

State Notices on Telehealth Policy in Response to COVID-19

(as of August 11, 2020)

As the US health care system responds to the COVID-19 crisis, the need for expanded use of appropriate telehealth care has become critically important. States are responding to the crisis by reducing barriers to telehealth care use in Medicaid, the Children's Health Insurance Program (CHIP), and with private insurers. Below you will find state notices on telehealth care policy released in response to the COVID-19 crisis. For guidance on advocating with Medicaid, CHIP, and private payers to ensure pediatricians can deliver telehealth care services and be paid appropriately, please see [AAP Guidance: Telehealth Payer Policy in Response to COVID-19](#).

There has also been a need to expand the use of telehealth for **well-child visits** during the COVID-19 crisis. AAP has released, [Guidance on Providing Pediatric Ambulatory Services via Telehealth During COVID-19](#), which supports the continuation of well-child visits during the emergency and provides guidance on the provision of these services via telehealth. States continue to respond to the crisis by reducing barriers to telehealth care use. Below you will find state notices on the performance of well-child visits via telehealth in response to the COVID-19 crisis. **For a list of state Medicaid notices specific to well-child visits via telehealth, please see the section at end of this document.**

Alabama – The state is extending access to telehealth services for established Medicaid patients. The extension allows clinicians to provide medically necessary services that can be appropriately delivered via telecommunication services including telephone consultations. The extension also allows some behavioral health services to be appropriately delivered via telecommunication services including telephone consultations. The notice includes information on codes, modifiers, and place of service codes.

Alabama Medicaid is also temporarily allowing for the provision of [speech and occupational therapy services](#) through telemedicine, as well as [physical therapy services](#). Medicaid also added [additional CPT procedure codes](#) that can be covered via telemedicine.

Alaska – There are no restrictions on the location of the patient or the provider, and modes of technology such as Zoom, Skype and Facetime are permitted. The notice includes information on how to bill for Evaluation and Management Services provided via telephone and online digital services. The notice also includes information on coding and payment. Information on case management services, therapy services, medication management, and behavioral health aide services is also provided.

Arizona – An [Executive Order](#) requires that all insurers regulated by the state cover telehealth care visits at a lower cost-sharing rate than in-person visits.

A [subsequent Executive Order](#) requires, in part, that all insurance plans regulated by the state to provide coverage for all services that are provided through telemedicine if the service would be covered if provided in-person. Insurers can impose certain requirements, such as documentation and recordkeeping, but they may not be more restrictive or less favorable than for services provided in-person. Insurers must pay providers at the same level of payment for a telemedicine visit as for an in-person visit. All electronic means, including telephone and video calls must be permitted and the patient's home must be an approved location to receive

telemedicine services. The EO further requires that the Arizona Health Care Cost Containment System (AHCCCS) require **Medicaid** plans to cover all services that are covered benefits to be accessible via telemedicine and to prohibit Medicaid plans for discounting rates for telemedicine services.

In a [telehealth Q&A resource](#) (question 22), AHCCCS states that providers are encouraged to outreach to patients to ensure their care needs are being met during the emergency. Information on what billing codes can be used for preventive medicine counseling are listed on the [Medical Coding Resource](#) web page (go to the Reference Extracts section and click on the Telehealth Code Set). The list includes **preventive medicine service codes 99381-99385 and 99391-99395**.

Arkansas – The state is lifting the requirement for Medicaid that there must be an established relationship before using telemedicine under certain conditions: the providing physician must have access to the patient's medical record; the service must be provided by any technology deemed appropriate, including the telephone, but must be provided in real time; physicians may use telemedicine to diagnose, treat, and when clinically appropriate, prescribe non-controlled drugs. Medicaid is also allowing for the patient's home to be the originating site. Medicaid is also opening the "virtual check-in" code for existing patients under certain circumstances listed in the guidance.

California – Medi-Cal providers can use existing telehealth rules to as an alternative modality for delivering covered services when medically appropriate to limit patients' exposure to others. Medi-Cal providers can be paid for brief virtual communications, which includes communications with other providers or patients who cannot or should not be seen face-to-face. This page includes HCPCS codes that can be paid for virtual communications.

Medi-Cal also issued [additional guidance](#) which includes information on FQHC and RHCs as well as additional information on coding and billing for telehealth services.

Colorado – The state's Medicaid program is making 3 temporary changes to its existing telemedicine policy: no longer restricting services allowed to be provided via telemedicine to only audiovisual modality, and now allows the use of telephone or live chat; allowing telemedicine visits to qualify as billable encounters for FQHCs, RHCs, and IHS; the list of providers has been expanded to include **pediatric behavioral health** providers, PTs, OTs, hospice, and home health providers. The payment rates for telehealth services are, as a minimum, the same rate as in-person services. Coding and billing information is included in the guidance.

Connecticut – CT Department of Social Services announced Medicaid is now paying for telehealth services.

[Provider Bulletin](#) - the state is implementing full coverage of **specified** synchronized telemedicine, defined as an audio or video telecommunication system with real-time communication between a patient and practitioner. Will be covered under both the state's Medicaid and CHIP programs. See the bulletin for detail on specific covered services.

[Provider Bulletin](#) – temporary rule change to allow for the coverage of certain E/M services via telemedicine. Certain originating site requirements are waived for psychiatric diagnostic evaluations.

The Connecticut Department of Social Services Medical Assistance Program (Medicaid) issued [this provider bulletin](#) which, in part, temporarily adds additional procedures to the list of eligible services to be performed via telemedicine. These include existing **preventive medicine service codes**.

Delaware – Delaware Medicaid is in the process of revising guidance to remove a requirement that patients present in-person before telehealth care can be provided. [Subsequent guidance](#) was released by the state which says that patients do not have to be seen in-person before relevant services are provided, Delaware residents do not have to be in the state at the time relevant services are provided, and out-of-state providers who would be permitted to provide services in Delaware with the appropriate license may provide telehealth services to residents of the state if they hold an active license in another state.

The state issued [additional guidance](#) adding telephonic, remote patient monitoring, and store and forward codes to the list of codes that are now open during the COVID-19 emergency.

District of Columbia – DC Department of Health Care Finance announced that Medicaid is adding the home as an eligible site for Medicaid payment for telehealth care. The District also released [general guidance](#) on the use of telehealth care in regards to licensing, standard of care, and payment.

[DC Medicaid Coding for Telemedicine and Coronavirus \(COVID-19\)](#) describes which services will be paid for and how to bill for telemedicine. The District also released [this document](#) on the provision of telemedicine services during COVID-19.

Florida – In a Medicaid Health Care Alert, the state is postponing face-to-face provider-site visit requirements until further notice. When possible, these requirements will be met telephonically or through audio/visual technology.

Georgia – Georgia Medicaid and PeachCare for Kids are expanding the use of telehealth by waiving existing originating site requirements, adding telehealth care modalities covered, and allowing initial and annual assessments for home and community-based care services to be conducted via telehealth.

Hawaii – The Department of Human Services announced that Med-QUEST Division (MQD) will be covering additional codes that may be used to deliver services through telehealth technology. This applies to QUEST Integration (QI) Health Plans and FQHCs. Providers are required to follow existing telehealth rules for the development of a patient relationship via telehealth. The memo includes a list of codes that will be covered by Medicaid for established patients. It also includes codes that will be covered for brief virtual check-ins and e-visits. Telehealth services shall be provided using telehealth or everyday communication technologies (ie: Skype, FaceTime). See additional state notices on telehealth services [here](#).

Idaho – Idaho Medicaid is expanding the number of codes that are payable via telehealth beyond the code set in a previous [Information Release](#) (which is now temporarily rescinded). Any procedure provided via telehealth may be covered when: the service can be safely and effectively delivered via telehealth; the service fully meets the code definition when delivered via telehealth; the service is billed with a GT modifier; and all other existing criteria are met. These changes apply to all services billed through fee-for-service Medicaid (DXC, formerly Molina Medical Solutions), all claims paid through the Idaho Behavioral Health Plan (Optum), and Idaho Smiles (MCNA). Services that can be provided effectively telephonically without real-time video may also be covered via telehealth. Services that cannot be effectively completed without visual interaction are not included and continue to require a video component. Claims for services delivered via telehealth will be paid at the same rate as face-to-face services. Please see the notice for additional information.

[Additional guidance](#) allows for the use of any non-public facing remote communication product that is available to communicate with participants. While [this guidance](#) includes information regarding **occupational, physical, and speech therapy**.

Illinois - These changes are for both Medicaid fee-for-service plans and a HealthChoice Illinois managed care plan. The state will pay for medically necessary and clinically appropriate telehealth services with dates of March 9 or later if they meet certain criteria. Services must be delivered using an “interactive telecommunication system” or “telecommunication system” as [currently defined](#) or a communication system where information exchanged between a provider and patient is of an amount or nature that would be sufficient to meet requirements of the same service via face-to-face interaction. Originating site may be the patient’s home, while the distant site provider is any enrolled provider operating within their scope of practice and has the appropriate license or certification. Payment for telehealth services will continue to be in parity to in-person services. See guidance for additional information on virtual check-ins and online patient portal or “e-visits”.

Indiana – An [Executive Order](#) indicates that the Family and Social Services Administration will suspend in-person requirements for telehealth care. An [Indiana Health Coverage Programs bulletin](#) provides billing details, including that the state is expanding the list of acceptable platforms and code sets.

Indiana Medicaid also developed an [FAQ document](#) on the provision of telehealth services.

Iowa – A Department of Human Services Medicaid letter indicates the Medicaid program will cover all Medicaid benefits via telehealth care if clinically feasible and appropriate, regardless of the patient's location.

The Department subsequently issued [additional guidance](#) for providers including lists of codes for services provided via telehealth. They also issued an [FAQ document](#).

Kansas – The [Governor's Executive Order](#), in part, encourages all physicians to utilize telemedicine services when appropriate to avoid unnecessary patient travel; directs the Kansas State Board of Healing Arts (Board) to stop enforcing statutes, rules, and regulations that require physicians to conduct in-person exams of people prior to issuing a prescription or the administration of medication, including controlled substances; allows out-of-state physicians to practice in Kaansas without a state license in certain circumstances. See the EO for more information and additional provisions.

The Kansas Medical Assistance Program (KMAP) issued a [bulletin to providers](#) which includes a list of codes for services that can be provided via telehealth or telephone. The updates do not modify current coverage but allows for a different delivery method. Payment for these services will be the same as an in-person visit. (See this [additional notice](#) regarding payment for more information.) The state is allowing for the patient’s home to be the originating site (POS code 12). “Virtual check-in” code G2012 is not being permitted due to the allowance of E/M codes being provided via telephone.

For Medicaid MCOs, services provided by out-of-network providers will be allowed, but all existing prior authorizations out-of-network requirements remain in place.

These Medicaid provisions are effective for dates of service on or after March 23.

Kentucky – A Medicaid provider letter indicates the state is encouraging the use of telehealth care and adding payment for telephone calls and remote evaluation.

Louisiana – The state issued a bulletin to all Medicaid providers which, in part addressed issues related to telehealth. The Medicaid program, including all Medicaid MCOs, allows for the telemedicine/telehealth mode of delivery for many common services. When otherwise covered by Medicaid, telemedicine/telehealth is allowed for all CPT codes located in Appendix P of the CPT manual, including, but not limited to new and

established outpatient office visit codes (see bulletin for list of codes). All services eligible for telemedicine/telehealth may be delivered via an interactive audio/visual telecommunications system. HIPAA compliant platforms are preferred, but if not immediately available everyday communication technologies (such as cell phones with audio/visual capabilities) can be used. Audio only systems may also be used if audio/visual technology is not available. The same standard of care must be met and the need and rationale for the use of audio only technology must be documented. There is no limitation on the originating site. The preferred distant site is a health care facility, however if there is a disruption to a facility or a risk to the provider, there is no formal limitation on the distant site. Payment for services provided through telehealth/telemedicine is the same level as in-person visits. MCOs with contracts that exclude providers from delivering services via telehealth/telemedicine have been instructed to amend those contracts to allow it when clinically appropriate. The notice also includes guidance on the use of telemedicine for **physical, occupational, and speech therapy** as well as **applied behavioral analysis (ABA)**. See guidance for additional details and information regarding coding.

The state also subsequent information on [telehealth facilitation of mental health rehabilitation services](#), telehealth by [licensed mental health practitioners](#), telehealth for [outpatient substance use disorder treatment services](#).

Maine - This guidance is extensive and includes information on using telehealth to satisfy face-to-face requirements, delivery of telehealth via telephone, information on originating and distant sites, telephone only E/M, billing and payment, and telehealth and behavioral health services. The state has also released separate guidance on [telehealth payment](#).

Maryland – A Department of Health memo indicates Medicaid fee-for-service and managed care will now recognize the home or any other secure location as an originating site.

Massachusetts – MassHealth released a [Managed Care Entity Bulletin](#), which, in part, outlines changes to coverage and payment policies for Medicaid MCOs. All MCOs must cover testing, treatment, and prevention of COVID-19 in at least the same amount, duration, and scope as covered by MassHealth FFS plans. Coverage must include telehealth and certain telephonic services as means by which beneficiaries may access clinically appropriate, medically necessary covered services. MCOs must not impose any referral requirements for testing or treatment related to COVID-19.

In this [MassHealth bulletin](#), the state indicates that telehealth services will be paid at the same rate for in-person services. Providers must use site of service code 02. The bulletin also allows qualified provider to deliver clinically appropriate, medically necessary MassHealth covered services notwithstanding any regulation to the contrary, including the physical presence requirement. Billing MassHealth for telehealth services can start on April 1, 2020 for dates of service beginning March 12. MassHealth then issued [subsequent guidance](#) which provided additional information on the provision of telehealth services, such as allowing a distant site provider to bill a facility fee in certain instances.

MassHealth has now established a temporary new provider type called [Telehealth Network Providers \(TNPs\)](#) whose primary purpose is to support member triage related to COVID-19.

Michigan – The state has issued 3 bulletins on telehealth. The [first bulletin](#), in part, allows for the patient's home to be considered an originating site and also includes billing information. The [second bulletin](#) allows for flexibility in the face-to-face requirement and allows for the use of telephonic, telemedicine, and video technology available on smart phones as long as they meet HIPAA compliance standards and the beneficiary

consents to the method. Plans included in these bulletins include Medicaid, Healthy Michigan Plan, and Children's Special Health Care Services.

The [third bulletin](#) allows for additional flexibility regarding telemedicine audio/video requirements. Effective retroactively to March 1 all codes on the telemedicine database will be allowed to be delivered via telephone only. The telemedicine database is attached to the bulletin. All other telemedicine policy requirements, including scope of practice requirements, are to continue to be followed. See the bulletin for coding information. The bulletin also addresses telephone only services for Prepaid Inpatient Health Plans and Community Mental Health Providers.

Minnesota – The Departments of Health and Commerce sent a letter to all health carriers in the state requesting that the fully insured market take all necessary steps to expand the availability of telemedicine services for enrollees and eliminate all barriers to its use. See letter for additional information.

The state just passed [legislation](#) which, in part, includes the patient's home in the definition of "originating site" and includes services or consultations provided to a patient in their home in the definition of "telemedicine"; and requires that a health carrier not exclude or reduce coverage for a health care service or consultation only because the service is provided via telemedicine directly to the patient's residence. These provisions expire on February 1, 2021.

Mississippi – The Division of Medicaid is expanding coverage of telemedicine services during the emergency. During the state of emergency, a beneficiary's home is approved as an originating site and patients may use their own personal devices, such as phones or tablets or other web camera-enabled device to receive medical care in a synchronous format with a DOM approved distant-site provider. Telehealth services do not include service delivery through text message, e-mail, or other formats that do not include audio and/or visual components. See the emergency policy for information regarding billing and payment.

The MS Insurance Commissioner also issued a [bulletin](#) regarding the use of telemedicine which directed insurers to adopt procedures that will encourage the use of telemedicine and suspended any existing rules that limit accessibility of telehealth.

Missouri – The MO HealthNet Division (MHD) has put out a notice to providers allowing for telehealth services to be provided to patients in their homes via their telephones. When the originating site is the patient's home, the originating site fee cannot be billed. There is no separate fee schedule to telehealth as payment to providers delivering the service is equal to the current fee schedule. Please find billing and payment information [here](#). The state is also: waiving the requirement that providers have an established relationship with patient prior to providing telehealth services; waiving co-pays for telehealth services; allowing telephone services; allowing quarantined providers or providers working from alternate sites to provide and bill for telehealth services; and waiving the requirement that providers be licensed in MO in order to treat patients in the state via telehealth (providers must be licensed in the state they are in and be enrolled as MHD providers).

Montana – There are no specific requirements for technologies to deliver telehealth services. Payment rates will be in parity with in-person service rates. The patient's home can be an originating site but is not payable as an enrolled originating site provider. The notice also includes coding guidance.

Nebraska – Nebraska Medicaid is temporarily allowing payment for telephonic evaluation and management for certain beneficiaries who are also existing patients: those experiencing mild COVID-19 symptoms prior to visiting an ED, urgent care, or other health care facility; those who need routine follow up care and are

experiencing no symptoms; those requiring behavioral health assessment and management. The notice includes coding guidance.

Nevada – The state is lifting the restriction on telephone only care. Telehealth services are paid at parity with in-person services.

New Hampshire – There is no restriction on the originating site and may include private residences. Medicaid pays for telehealth services on parity with in-person services. Providers should bill in the same manner they do for in-person visits but include a modifier GT and indicate a place of service 02. There is no additional payment to the originating site. Documentation is the same as for in-person services.

New Jersey – Medicaid fee-for-service and Medicaid managed care plans are required to: provide payment to physicians at the same rate as in-person encounters for telehealth and tele-mental health services as long as the same standard of care is applied; waive site of service requirements and allow NJ licensed clinicians to provide telehealth services from anywhere and beneficiaries to receive them from anywhere; and permit alternative technologies such as telephonic and video technology available on smart phones and other devices.

Private payers in the individual, small and large group markets are directed to: review their telehealth networks to ensure adequacy and grant any requested in-plan exceptions to access out-of-network providers if in-network providers are not available; cover, without cost sharing, any services or supplies delivered or obtained via telehealth; encourage providers to utilize telehealth to minimize COVID-19 exposure to their staffs; ensure that payment to in-network providers for telehealth services is not lower than the rates for in-person services; notify providers of what is needed to bill for telehealth services; allow for telephonic services and flexibility in technology; eliminate prior authorization requirements for medically necessary services via telehealth; and notify beneficiaries of these changes.

See guidance for additional state actions.

New Mexico – The state's Department of Human Services released a [letter to Medicaid managed care organizations](#), which includes language on telehealth care. The state is directing MCOs to allow telehealth services to be provided in all settings, including a patient's home until the end of the emergency declaration. They have also added new codes to encourage the use of telephonic visits and e-visits. The new codes and payment rates will be in effect for all provider types through the end of the emergency. See [letter](#) for specific codes and payment rates. The letter also have information regarding FQHCs, RHCs, and IHCs as well as information on behavioral telehealth.

New York – Medicaid will pay for telephonic E/M services when face-to-face visits are not recommended, and it is appropriate for the patient to be evaluated via telephone. Telephonic communication will be covered when provided by any qualified practitioner or service provider. All telephonic encounters documented as appropriate by the provider would be considered medically necessary for payment purposes in Medicaid FFS or Medicaid Managed Care. All other requirements in delivery of these services otherwise apply. This guidance also allows for the provider's home to be considered a distant site. Additionally, all sites are eligible to be distant sites for delivery and payment purposes, including FQHCs. The originating site can be anywhere the patient is located. This notice also discusses the telehealth applications telemedicine, store-and-forward, and remote patient monitoring. All Medicaid provider types are eligible to provide telehealth but the services should be appropriate for telehealth and within the provider's scope of practice. This notice also provides information on coding and billing for services.

The New York Department of Health also released an [FAQ document](#) regarding the use of telephonic services during the COVID-19 emergency.

North Carolina – NC Medicaid is offering payment for virtual patient communication and telephonic evaluation and management for certain beneficiaries who are established patients: those experiencing COVID-19 symptoms prior to visiting an ED, urgent care, or other facility; those who need routine follow-up and not experiencing symptoms, and those requiring behavioral health assessment and management. The bulletin also includes coding information.

North Carolina Medicaid has also released [webinar slides](#) that includes information on coding for telephonic visits as well as a list with links to [private insurer actions](#) related to telehealth.

NC Medicaid issued a [subsequent bulletin](#) which addresses the issue of payment parity for telemedicine and telepsychiatry with in-person services. Payment for these services will be in parity with in-person services as long as the standard of care is met and they are conducted via a secure HIPAA compliant technology with live video and audio capabilities, including smart phones, tablets, and computers. The state is also lifting any restrictions to originating and distant sites. This bulletin also has additional coding information for the [earlier bulletin](#) on virtual patient communication and telephonic E/M services, discussed above.

There is also a [Medicaid Telehealth Billing Code Summary](#), which includes information on how to code for E/M visits via telemedicine.

North Dakota – ND Medicaid covers telemedicine services and the patient's home can be an originating site. If the home is an originating site, no originating site fee can be billed. General information on telemedicine for Medicaid providers can be found [here](#).

Ohio – Governor DeWine signed an Executive Order which expanded telehealth options for Medicaid recipients. A subsequent [emergency rule](#) was released which, in part, provides a definition for telehealth and includes a list of provider types that are eligible to provide services via telehealth and a list of providers who are eligible to bill for those services. The rule also removes any existing limitations to what can be considered an originating site, which allows for the patient's home to be an originating site. It also removes limitations as to what can be considered the practitioner or distant site. The rule also outlines which specific technologies can be utilized to provide telehealth services. There is also a section which describes the types of services that will be paid for when provided via telehealth and includes E/M services for new and established patients, inpatient or office consultation for new and established patients, virtual check-in, and remote patient monitoring. Please see the full rule for a complete list of services. The rule also includes information on the submission of claims for services provided via telehealth. Please see the full emergency rule for more details. The state also published [an appendix](#) which includes specific codes for services that will be paid through telehealth during the emergency.

The state also released an [FAQ document](#).

Oklahoma - The state has temporarily waived the preexisting patient relationship requirement for the provision of telehealth services.

Oregon – The state has issued new guidance expanding coverage of telehealth services. Fee-for-service Medicaid is opening additional codes to payment: telephone service evaluation/assessment and management codes for behavioral health providers and synchronous audio and video visits, online services and provider to provider consultations for physical health providers. Coordinated Care Organizations (CCOs) will cover

telehealth services effective March 13 but are encouraged by the state to make this retroactive to January 1. Changes to existing rules to remove barriers to telehealth can be found [here](#).

The state issued [subsequent guidance](#) which address both private plans regulated by Department of Consumer and Business Services (DCBS) as well as Medicaid plans regulated by the Oregon Health Authority (OHA). Plans will cover telehealth services delivered by in-network providers to replace in-person visits whenever possible and medically appropriate; providers will be allowed to use all modes of telehealth delivery, including telephone based service delivery; health plans are required to examine payment rates to ensure they are adequate to enable providers to increase capacity to serve patients via telemedicine (the state “encourages” payment for telehealth services that mirror rates for the equivalent office visit or that providers and plans quickly agree to payment rates); and health plans will ensure that cost-sharing for telehealth services are not greater than for in-person visits. See the guidance for more details.

Pennsylvania – This guidance is for Medicaid fee-for-service and Physical HealthChoices members only. Providers should contact the individual MCO with questions about managed care coverage. The state announced a preference for telemedicine as a delivery method for medically necessary services. Services should be billed as though performed face-to-face and will be paid as listed on the current fee schedule. Telemedicine may be provided by any means that allows for two-way, real-time interactive communication. Telephone only services are allowable if video technology is not available.

There is a separate notice for the provision of telehealth services for [behavioral health](#).

Additionally, any health care professional licensed by one of the [Department of State’s Bureau of Professional and Occupational Affairs](#) licensing boards can provide services to patients via telemedicine.

Rhode Island – The state’s Health Insurance Commissioner and Medicaid program notified all insurers in the state to update all telemedicine policies to include telephone-only services within the definition of telemedicine for primary care and behavioral health providers. Includes information on coding. The state also requires that any out-of-state telemedicine providers contracted by an insurance plan follow all CDC and RI Department of Health instructions in relation to COVID-19.

The Governor also signed an [Executive Order](#) which allows patients to receive telehealth services from any location, suspends the prohibition on audio-only telephone conversations and limitations on video conferencing, suspends existing laws that limit the scope of telehealth services or payment for such services, and requires insurance companies to establish reasonable requirements for coverage of telehealth.

South Carolina – The state is expanding coverage for telephone and telehealth services for dates of service of March 15 forward. SCDHHS will begin accepting claims on these policy changes beginning on April 1. Video interactions can also be billed, but not other forms of electronic messaging such as e-mail or text messaging. Services are only allowable to existing patients. The notice includes specific billing and coding requirements.

SC Medicaid has also released an [FAQ document](#) and a [telehealth fee schedule](#).

Tennessee – TennCare (the state’s Medicaid program) has developed a resource for providers with information from each of the state’s Medicaid managed care organizations. Please review the document to see new guidance related to telehealth, including billing and coverage procedures. All MCOs will allow the patient’s home to be the originating site.

There is [separate guidance](#) from TennCare regarding telehealth services for behavioral health.

Texas – The Governor has issued [emergency rules](#) regarding payment for telehealth visits in the state. The rules require payment for telehealth services, including mental health, at the same rate for in-person visits for an in-network provider, allows the use of any platform permitted by law, and does not require any additional documentation than for in-person visits. Applies to fully funded health plans regulated by the state. [FAQ on emergency rules](#).

Governor Abbott also approved the [TX Medial Board's](#) request to temporarily suspended portions the Texas Occupation Code until the Governor rescinds it or the state's Emergency Declaration is lifted. As a result of this action, telemedicine, including phone only consultation, can be used to establish the physician patient relationship. This expansion can be used for diagnosis, treatment, ordering of testing, and prescribing for all conditions. The rules around standard of care remain intact.

Utah – The Governor issued an Executive Order which suspended enforcement of rules that were deemed to interfere with providers' ability to provide telehealth services and allows them to offer telehealth services that do not comply with security and privacy standards required by state law. Providers are required to inform patients that the service does not comply with state law, provide patients the opportunity to decline the service, and take reasonable care to ensure privacy and security.

Vermont – Vermont Medicaid has provided updated guidance to providers in regard to the provision of telehealth and telephone care. The Department of Health Access also released a [memo to Medicaid providers](#) which: allows for payment for 3 triage codes for both FQHC and RHC providers and non-FQHC and RHC providers to allow for payment for brief virtual communication services to determine if an office visit is needed; and provides for the same payment rate for medically necessary, clinically appropriate services delivered by telephone at the same rate as covered services provided through telemedicine or in-person encounters. See this memo for specific coding information.

The state also issued an [emergency rule](#) to expand patients' access to and providers' payment for health care services, including **preventive services**, delivered through telehealth, audio only telephone, store-and-forward, and brief telecommunications services. Specifically, the emergency rule directs insurers to pay the same rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the insurer/provider contract, regardless of whether the service was provided through an in-person visit or through telehealth or audio-only telephone. Please see the emergency rule for additional information.

Virginia – DMAS has issued an initial policy memo indicating the state will add audio only, waive the telepresenter requirement for a facility fee, add the home as an originating site, allow behavioral health and early intervention to be conducted via telehealth, and pay at parity with analogous in-person services.

Washington – The Washington Health Care Authority (HCA) put out an [FAQ on Medicaid policy and billing](#) during COVID-19, which includes information regarding the provision of telemedicine. Fee-for-service Medicaid and Managed Care Organizations (MCOs) cover telemedicine when delivered via interactive, real-time audio and video conference (including web-based applications), and when the provider works within their scope of practice to provide a covered services to an Apple Health eligible beneficiary. FFS and MCOs with pay for telemedicine services in the following settings: Inpatient hospitals, including ICU and CCU; outpatient hospitals, including the ER and hospital-based clinics, free standing clinic and office services. Providers are allowed to use telemedicine to provide patient care even when it within the same facility. If within the same facility, providers do not submit a claim for the originating site.

This FAQ also includes a list of codes outside of telemedicine (telephone care and online digital evaluation) that Apple Care will pay for on a temporary basis if telemedicine services are not available and “extraordinary circumstances are involved”. The FAQ includes a link to the COVID-19 fee schedule. Providers should check with their individual MCOs regarding specific billing requirements.

The Governor subsequently signed a [proclamation](#) that would increase parity between providers who provide in-person care and those who provide it via telemedicine and requiring telemedicine claims to be paid at the same level as face-to-face care. Telemedicine claims cannot be denied by insurers.

Washington Medicaid also developed a [clinical policy and billing document](#), which includes information on how to bill for **EPSDT visits** that were conducted via telehealth (page 5).

West Virginia – The state [issued a memo](#) to Medicaid providers allowing for the use of telemedicine for non-emergent E/M visits. The expansion is for the use of live video conferencing in a member’s home, with a Medicaid enrolled provider in the originating site. Currently, all other telemedicine rules should be followed, but the state is continuing to monitor the situation. CPT codes 99211 and 99212, billed with place of service 02 will be allowed.

The state’s [CHIP program](#) is allowing for patient’s homes to be the originating site for telehealth screening visits. Providers must be able to visually see and examine patients. Text messaging and e-mail are not payable services. This letter includes coding information.

Wisconsin – The Wisconsin Department of Public Health issued guidance for Medicaid and BadgerCare Plus plans. The guidance allows for payment for all originating sites, but originating sites not listed in existing telehealth policy will not be eligible for a facility fee; certain providers may be paid for services listed in [existing guidance](#) (Topic #510) and additional inpatient, nursing facility, e-visit, and telephone E/M services listed in the [DPH guidance](#). This guidance also includes new telehealth policy for FQHCs. These changes are for dates of service on or after March 1.

[Subsequent guidance](#) was released to change additional policy requirements for services delivered via telehealth. MCOs were advised by the state to align with these changes for benefits not solely administered under FFS. Providers should check with MCOs for information on their implementation of these changes. The state will allow remote services using interactive real-time technology, including audio-only phone communication, for services that can be delivered with functional equivalency to the face-to-face service. This applies to all services included in [existing guidance](#) (Topic #510). Providers must keep accurate and complete documentation according to existing requirements. The guidance also includes changes to the face-to-face mental health requirement, comprehensive community services, the community support program, community recovery services, behavioral treatment, and targeted case management. Coding information is also included in this [guidance](#). These changes began on March 12 and until the end of the state’s [emergency declaration](#).

The state also has a running list of [telehealth resources](#) including summaries and explanations of recently published materials.

Medicaid Payment for Well-Visits Via Telehealth in Response to COVID-19

Alabama – Alabama Medicaid is permitting EPSDT codes 99381EP – 99385EP and 99391EP – 99395EP to be billed via telemedicine. Medicaid recognizes that not all components of the screening may be completed via telemedicine but will be completed in person when appropriate with no additional payment. Providers should bill with place of service 02 and modifiers CR and 52. Follow up visits in-person should occur as soon as possible to complete the remaining exam screening components. These exam visits can be billed for tracking purposes utilizing CPT 99201EP-99205 EP and 99211EP – 99215EP with modifier 52.

Medicaid is allowing the following procedure codes for in-person EPSDT screenings (well child checkups) and for evaluation and management (E/M office visits) visits to be billed on the same day of service with modifier 25 appended to codes 99201EP – 99215EP:

Well checkups: 99381EP – 99385EP, 99391EP – 99395EP

E/M visits: 99201EP – 99205EP, 99211EP - 99215EP

Providers should bill 99211EP – 99215EP for interperiodic screenings.

Arizona - In a telehealth Q&A resource (question 22), AHCCCS states that providers are encouraged to outreach to patients to ensure their care needs are being met during the emergency. Information on what billing codes can be used for preventive medicine counseling are listed on the [Medical Coding Resource](#) web page (go to the Reference Extracts section and click on the Telehealth Code Set). The list includes **preventive medicine service codes 99381-99385 and 99391-99395**.

California - Medi-Cal has also issued guidance on well-child visits during the COVID-19 emergency. Medi-Cal is following the AAP's guidance on the provision of ambulatory services during the emergency and encouraging providers to prioritize in-person care for patients younger than 24 months. Medi-Cal's telehealth policy allows providers the flexibility to provide care via telehealth/virtual telephonic communication and to bill Medi-Cal when provided in this way. Providers should inform beneficiary parents/caregivers of their option to have some elements of a comprehensive well-child visit completed through telehealth and explain that some portions of the physical exam and/or immunizations must be completed in person. To the extent there are components of the comprehensive well-child visit provided in-person due to those components not being appropriate to be provided via telehealth (e.g., those requiring direct visualization and/or instrumentation of bodily structures, or that otherwise require the in-person presence of the patient for any reason) and those components are a continuation of companion services provided via virtual/telephonic communication, the provider should only be billing for one encounter/visit. For information on Medi-Cal's telehealth billing and policy instructions, refer to DHCS' existing policies, outlined in the Medi-Cal Provider Manual: section. "Medicine: Telehealth" and the recently released [fee for service and managed care telehealth guidance](#), posted to DHCS COVID-19 website.

Connecticut – The Connecticut Department of Social Services Medical Assistance Program (Medicaid) issued this provider bulletin which, in part, temporarily adds additional procedure to the list of eligible services to be performed via telemedicine. These include existing **preventive medicine service codes**.

Florida – The Florida Agency for Health Care Administration (AHCA) will pay for well-visits done via telemedicine (live two-way audio and video) for children 24 months to 20 years of age for codes 99382-99385 and 99392-99395. The GT modifier must be used. The AHCA expects that providers will schedule in-person follow-up visits to administer vaccinations and other physical components of the exam that could not be delivered via telemedicine. Immunizations should be scheduled as soon as possible to ensure children remain on schedule. The follow-up visit will be eligible for Medicaid payment and additional guidance is forthcoming on this. Florida will not pay for well-visits via telemedicine for children under 24 months.

Indiana - The Indiana Health Care Program (IHCP) issued clarification regarding the performance of well-child visits via telehealth care (see page 2 of document). IHCP considered well-child visits via telehealth appropriate for children 24 months and older. Visits should be billed using the appropriate procedure code and will be paid at the same rate as in-office visits. Providers need to complete the components of the visit that could not be done via telehealth in a follow-up visit within 6 months of the end of the public health emergency. The follow-up visit should be billed using the E/M code that is most appropriate for the complexity of the visit. Providers should use professional discretion regarding the safest way to deliver this care.

Kentucky - Kentucky Medicaid has released guidance on the provision of well-child visits via telehealth care. For children 24 months and younger Medicaid is recommending the continuation of in-person visits. For children over 24 months, providers may perform well-visits using telehealth modalities reporting the appropriate preventive medicine CPT code and the “02” place of service code. No telehealth modifier is required. Please see the guidance itself for additional coding information and documentation requirements. Providers will need to use their clinical judgement as to what components of the visit are appropriate to be performed during the telehealth visit. Audio-visual telehealth is preferred, but audio only is acceptable. Providers may provide vaccine counseling during the telehealth visit and then provide the vaccine administration later. The vaccine administration code, 90460, would be billed at the time of vaccine administration. An in-person follow up visit must be performed within 6 months of the end of the emergency and complete the rest of the components that were not able to be performed via telehealth. For the in person visit, the follow-up visit code of 99213 should be billed and well-child-visit can be used as a diagnosis code if another more specific code is not apparent.

Louisiana – The Louisiana Department of Health issued information (page 10) on the provision of EPSDT/well-child visits via telehealth/telemedicine. For both Medicaid fee-for-service and managed care, the use of telehealth/telemedicine to perform clinically appropriate components of EPSDT preventive services for members older than 24 months will be allowed. Components of the visit that cannot be done via telehealth/telemedicine can be performed at an in-person interperiodic visit at a later date when limitations on non-emergent clinical care are lessened. Pediatricians should use the usual preventive medicine service codes (99381-99385, 99391-99395) with the telehealth modifier (95) and the reduced services modifier (52) and

place of service (02). The in-person interperiodic visit should be billed using the normal EPSDT preventive service code (99391-99395). The telemedicine visit providing partial components will be paid at 75% of the normal rate, with the subsequent in-person visit being paid at 100% of the fee on file.

Maine - Maine continues to edit their guidance document which now includes specific information on the provision of **EPSDT/well-child visits via telehealth** (page 7). Medicaid encourages in-person well-visits for patients under 24 months so they can receive their necessary vaccines. Practices have discretion to do telehealth well-visits for patients under 24 months depending on the child's health, availability of PPE, and if no immunizations are due (or are available via curbside delivery at the practice). For patients over 24 months, a modified well-visit can be performed via telehealth by completing certain components (ie: history, anticipatory guidance, etc.). Any limitations of the exam should be noted in the patient record. The appropriate preventive medicine service should be reported with the GT modifier. Any separately reported services should also be billed with the GT modifier. If a well-visit is performed via telehealth, an in-person follow up should in a responsible time frame after the emergency is lifted. Please see the guidance for additional details.

Maryland – For children under 24 months, the Maryland Department of Health recommends that well-child visits should continue in the primary care office setting in order to assess the child's development, provide timely referrals for additional services as appropriate, and remain up-to-date with immunization schedules. Newborns, infants, and children under 24 months should receive priority for in-person office visits. For children older than 24 months, a telehealth visit may be offered to provide timely EPSDT services. However, the state notes that this does not replace the necessary components of a well-child visit that must take place in an office setting, such as immunizations, vision and hearing screening tests, oral health screening and fluoride varnish, and laboratory testing. Providers should clearly document any visit limitations in the child's medical record. Families must be notified of all required preventive service components that cannot occur during the telehealth visit, and that such services will need to be completed at a later time. An in-person visit is encouraged within 6 months from the date of the telehealth visit to conduct the remaining components of the well-child exam. Telehealth well-child visits for children over 24 months will be paid at the same rate as an in-person visit. Providers must document which elements of preventive care were provided and indicate the setting and module. See the guidance document for coding and billing information and a list of codes that are permitted.

New Hampshire - The New Hampshire Medicaid program has clarified its telehealth policy as it pertains to payment for evaluation and management office visits for well-child visits. During the state of emergency, annual (procedure codes 99385-99387 and 99395-99397) and well child preventive health checks (procedure codes 99381-99384 and 99391-99394) may be performed via telemedicine and, when indicated, combined with in-person administration of immunizations. Components of well child visits that cannot be completed via telehealth can be waived until a later date. Additional well child telehealth assessments may be included as appropriate (i.e., developmental screening, behavioral/emotional assessment, health risk assessment).

North Carolina - NC Medicaid released guidance on well-visits via telehealth. NC Medicaid is temporarily adding telemedicine coverage for providers to conduct well-child visits for children under the age of 21. This

includes guidance for the provision of well-visits for children under 24 months and 24 months and older. These services are generally not covered when delivered via telemedicine to children under 24 months, except in extenuating circumstances in which case the justification for a telemedicine visit must be well-documented in the patient's chart. For children under 24 months, providers may also bill for **maternal depression screening** using CPT code 96161 (NC Medicaid will pay for up to 4 maternal depression screens administered to the mother during the infant's first year postpartum). Providers are encouraged to continue providing vaccines during the pandemic. Providers may provide immunization counseling via telemedicine and then administer vaccines at a later date. The immunization administration code may be billed at the time of the vaccine administration by the provider. Patients who receive well-visits via telemedicine should have an in-person follow up as soon as possible. For the initial telemedicine visit, providers should bill the appropriate preventive medicine code with the appropriate modifier. The subsequent in-person visit providers should bill the appropriate evaluation and management code with the CR modifier to identify that remaining components of the preventative medicine visit have been completed. The updated [Medicaid Telehealth Billing Code Summary](#) includes information on coding for well-child visits, including appropriate modifiers, on Table 15.

Rhode Island – The Rhode Island Office of Health Insurance and the state's Office of Health and Human Services issued guidance for preventive care visits during the COVID-19 state of emergency. The state directs the Medicaid program as well as all Managed Care Organizations as well as commercial health insurers to follow this guidance. The state is recommending in-person visits for children under 24 months and those over 24 months who are in need of vaccinations. The state does allow for children over 24 months (and children under 24 months who are unable to be seen in person) to receive preventive medicine visits via telehealth. The state expects these visits to be split into 2 different visits. The first would include all components that are clinically appropriate to be performed via telemedicine or telephone only and pediatricians would bill for the appropriate E/M code, including an appropriate modifier. The second visit is intended to meet the face-to-face components of the preventive medicine exam (ie: immunizations, vision and hearing screening) and pediatricians should bill for only the services that are provided on the second date of service using appropriate procedure codes. MCOs and commercial carriers are to provide specific billing and coding requirements in their temporary wellness visit policies as well as any documentation requirements. In instance where E/M visits are conducted on 2 separate days, MCOs and commercial carriers are directed to pay providers at an amount no less than the amount they currently pay for in-person preventive medicine services conducted in a single visit. Please see the notice for more details.

South Carolina – The South Carolina Department of Health and Human Services (SCDHHS) released, **Child Well-Care and EPSDT Visits**. SC Medicaid will pay for well-child visits provided via telehealth for children through age 18. The visit is required to include developmental and behavioral screenings, health risk assessments, and anticipatory guidance prescribed by the current edition of Bright Futures. The guidance includes information on how to code for these services. When well-care is provided via telemedicine the beneficiary (or parent/guardian) must be notified of any immunizations that would routinely be administered and vaccine administration should be scheduled as soon as feasible following the telehealth encounter. SC will pay for vaccine administration when delivered outside of the well-visit. Claims for immunization administration should be bill on the date of service of the actual administration. Any child who receives a telehealth well-care visit should have an in-person follow-up well-care visit as soon as feasible and **Medicaid**

will pay for the follow-up visit. See guidance for additional information on FQHCs and RHCs as well as additional information.

Tennessee - TennCare has released guidance, **EPSDT/Well Visits During COVID-19**, which adds new preventive service codes that can be provided via telemedicine. This applies to TennCare and MCOs. The document includes guidance for well child visits for children 24 months and younger and older than 24 months and indicates which components of a well-child visits can be done via telemedicine. The guidance also includes coding information.

Texas – Texas Health and Human Services Commission (HHSC) is allowing remote delivery of certain components of Texas Health Steps medical checkups for children over 24 months of age (i.e. starting after the “24 month” checkup). Because some of these requirements (like immunizations and physical exams) require an in-person visit, providers must follow-up with their patients to ensure completion of any components within 6 months of the telemedicine visit. Telemedicine or telephone only delivery of Texas Healthy Steps for children birth through 24 months of age is not permitted. Providers should use their clinical judgement to determine the appropriate components of the checkup for telemedicine (audio and visual) or telephone-only delivery. Audio and visual delivery is preferred over telephone-only delivery. Providers should bill using the appropriate Texas Health Steps checkup codes for the initial visit as is currently required. Providers may also bill for “add-on” codes (e.g. developmental screening, mental health screening, etc.) as they normally would. Modifier 95 must be included on the claim form to indicate remote delivery. Provider documentation should include the components that were not completed during the initial checkup using “COVID-19” as the reason for an incomplete checkup. When patients are brought into the office within 6 months to complete the outstanding components, providers should bill the Texas Health Steps follow-up visit code, 99211. Providers may also bill an acute care Evaluation and Management (E/M) code at the time of the initial telemedicine checkup or at the “6-month” follow-up visit. Modifier 25 must be submitted with the acute care E/M procedure code to signify the distinct service rendered. Providers must bill the acute care visit on a separate claim without benefit code EP1. This guidance applies to both new and established patients and is applicable for members in both managed care and fee-for-service Medicaid.

Vermont - The state also issued an emergency rule to expand patients’ access to and providers’ payment for health care services, including **preventive services**, delivered through telehealth, audio only telephone, store-and-forward, and brief telecommunications services. Specifically, the emergency rule directs insurers to pay the same rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the insurer/provider contract, regardless of whether the service was provided through an in-person visit or through telehealth or audio-only telephone. Please see the emergency rule for additional information.

Washington – The Washington Health Care Authority developed a clinical policy and billing document, which includes information on how to bill for **EPSDT visits** that were conducted via telehealth (page 5).