moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM052
Policy Title:	Telehealth And Telemedicine		
Section:	Telemedicine	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☒ Other: Oregon Self-funded plans which adopt the Oregon telehealth mandate Note: This policy does not apply to Vision-only plans.
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

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Last Updated:	11/6/2024	Last Reviewed:	11/13/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		11/13/2024	

Reimbursement Guidelines

Navigation Quick Links:

A. Purpose of Policy

This policy is intended to define telehealth and telemedicine terminology for our company, plans, and claims, provide clarification of which services are and are not eligible for reimbursement, and specify the criteria and requirements which must be met.

B. Telemedicine Definition

For purposes of this policy, telemedicine is defined as direct patient care services which are:

- Replacing a service that is typically or traditionally delivered in-person with the provider and patient in the same location.
- But are instead delivered via some type of remote communication technology because the patient and the provider are in two different locations (remote services).

If the services are always performed with the patient and the provider in two different locations (e.g., interpretation of radiology studies), the provider does not need to have contact with the patient (e.g., pathology reports), or the procedure code definition specifies remote services (e.g., remote monitoring), then these services are not considered telemedicine for purposes of this policy. (For definitions of other terminology related to telemedicine, see Definition of Terms.)

C. New Patient versus Established Patient Determinations (for all lines of business)

1. Telemedicine visit services are performed as the remote/technology equivalent of an in-person service.

2. Telemedicine services count the same as an in-office visit for the purposes of determining if the patient is a new patient or an established patient when they are receiving future visits and services.

3. If a provider is seeing a new patient for the first time via telemedicine using audio/video capabilities, select and report the appropriate new patient E/M code with POS 02 or 10 for the telemedicine visit (and any telemedicine modifier if needed).

   Note: The additional RVU/reimbursement for a new patient visit is for the initial administrative work to set up billing records and a medical record for a new patient, and for the additional medical work of collecting, reviewing, and documenting the patient's past medical history for the first time. This additional work for a new patient is needed whether the patient is seen physically in the office, was seen for the first time in a hospital (inpatient or outpatient setting), or by telehealth.

4. If for some reason a new patient E/M code is not reported for that initial telemedicine visit, the patient is still considered an established patient for the next visit and any future E/M visits which occur in person.

5. New patient versus established patient visit code:
   a. CPT guidelines:

      "An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years." [29]

   b. The CMS and CPT guidelines differ for determining specialty for non-physician practitioners (NPP).
      i. CMS: "…classifies NPPs in a specialty that is not the same as a physician with whom the NPP is working…" [38]
      ii. AMA/CPT: "When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician." [39]
      iii. Moda follows the AMA/CPT guidelines for NPP specialty determination.

c. See also:
    i. Evaluation and Management Services Guide Booklet[30]
    ii. New Patient vs Established Patient Visit [31]
    iii. New vs Established Patient Decision Tree Flowchart [32]

D. General Requirements for Telehealth Services (for all lines of business)

1. Telemedicine services are eligible for reimbursement when: [20]
    a. The communication technology must use secure transmission methods and meet all federal and state requirements for privacy, security, and protected health information (HIPAA, etcetera).
    (*except during a state of emergency, as allowed by state and Federal law). [42, 44, 34]
    b. The billed services must be within the scope of the license or certification held by the provider.
    c. The billed services are a covered benefit under the member's plan.
        i. This includes meeting any applicable Medical Necessity Criteria.
        ii. Any benefit periods, limitations, and/or quantities exhausted will apply.
    d. The services can be safely and effectively performed as a telemedicine service.
    e. Additional requirements specific to a line of business are noted in the sections below.

2. Benefit Level: The same benefit cost-sharing (deductible, copayment, co-insurance) applies to the telemedicine service as would apply if the service were performed in person.

E. Services Covered as Telehealth – Commercial Plans

1. Telemedicine service requirements:
    a. The General Requirements for Performing Telehealth Services apply.
    b. Telemedicine procedure codes for Commercial plans:
        i. Procedure codes must meet the general requirements above.
        ii. Telemedicine services will *not be limited* to the procedure codes on the CMS list of approved telehealth procedure code list.
        iii. The CMS Audio-only list will apply (see "Can Audio-Only Interaction Meet the Requirements?" below).
    c. Approved telehealth communication technology methods vary by state:
        i. Real-time audio-video communication is preferred and strongly encouraged when possible.
        ii. Can Audio-Only Interaction Meet the Requirements?: Unless otherwise indicated in state telehealth statutes:
            1) For dates of service 12/31/2024 and prior, only procedures codes listed on the CMS telehealth procedure code file as "Can Audio-Only Interaction Meet the Requirements?" = "Yes" may be performed audio-only during the post-PHE transition period. (See RPM073, "Telehealth and Telemedicine Expanded Services for COVID-19 – Updated for Public Health Emergency Ending" § F.5.
            2) For dates of service 1/1/2025 and after, if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology, then any telehealth service (not restricted to a specific code list) may be delivered by two-way, real-time audio-only communication technology (such as phone calls). [80, 81]

iii. Additional requirements by State:
   1) **Oregon --** Asynchronous (delayed/not real-time) audio-video, audio-only, or video-only HIPAA compliant, secure communication technologies are allowed when they are necessary, clinically appropriate, and clinically effective. [20]
   2) **Alaska** –
      a) Synchronous two-way interactive audio + video (A/V) conferencing is required.[71]
      b) Asynchronous (time-delay) transmission is prohibited. [71]
      c) Audio-only conferencing or audio-web conferencing without person-to-person video abilities (modifier 93) is prohibited outside of the CMS list of Audio-only telehealth procedure codes. [71]
   3) **Texas** –
      a) Real-time, interactive audio and video is allowed. [33, 35]
      b) Asynchronous store and forward technology in conjunction with synchronous audio interaction is allowed. [33, 35]
      c) Note: **Audio-only technology (without store and forward information) is not permitted. [33]
   4) **Idaho –** Allows both synchronous (real-time) and asynchronous (delayed transmission) technologies. [70]

d. The billing and coding guidelines in this policy are met.
e. There are no restrictions on provider types. The only requirements are:
   i. The service must be within the provider's scope of license or certification.
   ii. The service must meet the general telehealth coverage requirements.
f. Patient location:
   i. Geographic restrictions: None. CMS geographic restrictions do not apply. The member does not have to reside in a rural location to receive telehealth services.
   ii. Originating site (patient service location): None. CMS originating site (patient location) restrictions do not apply. The member can receive telehealth services in their home or any setting of care.
g. Provider location ("distant site"): Provider may practice from home or in any location, so long as HIPAA privacy standards are met.
h. Providing telehealth services across state lines:
   Regulations and requirements vary from state to state for this situation.
   i. **Oregon** – [45]
      1) Providers licensed and practicing in the state of Oregon may provide telemedicine services to Oregon residents with whom they have an established patient relationship while the provider is out-of-state.
      2) Providers licensed and practicing outside of the state of Oregon may provide telehealth services if the patient was referred by their primary care or specialty provider located in Oregon.
   ii. **Alaska** – Alaska law requires telehealth providers to either be licensed in the state of Alaska or be registered with the Alaska telemedicine business registry.[64]
   iii. **Texas** – Texas law requires:
      1) Licensure in State of Texas
      2) Additionally, an out-of-state physician is allowed to provide "episodic consultations" without a Texas medical license.[66, 67]
      3) The Texas Medical Board indicates Out of State Telemedicine Licenses are no longer issued, due to 2017 change in law.[68]

iv. **Idaho** – Idaho law requires:
1) Licensure in the State of Idaho,
2) Provides a special interstate telehealth registration for mental health providers.[69]
3) Allows limited exceptions for other providers, as outlined in IC §54-5713.[63]

i. Telemedicine services performed by non-contracted providers will be eligible for available benefits at the member's out-of-network benefit level.

j. Additional **Alaska** information:
i. Effective for dates of service March 17, 2020 and following, telehealth services may be provided to new patients; there is no requirement for the provider and the member to have had prior contact in person before the telehealth service.
ii. Effective for dates of service March 17, 2020 and following, telephone visits and online medical evaluations for evaluation and management services are covered benefits for Alaska plans.

2. Telemedicine services are not eligible for reimbursement on Commercial plans when:
a. Non-real-time written communication technologies, such as email, provider portal communication, and instant messaging are used.
i. These are not considered "telemedicine services" and are not a covered benefit on our standard Commercial plans.
ii. Exception: If the member's plan has a specific benefit addressing coverage for online digital communication (email, portal communications, messaging, etcetera).
b. The service is not covered under the member's plan.
c. The service is provided using unsecure transmission methods such as Skype or FaceTime; unsecure transmission is not HIPAA-compliant (*except during a state of emergency, as allowed by state and Federal law).[44]
d. Other criteria in # 1 are not met.
e. Home health or safety monitoring (e.g., Medical Guardian Alert, VueZone, QuietCare Plus, LifeFone) is not considered a telemedicine services and is generally not a covered benefit on plans. Verify benefits on the member's plan through Benefit Tracker or by contacting Customer Service before submitting a claim.

3. Regulatory:
a. Commercial Oregon plans comply with ORS 743A.058[53] (including the HB2508 amendments making the Covid-19 telemedicine expansions permanent) and ORS 743A.185.[54]
b. Commercial Alaska plans comply with Alaska Statutes 21.42.422[55], 08.01.085[56], 08.64.364[57], and 08.68.710.[58]
c. Commercial Texas plans comply with Texas Occupations Codes (TOC) §111[59] and §151.056(a)[60], and Texas Insurance Codes (TIC) §§1455.001-1455.006.[61]
d. Commercial Idaho plans comply with Idaho Statute Title 54, Chapter 57 "Idaho Virtual Care Access Act.[62]

F. Services Covered as Telehealth – Medicare Advantage plans:

Telemedicine services are eligible for reimbursement when:

1. The requirements in General Requirements for Performing Telehealth Services are fully met, including HIPAA requirements for proper privacy and security.

2. Providers billing telehealth services (POS, modifiers) must be eligible to perform and receive reimbursement for covered telemedicine services under CMS requirements and subject to state law and scope of license restrictions.[5]

3. The services are on the CMS/Medicare Telehealth Services List that applies for the date of service. Services not on this list that are billed as telemedicine will be denied to provider liability.
   a. Medicare publishes a list of procedure codes approved for telemedicine/telehealth services which is updated annually and effective for the calendar year.
      This list of codes is available for download on the CMS website and is published in the MedLearn Matters Telehealth Services Fact Sheet annual update.
   b. Services not on the list of approved CMS telemedicine procedure codes will not be allowed as telemedicine services under Medicare Advantage plans.
   c. Non-covered telemedicine services will be denied to provider liability. See RPM036 for pre-service requirements to seek any payment. [B]

4. Transmission technology:
   a. Services must be provided using real-time, interactive audio and video telecommunications system. [75]
   b. Exceptions:
      i. The services may be delivered by audio-only (such as phone calls) if:
         1) The procedure is on the CMS Telehealth Services List indicating audio-only interaction will meet the requirements and the member is unable to use both audio and video, such as a smartphone or computer.[72, 73]
         2) Beginning 1/1/2025, services may be delivered by two-way, real-time audio-only communication technology for any procedure code if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology. [80, 81]
      ii. For opioid use disorder (OUD) opioid treatment programs (OTP) effective for dates of service January 1, 2022 and following, therapy and counseling may be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology if:
         1) Two-way audio/video communications technology is not available to the beneficiary,
         2) The beneficiary is not capable of using two-way audio/video communications technology, or,
         3) The beneficiary does not consent to use devices that permit a two-way audio/visual interaction,
         4) Provided all other applicable requirements are met.[36, 37]
   c. Medicare Advantage plans do not participate in the Federal telemedicine demonstration programs in Alaska or Hawaii for the use of asynchronous "store and forward" technology for telemedicine services. Services billed with modifier GQ are denied to provider write-off. ([75])

5. Telemedicine services may not, under any circumstances, expand the scope of practice of a healthcare professional or permit practice in a jurisdiction (the location of the patient) where the provider is not licensed. [37]

6. The member does not have to reside in a rural location to receive telehealth services through December 31, 2024. [74]

7. The member can receive telehealth services in their home or any setting of care through December 31, 2024. [74]

8. Providers may furnish telehealth services from any location, including the provider's home through December 31, 2024. [74]

9. PHE impacts.
    a. During the PHE, CMS was authorized to waive or modify telehealth payment requirements on an interim basis through emergency rulemaking, waivers, and flexibilities. Some of these flexibilities have been extended for varying periods of time after the end of the PHE on May 11, 2023. For further information on these PHE flexibilities and the extensions, see RPM073, "Telehealth and Telemedicine Expanded Services for COVID-19." [C]
    b. To avoid abruptly eliminating the full range of expanded telehealth services available during the PHE and potentially jeopardizing member access to telemedicine services that have been clinically beneficial, CMS has added a provision to the Medicare telehealth services list for a new category of codes, "Category 3." [18, 19]
        i. Codes will be added to Category 3 on a temporary, provisional basis while additional evidence is gathered for possible permanent addition to the Medicare telehealth services list.
        ii. Procedure codes added as part of the temporary PHE expansion list will be considered for Category 3 provisional status.
        iii. Adding services to the Medicare telehealth services list on a Category 3 basis will give the public the opportunity to gather data and generate requests to add certain services to the Medicare telehealth services list permanently, which would then be adjudicated on a Category 1 or Category 2 basis during future PFS annual rulemaking, while maintaining access during the study and research process.

G. Services Covered as Telehealth – Oregon Medicaid plans:

Telemedicine services are eligible for reimbursement when:

1. The requirements in General Requirements for Performing Telehealth Services are fully met.
2. Telemedicine procedure codes for Medicaid plans:
    a. Procedure codes must meet the general requirements above.
    b. Telemedicine services will *not be limited* to a specific list of procedure codes. [47, 53, 54]
3. Approved telehealth communication technology methods:
    a. OAR 410-141-3566 (3) requires that Medicaid members are offered a choice of in-person or telehealth services and modalities.
    b. Approved technology methods range from Real-time audio-visual communications to asynchronous (delayed/not real-time) audio-video, audio-only, or video-only methods, so long as they are:
        i. HIPAA compliant, secure, and private.
        ii. Clinically appropriate, and clinically effective. [20]
4. The billing and coding guidelines in this policy are met.
5. Approved providers for Medicaid telehealth must be:
    a. Enrolled as a provider with the Oregon Division of Medical Assistance Programs (DMAP).
    b. Billed procedure codes must be within the scope of their license or certification.
6. Patient location: There is no restriction on the location of the member/patient. [48]
7. Provider location ("distant site"): Providers may be located in any location where privacy can be ensured. [49]

8. Providing telehealth services across state lines:[45, 50]
    a. Providers licensed and practicing in the state of Oregon may provide telemedicine services to Oregon residents with whom they have an established patient relationship while the provider is out-of-state.
    b. Providers licensed and practicing outside of the state of Oregon may provide telehealth services if the patient was referred by their primary care or specialty provider located in Oregon.
9. Telemedicine services performed by non-contracted provider are allowed, so long as the provider is enrolled with DMAP.
10. Regulatory sources: ORS 743A.058 [53], ORS 743A.185[54], and OAR 410-141-3566.[47]

H. Billing for Telehealth Services

1. Procedure codes
    a. Report the primary service(s) using the appropriate CPT or HCPCS code(s) for the professional service(s) performed.
    b. Do not submit a telemedicine service or evaluation with CPT code 99499 (Unlisted evaluation and management service).
    c. If a telemedicine visit occurs the same day as an in-person visit by the same provider or provider specialty in the same group/TIN, the normal rules apply that only one visit per provider specialty in a group practice/TIN may be reported per day.

       The E/M services from both visits must be combined and submitted under a single E/M procedure code; use the in-person POS code.
    d. The code definitions for CPT codes 99421-99423 (*online evaluation and management service*) require that the patient be an established patient.
        i. Do not report for a new patient (with no previous billed services within the past 3 years) or a clinical edit denial will be generated.
            1) A corrected claim will be needed.
            2) If the member is an established patient but previous services occurred before the member became effective on the Moda plan, submit a brief cover letter with explanation and attached medical record documentation and request a reconsideration using the provider inquiry/appeal process.
        ii. To report a telemedicine visit to a new patient, use the appropriate new patient E/M code with POS 02 or 10.

2. Place of Service (POS) Codes
    a. Commercial & Medicare Advantage plans: [12, 13]
       Covered telemedicine procedure codes must be submitted with place of service 02 or 10. The use telehealth POS 02/10 certifies that the service meets the telehealth requirements.[14]
        i. Report with POS 10 if the patient is in their home when receiving services through telecommunication technology.
        ii. Report with POS 02 if the patient is somewhere other than in their home when receiving services through telecommunication technology.
        iii. Do not report with POS 99 (Other place of service not identified above).
    b. Medicaid plans:
        i. Report with POS 02 or 10.
        ii. For POS 10:
            1) On Thursday, December 16, 2021, the Oregon Health Authority (OHA) notified us that OHP Medicaid will not be utilizing POS 10 at this time. Continue to use POS 02

for all Medicaid claims for services delivered using a telehealth modality until further notice from OHA.

2) The OHA notified us mid-2024 that OHP Medicaid will accept POS 10. The change was due to identifying contradictory language between OAR 410-141-3566 [47] § (10)(c), § (10)(d) [79], and OAR 410-120-1990 [78]. However, the effective date for the change was unclear. After clarification with OHA, we determined the change would be applied on a go-forward basis to dates of service January 1, 2024 and following.

3. Modifiers
   a. Transmission technology modifiers:
      i. If real-time (synchronous) audio-visual technology is used:
         1) On CMS1500 claims, use of a modifier is optional; POS 02 or 10 is sufficient to signify this technology. If an optional modifier will be appended:
            a) For Medicare Advantage claims:
               i) Use modifier 95 for dates of service beginning 1/1/2024 when:
                  (1) The clinician is in the hospital and the patient is in the home.[52]
                  (2) For telemedicine outpatient therapy services by PT, OT, or SLPs.[51]
               ii) There is currently no known CMS guidance to deny professional claims submitted with modifier GT, however Moda Health requests modifier GT no longer be used on Medicare Advantage non-CAH professional claims.
            b) For Medicaid claims, use modifier GT.
            c) For Commercial claims, use either modifier 95 or GT. Do not use both.
         2) On CMS1450/UB Critical Access Hospital (CAH) method II claims modifier GT is required when billing distant-site services (e.g., under professional revenue codes 0960-0969).[14]
         3) For non-CAH facility claims modifier GT may not be used.
            Per CMS, modifier GT is only allowed on institutional claims billed under CAH Method II billing. Non-CAH claims billed with modifier GT will be denied to provider liability. [15]
      ii. For Medicare Advantage mental health services, if the telehealth service would normally be performed using audio and video communications, but the patient is unable to use audio and video technology so instead telephone-only (real-time audio-only) communication is used, use modifier FQ.[41, 46]
      iii. If telephone or other real-time (synchronous) interactive audio-only technology is used, report with modifier 93.
      iv. Note: Do not report modifier 93 or FQ with procedure codes specifying "Telephone assessment and management service" in the code description. Such combinations will deny to provider liability as invalid procedure to modifier combinations. Modifiers are only needed when the code description does not already specify the modifier information.
      v. If non-real-time (asynchronous) technology of any kind is used, report with modifier GQ (required).
      vi. Only one of these modifiers may be used per line item. Using more than one of these modifiers on the same line item will result in a denial to provider liability for incorrect combination of modifiers; a corrected claim will be needed to resolve the denial.
   b. Use modifier G0 (G Zero) for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. [17]

4. Originating site fee –
    a. An originating site fee may not be billed when the patient is located at home or at a self-service kiosk.
    b. Originating site fees may not be billed with POS 02 or 10.
        i. If you are having a telehealth visit with a patient located at home, you may not bill an originating site fee. You may only bill the procedure code for the primary service using the same procedure code as you would for an in-person service and use POS 02 or 10.
        ii. Originating site fees may only be submitted on a CMS1500 professional claim when the billing provider is hosting the patient at their location while they are having a telehealth visit with another provider at a different location. In this instance, bill the originating site fee with the appropriate POS code for your office where you are hosting the patient.
    c. The originating site (office or facility where the patient was located at the time of the telemedicine professional service) may submit an originating site facility fee for telemedicine services with HCPCS code Q3014 and one unit. This covers providing space, technology, and staff support to connect the patient with another provider at a distant location for a telehealth visit/service.
        i. Per Medically Unlikely Edits (MUE) unit limits for Q3014, a maximum of one unit per date of service will be reimbursed to a professional provider or clinic, and a maximum of two units per date of service for facilities.
        ii. The originating site fee (Q3014) may not be billed by the same provider or on the same claim as the telemedicine visit services performed by the provider at the distant site (where the patient is not located). Even if both office locations are within a large system of multi-location clinics or facilities and even if they share the same TIN, services where the patient is located (Q3014) and services where the patient is not located (e.g., 99213-GT/POS 02 or 10 or 99213-95/POS 02 or 10) need to be submitted under separate claims with separate NPIs and separate service addresses.
        iii. A provider may do a face-to-face E/M, and then also be the originating site (space and equipment) for the patient to have a telemedicine visit with a second provider at another location, when a different specialty or more advanced care is needed. Submit the face-to-face E/M visit with modifier 25 appended to indicate this sequence of events for both the face-to-face E/M visit and Q3014 to be eligible for reimbursement.
        iv. Procedure code Q3014 is not eligible for reimbursement when ordinary non-secure smart phone or internet video phone call technology (e.g., Skype, FaceTime), applications, etcetera is utilized to provide the audio + visual connection for the telemedicine services. These non-secure communication services are not HIPAA-compliant for a telemedicine service/PHI. Nor do they require distant-site equipment and resources to facilitate a telehealth visit.
        v. Procedure code T1014 (Telehealth transmission, per minute, professional services bill separately) is not eligible for reimbursement for any line of business. (Although T-codes are designated for Medicaid services, T1014 is not on the OHP fee schedule.)

I. Documentation Requirements For Telemedicine

1. Document the service in the patient's record in the same manner as if it were performed in-person. The written record is in addition to any stored recording of the data transmission of the service.
    a. Include additional notations indicating the service was performed as a telemedicine service and document any relevant impacts this had on the encounter or service.

b. Specify the type of transmission utilized (e.g., real-time or delayed, telephonic, audio + video, encrypted transmission of diagnostic test data, etc.).
c. Identify and note participation of any additional staff present at the member's location to assist with the telemedicine service.
d. The medical record must be available and provided to the health plan upon request for review at any time (pre-payment or post-payment) to substantiate the service. This requirement applies to originating site facility fee claims also.

2. Care provided via telemedicine will be evaluated according to the clinical standard of care applicable to the relevant area of specialty for more traditional in-person medical care (e.g., pertinent physical exam findings). Additionally, telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes.

3. The originating site provider (who is submitting Q3014) is to keep a written record of the telemedicine session in the member's medical record, just as for any other patient service. The documentation needs to include the date, time, and duration of session; technology and equipment used; staff members present (name and licensure) at originating site; name, licensure, specialty, and location of the telemedicine provider at distant site; and reason for the telemedicine service.

J. Remote Services Never Performed Face-to-Face

1. Some professional services do not require the patient to be present in-person with the practitioner when they are furnished. They are commonly furnished using some form of telecommunications technology, often asynchronous store-and-forward technology. These services may be included in the topic of telemedicine by other organizations or entities. However, we do not consider these services to be *telemedicine* services because they do not replace face-to-face services.
   a. Billing and Coding:
      i. Do not report with modifier GQ to signify asynchronous technology was used.
      ii. Do not report with POS 02 or 10.
   b. Benefits: These services are processed as usual under the member's benefits and reimbursed under the usual fee schedule.
   c. Examples of such services include (list not all-inclusive):
      i. Home cardiac event monitoring.
         1) May utilize real-time or asynchronous transmission technology.
         2) Duration of monitoring and monitor technology utilized must be documented, as proper code selection relies on a combination of both factors.
      ii. Remote transmission of data from home glucose monitor, INR testing device, etcetera.
      iii. Pathology - Transfer of image-rich pathology data between remote locations for diagnosis, interpretation and report, or consultation.
      iv. Radiology - Transmission of radiological patient images (x-rays, CTs, MRIs, etc.) from one location to another for reading, diagnosis, or consultation.
      v. Other remote monitoring devices & data transmission.

2. Beginning in 2017, the current CPT book Appendix P includes some procedure codes of this nature. Modifier 95 will be considered valid for these codes (based upon the CPT book information only), but modifier GT and GQ will not be considered valid for these procedure codes.

K. Services Generally Not Eligible to be Billed as Telemedicine Services

1. Services which cannot be safely and effectively performed as telemedicine services (common examples, list not all-inclusive):

Service	Comments
Anesthesia services	Requires member and provider to be in the same physical location to be performed safely and effectively.
Surgery	Requires member and provider to be in the same physical location to be performed safely and effectively.

2. Services which do not replace an in-person face-to-face service to the patient. These services may always be performed remotely, and may be covered benefits, but are not correctly reported with telemedicine modifiers, place of service codes, or an originating site fee (common examples, list not all-inclusive):

Service	Comments
Consultation between two physicians or providers	Does not require the presence of the patient for an in-person service. Telemedicine services are intended to replace an in-person face-to-face service to the patient.
Laboratory tests	Not performed as an in-person service.
Radiology interpretation and report services	Not performed as an in-person service.
Remote monitoring of physiologic parameter(s)	Per code definitions, not performed as an in-person service.
Cardiovascular monitoring services (93224 – 93248)	These services always performed as remote monitoring.
Real-time remote intraoperative neurophysiologic monitoring.	These services always performed as remote monitoring.
Radiology interpretations.	Bill with modifier 26 unless billing an interpretation-only procedure code.
Beginning in 2017, the current CPT book Appendix P includes some procedure codes which are always performed remotely, some of which are listed above in this table.	Modifier 95 will be considered valid for these codes (based upon the CPT book information only), but modifier GT and GQ will not be considered valid for these procedure codes.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation	Definition
AMA	American Medical Association

Acronym or Abbreviation	Definition
AS	Alaska Statute.
ASO	Administrative Services Only
ATA	American Telemedicine Association
CAH	Critical Access Hospital
CCI	Correct Coding Initiative (see “NCCI”)
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DMAP	Division of Medical Assistance Programs
DOS	Date Of Service
DSMT	Diabetes self-management training
DRG	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	Evaluation and Management (services, visit) (Abbreviated as “E/M” in CPT book guidelines, sometimes also abbreviated as “E&M” or “E & M” in some CPT Assistant articles and by other sources.)
ESRD	End-stage renal disease
FQHC	Federally Qualified Health Center
HealthIT.gov	A federal government resource website maintained by ONC.
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009
IC	Idaho Code (Statute)
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	National Correct Coding Initiative (aka “CCI”)
NPI	National Provider Identifier
NRTRC	Northwest Regional Telehealth Resource Center
OCR	Office of Civil Rights (branch of HHS that enforces HIPAA)
OAR	Oregon Administrative Rules
OHA	Oregon Health Authority
OHP	Oregon Health Plan (aka Oregon Medicaid)
ONC	Office of the National Coordinator for Health Information Technology (ONC)
OTP	Opioid Treatment Program
ORS	Oregon Revised Statute
OUD	Opioid Use Disorder
PHE	Public Health Emergency
PHI	Protected Health Information
POS	Place of Service
RHC	Rural Health Clinic
RPM	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
RPM	Remote Patient Monitoring (also known as/see also Remote Physiologic Monitoring)

Acronym or Abbreviation	Definition
RPM	Remote Physiologic Monitoring (also known as/see also Remote Patient Monitoring)
SBIRT	Screening, Brief Intervention and Referral to Treatment
SNF	Skilled Nursing Facility
TAC	Texas Administrative Code
TIC	Texas Insurance Code
TIN	Tax ID Number
TOC	Texas Occupational Code
UB	Uniform Bill
VoIP	Voice over Internet Protocol

Definition of Terms

Sorting-out "Tele-" Terminology	
Term	**Definition**
Telehealth	Telehealth is the use of technology to deliver health care, health information or health education at a distance. Telehealth is a broad term that includes: • Telemedicine clinical services • Other clinical services. Examples include: o Provider-to-provider consultations which are not face-to-face o Remote patient monitoring o Remote patient health education (e.g. webinars on specific health issues), prescribed or voluntary. • Non-clinical services. Examples include: o Physician teleconference about new best practices in treating angina o Provider training (medical students or licensed staff) o Administrative meetings o Continuing medical education • Technology – o Audio plus video o Audio-only (telephone) o Data-only (remote intraoperative monitoring) o Audio plus data or webinar, no person-to-person video o Instant messaging o Email contact • Timing – o Immediate, real-time, interactive exchanges. o Delayed data transmission and/or delayed interpretation and results. "Telehealth is different from telemedicine because it refers to a *broader scope of remote healthcare services* than telemedicine." (ONC/HealthIT.gov[1])

Sorting-out "Tele-" Terminology	
Term	**Definition**
Telemedicine	Remote clinical services which are typically or traditionally delivered in-person with the provider and patient in the same location. Telemedicine services are delivered via technology because the patient and the provider are in two different locations (remote services). **Note 1 (Commercial plans):** Services performed via synchronous two-way interactive audio + video secure conferencing by a contracted provider are considered ***covered*** telemedicine services eligible for reimbursement, when all other requirements are met. Services performed by a non-contracted provider or by contracted providers via asynchronous technology are ***not considered covered*** telemedicine services and are not eligible for reimbursement under a Moda Health Commercial plan. **Note 2 (Medicare Advantage plans):** Medicare and Medicaid (CMS) considers Telemedicine to **only** include: Remote, face-to-face clinical services with real-time, two-way, interactive communication using both audio and video transmission. (CMS[2, 3]) This CMS definition is very strict. Any communication or data exchange which is time-delayed or does not include video (visual) transmission of information and data is not considered a telemedicine service by CMS. For Moda Health Commercial plans, there are covered telemedicine services and non-covered telemedicine services; but for CMS and Medicare Advantage, if the service does not meet the coverage requirements, it may not be called a "telemedicine service."
Telemonitoring	The use of telecommunications and information technology to provide patient monitoring (real-time or delayed store and transmit) to a separate monitoring and interpretation site.
Telepresenter	An individual, at the same location as the member who provides support to the patient and the telemedicine consulting provider, in completing the physical examination and/or telemedicine activity. The telepresenter is trained to use specialized telemedicine technology, such as digital stethoscope, otoscope, ophthalmoscope, and examination camera, to facilitate comprehensive exams under physician guidance.[7, 8]

Telehealth-related Terms	
Term	**Definition**
Asynchronous (also called "Store and Forward")	Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image or information data that is sent (forwarded) via telecommunication to another site for consultation.
Distant site (also called "Hub site")	Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

Telehealth-related Terms	
Term	**Definition**
E-visit	An exchange of emails between member and provider asking and addressing clinical concerns are sometimes referred to as an "e-visit." Most groups do not provide benefits for email exchanges between member and provider or "e-visits;" a few select plans may specifically have an additional benefit for this service.
Hub site (also called "Distant site")	Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.
In-person	Face to face interaction when the member and provider are physically in the same location.
Originating site (or Spoke site)	Location of the patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.
Remote Patient Monitoring (RPM) **Remote Physiologic Monitoring** (RPM)	Remote patient/physiologic monitoring (RPM) is using technology to enable monitoring of patients outside of conventional clinical settings (e.g., monitoring the patient in the home instead of in the clinic or the hospital). The monitoring involves the collection and analysis of patient physiologic data (e.g., heart rate, blood pressure, weight, temperature, glucose level, etc.) that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition.[40] Remote patient monitoring may be part of Home Health Agency services or may be handled directly by a physician/clinic.
Remote services	Services which occur when the member and provider are not physically in the same location. The amount of distance between the member's location and the provider's location is not significant; the member and provider may be located in the same city but different buildings and communicating via technology. The member may be in a rural or urban location and does not need to be in a Health Professional Shortage Area (HPSA).
Secondary Provider Network AKA: "Rented Network" or "Travel Network."	A group of providers contracted directly with another company. Moda Health then contracts with that other company to use their network of providers for specific member plans under specific circumstances. The secondary network company has control over the list of participating providers, fee schedule, and other contract terms. Moda Health pays for the additional provider access and hold-harmless protection for our members. Claims are processed as in-network when criteria is met. Different plans/groups may use different secondary networks. Examples include: Private Healthcare Services (PHCS), First Choice Health Network, Idaho Physician's Network (IPN), and First Health Network. Sometimes also called "rented network" or "travel network."
Spoke site (or Originating site)	Location of the patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.
"Store and Forward" (also called Asynchronous)	Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.

Telehealth-related Terms	
Term	**Definition**
Virtual Care	A wide-ranging term that includes telemedicine, virtual visits, and other non-telemedicine benefits and/or services. May include a nurse-advice line, emailing a physician, etc. which are not considered telemedicine.
Virtual Visit	A telemedicine visit that uses real-time, audio-visual technology and special equipment to accomplish a visit that is virtual or "the same as being there in person." Qualifies for modifier GT or 95.

Procedure codes (CPT & HCPCS):

Online evaluation and management service procedure codes		
Code	**Code Description**	**Applicable DOS**
99444	Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network	Terminated 12/31/2019. **Do not use for 2020 dates of service.**
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	Effective 1/1/2020
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	Effective 1/1/2020
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	Effective 1/1/2020

Note: These are originating site fees. They do not represent the primary service performed.	
Code	**Code Description**
Q3014	Telehealth originating site facility fee
T1014	Telehealth transmission, per minute, professional services bill separately **(T1014 not accepted for any of our plans)**

Modifier Definitions:

Modifier	**Modifier Description & Definition**
FQ	The service was furnished using audio-only communication technology
FR	The supervising practitioner was present through two-way, audio/video communication technology
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunication systems

Modifier	Modifier Description & Definition
93	**Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system:** Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.
95	**Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System:** Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Modifier 95 may only be appended to the services listed in Appendix P. Appendix P is the list of CPT codes for services that are typically performed face-to-face but may be rendered via a real-time (synchronous) interactive audio and video telecommunications system.

Place of Service code:

Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service. (CMS MM9726[3])

Code	Short Description	Place of Service Code Long Description
02	Telehealth	The location where health services and health related services are provided or received, through telecommunication technology. (Does not apply to originating site facilities billing a facility fee.) **(Effective for claims submitted 1/1/2017 – 12/31/2021, regardless of date of service.)**
02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. (Does not apply to originating site facilities billing a facility fee.) **(Description change effective January 1, 2022, and applicable for Medicare LOB April 1, 2022.)** [25]

Code	Short Description	Place of Service Code Long Description
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology. (Does not apply to originating site facilities billing a facility fee.) (This code is effective January 1, 2022, and available to Medicare April 1, 2022.) [25]

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems" (for example,99201 GT). By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the beneficiary was present at an eligible originating site when you furnished the telehealth service. By coding and billing the GT modifier with a covered ESRD-related service telehealth code, you are certifying that you furnished one "hands on" visit per month to examine the vascular access site." [5]

"Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838…"[5]

"The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies. This fee is subject to post payment verification." [10]

"The list of settings where a physician's services are paid at the facility rate include:

- Telehealth (POS code 02);
- Outpatient Hospital-Off campus (POS code 19);
- Inpatient Hospital (POS code 21);
- Outpatient Hospital-On campus (POS code 22);
- Emergency Room-Hospital (POS code 23);
- Medicare-participating ambulatory surgical center (ASC) for a HCPCS code included on the ASC approved list of procedures (POS code 24);
- Medicare-participating ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24);
- Military Treatment Facility (POS code 26);
- Skilled Nursing Facility (SNF) for a Part A resident (POS code 31);
- Hospice – for inpatient care (POS code 34);
- Ambulance – Land (POS code 41);
- Ambulance – Air or Water (POS code 42);
- Inpatient Psychiatric Facility (POS code 51);
- Psychiatric Facility -- Partial Hospitalization (POS code 52);
- Community Mental Health Center (POS code 53);
- Psychiatric Residential Treatment Center (POS code 56); and

- Comprehensive Inpatient Rehabilitation Facility (POS code 61)." [27]

"During the PHE, Medicare does not require use of telehealth Place of Service codes. … However, Medicare contractors are to adjudicate claims containing this new code should it appear on a claim they (sic) same way they would adjudicate claims with POS 02." [25]

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Background Information

Telehealth and telemedicine are terms which are defined in multiple ways by multiple entities and organizations. The terms “telemedicine” and “telehealth” are often used interchangeably, although “telehealth” typically refers to a broader range of services, and “telemedicine” is a specific subset of “telehealth” services.

In general, the terms “telehealth” and “telemedicine” refer to the use of technology to deliver health care, health information or health education at a distance. Some of these applications involve the patient directly, others are professional-to-professional consultations regarding patient care, and yet others are professional education which is not connected to the care of a patient. Some of these telehealth applications are covered and eligible for reimbursement and others are not. Telemedicine and telehealth comprise a significant and rapidly growing component of health care in the United States. (ATA[6]) The boundaries of telehealth are limited only by the technology available – new applications are being invented and tested every day. [1]

Telehealth is a potentially useful tool that, if employed appropriately, can provide important benefits to patients and improve healthcare. A wide variety of services may be performed as telemedicine services; some may meet the requirements for coverage, and others may not. The basic service is reported with the normal procedure code(s) for the service performed. The fact that the services were performed as a telemedicine service may be identified with a modifier.

The Centers for Medicare and Medicaid Services (CMS) promotes telemedicine as beneficial and useful to improve primary and preventative care to Medicare beneficiaries who live in underserved and rural areas. CMS states that telemedicine provides remote access for face-to-face services when beneficiaries and providers are geographically separated and offers great promise for reducing access barriers for chronically ill Medicare beneficiaries.

In addition, there are legislative mandates for coverage of some specific telehealth and telemedicine services. Oregon state law mandates certain specific telemedicine services. OR SB 144 modified an existing

telemedicine mandate, ORS 743A.058. The modified mandate of OR SB 144 applies to Oregon commercial insured medical benefit plans which are issued or renewed on and after 1/1/2016. Alaska HB 234 incorporated telehealth coverage for mental health benefits in Alaska Statute 21.42.422 for new and renewing plans on and after 10/1/2016.

This policy is intended to define telehealth and telemedicine terminology for our company, plans, and claims, provide clarification of which services are and are not eligible for reimbursement, and specify the criteria and requirements which must be met.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
11/13/2024	Medicaid will now accept POS 10. Permanent CMS regulation changes to allow two-way, real-time audio-only communication technology with minimal requirements. Updated Cross References, Reference & Resources, and Appendix. Formatting updates.
1/10/2024	Reorganized information by topic rather than line of business. Clarified processing for T1014 for Medicaid. Idaho added to Scope. Updated Acronyms, Modifiers, POS codes, References & Resources. Formatting updates. No policy changes.
12/14/2022	Clarified long-standing same specialty policy for non-physician practitioners, coding for face-to-face E/M results in same-day telehealth consultation with specialty provider or higher level of care visit. Updated Medicaid Preventive E/M codes, Acronyms, References & Resources. Formatting updates. No policy changes.
8/10/2016	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.

Date	Summary of Update
1/1/2010	Original Effective Date (with or without formal documentation). Policy based on CMS telehealth policy. (Note: Various additional state mandates and other factors were later included/addressed.)

Appendix

Telemedicine Key Requirements by Line of Business – Quick Reference Grid

Legend:

category	Variations of criteria across jurisdictions and/or line of business Jurisdiction that is different will also be identified with amber fill color
category	Criteria is consistent across jurisdictions and lines of business

Requirement Category	Commercial Oregon	Commercial Alaska	Commercial Texas	Commercial Idaho	Medicare Advantage	Medicaid Oregon
Telemedicine Regulations (plans compliant with)	ORS 743A.058 (including HB2508 amendments making the Covid-19 telemedicine expansions permanent) ORS 743A.185	AS 21.42, including AK HB 234 added section AS §21.42.422 AS 08.01, including added section AS §08.01.085 (hyperlink is to the AK HB 265 since Alaska has not updated their online formbook to 2023 yet) AK §08.64.364 (physician)/ AK §08.68.710 (APRNs) – Allows for prescription of drugs without physical examination	Texas Occupations Code Chapter 111, Telemedicine, Teledentistry, and Telehealth (29exas.gov) TIC §§1455.001-1455.006; TIC §111.001 See Tex. Occ. Code §111.001; TOC §151.056(a).	IS 54-57, Idaho Virtual Care Access Act	CMS telemedicine regulations [CMS Fact Sheet ([5]) has not yet reverted back to full information addressed pre-Covid PHE.] (See also Noridian[76])	ORS 743A.058, ORS 743A.185, and OAR 410-141-3566
Privacy/Security requirement	HIPAA Compliant	HIPAA Compliant	HIPAA Compliant	HIPAA Compliant	HIPAA Compliant	HIPAA Compliant

Requirement Category	Commercial Oregon	Commercial Alaska	Commercial Texas	Commercial Idaho	Medicare Advantage	Medicaid Oregon
Communication Technology	Real-time, interactive audio and video encouraged by Moda whenever possible. All allowed, up to synchronous audio-only [ORS743A.058 (3) (a & b) & (4)], when necessary, appropriate & clinically effective	Real-time, interactive audio and video required	1) Real-time, interactive audio and video is allowed. 2) Asynchronous store and forward technology in conjunction with synchronous audio interaction is allowed. **Audio-only technology (without store and forward information) is not permitted.	Real-time, interactive audio and video encouraged by Moda whenever possible. All allowed, both synchronous and asynchronus [IS 54-5703]. All virtual care must be within scope of license and meet community standard of care [IS 54-5704].	Real-time, interactive audio and video required <u>Exceptions:</u> Procedure codes CMS approved for audio-only Opioid treatment programs (OTP) audio-only telephone calls allowed for therapy & counseling under specific CMS requirements.	Real-time, interactive audio and video encouraged whenever possible. All allowed, up to synchronous audio-only [ORS743A.058 (3) (a & b) & (4)], when necessary, appropriate & clinically effective
Provider Scope of License	Billed procedure code(s) must be within scope of license or certification	Billed procedure code(s) must be within scope of license or certification	Billed procedure code(s) must be within scope of license or certification	Billed procedure code(s) must be within scope of license or certification	Billed procedure code(s) must be within scope of license or certification	Billed procedure code(s) must be within scope of license or certification
Member Benefits - Telemedicine Coverage Requirements	Must be covered benefit if performed in person	Must be covered benefit if performed in person	Must be covered benefit if performed in person	Must be covered benefit if performed in person	Must be covered benefit if performed in person	Must be covered benefit if performed in person
Member Benefit Level	Equivalent to in-person services for both in-network and out-of-network providers.	Equivalent to in-person services for both in-network and out-of-network providers.	Equivalent to in-person services for both in-network and out-of-network providers.	Equivalent to in-person services for both in-network and out-of-network providers.	Equivalent to in-person services for both in-network and non-contracted providers who accept Medicare. No coverage if provider does not accept Medicare.	Equivalent to in-person services.

Requirement Category	Commercial Oregon	Commercial Alaska	Commercial Texas	Commercial Idaho	Medicare Advantage	Medicaid Oregon
Member Location	No restrictions	No restrictions	No restrictions	No restrictions	The member does not have to reside in a rural location to receive telehealth services through December 31, 2024. The member can receive telehealth services in their home or any setting of care through December 31, 2024.	No restrictions
Provider Location	No restrictions	No restrictions	No restrictions	No restrictions	Providers may furnish telehealth services from any location, including the provider's home through December 31, 2024.	No restrictions; OHA reminds to ensure privacy
provider-type requirements	Billed procedure code(s) must be within scope of license or certification	Billed procedure code(s) must be within scope of license or certification	Billed procedure code(s) must be within scope of license or certification	Billed procedure code(s) must be within scope of license or certification	Must be eligible to perform and receive reimbursement for covered telemedicine services under CMS requirements & subject to state law and scope of license restrictions.	Enrolled in DMAP. Billed procedure code within scope of license/certification.

Requirement Category	Commercial Oregon	Commercial Alaska	Commercial Texas	Commercial Idaho	Medicare Advantage	Medicaid Oregon
remote servicing across state lines (allow	1) Providers licensed and practicing in the state of Oregon may provide telemedicine services to Oregon residents with whom they have an established patient relationship while the provider is out-of-state. 2) Providers licensed and practicing outside of the state of Oregon may provide telehealth services if the patient was referred by their primary care or specialty provider located in Oregon.	1) Licensed in the state of Alaska 2) Registered with the Alaska telemedicine business registry	1) Licensed in State of Texas 2) Additionally, an out-of-state physician is allowed to provide "episodic consultations" without a Texas medical license, as provided by §151.056, §172.2(g)(4), and §172.12(f)(1-6) 3) Out of State Telemedicine Licenses are no longer issued, due to 2017 change in law, per Texas Medical Board. https://www.tmb.state.tx.us/page/telemedicine-license	1) Licensed & practicing in Idaho. 2) Mental or behavioral health provider registered with state of Idaho for telehealth (2023 HB 61). 3) Otherwise meets all the requirements under IS 54-5713.	Not allowed (CMS[37])	1) Providers licensed and practicing in the state of Oregon may provide telemedicine services to Oregon residents with whom they have an established patient relationship while the provider is out-of-state. 2) Providers licensed and practicing outside of the state of Oregon may provide telehealth services if the patient was referred by their primary care or specialty provider located in Oregon.
Specific list of procedure codes for telehealth	None Must be safely and effectively performed via telehealth.	None Must be safely and effectively performed via telehealth.	None Must be safely and effectively performed via telehealth.	None Must be safely and effectively performed via telehealth.	CMS-published telehealth procedure code list	None Must be safely and effectively performed via telehealth.

Requirement Category	Commercial Oregon	Commercial Alaska	Commercial Texas	Commercial Idaho	Medicare Advantage	Medicaid Oregon
Coding and Billing Requirements						
Procedure codes	Use appropriate CPT or HCPCS code(s) for service(s) performed.	Use appropriate CPT or HCPCS code(s) for service(s) performed.	Use appropriate CPT or HCPCS code(s) for service(s) performed.	Use appropriate CPT or HCPCS code(s) for service(s) performed.	Use appropriate CPT or HCPCS code(s) for service(s) performed.	Use appropriate CPT or HCPCS code(s) for service(s) performed.
Place of Service (POS) codes	POS 02 or 10	POS 02 or 10	POS 02 or 10	POS 02 or 10	POS 02 or 10	POS 02 or 10 [79]
Modifiers 95 & GT	95 or GT not needed with POS 02/10 (optional but redundant) GT required for CAH (no POS field on UB04 claims). GT not allowed on UB04 claims from non-CAH facilities.	95 or GT not needed with POS 02/10 (optional but redundant) GT required for CAH (no POS field on UB04 claims). GT not allowed on UB04 claims from non-CAH facilities.	95 or GT not needed with POS 02/10 (optional but redundant) GT required for CAH (no POS field on UB04 claims). GT not allowed on UB04 claims from non-CAH facilities.	95 or GT not needed with POS 02/10 (optional but redundant) GT required for CAH (no POS field on UB04 claims). GT not allowed on UB04 claims from non-CAH facilities.	Use modifier 95 when the clinician is in the hospital and the patient is in the home and for telemedicine outpatient therapy services by PT, OT, or SLPs. (Transmittal 12372) Modifier GT not required on CMS1500 claims; use POS 02/10. GT required for CAH (no POS field on UB04 claims). GT not allowed on UB04 claims from non-CAH facilities.	Do not use modifier 95. Modifier GT not required on CMS1500 claims; use POS 02. GT required for CAH (no POS field on UB04 claims). GT not allowed on UB04 claims from non-CAH facilities.
Modifiers 93 & GQ	93 (audio-only/telephone) or GQ (asynchronous) needed if that technology is used	93 (audio-only/telephone) or GQ (asynchronous) needed if that technology is used	93 (audio-only/telephone) or GQ (asynchronous) needed if that technology is used	93 (audio-only/telephone) or GQ (asynchronous) needed if that technology is used	93 (audio-only/telephone) or GQ (asynchronous) needed if that technology is used	93 (audio-only/telephone) or GQ (asynchronous) needed if that technology is used

Requirement Category	Commercial Oregon	Commercial Alaska	Commercial Texas	Commercial Idaho	Medicare Advantage	Medicaid Oregon
Modifiers, combinations	93/95/GT/GQ are mutually exclusive; only one of these may be reported; combining together will cause denial.	93/95/GT/GQ are mutually exclusive; only one of these may be reported; combining together will cause denial.	93/95/GT/GQ are mutually exclusive; only one of these may be reported; combining together will cause denial.	93/95/GT/GQ are mutually exclusive; only one of these may be reported; combining together will cause denial.	93/95/GT/GQ are mutually exclusive; only one of these may be reported; combining together will cause denial.	93/95/GT/GQ are mutually exclusive; only one of these may be reported; combining together will cause denial.
Modifier G0	Add G0 (G Zero) if telehealth is for acute stroke	Add G0 (G Zero) if telehealth is for acute stroke	Add G0 (G Zero) if telehealth is for acute stroke	Add G0 (G Zero) if telehealth is for acute stroke	Add G0 (G Zero) if telehealth is for acute stroke	Add G0 (G Zero) if telehealth is for acute stroke
Originating site fee (Q3014)	Use Q3014 when criteria met. T1014 not accepted.	Use Q3014 when criteria met. T1014 not accepted.	Use Q3014 when criteria met. T1014 not accepted.	Use Q3014 when criteria met. T1014 not accepted.	Use Q3014 when criteria met. T1014 not accepted.	Use Q3014 when criteria met. T1014 not accepted (per OHP fee schedule).