Clinical Policy: Telehealth, Virtual Communications and Remote Patient Monitoring

Reference Number: WNC.CP.193 Coding Implications
Last Review Date: Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

This policy is intended to provide new definitions and overarching guidance related to the delivery of services via telehealth, virtual communications and remote patient monitoring that are not otherwise included in a WellCare of North Carolina® program or service-specific clinical coverage policy.

Please refer to the applicable clinical coverage policy for the complete list of telehealth eligible services.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover services delivered via telehealth, virtual communications, and remote patient monitoring services when the **all** the following additional criteria are followed before rendering services via telehealth, virtual communications, or remote patient monitoring:

A. Provider(s) shall ensure that services can be safely and effectively delivered using telehealth, virtual communications, or remote patient monitoring.
B. Provider(s) shall consider a member's behavioral, physical and cognitive abilities to participate in services provided using telehealth, virtual communications, or remote patient monitoring.
C. The member'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, virtual communications, or remote patient monitoring, their ability to assist and their safety must also be considered.
E. Delivery of services using telehealth, virtual communications, or remote patient monitoring 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
G. Beneficiaries are not required to seek services through telehealth, virtual communications, or remote patient monitoring, and shall be allowed access to in-person services, if the member requests;
H. Provider(s) shall verify the member's identity using two points of identification before initiating service delivery via telehealth, virtual communications, or remote patient monitoring.
I. Provider(s) shall ensure that member privacy and confidentiality is protected to the best of their ability.

II. A range of services may be delivered via telehealth, virtual communication, and remote patient monitoring to beneficiaries. All telehealth, virtual communication, and remote monitoring services must be delivered in a manner that is consistent with the quality of care provided in-person. Eligible services, eligible providers, and related detailed guidance for the following may be found below:

A. Telehealth, including:
   1. Office or other outpatient services and office and inpatient consultation codes; **and**
   2. Hybrid telehealth visit with supporting home visit codes.
B. Virtual communication, including:
   1. Online digital evaluation and management codes;
   2. Telephonic evaluation and management;
   3. Telephonic evaluation and management and virtual communication codes; **and**
   4. Interprofessional assessment and management codes.
C. Remote patient monitoring, including:
   1. Self-measured blood pressure monitoring; **and**
   2. Remote physiologic monitoring.

Background[1]

I. Eligible Technology

A. Telehealth - All telehealth services must be provided over a secure HIPAA compliant technology with live audio and video capabilities including (but not limited to) smart phones, tablets and computers.
B. Virtual Patient Communications - Virtual patient communications must be transmitted between a patient and 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.
C. Remote Patient Monitoring - Remote patient monitoring requires use of a device that is defined by the FDA as a medical device and is in real-time and transmittable. Some forms of remote patient monitoring, such as remote physiologic monitoring (detailed below), require a device that is wirelessly synchronized where the provider can evaluate the data in real or near-real time. All remote patient monitoring must be conducted in a

HIPAA compliant manner, particularly with respect to protecting transmission of patient health data.

D. Originating Site Facility Fees - Any Medicaid enrolled provider who provides a member 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 member is located when the service is provided and the distant site provider is at a different physical location.
   1. Skilled nursing facilities (SNF) shall not bill an originating site facility fee when the SNF Medical Director or a member's attending physician is conducting a telehealth visit.

II. Additional Limitations or Requirements

Up to three different consulting providers may be reimbursed for a separately identifiable telehealth service provided to a member per date of service.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Table 1. Telehealth Services

	Eligible Providers					
Eligible Service/Codes	**Physician**	**NP**	**Psychiatric NP**	**Physician Assistant**	**Certified Nurse Midwife**	**Clinical Pharmacist Practitioner**
Office or Other Outpatient Service and Office and Inpatient Consultation Codes						
99202	X	X	X	X	X	X
99203	X	X	X	X	X	X
99204	X	X	X	X	X	X
99205	X	X	X	X	X	X
99211	X	X	X	X	X	X
99212	X	X	X	X	X	X
99213	X	X	X	X	X	X
99214	X	X	X	X	X	X
99215	X	X	X	X	X	X
99242	X	X	X	X	X	X
99243	X	X	X	X	X	X
99244	X	X	X	X	X	X

	Eligible Providers					
Eligible Service/Codes	**Physician**	**NP**	**Psychiatric NP**	**Physician Assistant**	**Certified Nurse Midwife**	**Clinical Pharmacist Practitioner**
99245	X	X	X	X	X	X
99252	X	X	X	X	X	X
99253	X	X	X	X	X	X
99254	X	X	X	X	X	X
99255	X	X	X	X	X	X
Hybrid Telehealth Visit with Supporting Home Visit Codes (See additional guidance below)						
99347	X	X	X	X	X	
99348	X	X	X	X	X	
99349	X	X	X	X	X	
99350	X	X	X	X	X	

* Family Planning beneficiaries are not eligible for new patient visit via telehealth.

Guidance: Hybrid Telehealth with Supporting Home Visit ("Hybrid Model")

1. Eligible providers may conduct telehealth visits with a supporting home visit by a delegated staff member ("hybrid model") with new or established patients, for a range of scenarios including (but not limited to):
   a. **Chronic Disease Management**: Providers shall use the home visit codes in this policy with appropriate modifiers.
   b. **Perinatal Care:** Providers shall only use the home visit codes in this policy with appropriate modifiers if they are not billing the pregnancy global package codes.
2. Well-child services are not eligible to be delivered via the hybrid model.
3. 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).
4. The delegated staff person may perform vaccinations in the home as long as they comply with applicable vaccination requirements (e.g., staff person's scope of practice), and may conduct other tests or screenings, as appropriate.
   a. Any vaccinations, tests or screenings conducted in the home should be billed as if they were delivered within the office, without modifiers.
5. Local Health Departments may also utilize the hybrid model when the telehealth visit is rendered by an eligible provider and may bill the home visit codes..
6. FQHCs, FQHC-Lookalikes, and RHCs may utilize this hybrid model but shall not bill the home visit codes; FQHCs, FQHC-Lookalikes and RHCs may bill their core service code (T1015) and an originating site facility fee (Q3014) for hybrid model visits to reflect the additional cost of the delegated staff person attending the member's home. To be reimbursed for the originating site facility fee, all of the following requirements must be met for each home visit:

a. The assistance delivered in the home must be given by an appropriately trained delegated staff person.
b. The fee must be billed for the same day that the home visit is conducted.
c. HCPCS code Q3014 must be appended with the GT modifier and billed with a place of service '12' to designate that the originating site was the home.
d. The core service code (T1015) must be billed separately from the originating site facility fee code (Q3014).

Table 2. Virtual Communication Services

Eligible Service/Codes	Eligible Providers: Physician	Nurse Practitioner	Psychiatric NP	Physician Assistant	Certified Nurse Midwife
Online Digital Evaluation and Management Codes					
99421+	X	X	X	X	X
99422+	X	X	X	X	X
99423+	X	X	X	X	X
Telephonic Evaluation and Management and Virtual Communication Codes					
99441	X	X	X	X	X
99442	X	X	X	X	X
99443	X	X	X	X	X
G2012	X	X	X	X	X
Interprofessional Assessment and Management Codes					
99446	X				
99447	X				
99448	X				
99449	X				

Services billable by FQHCs, FQHC Lookalikes and RHCs are identified with a plus sign (+).

Table 3. Remote Patient Monitoring Services

Eligible Service/Codes	Eligible Providers: Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwife	Code-Specific Guidance
Self-Measured Blood Pressure Monitoring Codes (see additional guidance below)						
99473+	X	X	X	X	X	Providers may bill once per member, per device. May be performed remotely. No more than one provider may bill for the same member.
99474+	X	X	X	X	X	Providers may bill once in a 30-day period if they

Eligible Service/Codes	Eligible Providers Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwife	Code-Specific Guidance
						complete a minimum of 12 readings. No more than one practice may bill for the same member in the same month.
Remote Physiologic Monitoring Codes (see additional guidance below)						
99453+	X	X	X	X	X	May be billed only once for each episode of care, which begins when the RPM is initiated and ends with attainment of targeted treatment goals.
99454+	X	X	X	X	X	May be billed once every 30 days continuously (not calendar month, by contrast with code 99457 below).
99457+	X	X	X	X	X	May be billed for the first twenty minutes of communication with the member or caregiver in the calendar month, and only once per calendar month per member.
99458+	X	X	X	X	X	May be billed for each additional twenty minutes of communication with the member or caregiver in the calendar month

Services billable by FQHCs, FQHC Lookalikes and RHCs are identified with a plus sign (+).

Guidance: Self-Measured Blood Pressure Monitoring (SMBPM)

a. SMBPM is a member's regular use of a personal blood pressure monitoring device to assess and record blood pressure across different points in time outside of a clinical setting, typically at home. This service is available for new or established patients. SMBPM require a device that is wirelessly synced where the provider can evaluate the data in real or near-real time. All remote patient monitoring must be conducted in a HIPAA compliant manner, particularly with respect to protecting transmission of patient health data.

Guidance: Remote Physiologic Monitoring (RPM)

a. **RPM** is the collection and interpretation of an established member's physiologic data digitally transmitted to the eligible provider. **Codes 99453 and 99454 are used for device set-up, training and supply – the following guidance applies to both of these codes**:

1. 99453 and 99454 can be used for blood pressure RPM if the device used to measure blood pressure meets RPM requirements. If the member self-reports blood pressure readings, the provider should instead bill SMBPM codes 99473/99474.
2. 99453 and 99454 cannot be reported if monitoring is less than 16 days in duration.
3. Providers should not report codes 99453 or 99454 if the services are included in any other codes covered by NC Medicaid for the duration of time of the RPM (for example, continuous glucose monitoring that is covered under code 95250).

b. **RPM treatment management services** are the use of the RPM results by the eligible provider to manage an established patient's treatment plan. **Codes 99457 and 99458 are used to report RPM treatment management services – the following guidance applies to both of these codes.**
   1. Codes 99457 and 99458 require a live, interactive communication between the member or caregiver.
   2. Providers may not bill code 99457 or 99458 for interactions of less than 20 minutes.

c. **For all RPM and RPM treatment management service codes**: If the services described by codes 99453, 99454, 99457 or 99458 are provided on the same day a member presents for an evaluation and management service to the same provider (whether by telehealth or in person), these services should be considered part of the E/M service and not billed under the RPM code.

   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 patient communications (including telephonic evaluation and management services) or remote patient monitoring.

Telehealth, virtual communication, and remote patient monitoring 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).

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	06/21
Added statement directing providers to applicable policy for complete list of telehealth codes. Added notes for modifier GT and POS.	07/21	08/21
Deleted CPT code 99201.	07/22	08/22
Annual Review. Background I.C. Add to end of first sentence "and is in real-time and transmittable." Under table "Eligible Providers," added "Family Planning beneficiaries are not eligible for new patient visit via telehealth" at the bottom of the table. Under table "Eligible providers," Add "self-monitored blood pressure monitoring (SMBPM) requires a device that is wirelessly synced where the provider can evaluate the date in real or near real time. Monitoring must be	10/22	11/22

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
conducted on a HIPPA compliant manner particularly with respect to protecting transmission of patient health data."		
Annual Review. NCHC verbiage removed from NC Guidance Verbiage. Under Background I.E., "Added: "Up to three different consulting providers may be reimbursed for a separately identifiable telehealth service provided to a member per date of service." (Per State documented update, "This line was inadvertently left out of the updated policy during the PHE.") Remove end dated codes, 99241 and 99251 from the table.	05/23	05/23
Annual Review.		

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 1H Telehealth, Virtual Communications and Remote Patient Monitoring. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov), . Published June 1, 2023. Accessed January 3, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay

the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service

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

a. meet Medicaid 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 procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

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) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
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 procedure, product or 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 procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers,

members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.