State Medicaid Telehealth Findings & Summary Report

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# Introduction

While telehealth service delivery for Medicare beneficiaries is fairly homogeneous across the nation, state Medicaid agencies differ widely in services that are covered, reimbursement, consent and more. For purposes of this report, telehealth is defined as synchronous telecommunication using both audio and video for delivery of health care services and is confined to the ~ 110 Category 1 (permanent) codes listed on the Centers for Medicaid & Medicaid Services (CMS) [List of Telehealth Services](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

There are additional state-specific variances in coverage of remote physiologic monitoring, audio-only telehealth and other virtual services. This report seeks to highlight some of those differences, including any best practices, recommendations or suggestions to help inform post-pandemic remote service delivery in Idaho.

Several states were researched, including California (CA), Colorado (CO), Louisiana (LA), New York (NY), Pennsylvania (PA), Tennessee (TN), Texas (TX) and Utah (UT). The details for telehealth were most comprehensive, robustly developed and organized in the materials reviewed for TX. PA seems to have the least developed telehealth support. Prior to the pandemic, telehealth reimbursement in PA primarily focused only on consultations by enrolled physician specialists for consults rendered using real-time, interactive telecommunication technology. The currently (June 2021) pending [HB 642](https://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2021&sessInd=0&billBody=H&billTyp=B&billNbr=0642&pn=0598) that was introduced to the Pennsylvania General Assembly in February 2021 has the potential to expand telehealth in PA. Because TennCare services are offered through managed care entities, each managed care organization (MCO) has its own telehealth policies, making it challenging to clarify the status telehealth for the entire state of TN.

The consultant, Trudy Bearden, began research efforts at the [Center for Connected Health Policy](https://www.cchpca.org) (CCHP) website for the initial source for state-specific telehealth information and then researched the statutes, provider manuals, etc. See [State Medicaid Telehealth Resources](#TelehealthResources) in the Appendix.

# Best practices

* Simplify consent for telehealth services
* Create a one-stop resource with all telehealth-related information – an Idaho Medicaid Telehealth Guide – with links to the relevant resources, statutes, etc. None of the seven states had one-stop shopping for all telehealth information. Researching to find all references and regulations is time-consuming. If the information is not readily available and clear for telehealth providers, there is the risk for poor quality telehealth service delivery.
* Clearly state that any services delivered by telehealth must comply with all components and procedural definitions for the CPT/HCPCs code that is billed. Medi-Cal reiterates this seemingly obvious but important point in several places.
* Reinforce that telehealth services must be clinically appropriate (again, seemingly obvious)

# In-person visit prior to delivering telehealth

Some states clearly state that an in-person visit is required prior to delivering telehealth services. For other states (e.g., CA), there is nothing stated, and in CO and TX it is clearly stated that an in-person visit is not required prior to a telehealth visit.

There has recently been some concern about the requirement to have an in-person visit prior to diagnosis, evaluation, or treatment of a mental health disorder. (See [Consolidated Appropriations Act, 2021](#ConsolidatedAppropriationsAct) quote in Appendix). The concern is that the requirement can cause a delay in care, leading to suffering and possible loss of life by the patient. It also exacerbates challenges with access to health care services. There is some guidance in the [Idaho Telehealth Access Act – Provider-Patient Relationship. Section 54-5705](https://legislature.idaho.gov/wp-content/uploads/statutesrules/idstat/Title54/T54CH57.pdf) that regards established relationships, but it does not stipulate that an in-person visit is required.

*Options include but are not limited to:*

* Require in-person visit prior to telehealth service delivery unless delaying care will be detrimental to the patient’s physical health or wellbeing with the further requirement for appropriate documentation of why the in-person visit was not performed. Include guidelines of what needs to be documented.
* Alternatively, ID Medicaid could require an in-person visit as soon as possible if not accomplished first, but that will increase per beneficiary cost and may create additional barriers to care.
* Do not require the in-person visit prior to telehealth services or only require it for specific visit types.

# Consent

Medicare consent is straightforward. Medicare requires beneficiary consent — verbal or written — for telehealth and other virtual services that includes notification of any applicable cost-sharing, including potential deductible and coinsurance amounts. Consent must be documented in the patient’s medical record. This aligns with cost transparency and helps reinforce that “Telehealth services substitute for an in-person encounter.”[[1]](#footnote-1) State Medicaid agency requirements for consent have great variation. Oddly, several states approach consent for a telehealth visit the same as consent for a surgery or procedure with a complex list of risks, benefits and alternatives.

Idaho telehealth consent requirements: “The participant must be informed and consent to the delivery models, provider qualifications, treatment methods, or limitations and telehealth technologies. The rendering provider at the distant site must also disclose to the participant their identity, current location, telephone number and Idaho license number.”[[2]](#footnote-2) It’s unclear why the participant needs to consent to the delivery model, treatment methods and telehealth technologies as they seem fairly interrelated. See [State-Specific Consent Examples](#Consent) in Appendix.

*Suggestions for inclusion in consent:*

* Include the Medicare consent requirements above.
* Advise patients as part of consent that telehealth visits are just like in-person visits only they are conducted by audio and video with the patient in one location and the provider in a different location. All of the requirements for the telehealth visit are the same, although telehealth makes physical exams and vital signs more challenging.
* Provide guidance to telehealth providers on frequency of consent (e.g., prior to each visit or annually)
* Clarify that the care team or nonclinical staff with appropriate training may discuss, obtain and document consent in the medical record.

# Geographic restrictions

There is pending legislation to make permanent the waiver lifting geographic restrictions for Medicare beneficiaries that previously required that an originating site be either in a county outside a Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA) in a rural census tract. None of the reviewed states required any restrictions based on geography.

# Continuity and coordination of care

Some but not all states required that distant site providers ensure continuity by providing the primary care provider with notes from the telehealth visit.

*Assessment.* The current Idaho Medicaid requirement is a great model. “Rendering providers must provide timely coordination of services, within three business days, with the participant’s primary care provider. The PCP should be provided in written or electronic format a summary of the visit, prescriptions and DME ordered, if applicable, and any other pertinent information from the visit.”[[3]](#footnote-3) The only recommendation is to clearly list that sharing the assessment and plan of care is required rather than just “summary of the visit”.

# Federally Qualified Health Centers (FQHCs) & Rural Health Clinics (RHCs)

Most if not all state Medicaid agencies reimbursed FQHCs and RHCs as distant sites for delivering telehealth but pay according to the prospective payment system (PPS) or all-inclusive rate (AIR), respectively. Similarly, some states reimburse for originating site fees and others do not.

# Audio-only

Most state Medicaid agencies do not reimburse for audio-only telehealth (with exceptions during the public health emergency declaration (PHE)). CO is an exception; Colorado [SB20-212](http://leg.colorado.gov/sites/default/files/2020a_212_signed.pdf) states that “Telemedicine may be provided through interactive audio, interactive video, or interactive data communication, including but not limited to telephone, relay calls, interactive audiovisual modalities, and live chat” as long as the technologies are HIPAA-compliant.

# Service parity (reimbursement for *all* of the Category 1 (permanent) telehealth services)

Most states offer a select set of services for telehealth service delivery, but it is unclear if or how many offer the full ~ 110 Category 1 telehealth codes. LA Medicaid offers broad coverage “Louisiana Medicaid encourages the use of telemedicine/telehealth, when appropriate, for any and all healthcare services” and may be delivered via an interactive audio/video telecommunications system. Texas offers a limited set of codes – see table in [Telecommunication Services Handbook](https://www.tmhp.com/sites/default/files/microsites/provider-manuals/tmppm/html/index.html#t=TMPPM%2F2_Telecommunication_Srvs%2F2_Telecommunication_Srvs.htm%23XREF_35335_Telecommunication) – with a more restrictive list for some organization types (e.g., FQHCs limited to G0466-70 and T1015). PA has the most restricted set of telehealth services, which are only allowed for consultants (pre-pandemic).

# Payment parity (reimbursement equal to in-person visit)

All of the seven researched state Medicaid agencies provide payment parity for telehealth services.

# Distant (where provider is) & originating site (where patient is)

**Distant site.** Most states do not limit the distant site. However, LA Medicaid prefers that the location is in a healthcare facility. If there is disruption to the facility or risk of health or safety of the provider, there is no formal limit to where the provider can be.

**Originating site.** Most states do not limit the originating site and include the patient’s home. Most follow along the lines of what Medi-Cal does.

* Patient location is not limited to any setting and includes the patient’s home (originating site)
* Provider may deliver services from anywhere in the community (distant site)
* Reimbursement for originating site fee (providing room, telecommunications equipment, etc.) using Q3014 (note that LA does not reimburse originating site fee)
* Presence of a health care provider is not required as a condition of payment.
* TX reimburses FQHCs/RHCs for the originating site fee (see section 3.3.4.2. Patient Site in the [Telecommunication Services Handbook](https://www.tmhp.com/sites/default/files/microsites/provider-manuals/tmppm/html/index.html#t=TMPPM%2F2_Telecommunication_Srvs%2F2_Telecommunication_Srvs.htm%23XREF_35335_Telecommunication)). However, Medi-Cal considers costs of being an originating site as included in the PPS and AIR.

**ID Medicaid and distant and originating sites.** The locations of the patient and provider for the telehealth visit can be “nearly anywhere” with either the patient or the provider located in their home.

# Telebehavioral health and substance use disorder services

There was broad support across all of the researched states to provide telebehavioral health and substance use disorder (SUD) services. However, it does not appear that any are taking full advantage of the full set of telebehavioral codes or the new SUD telehealth codes, effective Jan 1, 2021, to expand services. See [2021 Behavioral/Mental Health and SUD Telehealth Codes](#BHSUDCODES) in Appendix. TX describes behavioral health and substance use disorder services in the [Telecommunication Services Handbook](https://www.tmhp.com/sites/default/files/microsites/provider-manuals/tmppm/html/index.html#t=TMPPM%2F2_Telecommunication_Srvs%2F2_Telecommunication_Srvs.htm%23XREF_35335_Telecommunication)

# Documentation

Documentation for telehealth visits requirements is mostly the same as for in-person visits but should also include that the visit was conducted by telehealth, patient consent, locations of the originating and distant sites, start and stop times, names and roles of all individuals participating or observing at the originating and distant sites, back-up and emergency plan if the technology fails or patient requires emergency medical services (EMS), and if treating a minor, documentation that parent/guardian was present. Most states require documentation that the visit was conducted by telehealth.

**ID Medicaid documentation requirements in the medical record** include but not limited to:

* Same quality and documentation as for in-person visit
* All services provided and any related medical necessity
* Services were provided by telehealth
* Consent to receive telehealth services

The telehealth provider must also disclose:

* Their identity
* Current location
* Telephone number
* Idaho license number

# Cross-state licensure

Most state Medicaid agencies required licensure within the Medicaid beneficiary’s state to provide telehealth services, and several also include the requirement to be a Medicaid-enrolled provider (e.g., refer to “Provider Requirements” p. 3 [Medicine: Telehealth](https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf). *State of California-Health and Human Services Agency (CA HHS)).* LA Medicaid’s requirements are fairly complex – see the [CCHP summary of Cross-State Licensing](https://www.cchpca.org/louisiana/?category=professional-requirements&topic=cross-state-licensing-professional-requirements). In TX “Physicians who treat and prescribe through communications technology are practicing medicine and must possess a full Texas medical license when treating residents of Texas.” There is some leeway for out-of-state physicians to provide episodic consultations without a Texas medical license.[[4]](#footnote-4)

**Cross-state Licensure in ID.** “Providers at the distant site, who regularly provide telehealth services to Idaho Medicaid participants are required to maintain current Idaho licensure”5. Idaho participates in the [Interstate Medical Licensure Compact](https://www.imlcc.org/).

# Remote physiologic (or patient) monitoring (RPM)

RPM is the one virtual service that has the greatest potential to reduce ED visits, admissions and readmissions. RPM is a great addition to self-management support for patients, and many primary care clinics often include and bill for these services as part of Chronic and Principal Care Management. ID Medicaid added the five billing codes during the PHE but questions whether and how to continue reimbursing for these services. Most of the seven states did not cover RPM (as defined by Medicare). Interestingly, CO lists code 98970 as an RPM code, but this is a code for e-visits. (See [2021 Annual Update to the Therapy Code List](https://www.cms.gov/files/document/mm12126.pdf). CMS. Updated Dec 2020.) CO only allows RPM for Home Health services and does not reimburse for any the five RPM codes – see below. The [CCHP summary of RPM coverage by Louisiana Medicaid](https://www.cchpca.org/louisiana/?category=medicaid-medicare&topic=remote-patient-monitoring) indicates that in LA Medicaid refers to RPM as telecare and is limited to the [Community Choices Waiver](https://ldh.la.gov/index.cfm/page/380) (i.e., seniors and persons with adult-onset disabilities). Texas Medicaid refers to RPM as telemonitoring, which can be provided only by a home health agency or hospital providers who must notify the Texas Medicaid & Healthcare Partnership. See the [Telecommunications Services Handbook](https://www.tmhp.com/sites/default/files/microsites/provider-manuals/tmppm/html/index.html#t=TMPPM%2F2_Telecommunication_Srvs%2F2_Telecommunication_Srvs.htm%23XREF_35335_Telecommunication) and this [Texas Administrative Code link](https://texreg.sos.state.tx.us/public/readtac%24ext.TacPage?sl=T&app=9&p_dir=N&p_rloc=183233&p_tloc=&p_ploc=1&pg=7&p_tac=&ti=1&pt=15&ch=354&rl=1430) for additional details. There is reimbursement for the RPM code 99091, but the code is described as transmission of data to a licensed home health agency or hospital (which is not the official CPT description), suggesting that RPM is not an option for outpatient facilities.

There are at least three versions of RPM to keep distinct.

1. RPM as defined by Medicare, includes five billing codes (see [Remote Physiologic Monitoring (RPM)](#RPM) in appendices) and have several conditions and requirements. These RPM services require that “the medical device should digitally (that is, automatically) upload patient physiologic data (that is, data are not patient self-recorded and/or self-reported)”[[5]](#footnote-5), which is not the case for 2 and 3 below.
2. Medicare reimburses for other RPM services (e.g., self-measured blood pressure monitoring and continuous glucose monitoring (CGM), and [ambulatory blood pressure monitoring](https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=294)) that don’t technically fall under their RPM definition from 1 above.
3. Remote patient monitoring that may or may not be “physiologic” can be a great adjunct for chronic disease and other self-management and may include regular check-ins, reminders, diet logs and so much more. With the explosion of patient health apps, the possibilities continue to expand.

*Recommendation.* Using the five RPM codes and services, it is possible for ID Medicaid to continue to provide RPM as an option for select patients to reduce per beneficiary cost and improve patient outcomes. ID Medicaid can ensure that RPM is provided for patients at high risk of ED visits, hospitalizations or readmissions or adverse outcomes.

* Limit RPM to a select set of diagnoses (e.g., heart failure-daily weights to monitor fluid status, chronic obstructive pulmonary disease (COPD)-oxygen saturation to tailor medications when/if decompensating, diabetes for those with labile blood glucose that has led to recent ED visits or hospitalizations)
* Define high-risk patients (e.g., those with an admission within the past six months, two or more ED visits, and a poorly controlled chronic or acute condition) – or examine list of top 5% of high-cost beneficiaries and include in the population eligible for RPM
* Require specific documentation such as treatment goals related to the condition for which RPM is used (e.g., less than two pounds within 24 hours or five pounds in a week weight change for at least one month to ensure fluid control in patient with heart failure)
* Tie the specific treatment goals to an episode of care. Once goal(s) are reached, the episode of care and RPM ends.

# Interprofessional consults

This remote service option was not specifically researched among the seven states. Curiously, Medi-Cal reimburses for one of the interprofessional consult codes – 99451 – but refers to the services as “e-consults”.

# Teledentistry

There is a full range of coverage of teledentistry, and it can be challenging to find the details. CO only permits registered dental hygienists in consultation with a supervising dentist to perform limited procedures pertaining to Interim Therapeutic Restorations (ITR). (For existing policy information, refer to the [DentaQuest Office Reference Manual for Health First Colorado](https://www.dentaquest.com/getattachment/State-Plans/Regions/Colorado/Health-First-Colorado/Provider-Page/CO-Medicaid-ORM.pdf/?lang=en-US) – Teledentistry and ITR Billing Procedures p. 78 (note FQHC-specific info) and Exhibit A p. 160, Exhibit B p. 19 , and Exhibit C p. 255). According to [MouthWatch Teledentistry Regulations in Your State](https://www.mouthwatch.com/teledentistry-in-your-state-regulations-quick-facts/#LA) TN is one of the few states to specify teledentistry as a covered service by both Medicaid and private payers and has extensive teledentistry regulations, including a specific definition of teledentistry (see [SECTION 5 of HB2510](https://www.capitol.tn.gov/Bills/109/Bill/SB2510.pdf) see also [SB1214](https://www.capitol.tn.gov/Bills/109/Amend/HA1005.PDF) ). Dental hygienists may practice in offsite locations under general supervision to provide dental exams. “No teledentistry regulations exist in Texas”[[6]](#footnote-6) nor is teledentistry in the state specifically defined. However, note that [TX HB2056](https://legiscan.com/TX/text/HB2056/2021) was introduced during the 87th Legislature (2021-2022), which suggests it may soon be an option.

# Appendix

## State Medicaid Telehealth Resources

**California Medicaid Telehealth Resources**

1. [California Current Telehealth State Laws and Policy](https://www.cchpca.org/california/). *Center for Connected Health Policy*. Accessed June 2021.
	* [California Current State Laws & Policy PDF](https://www.cchpca.org/california/?pdf)
2. [Medi-Cal Provider Manuals - Part 2 - Clinics and Hospitals (CAHs)](https://files.medi-cal.ca.gov/pubsdoco/manual/man_query.aspx?wSearch=*_*o00*+OR+*_*o03*+OR+*_*z00*+OR+*_*z02*&wFLogo=Part2+%23+Clinics+and+Hospitals+(CAH)&wPath=N)
	* [Medicine: Telehealth](https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf). *State of California-Health and Human Services Agency (CA HHS). Great* on delivering telehealth services in California. Includes several definitions, documentation requirements, billing and more. Note that individual pages are periodically updated.
	* [Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)](https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/rural.pdf). *State of California-Health and Human Services Agency (CA HHS).*
3. [CA Department of Health Care Services (DHCS) Telehealth Frequently Asked Questions](https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx). Great resource.
4. [CA DHCS Telehealth Definitions](https://www.dhcs.ca.gov/provgovpart/Pages/telehealthdefinitions.aspx).
5. [Medi-Cal Rates](https://files.medi-cal.ca.gov/Rates/RatesHome.aspx). *State of California-Health and Human Services Agency (CA HHS).*
6. [CA Department of Health Care Services (DHCS) Telehealth Resources](https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx).
	* For questions about submitting a claim for services provided by telehealth, please call the [Telephone Service Center (TSC) at 1-800-541-5555](https://files.medi-cal.ca.gov/pubsdoco/contact.aspx) (outside of California, please call (916) 636-1980).
	* Providers may email questions about Medi-Cal telehealth policy to Medi-Cal\_Telehealth@dhcs.ca.gov.
7. [Welfare and Institutions Code Sec. 14132.723 & 724 (AB 1494 – 2019 Legislative Session). Includes definitions, including telephonic services as well as provisions specific to state of emergency and the 90 days immediately following the state of emergency.](https://www.cchpca.org/california/?category=medicaid-medicare&topic=miscellaneous-medicaid-medicare)

**Colorado Medicaid Telehealth Resources**

1. [Colorado Current State Laws and Policy](https://www.cchpca.org/colorado/). *Center for Connected Health Policy*. Accessed June2021
	* [Colorado Current State Laws & Policy PDF](https://www.cchpca.org/colorado/?pdf)
2. [Telemedicine Billing Manual](https://hcpf.colorado.gov/telemedicine-manual). *Colorado Department of Health Care Policy & Financing.* Must-read information on delivering telehealth services in Colorado.
3. [Federally Qualified Health Care and Rural Health Care Billing Manuals](https://hcpf.colorado.gov/fqhc-rhc).*Colorado Department of Health Care Policy & Financing.* Two short paragraphs about telemedicine billing and originating sites.
4. [2018 Colorado Revised Statutes § 25.5-5-320. Telemedicine](https://law.justia.com/codes/colorado/2018/title-25.5/colorado-medical-assistance-act/article-5/part-3/section-25.5-5-320/). Covers reimbursement and disclosure statement to be used before treating a patient through telemedicine for the first time.
5. [Code of Colorado Regulations Medical Services Board 10 CCR 2505-10 8.200](https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=9448&fileName=10%20CCR%202505-10%208.200). *Colorado Department of Health Care Policy & Financing.* See section 8.200.3.B for the definition of telemedicine in Colorado. Note that [HB21-1190 – Defining Telemedicine for Medical Practitioners](http://leg.colorado.gov/bills/hb21-1190) signed by the Governor on May 18, 2021, makes slight modifications to the definition.
6. Colorado [SB20-212](http://leg.colorado.gov/sites/default/files/2020a_212_signed.pdf) – see the bill summary [here](http://leg.colorado.gov/bills/sb20-212), but this bill requires the state department to reimburse FQHCs for telemedicine services provided to Medicaid recipients and to do so at the same rate as when those services are provided in person.
7. [Provider Rates and Fee Schedule](https://hcpf.colorado.gov/provider-rates-fee-schedule). *Colorado Department of Health Care Policy & Financing.* Great resource to double-check coverage. For example, the five remote physiologic monitoring codes are 99091, 99453, 99454, 99457 and 99458. Only 99091 is on the fee schedule but is noted as “Not A Benefit”; the other four codes are not on the fee schedule.
8. [Prime Health Telehealth Tools](https://www.primehealthco.com/directory). *Prime Health.* There is a wealth of resources here, including a [Video Technology Decision Matrix](https://static1.squarespace.com/static/5e7a59954770eb76b4ac3960/t/5eaa0d33525cf600be532655/1588202804399/PrimeHealth_Video%2BConference%2BMatrix-FinalLook.pdf) and telehealth workflows.
9. [Stay Healthy at Home Using Virtual Care](https://healthathome.colorado.gov/) – Colorado patient education page with video “Understanding Virtual Care” (just under 4 min).

**Idaho Medicaid Telehealth Resources**

1. [Idaho Medicaid Provider Handbook. General Information and Requirements for Providers](https://www.idmedicaid.com/General%20Information/General%20Information%20and%20Requirements%20for%20Providers.pdf). Updated June 9, 2021.
2. [Medicaid Provider Information Regarding Telehealth](https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3234&dbid=0&repo=PUBLIC-DOCUMENTS) - Medicaid Information Release MA20-07. *Idaho Department of Health & Welfare (ID DHW)*. Updated April 7, 2020.
3. [Information for Medicaid Providers](https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers) – [Fee Schedules 2021](https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=15127&dbid=0&repo=PUBLIC-DOCUMENTS) April to June. *ID DHW.* Accessed June 2021.
4. [Idaho Telehealth Task Force Report, Recommendations and Action Plan](https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=7824&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1) – October 2020. *ID DHW.*
5. [Division of Public Health Telehealth Brief](https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=15907&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1). *ID DHW.* Two-page summary of telehealth use in Idaho from March-July 2020 with recommendation to advance telehealth.
6. [Idaho Telehealth Access Act](https://legislature.idaho.gov/wp-content/uploads/statutesrules/idstat/Title54/T54CH57.pdf). *ID Legislature.*
7. [House Bill 127](https://track.govhawk.com/public/bills/1441917) - Broadband. *ID Legislature.* Adds to existing law to establish Idaho Broadband Fund and the Idaho Broadband Advisory Board. 2021 Legislative Session. Signed by governor and effective March 19, 2021.
8. [House Bill 38](https://track.govhawk.com/public/bills/1413588). Telehealth Access. ID Legislature. Amends existing law to provide for the prescribing of certain drugs via telehealth in compliance with federal law. 2021 Legislative Session. Signed by governor and effective July 1, 2021.

**Louisiana Medicaid Telehealth Resources**

1. [Louisiana Current State Laws and Policy](https://www.cchpca.org/louisiana/). *Center for Connected Health Policy*. Accessed June 2021.
	* [Louisiana Current State Laws & Policy PDF](https://www.cchpca.org/louisiana/?pdf)
2. [Federally Qualified Health Centers Provider Manual – Chapter Twenty-Two of the Medicaid Services Manual](https://www.lamedicaid.com/provweb1/Providermanuals/manuals/FQHC/FQHC.pdf). Issued Dec 2010 – updates are per section. The only mention of telehealth is in Section 22.4: Reimbursement, which directs providers to Chapter Five of the Professional Services Provider Manual.
3. [Professional Services Provider Manual – Chapter Five of the Medicaid Services Manual](https://www.lamedicaid.com/provweb1/providermanuals/manuals/PS/PS.pdf). Issued Feb 2012 – updates per section. See Section 5.1: Covered Services for telehealth-related information – less than 1.5 pages.
4. [Behavioral Health Services Provider Manual – Chapter Two of the Medicaid Services Manual](https://www.lamedicaid.com/provweb1/Providermanuals/manuals/BHS/BHS.pdf). Issued Mar 2017 – updates per section. See Section 2.3: Outpatient Services for telehealth-related information.
5. [Behavioral Health Services Provider Manual](https://www.lamedicaid.com/provweb1/Providermanuals/manuals/BHS/BHS.pdf) (Chapter 2 of the Medicaid Services Manual). Louisiana Department of Health. Updates are per section. See Telehealth under section 2: Outpatient Services for the definition of telehealth.
6. [Louisiana Telehealth Access Act](http://www.lsbme.la.gov/sites/default/files/documents/In%20The%20News%20Items/La.%20R.S.%2040.1223.1-5%20Telehealth%20Law.pdf). Effective Jun 2015. Only five pages, mostly telehealth definitions.
7. [HB589 (2020 Regular Session)](http://www.legis.la.gov/Legis/ViewDocument.aspx?d=1180309). Louisiana State Legislature. Three pages: important telehealth-related clarifications and revisions to Louisiana statutes. Includes that Louisiana Medicaid must have an exhaustive list of covered healthcare services that can be delivered by telehealth.
8. [RS 37.1271](https://www.legis.la.gov/legis/Law.aspx?p=y&d=93150). Louisiana State Legislature. Covers license to practice medicine or telemedicine.
9. [RS 37.1271.1](https://www.legis.la.gov/legis/Law.aspx?d=1017179). Louisiana State Legislature. Covers the practice of telemedicine in licensed healthcare facilities.

**Pennsylvania Medicaid Telehealth Resources**

1. [Pennsylvania Current State Laws and Policy](https://www.cchpca.org/pennsylvania/). *Center for Connected Health Policy*. Accessed June 2021.
	* [Pennsylvania Current State Laws & Policy PDF](https://www.cchpca.org/pennsylvania/?pdf)
2. [Pennsylvania Medicaid Outpatient Fee Schedules](https://www.humanservices.state.pa.us/outpatientfeeschedule). Looking up certain codes can be helpful to understand if a virtual service is covered by PA Medicaid. For example, none of the remote physiologic codes are listed, indicating that these services are not currently covered.
3. [PA PROMISe, 837 Professional/CMS-1500 Claim Form, Provider Handbook, Appendix E – FQHC/RHC. p. 10](https://www.dhs.pa.gov/providers/PROMISe_Guides/Documents/appendix%20E.pdf)Includes details on telepsych encounters, covering only psychiatrists or psychologists – no other mention of telehealth.
4. [Consultations Performed Using Telemedicine](https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/d_005993.pdf) *Pennsylvania Department of Public Welfare.* Includes specific codes to be used.
5. [Guidelines for the Use of telehealth Technology in the Delivery of Behavioral Health Services](https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMHSAS/Final%20-%20OMHSAS%20Telehealth%20Bulletin%202.20.20.pdf) *Pennsylvania Department of Human Services.* Includes set of codes that can be used for telehealth for behavioral health.

**Tennessee Medicaid Telehealth Resources**

1. [Tennessee Current State Laws and Policy](https://www.cchpca.org/tennessee/). *Center for Connected Health Policy*. Accessed June 2021
* [Tennessee Current State Laws & Policy PDF](https://www.cchpca.org/tennessee/?pdf)
1. [Tenn. Code Ann. § 56-7-1002](https://advance.lexis.com/api/document/collection/statutes-legislation/id/5CFR-RBC0-R03K-G556-00008-00?cite=Tenn.%20Code%20Ann.%20%C2%A7%2056-7-1002&context=1000516) Telehealth services. Includes definitions, verbiage supporting service parity, and coverage for telehealth regardless of the patient’s geographic location.
	* [HOUSE BILL 8002](https://www.capitol.tn.gov/Bills/111/Bill/HB8002.pdf) amends 56-7-1002 and clarifies that health insurance entities shall reimburse for originating site fees.
2. [Tenn. Code Ann. § 56-7-1003](https://advance.lexis.com/api/document/collection/statutes-legislation/id/5CFR-SBS0-R03J-M558-00008-00?cite=Tenn.%20Code%20Ann.%20%C2%A7%2056-7-1003&context=1000516) Provider-based telemedicine. Clarifies that the healthcare services provider must have access to the relevant medical records, that audio-only, email, text, fax or remote patient monitoring is not included.
3. [TN Dept. of Mental Health and Substance Abuse Services. Office of Crisis Services and Suicide Prevention. Minimal Standards of Care](https://www.tn.gov/content/dam/tn/mentalhealth/documents/TN_Crisis_Services_2017_Minimal_Standards_of_Care.pdf)This document is essential and is must-read if providing these services by telehealth. See pp. 32-33 for details of minimal documentation for each crisis encounter for either face-to-face or telehealth.
	* [Telecommunications Guidelines for Tennessee Department of Mental Health and Substance Abuse Services Designated Service](https://www.tn.gov/content/dam/tn/mentalhealth/documents/Telehealth_Guidelines.pdf)s. This is Appendix 2 of the above document but does not include the documentation details noted on pp. 32-33 above.
4. [Rules of Tennessee Board of Dentistry](https://publications.tnsosfiles.com/rules/0460/0460-01.20190812.pdf). See section TELEDENTISTRY pp. 45-46.

**Texas Medicaid Telehealth Resources**

1. [Texas Current State Laws and Policy](https://www.cchpca.org/texas/). *Center for Connected Health Policy*. Accessed June 2021.
	* [Texas Current State Laws & Policy PDF](https://www.cchpca.org/texas/?pdf)
2. [Texas Medicaid Provider Procedures Manual – June 2021](https://www.tmhp.com/sites/default/files/microsites/provider-manuals/tmppm/html/index.html#t=TMPPM%2F1_00a_Preliminary_Information%2F1_00a_Preliminary_Information.htm) *Texas Medicaid & Healthcare Partnership.*
	* [Telecommunication Services Handbook](https://www.tmhp.com/sites/default/files/microsites/provider-manuals/tmppm/html/index.html#t=TMPPM%2F2_Telecommunication_Srvs%2F2_Telecommunication_Srvs.htm%23XREF_35335_Telecommunication) Must-read information on delivering telehealth services in Texas.
3. [Frequently Asked Questions – Nursing Practice](https://www.bon.texas.gov/faq_nursing_practice.asp#Telehealth) *Texas Board of Nursing*. See section “Telehealth”. Very short but worth a read – includes information about telenursing across state lines and some information about providing services by telephone only.
4. [Texas Administrative Code. Title 1. Part 15. Chapter 355. Subchapter J. Division 14. RULE §355.8261. Federally Qualified Health Center Services Reimbursement](https://texreg.sos.state.tx.us/public/readtac%24ext.TacPage?sl=T&app=9&p_dir=F&p_rloc=203953&p_tloc=29537&p_ploc=14679&pg=3&p_tac=&ti=1&pt=15&ch=355&rl=8261)Note the long list of providers who can conduct a telehealth encounter: physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, a qualified clinical psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or an optometrist.
5. [Texas Administrative Code. Title 1. Part 15. Chapter 354. Subchapter A. Division 33. RULE §354.1430. Definitions](https://texreg.sos.state.tx.us/public/readtac%24ext.TacPage?sl=T&app=9&p_dir=N&p_rloc=155324&p_tloc=&p_ploc=1&pg=3&p_tac=&ti=1&pt=15&ch=354&rl=1430)Excellent source for definitions.
6. [Texas Administrative Code. Title 1. Part 15. Chapter 354. Subchapter A. Division 33. RULE §354.1432. Telemedicine and Telehealth Benefits and Limitations](https://texreg.sos.state.tx.us/public/readtac%24ext.TacPage?sl=T&app=9&p_dir=N&p_rloc=155324&p_tloc=&p_ploc=1&pg=3&p_tac=&ti=1&pt=15&ch=354&rl=1430)Note here that the patient’s PCP must be notified of a telemedicine service (unless there is no PCP). There are other details in this rule that are must-read to ensure compliance.

**Utah Medicaid Telehealth Resources** - A comprehensive review of UT was not included.

1. [Utah Medicaid Provider Manual – Physician Services – Section 2](https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Physician%20Services/Physician%20Services%20Manual/PhysicianServices.pdf). *Division of Medicaid and Health Financing*. Updated May 2021.
2. [Utah Medicaid Provider Manual – General Information – Section 1](https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/All%20Providers%20General%20Information%20Section%20I/AllProvidersGeneralInfo_Section_1.pdf). *Division of Medicaid and Health Financing.* Updated May 2021.

## State-Specific Consent Examples

Medi-Cal consent is simple and straightforward: “…inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services.”[[7]](#footnote-7)

Colorado Medicaid consent includes that providers must document the member's consent, either verbal or written, to receive telemedicine services and must provide the following written statements to each patient before treating that patient through telemedicine for the first time (does not apply in an emergency):

1. “That the patient retains the option to refuse the delivery of the services via telemedicine at any time without affecting the patient's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled;
2. That all applicable confidentiality protections shall apply to the services; and
3. That the patient shall have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to his or her medical records.” ~ [CO Rev Stat § 25.5-5-320 (2018)](https://law.justia.com/codes/colorado/2018/title-25.5/colorado-medical-assistance-act/article-5/part-3/section-25.5-5-320/)

Louisiana

* “Providers must have informed consent to deliver telemedicine/telehealth services. The consent must include the following. A recipient’s authorization to receive telemedicine/telehealth services after a discussion of the following elements:
	1. The rationale for using telemedicine/telehealth in place of in-person services.
	2. The risks and benefits of the telemedicine/telehealth, including privacy-related risks.
	3. Possible treatment alternatives and those risks and benefits.
	4. The risks and benefits of no treatment.”[[8]](#footnote-8)

Texas

* Patient may give written or oral consent and consent must be documented in the patient’s medical record but unclear what the requirements of consent are.
	1. Adult client must provide written or verbal consent to distant site provider to allow any other individual to be present during telehealth service
	2. Must provide written or electronic notification of privacy practices prior to evaluation or treatment via a telemedicine medical service and good faither effort must be made to obtain patient’s written or electronic acknowledgement, including by email, of the notice.
	3. Must provide notice of how patients may file a complaint with the Board on the physician's website or with informed consent materials provided to patients prior to the telemedicine medical service. [[9]](#footnote-9)

## 2021 Behavioral/Mental Health and SUD Telehealth Codes

Codes in italics are new for 2021. National payment amount for the non-facility price (or facility price if no non-facility option) from the [Physician Fee Schedule is included only as an indication of the value of each code](https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx).

|  |
| --- |
| Behavioral/Mental Health and Substance Use DisorderMust-Have Resource: [Medicare Mental Health](https://www.cms.gov/files/document/medicare-mental-health.pdf). CMS. Updated June 2021. |
| Individual psychotherapy | 90832($78)90833($71)90834($103)90836($90)90837($152)90838($119) |
| Psychiatric diagnostic interview examination | 90791($181)90792($202) |
| Neurobehavioral status examination (clinical assessment of thinking, reasoning and judgement) – includes face-to-face time and interpreting test results and preparing the report, first hour (96116) *and each additional hour (96121)* | 96116($97)*96121($82)* |
| Psychoanalysis | 90845($98) |
| Family psychotherapy (without the patient present) | 90846($99) |
| Family psychotherapy (conjoint psychotherapy) (with patient present) | 90847($103) |
| *Group psychotherapy (other than of a multiple-family group)* | *90853($28)* |
| Psychotherapy for crisis  | 90839($145)90840($69) |
| Interactive complexity add-on (for psychotherapy codes)See Commonly Used CPT Codes section in [Medicare Mental Health](https://www.cms.gov/files/document/medicare-mental-health.pdf). CMS. Updated June 2021. | 90785($15) |
| 96156 Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making) 96159 Health behavior intervention (HBI), individual–Each additional 15 minutes (list separately in addition to 96158, which is not a Category 1 code but is listed as a temporary code during the PHE) 96164 HBI, group (2 or more patients), face-to-face; initial 30 minutes96165 HBI, group - each additional 15 minutes (list separately in addition to code for primary services)96167 HBI, family (with the patient present), face-to-face; initial 30 minutes96168 HBI, family (with the patient present)-each additional 15 minutes (list separately in addition to code for primary services) | 96156($97)96159($23)96164($10)96165($5)96167($71)96168($25) |
| Substance Use Disorder (in addition to Behavioral/Mental Health above) |
| *G2086: Office-based treatment for a substance use disorder (SUD), including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.**G2087: Office-based treatment for (SUD), including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month. G2088: Office-based treatment for (SUD), including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes* For full discussion of the SUD codes and services see Bundled Payments Under the PFS for Substance Use Disorders (HCPCS Codes G2086, G2087, and G2088) in the [CY 2021 PFS FR](https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf) (pp. 84642-3) | *G2086($395)**G2087($351)**G2088($66)* |

**Remote Physiologic Monitoring (RPM)**

Remote physiologic or patient monitoring (RPM) allows clinicians and health care teams the ability to monitor weight, blood pressure, blood glucose, pulse, temperature, oximetry, respiratory flow rates and more in a variety of settings, including patients’ homes. Based on the transmitted data, treatment plans are developed to help patients and care givers optimally manage health issues, keeping patients out of hospitals and emergency departments. Remote monitoring is especially important during a public health emergency (PHE) to reduce risk of infection transmission while keeping patients and staff safe, especially after a recent hospital discharge.

While the Centers for Medicare and Medicaid Services (CMS) has reimbursed for RPM since 2019, to date they have not created RPM-related educational materials as they have for other Medicare services. Using proposed and final rules published in the Federal Register by CMS, **Comagine Health** has compiled relevant regulatory details for health care organizations to implement RPM, which enhances service delivery options and improves outcomes, enhances the patient experience, and reduces health care costs.

**Summary of Key Details and Requirements for the Five RPM Codes Listed in Table 1 Below**

* Beneficiaries’ consent (verbal or written) to receive RPM and notification of any applicable cost sharing must be documented in the patient’s medical record.

# During the PHE, RPM may be:

* Furnished to new patients, as well.
* Initiated for patients for whom a face-to-face visit has not occurred.
* Delivered without the requirement of cost-sharing by the patient.
* Reported for shorter periods of time than 16 days - if the other code requirements are met.
* Because CMS has designated RPM as care management services, CPT codes 99457 and 99458 can be furnished by clinical staff under the general supervision of the physician or nonphysician practitioner.
* CMS clarifies that “the medical device should digitally (that is, automatically) upload patient physiologic data (that is, *data are not patient self-recorded and/or self-reported*)”[[10]](#footnote-10).
* Practitioners may provide RPM services for patients with acute and/or chronic conditions. This had been a provision during the PHE, and CMS has made this permanent[[11]](#footnote-11).
* Nurses, working with clinicians, can check in with the patient and then using patient data, determine whether home treatment is safe.
* RPM and Chronic Care Management codes, including Principal Care Management (new in 2020) can be billed concurrently by the same practitioner for the same beneficiary provided that the time is not counted twice.
* Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) cannot bill for RPM for Medicare beneficiaries. According to CMS “Services such as RPM are not separately billable because they are already included in the RHC AIR or FQHC PPS payment.”[[12]](#footnote-12) CMS did not change this in the CY 2021 PFS Final Rule.

**Figure 1. Overview and progression of services and codes through the end of an RPM episode of care**

**Table 1. Service Descriptions, Codes and Prices for General Remote Physiologic Monitoring (RPM)**

| Service Description | Code – Price |
| --- | --- |
| Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment (clinical staff time) | 99453 - $19 |
| Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days (may include the medical device or devices supplied to the patient and the programming of the medical device for repeated monitoring[[13]](#footnote-13)) | 99454 - $63 |
| CPT 99453 and 99454 (considered care management codes)* Include clinical staff time, supplies and equipment (including the medical device(s))
* Consent may be obtained at the time the services for these two codes are furnished[[14]](#footnote-14)
* Auxiliary personnel (which includes other individuals who are not clinical staff but are employees or leased or contracted employees) may furnish services for 99453 and 99454 under the general supervision of the billing physician or practitioner4
* Monitoring must occur over at least 16 days of a 30-day period to bill these codes and cannot be billed by more than one practitioner per beneficiary even when multiple devices are provided to the patient
* Not to be reported for a patient more than once during a 30-day period, even when multiple medical devices are provided to a patient
* Can be billed only once per episode of care, where an episode of care is defined as ‘‘beginning when the remote physiologic monitoring service is initiated and ends with attainment of targeted treatment goals2’’
 |
| Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days | 99091 - $57 |
| CPT 99091 * After the 30-day data collection period for CPT codes 99453 and 99454, the physiologic data that are collected and transmitted are analyzed and interpreted by the physician or practitioner as described by CPT code 99091
* Includes a total time of 40 minutes of physician or nonphysician practitioner work broken down as follows: 5 minutes of preservice work (e.g., chart review); 30 minutes of intra-service work (e.g., data analysis and interpretation, report based upon the physiologic data, as well as a possible phone call to the patient); and 5 minutes of post-service work (that is, chart documentation).
* Can be billed once per patient during the same service period as Chronic Care Management CPT codes (99487, 99489, and 99490), Transitional Care Management CPT codes (99495 and 99496), and behavioral health integration (BHI) CPT codes (99492, 99493, 99494, and 99484).
 |
| BASE CODE: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes | 99457 - $51 |
| ADD-ON CODE: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes | 99458 - $41 |
| CPT 99457 and 99458 – 20 minutes of interactive communication* Can be furnished by clinical staff under the general supervision of the physician or nonphysician practitioner[[15]](#footnote-15).
* Interactive communication must total at least 20 minutes of interactive time with the patient over the course of a calendar month for CPT code 99457 to be reported. CMS clarifies that the work associated includes non-face-to-face care management services during the month.[[16]](#footnote-16)
* Time spent in direct, real-time interactive communication with the patient.
* CMS defines interactive communication as “real-time interaction, between a patient and the physician, nonphysician practitioner, or clinical staff who provide the services” and “involves, at a minimum, a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission.”
 |
| The national payment amount for the non-facility price from the [Physician Fee Schedule Search](https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx) as of Jun 22, 2021 is rounded to the nearest dollar. Do not rely on the pricing information in this table; have your biller/coder double-check. |

**Table 2.** **Service Descriptions, Codes and Prices for Self-Measured Blood Pressure Monitoring and Continuous Glucose Monitoring (CGM)** Note that the codes and services listed in Table 2 are not technically remote physiologic monitoring, but they do offer the opportunity to support patients with monitoring and self-management support.

|  |  |
| --- | --- |
| Service Description | Code – Price |
| Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration | 99473 - $12 |
| Separate self-measurements of two blood pressure readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional (QHCP), with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient | 99474 - $15 |
| Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording (check additional reporting requirements in an official CPT codebook). | 95249 - $59 |
| Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording | 95250 - $157 |
| Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report. | 95251 - $36 |
| Note that for CGM there are Category III CPT codes 0446T, 0447T and 0448T that describe services related to the insertion and removal of an implantable interstitial glucose sensor system.[[17]](#footnote-17) These may sunset in Jan 2022. |  |
| The national payment amount for the non-facility price from the [Physician Fee Schedule Search](https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx) as of Jun 22, 2021 is rounded to the nearest dollar. Do not rely on the pricing information in this table; have your biller/coder double-check. |

**Medical Devices per the FDA**

Since the initiation of RPM codes for reimbursement, there has been some debate over which kinds of medical devices can be used to collect the patient’s physiologic data. CMS reiterates that devices used to capture a patient’s physiologic data must meet the FDA definition of being a medical device as described as described in [section 201(h) of the Federal, Food, Drug and Cosmetic Act (FFDCA)](https://www.fda.gov/regulatory-information/search-fda-guidance-documents/classification-products-drugs-and-devices-and-additional-product-classification-issues#:~:text=For%20a%20medical%20product%20also,primary%20intended%20purposes%20through%20chemical) but do not need to be an FDA-approved or cleared device[[18]](#footnote-18). Additionally, CMS clarifies that the medical device does not need to be prescribed by a physician, although this could be possible depending upon the medical device.

CMS also notes that the medical device or devices must be “reasonable and necessary for the diagnosis or treatment of the patient’s illness or injury or to improve the functioning of a malformed body member” and that “the device must be used to collect and transmit reliable and valid physiologic data that allow understanding of a patient’s health status to develop and manage a plan of treatment.”

**References**

* Calendar Year 2018 Physician Fee Schedule Final Rule

<https://www.govinfo.gov/content/pkg/FR-2017-11-15/pdf/2017-23953.pdf>

* Calendar Year 2019 Physician Fee Schedule Final Rule

<https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf>

* Calendar Year 2020 Physician Fee Schedule Final Rule

<https://www.govinfo.gov/content/pkg/FR-2019-11-15/pdf/2019-24086.pdf>

* CMS Interim Final Rule, April 6, 2020

<https://www.cms.gov/files/document/covid-final-ifc.pdf>

* Calendar Year 2021 Physician Fee Schedule Proposed Rule

<https://www.govinfo.gov/content/pkg/FR-2020-08-17/pdf/2020-17127.pdf>

* Calendar Year 2021 Physician Fee Schedule Final Rule

<https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf>

* COVID-19 FAQs on Medicare Fee-for-Service Billing

<https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

* Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

<https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>

## Consolidated Appropriations Act, 2021

[Consolidated Appropriations Act, 2021](https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf) Section 123 – Expanding Access to Mental Health Services Furnished through Telehealth - subsection B (modification to the Social Security Act (SSA) – emphasis added:

“(B) REQUIREMENTS FOR MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH.

(i) IN GENERAL. **Payment may not be made under this paragraph for telehealth services furnished by a physician or practitioner to an eligible telehealth individual for purposes of diagnosis, evaluation, or treatment of a mental health disorder unless such physician or practitioner furnishes an item or service in person**, without the use of telehealth, for which payment is made under this title (or would have been made under this title if such individual were entitled to, or enrolled for, benefits under this title at the time such item or service is furnished)

(I) within the 6-month period prior to the first time such physician or practitioner furnishes such a telehealth service to the eligible telehealth individual; and

(II) during subsequent periods in which such physician or practitioner furnishes such telehealth services to the eligible telehealth individual, at such times as the Secretary determines appropriate.

(ii) CLARIFICATION. This subparagraph shall not apply if payment would otherwise be allowed— ‘‘(I) under this paragraph (with respect to telehealth services furnished to an eligible telehealth individual with a substance use disorder diagnosis for purposes of treatment of such disorder or cooccurring mental health disorder); or ‘‘(II) under this subsection without application of this paragraph.”

1. CMS Telehealth Booklet. March 2020. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf> [↑](#footnote-ref-1)
2. Idaho Medicaid Provider Handbook. General Information and Requirements for Providers. Updated June 9, 2021. <https://www.idmedicaid.com/General%20Information/General%20Information%20and%20Requirements%20for%20Providers.pdf> (Note that the numbers in the table of contents do not match the content with telehealth.) [↑](#footnote-ref-2)
3. Idaho Medicaid Provider Handbook. General Information and Requirements for Providers. Updated June 9, 2021. <https://www.idmedicaid.com/General%20Information/General%20Information%20and%20Requirements%20for%20Providers.pdf> [↑](#footnote-ref-3)
4. [Texas Administrative Code. Title 22. Part 9. Chapter 174. Subchapter A. RULE §174.8. State Licensure](https://s3.amazonaws.com/govhawk-registers/TX_20210219_Adopted%2BRules_1.ADMINISTRATION.html) [↑](#footnote-ref-4)
5. Calendar Year 2021 Physician Fee Schedule Final Rule (CY 2021 PFS FR) p. 84543 [↑](#footnote-ref-5)
6. [Teledentistry Regulations in Your State](https://www.mouthwatch.com/teledentistry-in-your-state-regulations-quick-facts/#LA). *Mouthwatch*. Accessed June 2021. [↑](#footnote-ref-6)
7. Medicine: Telehealth. *State of California-Health and Human Services Agency (CA HHS).* Updated August 2020. <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele.pdf> [↑](#footnote-ref-7)
8. [Telemedicine/Telehealth Facilitation of Outpatient Substance Use Disorder (OPSUD) Treatment Services during the COVID-19 Declared Emergency](https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2020/IB20-7_rev_1.26.21.pdf). Louisiana Department of Health. Revised Jan 2021. p. 3. [↑](#footnote-ref-8)
9. [Texas Administrative Code. Title 22. Part 9. Chapter 174. Subchapter A. RULE §174.4. Notice to Patients](https://s3.amazonaws.com/govhawk-registers/TX_20210219_Adopted%2BRules_1.ADMINISTRATION.html) [↑](#footnote-ref-9)
10. Calendar Year 2021 Physician Fee Schedule Final Rule (CY 2021 PFS FR) p. 84543 [↑](#footnote-ref-10)
11. CY 2021 PFS FR p. 84546 [↑](#footnote-ref-11)
12. CY 2021 PFS FR p. 62698; AIR – all-inclusive rate; PPS – prospective payment system [↑](#footnote-ref-12)
13. CY 2021 PFS FR p. 84543 [↑](#footnote-ref-13)
14. CY 2021 PFS FR p. 84536 [↑](#footnote-ref-14)
15. CY 2021 PFS FR p. 84544 [↑](#footnote-ref-15)
16. CY 2021 PFS FR; Correction. P. 5021. Published Jan 21, 2021. <https://www.govinfo.gov/content/pkg/FR-2021-01-19/pdf/2021-00805.pdf> [↑](#footnote-ref-16)
17. CMS Manual System – Transmittal 4468. Centers for Medicare & Medicaid Services. Nov 27, 2019. <https://www.cms.gov/files/document/r4468cp#:~:text=Category%20III%20CPT%20codes%200446T,contractor%20priced%20in%20CY%202020>. [↑](#footnote-ref-17)
18. CY 2021 PFS FR p. 84543 [↑](#footnote-ref-18)