

VIRGINIA MEDICAID TELEHEALTH RESOURCE GUIDE



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***This resource guide was updated on 7/24/2022. Revisions to Medicaid and Managed Care policies may be ongoing. Please refer to individual plans for any further updates.*





DMAS Guidance on Telehealth Services

Telehealth provision has dramatically changed over the past few years. Administration of care and best practices for telehealth are continuously evolving. Both workflows and billing processes and revisions to policies for Medicaid and contracted MCOs are ongoing. This document is a summary of resources available at the time of this writing and is not intended to replace guidance from DMAS or from any of the contracted MCOs. Please refer directly to these entities for the most up-to-date and accurate information.

For providers in Virginia, the most comprehensive guidance on Medicaid telehealth service policy for practice, billing, and reimbursement can be found in the DMAS Telehealth Services Supplement. This document was most recently updated on 6/30/2022 and can be found at <https://vamedicaid.dmas.virginia.gov/manual-chapters/telehealth-services-supplement>.

The supplement provides current definitions of key terms and modalities related to telehealth, and indicates conditions that are required for eligibility of reimbursement under Virginia Medicaid policy. The following information is excerpted from the Medicaid Telehealth Supplement referenced above: Services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

- The Provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth;
- The service delivered via telehealth meets the procedural definition and components of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as defined by the American Medical Association (AMA), unless otherwise noted, see Table 1 – Table 6 of the Supplement;
- The service provided via telehealth meets all state and federal laws regarding confidentiality of health care information and a patient's right to his or her medical information;
- Services delivered via telehealth meet all applicable state laws, regulations and licensure requirements on the practice of telehealth; and
- DMAS deems the service eligible for delivery via telehealth.

Modality Specific Conditions

There are additional modality-specific conditions for reimbursement that providers will need to follow when utilizing Telemedicine, Remote Patient Monitoring, and Virtual Check-in Services. These conditions are outlined below, as well as in the DMAS Supplement.

Telemedicine

- Services delivered via telemedicine must be provided with the same standard of care as services provided in person.
- Telemedicine must not be used when in-person services are medically and/or clinically necessary. The distant Provider is responsible for determining that the service meets all requirements and standards of care. Certain types of services that would not be expected to be appropriately delivered via telemedicine include, but are not limited to, those that: are performed in an operating room or while the patient is under anesthesia; require direct visualization or instrumentation of bodily structures; involve sampling of tissue or insertion/removal of medical devices; and/or otherwise require the in-person presence of the patient for any reason.
- If, after initiating a telemedicine visit, the telemedicine modality is found to be medically and/or clinically inappropriate, or otherwise can no longer meet the requirements stipulated in the "Reimbursable Telehealth Services" section, the Provider shall provide or arrange, in a timely manner, an alternative to meet the needs of the individual (e.g., services delivered in-person; services delivered via telemedicine when conditions allow telemedicine to meet requirements stipulated in the "Reimbursable Telehealth Services" section). In this circumstance, the Provider shall be reimbursed only for services successfully delivered.

Remote Patient Monitoring

- The Provider must have an established relationship with the member receiving the RPM service, including at least one visit in the last 12 months (which can include the date RPM services are initiated).
- The member receiving the RPM service must fall into one of the following five populations, with duration of initial service authorization in parentheses as per below:
 - o Medically complex patient under 21 years of age (6 months);
 - o Transplant patient (6 months);
 - o Post-surgical patient (up to 3 months following the date of surgery);
 - o Patient with a chronic health condition who has had two or more hospitalizations or emergency department visits related to such chronic health condition in the previous 12 months (6 months); and/or a
 - o High-risk pregnant person (6 months).
- All service authorization criteria outlined in the DMAS Form "DMAS-P268"* are met prior to billing the following CPT/HCPCS codes:
 - o Physiologic Monitoring: 99453, 99454, 99457, 99458, and 99091
 - o Therapeutic Monitoring: 98975, 98976, 98977, 98980, and 98981
 - o Self-Measured Blood Pressure: 99473, 99474
- Providers must meet the criteria outlined in the DMAS Form "DMAS-P268"* and submit their requests to the DMAS service authorization contractor by direct data entry (DDE) via their provider portal. See Appendix D of the Physician/Practitioner manual for details on the current service authorization contractor and accessing the provider portal.
- Service authorization requests must be submitted at least 30 days prior to the scheduled date of initiation of services.
- Reauthorizations will be permitted for select services, as appropriate and as per criteria in the DMAS Form "DMAS-P268".

Virtual Check-In

- Services must be patient-initiated.
- Patients must be established with the provider practice.
- Must not be billed if services originated from a related service provided within the previous 7 days or lead to a service or procedure within the next 24 hours or at the soonest available appointment.

Reimbursable Telehealth Services

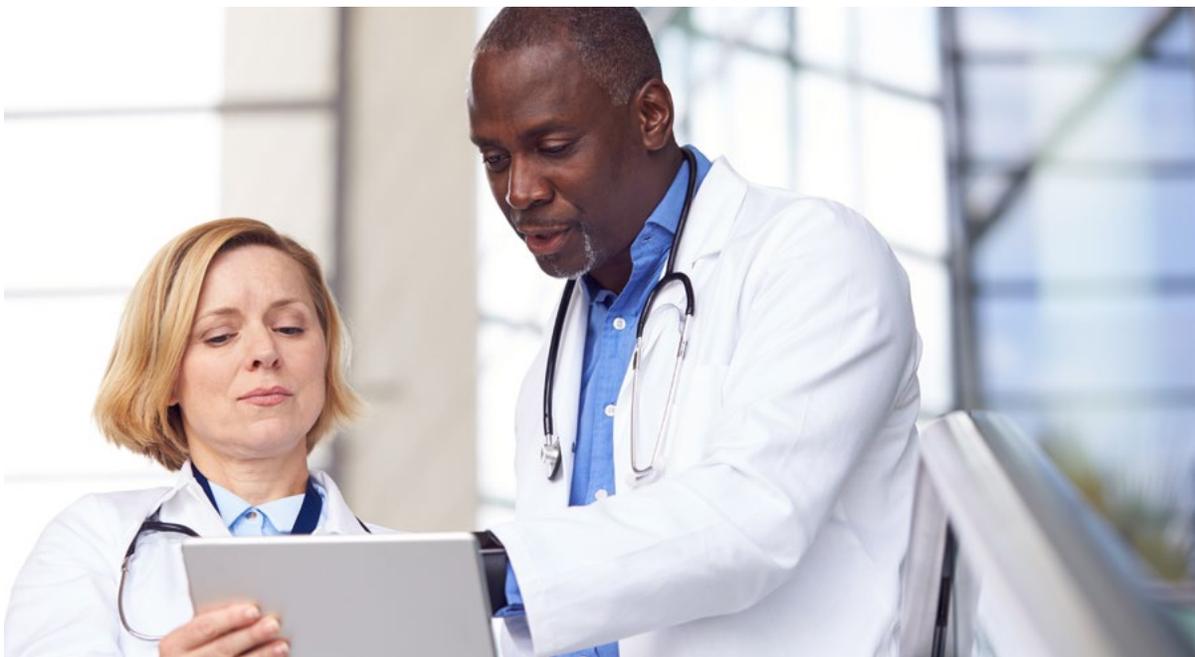
Attachment A (found at the bottom of the Supplement) lists covered services that may be reimbursed when provided via telehealth. Specifically:

- **Table 1** lists Medicaid-covered medical services authorized for delivery by telemedicine
- **Table 2** lists Medicaid-covered mental health and substance use disorder services authorized for delivery by telemedicine
- **Table 3** lists Telemedicine and Store-and-Forward services
- **Table 4** lists Remote Patient Monitoring services
- **Table 5** lists Virtual Check-In services
- **Table 6** lists audio only services

Services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

- The Provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth;
- The service delivered via telehealth meets the procedural definition and components of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as defined by the American Medical Association (AMA), unless otherwise noted in Table 1 – Table 6 in this Supplement;
- The service provided via telehealth meets all state and federal laws regarding confidentiality of health care information and a patient’s right to his or her medical information;
- Services delivered via telehealth meet all applicable state laws, regulations and licensure requirements on the practice of telehealth; and
- DMAS deems the service eligible for delivery via telehealth.

In order to be reimbursed for services using telehealth that are provided to Managed Care Organization (MCO)-enrolled individuals, Providers must follow their respective contract with the MCO. Additional information about the Medicaid MCO programs can be found at <https://www.dmas.virginia.gov/#/cccplus> and <https://www.dmas.virginia.gov/#/med4>.





Virginia Medicaid MCO Payor Guidelines

Overview

This document will provide some general guidance from Medallion 4.0, the organizing body of the Managed Care Organization (MCO) programs, and each of the 6 Medicaid MCOs, as well as any current updates and resources.

An important point to note regarding services administered to MCO enrolled individuals, in order to be reimbursed for services using telehealth, providers must follow their respective contract with the MCO.

Regarding each of the contractor policies, it is important to note that Medicaid stipulates that “contractors will be required to provide coverage for store-and-forward, RPM, audio-only, provider-to-provider consultations, and virtual check-ins that is **no more restrictive than, and is at least equal in amount, duration, and scope as is available through, the Medicaid fee-for-service program.**” (<https://www.dmas.virginia.gov/media/3583/medallion-4-contract-sfy22-v1.pdf>, p.200) So while there may be nuances between the different contractor policies, the overall governing guidance comes directly from DMAS

Medallion 4.0 Managed Care Telehealth Summary

The following is excerpted from the Medallion Managed Care Contract SFY22v1 outlining definitions and policy governing each of the MCOs as it relates to the administration of Telehealth. The entirety of the contract can be found at <https://www.dmas.virginia.gov/media/3583/medallion-4-contract-sfy22-v1.pdf>. Telehealth is covered on pages 199-200:

8.2.II Telemedicine and Telehealth Services

Telemedicine is a service delivery model that uses real time two-way telecommunications to deliver covered physical and behavioral health services for the purposes of diagnosis and treatment of a covered Member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment (see temporary exception for audio only telecommunications in this section) to link the Member to an enrolled provider approved to provide telemedicine services at the distant (remote) site.

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth is different from telemedicine because it refers to the broader scope of remote health care services used to inform health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes such technologies such as telephones, facsimile machines, electronic mail systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

Remote patient monitoring (RPM) means the use of digital technologies to collect medical and other forms of health data from patients in one location and electronic transmission of that information securely to health providers in a different location for analysis, interpretation, recommendation, and management of a patient with a chronic or acute health illness or condition. These services include monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other patient physiological data; treatment adherence monitoring; and interactive video conferencing with or without digital image upload.

The Contractor must provide coverage for telemedicine and telehealth services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program. The Contractor must provide telemedicine and telehealth services regardless of the originating site and regardless of whether the patient is accompanied by a health care provider at the time such services are provided.

The Contractor cannot require providers to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

The Contractor must allow the prescribing of controlled substances via telemedicine and requires such scripts to comply with the requirements of § 54.1-3303 and all applicable federal law.

The Contractor also must encourage the use of telemedicine and telehealth to promote community living and improve access to health services.

DMAS Medicaid Manuals and Memos on telemedicine specify the types of providers that may provide Medicaid-covered telemedicine and telehealth services. The Contractor may propose additional provider types for the Department to approve for use.

The decision to participate in a telemedicine or telehealth encounter will be at the discretion of the Member and/or their authorized representative(s), for which informed consent must be provided, and all telemedicine and telehealth activities must be compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Department's program requirements.

Covered services include the following:

1. Synchronous audio-visual telemedicine
2. Store and Forward Applications: The Contractor must reimburse for teleretinal screening for diabetic retinopathy. The Contractor is required to provide coverage for teleretinal screening for diabetic retinopathy that is at least equal in amount, duration, and scope as is available through the Medicaid fee-for-service program. The Contractor cannot be more restrictive and cannot require additional fields or photos not required by the Medicaid fee-for-service program. The Contractor may also reimburse for additional Store and Forward Applications, including but not limited to, tele-dermatology and tele-radiology.
3. Remote patient monitoring (RPM) for (i) high-risk pregnant persons; (ii) medically complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up to three months following the date of such surgery; and (v) patients with a chronic health condition who have had two or more hospitalizations or emergency department visits related to such chronic health condition in the previous 12 months. The Contractor is required to provide coverage for RPM for conditions (i)- (v) that is at least equal in amount, duration, and scope as is available through the Medicaid fee-for-service program.
4. Audio only services
5. Provider-to-provider consultations
6. Virtual check-ins with patients

DMAS will publish additional guidance for coverage for store-and-forward, RPM, audio-only, provider-to-provider consultations, and virtual check-ins and specific CPT Codes in upcoming Medicaid Memoranda and Provider Manuals and regulations.



PAYOR SPECIFIC KEY POINTS

From the Aetna Better Health Provider Manual found at: https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/virginia/provider/pdf/abhva_provider_manual.pdf (p. 135)

Telehealth means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

- The Provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth.
- The service delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code, as defined by the American Medical Association (AMA);
- The service provided via telehealth meets all state and federal laws regarding confidentiality of health care information and a patient's right to his or her medical information; and
- Services delivered via telehealth meet all applicable state laws, regulations, and licensure requirements on the practice of telehealth.

Telehealth Billing Requirements

Providers shall submit claims for telehealth services using the appropriate CPT/HCPCS, modifier and place of service code for the professional service delivered.

- Place of Service (POS) should indicate where the service would have been provided had the client been served face-to-face (not where the client is located, or necessarily where the provider is located, when the service is received). For example, if the member would have come to a private office to receive the service outside of a telehealth modality, a POS 11 would be applied. POS 02 ("telehealth") should not be used.
- GT is used as a modifier to telemedicine services delivered synchronously. GQ is used as a modifier to telemedicine services delivered asynchronously.

Provider Manual

- https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/virginia/provider/pdf/abhva_provider_manual.pdf (p. 135)

Provider Portal- tools, updates and claims information for providers

- <https://www.aetnabetterhealth.com/virginia/providers/portal.html>

Provider Newsletters

- <https://www.aetnabetterhealth.com/virginia/providers/notices-newsletters.html>

PAYOR SPECIFIC KEY POINTS

From the Anthem HealthKeepers Plus notice on Remote Patient Monitoring, found at:
https://providers.anthem.com/docs/gpp/VA_CAID_RemotePatientMonitoringUpdate.pdf

HealthKeepers, Inc. is dedicated to quality care to enrollees in a safe and clinically appropriate environment. To align with Department of Medical Assistance Services (DMAS) requirements for remote patient monitoring, HealthKeepers, Inc. will require prior authorization for remote patient monitoring effective May 1, 2022.

Providers will be required to submit requests for authorizations for members when remote patient monitoring is indicated. Please refer to the DMAS memo dated March 10, 2022 Coverage of Remote Patient Monitoring/Update to Telehealth Services Supplement, for a detailed explanation of the medical necessity criteria that will be used to make these determinations. The following codes are listed on the above referenced memo.

Provider Manual

- https://providers.anthem.com/docs/gpp/VA_CAID_ProviderManual.pdf?v=202110141650

Clinical Guidelines

- https://providers.anthem.com/docs/gpp/VA_CAID_ClinicalPracticeGuidelinesMatrix.pdf?v=202206231352

News/Memos

- Provider Bulletin, 05/2022: https://providers.anthem.com/docs/gpp/VA_CAID_RemotePatientMonitoringUpdate.pdf
- Virtual Visits: New CMS place of service code (professional and facility), 03/01/2022
<https://providernews.anthem.com/virginia/article/virtual-visits-new-cms-place-of-service-code-professional-and-facility>
- HEDIS telehealth-eligible measures coding bulletin: A list of HEDIS® measures, which are eligible for provider gap closure through telehealth, 06/2021
https://providers.anthem.com/docs/gpp/VA_CAID_HEDIStelehealtheligiblemeasurescodingbulletin.pdf?v=202106242022
- Closing Gaps in Healthcare Through Telehealth:
<https://providernews.anthem.com/virginia/article/closing-gaps-in-care-through-telehealth>

PAYOR SPECIFIC KEY POINTS

From the Molina Healthcare Provider Manual found at:

https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/va/VA-ALL-PHB-21256-22-MCC-VA-Provider-Manual-FINAL_508c.pdf (p.77)

Molina Complete Care (MCC) supports the use of telemedicine. Providers interested in providing telemedicine services should contact their provider contracting representative to add the appropriate addenda to their contract. The contract documents will spell out requirements and rates for telehealth, and training will be scheduled.

At a minimum, the requirements for providers participating in MCC's telemedicine program include:

- Interactive and real-time synchronized multimedia (audio and video) transmission
- Remote camera control is preferred; the provider must have a dedicated secure line and utilize an acceptable method of encryption
- The originating site (location of the member) must have telehealth support staff able to assist the member with the technical equipment and connection
- A protocol must be in place to access emergent or urgent clinical care if the designated telehealth support staff are not clinicians
- The member site must be a room that provides privacy
- Providers must:
 - o Have completed basic training on telehealth equipment
 - o Provide the same rights to confidentiality and security of clinical information as provided in face- to-face services
 - o Include in the member's clinical record that the service was provided via telehealth

Provider Manual

- https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/va/VA-ALL-PHB-21256-22-MCC-VA-Provider-Manual-FINAL_508c.pdf (p.77)

HEDIS Telehealth Accepted Codes

- https://www.molinahealthcare.com/providers/va/medicaid/resources/~media/Molina/PublicWebsite/PDF/Providers/va/VA-ALL-PRV-19761-21%20MCC%20Telehealth%20HEDIS%20Codes%20Reference%20Guide%20FINAL_508c.pdf

Molina Electronic Visit Verification

- https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/va/VA-ALL-PRV-19611-21-EVV-Provider-One-Pager-FINAL_508c.pdf

Optima Health - Optima Family Care (OFC)

PAYOR SPECIFIC KEY POINTS

From the Optima Health Provider Manual, found at: <https://www.optimahealth.com/documents/provider-manuals/optima-family-care-provider-manual-supplement-medallion-4.0-en.pdf> (p. 25)

Optima Family Care (OFC) provides coverage for telemedicine services for OFC Members. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.

Physicians, nurse practitioners, certified nurse midwives, clinical nurse specialists, psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors are permitted to use medical telemedicine services and one of these types of providers at the main (hub) and satellite (spoke) sites is required for a telemedicine service to be reimbursed. Federal and state laws and regulations apply; including laws that prohibit debarred or suspended providers from participating in the Medicaid program.

The decision to participate in a telemedicine encounter will be at the discretion of the OFC Member and/or their authorized representative(s), for which informed consent must be provided, and all telehealth activities must be compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and DMAS's program requirements. All telemedicine services must be provided in a manner that meets the needs of vulnerable and emerging high-risk populations and consistent with integrated care delivery. Telemedicine services can be provided in the home or another location if agreeable with the OFC Member. (See Provider Manual, linked below)

Telemedicine for Addiction and Recovery Treatment Services Program (ARTS)

Telemedicine services are covered under specific criteria. Providers should contact their Provider Services with questions or for specific policies and requirements. (See Optima ARTS Provider Manual below)

Provider Manual

- <https://www.optimahealth.com/documents/provider-manuals/optima-family-care-provider-manual-supplement-medallion-4.0-en.pdf> (p. 25)

Optima Health Plan Addiction and Recovery Treatment Services Program Provider Manual

- <https://www.optimahealth.com/documents/provider-manuals/optima-health-addiction-and-recovery-treatment-program-provider-manual-supplement-en.pdf> (p.17)

PAYOR SPECIFIC KEY POINTS

From the UnitedHealthcare Community Plan Reimbursement Policy, found at: <https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Telehealth-and-Telemedicine-Policy-R0046.pdf>

UnitedHealthcare Community Plan will consider for reimbursement Telehealth services which are recognized by The Centers for Medicare and Medicaid Services (CMS) and appended with modifiers GQ or GT, or G0 (numeric zero, not alpha O) for Telehealth services related to acute stroke, as well as services recognized by the American Medical Association (AMA) included in Appendix P of CPT and appended with modifier 95.

In addition, UnitedHealthcare Community Plan recognizes certain additional services which can be effectively performed via Telehealth/Telemedicine. These services will be considered for reimbursement when reported with modifier GQ or GT:

- Medical genetics and genetic counseling services (code 96040)
- Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum (codes 98960-98962)
- Alcohol and/or substance abuse screening and brief intervention services (codes 99408-99409)
- Remote real-time interactive video-conferenced critical care evaluation and management (E/M) of the critically ill or critically injured patient, use G0508 or G0509

UnitedHealthcare Community Plan requires one of the Telehealth-associated modifiers (GQ, GT, G0 or 95) to be reported when performing a service via Telehealth to indicate the type of technology used and to identify the service as Telehealth/virtual visits. UnitedHealthcare Community Plan will consider reimbursement for a procedure code/modifier combination using these modifiers only when the modifier has been used appropriately. Coding relationships for modifier GQ and modifier 95 are administered through the UnitedHealthcare Community Plan Procedure to Modifier Policy.

UnitedHealthcare Community Plan recognizes the CMS-designated Originating Sites considered eligible for furnishing Telehealth services to a patient located in an Originating Site.

Telehealth services to a patient located in an Originating Site. Examples of Originating Sites are listed below:

- The office of a physician or practitioner
- A hospital (inpatient or outpatient)
- A critical access hospital (CAH)
- A rural health clinic (RHC)
- A federally qualified health center (FQHC)
- A hospital-based or critical access hospital-based renal dialysis center (including satellites); NOTE: Independent renal dialysis facilities are not eligible Originating Sites
- A skilled nursing facility (SNF)
- A community mental health center (CMHC)
- Mobile Stroke Unit

United Healthcare Community Plan *(continued)*

- Patient home - only for monthly end stage renal, ESRD-related clinical assessments, and for purposes of treatment of a substance use disorder or a co-occurring mental health disorder to an individual with a substance use disorder diagnosis

UnitedHealthcare Community Plan recognizes the CMS-designated practitioners eligible to be reimbursed for Telehealth services:

Examples of practitioners are listed below:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse-midwife
- Clinical nurse specialist
- Registered dietitian or nutrition professional
- Clinical psychologist
- Clinical social worker
- Certified Registered Nurse Anesthetists

UnitedHealthcare Community Plan recognizes but does not require Place of Service (POS) code 02 or 10 for reporting Telehealth services rendered by a physician or practitioner from a Distant Site. Modifiers GQ, GT or 95 are required instead to identify Telehealth services.

UnitedHealthcare Community Plan recognizes federal and state mandates regarding Telehealth/virtual health.

Provider Manual

<https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/comm-plan/VA-UHCCP-Care-Provider-Manual.pdf>

Reimbursement Policy

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Telehealth-and-Telemedicine-Policy-R0046.pdf>

PAYOR SPECIFIC KEY POINTS

The following telehealth guidance is excerpted from the Virginia Premier memo, found at: <https://www.virginiapremier.com/providers/coronavirus/covid-19-telehealth/>

Delivery of Services via Telehealth for Medicaid, Medicare, and Individual and Family Health Plans (New Guidelines):

When delivering services via telehealth, providers are required to adhere to the same standards of clinical practice and record keeping that apply to other covered services.

1. This applies to telehealth provided for any reason and does not have to be related to diagnosis and treatment of coronavirus (COVID-19). The full notice and related guidance on acceptable applications for Medicaid (DMAS) can be found here.
2. CMS maintains a list of services that are normally furnished in-person that may be furnished via Medicare telehealth. This list is available here:

DMAS and CMS will reimburse for Medicare/Medicaid-covered services delivered via telehealth where the following conditions are met:

- Providers must assure the same rights to confidentiality and security as provided in face-to-face services. Providers must ensure the patient's informed consent to the use of telehealth and advise members of any relevant privacy considerations.
- The requirement that services delivered via telehealth (real-time, two-way communications) must use both audio and visual connection is being waived. Both DMAS and CMS are allowing the use of audio connections, in addition to audio-visual connections.
- Both DMAS and CMS are waiving the requirement that provider staff must be with the patient at the originating site in order to bill DMAS for the originating site facility fee. These "tele-presenters" should not be required for payment of the originating site fee.
- Click here to view Frequently asked Provider Questions for Telehealth provided by CMS
- Providers should submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service delivered.
- Providers are asked to update their systems and procedures as soon as possible to enable the use of modifiers (GT or GQ) and telehealth POS (02) when billing for services delivered via telehealth.
- Providers using telehealth POS (02) and modifiers for telehealth services covered under the prior policy shall continue to use the modifier GT (via interactive audio and video telecommunications system) or GQ (via synchronous telecommunications system), or POS code (02) when billing for services delivered via telehealth.
- Both services delivered via telehealth and billed using telehealth modifiers, and services delivered via telehealth and billed without modifiers will be reimbursed at the same rate as the analogous service provided face-to-face.
- Providers should maintain appropriate documentation to support medical necessity for the service delivery model chosen, as well as to support medical necessity for the ongoing delivery of the service through that model of care.

Home as Originating Site

During the coronavirus (COVID-19) pandemic, DMAS is relaxing the requirement that provider staff must be with the patient at the originating site in order to bill DMAS for the originating site facility fee.

- This is particularly important for members, who are quarantined, those who are diagnosed with or demonstrating symptoms of coronavirus (COVID-19), or those who are at high risk of serious illness from coronavirus (COVID-19).
- Clinicians should use clinical judgment when determining the appropriate use of home as the originating site.
- No originating site fee will be paid for telehealth in the home.

Telehealth in the Delivery of Behavioral Health Services

DMAS will allow for telehealth, including telephonic delivery of all behavioral health services with several exceptions.

Services that will be allowed using telehealth include:

- Care coordination, case management and peer services
- Service Needs Assessments, including the Comprehensive Needs Assessment; the IACCT assessment in Mental Health; the Multi-Dimensional Assessment in ARTS; and all treatment planning activities
- Outpatient Psychiatric Services
- Community Mental Health and Rehabilitation Services
- Addiction Recovery and Treatment Services
- The per diem rates for therapeutic group homes, psychiatric residential treatment facilities, and inpatient psychiatric hospitalization will not be billable through telehealth; however, within these services, activities including assessments, therapies (individual, group, family), care coordination, team meetings, and treatment planning are allowable via telehealth
- Behavioral health providers delivering services via telehealth, including telephonic communications, should simply bill and submit a claim as they normally would in their regular practice.
- The Place of Service (POS) that the provider usually bills should remain the same and no modifiers will be necessary in order to minimize systems errors during this critical time.
- Providers should maintain appropriate documentation to indicate the mode of delivery and to support medical necessity for the ongoing delivery of the service through that model of care. Providers should move to systems changes to allow Place of Service Codes (02) to reflect telehealth delivery, as this will be required at a future date.

Provider Manual

- <https://www.virginiapremier.com/wp-content/uploads/VPEProviderManual.pdf> (pgs. 74-80)

Virginia Premier FAQs

- https://www.virginiapremier.com/wp-content/uploads/provider-vphp-notice-faq-for-providers_05252022.pdf

Virginia Premier Coronavirus Telehealth Memo

- <https://www.virginiapremier.com/providers/coronavirus/covid-19-telehealth/>

Magellan Behavioral Health

PAYOR SPECIFIC KEY POINTS

Magellan Behavioral Health is contracted with DMAS to provide administration of behavioral health services in Virginia.

The following telehealth guidance is excerpted from the 2022 Magellan Healthcare Provider Manual, found at: https://www.magellanprovider.com/media/11893/provider_handbook.pdf, p.34:

Magellan defines telehealth as a method of delivering behavioral health services using interactive telecommunications when the member and the behavioral health provider are not in the same physical location. Telecommunications must be the combination of audio and live, interactive video. The Magellan member must have a covered mental health benefit that permits telehealth in order for providers to receive payment for telehealth services.

Provider Responsibilities:

- Complete Magellan's telehealth services provider attestation if you are interested in providing behavioral health services via telehealth;
- Meet the specific requirements outlined in the telehealth services attestation surrounding the provision of telehealth services, including the ability to provide all telehealth sessions through secure and HIPAA- compliant technology; and

To stay up-to-date on the latest news from Magellan Behavioral Health, visit the Communications archive at <https://www.magellanofvirginia.com/for-providers/communications/>.

Provider Manual

- https://www.magellanprovider.com/media/11893/provider_handbook.pdf

Communications

- <https://www.magellanofvirginia.com/for-providers/communications/>

Attachment A (<https://vamedicaid.dmas.virginia.gov/manual-chapters/telehealth-services-supplement>).

Clinicians shall use their clinical judgment to determine the appropriateness of service delivery via telehealth considering the needs and presentation of each individual.



TABLE 1
Medicaid-covered medical services authorized for delivery by telemedicine*

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Colposcopy		57452, 57454, 57455, 57456, 57460, 57461
Fetal Non-Stress Test		59025
Prenatal and Postpartum Visits	<p>Synchronous audio-visual delivery is permissible for the prenatal and postpartum services stipulated in CPT 59400, 59410, 59510 and 59515; delivery services for those codes must be completed in person.</p> <p>Providers should complete at least one in-person visit per trimester for which they bill prenatal services for the purposes of appropriate evaluation, testing, and assessment of risk.</p>	59400, 59410, 59425, 59426, 59430, 59510, 59515
Radiology and Radiology-related Procedures		70010-79999 and radiology related procedures as covered by DMAS; GQ modifier if store and forward**
Obstetric Ultrasound		76801, 76802, 76805, 76810, 76811-76817
Echocardiography, Fetal		76825, 76826
End Stage Renal Disease		90951 - 90970
Remote Fundoscopy		<p>92250; TC if applicable; GQ modifier if store and forward</p> <p>92227, 92228; 26 if applicable; GQ modifier if store and forward</p>
Speech Language Therapy/ Audiology		92507†, 92508†, 92521, 92522, 92523, 92524
Diagnosis, analysis cochlear implant function		92601-92604, 95974
Cardiography interpretation and report		93010

TABLE 1 (continued)

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Echocardiography		93307, 93308, 93320, 93321, 93325
Genetic Counseling		96040
Maternal Mental Health Screening		96127, 96160††, 96161††
Physical therapy / Occupational therapy		<ul style="list-style-type: none"> • 97110†, 97112†, 97150† • 97530†, S9129†
Medical Nutrition Therapy		97804
Evaluation & Management (Office/Outpatient)		99202-99205, 99211-99215; GQ modifier if teledermatology and store and forward
Evaluation & Management (Hospital)		99221-99223, 99231-99233; GQ modifier if teledermatology and store and forward
Evaluation & Management (Nursing facility)		<ul style="list-style-type: none"> • 99304-99306 • 99307-99310
Respiratory therapy	<p>Must have respiratory equipment set up in home and initial in-person visit by a respiratory therapist or member of the clinical team.</p> <p>Restricted to outpatient respiratory therapy.</p>	99503, 94664
Education for Diabetes, Smoking, Diet		G0108, 97802, 97803
Early Intervention	<ul style="list-style-type: none"> • Must have family member/caregiver, service coordinator, or member of the clinical team physically present with member during visit. • Initial assessment (T1023) must be in-person with each assessing member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery. • Initial service visit (G* codes) must be in-person with a member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery. 	

TABLE 2**Medicaid-covered mental health and substance use disorder services authorized for delivery by telemedicine**

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Diagnostic Evaluations		90791-90792
Psychotherapy		90832, 90834, 90837
Psychotherapy for Crisis		90839-90840
Pharmacologic counseling		90863
Psychotherapy w/ E&M svc		90833, 90836, 90838
Psychoanalysis		90845
Family/Couples Psychotherapy		90846-90847
Group Psychotherapy		90853
Prolonged Service, in office or outpatient setting		99354-99357
Psychological testing evaluation		96130, 96131
Neuropsychological testing evaluation		96132, 96133
Psychological or neuropsychological test administration & scoring		96136, 96137, 96138, 96139, 96146
Neurobehavioral Status Exam		96116, 96121
Add-on Interactive Complexity		90785
Health Behavior Assessment		96156
Health Behavior Intervention (Individual, group, family)		<ul style="list-style-type: none"> • 96158-96159 • 96164-96165 • 96167-96168 • 96170-96171
Evaluation & Management (Outpatient)		99202-99205, 99211-99215
Evaluation & Management (Inpatient)		99221-99223, 99231-99233
Smoking and tobacco cessation counseling		99406-99407
Alcohol/SA structured screening and brief intervention		99408-99409
OTP/OBOT Specific Services		H0004, H0005, H0014*, G9012
SUD Case Management		H0006
Mental Health Case Management Services		H0023

TABLE 2 (continued)

Service(s)	Telemedicine-specific Service Limitations	Code(s)
IACCT Initial Assessment		90889 HK
IACCT Follow-Up Assessment		90889 TS
Mental Health Skill Building		H0046
Crisis Stabilization		H2019 (ended 11/30/2021)
Crisis Intervention		H0036 (ended 11/30/2021)
Mobile Crisis Response	Assessment only (See Appendix G to the Mental Health Services Manual)	H2011 (effective 12/1/2021)
Community Stabilization	Telemedicine-assisted assessment only (See Appendix G to the Mental Health Services Manual)	S9482 (effective 12/1/2021)
23 Hour Residential Crisis Stabilization	Psychiatric evaluation only (See Appendix G to the Mental Health Services Manual)	S9485 (effective 12/1/2021)
Residential Crisis Stabilization	Psychiatric evaluation only (See Appendix G to the Mental Health Services Manual)	H2018 (effective 12/1/2021)
Assertive Community Treatment		H0040
Psychosocial Rehabilitation		H2017
Intensive In-Home Services		H2012
Therapeutic Day Treatment		H2016
Behavioral Therapy Program		H2033 (ended 11/30/2021)
Applied Behavior Analysis (ABA)	97151 and 97152 may be provided through telemedicine for reassessments only.	97151-97158 (effective 12/1/2021)
Multisystemic Therapy (MST)		H2033 (effective 12/1/2021)
Functional Family Therapy (FFT)		H0036 (effective 12/1/2021)
Foster Care Case Management		T1016
Peer Recovery Support Services (PRSS)		H0024, H0025, S9445, T1012
Mental Health Partial Hospitalization Program		H0035
Mental Health Intensive Outpatient Program		S9480
SUD Partial Hospitalization Program		S0201
SUD Intensive Outpatient Program		H0015

TABLE 3**Radiology-Related Procedures for Physician Billing Included under Telehealth Coverage**

Procedure Title (Reduced Length)	CPT Code
Fine needle aspiration; with imaging guidance	10022
Biopsy of breast; percutaneous, needle core, using image guidance	19102
Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device	19103
Preoperative placement of needle localization wire, breast	19290
Image guided placement, metallic localization clip, percutaneous, breast biopsy/aspiration	19295
Arthrocentesis, aspiration, and/or injection; major joint or bursa	20610
Transcatheter occlusion or embolization (eg, for tumor destruction, other)	37204
Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stage	47011
Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	49083
Electrocardiogram, routine ecg with at least 12 leads; with interpretation	93000
Electrocardiogram, routine ecg with at least 12 leads; interpretation and report only	93010
Echocardiography, transthoracic, real-time with image documentation (2d)	93306
Duplex scan of extremity veins including responses to compression and other	93970
Duplex scan of extremity veins including responses to compression and other	93971
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs	93975
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs	93976

TABLE 4**Radiology-Related Procedures for Physician Billing Included under Telehealth Coverage**

Procedure Title (Reduced Length)	CPT Code
Collection & interpretation of physiologic data digitally stored/transmitted 30 min per 30d	99091
Remote monitoring of physiologic parameter(s); set-up and education on use of equipment	99453
Remote monitoring of physiologic parameter(s); device(s) supply & daily recording(s) or programmed alert(s) transmission, each 30 days	99454
Remote physiologic monitoring treatment management services; interactive communication with the patient/caregiver during the month; first 20 minutes	99457
Each additional 20 minutes	99458
Remote therapeutic; initial set-up and patient education on use of equipment	98975
Respiratory system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days	98976
Musculoskeletal system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days	98977
Remote therapeutic monitoring treatment management services; interactive communication with the patient or caregiver during the calendar month; first 20 minutes	98980
Each additional 20 minutes	98981
Self-measured blood pressure; patient education/training and device calibration	99473
Self-measured blood pressure; reported 2x daily for 30d w/ clinician review and communication of treatment plan	99474

TABLE 5
Virtual Check-In Services

Service	Code
Virtual check-in, E&M-eligible providers, 5-10 min	G2012
Virtual check-in, non-E&M-eligible providers, 5-10 min	G2251
Virtual check-in, E&M-eligible providers, 11-20 min	G2252
Remote evaluation of recorded video and/or images, E&M-eligible providers	G2010
Remote evaluation of recorded video and/or images, non-E&M-eligible providers	G2250

TABLE 6
Audio Only Services*

Service	Code
Telephone evaluation and management service provided by a physician; 5-10 minutes of medical discussion	99441
Telephone evaluation and management service provided by a physician; 11-20 minutes of medical discussion	99442
Telephone evaluation and management service provided by a physician; 21-30 minutes of medical discussion	99443
Telephone assessment and management service provided by a qualified nonphysician health care professional; 5-10 minutes of medical discussion	98966
Telephone assessment and management service provided by a qualified nonphysician health care professional; 11-20 minutes of medical discussion	98967
Telephone assessment and management service provided by a qualified nonphysician health care professional; 21-30 minutes of medical discussion	98968

** All fee-for-service claims for audio only codes should be billed directly to DMAS, including those delivered in the context of mental health and substance use disorder services. See Chapter V of the Physician/Practitioner Manual for detailed billing instructions.*

CITATIONS

DMAS Guidance on Telehealth Services

Telehealth Services Supplement | MES, 3 June 2022

<https://vamedicaid.dmas.virginia.gov/manual-chapters/telehealth-services-supplement>.

Medallion 4.0 Managed Care Contract Telehealth Summary

Medallion 4.0 Managed Care Services Agreement - Virginia. Commonwealth of Virginia Department of Medical Assistance Services, July 2021

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https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/virginia/provider/pdf/abhva_provider_manual.pdf

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https://providers.anthem.com/docs/gpp/VA_CAID_RemotePatientMonitoringUpdate.pdf.

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https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/va/VA-ALL-PHB-21256-22-MCC-VA-Provider-Manual-FINAL_508c.pdf

Optima Health

"Optima Family Care FAMIS/FAMIS Moms Medallion 4.0 Provider Manual: Supplemental Information For Virginia." *Optimahealth.com*, 11 Nov. 2021

<https://www.optimahealth.com/providers/provider-support/manuals>

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<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Add-On-Codes-Policy-Professional-R0071.pdf>

Virginia Premier

"Coronavirus (COVID-19) Telehealth." *Virginiapremier.com*, July 2020

<https://www.virginiapremier.com/providers/coronavirus/covid-19-telehealth/>

Magellan Behavioral Health

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https://www.magellanprovider.com/media/11893/provider_handbook.pdf

Appendix A

Telehealth Services Supplement | MES, 3 June 2022

<https://vamedicaid.dmas.virginia.gov/manual-chapters/telehealth-services-supplement>.

ADDITIONAL RESOURCES

Medicaid

<https://www.dmas.virginia.gov>

<https://www.dmas.virginia.gov/media/4487/msr-2022-062-003-w-attachment-telehealth-services-supplement-rpm.pdf>

<https://vamedicaid.dmas.virginia.gov/manual-chapters/telehealth-services-supplement>

<https://www.dmas.virginia.gov/for-providers/telehealth-services/>

<https://vamedicaid.dmas.virginia.gov/manual-chapters/telehealth-services-supplement>

Medallion 4.0

<https://www.virginiamanagedcare.com>

<https://www.dmas.virginia.gov/media/3583/medallion-4-contract-sfy22-v1.pdf>

Aetna Better Health

https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/virginia/provider/pdf/abhva_provider_manual.pdf

Anthem Healthkeepers Plus

https://providers.anthem.com/docs/gpp/VA_CAID_ProviderManual.pdf?v=202105212022

<https://mss.anthem.com/va/benefits/medicaid-plans.html>

Molina Healthcare

<https://www.molinahealthcare.com/providers/va/medicaid/home.aspx>

Optima Healthcare

<https://www.optimahealth.com/providers/>

United Healthcare Community Plan

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Telehealth-and-Telemedicine-Policy-R0046.pdf>

Virginia Premier

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Magellan Behavioral Health

<https://www.magellanofvirginia.com/for-providers/>

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