INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

# Telehealth and Virtual Services

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# Revision History

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| 1.1 | Policies and procedures as of April 1, 2016<br>Published: Sept. 20, 2016 | Scheduled update | FSSA and HPE |
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| 4.1 | Policies and procedures as of Oct. 1, 2019<br>Published: March 30, 2021 | Added note box to title page with information about temporary policies for the COVID-19 public health emergency | FSSA and Gainwell |
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| 6.0 | Policies and procedures as of Nov. 1, 2023<br>Published: Feb. 29, 2024 | Scheduled update:<br>• Edited and reorganized text as needed for clarity<br>• Added subheading and updated information in *Professional and Dental Claims for Telehealth Services*<br>• Added the *Outpatient Institutional Claims for Telehealth Services* subsection<br>• Removed the note about Appendix K authority from the *Nonhealthcare Virtual Services* section<br>• Added a note about MRO Skills Development and Training in the *Special Considerations for Certain Services and Providers* section | FSSA and Gainwell |

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| | | • Added the *Applied Behavior Analysis Therapy Services via Telehealth* section | |
| 6.1 | Policies and procedures as of Nov. 1, 2023<br>Published: Oct. 30, 2024 | Correction:<br>• Updated the *Originating Site Services* section | FSSA and Gainwell |

# Table of Contents

# Telehealth and Virtual Services

> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
>
> *For updates to coding, coverage, and benefit information, see IHCP Bulletins at in.gov/medicaid/providers.*

## Introduction

The Indiana Health Coverage Programs (IHCP) covers select medical, dental and remote patient monitoring services delivered via telehealth. IHCP coverage is also available for the virtual delivery of certain nonhealthcare services (such as case management) for members who are eligible to receive such services. For applicable procedure codes, see *Telehealth and Virtual Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

This module contains information related to the delivery and reimbursement of covered telehealth and nonhealthcare virtual services, including coverage requirements and billing guidelines.

> *Note: Most telehealth services must be provided via video **and** audio, although a few designated telehealth services can be provided via audio only. Audio-only delivery is allowable for all nonhealthcare virtual services.*

## Telehealth Services

The IHCP follows the rules laid out in *Indiana Code IC 25-1-9.5-6* for telehealth services.

*Telehealth* means the delivery of healthcare services between a practitioner in one location (the *distant site*) and a patient in another location (the *originating site*), using interactive electronic communications and information technology, in compliance with the federal *Health Insurance Portability and Accountability Act* (HIPAA), including any of the following:

- Secure videoconferencing
- Store-and-forward technology
- Remote patient monitoring technology

Unless the practitioner has an established relationship with the patient, telehealth does **not** include the use of electronic mail, an instant messaging conversation, facsimile, internet questionnaire or an internet consultation.

The member should always be given the choice between a traditional clinical encounter versus a telehealth visit. The provider must obtain appropriate consent from the member prior to delivering services, and must maintain documentation as described in the *Telehealth Documentation Standards* section.

Telehealth services may be rendered in an inpatient, outpatient or office setting. The provider and/or patient may be located in their home during the time of these services. For IHCP reimbursement of telehealth services, the member must be physically present at the originating site and must participate in the visit.

All services delivered through telehealth are subject to the same limitations and restrictions as they would be if delivered in-person. For service-specific limitations and restrictions, including prior authorization (PA) requirements, see the appropriate provider reference module, available from the *IHCP Provider Reference Modules* page at in.gov/medicaid/providers. (For PA requirements related to remote patient monitoring services, see the *Remote Patient Monitoring Services* section of this module.)

## Telehealth Services Allowed and Excluded

Providers are allowed to use telehealth for the medical, dental and remote patient monitoring services listed in *Telehealth and Virtual Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

The following services may not be provided using telehealth:

- Surgical procedures
- Radiological services
- Laboratory services
- Anesthesia services
- Durable medical equipment (DME)/home medical equipment (HME) services
- Transportation services

## Practitioners Eligible to Provide Telehealth Services

The practitioners listed in *IC 25-1-9.5-3.5* are authorized to provide telehealth services under the scope of their licensure within the state of Indiana.

> *Note: Not all practitioners that are authorized to provide telehealth services are allowed to enroll as rendering providers in the IHCP. Those that are not eligible for IHCP enrollment must bill under the IHCP-enrolled supervising practitioner's National Provider Identifier (NPI), using the appropriate modifiers (as applicable). The rendering NPI entered on the claim must be enrolled under a specialty that is allowable for telehealth.*

The IHCP will allow these practitioners to provide telehealth services and receive reimbursement for IHCP services, within the established IHCP billing rules and policies. Providers *not* on this list are not allowed to practice telehealth or receive IHCP reimbursement for such services, even under the supervision of one of these listed practitioners.

Providers rendering services within the state of Indiana are encouraged to have a telehealth provider certification filed with the Indiana Professional Licensing Agency. Providers rendering services out of state are required to have a telehealth provider certification under *IC 25-1-9.5-9*; see the *Out-of-State Telehealth Providers* section for more information.

## Special Considerations for Telehealth

The following special circumstances apply to telehealth services:

- The practitioner who will be examining the patient from the distant site must determine if it is medically necessary for a medical professional to be at the originating site. Separate reimbursement for a provider at the originating site is payable only if that provider's presence is medically necessary. Documentation must be maintained in the patient's medical record to support the need for the provider's presence at the originating site during the visit. Such documentation is subject to

postpayment review. If a healthcare provider's presence at the originating site is medically necessary, billing of the appropriate evaluation and management code is permitted.

- When ongoing services are provided, the member should be seen by a physician for a traditional clinical evaluation at least once a year, unless otherwise stated in policy. In addition, the distant provider should coordinate with the patient's primary care physician.
- Office visits conducted via telehealth are subject to existing service limitations for office visits. Telehealth office visits billed using applicable codes from *Telehealth and Virtual Services Codes* (accessible from the *Code Sets* page at in.gov/medicaid/providers) are counted toward the member's office visit limit. See the *Evaluation and Management Services* module for information about office visit limitations.
- Although reimbursement for end-stage renal disease (ESRD)-related services is permitted in the telehealth setting, the IHCP requires at least one monthly visit for ESRD-related services to be a traditional clinical encounter to examine the vascular access site.
- A provider can use telehealth to prescribe a controlled substance to a patient who has not been previously examined. Opioids, however, cannot be prescribed via telehealth, except in cases in which the opioid is a partial agonist (such as buprenorphine) and is being used to treat or manage opioid dependence.

## Telehealth Documentation Standards

Patient consent for receiving a service through telehealth should be documented. Patient consent may be received verbally or by electronic signature, and should be documented as such. Documentation must be maintained by the provider to substantiate the services provided and that consent was obtained. Documentation must indicate that the services were rendered via telehealth, clearly identify the location of the provider and the patient, and be available for postpayment review.

All other IHCP documentation guidelines apply for services rendered via telehealth, such as chart notes and start and stop times.

Providers should always give the member the choice between a traditional clinical encounter versus a telehealth visit. Appropriate consent from the member must be obtained by the provider prior to delivering services. Providers must have written protocols for circumstances when the member requires a hands-on visit with the provider.

## Billing and Reimbursement for Telehealth Services

IHCP reimbursement for telehealth services is limited to the medical, dental and remote patient monitoring services listed in the telehealth code set (see the *Telehealth Services Allowed and Excluded* section). Additionally, the rendering NPI on the claim must be enrolled in the IHCP under one of the specialties allowable for telehealth services (see the *Practitioners Eligible to Provide Telehealth Services* section).

With the exception of services billed by a federally qualified health center (FQHC) or rural health clinic (RHC) (see the *Telehealth Services for FQHCs and RHCs* section) or RPM services billed by a home health agency (see the *RPM Billing and Reimbursement for Home Health Agencies* section), the payment for telehealth services is equal to the current Fee Schedule amount for the procedure codes billed (see the *IHCP Fee Schedules* page at in.gov/medicaid/providers).

The following subsections provide general information for billing telehealth services. Additional billing information for specific types of telehealth services is provided in the *Special Considerations for Certain Services and Providers* section.

## Professional and Dental Claims for Telehealth Services

The information in this section applies to telehealth services that are billed on a professional claim (*CMS-1500* claim form, IHCP Provider Healthcare Portal professional claim or 837P electronic transaction) or a dental claim (*ADA 2012* claim form, IHCP Provider Healthcare Portal dental claim or 837D electronic transaction).

All services delivered via telehealth and billed on a professional or dental claim **must** be billed with one of the following place of service (POS) codes:

- 02 – *Telehealth provided other than in patient's home*
- 10 – *Telehealth provided in the patient's home*

The procedure code billed must appear on the telehealth code set (Tables 1–3 of *Telehealth and Virtual Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers). In addition, an appropriate telehealth modifier **may** be required, depending on the type of service:

- **Medical services** – Procedure codes for medical services delivered via telehealth (with the exception of services delivered through a Home- and Community-Based Services [HCBS] or Money Follows the Person [MFP] program) require one of the following modifiers:
  - 95 – *Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system*
  - 93 – *Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system*

> *Note: Modifier 93 is used to signify when a service is delivered via audio-only telehealth. Only certain, designated medical services can be delivered via **audio-only** telehealth. Services eligible for reimbursement when billed with modifier 93 are identified within the Medical Service Procedure Codes Covered for Telehealth table in Telehealth and Virtual Services Codes, accessible from the Code Sets page at in.gov/medicaid/providers. All other medical telehealth services must be delivered via audio **and** video.*

- **Remote patient monitoring services** – All RPM procedure codes must be billed with modifier 95, except when rendered by a home health agency (see the *Home Health Agency Requirements for Remote Patient Monitoring Services* section for details).
- **Dental services** – The use of modifiers 95 or 93 is not required for dental services delivered via telehealth. Dental services cannot be delivered via audio-only telehealth.

Any of the following circumstances will result in a claim denial with explanation of benefits (EOB) 3428 – *Telemedicine services require place of service 02 or 10 and modifier 93 or 95:*

- A procedure code is billed with modifier 93 or 95, but with a POS code other than 02 or 10.
- A procedure code not listed in the telehealth code set is billed with POS code 02 or 10 and/or modifier 93 or 95.
- A procedure code not identified in the telehealth code set as allowable for audio-only delivery is billed with modifier 93.

## Outpatient Institutional Claims for Telehealth Services

For providers that use the outpatient institutional claim (*UB-04* claim form, IHCP Provider Healthcare Portal institutional claim or 837I electronic transaction), services delivered via telehealth should be billed as follows:

- If the service can be billed with a procedure code, providers should enter the procedure code and, if applicable, use the appropriate modifier (93 or 95) to indicate that the service was delivered via telehealth. POS codes are not used on outpatient claims.

- If the service cannot be billed with a procedure code (for example, procedure codes cannot be used with revenue codes 905 or 906), the service should be billed as it normally would if delivered in person. Procedure code, modifier and POS code requirements do not apply in this case. Providers are advised to mark in their patient records that the service was delivered via telehealth.

In either case, the service provided must be a one that is allowable for telehealth delivery, as indicated on the telehealth code set (Tables 1–3 of *Telehealth and Virtual Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers).

# Nonhealthcare Virtual Services

*Nonhealthcare virtual services* are services centering on patient wellness and case management that are delivered between a patient and a provider via interactive electronic communications technology. A licensed practitioner listed under *IC 25-1-9.5-3.5* is not required to perform these services, as they are not considered healthcare services under the definition listed in *IC 25-1-9.5-2.5*.

For a list of nonhealthcare procedure codes allowable for virtual delivery, see the *Nonhealthcare Services Covered for Virtual Delivery* table in *Telehealth and Virtual Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Nonhealthcare virtual services must be billed with POS code 02 or 10. These services and do **not** require modifiers 93 or 95. All services in this category can be provided either through audio and video technology or via audio only.

# Special Considerations for Certain Services and Providers

Special billing or reimbursement criteria apply for certain telehealth services or providers, as described in the following sections.

> *Note: For information about special requirements related to Skills Development and Training services delivered via telehealth, see the Medicaid Rehabilitation Option Services module.*

## *Originating Site Services*

The current IHCP *Telehealth and Virtual Services Codes* (accessible from the *Code Sets* page at in.gov/medicaid/providers) includes coverage of procedure code Q3014 – *Telehealth originating site facility fee*. Per *Indiana Code IC 25-1-9.5-3*, "originating site" means any site at which a patient is located at the time healthcare services through telehealth are provided to the individual. Accordingly, eligible providers may be reimbursed for procedure code Q3014 when the provider location is acting as an originating site for telehealth services.

If the originating site is a hospital or other location that bills on an **institutional claim**, HCPCS code Q3014 is reimbursable when billed with revenue code 780 – *Telemedicine – General*. If a different, separately reimbursable treatment room revenue code is provided on the same day as the telehealth service, the appropriate treatment room revenue code should also be included on the claim. Documentation must be maintained in the patient's record to indicate that services were provided separately from the telehealth visit.

If the originating site is a practitioner's office, clinic or other location that bills on a **professional claim**, POS code 02 must be used for Q3014, along with modifier 95. If other services are provided on the same date as the telehealth service, the medical professional should bill Q3014 as a separate line item from other professional services.

If the originating site is an FQHC or RHC, additional billing requirements apply. See the *FQHC and RHC Telehealth Services* section.

## FQHC and RHC Telehealth Services

Special billing considerations apply for federally qualified health center (FQHC) and rural health clinic (RHC) providers. FQHC and RHC providers may bill for telehealth services if the service rendered is considered a valid FQHC or RHC encounter (as defined in the *Federally Qualified Health Centers and Rural Health Clinics* module) **and** a covered telehealth service (as defined by the *Telehealth and Virtual Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers). Subject to the following criteria, reimbursement is available to FQHCs and RHCS when they are serving as either the distant site or the originating site for telehealth services.

When the FQHC or RHC is the ***distant site***, the service provided by the FQHC or RHC must meet the requirements both for a valid encounter and for an approved telehealth service. The claim must include the following:

- Encounter code T1015 (or D9999 for valid dental encounters), billed with POS code 02, 03, 04, 10, 11, 12, 31, 32, 50 or 72
- One or more appropriate procedure codes for the specific services rendered, billed with modifier 93 or 95, and a POS code of either 02 or 10, depending on the originating site/location of the patient

When the FQHC or RHC is the ***originating site*** (the location where the patient is physically located), the FQHC or RHC may be reimbursed if it is medically necessary for a medical professional to be present with the member, and the service provided includes all components of a valid encounter code. The claim must include the following:

- Encounter code T1015 (or D9999 for valid dental encounters), billed with POS code 02, 03, 04, 11, 12, 31, 32, 50 or 72
- Procedure code Q3014 – *Telehealth originating site facility fee*, billed with POS code 02 and modifier 95
- One or more appropriate procedure codes for the specific services rendered, billed with modifier 93 or 95, and a POS code of either 02 or 10, depending on the originating site/location of the patient

> *Note: The procedure code must appear on both the telehealth services code set **and** must be on the list of procedure codes allowable for an FQHC/RHC medical or dental encounter (see the Myers and Stauffer website at myersandstauffer.com).*

In either case, reimbursement for the encounter code (T1015 or D9999) is based on the prospective payment system (PPS) rate specific to the FQHC or RHC facility. All other procedures codes on the claim will deny with EOB 6096 – *The CPT/HCPCS code billed is not payable according to the PPS reimbursement methodology*.

All components of the service must be provided and documented, and the documentation must demonstrate medical necessity. All documentation is subject to postpayment review.

Separate reimbursement for merely serving as the originating site is not available to FQHCs and RHCs. When the presence of a medical professional is not medically necessary at the originating site, neither the facility fee, as billed by HCPCS code Q3014, nor the facility-specific PPS rate is available, because the requirement of a valid encounter is not met. Pursuant to the *Code of Federal Regulations 42 CFR 405.2463*, an encounter is defined by the CMS as a face-to-face meeting between an eligible provider and a Medicaid member during which a medically necessary service is performed. Consistent with federal regulations, for an FQHC or RHC to receive reimbursement for services, including those for telehealth, the criteria of a valid encounter must be met.

## *Intensive Outpatient Treatment via Telehealth*

The IHCP reimburses for intensive outpatient treatment (IOT) services (procedure codes H0015 and S9480) when delivered via telehealth.

The IHCP is approaching this temporary policy expansion as a pilot initiative, where any healthcare provider engaging in telehealth IOT will be opting in to the analysis of the efficacy of this model through data collection and analysis. This data collection and analysis will be administered through the state and is intended to have a minimal administrative impact on providers. All providers submitting claims for telehealth IOT will automatically be included in the study and are expected to participate by providing data if requested. Telehealth IOT will be available for 12 months after which the data collected will be analyzed by the Division of Mental Health and Addiction (DMHA).

IOT requires prior authorization for medical necessity, regardless of whether it is delivered in person or via telehealth. Additionally, the IHCP requires the following criteria are met when performing IOT via telehealth:

- The intake process for telehealth IOT must be conducted in person, such as at the IOT provider location or at another location with an appropriately licensed service provider contracted by or otherwise approved by the IOT provider.
- The patient chart must include a record of the call/check-in by a staff member (case manager or peer) prior to IOT session to confirm that the patient is still eligible and appropriate for telehealth IOT.
- A maximum of eight patients per group can participate in IOT via telehealth. If a provider uses a hybrid model that includes both telehealth and in person, a maximum of eight patients per group may participate via telehealth, and the total group size may not exceed 12 people.
- A physician, psychiatric nurse practitioner or physician assistant assessment of the appropriateness and potential risks of telehealth IOT care for each patient must be documented in the patient's medical record.
- Each patient log-in and log-off time and total time on the call/meeting for each three-hour session must be documented.
- The individualized treatment plan for each virtual patient must indicate who will be in the home with them during telehealth IOT in the event that an emergency takes place:
  - For minors or individuals under guardianship, an adult caregiver must be present in the home during telehealth IOT.
  - For adults, if there is no one in the home, an emergency contact must be documented. Additionally, there must be a release of information for the emergency contact that allows disclosure of the nature of the emergency event.
- Documented protocols must be in place to address risk behaviors and decompensation in the individual's home.
- A crisis plan must be completed and documented in the patient chart prior to start of the IOT service and must contain, at minimum:
  - An emergency contact
  - A plan with multiple options for who the client may contact and/or what the client may do to deescalate if they experience a mental health or substance use crisis and/or suicidal or homicidal ideation. One copy of this plan should be given to the client and another copy kept in the chart.
- IOT delivered via telehealth must have a video component. Telehealth IOT cannot be audio-only (for example, via telephone). Telehealth IOT cannot be billed with modifier 93. Cameras must be on and used by IOT participants for the entire duration of the session, with camera-off time documented and not billable.

- The standard practice of routine discharge processes must be followed, including after-care appointment expectations regarding continuity of care for psychiatric medication monitoring within a specific time frame.
- At least one one-on-one meeting must occur every seven days between staff (case manager, peer) and patient – via telehealth or in community or office. For minors or individuals under guardianship, this meeting is required one time every seven days between staff member, client, and parent or guardian. Every 14 days, the one-on-one meeting between staff (case manager, peer) and patient (and parent or guardian for minors or individuals under guardianship) is required to be in person.
- To the extent required by the patient's individual treatment plan, drug screens must be completed in person at the IOT provider location or other location approved by the IOT provider. Those with a primary or secondary substance use disorder (SUD) diagnosis must have a drug screen at least once every seven days. Those without an SUD diagnosis must receive a random drug screen at least monthly to maintain an objective analysis of any new substance use issues that may occur.
- To the extent required by the patient's individual treatment plan, verification of compliance with prescribed medication must be conducted every seven days, at the IOT provider location or other location approved by the IOT provider. This verification could include pill counts, a report from the client, a report from the client, a report from a parent or guardian, and/or laboratory monitoring.
- Every virtual program must also have an in-person option available for people who are not complying with the rules of the telehealth care model or who are not stable enough or interested in the virtual care option.

## Applied Behavior Analysis Therapy Services via Telehealth

The IHCP provides coverage for applied behavior analysis (ABA) therapy when medically necessary for the treatment of autism spectrum disorder (ASD). All ABA therapy services require prior authorization.

Besides the PA criteria outlined in the *Behavioral Health Services* module, procedure codes 97155 and 97156 are subject to the following additional requirements when rendered via telehealth:

- Credentialed registered behavior technicians (RBTs) may not deliver any ABA service via telehealth. Only a health service provider in psychology (HSPP) or a licensed or board-certified behavior analyst (BCBA) are eligible for using telehealth when supervising the delivery of ABA services remotely.
- Procedure code 97155 is reimbursable via telehealth only when an HSPP or BCBA is providing guidance/supervision to an RBT remotely, and the RBT is rendering adaptive behavioral treatment in person to the member.
- All ABA services must include synchronous audiovisual interaction. No ABA services are reimbursable when delivered via audio-only telehealth.

The complete list of procedure codes for applied behavior analysis therapy can be found in *Behavioral Health Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. Procedure codes 97155 and 97156 are the only two ABA services that are allowable as telehealth.

> *Note: For dates of service on and after Jan. 1, 2024, all ABA services must be billed with an appropriate modifier to indicate the credentials of the practitioner delivering the service. When ABA services are delivered via telehealth, modifier 95 must also be included.*

# *Remote Patient Monitoring Services*

Remote patient monitoring (RPM) is the scheduled monitoring of clinical data transmitted through technologic equipment in the member's home. Data is transmitted from the member's home to the provider location to be read and interpreted by a qualified practitioner. The technologic equipment enables the provider to detect minute changes in the member's clinical status, which allows providers to intercede before the member's condition advances and requires emergency intervention or inpatient hospitalization.

The IHCP has implemented a single RPM coverage and prior authorization policy to be used for fee-for-service (FFS) and managed care delivery systems. This coverage and PA policy applies to all IHCP programs that offer such services – including but not limited to Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise and Traditional Medicaid.

The IHCP covers the RPM services listed in the *Remote Patient Monitoring Procedure Codes Covered for Telehealth* table on *Telehealth and Virtual Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. The service must be billed with POS code 02 or 10 and with modifier 95, as described in the *Billing and Reimbursement for Telehealth Services section*.

> *Note: Home health agencies must follow the same coverage and PA policies for RPM as all other providers; however, when billing the service, home health agencies must follow the guidance in the Home Health Agency Requirements for Remote Patient Monitoring Services section.*

## Prior Authorization Requirements for Remote Patient Monitoring Services

Prior authorization is required for specified RPM services, as indicated on the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

The following items must be submitted with the RPM PA request:

- Prescriber's written order for RPM, signed and dated by the prescriber
- A plan of care (POC), signed and dated by the prescriber, that includes:
  - Monitoring criteria and interventions for the treatment of the member developed by the member's prescriber

    > *Note: The monitoring criteria and interventions should be directly related to the member's chronic conditions.*

  - A clear outline of the patient's health data, information to be monitored and measured, and the circumstances under which the ordering prescriber should be contacted to address any potential health concerns
  - The frequency with which a qualified practitioner will be performing a reading of the transmitted health information

The member must meet ***one*** or more of the following criteria to receive prior authorization for an RPM service:

- Received an organ transplantation within one year following the date of surgery
- Had a surgical procedure (three-month service authorization following the date of surgery)
- Had one or more uncontrolled chronic conditions that significantly impaired the patient's health or resulted in two or more related hospitalizations or emergency department visits in the previous 12 months

- Had been readmitted within 30 days for the same or similar diagnosis or condition
- Identified as having a high-risk pregnancy (up to three-month service authorization postpartum); see the *Obstetrical and Gynecological Services* provider reference module for more information about high-risk pregnancy

The duration of initial service authorization is six months, unless otherwise indicated. Reauthorizations will be permitted for select services as appropriate.

## Home Health Agency Requirements for Remote Patient Monitoring Services

The IHCP covers RPM services provided by home health agencies to members who are approved for other home health services, as described in the *Home Health Services* module. The IHCP reimburses for RPM telehealth services when the service is provided in compliance with all IHCP guidelines, including the prior authorization guidelines described in the previous section.

The PA request for RPM services must be submitted separately from other home health service PA requests. Within the POC for home health RPM services, the monitoring criteria and interventions for treatment of the member's qualifying conditions must be developed collaboratively between the member's physician and the home health agency.

In addition to the prescriber's order and the POC, PA requests for RPM from a home health agency must also include an attestation from the home health agency that the telehealth equipment to be placed in the member's home is capable of monitoring any data parameters included in the POC, and that the transmission process meets HIPAA compliance standards.

In any home health agency RPM services encounter, a licensed registered nurse (RN) must read the transmitted health information provided from the member, in accordance with the written order. See *405 IAC 1-4.2-6*. The nurse must review all data on the day the ordered data is received or, in cases when the data is received after business hours, on the first business day following receipt of the data.

The home health agency will follow the monitoring criteria and interventions for the treatment of the member's qualifying condition, as outlined in the plan of care. Any potential medical concerns should be communicated to the ordering practitioner. Members who are unable or unwilling to use the telehealth equipment appropriately will be disenrolled from RPM services.

### *RPM Billing and Reimbursement for Home Health Agencies*

Home health agencies should not use the procedure codes listed on the RPM code set, but should instead bill remote patient monitoring services on an institutional claim, using revenue code 780 along with procedure code 99600 and the appropriate modifiers, as follows:

- 99600 U1 – *Unlisted home visit service or procedure; one time initial face-to face visit necessary to train the member or caregiver to appropriately operate the telehealth equipment*
- 99600 U2 TD – *Unlisted home visit service or procedure; remote skilled nursing visit to monitor and interpret telehealth reading; RN*

RPM services are reimbursed separately from other home health services. The initial visit is limited to a one-time visit to educate the member or caregiver about how to properly operate the telehealth equipment. A remote skilled nursing visit cannot be billed on the same date that a member received a skilled nursing visit in the home. The telehealth reading should be included in the skilled nursing home visit when the reading and the home visit are performed on the same day.

All equipment and software costs associated with the RPM services must be separately identified on the home health provider's annual cost report so that the equipment and software costs may be removed from the calculation of overhead costs.

Rates for RPM services are not adjusted annually.

## *Electronic Visit Verification for Telehealth Services*

In accordance with federal requirements, the IHCP requires providers to use an electronic visit verification (EVV) system to document designated personal care services rendered on or after Jan. 1, 2021, and designated home health services on or after Jan. 1, 2024. See the *Electronic Visit Verification* page at in.gov/medicaid/providers for details. For a list of services that require EVV, see *Service Codes That Require Electronic Visit Verification*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

For services that require EVV and that are also allowable as telehealth, providers can create a manual visit record for virtual visits. Providers are also strongly encouraged to use the Memo feature within Sandata (or equivalent feature if using an alternate EVV vendor) to document that services are being performed virtually.

## *Out-of-State Telehealth Providers*

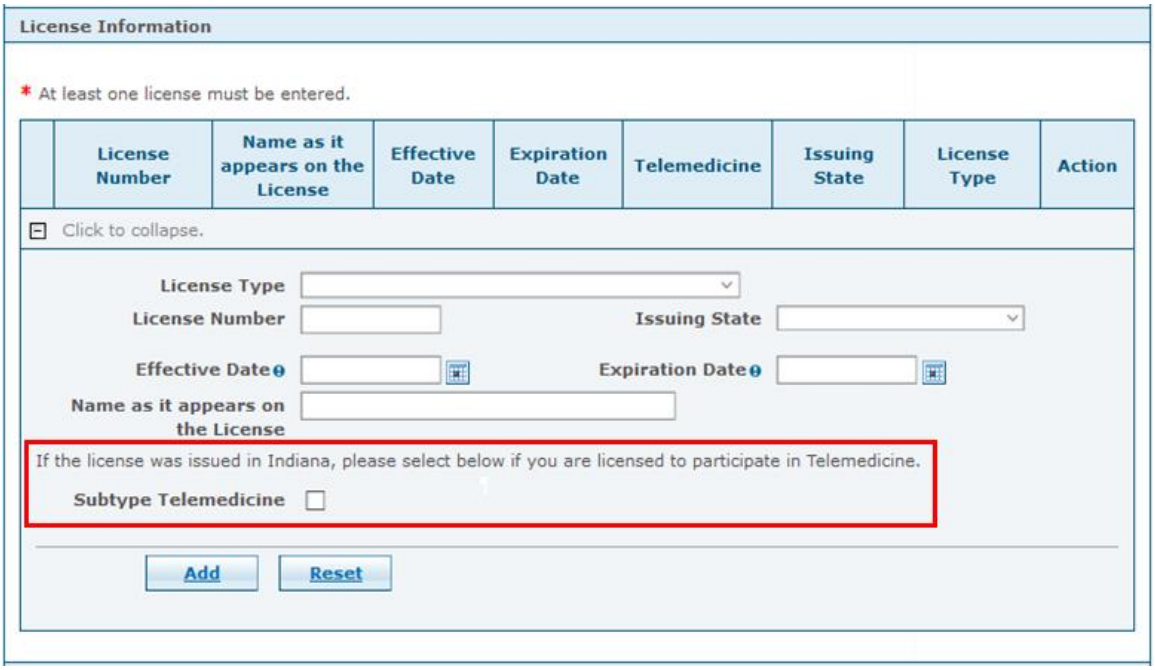
Out-of-state providers can perform telehealth services without fulfilling the out-of-state prior authorization requirement if they have the subtype "Telemedicine" attached to their enrollment.

The Telemedicine subtype is available only to providers that meet all the following requirements:

- The enrollment must be for one of the following provider types:
  - 09 – *Advanced Practice Registered Nurse*
  - 10 – *Physician Assistant*
  - 14 – *Podiatrist*
  - 18 – *Optometrist*
  - 31 – *Physician*
- The enrollment must have one of the following classifications:
  - Rendering
  - Billing
- The provider must have a license issued from the Indiana Professional Licensing Agency (IPLA) with a telehealth provider certification.

Out-of-state providers that meet all the preceding requirements can add the Telemedicine subtype during the initial enrollment process, at revalidation or as an update to a current enrollment. During the enrollment application process on the IHCP Provider Healthcare Portal (IHCP Portal), the option to add the Telemedicine subtype appears in the *License Information* section of the *Provider Identification* panel (see Figure 1). Currently enrolled providers can access this option by logging in to their registered IHCP Portal account and selecting **Provider Maintenance > Provider Identification Changes** and scrolling to the *License Information* section. To add the Telemedicine subtype to their out-of-state enrollment, providers must enter information about their IPLA license and select the **Subtype Telemedicine** checkbox. This option is displayed only for the five provider types listed and only for rendering or billing classifications.

Figure 1 – The Telemedicine Subtype Option for Out-of-State Providers




A copy of the IPLA license must also be submitted. On the *Attachments* page of the enrollment or provider maintenance process, select **Provider License** from the Attachment Type drop-down menu. From the Transmission Method drop-down box, select FT-File Transfer if attaching the license electronically, or select BM-By Mail if sending a copy of the license by mail. If FT-File Transfer was selected, use the **Upload File** field to attach the electronic copy of the license and then click **Add**.

After the enrollment application or update is processed and approved, a Telemedicine indicator will be added to the provider account in *Core*MMIS, allowing the out-of-state provider to be viewed as an in-state provider when billing telehealth services.