

Cover Letter

The purpose of this document is to provide background and context for changes that NC Medicaid is making to its telehealth policies. This is not a policy document, but rather is intended to help providers understand upcoming telehealth-related policy changes.

NC Medicaid is proposing several key changes to current Clinical Coverage Policy [1-H: Telemedicine and Telepsychiatry Clinical Coverage Policy](#) to enable expanded coverage of remote care to Medicaid and North Carolina Health Choice (NCHC) beneficiaries beyond the current public health emergency and to become permanent policy. The new version of 1-H, “Telehealth, Virtual Patient Communications and Remote Patient Monitoring Policy” builds upon the former policy and will replace it in its entirety on a date to be determined later in 2020. NC Medicaid has issued several temporary Special Medicaid bulletins related to telehealth coverage that remain in effect until further notice. The Special Medicaid bulletins can be found at: <https://medicaid.ncdhhs.gov/about-us/covid-19-guidance-and-resources/providers/covid-19-special-medicaid-bulletins>. NC Medicaid will provide 30 days of advance notice for when the revised 1-H will come into effect and the temporary Special Medicaid bulletins sunsetted.

The proposed revised 1-H policy includes the following key changes:

- Redefines telehealth to include all forms of two-way, real-time audio telecommunications, such as telemedicine, telepsychiatry, teletherapy, etc. The telepsychiatry codes that were in the previous version of 1-H will be included in a forthcoming revised 8-C clinical coverage policy.
- Adds coverage for virtual patient communications (telephone and online digital evaluation and management, interprofessional consultation) and remote patient monitoring codes.
- Eliminates restriction on "video cell phone interactions;" telehealth can occur over a HIPAA-compliant platform on any device with audio/visual capabilities.
- Eliminates restrictions on originating sites: an originating site can be the patient's home and there are no distance requirements between originating and distant sites.
- Eliminates requirements for referring providers.
- Expands eligible provider types (varies by service).
- Eliminates consulting provider language; medical examinations can occur without oversight from a consulting provider.

The revised Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications and Remote Patient Monitoring is intended to provide overarching guidance related to the delivery of services via telehealth, virtual patient communications and remote patient monitoring that are not otherwise included in a program or service-specific clinical coverage policy. To complement 1-H, NC Medicaid is in the process of revising several other clinical coverage policies to include new telehealth-specific guidance that is tailored to the services covered by each clinical coverage policy. These revised clinical coverage policies will be submitted to the July meeting of the Physician Advisory Group (PAG) for review.

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To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

Note: This policy provides general guidance for telehealth, virtual patient communications, and remote patient monitoring services delivered to Medicaid and North Carolina Health Choice (NCHC) beneficiaries. In addition to this policy, please refer to the clinical coverage policies listed in Section 8.2 below for service-specific guidance regarding covered telehealth services.

1.0 Definitions

1.1 Telehealth

Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.

1.2 Virtual Patient Communications

Virtual patient communication is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a patient or a provider and another provider. As outlined in **Attachment A** below and program-specific clinical coverage policies, covered virtual patient communication services include: telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation).

1.3 Remote Patient Monitoring

Remote patient monitoring is the use of digital devices to measure and transmit personal health information from a patient in one location to a provider in a different location. Remote patient monitoring enables providers to collect and analyze information such as vital signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. There are two types of remote patient monitoring included within this policy:

- a. Self-Measured and Reported Monitoring: When a patient uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation.
- b. Remote Physiologic Monitoring: When a patient's physiologic data is wirelessly synced from a patient's digital device where it can be evaluated immediately or at a later time by a provider.

1.4 Originating Site

Originating site is the location in which the beneficiary is located. There are no restrictions on originating sites, except that the patient must be located within the state of North Carolina. Originating sites may include health care facilities, schools, community sites, the home, or wherever the beneficiary may be located. **Refer to Section 7.0** below for information related to originating site facility fees.

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1.5 Distant Site

Distant site is the location from which the provider furnishes the telehealth, virtual patient communications, or remote patient monitoring services. There are no restrictions on distant sites. Distant sites may be wherever the provider may be located. Providers should ensure that patient privacy is protected (e.g., taking calls from private, secure spaces; using headsets).

Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes and Rural Health Centers (RHCs) are considered eligible distant sites and should follow the coding and billing guidelines in **Attachment A** below.

1.6 Established Patient

An established patient refers to a beneficiary who has received any professional services (including services via telehealth) from the provider or another provider of the same specialty who belongs to the same group practice within the past three years. Since telehealth services are considered professional services, a patient/provider relationship may be established via telehealth.

1.7 New Patient

A new patient refers to a beneficiary who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

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2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. **Medicaid**
None Apply

- b. **NCHC**
None Apply

2.2 Special Provisions

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

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

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

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

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

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

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

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

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problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

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3.2 Telehealth-Specific Criteria

3.2.1 Specific Criteria Covered by Both Medicaid and NCHC

NC Medicaid and NCHC shall cover services delivered via Telehealth when the following additional criteria is considered before delivering services via telehealth:

- a. Providers shall ensure that services can be safely and effectively delivered using telehealth;
- b. Providers shall consider a beneficiary's behavioral, physical and cognitive abilities to participate in services provided using telehealth;
- c. The beneficiary's safety must be carefully considered for the complexity of the services provided;
- d. In situations where a caregiver or facilitator is necessary to assist with the delivery of services via telehealth, their ability to assist and their safety should also be considered;
- e. Delivery of services using telehealth must conform to professional standards of care including but not limited to ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements including Practice Act and Licensing Board rules;
- f. Providers shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this should be documented;
- g. Providers shall verify the beneficiary's identity using two points of identification before initiating a telehealth encounter; and,
- h. Providers shall ensure that beneficiary privacy and confidentiality is protected.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

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5.0 Eligible Technology

5.1 Telehealth

All telehealth services shall be provided over a secure HIPAA compliant technology with live audio and video capabilities including (but not limited to) smart phones, tablets and computers.

5.2 Virtual Patient Communications

Virtual patient communications may be transmitted between a patient and provider, or between two providers, in a manner that is consistent with the CPT code definition for those services. Providers shall follow all applicable HIPAA rules.

5.3 Remote Patient Monitoring

Remote patient monitoring requires use of a device that is defined by the FDA as a medical device. Some forms of remote patient monitoring, such as remote physiologic monitoring (detailed below), require a device that is wirelessly synced where the provider can evaluate the data in real or near-real time.

6.0 Prior Authorization and In-Person Examinations

Unless otherwise required for a specific service, beneficiaries are not required to obtain prior authorization or have an initial in-person examination in order to receive care via telehealth, virtual patient communication, or remote patient monitoring; however, when establishing a new relationship with a patient via these modalities, the provider must meet the prevailing standard of care and complete all appropriate exam requirements and documentation dictated by relevant CPT or HCPCS coding guidelines.

7.0 Originating Site Facility Fees

Any Medicaid enrolled provider who provides a beneficiary with access to audio/visual equipment in order to complete a telehealth encounter may bill for a facility fee when their office or facility is the site at which the beneficiary is located when the service is provided and the distant site provider is at a different physical location.

Skilled nursing facilities (SNF) may not bill an originating site facility fee when the SNF Medical Director or a beneficiary's attending physician is conducting a telehealth visit.

8.0 Eligible Services and Providers

8.1 Telehealth, Virtual Patient Communications, and Remote Patient Monitoring Services Covered in Clinical Coverage Policy 1-H

A range of services may be delivered via telehealth, virtual patient communication, and remote patient monitoring to Medicaid and NCHC beneficiaries. All telehealth, virtual

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patient communication, and remote monitoring services shall be delivered in a manner that is consistent with the quality of care provided in-person.

Each set of eligible services has its own set of eligible providers as defined in **Attachment A** of this policy or the relevant Clinical Coverage Policy.

Eligible services, eligible providers, and related detailed guidance for the following may be found in **Attachment A** below:

8.1.1 Telehealth, including:

- a. Office or other outpatient services and office and inpatient consultation codes; and,
- b. Hybrid telehealth visit with supporting home visit codes.

8.1.2 Virtual patient communication, including:

- a. Online digital evaluation and management codes;
- b. Telephonic evaluation and management;
- c. Telephonic evaluation and management and virtual patient communication codes; and,
- d. Interprofessional assessment and management codes.

8.1.3 Remote patient monitoring, including:

- a. Self-measured blood pressure monitoring; and,
- b. Remote physiologic monitoring.

8.2 Services Covered in Other Program-Specific Clinical Coverage Policies

In addition to the eligible services and providers listed in **Attachment A** of this policy, please refer to the following program-specific clinical coverage policies (available within the [Clinical Coverage Policy Index](#)), which include additional program-specific telehealth guidance:

- a. 1A-24: Diabetes Self-Management Education
- b. 1A-34: End-Stage Renal Disease (ESRD) Services
- c. 1D-4: Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
- d. 1E-5: Obstetrics
- e. 1E-7: Family Planning Services
- f. 1E-6: Pregnancy Medical Home
- g. 1-I: Dietary Evaluation and Counseling and Medical Lactation Services
- h. 1M-2: Childbirth Education
- i. 1M-3: Health and Behavior Intervention
- j. 4-A: Dental Services
- k. 8-A: Enhanced Mental Health and Substance Abuse Services
- l. 8-C: Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
- m. 8D-2 Residential Treatment Services
- n. 8-F: Research-Based Behavioral Health Treatment (RB-BHT) For Autism Spectrum Disorder (ASD)
- o. 8-G: Peer Support Services

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- p. 8-J: Children's Developmental Service Agencies (CDSAs)
- q. 8-P: North Carolina Innovations
- r. 10-A: Outpatient Specialized Therapies
- s. 10-C: Local Education Agencies (LEAs)

8.3 Documentation and Billing Requirements

Unless a beneficiary requests that information about their telehealth visit is not shared with another provider, providers are expected to send documentation of any telehealth services rendered to a beneficiary's identified primary care provider or medical home within 48 hours of the encounter. Documentation can be sent by any other secure means.

Claims for all telehealth, virtual patient communication, and remote patient monitoring services must be billed according to the guidance set forth in **Attachment A** below.

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9.0 Policy Implementation and History

Original Effective Date: August 01, 1999

History:

Date	Section Revised	Change
	All Sections and Attachment(s)	

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Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) may bill for telehealth, virtual patient communication, and remote patient monitoring services if the service follows core service billing requirements as outlined in clinical coverage policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics. Information concerning Virtual Communication Services provided by FQHCs and RHCs is located here: <https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center>

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

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C. 1. Telehealth Services

Eligible Services/ Codes	Eligible Providers					
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwives	Clinical Pharmacist Practitioners
Office or Other Outpatient Service and Office and Inpatient Consultation Codes						
99201	X	X	X	X	X	X
99202	X	X	X	X	X	X
99203	X	X	X	X	X	X
99204	X	X	X	X	X	X
99205	X	X	X	X	X	X
99211	X	X	X	X	X	X
99212	X	X	X	X	X	X
99213	X	X	X	X	X	X
99214	X	X	X	X	X	X
99215	X	X	X	X	X	X
99241	X	X	X	X	X	X
99242	X	X	X	X	X	X
99243	X	X	X	X	X	X
99244	X	X	X	X	X	X
99245	X	X	X	X	X	X
99251	X	X	X	X	X	X
99252	X	X	X	X	X	X
99253	X	X	X	X	X	X
99254	X	X	X	X	X	X
99255	X	X	X	X	X	X
T1015+	X	X	X	X	X	X
Hybrid Telehealth Visit with Supporting Home Visit Codes (see additional guidance below)						
99347	X	X	X	X	X	
99348	X	X	X	X	X	
99349	X	X	X	X	X	
99350	X	X	X	X	X	

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

Guidance: Hybrid Telehealth with Supporting Home Visit (“Hybrid Model”)

- Eligible providers may conduct telehealth visits with a supporting home visit by a delegated staff member (“hybrid model”) with new or established patients, for a range of scenarios including (but not limited to):
 - **Chronic Disease Management:** Providers shall use the home visit codes in this policy with appropriate modifiers.
 - **Perinatal Care:** Providers shall only use the home visit codes in this policy with appropriate modifiers if they are not billing the pregnancy global package codes. Providers billing the

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pregnancy global package codes shall refer to NC Medicaid Clinical Coverage Policy 1-EF: Obstetrics for billing guidance for this model.

- Well-child services are not eligible to be delivered via the hybrid model.
- Providers shall choose the most appropriate code based on the complexity of the services provided and document accordingly. If time is used as a determining factor, providers shall choose the code that corresponds with the length of the telehealth visit provided by the eligible provider (not the duration of the home visit performed by the delegated staff person).
- The delegated staff person may perform vaccinations in the home as long as they comply with applicable vaccination requirements (e.g., staff person’s scope of practice), and may conduct other tests or screenings, as appropriate.
 - Any vaccinations, tests or screenings conducted in the home should be billed as if they were delivered within the office, without modifiers.
- Local Health Departments may also utilize the hybrid model when the telehealth visit is rendered by an eligible provider and may bill the home visit codes listed in table C.1.
- FQHCs, FQHC-Lookalikes, and RHCs may utilize this hybrid model but shall not bill the home visit codes in table C.1.; FQHCs, FQHC-Lookalikes and RHCs may bill their core service code (T1015) and an originating site facility fee (Q3014) for hybrid model visits to reflect the additional cost of the delegated staff person attending the patient’s home. To be reimbursed for the originating site facility fee, all of the following requirements must be met for each home visit:
 - The assistance delivered in the home must be given by an appropriately trained delegated staff person.
 - The fee must be billed on the same day that the home visit is conducted.
 - HCPCS code Q3014 must be appended with the GT modifier and billed with a place of service ‘12’ to designate that the originating site was the home.
 - The core service code (T1015) must be billed separately from the originating site facility fee code (Q3014).

C.2. Virtual Patient Communication Services

Eligible Services/ Codes	Eligible Providers				
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwives
Online Digital Evaluation and Management Codes					
99421+	X	X	X	X	X
99422+	X	X	X	X	X
99423+	X	X	X	X	X
Telephonic Evaluation and Management and Virtual Patient Communication Codes					
99441	X	X	X	X	X
99442	X	X	X	X	X
99443	X	X	X	X	X
G0071+	X	X	X	X	X
G2012	X	X	X	X	X

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Interprofessional Assessment and Management Codes					
99446	X				
99447	X				
99448	X				
99449	X				

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

C.3. Remote Patient Monitoring Services

Eligible Services/ Codes	Eligible Providers					Code-Specific Guidance
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwives	
Self-Measured Blood Pressure Monitoring Codes (see additional guidance below)						
99473+	X	X	X	X	X	Providers may bill once per patient, per device. May be performed remotely. No more than one provider may bill for the same patient.
99474+	X	X	X	X	X	Providers may bill once in a 30-day period if they complete a minimum of 12 readings. No more than one practice may bill for the same patient in the same month.
Remote Physiologic Monitoring Codes (see additional guidance below)						
99453+	X	X	X	X	X	May be billed only once for each episode of care, which begins when the RPM is initiated and ends with attainment of targeted treatment goals.
99454+	X	X	X	X	X	May be billed once every 30 days continuously (not calendar month, by contrast with code 99457 below).
99457+	X	X	X	X	X	May be billed for the first twenty minutes of communication with the patient or caregiver in the calendar month, and only

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Eligible Services/ Codes	Eligible Providers					Code-Specific Guidance
	Physician	Nurse Practitioner	Psychiatric Nurse Practitioner	Physician Assistant	Certified Nurse Midwives	
						once per calendar month per patient.
99458+	X	X	X	X	X	May be billed for each additional twenty minutes of communication with the patient or caregiver in the calendar month

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

Guidance: Self-Measured Blood Pressure Monitoring (SMBPM)

- SMBPM is a patient’s regular use of a personal blood pressure monitoring device to assess and record blood pressure across different points in time outside of a clinical setting, typically at home. This service is available for new or established patients.

Guidance: Remote Physiologic Monitoring (RPM)

- **RPM** is the collection and interpretation of an established patient’s physiologic data digitally transmitted to the eligible provider. **Codes 99453 and 99454 are used for device set-up, training and supply – the following guidance applies to both of these codes:**
 - 99453 and 99454 can be used for blood pressure RPM if the device used to measure blood pressure meets RPM requirements. If the patient self-reports blood pressure readings, the provider should instead bill SMBPM codes 99473/99474.
 - 99453 and 99454 cannot be reported if monitoring is less than 16 days in duration.
 - Providers should not report codes 99453 or 99454 if the services are included in any other codes covered by NC Medicaid for the duration of time of the RPM (for example, continuous glucose monitoring that is covered under code 95250).
- **RPM treatment management services** are the use of the RPM results by the eligible provider to manage an established patient’s treatment plan. **Codes 99457 and 99458 are used to report RPM treatment management services – the following guidance applies to both of these codes.**
 - Codes 99457 and 99458 require a live, interactive communication between the patient or caregiver.
 - Providers may not bill code 99457 or 99458 for interactions of less than 20 minutes.
- **For all RPM and RPM treatment management service codes in table C.3:** If the services described by codes 99453, 99454, 99457 or 99458 are provided on the same day a patient presents for an evaluation and management service to the same provider (whether by telehealth or in-person), these services should be considered part of the E/M service and not billed under the RPM code.

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C.4. HCPCS Codes

The following HCPCS code can be billed for the Telehealth originating site facility fee by the originating site (the site at which the beneficiary is located): Q3014.

C.5. Revenue Codes

When the originating site is a hospital, the originating site facility fee must be billed with RC780 and Q3014.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

Note: Unlisted procedure codes cannot be used to bill for non-covered services or services for which a provider is not allowed to bill.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

- Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Telehealth, virtual patient communication, and remote patient monitoring claims should be filed with the provider's usual place of service code(s) and not place of service 02 (Telehealth).

Exception: Hybrid telehealth with supporting home visits should be filed with Place of Service (POS) 12 (home).

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <https://medicaid.ncdhhs.gov/>.

For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

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H. Reimbursement

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

When the GT modifier is appended to a code billed for professional services, the service is paid at the allowed amount of the fee schedule.

1. For hospitals, this is a covered service for both inpatient and outpatient and is part of the normal hospital reimbursement methodology.
2. Reimbursement for these services is subject to the same restrictions as face-to-face contacts (such as; place of service, allowable providers, multiple service limitations, prior authorization).