CareSource

PARTNER with Purpose

Telehealth ODM Billing Guidelines

Applies to dates of service on or after July 15, 2022

Ohio Department of Medicaid

Telehealth Services: Guidelines for Managed Care Entities (version 5.0)

THE OHIO DEPARTMENT OF MEDICAID

Medicaid Managed Care Organizations (MCOs), MyCare Ohio Plans (MCOPs) and the OhioRISE plan (hereinafter referred to collectively as managed care entities or MCEs) will use the guidelines outlined in this document to allow their Ohio Department of Medicaid (ODM) members to continue using telehealth. In addition to the guidelines within this document, billing guidance regarding how FFS handles telehealth can be found within the telehealth billing guidelines located here: Telehealth Billing Guidelines

In accordance with the MCE provider agreements, MCEs shall cover telehealth services as specified in this document. Providers are directed to contact the MCEs directly with questions about telehealth claims. This document has been developed specifically for MCEs, and outlines requirements related to payment for telehealth services as well as information regarding the provider types allowed to deliver services through telehealth. The telehealth services included in this document reiterate the requirements outlined in Ohio Administrative Code (OAC) rule 5160-1-18, Telehealth Services, effective 07/15/2022.

Where can Telehealth be provided?

There is no limitation on the patient or practitioner site except for penal facilities or public institutions in accordance with OAC rule 5160:1-1-03. In accordance with section 5121 of the Consolidated Appropriations Act of 2023, U.S.C. 1396a, screening and diagnostic services are covered for incarcerated individuals under the age of 21 in the 30 days prior to release from the public institution. The POS code set is maintained by the Centers for Medicare and Medicaid Services (CMS).

Billing guidance for BH agencies certified by MHAS can be found at Behavioral Health Provider Manual .

If the practitioner site does not bill the MCE directly (i.e., holds a contractual agreement with the practice), the patient site or practice who holds the contractual agreement may instead bill for the service delivered using telehealth.

- In such cases, ODM recommends the place of service (POS) code reported on the professional claim should reflect the location of the billing provider if the rendering practitioner's location is unknown.

When to pay a member's claim as primary where Medicare or commercial insurance is present?

The appendices to this document have identified the service codes that should allow Medicaid to pay as primary, as follows:

- Codes that are not covered for Medicare or primary insurance as telehealth have a 'No' in the **Medicare Telehealth Coverage** column.
- Codes that are covered for Medicare when rendered by telephone as telehealth have 'Yes' in the **Audio-only interaction allowed by Medicare** column.

ODM periodically reviews telehealth coding changes from Medicare to add/remove codes. The billing guidelines may not always have the most up-to-date coding changes and MCEs should note that providers can still provide these services to dually eligible individuals and if Medicare pays, MCEs should consider payment of cost sharing even if ODM does not cover that service in FFS.

Eligible Rendering and Billing Providers

Provider Type Description	Provider Type Number	Rendering	Billing
Outpatient Hospitals (01) on behalf of licensed psychologists and independent practitioners not eligible to separately bill in this setting	01	N	Y
Psychiatric Hospitals	02	N	Y
Rural Health Clinic	05	N	Y
Dietitians	07	Y	Y
Federally Qualified Health Center	12	N	Y
Doula (effective 10/1/24)	09	Y	Y
Independent practitioners enrolled with the International Board- Certified Lactation Consultant (IBCLC) specialty under OAC 5160-8-42 effective 10/1/2024	30, 09, 38, 41, 69,39,40 Specialty (091)	Y	Y
Home Health and hospice agencies (hospice agencies through 12/31/24)	16, 44, 60	N	Y
Physician, Psychiatrist, Ophthalmologist	20	Y	Y
Professional Medical Group	21	N	Y
Physician Assistant	24	Y	Y
Chiropractors	27	Y	Y
Medicaid School Program Provider (Carved out of managed care)	28	N	Y
Dentist	30	Y	Y
Professional Dental Group	31	N	Y
Optometrists	35	Y	Y
Podiatrist	36	Y	Y
Licensed Independent Social Worker	37	Y	Y
Non-Agency Nurses/Private Duty Nurses	38	Y	Y
Physical Therapist	39	Y	Y
Speech-language pathologist	40	Y	Y
Occupational Therapist	41	Y	Y
Psychologist	42	Y	Y
Audiologist	43	Y	Y
Licensed Professional Clinical Counselor	47	Y	Y
Ambulatory Health Care Clinics	50	N	Y
Licensed Independent Marriage and Family Therapist	52	Y	Y
Licensed Independent Chemical Dependency Counselor	54	Y	Y
Advanced Practice Registered Nurse (APRN): Clinical Nurse Specialist, Certified Nurse Midwife, and Certified Nurse Practitioner	65, 71, 72	Y	Y

Pharmacists (as of 1/17/21)	69	Y	Y

Pharmacy (as of 1/17/21 submitted on a professional claim)	70	N	Y
OhioMHAS certified agencies (all claims must be submitted by the billing agency)	84 or 95	N	Y
Occupational or Physical therapist assistant	*	Y	N
Speech-language pathology and audiology aides	*	Y	N
Individuals holding a conditional license as described in section 4753.071 of the Revised Code	*	Y	N
Licensed health professionals providing medically necessary supportive services	*	Y	N
Registered Nurses (RN) and Licensed Practical Nurses (LPN) working in a hospice setting (through 12/31/24)	*	Y	N
Registered Nurses (RN) and Licensed Practical Nurses (LPN) working in a home health setting	*	Y	N
Home health and hospice aides (hospice aides through 12/31/24)	*	Y	N
For OhioMHAS certified agencies, those practitioners that can render the service according to BH provider billing manual may render the service via telehealth.	Multiple	Y	N
For OhioRISE services, those provider types that can render the service according to OhioRISE Provider Enrollment and Billing Guidance may render the service via telehealth.	Multiple	Y	N
Care Management Entity	21, 45, 84, 95	N	Y
Supervised practitioners, trainees, residents, and interns as defined in rules 5160-4-05 and 5160-8-05 of the Administrative Code	Multiple, *	Y	N

*Along with modifier GT. Modifiers GC and GE are to be used to indicate a resident performed a service under the direction of a teaching physician or that the resident has a primary care exception. These modifiers would be situational depending on who provided the service and are not specific to telehealth.

Service Codes Covered via Telehealth

Dental	
Procedure Code	**Description**
D0140	Limited Oral Evaluation – problem focused
D0120	Periodic oral evaluation
D9995	Teledentistry-synchronous; real-time encounter; Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

Long Term Services and Supports (LTSS): Hospice, Private Duty Nursing (PDN) and State Plan Home Health Services; Covered under 5160-12, 5160–56-05, 5160-56-06	
Procedure Code	**Description**
T1001	Nursing assessment/evaluation
T1001 U9	RN Consultation
T2042	Hospice routine home care; per diem (for dates of service through 12/31/2024)
T2043	Hospice continuous home care; per hour (for dates of service through 12/31/2024)
T2046	Hospice long-term care, room and board only; per diem (for dates of service through 12/31/2024)
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice (through 12/31/2024) setting, each 15 minutes
G0151	Physical Therapy, each 15 minutes
G0152	Occupational Therapy, each 15 minutes
G0153	Speech-language pathology, each 15 minutes
G0155	Services of clinical social worker in home health or hospice (through 12/31/2024) settings, each 15 minutes
G0156	Services of home health/hospice aide in home health or hospice (through 12/31/2024) settings, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice (through 12/31/2024) setting, each 15 minutes

Medical and Behavioral Health Services (non OhioMHAS certified providers)	
Procedure Code	**Description**
0403T (added 7/1/2024)	Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day
0488T	Diabetes Prevention Online/Electronic Program per 30 Days
90785	Psychiatric Treatment Complex Interactive
90791	Psychiatric Diagnostic Evaluation

90792	Psychiatric Diagnostic Evaluation with Medical
90832	Individual Psychotherapy
90833	Individual Psychotherapy w/ E/M Service
90834	Individual Psychotherapy
90836	Individual Psychotherapy w/ E/M Service
90837	Individual Psychotherapy
90838	Psychotherapy w/ E/M Service
90846	Family psychotherapy without patient present
90847	Family psychotherapy with patient present
90849	Multiple-family group psychotherapy
90853	Group Psychotherapy
90951	Dialysis related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90952	Dialysis related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90953	Dialysis related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90954	Dialysis related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90955	Dialysis related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90956	Dialysis related services monthly, for patients 2-11 years of age
90957	Dialysis related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face
90958	Dialysis related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90959	Dialysis related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month

90960	Dialysis related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90961	Dialysis related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90962	Dialysis related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month
90963	Dialysis related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	Dialysis related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	Dialysis related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	Dialysis related services for home dialysis per full month, for patients 20 years of age and older
90967	Dialysis related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	Dialysis related services for dialysis less than a full month of service, per day; for patients 2-11 years of age
90969	Dialysis related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	Dialysis related services for dialysis less than a full month of service, per day; for patients 20 years of age and older
92012	Eye exam, established patient (added 11/15/2020)
92065	Orthoptic/Pleoptic training (added 11/15/2020)
96112	Developmental Test Administration
96113	Developmental Test Administration add-on
96116	Neurobehavioral Status Exam
96121	Neurobehavioral Status Exam
96132	Neuropsychological Testing Evaluation
96133	Neuropsychological Testing Evaluation add-on
97542	Wheelchair management, each 15 minutes
97802	Medical nutrition therapy; initial assessment and intervention, each 15 minutes
97802 TH	Lactation counseling provided by dietitian; initial assessment and intervention, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, each 15 minutes

97803 TH	Lactation counseling by dietitian; re-assessment and intervention, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes
97804 TH	Lactation counseling; group with 2 or more individuals), each 30 minutes.
98000 (effective 1/1/25)	New patient synchronous audio-video visit with straightforward medical decision making, if using time 15 minutes or more
98001 (effective 1/1/2025)	New patient synchronous audio-video visit with low medical decision making, if using time 30 minutes or more
98002 (effective 1/1/2025)	New patient synchronous audio-video visit with moderate medical decision making, if using time 45 minutes or more
98004 (effective 1/1/2025)	Established patient synchronous audio-video visit with straightforward medical decision making, if using time 10 minutes or more
98005 (effective 1/1/2025)	Established patient synchronous audio-video visit with low medical decision making, if using time 20 minutes or more
98006 (effective 1/1/2025)	Established patient synchronous audio-video visit with moderate medical decision making, if using time 30 minutes or more
98008 (effective 1/1/202)	New patient synchronous audio-only visit with straightforward medical decision making and 10 minutes or more of medical discussion, if using time 15 minutes or more
98009 (effective 1/1/2025)	New patient synchronous audio-only visit with low medical decision making and 10 minutes or more of medical discussion, if using time 30 minutes or more
98010 (effective 1/1/2025)	New patient synchronous audio-only visit with moderate medical decision making and 10 minutes or more of medical discussion, if using time 45 minutes or more
98012 (effective 1/1/2025)	Established patient synchronous audio-only visit with straightforward medical decision making and 10 minutes or more of medical discussion, if using time 10 minutes or more
98013 (effective 1/1/2025)	Established patient synchronous audio-only visit with low medical decision making and 10 minutes or more of medical discussion, if using time 20 minutes or more
98014 (effective 1/1/2025)	Established patient synchronous audio-only visit with moderate medical decision making and 10 minutes or more of medical discussion, if using time 30 minutes or more
98016 (effective 1/1/2025)	Established patient brief communication technology-based service with 5-10 minutes of medical discussion
99202	E/M New Patient
99203	E/M New Patient
99204	E/M New Patient
99211	E/M Established Patient
99212	E/M Established Patient
99213	E/M Established Patient
99214	E/M Established Patient
99241 (through 12/31/2022)	Office consultation for a new or established patient. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes.
99242 (description changed as of 1/1/2023)	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the

	date of the encounter for code selection, 20 minutes must be met or exceeded.
99243(description changed as of 1/1/2023)	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99244(description changed as of 1/1/2023)	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99245(description changed as of 1/1/2023)	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
99251(through 12/31/2022)	Inpatient consultation for a new or established patient; straightforward medical decision making. Typically, 20 minutes.
99252(description changed as of 1/1/2023)	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99253(description changed as of 1/1/2023)	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99254(description changed as of 1/1/2023)	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99255(description changed as of 1/1/2023)	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.
99281	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of low to moderate severity.

99283	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
99304	Initial nursing facility care, per day, for the E/M of a patient. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99305	Initial nursing facility care, per day, for the E/M of a patient. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99306	Initial nursing facility care, per day, for the E/M of a patient. 45 minutes are spent at the bedside and on the patient's facility floor or unit.
99307	Subsequent nursing facility care, per day, for the E/M of a patient. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.
99308	Subsequent nursing facility care, per day, for the E/M of a patient. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

99309	Subsequent nursing facility care, per day, for the E/M of a patient. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the E/M of a patient. 35 minutes are spent at the bedside, on the patient's facility floor or unit.
99315	Nursing facility discharge day management; 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99324 (end date 1/1/23)	Domiciliary or rest home visit for the evaluation and management of a new patient. Typically, 20 minutes are spent with the patient and/or family or caregiver
99325 (end date 1/1/23)	Domiciliary or rest home visit for the evaluation and management of a new patient. Typically, 30 minutes are spent with the patient and/or family or caregiver.
99326(end date 1/1/23)	Domiciliary or rest home visit for the evaluation and management of a new patient. Typically, 45 minutes are spent with the patient and/or family or caregiver.
99327(end date 1/1/23)	Domiciliary or rest home visit for the E/M of a new patient. 60 min are spent with the patient and/or family or caregiver.
99328(end date 1/1/23)	Domiciliary or rest home visit for the E/M of a new patient. 75 min are spent with the patient and/or family or caregiver.
99334 (end date 1/1/23)	Domiciliary or rest home visit for the E/M of an established patient. 15 min spent with the patient and/or family or caregiver.
99335 (end date 1/1/23)	Domiciliary or rest home visit for the E/M of an established patient. 25 min spent with the patient and/or family or caregiver.
99336 (end date 1/1/23)	Domiciliary or rest home visit for the E/M of an established patient. 40 min spent with the patient and/or family or caregiver.
99337 (end date 1/1/23)	Domiciliary or rest home visit for the evaluation and management of an established patient. 60 min are spent with the patient and/or family or caregiver.
99341 (effective 1/1/23)	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99342 (effective 1/1/23)	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99344 (effective 1/1/23)	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99345 (effective 1/1/23)	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or

	examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99347 (effective 1/1/23)	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99348 (effective 1/1/23)	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99349 (effective 1/1/23)	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99401	Preventive medicine counseling, first 15 minutes
99402	Preventive medicine counseling, 15-30 minutes
99406	Smoking and Tobacco Use Cessation intermediate
99407	Smoking and Tobacco Use Cessation intensive
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
99441 (through 12/31/2024) To report, see 98009-98014	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion
99442 (through 12/31/2024) To report, see 98009-98014	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next

	24 hours or soonest available appointment: 11-20 minutes of medical discussion
99453	Remote monitoring of physiologic parameter(s) initial; set-up and patient education on use of equipment
99454	Remote monitoring of physiologic parameter(s) initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)
G0108	Diabetes management training, individual, 30 minutes
G0109	Diabetes management training, group, 30 minutes
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
G2012 (through 12/31/24)	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report

	evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion
H2000	Initial Supplemental Assessment - Per Encounter
S9436	Childbirth prep/Lamaze classes, non-physician
S9437	Childbirth refresher classes, no-physician
S9443 (added 10/1/2024)	Lactation consulting, per session
S9444	Baby parenting classes, non-physician provider, per session
S9447	Infant safety (including CPR) training, non-physician provider, per session
S9452	Prenatal nutrition classes, non-physician provider, per session
S9453	Smoking cessation class , non-physician provider, per session
S9470	Prenatal nutrition counseling, dietician visit
T1032 (effective 10/3/2024)	Services performed by a doula birth worker, per 15 minutes

Occupational Therapy, Physical Therapy, Speech-Language Pathology, and Audiology Services As Found in OAC 5160-8-35	
Procedure Code	**Description**
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production
92523	Evaluation of speech sound production; with evaluation of language comprehension and expression
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92556	Speech audiometry threshold; with speech recognition
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming

92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 min
92609	Therapeutic services for the use of speech-generating device, including programming and modification
96110	Developmental screening, with scoring and documentation, per standardized instrument
96112	Developmental test administration, by physician or other qualified health care professional, with interpretation and report; first hour
96113	Developmental test administration, by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97129	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97161	Physical therapy evaluation: low complexity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care
97164	Re-evaluation of physical therapy established plan of care. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97165	Occupational therapy evaluation, low complexity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance

97168	Re-evaluation of occupational therapy established plan of care. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training direct one-on-one contact, each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment, direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training, upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes

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

Services Covered under 5160-59 Service Codes Covered via Telehealth (OhioRISE only services)	
Procedure Code	**Description**
T2023	Intensive Care Coordination (ICC) - Monthly
T2022	Moderate Care Coordination (MCC) – Monthly
H2000	Initial Supplemental Assessment
H2015	Intensive Home-Based Treatment (IHBT)
H2015 TF	Functional Family Therapy (FFT)
H2033	Multisystemic Therapy (MST)

*See the CME Billing Guidelines for the care coordination activities where the GT modifier will be recorded: OhioRISE CME Manual

Service Codes Covered via Telehealth for Applied Behavioral Analysis (ABA) {5160-34-01}	
Procedure Code	**Description**
Adaptive Behavior Assessment	
97151	Behavior identification assessment
97152	Behavior identification – supporting assessment
0362T	Behavior identification – supporting assessment – technician
Adaptive Behavior Treatment	
97153	Adaptive behavior treatment by protocol
97154	Group adaptive behavior treatment by protocol
97155	Adaptive behavior treatment with protocol modification
97156	Family adaptive behavior treatment guidance
97157	Multi-family adaptive behavior treatment guidance
97158	Group adaptive behavior treatment with protocol modification

Managed Care Organizations must allow Applied Behavioral Analysis (ABA) services to be available through telehealth under the current guidelines . If the provider is not enrolled with Medicaid, a single case agreement would be needed.

Professional Claim Submission for Services Delivered via Telehealth1		
Billing provider type	Providers of Professional Services	FQHC and RHC (FFS or claims for wraparound payments)[2]
Claim type	Professional (Submitted via PNM portal or EDI)	
Procedure code	CPT code for service delivered via telehealth When a covered telehealth procedure code is deleted due to annual CPT and HCPCS updates,	First detail line: T1015 encounter code and the appropriate U modifier

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

[2] For a covered telehealth service that is also an FQHC or RHC prospective payment (PPS) service, the face-to-face requirement is waived, and payment is made in accordance with Chapter 5160-28 of the Administrative Code.

	ODM will adopt the replacement procedure code if a replacement is identified.	Second detail line: procedure code for service delivered via telehealth
Telehealth Modifier	GT modifier Any other required modifiers based on provider contract Above-mentioned U modifier to identify patient location, if applicable If the description of a covered procedure code in an ODM fee schedule indicates a telehealth or electronic service, the GT modifier is not required. Example: CPT code 98000 New patient **synchronous audio-video** visit with straightforward medical decision making, if using time 15 minutes or more	GT modifier with the procedure code Any other required modifiers based on provider contract Above-mentioned U modifier to identify patient location, if applicable
Place of service (POS) code	Physical location of the practitioner when the service was delivered	

Important Clarifications

- If the practitioner site does not bill the Ohio Department of Medicaid (ODM) directly (i.e., holds a contractual agreement with the practice), the patient site or practice who holds the contractual agreement may instead bill for the service delivered using telehealth.
    - If the physical location of the practitioner at the time of service is not known, the POS code reported on the claim should reflect the location of the billing provider.
- All services identified in this document and the appendix to rule 5160-1-18 may be delivered through telehealth. Other practitioners and services authorized in rules promulgated under agency 5160 of the Administrative Code may also be delivered through telehealth. This includes procedure codes with a telehealth description added to appendix DD of rule 5160-1-60.
- Providers should use professional judgment when delivering telehealth services and should select the appropriate procedure code that reflects the service provided.
- The place of service (POS) code reported on a professional claim must reflect the physical location of the practitioner. The POS code set is maintained by the Centers for Medicare and Medicaid Services (CMS) and can be found here: Place of Service Code Set | CMS. As of 1/1/2025, place of service code 09 may be used when services are delivered to youth under 21 prior to release in accordance with section 5122 of the Consolidated Appropriations Act (CAA).

- Place of service 02 (Telehealth) will not be accepted on FFS claims where Medicaid is the primary payer. While FFS does not accept POS 02 and POS 10, MCEs may choose to allow these codes to identify telehealth services.

Patient Location Modifiers (not applicable to OhioMHAS certified behavioral health agencies)	
Telehealth Modifier[3]	Description
U1	Patient home or place of residence at the time of service (includes homeless shelter, residential facility other than a nursing facility, temporary housing, etc.)
U2	School
U3	Inpatient Hospital
U4	Outpatient hospital
U5	Nursing Facility
U6	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICD/IID)

OH-Multi-P-3556743

[3] If the patient site is not one of these locations, a modifier identifying patient location is not needed.