Ohio Department of Medicaid

Telehealth Billing Guidelines During COVID-19 State of Emergency

Applies to dates of service on or after March 9, 2020 until end of State of Emergency

Revised 5/21/2020 (added procedure codes & originating site clarification)

Telehealth Billing Guidelines During the COVID-19 State of Emergency

THE OHIO DEPARTMENT OF MEDICAID

These billing guidelines, pursuant to emergency rule 5160-1-21 of the Ohio Administrative Code (OAC), applies to Ohio Medicaid providers and is applicable for dates of service beginning on March 9, 2020 when Governor DeWine declared a state of emergency. The emergency rule adopted by the Ohio Department of Medicaid (ODM) will be implemented by Medicaid fee-for-service (FFS), Medicaid Managed Care Plans (MCPs), and MyCare Ohio Plans (MCOPs).

Providers may start billing FFS and to the MCPs under these guidelines once system changes are implemented on April 15, 2020, with the exception of the end stage renal disease (ESRD)-related services and some of the skilled therapies services, as noted in the detailed guidance below; the claims processing implementation date for these services will be released in a forthcoming communication. The Claims for dates of service beginning March 9, 2020 and for the duration of the state of emergency will be considered valid under these guidelines.

If you are a behavioral health agency certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS), these guidelines do not apply. Refer to paragraph (C) of emergency rule 5160-1-21 and OhioMHAS rule 5122-29-13. Billing guidance for these providers can be found at https://bh.medicaid.ohio.gov/.

Specific instructions for the following program areas are contained in this document:

- Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)
- Outpatient Hospitals
- Dental
- Long Term Services and Supports:
    - Hospice
    - Private Duty Nursing
    - State Plan Home Health services
    - Nursing Facilities
- Pre-Admission Screening and Resident Review (PASRR)

Information concerning ODM's response to COVID-19 will continue to be updated on our website: https://medicaid.ohio.gov/COVID. Here you will find several helpful resources such as a Telehealth FAQ document and the emergency telehealth rule with appendix.

What is Telehealth?

Under this emergency rule, the following is considered telehealth:

- Delivery of health care services to a patient via synchronous, interactive, real-time electronic communication that includes both audio and video elements; **OR**
- Activities that are asynchronous and activities that do not have both audio and video elements such as:
    - Telephone calls
    - Images transmitted through fax
    - Electronic mail
- Medicaid covered individuals can access telehealth services wherever they are located. This includes:
    - Home
    - School
    - Temporary housing
    - Homeless shelter
    - Nursing Facility
    - Hospital
    - Group home
    - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)

	Practitioner Site	**Patient Site**
Definition	» Physical location of the treating practitioner when the service was delivered » There is no limitation on practitioner site	» Physical location of the patient when the service was delivered » There is no limitation on patient site
Rendering providers (MITS Provider Type)	» Physician and Psychiatrist (20) » Podiatrist (36) » Psychologist (42) » Physician Assistant (24) » Dentist (30) » Advanced Practice Registered Nurses: o Clinical Nurse Specialist (65) o Certified Nurse Midwife (71) o Certified Nurse Practitioner (72) » Licensed Independent Social Worker (37) » Licensed Independent Chemical Dependency Counselor (54) » Licensed Independent Marriage and Family Therapist (52) » Licensed Professional Clinical Counselor (47)	» Not applicable

	» Dietitians (07)
	» Audiologist (43)
	» Occupational Therapist (41)
	» Physical Therapist (39)
	» Speech-language pathologist (40)
	» Practitioners who are supervised or cannot practice independently:
	  ○ Supervised practitioners and supervised trainees defined in 5160-8-05
	  ○ Occupational therapist assistant
	  ○ Physical therapist assistant
	  ○ Speech-language pathology aide
	  ○ Audiology Aide
	  ○ Individuals holding a conditional license as described in section 4753.071 of the Revised Code
	  ○ Licensed health professionals providing medically necessary supportive services
	» Registered Nurses (RN) and Licensed Practical Nurses (LPN) working in a hospice or home health setting
	» Non-Agency Nurses (38)
	» Medicaid School Program (MSP) practitioners described in 5160-35 of the Administrative Code
	» Other providers as designated by the Director of ODM	

Provider Types able to bill (MITS Provider Type/Provider Specialty)	» Rendering practitioners listed above except:
	  ○ Supervised practitioners and supervised trainees defined in 5160-8-05
	  ○ Occupational therapist assistant
	  ○ Physical therapist assistant
	  ○ Speech-language pathology and audiology aides
	  ○ Individuals holding a conditional license
	  ○ Registered Nurses (RN) and Licensed Practical Nurses (LPN) working in a hospice or home health setting
	» Professional Medical Group (21)
	» Professional Dental Group (31)
	» Federally Qualified Health Center (12)
	» Rural Health Clinic (05)
	» Ambulatory Health Care Clinics (50)
	» Outpatient Hospitals (01)
	» Psychiatric Hospitals providing OPHBH services (02)
	» Medicaid School Program Provider (28)
	» Private Duty Nurses (38)
	» Other providers as designated by the Director of ODM
		» Not applicable

Excluded place of service (POS) – federal exclusion	» Penal facility or Public institution such as jail or prison (09)	» Penal facility or Public institution such as jail or prison (09)

Professional Claims

When billing for professional services:

- Most procedure codes should be reported with the "GT" modifier to identify the service delivery through telehealth. See instructions for your specific program areas for further clarification.
- In most cases, the place of service reported on the claim must be the location of the practitioner. See instructions for your specific program areas for further clarification.
- If applicable, any other required modifiers must be reported.

Professional Claim Submission for Services Delivered via Telehealth*		
Billing provider type	**Providers of Professional Services**	**FQHC and RHC (FFS or claims for wraparound payments)**
Claim type	» Professional (Submitted via MITS portal or EDI)	» Professional (Submitted via MITS portal or EDI)
Procedure code	» CPT code for service delivered via telehealth	» First detail line: T1015 encounter code and the appropriate U modifier » Second detail line: CPT code for service delivered via telehealth
Modifier	» GT modifier » Any other required modifiers based on provider contract	» GT modifier with the procedure code » Any other required modifiers based on provider contract
Place of service (POS) code	Physical location of the practitioner when the service was delivered	Physical location of the practitioner when the service was delivered

*Does not apply to crossover claims from Medicare. Provider-submitted crossover claims should be submitted with the information provided by Medicare on the explanation of benefits.

Institutional Claims

Outpatient hospital billing:

Hospital providers are eligible to bill for telehealth services identified in the Appendix to Ohio Administrative Code (OAC) rule 5160-1-21 to the extent they appear on the EAPG covered code list, located on our website: https://www.medicaid.ohio.gov/provider/feescheduleandrates.

To bill outpatient hospital telehealth services, please append modifier "GT" to the procedure code.

If telehealth services are performed as a result of the COVID-19 pandemic, please also append Modifier "CR" – Catastrophe/Disaster to the applicable procedure codes and include Condition Code "DR" – Disaster Related at the header level of the institutional claim.

Outpatient hospital telehealth services will pay according to the Enhanced Ambulatory Patient Grouping (EAPG) pricing methodology as described in OAC rule 5160-2-75.

Outpatient hospital behavioral health services (OPHBH):

- Hospitals are eligible to provide outpatient behavioral health services via telehealth to the extent they appear on the OPHBH fee schedule on our website: https://www.medicaid.ohio.gov/provider/feescheduleandrates and are included on the list of allowable telehealth billing codes for community behavioral health providers posted at https://bh.medicaid.ohio.gov/ .
- To bill OPHBH services performed telehealth, it remains necessary to append modifier "HE", along with a practitioner modifier, and any additional pricing modifiers as indicated on the OPHBH fee schedule.
- A mental health/substance abuse diagnosis code is still required to receive OPHBH reimbursement.
- OPHBH telehealth services will pay according to the OPHBH fee schedule.
- Please note: To the extent possible, please include modifier "GT" to indicate it was a telehealth service. If the service provided already requires four modifiers per the OPHBH fee schedule, do not substitute "GT" for one of the required modifiers. List all applicable modifiers from the OPHBH fee schedule first.
- Lastly, please include Condition Code "DR" to indicate that a telehealth service was provided as a result of the COVID19 pandemic.

Instructions for Specific Program Areas

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

During the COVID-19 state of emergency, most of the covered telehealth services listed in the appendix to rule 5160-1-21 will be covered under the prospective payment system (PPS) as FQHC or RHC services when rendered by eligible FQHC and RHC practitioners.

- Medical nutrition therapy and lactation services rendered by eligible FQHC and RHC practitioners will be paid under the PPS. When these services are rendered by a practitioner not listed in Chapter 5160-28 of the Administrative Code, these services shall be paid through FFS under the clinic provider type 50 (using ODM's payment schedules).
- Remote monitoring will be paid through FFS as a covered non-FQHC/RHC service under the clinic provider type 50 (using ODM's payment schedules).
- Group therapy will continue to be paid through FFS as a covered non-FQHC/RHC service under the clinic provider type 50 (using ODM's payment schedules).
- Services under the Specialized Recovery Services (SRS) program are not currently covered FQHC or RHC services.
- When the FQHC or RHC is billing as the practitioner site:
    - The T1015 encounter code must be reported in the first detail line of the claim with the appropriate U modifier indicating the type of visit.
    - The next detail line reported on the claim must be the service (procedure code) provided via telehealth. Modifier "GT" should be reported with the procedure code in addition to any other required modifiers.
    - The place of service reported on the claim must be the practitioner site.
- Serving as the originating site for a telehealth service is not an FQHC or RHC service. If conditions of the originating site fee are met, an FQHC or RHC may submit a claim under its ambulatory health care clinic (provider type 50) provider number. The fee-for-service payment amount for the originating site fee will be listed in Appendix DD to OAC rule 5160-1-60.

Dental

Dentists may provide a limited problem-focused oral exam (CDT D0140) through telehealth during this state of emergency. When billing for the procedure on a **professional claim**, providers should use the GT modifier and include procedure code D9995 to indicate the service was provided through telehealth. When billing for the procedure on a **dental claim**, providers should use the place of service code 02 to indicate telehealth.

Dental services covered under the emergency rule are paid as a covered FQHC service. On the first service line of the claim, the provider should report T1015 with the appropriate modifier to identify the type of encounter (in this case U2). The next service line on the claim will be the procedure code (D0140) for the service that was provided and the GT modifier to identify it as a telehealth service. The place of service code should reflect the practitioner's physical location. There is no need to report D9995.

Hospice

Hospice services can be provided using telehealth when clinically appropriate. In order to track the services that are provided through telehealth, we are asking that you bill using the appropriate procedure codes below in addition to using the modifier GT on any claims that include at least one telehealth component for that date of service.

- T2042 routine home care
    - Billed one unit per day
- T2043 continuous home care
    - Billed one unit per hour with a minimum of 8 hours per day –
    - This type of care consists predominately of nursing care (it may involve services provided by a home health aide and/or homemaker services)
- T2046 room and board payments in a NF (reimbursed at 95% of the NF's daily rate) – the following services are included in the room and board per diem:
    - Performing personal care services;
    - Assisting with Activities of daily living (ADLs);
    - Administering medication;
    - Socializing activities;
    - Maintaining the cleanliness of the individual's room; and
        - Supervising and assisting in the use of durable medical equipment and prescribed therapies.
- Service Intensity Add-On (SIA) Codes: This is payment for routine home care provided by an RN or licensed social worker within the last 7 days of life, when discharge from hospice is due to death (and when a T2042 claim has already been billed and paid):
    - Use code G0299 for direct care by in-person visit from an RN
    - Use code G0155 for direct care by in-person visit from a social worker

Home Health Services, RN Assessment and RN Consultation

Home health services, the RN assessment service and the RN consultation service can be provided using telehealth when clinically appropriate. These services should be billed using the procedure codes below. The value "02" should be used to indicate telehealth as the "Place of Service" on all claims for services provided using telehealth.

- G0156 Home Health Aide
- G0299 Home Health Nursing – RN
- G0300 Home Health Nursing – LPN
- T1001 RN Assessment
- T1001 w/U9 Modifier – RN Consultation
- G0151 Physical Therapy
- G0152 Occupational Therapy
- G0153 Speech-Language Pathology

Nursing Facilities

Nursing facilities (NF) are reimbursed for all telehealth related services through the NF per diem rate. Nursing Facilities do not bill for the telehealth related services they provide. Per the telehealth rule 5160-1-18, physicians and other eligible providers may bill for the services they provide to nursing facility residents from the practitioner's site in accordance with the rule.

When nursing facilities provide telehealth related services to their residents, they report the costs they incur for those services on the Medicaid NF cost report using the following cost center codes:

- **DIRECT CARE COSTS**
  - 6110 – RN Charge Nurse
  - 6115 – LPN Charge Nurse
  - 6120 – Registered Nurse
  - 6125 – Licensed Practical Nurse
  - 6210 – Consulting and Management Fees
  - 6401 – Registered Nurse Purchased Nursing
  - 6411 – Licensed Practical Nurse Purchased Nursing
  - 6600 – Physical Therapist
  - 6610 – Occupational Therapist
  - 6620 – Speech Therapist
  - 6630 – Audiologist

- **ANCILLARY/SUPPORT COSTS**
  - 7000 – Dietitian
  - 7231 – Psychologist
  - 7251 – Social Work/Counseling
  - 7261 – Social Services/Pastoral Care
  - 7302 – Medical Minor Equipment Non-Billable to Medicare

- **CAPITAL COSTS**
  - 8040 – Depreciation – Equipment
  - 8065 – Lease and Rent – Equipment

No changes to MITS, Administrative Code rules, or the Medicaid State Plan are necessary to implement telehealth in nursing facilities.

Pre-admission Screening and Resident Review

Pre-admission Screenings and Resident Reviews (PASRR) should be completed via the electronic HENS system as they are today as these screenings are primarily via desk review. In instances where a face-to-face is required a telephonic &/or desk review is permissible.

Level II evaluations can be provided either by telephone or desk review when appropriate. There is no system or reimbursement impact as these functions are supported by the level II entities and the applicable contractor.

Important Clarifications

- If the practitioner site does not bill the Ohio Department of Medicaid (ODM) directly (i.e., holds a contractual agreement with the practice), the patient site or practice who holds the contractual agreement may instead bill for the service delivered using telehealth.
    - In such cases, POS code reported on the professional claim should reflect the location of the billing provider.
- All services identified in this document and appendix to the emergency rules may be delivered through telehealth during a state of emergency. Providers should use professional judgment when delivering telehealth services and should select the appropriate procedure code that reflects the service provided.

Originating Site Fee (Q3014)

- The originating site fee may be paid to a practitioner site who either:
    - Provided no other service to the presenting patient; or
    - Provided a separately identifiable evaluation and management service.

  Examples:
    - The patient presents to an office location and staff initiate the telehealth visit with a practitioner who is offsite.
    - The patient does not present to an office location, but office staff provided technical assistance or troubleshooting to set up or join the telehealth visit with the practitioner who is either onsite or offsite.

The originating site fee is not to be used as an automatic add-on when technology is used.

Covered Telehealth Services During the COVID-19 State of Emergency

Dental	
Procedure Code	**Description**
D0140	Limited oral evaluation – problem focused
D9995	Teledentistry - synchronous; real-time encounter; Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

Long Term Services and Supports: Hospice, Private Duty Nursing, State Plan Home Health	
Procedure Code	**Description**
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per hour
T2046	Hospice long-term care, room and board only; per diem
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
T1001	RN Assessment Services prior to the provision of home health, private duty nursing, waiver nursing, personal care aide and home choice services, per initial base, and each 15-minute increment
T1001 U9	RN Consultation
G0151	Physical Therapy
G0152	Occupational Therapy
G0153	Speech-language Pathology

Medical and Behavioral Health Services (non OhioMHAS certified providers)	
Procedure Code	**Description**
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service
99201	Office or other outpatient visit for the evaluation and management of a new patient; Straightforward medical decision making. Typically, 10 minutes.

99202	Office or other outpatient visit for the evaluation and management of a new patient; Straightforward medical decision making. Typically, 20 minutes.
99203	Office or other outpatient visit for the evaluation and management of a new patient; Medical decision making of low complexity. Typically, 30 minutes.
99204	Office or other outpatient visit for the evaluation and management of a new patient; Medical decision making of moderate complexity. Typically, 45 minutes.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes.
99212	Office or other outpatient visit for the evaluation and management of an established patient; Straightforward medical decision making. Typically, 10 minutes.
99213	Office or other outpatient visit for the evaluation and management of an established patient; Medical decision making of low complexity. Typically, 15 minutes.
99214	Office or other outpatient visit for the evaluation and management of an established patient; Medical decision making of moderate complexity. Typically, 25 minutes.
99241	Office consultation for a new or established patient. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes.
99242	Office consultation for a new or established patient; Straightforward medical decision making; Typically, 30 minutes.
99243	Office consultation for a new or established patient; Medical decision making of low complexity. Typically, 40 minutes.
99244	Office consultation for a new or established patient; Medical decision making of moderate complexity. Typically, 60 minutes.
99245	Office consultation for a new or established patient; Medical decision making of high complexity. Typically, 80 minutes.
99251	Inpatient consultation for a new or established patient; straightforward medical decision making. Typically, 20 minutes.
99252	Inpatient consultation for a new or established patient; Straightforward medical decision making. Typically, 40 minutes.
99253	Inpatient consultation for a new or established patient; medical decision making of low complexity. Typically, 55 minutes.
99254	Inpatient consultation for a new or established patient; medical decision making of moderate complexity. Typically, 80 minutes.
99255	Inpatient consultation for a new or established patient; medical decision making of high complexity. Typically, 110 minutes.
99281	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of low to moderate severity.

99283	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour

96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
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
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
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

99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99453	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
99454	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
99457	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; first 20 minutes
99458	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; each additional 20 minutes (list separately in addition to code for primary procedure)
97802	Medical nutrition therapy; initial assessment and intervention, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes
97802 TH	Lactation counseling by dietitian; initial assessment and intervention, each 15 minutes
97803 TH	Lactation counseling by dietitian; re-assessment and intervention, each 15 minutes
97804 TH	Lactation counseling by dietitian; group with 2 or more individuals), each 30 minutes
90846	Family psychotherapy without patient present
90847	Family psychotherapy with patient present
Q3014	Telehealth originating site fee

Updated 5/21: The following end-stage renal disease (ESRD) related services can be delivered via telehealth and can be billed with the GT Modifier as of April 15, 2020 for dates of service on or after March 9, 2020.

90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month

90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older
90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older

Updated 5/21/2020: The following evaluation and management services can be delivered via telehealth and can be billed with the GT Modifier as of May 13, 2020 for dates of service on or after March 9, 2020.

99304	Initial nursing facility care, per day, for the evaluation and management of a patient. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99315	Nursing facility discharge day management; 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99327	Domiciliary or rest home visit for the evaluation and management of a new patient. Typically, 60 minutes are spent with the patient and/or family or caregiver.
99328	Domiciliary or rest home visit for the evaluation and management of a new patient. Typically, 75 minutes are spent with the patient and/or family or caregiver.
99334	Domiciliary or rest home visit for the evaluation and management of an established patient. Typically, 15 minutes are spent with the patient and/or family or caregiver.
99335	Domiciliary or rest home visit for the evaluation and management of an established patient. Typically, 25 minutes are spent with the patient and/or family or caregiver.
99336	Domiciliary or rest home visit for the evaluation and management of an established patient. Typically, 40 minutes are spent with the patient and/or family or caregiver.
99337	Domiciliary or rest home visit for the evaluation and management of an established patient. Typically, 60 minutes are spent with the patient and/or family or caregiver.

Occupational Therapy, Physical Therapy, Speech-Language Pathology, and Audiology Services
As Found in OAC 5160-8-36

Procedure Code	Code Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);

92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92556	Speech audiometry threshold; with speech recognition
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)
92609	Therapeutic services for the use of speech-generating device, including programming and modification
96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes
97161	Physical therapy evaluation: low complexity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97165	Occupational therapy evaluation, low complexity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

97166	Occupational therapy evaluation, moderate complexity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97129	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure)
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (eg, activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes

The following skilled therapies can be delivered via telehealth and can be billed with the GT Modifier as of April 15, 2020 for dates of service on or after March 9, 2020.

97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance

97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes

Specialized Recovery Services (SRS) Program **As found in Chapter 5160-43 of the OAC**	
Procedure Code	**Description**
H2023	Specialized Recovery Services (SRS) program – supported employment
H2025	Specialized Recovery Services (SRS) program – ongoing support to maintain employment
T1016	Specialized Recovery Services (SRS) program – case management
H0038	Specialized Recovery Services (SRS) program – peer recovery support services

Questions?

Contact: medicaid@medicaid.ohio.gov
For more information go to: Medicaid.Ohio.gov

Are you an agency certified by OhioMHAS?
Contact: BH-enroll@medicaid.ohio.gov
For more information go to: BH.Medicaid.ohio.gov