Ohio Department of Medicaid

Office of Policy Telehealth Billing Guidelines

Applies to dates of service July 4, 2019 through March 8, 2020

Revised 11/17/2020 (The title page was revised to reflect the dates of service in which these guidelines apply. For dates of service outside of this range, refer to additional billing guidelines found on the ODM website)

Health Plan Policy

THE OHIO DEPARTMENT OF MEDICAID

Telehealth Billing Guidelines

Telehealth is the direct delivery of services to a patient via secure, synchronous, interactive, real-time electronic communication with both video and audio elements. This service can be utilized for all individuals enrolled in the Ohio Medicaid program and specific requirements may be found in Administrative Code rule 5160-1-18.

This billing guidance document applies specifically to fee-for-service claims therefore providers should check with each Medicaid Managed Care Plan (MMCP) or MyCare Ohio Plan (MCOP) for specific billing requirements.

Entities who provide services certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) are not subject to this rule. Telehealth services rendered by these provider types (84 and 95 in MITS) are subject to the rules found in Chapter 5160-27 of the Administrative Code. Telehealth services billed by hospitals under the Outpatient Hospital Behavioral Health Services (OPHBH) benefit package are billed in accordance with paragraph (G)(2) of Ohio Administrative Code (OAC) rule 5160-2-75.

	Practitioner Site	**Patient Site**
Definition	» Physical location of the practitioner when the service was delivered » Cannot be the same location as the patient » Must be the practitioner service location as reported to ODM unless patient is active, practice participates in Ohio CPC, or consultation service is being provided	» Physical location of the patient when the service was delivered » Locations include: a. Practitioner's office b. Patient's home c. School d. Federally Qualified Health Center (FQHC), e. Rural Health Clinic (RHC) f. Public health department g. Primary care clinic h. Family planning clinic i. Inpatient hospital j. Outpatient hospital k. Nursing facility l. Intermediate care facility for individuals with intellectual disability (ICF/IID)
Rendering providers (MITS Provider Type)	» Physician and Psychiatrist (20) » Podiatrist (36) » Psychologist (42) » Physician Assistant (24) » Clinical Nurse Specialist (65)	» Not applicable

	» Certified Nurse Midwife (71) » Certified Nurse Practitioner (72) » Licensed Independent Social Worker (37) » Licensed Independent Chemical Dependency Counselor (54) » Licensed Independent Marriage and Family Therapist (52) » Licensed Professional Clinical Counselor	
Provider Types able to bill (MITS Provider Type/Provider Specialty)	» Rendering practitioners listed above » Professional Medical Group (21) » Federally Qualified Health Center (12) » Rural Health Clinic (05) » Public Health Department (50/501) » Primary Care Clinic (50/500) » Family Planning Clinic (50/503)	» Not applicable
Excluded place of service (POS)	» Penal facility or Public institution such as jail or prison, etc. (09) » Other Place of Service (99) » No other POS restrictions for practitioner if: a. patient is "active" as defined in Ohio Administrative Code rule (OAC) 5160-1-18; or b. the practice is a patient centered medical home as defined in OAC 5160-1-71 c. The service provided is an inpatient or office consultation » If an exception in paragraph (B)(4) does not apply, practitioner service location must be the location as reported to ODM	» Penal facility or Public institution such as jail or prison, etc. (09) » Other Place of Service (99)

Professional Claims

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

- When the FQHC or RHC is billing as the practitioner site, the T1015 encounter code must be reported first on the claim with the appropriate modifier indicating the type of visit.
- The next line reported on the claim must be the service (CPT code) provided via telehealth. Modifier "GT" should be reported with the procedure code in addition to one of the designated modifiers indicating the location of the patient, and any other required modifiers.
- The place of service reported on the claim must be the practitioner site.
- If applicable, a modifier indicating the patient site location should be reported

Professional Services billing:

- The CPT procedure code must be reported with the "GT" modifier, one of the designated modifiers indicating the location of the patient when applicable, and any other required modifiers
- The place of service reported on the claim must be the location of the practitioner
- If applicable, a modifier indicating the patient site location should be reported

Professional Claim Submission for Services Delivered via Telehealth*		
Billing provider type	**Providers of Professional Services**	**FQHC and RHC**
Claim type	» Professional (Submitted via MITS portal or EDI)	» Professional (Submitted via MITS portal or EDI)
Procedure code	» CPT code for service delivered via telehealth	» T1015 encounter code » CPT code for service delivered via telehealth
Modifier	- GT modifier - Modifier to identify patient site (see below) - Any other required modifiers based on provider contract	- GT modifier - Modifier to identify patient site (see below) - Any other required modifiers based on provider contract
Place of service (POS) code	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:

When a telehealth service is rendered by one of the following licensed independent behavioral health practitioners, ODM will accept an institutional claim and pay according to the Enhanced Ambulatory Patient Grouping (EAPG) pricing:

- Licensed Clinical Psychologist
- Licensed Independent Social Worker (LISW)
- Licensed Independent Marriage and Family Therapist (LIMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Independent Chemical Dependency Counselor (LICDC)

EAPG Instructions:

- The CPT procedure code must be reported with the "GT" modifier, one of the designated modifiers indicating the location of the patient when applicable, and any other required modifiers.
- Rendering practitioner NPI is not reported on this claim form; report only the attending practitioner NPI

Important Clarification:

- Only **one** professional or institutional claim may be paid for a service delivered using telehealth. 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.
    - In such cases, POS code reported on the professional claim should reflect the location of the billing provider.

Procedure codes valid for telehealth claims	
Procedure Code	**Code Description**
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
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.

**Available only to Patient Centered Medical Homes (PCMHs) participating in the Ohio Comprehensive Primary Care program (Ohio CPC) under OAC 5160-1-71.

Modifiers used to identify patient location*	
U1	Patient home
U2	School
U3	Inpatient Hospital
U4	Outpatient Hospital
U5	Nursing Facility
U6	ICF/IID

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

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For more information, go online: Medicaid.Ohio.gov