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1.0 Description of the Procedure, Product, or Service

1.1 Definitions

1.1.1 Telemedicine

Telemedicine is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via telemedicine.

1.1.2 Telepsychiatry

Telepsychiatry is the use of two-way real–time interactive audio and video between places of lesser and greater psychiatric expertise to provide and support psychiatric care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via telepsychiatry.

1.1.3 Service Sites

The originating site (formally known as the spoke site) is the facility in which the beneficiary is located. The distant site (formally known as the hub site) is the facility from which the provider furnishes the telemedicine or telepsychiatric service. All service sites must be Medicaid-enrolled *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*) providers.

1.1.4 Providers

The referring provider evaluates the beneficiary, determines the need for a consultation, and arranges the services of a consulting provider for the purpose of diagnosis and treatment.

The consulting provider evaluates the beneficiary via either telemedicine or telepsychiatry upon the recommendation of the referring provider. Treatment is initiated as needed.

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**.

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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.

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 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: http://dma.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

The Division of Medical Assistance (DMA) 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 DMA 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 or NCHC shall cover procedures, products, and services related to this policy when they are 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.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover Telemedicine and Telepsychiatry services when medically necessary under all of the following conditions:

a. The beneficiary shall be present at the time of consultation.
b. The medical examination of the beneficiary must be under the control of the consulting provider.
c. The distant site of the service(s) must be of a sufficient distance from the originating site to provide service(s) to a beneficiary who does not have readily available access to such specialty services.
d. The consultation must take place by two-way real-time interactive audio and video telecommunications system.

Note: The licensed provider using Telemedicine or Telepsychiatry Services shall ensure the availability for appropriate follow-up care and maintain a complete health record that is available to the beneficiary and other treating providers.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

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 or NCHC shall not cover procedures, products, and services 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.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover Telemedicine and Telepsychiatry Services for all of the following:

a. Facility fees for the distant site.
b. Interactions that do not constitute covered telemedicine or telepsychiatry services including:
    1. Telephone conversations
    2. Video cell phone interactions
    3. E-mail messages

4. Facsimile transmission between a health care provider and a beneficiary.
5. “Store and forward”--Transfer of data from beneficiary visits and consultations from one site to another through the use of a camera or similar devise that records (stores) an image that is sent by telecommunication to another site for consultation.

c. When the beneficiary is located in a jail, detention center, or prison.
d. The consulting provider is not a Medicaid or NCHC enrolled provider.
e. The consultant does not follow established criteria for the service provided.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

The provider at the distant site shall obtain prior approval for services when these medical or psychiatric services require prior approval based on service type or diagnosis.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

None Apply.

5.3 Limitations or Requirements

a. The beneficiary shall be present at the time of consultation.
b. The telecommunications must permit encrypted real-time interactive audio and video communication with the consulting provider.
c. The referring provider participates in the service as appropriate to meet the medical needs of the beneficiary.
d. Up to three different consulting providers may be reimbursed for a separately identifiable telemedicine or telepsychiatry service provided to a beneficiary per date of service.
e. Only one facility fee is allowed per date of service “per beneficiary.”
f. There is no reimbursement to the referring provider at the originating site on the same date of service unless the referring provider is billing for a separately identifiable billable service. Health records must document that all of the components of the service being billed were provided to the beneficiary.
g. These services are subject to the same restrictions as face-to-face contacts (e.g., place of service, allowable providers, multiple service limitations, prior authorization).

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

a. meet Medicaid or NCHC qualifications for participation;
b. be currently Medicaid or NCHC enrolled; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Telemedicine Professional Services

The following providers enrolled in the Medicaid or NCHC program who provide this service may bill Medicaid or NCHC:

a. Physicians.
b. Nurse practitioners.
c. Nurse midwives.
d. Physician’s Assistants.

6.2 Telepsychiatry Professional Services

The following providers enrolled in the Medicaid program who provide this service may bill Medicaid or NCHC:

a. Physicians.
b. Advanced practice psychiatric nurse practitioners.
c. Advanced practice psychiatric clinical nurse specialists.
d. Licensed psychologists (doctorate level).
e. Licensed clinical social workers (LCSW).
f. Community diagnostic assessment agencies.

6.3 Facility Fees

The following providers 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:

a. Physicians.
b. Nurse practitioners.
c. Nurse midwives.
d. Advanced practice psychiatric nurse practitioners.
e. Advanced practice psychiatric clinical nurse specialists.
f. Licensed psychologists (doctorate level).
g. Licensed clinical social workers (LCSW).
h. Physician's Assistants.
i. Hospitals (inpatient or outpatient).
j. Federally qualified health centers.
k. Rural health clinics.
l. Local health departments.
m. Local Management Entities.

Refer to **Attachment A, Section C,** for a list of billable codes.

7.0 Additional Requirements

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

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: August 1, 1999

Revision Information:

Date	Section Revised	Change
06/01/2007	Subsection 1.3	Implemented coverage of a facility fee for the originating site.
06/01/2007	Subsection 6.2	Added community diagnostic assessment agencies as a provider type eligible to bill for telemedicine/telepsychiatry services.
06/01/2007	Subsection 6.3	Added provider types eligible to bill for facility fees.
06/01/2007	Attachment A, item C	Implemented coverage of HCPCS procedure code T1023 for telemedicine/telepsychiatry services.
07/01/2010	All sections and attachment(s)	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
03/12/2012	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1H under Session Law 2011-145 § 10.41.(b)
03/12/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
07/01/2012	Section 1.0 Subsections 1.1, 1.3 and 1.4	In 1.1, removed and/ replaced with or, In 1.3 deleted provides and replaced with furnishes, In 1.4, deleted "is the provider who has" in the first sentence, removed d from evaluated, determined and arranged and replaced with s, deleted has and replaced with a. Deleted "is the provider who" from the second sentence, added the word either, removed / between telemedicine and telepsychiatry and replaced with or.
07/01/2012	Subsection 4.2	Deleted must and replaced it with shall in 4.2 (b)
07/01/2012	Section 5.0 Subsections 5.1, 5.3 and 5.4	In 5.1, removed "when the service is rendered outside a 40-mile radius of North Carolina borders (10A NCAC 220.0119)" and replaced with a Medicaid or NCHC recipient and shall comply with 10A NCAC 25S.0201." In 5.3, removed heading Additional Prior Approval Requirements and replaced with Other Requirements or Limitations and combined 5.3 and 5.4.
11/15/2013	Subsection 3.2	Added "3.2 Specific Criteria Medicaid and NCHC shall cover Telemedicine and Telepsychiatry services when medically necessary under all of the following conditions:

Date	Section Revised	Change
		1. The beneficiary shall be present at the time of consultation. 2. The medical examination of the beneficiary must be under the control of the consulting provider. 3. The distant site of the service(s) must be of a sufficient distance from the originating site to provide service(s) to a beneficiary who does not have readily available access to such specialty services. 4. The consultation must take place by two-way real-time interactive audio and video telecommunications system. **Note:** The licensed provider using Telemedicine or Telepsychiatry Services shall ensure the availability for appropriate follow-up care and maintain a complete health record that is available to the beneficiary and other treating providers."
11/15/2013	Subsection 4.2	Added "Medicaid and NCHC shall not cover Telemedicine and Telepsychiatry Services for all of the following:" (a) removed "are not covered" (b) removed "the following" "reimbursable" "and shall not be reimbursed:" added "covered" and "services including:" 4.2 (b) 5 removed "beneficiary visits and consultations, which are transmitted after the beneficiary is no longer available" and replaced with "Transfer of data from beneficiary visits and consultations from one site to another through the use of a camera or similar devise that records (stores) an image that is sent by telecommunication to another site for consultation" 4.2 (c) Added "When" 4.2 (d) Removed "in-state" Removed 4.2 "(e) The consulting provider is not physically located in North Carolina or within the 40 miles radius." 4.2 (f) Added "The consultant does not follow established criteria for the service provided."
11/15/2013	Subsection 5.1	Deleted "The provider shall obtain prior approval before rendering Telemedicine and Telepsychiatry for a Medicaid or NCHC beneficiary "for non-emergency out-of-state services more than 40 miles outside North Carolina's border" (10 A NCAC 25S.0201 (b)." Moved from Subsection 5.3: "The provider at the distant site shall obtain prior approval for services when these

Date	Section Revised	Change
		medical or psychiatric services require prior approval, based on service type or diagnosis."
11/15/2013	Subsection 5.3	In 5.3 the following wording was added: (a) added "at the time of consultation" Deleted and moved 5.3 (d) to 5.1 Prior Approval "The provider at the distant site shall obtain prior approval for services when these medical or psychiatric services require prior approval, based on service type or diagnosis." (e), added "per beneficiary" (f) Deleted "Medical" and replaced with "Health"
11/15/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
11/15/2013	Attachment A Subsection C. Billing Codes	4. HCPCS Codes added the wording "Telehealth originating site"
11/15/2013	Attachment A Subsection E. Billing Units	Changed "The provider" to "Providers"
11/15/2013	Attachment A Subsection C Billing Codes	1. Removed provider and added physician and psychiatric NP. CPT codes 90801, 90804, 90805, 90806, 90807, 90808, 90809 and 90862 were deleted from the policy and replaced with CPT codes 90971, 90972, 90832, 90833, 90834, 90836, 90837 and 90838 per the American Medical Association during CPT Code Update 2013. Revisions made to the descriptions for CPT codes 99201-99215, 99241-99245 and 99251-99255 per the American Medical Association during CPT Code Update 2013.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
01/01/2018	Attachment A: C	Policy amended so codes 90791 and 90792 can be billed by physician's assistant's or non-psychiatric NP.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA'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)

B. International Classification of Diseases, 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.

1. The following CPT procedure codes can be billed by the consulting physician and psychiatric NP for professional services:
   Note: Codes marked with an asterisk (*) can not be billed by physician's assistant's or non-psychiatric NP.

Codes		
90791	99203	99243
90792	99204	99244
90832*	99205	99245
90833*	99211	99251
90834*	99212	99252
90836*	99213	99253
90837*	99214	99254
90838*	99215	99255
99201	99241	
99202	99242	

2. Advanced practice psychiatric nurse practitioners may bill only the following codes:

Codes
90791
90792
90832
90833
90834
90836
90837
90838

3. Advanced practice psychiatric clinical nurse specialists, licensed psychologists, and licensed clinical social workers as consulting providers may bill only the following codes:

Codes
90791
90832
90834
90837

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. Refer to **Subsection 6.3** for list of providers.

   HCPCS code T1023 can be billed only by diagnostic assessment agencies for screening/evaluation to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter (1 unit =1 event). T1023 (1 unit) is billed for the date that the total assessment is completed by the agency that employs the providers of service.

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.

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 Telecommunication.” Other modifiers must be appended to the CPT codes, as appropriate.

E. Billing Units

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

F. Place of Service

Inpatient, Outpatient, Office /Clinic settings.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://dma.ncdhhs.gov/.
For NCHC refer to G.S. 108A-70.21(d),

H. Reimbursement

Provider(s) shall bill their usual and customary charges:

1. When the GT modifier is appended to a code billed for professional services, the service is paid at 100% of the allowed amount of the fee schedule.
2. For hospitals, this is a covered service for both inpatient and outpatient and is part of the normal hospital reimbursement methodology.
3. Reimbursement for these services is subject to the same restrictions as face-to-face contacts (e.g., place of service, allowable providers, multiple service limitations, prior authorization).

For a schedule of rates, refer to: http://dma.ncdhhs.gov/