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**State-Funded  
Telehealth and Virtual  
Communications  
Services**

**Division of Mental Health,  
Developmental Disabilities  
& Substance Abuse Services  
Publish Date: November 1, 2021**

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This clinical policy has an effective date of November 1, 2021; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by the Division of MH/DD/SAS and NC Medicaid through a series of Joint Communication Bulletins will remain in effect.

#### Related State-Funded Policies

Refer to <https://www.ncdhhs.gov/divisions/mhddsas/blueprintdefinitions> for the related state-funded policies listed below:

- State-Funded Enhanced MH/SA Services
- State-Funded Diagnostic Assessment
- State-Funded Facility-Based Crisis -Child
- State-Funded Peer Support Services

## 1.0 Description of the Service

This new policy is intended to provide definitions and overarching guidance related to the delivery of services via telehealth and virtual communications that are not otherwise included in a state-funded service definition specific policy.

### 1.1 Definitions

#### 1.1.1 Telehealth

Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.

#### 1.1.2 Virtual Communications

Virtual communications is the use of technologies other than video to enable remote evaluation and consultation support between a provider and an individual or a provider and another provider. As outlined in **Attachment A** and program-specific service definition policies, covered virtual communication services include: telephone conversations (audio only); virtual portal communications (secure messaging); and store and forward (transfer of data from individuals receiving services using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation).

#### 1.1.3 Originating Site

The Originating Site is the location in which the individual receiving services is located, which may be health care facilities, schools, community sites, the home, or wherever the individual may be at the time they receive services via telehealth and virtual communications. There are no restrictions on originating sites. Refer to **Section 5.4 below** for information related to originating site facility fees.

#### 1.1.4 Distant Site

The distant site is the location from which the provider furnishes the telehealth and virtual communications services. There are no restrictions on distant sites. Distant sites may be wherever the provider may be located. Provider(s) shall ensure that the individual receiving services privacy is protected (such as taking calls from private, secure spaces; using headsets).

#### 1.1.5 Established Individual Receiving Services

An Established Individual Receiving Services refers to an individual who has received any professional services (including services via telehealth) from the provider or another provider of the same specialty who belongs to the same group practice within the past three years. Since telehealth services are considered professional services, an individual and provider relationship may be established via telehealth.

#### 1.1.6 New Individual Receiving Services

A New Individual Receiving Services refers to an individual who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*The term “General” found throughout this policy applies to all state-funded policies.*

An individual eligible for this service shall be enrolled with the LME-MCO on or prior to the date of service; meet the eligibility criteria for a State-funded benefit plan; and shall meet the criteria **in Section 3 of this policy**.

## 3.0 When the Service Is Covered

### 3.1 General Criteria Covered

State funds shall cover the service related to this policy when medically necessary, and:

- a. the service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the individual’s needs;
- b. the service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the service is furnished in a manner not primarily intended for the convenience of the individual, the individual’s caretaker, or the provider.

## 3.2 Specific Criteria Covered

### 3.2.1 Specific criteria covered by State Funds

State funds shall cover services delivered via telehealth and virtual communications services when the all the following additional criteria are followed before rendering services via telehealth and virtual communications:

- a. Provider(s) shall ensure that services can be safely and effectively delivered using telehealth and virtual communications.
- b. Provider(s) shall consider an individual's behavioral, physical and cognitive abilities to participate in services provided using telehealth and virtual communications.
- c. The individual's safety must be carefully considered for the complexity of the services provided.
- d. In situations where a caregiver or facilitator is necessary to assist with the delivery of services via telehealth and virtual communications their ability to assist and their safety must also be considered.
- e. Delivery of services using telehealth and virtual communications must conform to professional standards of care: ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements, such as Practice Act and Licensing Board rules;
- f. Provider(s) shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this must be documented. For substance use services, consent must be in compliance with 42 CFR Part 2.
- g. Individuals shall be informed that they are not required to seek services through telehealth or virtual communications and shall be allowed access to in-person services, if the individual requests;
- h. Provider(s) shall verify the individual's identity using two points of identification before initiating service delivery via telehealth and virtual communications.
- i. Provider(s) shall ensure that the individual's privacy and confidentiality is protected to the best of their ability.

## 3.3 Eligible Services and Providers

### Telehealth and Virtual Communications Services Covered in This Policy

A range of services may be delivered via telehealth and virtual communications to individuals who meet eligibility for a state-funded benefit plan. All telehealth and virtual communications services must be delivered in a manner that is consistent with the quality of care provided in-person.

Each set of eligible services has its own set of eligible provider(s) as defined in **Attachment A** of this policy or *Refer* to <https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions> for the related service definition policies.

Eligible services, eligible providers, and related detailed guidance for the following may be found in **Attachment A** below:

**3.3.1 Telehealth, including:**

- a. office or other outpatient services and office and inpatient consultation codes; and
- b. hybrid telehealth visit with supporting home visit codes.

**3.3.2 Virtual communications, including:**

- a. online digital evaluation and management codes;
- b. telephonic (audio-only) evaluation and management codes;
- c. telephonic evaluation and management and virtual communication codes; and
- d. interprofessional assessment and management codes.

**3.4 Services Covered in Other Program-Specific Service Definition Policies**

In addition to the eligible services and providers listed in **Attachment A** of this policy, the policies listed under “Related State-Funded Policies” at the top of this document also include telehealth coverage information, such as telehealth-eligible services and providers. Please refer to those policies for program-specific telehealth guidance.

**4.0 When the Service Is Not Covered**

**4.1 General Criteria Not Covered**

State funds shall not cover the service related to this policy when:

- a. the individual does not meet the eligibility requirements listed in **Section 2.0**;
- b. the individual does not meet the criteria listed in **Section 3.0**;
- c. the service duplicates another provider’s service; or
- d. the service is experimental, investigational, or part of a clinical trial.

**5.0 Requirements for and Limitations on Coverage**

**5.1 Prior Approval**

**Prior Authorization and In-Person Examinations:**

Unless otherwise required for a specific service, *State-Funded Telehealth and Virtual Communications* shall not require prior approval. Prior authorization or an initial in-person examination is not required in order to receive care via telehealth and virtual communication; however, when establishing a new relationship with an individual via these modalities, the provider shall meet the prevailing standard of care and complete all appropriate exam requirements and documentation dictated by relevant CPT or HCPCS coding guidelines.

## **5.2 Prior Approval Requirements**

### **5.2.1 General**

None Apply.

### **5.2.2 Specific**

None Apply.

## **5.3 Eligible Technology**

### **5.3.1 Telehealth**

All telehealth services must be provided over a secure HIPAA compliant, and for substance use services, 42 CFR Part 2 compliant, as relevant, technology with live audio and video capabilities including (but not limited to) smart phones, tablets and computers.

### **5.3.2 Virtual Communications**

Virtual communications must be transmitted between an individual and a provider, or between two providers, in a manner that is consistent with the CPT code definition for those services. Provider(s) shall follow all applicable HIPAA rules and 42 CFR Part 2 regulations, as relevant.

## **5.4 Originating Site Facility Fees**

Any LME/MCO enrolled provider who provides an individual with access to audio and visual equipment in order to complete a telehealth encounter may bill for a facility fee when their office or facility is the site at which the individual is located when the service is provided and the distant site provider is at a different physical location.

## **5.5 Additional Limitations or Requirements**

None Apply

## **6.0 Provider(s) Eligible to Bill for the Service**

To be eligible to bill for the service related to this policy, the provider(s) shall:

- a. meet LME-MCO qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### **6.1 Provider Qualifications and Occupational Licensing Entity Regulations**

None Apply.

### **6.2 Provider Certifications**

None Apply.

## 7.0 Additional Requirements

### 7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 (when applicable) and record retention requirements; and
- b. All state funded service definition policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by DHHS, DHHS division(s) or fiscal contractor(s).

### 7.2 Documentation and Billing Requirements

Provider(s) are expected to send documentation of any telehealth services rendered to an individual's identified primary care provider or medical home within 48 hours of the encounter for medical services (including behavioral health medication management), obtaining required consent when necessary (as per 42 CFR Part 2 for relevant substance use disorder related disclosures). Documentation can be sent by any HIPAA-compliant secure means.

Claims for all telehealth and virtual communication services must be billed according to the guidance in **Attachment A** below.

## 8.0 Policy Implementation and History

**Previous Policy:**

**Original Effective Date: November 1, 2021**

**History:**

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
11/1/21	All sections and attachment(s)	Implementation of new policy.



## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Joint Communication Bulletins, fee schedules, state-funded service definition clinical policies and any other relevant documents for specific coverage and reimbursement for state funds:

### A. Claim Type

Professional (CMS-1500/837P transaction)

### B. International Classification of Diseases and Related Health Problems, Tenth Revisions, 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 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 service using the appropriate unlisted procedure or service code.

#### C. 1. Telehealth Services

Eligible Services/ Codes	Eligible Providers			
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant
<b>Office or Other Outpatient Service and Office and Inpatient Consultation Codes</b>				
99201	X	X	X	X
99202	X	X	X	X
99203	X	X	X	X
99204	X	X	X	X
99205	X	X	X	X
99211	X	X	X	X
99212	X	X	X	X
99213	X	X	X	X
99214	X	X	X	X
99215	X	X	X	X
99241	X	X	X	X
99242	X	X	X	X
99243	X	X	X	X
99244	X	X	X	X
99245	X	X	X	X

Eligible Services/ Codes	Eligible Providers			
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant
<b>Office or Other Outpatient Service and Office and Inpatient Consultation Codes</b>				
99251	X	X	X	X
99252	X	X	X	X
99253	X	X	X	X
99254	X	X	X	X
99255	X	X	X	X
<b>Hybrid Telehealth Visit with Supporting Home Visit Codes (see additional guidance below)</b>				
99347	X	X	X	X
99348	X	X	X	X
99349	X	X	X	X
99350	X	X	X	X

Guidance: Hybrid Telehealth with Supporting Home Visit (“Hybrid Model”)

- a. Eligible providers may conduct telehealth visits with a supporting home visit by a delegated staff member (“hybrid model”) with new or established individuals, for a range of scenarios including (but not limited to):
  1. **Chronic Disease Management:** Providers shall use the home visit codes in this policy with appropriate modifiers. This is limited to mental health and substance use disorders that require a chronic disease management approach,
- b. Providers shall choose the most appropriate code based on the complexity of the services provided and document accordingly. If time is used as a determining factor, providers shall choose the code that corresponds with the length of the telehealth visit provided by the eligible provider (not the duration of the home visit performed by the delegated staff person).

**C.2. Virtual Communication Services**

Eligible Services/ Codes	Eligible Providers			
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant
<b>Online Digital Evaluation and Management Codes</b>				
99421+	X	X	X	X
99422+	X	X	X	X
99423+	X	X	X	X
<b>Telephonic Evaluation and Management and Virtual Communication Codes</b>				
99441	X	X	X	X
99442	X	X	X	X
99443	X	X	X	X
<b>Interprofessional Assessment and Management Codes</b>				
99446	X			
99447	X			
99448	X			
99449	X			

### **C.3. 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 individual is located): Q3014.

### **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 should not be used for virtual communications (including telephonic evaluation and management services).

### **E. Billing Units**

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

### **F. Place of Service**

Telehealth and virtual communication claims should be filed with the provider's usual place of service code(s) and not place of service 02 (Telehealth).

Exception: Hybrid telehealth with supporting home visits should be filed with Place of Service (POS) 12 (home).

### **G. Co-payments**

Not applicable.

### **H. Reimbursement**

Provider Provider(s) shall bill their usual and customary charges.

When the GT modifier is appended to a code billed for professional services, the service is paid at the allowed amount of the fee schedule.

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).