing care (it may involve services provided by a home health aide and/or homemaker services)
- T2046 room and board payments in a NF (reimbursed at 95% of the NF's daily rate) – the following services are included in the room and board per diem:
  - Performing personal care services;
  - Assisting with Activities of daily living (ADLs);
  - Administering medication;
  - Socializing activities;
  - Maintaining the cleanliness of the individual's room; and
    - Supervising and assisting in the use of durable medical equipment and prescribed therapies.
- Service Intensity Add-On (SIA) Codes: This is payment for routine home care provided by an RN or licensed social worker within the last 7 days of life, when discharge from hospice is due to death (and when a T2042 claim has already been billed and paid):
  - Use code G0299 for direct care by in-person visit from an RN
  - Use code G0155 for direct care by in-person visit from a social worker

## **Home Health Services, RN Assessment and RN Consultation**

Home health services, the RN assessment service and the RN consultation service can be provided using telehealth when clinically appropriate. These services should be billed using the procedure codes below. The value “02” should be used to indicate telehealth as the “Place of Service” on all claims for services provided using telehealth.

- G0156 Home Health Aide
- G0299 Home Health Nursing – RN
- G0300 Home Health Nursing – LPN
- T1001 RN Assessment
- T1001 w/U9 Modifier – RN Consultation
- G0151 Physical Therapy
- G0152 Occupational Therapy
- G0153 Speech-Language Pathology

## **Nursing Facilities**

Nursing facilities (NF) are reimbursed for all telehealth related services through the NF per diem rate. Nursing Facilities do not bill for the telehealth related services they provide. Per the telehealth rule 5160-1-18, physicians and other eligible providers may bill for the services they provide to nursing facility residents from the practitioner's site in accordance with the rule.

When nursing facilities provide telehealth related services to their residents, they report the costs they incur for those services on the Medicaid NF cost report using the following cost center codes:

- **DIRECT CARE COSTS**

- 6110 – RN Charge Nurse
- 6115 – LPN Charge Nurse
- 6120 – Registered Nurse
- 6125 – Licensed Practical Nurse
- 6210 – Consulting and Management Fees
- 6401 – Registered Nurse Purchased Nursing
- 6411 – Licensed Practical Nurse Purchased Nursing
- 6600 – Physical Therapist
- 6610 – Occupational Therapist
- 6620 – Speech Therapist
- 6630 – Audiologist

- **ANCILLARY/SUPPORT COSTS**

- 7000 – Dietitian
- 7231 – Psychologist
- 7251 – Social Work/Counseling
- 7261 – Social Services/Pastoral Care
- 7302 – Medical Minor Equipment Non-Billable to Medicare

- **CAPITAL COSTS**

- 8040 – Depreciation – Equipment
- 8065 – Lease and Rent – Equipment

No changes to MITS, Administrative Code rules, or the Medicaid State Plan are necessary to implement telehealth in nursing facilities.

### **Pre-admission Screening and Resident Review**

Pre-admission Screenings and Resident Reviews (PASRR) should be completed via the electronic HENS system as they are today as these screenings are primarily via desk review. In instances where a face-to-face is required, a telephonic and/or desk review is permissible.

Level II evaluations can be provided either by telephone or desk review when appropriate. There is no system or reimbursement impact as these functions are supported by the level II entities and the applicable contractor.

## Important Clarifications

- If the practitioner site does not bill the Ohio Department of Medicaid (ODM) directly (i.e., holds a contractual agreement with the practice), the patient site or practice who holds the contractual agreement may instead bill for the service delivered using telehealth.
  - o If the physical location of the practitioner at the time of service is not known, the POS code reported on the claim should reflect the location of the billing provider.
- All services identified in this document and the appendix to new rule 5160-1-18 may be delivered through telehealth for dates of service on or after November 15, 2020.
- Providers should use professional judgment when delivering telehealth services and should select the appropriate procedure code that reflects the service provided.
- The place of service (POS) code reported on a professional claim must reflect the physical location of the practitioner. The POS code set is maintained by the Centers for Medicare and Medicaid Services (CMS) and can be found here: [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_service\\_code\\_set](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_service_code_set)
  - o Place of service 02 (Telehealth) will not be accepted on claims where Medicaid is the primary payer
- Similar to what CMS allows for Medicare services provided during the public health emergency, ODM adopts the following workforce flexibility: For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology.

## Patient Location Modifiers

(not applicable to OhioMHAS certified behavioral health agencies)

Modifier*	Description
U1	Patient home or place of residence at the time of service (includes homeless shelter, residential facility other than a nursing facility, temporary housing, etc.)
U2	School
U3	Inpatient Hospital
U4	Outpatient Hospital
U5	Nursing Facility
U6	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

\*If the patient site is not one of these locations, a modifier identifying patient location is not required

## Covered Telehealth Services During the COVID-19 State of Emergency

Dental	
Procedure Code	Description
D0140	Limited oral evaluation – problem focused
D0120	Periodic oral evaluation (added 11/15/2020)
D9995	Teledentistry - synchronous; real-time encounter; Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

Long Term Services and Supports: Hospice, Private Duty Nursing, State Plan Home Health	
Procedure Code	Description
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per hour
T2046	Hospice long-term care, room and board only; per diem
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
T1001	RN Assessment Services prior to the provision of home health, private duty nursing, waiver nursing, personal care aide and home choice services, per initial base, and each 15-minute increment
T1001 U9	RN Consultation
G0151	Physical Therapy
G0152	Occupational Therapy
G0153	Speech-language Pathology

## Medical and Behavioral Health Services (non-OhioMHAS certified behavioral health agencies)

Procedure Code	Description
90785	Interactive complexity (added 11/15/2020)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service
90846	Family psychotherapy without patient present (added 11/15/2020)
90847	Family psychotherapy with patient present (added 11/15/2020)
90849	Multiple-family group psychotherapy (added 11/15/2020)
90853	Group psychotherapy (added 11/15/2020)
99201	Office or other outpatient visit for the evaluation and management of a new patient; Straightforward medical decision making. Typically, 10 minutes.
99202	Office or other outpatient visit for the evaluation and management of a new patient; Straightforward medical decision making. Typically, 20 minutes.
99203	Office or other outpatient visit for the evaluation and management of a new patient; Medical decision making of low complexity. Typically, 30 minutes.
99204	Office or other outpatient visit for the evaluation and management of a new patient; Medical decision making of moderate complexity. Typically, 45 minutes.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes.
99212	Office or other outpatient visit for the evaluation and management of an established patient; Straightforward medical decision making. Typically, 10 minutes.
99213	Office or other outpatient visit for the evaluation and management of an established patient; Medical decision making of low complexity. Typically, 15 minutes.

99214	Office or other outpatient visit for the evaluation and management of an established patient; Medical decision making of moderate complexity. Typically, 25 minutes.
99241	Office consultation for a new or established patient. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes.
99242	Office consultation for a new or established patient; Straightforward medical decision making; Typically, 30 minutes.
99243	Office consultation for a new or established patient; Medical decision making of low complexity. Typically, 40 minutes.
99244	Office consultation for a new or established patient; Medical decision making of moderate complexity. Typically, 60 minutes.
99245	Office consultation for a new or established patient; Medical decision making of high complexity. Typically, 80 minutes.
99251	Inpatient consultation for a new or established patient; straightforward medical decision making. Typically, 20 minutes.
99252	Inpatient consultation for a new or established patient; Straightforward medical decision making. Typically, 40 minutes.
99253	Inpatient consultation for a new or established patient; medical decision making of low complexity. Typically, 55 minutes.
99254	Inpatient consultation for a new or established patient; medical decision making of moderate complexity. Typically, 80 minutes.
99255	Inpatient consultation for a new or established patient; medical decision making of high complexity. Typically, 110 minutes.
99281	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)

96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and

	management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
90951	Dialysis related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90952	Dialysis related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90953	Dialysis related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90954	Dialysis related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90955	Dialysis related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90956	Dialysis related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and



	counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month.
90957	Dialysis related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90958	Dialysis related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90959	Dialysis related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90960	Dialysis related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90961	Dialysis related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90962	Dialysis related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month
90963	Dialysis related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	Dialysis related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	Dialysis related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	Dialysis related services for home dialysis per full month, for patients 20 years of age and older
90967	Dialysis related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	Dialysis related services for dialysis less than a full month of service, per day; for patients 2-11 years of age
90969	Dialysis related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	Dialysis related services for dialysis less than a full month of service, per day; for patients 20 years of age and older

99304	Initial nursing facility care, per day, for the evaluation and management of a patient. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99315	Nursing facility discharge day management; 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99324	Domiciliary or rest home visit for the evaluation and management of a new patient. Typically, 20 minutes are spent with the patient and/or family or caregiver.
99325	Domiciliary or rest home visit for the evaluation and management of a new patient. Typically, 30 minutes are spent with the patient and/or family or caregiver.
99326	Domiciliary or rest home visit for the evaluation and management of a new patient. Typically, 45 minutes are spent with the patient and/or family or caregiver.
99327	Domiciliary or rest home visit for the evaluation and management of a new patient. Typically, 60 minutes are spent with the patient and/or family or caregiver.
99328	Domiciliary or rest home visit for the evaluation and management of a new patient. Typically, 75 minutes are spent with the patient and/or family or caregiver.
99334	Domiciliary or rest home visit for the evaluation and management of an established patient. Typically, 15 minutes are spent with the patient and/or family or caregiver.
99335	Domiciliary or rest home visit for the evaluation and management of an established patient. Typically, 25 minutes are spent with the patient and/or family or caregiver.
99336	Domiciliary or rest home visit for the evaluation and management of an established patient. Typically, 40 minutes are spent with the patient and/or family or caregiver.
99337	Domiciliary or rest home visit for the evaluation and management of an established patient. Typically, 60 minutes are spent with the patient and/or family or caregiver.

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
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
99454	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (list separately in addition to code for primary procedure)
97802	Medical nutrition therapy; initial assessment and intervention, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes
97802 TH	Lactation counseling by dietitian; initial assessment and intervention, each 15 minutes
97803 TH	Lactation counseling by dietitian; re-assessment and intervention, each 15 minutes
97804 TH	Lactation counseling by dietitian; group with 2 or more individuals), each 30 minutes
92012	Eye exam, established patient (added 11/15/2020)
92065	Orthoptic/Pleoptic training (added 11/15/2020)
97542	Wheelchair management, each 15 minutes (added 11/15/2020)

**Occupational Therapy, Physical Therapy, Speech-Language Pathology, and  
Audiology Services  
As Found in OAC 5160-8-35**

<b>Procedure Code</b>	<b>Code Description</b>
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92556	Speech audiometry threshold; with speech recognition
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)
92609	Therapeutic services for the use of speech-generating device, including programming and modification
96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument

96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97161	Physical therapy evaluation: low complexity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care
97164	Re-evaluation of physical therapy established plan of care. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97165	Occupational therapy evaluation, low complexity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance
97168	Re-evaluation of occupational therapy established plan of care. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97129	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes

97130	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure)
97530	Therapeutic activities
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (eg, activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes

<b>Specialized Recovery Services (SRS) Program</b> <b>As found in Chapter 5160-43 of the OAC</b>	
<b>Procedure Code</b>	<b>Description</b>
H2023	Specialized Recovery Services (SRS) program – supported employment
H2025	Specialized Recovery Services (SRS) program – ongoing support to maintain employment
T1016	Specialized Recovery Services (SRS) program – recovery management
H0038	Specialized Recovery Services (SRS) program – peer recovery support services

## Questions?

Contact: [medicaid@medicaid.ohio.gov](mailto:medicaid@medicaid.ohio.gov)

For more information go to: [Medicaid.Ohio.gov](https://Medicaid.Ohio.gov)

### **Are you an agency certified by OhioMHAS?**

Contact: [BH-enroll@medicaid.ohio.gov](mailto:BH-enroll@medicaid.ohio.gov)

For more information go to: [BH.Medicaid.ohio.gov](https://BH.Medicaid.ohio.gov)