Last Updated: February 28th, 2026

Prepared for:
Great Plains Telehealth Resource & Assistance Center

Telehealth Billing and Reimbursement Guide– North Dakota

Brought to you by:

gpTRAC
Great Plains Telehealth Resource & Assistance Center

Partnered with:

ruralMED
REVENUE CYCLE RESOURCES

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number G22RH30357. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

TABLE OF CONTENTS

Virtual Visit Types

- Telehealth
- E-visit
- Virtual Check-Ins
- Telephone

Payor Matrix

Payor Guidelines

- Aetna
- Blue Cross Blue Shield of North Dakota
- Cigna
- Medica
- Medicare
- North Dakota Medicaid
- Sanford Health
- United Healthcare

Rural Health Clinic/Federally Qualified Health Center

- Medicare
- Medicaid

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

TELEHEALTH

Definition:

There are two types of telehealth services:

- **Asynchronous Telehealth (Store & Forward)** is the transfer of digital images, sounds, or previously recorded video from one location to another to allow a consulting practitioner (usually a specialist) to obtain information, analyze it, and report back to the referring practitioner. This is a non-interactive telecommunication because the physician or health care practitioner views the medical information without the patient being present.
- **Synchronous Telehealth** is real-time interactive video teleconferencing that involves communication between the patient and a distant practitioner who is performing the medical service. The practitioner sees the patient throughout the communication, so that two-way communication (sight and sound) can take place.

CPT/HCPCS Codes:

Synchronous Audio/Video CPT Codes:

- **98000:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
- **98001:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98002:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
- **98003:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
- **98004:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded
- **98005:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
- **98006:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98007:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded

Other CPT/HCPCS are often eligible to be reported via synchronous audio/video telehealth (refer to payor guidelines section for specific code sets)

Synchronous Audio-Only CPT Codes:

- **98008:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
- **98009:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98010:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
- **98011:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded

- **98012:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded
- **98013:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
- **98014:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98015:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded

Place of Service Codes

POS 02: Telehealth Provided Other than in Patient's Home

- The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

POS 10: Telehealth Provider in Patient's Home

- The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care

Modifiers

Synchronous Telehealth Modifiers:

- **95**: synchronous telemedicine service rendered via real-time Interactive audio and video telecommunications system
- **GT**: Via interactive audio and video telecommunication systems
- **G0**: Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke
- **FQ**: The service was furnished using audio-only communication technology.
- **93**: Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system
- **FR**: The supervising practitioner was present through two-way, audio and video communication technology

Asynchronous Telehealth Modifier:

- **GQ**: Via an asynchronous telecommunications system

Reporting Criteria:

- Must be initiated by the patient
- Communication must be a direct interaction between the patient and the healthcare professional
- HIPAA compliant platform must be utilized

Documentation Requirements:

Telehealth services have the same documentation requirements as a face-to-face encounter. The information of the visit, history, review of systems, consultative notes, or any information used to make a medical decision about the patient should be documented. In addition, the documentation should note that the service was provided through telehealth, both the location of the patient and the provider, and the names and roles of any other persons participating in the telehealth visit, and the length of the call. Obtain consent at the start of the visit and ensure consent is documented. Maintain a permanent record of the telehealth visit in the patient's medical record.

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Definition:

Online Digital Evaluation and Management Services (E-Visits) are an E/M service provided by a Qualified Healthcare Professional or an assessment provided by a Qualified Nonphysician Healthcare Professional to a patient using an audio and visual software-based communication, such as a patient portal.

CPT/HCPCS Codes:

Reportable by a Qualified Healthcare Professionals:

- **99421**: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes.
- **99422**: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes.
- **99423**: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Reportable by Qualified Nonphysician Healthcare Professionals (Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists Registered Dietitian, etc.):

- **G2061/98970**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- **G2062/98971**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- **G2063/98972**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Reporting Criteria:

- Online visits must be initiated by the patient. However, practitioners can educate beneficiaries on the availability of e-visits prior to patient initiation.
- The patient must be established
- E-Visit codes can only be reported once in a 7-day period.
- Cannot report when service originates from a related E/M service performed/reported within the previous 7 days, or for a related problem within a postoperative period.
- E-Visits are reimbursed based on time.
    - The 7-day period begins when the physician personally reviews the patient's inquiry.
    - Time counted is spent in evaluation, professional decision making, assessment and subsequent management.
    - Time is accumulated over the 7 days and includes time spent by the original physician and any other physicians or other qualified health professionals in the same group practice who may contribute to the cumulative service time.
    - Does not include time spent on non-evaluative electronic communications (scheduling, referral notifications, test result notifications, etc.). Clinical staff time is also not included.

Documentation Requirements:

These are time-based codes, and documentation must support what the physician did and for how long. Time is documented and calculated over the 7-day duration and must meet the CPTs time requirement. Obtain verbal consent at the start of the visit and ensure the consent is documented. Maintain a permanent record of the telehealth visit in the patient's medical record.

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Definition:

A brief check in between a practitioner and a patient via telephone or other audiovisual device to decide whether an office visit or other service is needed. A remote evaluation is recorded video and/or images submitted by an established patient.

CPT/HCPCS Codes:

- **98016**: Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion
- **G2010**: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
- **G2250**: Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.
- **G2251**: Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion.
- **G2252**: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
- **G0071**: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only

Reporting Criteria:

- The patient must be established
- Communication must be a direct interaction between the patient and the practitioner. Not billable if performed by clinical staff.
- If the virtual check-in originates from a related E/M provided within the previous 7 days, then the service is considered bundled into that previous E/M and would not be separately billable.
- If the virtual check-in leads to an E/M within the next 24 hours or soonest available appointment, then the service is considered bundled into the pre-visit time of the associated E/M and would not be separately billable.

Documentation Requirements:

Documentation should include medical decisions made, names and roles of any persons participating in the evaluation, and the communication method (telephone, video/audio software, etc.). Obtain verbal consent at the start of the visit and ensure the consent is documented. Maintain a permanent record of the telehealth visit in the patient's medical record.

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Definition:

A telephone visit is an assessment and management service provided by a nonphysician qualified health care professional via audio telecommunication

CPT/HCPCS Codes:

Reportable by Qualified Nonphysician Healthcare Professionals (Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists Registered Dietitian, etc.):

- **98966:** Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided with the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- **98967:** Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided with the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
- **98969:** Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided with the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

Reporting Criteria:

- Call must be initiated by the patient
- Communication must be a direct interaction between the patient and the healthcare professional
- If the call originates from a related E/M or assessment provided within the previous 7 days, then the service is considered bundled into that previous E/M or assessment and would not be separately billable
- If the call leads to an E/M or assessment within the next 24 hours or soonest available appointment, then the service is considered bundled into the pre-visit time of the associated E/M or assessment and would not be separately billable
- The patient must be established

Documentation Requirements:

Documentation should include medical decisions made, the names and roles of any persons participating in the call, and the length of call. Obtain consent at the start of the visit and ensure the consent is documented. Maintain a permanent record of the telehealth visit in the patient's medical record.

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

PAYOR MATRIX

PAYOR	E-VISIT	TELEHEALTH-AUDIO/VIDEO	TELEHEALTH-AUDIO ONLY	VIRTUAL CHECK-IN
AETNA	CONDITIONAL Check Contracted Fee Schedule	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: GT, 95, FR	ALLOWABLE Allowable Codes: Audio Only Telehealth Eligible Code POS: 02 or 10 Modifier: 93, FQ	CONDITIONAL Check Contracted Fee Schedule
BCBS ND	ALLOWABLE 99421-99423 98970 -98972 POS 10	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: None Required	ALLOWABLE Allowable Codes: CPT 98008-98015 POS: 02 or 10 Modifier: 93	ALLOWABLE 98016 G2010 98966-98968 G2251-G2252 POS 10
CIGNA	NOT ALLOWABLE	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 Modifier: 95, GT	ALLOWABLE Allowable Codes: CPT 98008-98015 POS: 02 Modifier: Not Required	ALLOWABLE 98016
MEDICA	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: GT, 95	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 93, FQ	ALLOWABLE G2010 98016
MEDICARE	ALLOWABLE 99421-99423 G2061-G2063	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: Hospital Based Provider-95 Method II: Modifier GT RHC: G2025	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 93 Method II: Modifier GT RHC: G2025	ALLOWABLE 98016 G2010 G2250-G2252
ND MEDICAID	ALLOWABLE 99421-99423	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: Not Required	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 93	NOT ALLOWABLE
SANFORD HEALTH	CONDITIONAL Check Contracted Fee Schedule	ALLOWABLE Allowable Codes: Code on Provider's Fee Schedule POS: 02 or 10 Modifier: 95, FR, GT	CONDITIONAL Refer to Sanford Health Telehealth Reimbursement Policy	CONDITIONAL Check Contracted Fee Schedule
UHC COMMERCIAL	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 95 or GT	ALLOWABLE Allowable Codes: Audio Only Telehealth Eligible Code POS: 02 or 10 Modifier: 93	ALLOWABLE 98016 G2010 G2250-G2252

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Payor Specific Key Points

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Check Contracted Fee Schedule
- **Virtual Check-Ins**: Check Contracted Fee Schedule

Remote Patient Monitoring:

Allowable Codes:

- 98975, 98976, 98977, 98978, 98980, 98981, 99453, 99454, 99445, 99470, 99457, 99458

Interprofessional Codes:

Allowable Codes:

- 99446-99449, 99451, 99452, G9037, G0546-G0551

Modifier:

- No telehealth modifier required

Telehealth:

Allowable Services:
See table below for allowable code set

Audio Only Services:
Designated codes, highlighted in blue in the below “Telehealth Allowable Codes” matrix, can be performed via an audio only connection

Modifiers/POS:

- **POS** 02 or 10
- **Modifiers**
  - **Audio-Visual:** GT, 95, FR
  - **Audio-Only**: 93, FQ (only for codes that explicitly allow them)
  - **Asynchronous:** GQ
  - **Tele-Stroke**: G0

Direct Patient Contact:
Unless listed as a covered service, medical services that do not include direct in-person patient contact are not payable

Reimbursement:
Refer to contracted fee schedule

Not Reimbursable:.

- Care Plan Oversight (Except if authorized by Patient Management)
- Concierge Medicine (boutique medicine)
- Missed appointments

Transmission & Originating Site Fees:
T1014 and Q3014 are not eligible for payment, Aetna considers these services as incidental to the charges associated with the E/M.

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

AETNA ELIGIBLE TELEHEALTH CODES													
Telehealth Allowable Codes													
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	90846	90847
90849	90853	90863	90951	90952	90954	90955	90957	90958	90960	90961	90963	90964	90965
90966	90967	90968	90969	90970	92227	92228	92507	92508	92521	92522	92523	92524	92526
92601	92602	92603	92604	93228	93229	93268	93270	93271	93272	94664	96041	96105	96110
96112	96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138	96139
96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171	97110	97112	97116
97129	97130	97151	97153	97155	97156	97157	97161	97162	97163	97164	97165	97166	97167
97168	97530	97535	97750	97755	97760	97761	97802	97803	97804	98960	98961	98962	99202
99203	99204	99205	99211	99212	99213	99214	99215	99231	99232	99233	99252	99253	99254
99255	99307	99308	99309	99310	99406	99407	99408	99409	99417	99418	99446	99447	99448
99449	99451	99452	99483	99495	99496	99497	99498	C7900	C7901	C7902	G0108	G0109	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0425	G0426	G0427	G0438
G0439	G0442	G0443	G0444	G0445	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087
G2088	G2212	G3002	G3003	H0015	H0035	H0038	H2012	H2036	S9443	S9480	97152	97154	97158
97542	98000	98001	98002	98003	98004	98005	98006	98007					
Cells Highlighted in Yellow do **NOT** Require a Modifier Codes in Blue are Allowable via an audio-only connection													

Reference:

- Telemedicine and Direct Patient Contact Payment Policy available on Availity

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423, 98970-98972
- **Virtual Check-In**: 98016, 98966, 98967, 98968, G2010, G2251, G2252

Separate payment will be made if:

- POS is 10
- Service was not initiated from a related E/M service provided within the previous 7 days
- Service did not lead to a related E/M service or procedure within the next 24 hours or soonest available appointment

If the billing provider submits an Online Digital Visit, Brief Virtual Check-In, or an E/M service without modifier 25 with a date of service within seven days from another Online Digital Visit, Virtual Check-In, or an E/M service the first claim received will receive reimbursement. The second claim without a modifier 25 will be rejected as the service has been unbundled.

Remote Patient Monitoring:

Remote Patient Monitoring is approved when the following criteria are met:

- Prescribed or administered by a board-eligible or board-certified medical provider or subspecialist
- Physiologic data are electronically collected and automatically uploaded to a secure location for analysis and interpretation
- Technology used has been FDA approved, cleared, or has an emergency use authorization designation.

Documentation:

Medical records should include the following:

- Physician order
- All online communications relevant to the ongoing medical care of the individual
- Support for the medical necessity of continued use of remote patient monitoring
- Results of the monitoring and how it is used for medical decision making
- Physician interpretation of the physiological or psychological data
- In a given 30-day period, at least 16 days of data should be available

Ongoing benefits are dependent upon measurable clinical improvements in acute symptoms and stabilization of the individual's acute symptoms.

Codes:

- **Remote Patient Monitoring**: 99091, 99453, 99454, 99457, 99458, 99473, 99474, G0322
- **Remote Therapeutic Monitoring**: 98975, 98976, 98977, 98978, 98979, 98980, 98981, 98984, 98985, 98986, 99445, 99470, 1008T

Telehealth:

Allowable Services:

Telehealth services may be rendered and billed if they meet all criteria of the CPT/HCPCS code rendered. Services include, but are not limited to, the following:

- Electronic connections that are conducted over a secure encrypted web site as specified by HIPAA
- Audio-only telephone for e-visits or virtual check-ins (all other Audio-only are non-covered)
- Physical therapy (PT)
- Occupational therapy (OT)

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

- Speech therapy
- Behavioral health and substance use disorder treatment/therapies (including group)
- Applied Behavioral Analysis (ABA)
- Diabetes education
- Nutrition counseling
- Lactation counseling
- Chiropractic Services included but not limited to: consultations, range of motion assessments, therapeutic exercise prescription, gait training, neuromuscular reeducation, history intake and assessment, etc.
- Dental Care; excluding dental procedures
    - A dentist may not practice telehealth unless a bona fide dentist-individual relationship is established in person or through telehealth.

Providers may report E/M telehealth codes [98000 – 98015] which distinguish between audio-visual and audio-only visits. Providers must report POS 02 or 10 with these Telehealth codes or the services will be rejected

Providers are not allowed to report Distant Site services on the UB-04 Claim Form

Administrative Requirements:

Providers delivering telehealth services should follow the technical and administrative guidelines established by the American Telemedicine Association and applicable standards from relevant professional organizations.

Telehealth services must generally include real-time audio and visual communication between the provider and the member. E-visits and Virtual Check-Ins may be performed using audio-only communication when video is unavailable. Modifier 95 should be appended to services delivered via audio-visual communication. Telehealth services are only covered if the service is also covered when provided in person.

Member-initiated online visits through consumer devices (e.g., mobile apps, kiosks, or EHR portals) may be eligible for coverage if included in the member's benefit plan. A HIPAA-compliant connection must be used for all telehealth encounters.

Documentation must support medical necessity and include the location of the member and provider, the telehealth modality used (e.g., synchronous or store-and-forward), and the originating site when applicable. Providers must be licensed and practicing within the scope of their licensure in the state where services are delivered.

Audio Only Services:
The video component is required for telehealth. E-visits and Virtual Check-Ins can be performed via an audio only communication when face-to-face communication is unavailable.

- However, BCBS of ND notes allowed utilization of CPT 98008-98015, representing audio only visits

Modifiers/POS:

- **POS** 02 or 10
- **Modifier**
    - **Audio-Visual:** 95*
    - **Audio Only:** 93
- **Facility Claims:** Providers are not allowed to report distant site services on the UB-04 claim form

*Effective for dates of service January 1, 2025, providers are no longer required to report modifier 95 for distant site telehealth reimbursement consideration

Not Covered:

- Audio-only telephone, e-mail, text messages, communication through patient portal, or facsimile transmissions
    - The following services are allowed for Audio-Only: e-visits & virtual check-ins.
- Provider to provider consultation
- The following Chiropractic Services:
    - Spinal manipulative therapy
    - Manual therapy

ruralMED REVENUE CYCLE RESOURCES
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

- Dental Procedures
- Acupuncture
- G0071, G0546, G0547, G0548, G0549, G0550, G0551, G2250, 994646, 99447, 99448, 99449, 99451, 99452

Reimbursement:
Payments for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated, if appropriate, using the appropriate facility or non-facility components, based on the site of service identified, as submitted by the provider.

Provider Type:
Practitioners at the distant site who may furnish covered telehealth services (subject to State law) are those providers licensed, registered or certified by the appropriate state agency where the services are performed and provided in accordance with the provider's scope of licensure as provided by law. Where there is no appropriate state agency, the provider must be registered or certified by the appropriate professional body.

Transmission & Originating Site Fees:
Separate payment will be made if the patient is physically present at an originating site location such as a clinic or facility setting. Separate payment for the originating site location where the patient is participating with a distant site practitioner will not be reimbursed if it is the patient's home, community setting, or other non-provider owned location

- Report Q3014 with POS code reflecting the location of the patient on a 1500 when the patient is not in a hospital place of service
- Report Q3014 with revenue code 0780 on a UB when the patient is in a hospital place of service

Reference:
BCBS of ND Telehealth Reimbursement Policy
BCBS of ND Telehealth Medical Policy
BCBS of ND Remote Patient Monitoring (RPM)

ruralMED REVENUE CYCLE RESOURCES
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** Not Allowable
- **Virtual Check-Ins:** 98016

Interprofessional Consultations:

Cigna recognizes E-Consult codes, which occurs when a treating health provider seeks guidance from a specialist physician through electronic means (phone, internet, EHR consultation, etc.)

- **Allowable Codes:** 99446-99452
- **Non-Billable:**
  - If the consultation to a transfer of care or other face-to-face service (e.g., a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes should not be billed.
  - If the consultation lasted less than 5 minutes.
  - If the consultation was for the sole purpose to arrange transfer of care or a face-to-face visit.

Remote Patient Monitoring:

Cigna recognizes remote patient monitoring, which is the use of digital technologies to monitor and capture medical data from patients and electronically transmit this information to healthcare providers for assessment:

- **Allowable codes:** 99091, 99453, 99454, 99457, 99458, G0322
- Coverage Policy 0563- Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

Telehealth Medical:

Allowable Services:

See below table for allowable medical telehealth codes

Audio Only:

An audiovisual connection is required, except for audio-only telehealth E/M CPT 98008-98015

All of the following must also be met:

- Services must be interactive and use both audio and video internet-based technologies, and would be reimbursed if the service was provided face-to-face
  - Exception for CPT 98008-98015
- The patient or involved caregiver must be present on the receiving end and the service must occur in real time
- All technology used must be secure and meet or exceed federal and state privacy requirements
- A permanent record of online communications relevant to the ongoing medical care and follow-up is maintained as part of the record as if the service were provided as an in-office visit
- The permanent record must include documentation which identifies the virtual service delivery method. i.e.: audio/video or telephone only
- All services provided are medically appropriate and necessary
- The evaluation and management services (E/M) provided virtually must meet E/M criteria
- The patient's clinical condition is of low to moderate complexity, and while it may be an urgent encounter, it should not be an emergent clinical condition
- Virtual care services must be provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.

Excluded Services:

- The virtual care service occurs on the same day as a face to face visit, when performed by the same provider and for the same condition.
- Transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

- Virtual care services billed within the post-operative period of a previously surgical procedure will be considered part of the global payment for the procedure.
- Services were performed via asynchronous communications systems (e.g., fax).
- Store and forward telecommunication, whether an appropriate virtual care modifier is appended to the procedure code or not.
- Patient communications are incidental to E/M services, counseling, or medical services, including, but not limited to reporting of test results and provision of educational materials.
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
- No reimbursement will be made for any equipment used for virtual care communications.

Telehealth Behavioral Health:

Allowable Services:
See below table for allowable medical telehealth codes.

All of the following must also be met:

- Services must be interactive and use audio and/or video internet-based technologies (synchronous communication), and would be reimbursed as if the service was provided face-to- face
- The patient and/or actively involved caregiver must be present on the receiving end
- All technology used must be secure and meet or exceed federal and state privacy requirements.
- A permanent record of online communications relevant to the ongoing care and follow- up is maintained as part of the medical record as if the service were provided as an in-office visit
- The permanent record must include documentation which identifies the virtual service delivery method. I.E.: audio/video or telephone only
- All services provided are medically appropriate and necessary
- The evaluation and management services (E/M) provided virtually must meet E/M criteria
- While some aspects of care in an acute setting may be rendered virtually, exclusively virtual services should be limited to situations when the clinical condition is low to moderate complexity and not the primary intervention for an emergent clinical condition.
- Virtual care services must be provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.

Excluded Services:

- The virtual care service occurs on the same day as a face to face visit, when performed by the same provider and for the same condition.
- Transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.
- Patient communications are incidental to E/M services, counseling, or medical services, including, but not limited to reporting of test results and provision of educational materials
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
- No reimbursement will be made for the originating site of service fee or facility fee, unless otherwise mandated by state or federal law
- No reimbursement will be made for any equipment used for virtual care communications.

Modifiers/POS:

- **POS** 02
    - Do not bill POS 10 until further notice
- **Modifier**
    - **Audio-Visual**: GT, 95
    - **Audio-Only**: 93
    - **Asynchronous**: GQ

ruralMED REVENUE CYCLE RESOURCES
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Provider Type:
Providers who are licensed, registered, or otherwise acting within the scope of their licensure may provide telehealth services.

Reimbursement:
Refer to contracted fee schedule

Transmission & Originating Site Fees:
Cigna will not reimburse an originating site of service fee/facility fee for telehealth visits (HCPCS Q3014). Cigna will also not reimburse transmission fees; transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.

CIGNA MEDICAL ELIGIBLE VIRTUAL CODES												
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92507	92508	92521	92522	92523	92524
92601	92602	92603	92604	96041	96112	96113	96116	96156	96158	96159	96160	96161
96164	96165	96167	96168	97110	97112	97161	97162	97163	97164	97165	97166	97167
97168	97530	97755	97760	97761	97802	97803	97804	99202	99203	99204	99205	99211
99212	99213	99214	99215	99406	99407	99408	99409	99404	99411	99412	99495	99496
99497	99498	G0108	G0151	G0152	G0153	G0155	G0157	G0158	G0270	G0296	G0299	G0300
G0396	G0397	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447	G0493	G0513	G0514
98016	S9123	S9128	S9129	S9131	S9152	99446	99447	99448	99449	99451	99452	99381
99382	99383	99384	99385	99386	99387	99391	99392	99393	99394	99395	99396	99397
99401	99402	99403	98000	98001	98002	98003	98004	98005	98006	98007	98008	98009
98010	98011	98012	98018	98014	98015							

NON-REIMBURSABLE CODES REGARDLESS OF MODIFIER												
98966	98967	98968	98970	98971	98972	99421	99422	99423	G0406	G0407	G0408	G0425
G0426	G0427	G0459	G0508	G0509	G2025	Q3014	S0320	T1014				

CIGNA BEHAVIORAL HEALTH ELIGIBLE VIRTUAL CODES												
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	90846
90847	90849	90853	90863	90875	90876	90880	96110	96127	96156	96158	96159	96164
96165	96167	96168	96170	96171	97151	97152	97153	97154	97155	97156	97157	97158
99058	99078	99202	99203	99204	99205	99211	99212	99213	99214	99215	99217	99218
99219	99220	99221	99222	99223	99224	99225	99226	99231	99232	99233	99234	99235
99236	99238	99239	99281	99282	99283	99284	99285	99304	99305	99306	99307	99308
99309	99310	99315	99316	99318	99324	99325	99326	99327	99328	99334	99335	99336
99337	99354	99335	99336	99337	99354	99355	99356	99357	99404	99408	99409	99415
99416	99417	H2011	S0201	S9480	99446	99447	99448	99449	99456	99484	99495	99496
0591T	0592T	G0410	H0015	H0035	H0038							

References:

- Reimbursement Policy- Virtual Care and Remote Patient Monitoring

ruralMED REVENUE CYCLE RESOURCES
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Payor Specific Key Points:

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423, 98970-98972, G2061-G2063
- **Virtual Check-In:** G2010, 98016

Telehealth:

Telehealth Allowable Codes:

Interactive audio and video communications that permit real-time communication between the distant site physician or practitioner and the member. The services must be of sufficient audio and visual fidelity with clarity and function equivalent to a face-to-face encounter

See table below for specific codes.

- **Wellness Visits:** Medica will temporarily allow preventive care services, CPT 99381-99387 and 99391-99397, to be provided via telehealth services. Providers may perform all, or portions of, a preventive medicine visit that can be done so appropriately via telehealth services. Services that require face-to-face interaction may be provided later, however, providers may only bill one preventive medicine code to cover both the portion done via telehealth and any necessary face-to-face interaction associated with the preventive care service.

- **Behavioral Health:**
  - For more information regarding telemental health refer to the Telemental Health Services - Commercial

Store and Forward Telehealth:

Medica allows asynchronous (store and forward) telehealth. Utilize modifier GQ. Medical information may include without limitation: video clips, still images, X-rays, MRIs, EKGs, laboratory results, audio clips and text. The physician at the distant site reviews the case without the member being present. Store and Forward substitutes for an interactive encounter with the member present (i.e., the member is not present in real-time).

Audio Only:

Audio only allowable codes defined in the below *Medica Eligible Telehealth Code list*

Modifiers/POS:

- **POS** 02 or 10
- **Modifier**
  - **Audio-Visual:** GT, 95
  - **Audio-Only**: 93, FQ
  - **Asynchronous:** GQ
  - **Tele-Stroke**: G0

Provider Type:

Audiologist, Certified Genetic Counselor, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist, Licensed Drug & Alcohol Counselor, Dentist, Nurse Midwife, Nurse Practitioner, Occupational Therapist, Physical Therapist, Physician, Physician Assistant, podiatrist, Registered Dietitian or Nutrition Professional, and Speech Therapist.

Reimbursement:

Refer to contracted fee schedule

Originating Sites:

The following are examples of originating sites: Community mental health center, Critical-access hospital (CAH), End stage renal disease (ESRD) facilities, Home, Hospital (inpatient or outpatient), Hospital or CAH-based renal dialysis

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

center (including satellites), Office of physician or practitioner, Other eligible medical facilities, Other locations as required by applicable state law, Residential substance abuse treatment facility, Rural health clinic (RHC) and federally qualified health center (FQHC), Skilled nursing facility (SNF)

Transmission & Originating Site Fees:
Transmission fees (HCPCS T1014) are not eligible for payment, however Medica will allow an originating site fee (HCPCS Q3014) to be billed by an originating site facility.

Coverage Limitations:
Provider initiated e-mail, refilling or renewing existing prescriptions, scheduling a diagnostic test or appointment, clarification of simple instructions or issues from a previous visit, reporting test results, reminders of scheduled office visits, requests for a referral, non-clinical communication, educational materials, brief follow-up of a medical procedure without indication of complication or new condition including, but not limited to, routine global surgical follow-up, brief discussion to confirm stability of the patient's without change in current treatment, when information is exchanged and the patient is subsequently asked to come in for an office visit, a service that would similarly not be charged for in a regular office visit, consultative message exchanges with an individual who is seen in the provider's office immediately afterward, communication between two licensed health care providers that consists solely of a telephone conversation, email or facsimile, communications between a licensed health care provider and a patient that consists solely of an e-mail or facsimile

References:

- Reimbursement Policy: Telehealth excluding Minnesota Health Care Program (MHCP) Members
- Reimbursement Policy: Telephone and Virtual Care Services

MEDICA ELIGIBLE TELEHEALTH CODE LIST											
0362T	0373T	0591T	0592T	0593T	77427	87633	90785	90791	90792	90832	90833
90834	90836	90837	90838	90839	90840	90845	90846	90847	90853	90863	90875
90901	90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961
90962	90963	90964	90965	90966	90967	90968	90969	90970	92002	92004	92012
92014	92227	92228	92507	92508	92521	92522	92523	92524	92526	92550	92552
92553	92555	92556	92557	92563	92565	92567	92568	92570	92587	92588	92601
92602	92603	92604	92607	92608	92609	92610	92625	92626	92627	93228	93229
93268	93750	93270	93271	93272	93298	93797	93798	94002	94003	94004	94005
94625	94626	94664	95970	95971	95972	95983	95984	96040	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961
98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99242	99243	99244	99245	99252	99253	99254	99255	99281	99282	99283	99284
99285	99291	99292	99304	99305	99306	99307	99308	99309	99310	99315	99316
99341	99342	99344	99345	99347	99348	99349	99350	99406	99407	99408	99409
99417	99418	99441	99442	99443	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0136
G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420
G0421	G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445
G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211
G2212	G3002	G3003	G9685	Q3014							
Codes in blue may be performed via an audio-only connection											

ruralMED REVENUE CYCLE RESOURCES
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Payor Specific Key Points:

E-Visits/ Virtual Check Ins:

Allowable Codes:

- **E-Visits:** 99421-99423, G2061-G2063
- **Virtual Check-In**: G2010, 98016, G2250-G2252

Modifiers: None

Telehealth:

Consolidated Appropriations Act, 2026

Extends certain telehealth flexibilities for Medicare patients through December 31st, 2027

- **Medicare Beneficiary Location**: Patients can receive Medicare telehealth services, regardless of patient location in the United States
- **Medicare Telehealth Practitioners Type**: An extended range of practitioners may bill for telehealth services, including physical therapists, occupational therapists, speech-language pathologists, and audiologists
- **Hospital-Based Outpatient Therapy, Diabetes Self-Management Training, and Medical Nutrition Therapy:** Hospitals may bill for certain outpatient therapy services, diabetes self-management training, and medical nutrition therapy services furnished remotely by hospital staff
- **In-Person Mental Health Visit Requirements:** Delayed in-person visit requirements for behavioral health services provided via telehealth
- **RHC & FQHC Distant Site:** RHCs and FQHCs may continue to bill for non-behavioral health services furnished through interactive telehealth

Allowable Codes:

See table below for codes allowable via telehealth

- Effective January 1st, 2026, CMS permanently removed the application of telehealth frequency limits on subsequent inpatient and nursing facility visits and critical care consultations

Audio Only:

Beneficiaries may continue to receive audio-only telehealth services in their homes through December 31, 2027

- Audio-only can be used for both new and established patients
- Utilized when the patient is not capable of or does not consent to using audio-video communication technology
- Provider must be technically capable of using audio-video communication technology
- Beneficiaries who are receiving remote mental health services, as defined in the CY 2023 and 2024 OPPS Final Rules, furnished by hospital-employed staff in their homes may also receive these services via audio-only communication technology
- Starting January 1, 2028, providers may only use audio-only communication technology for behavioral health services furnished to a patient in their home

Consent:

Providers may get patient consent at the same time they initially provide the services. Direct supervision isn't required to get consent. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for these services.

***Hospital Based Providers*:**

Hospitals and other providers of PT, OT, SLP, diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services can continue to bill for telehealth services through December 31st, 2027

- For outpatient hospitals, patients' homes no longer need to be registered as provider-based entities to allow for hospitals to bill for these services

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

- The 95 modifier is required on claims from all providers, except for Critical Access Hospitals (CAHs) electing Method II (which utilize a GT modifier)

Medicare Shared Savings Program Accountable Care Organizations (ACOs)

- The Bipartisan Budget Act of 2018 allows clinicians participating in certain Medicare Shared Savings Program (MSSP) ACOs to provide and receive payment for covered telehealth services without geographic restrictions, including services furnished in the beneficiary's home
    - These flexibilities apply only to applicable ACOs with prospective beneficiary assignment in the ENHANCED track or BASIC track Levels C–E, and services must be billed under the ACO participant's TIN for assigned beneficiaries
    - ACOs using retrospective assignment and non-risk ACOs do not qualify and must follow standard Medicare fee-for-service telehealth rules

Modifiers/POS:

- **POS:**
    - 02 or 10
- **Modifier:**
    - Modifier 95
        - Required when the clinician is in the hospital, and the patient is in the home, as well as for outpatient therapy services provided via telehealth by qualified PTs, OTs, or SLPs through December 31st, 2027
    - Modifier GT for CAH Method II (UB) Claims

Patient Location:

Through December 31st, 2027, there is no originating site or geographic restriction

Mental Health Place of Service:

CMS permanently added a patient's home as an originating site for patients receiving mental health services via telehealth. "Home" includes temporary lodging. Must meet the following requirements:

- The provider (or another provider in the same practice and subspecialty) has conducted an in-person (non-telehealth) visit within 6 months
- After the initial tele-mental health visit, the provider must conduct an in-person visit at least once every 12 months
    - However, this visit is not required if the patient and provider consider the risks of an in-person visit and agree that the risks outweigh the benefits
    - Provider should document the decision in the patient's medical record
- Through December 31st, 2027, the initial 6 month visit requirement and the in person visit every 12 month requirement, is waived

Provider Type:

Allowable telehealth providers are physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, marriage and family therapists, mental health counselors, and nutrition professionals

- Through December 31st, 2027, physical therapists, occupational therapists, speech-language pathologists, and audiologists to provide Medicare telehealth services

Provider Location:

Practitioners who furnish telehealth services from their homes but have a physical practice location are not required to report their home address on their Medicare enrollment application. Practitioners can enroll and bill from their physical practice location as if they furnished the telehealth service in person. Virtual-only telehealth practitioners whose only physical practice location is their home address will need to enroll their home address as a practice location.

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Reimbursement:
When telehealth services are provided to people in their homes (POS 10), the service will be reimbursed at the non-facility rate. If the telehealth service is provided when the patient is not in their home, and POS 02 is utilized, then the service will be reimbursed at the facility rate.

Rural Health Clinics & Federally Qualified Health Centers:
See the RHC and FQHC section for specific billing regulations

Supervision:
Effective January 1, 2026, the presence of the physician (or other practitioner) required for direct supervision may include virtual presence through audio/video real-time communications technology (excluding audio-only) for services without a 010 or 090 global surgery indicator

- Applies to services where direct supervision is required which do not have a 010 or 090 global surgery indicator
    - Includes most incident-to services under § 410.26, many diagnostic tests under § 410.32, pulmonary rehabilitation services under § 410.47, cardiac rehabilitation and intensive cardiac rehabilitation services under § 410.49, and certain hospital outpatient services as provided under § 410.27(a)(1)(iv)

Teaching Physicians:
CMS will allow teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service was furnished virtually, on a permanent basis

Transmission/ Originating Site Fees:

Medicare will reimburse an originating site fee (HCPCS Q3014) if the patient is present at a healthcare facility. Medicare does not reimburse for transmission fees.

- Modifier 95 not required when billing Q3014

MEDICARE ELIGIBLE TELEHEALTH CODES											
2026 Telehealth Codes											
0362T	0373T	0591T	0592T	0593T	77427	90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	90845	90846	90847	90853	90875	90901	90951
90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92002	92004	92012	92014	92507
92508	92521	92522	92523	92524	92526	92550	92552	92553	92555	92556	92557
92563	92565	92567	92568	92570	92587	92588	92601	92602	92603	92604	92607
92608	92609	92610	92625	92626	92627	93750	93797	93798	94002	94003	94004
94005	94625	94626	94664	95970	95971	95972	95983	95984	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961
98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307	99308
99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349	99350
99406	99407	97550	97551	97552	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0136

ruralMED REVENUE CYCLE RESOURCES
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420
G0421	G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445
G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211
G2212	G3002	G3003	G9685	96202	96203	G0011	G0013	G0539	G0540	G0541	G0542
G0543	G0560	90849	92622	92623	G0473	G0545					

Reference:

MLN Matters-Telehealth Services
SE22001 Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
CMS Telehealth FAQ 2026
Consolidated Appropriations Act, 2026
CMS Telehealth Services List

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423
- **Virtual Check-In**: Not allowable

Digital E/M Services: Cumulative online digital evaluation and management (E/M) services occurring within a seven-day period beginning with the health care professional's review of the patient generated inquiry. Included services not separately billable:

- For the same or a related problem within seven days of a previous E/M service
- Related to a surgical procedure occurring within the postoperative period of a previously completed procedure
- Any subsequent online communication that does not include a separately reported E/M service.
- E/M services related to the patient's inquiry provided by qualified health care professionals in the same group practice.

Separate reimbursement may be allowed for:

- Online digital inquiries initiated for a new problem within seven days of a previous online digital E/M service.

Permanent documentation storage (electronic or hard copy) of the encounter is required.

Interprofessional Telephone/Internet/Electronic Record Assessment & Management Services:

Allows treating providers to consult with a specialist to assist the treating provider in diagnosis and/or management of a patient's health condition without requiring the patient to have face-to-face contact with the specialist. Specialists bill their consultation time with these codes. These services are limited to four per member per year.

Codes:

- 99447, 99448, 99451, 99452

Service Requirements:

- Both the treating practitioner and the consultant must be enrolled in ND Medicaid
- Consultations must directly related to the patient's diagnosis and treatment; for the patient's direct benefit, and documented
- Review of patient records and reports is included in this service

Treating practitioners and consultants must follow all state and federal privacy laws regarding patient privacy and the exchange of patient information.

Non-Reportable Service:

Do not report this service if:

- Direct specialty care is clinically indicated
- Consultant has seen the patient in a face-to-face encounter in the last 14 days
- The consultation leads to a transfer of care or other face-to-face service within the next 14 days or the next available appointment date of the consultant
- Greater than 50% of the service time is devoted to data review and/or analysis (for codes 99446-99449 only)

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Telehealth:

Allowable Codes:

Synchronous Audio-Video Outpatient E/M Services: Utilize CPT 98000-98007

- Do not report CPT E/M services 99202-99215 when the service was performed via telehealth
  - The only exception is for claims that Medicare has processed as the primary payer. Medicare does not recognize CPT 98000-98015 and requires them to be billed under regular E/M codes.

The Procedure Code Look-up Tool should be utilized to verify if specific codes can be delivered via telehealth

- Examples include, but are not limited to, the following: 1915i Services; Behavioral Health Services; Diabetes Self-Management and Training; ESRD Services; Medical Nutrition Therapy; Medication Therapy Management (MTM) Services; Occupational Therapy Services; Physical Therapy Services; Speech Language Pathology Services; Smoking Cessation; Substance Use Disorder Services; Telehealth Consultations: Emergency Department or Inpatient Care

Audio Only Services:

Synchronous Audio-only E/M Services: Utilize 98008-98015

Use the Procedure Code Look-up Tool to verify if a service can be rendered audio-only

General Provider Policies:

All qualified telehealth services must:

- Meet the same standard of care as in-person care
- Be medically appropriate and necessary, with supporting documentation included in the patient's clinical medical record
- Be provided with secure and appropriate equipment to ensure confidentiality and quality in the delivery of the service. The service must be provided using a HIPAA-compliant platform
- Health care professionals must follow CPT coding guidelines
- A telecommunications system may include two-way, real-time, audio-only communication technology for any Medicaid telehealth service furnished to a member in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology. The reason for audio-only must be documented in the medical record for the service. Use the Procedure Code Look-up Tool to verify if a service can be rendered audio-only.

Documentation:

Originating site documentation is required for originating sites that are eligible for reimbursement. North Dakota Medicaid does not require documentation to be maintained for originating sites that are not eligible for reimbursement. The originating site must document the physical location of the recipient and provider at the time the services were provided. The originating site must also document if a nurse or other healthcare professionals were present and provided any services, such as checking vitals. The distant site must document the physical location of the recipient and provider at the time the services were provided. The distant site provider must follow the documentation requirements in the Provider Requirements Policy.

Modifiers/POS:

- **POS** 02 or 10
- **Modifier**
  - Audio Visual: Not Required
  - Audio Only: 93
- **Facility (UB) Claims**: Revenue code 780 with modifier GT, 95, 93

Non-Covered Services:

- Store and Forward – G2010
- Virtual Check-In – 98016
- Interprofessional services – 99446, 99499
- Digital Assessment and Management Services – 98970-98972

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Reimbursement
A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement. Payment will be made only to the distant health care professional during the telehealth session. No payment is allowed to a professional at the originating site if their sole purpose is the presentation of the patient to the professional at the distant site

Transmission & Originating Site Fees:
Payment will be made to the originating site as a facility fee only in the following places of service: office, inpatient hospital, outpatient hospital, or skilled nursing facility/nursing facility. There is no additional payment for equipment, technicians, or other technology or personnel utilized in the performance of the telehealth service.

- **Professional (1500) Claims:** HCPCS Q3014, with POS 02 or 10
- **Facility (UB) Claims**: HCPCS Q3014 with revenue code 780

Reference:

- ND Telehealth Policy

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes

- **E-Visits**: Check Contracted Fee Schedule
- **Virtual Check-In**: Check Contracted Fee Schedule

E-Visit Requirements

Evaluation, management, and consultation services using asynchronous technologies (any type of online patient-provider consultation where electronic information is exchanged involving the transmission via secure servers) may be covered when **ALL** of the following criteria are met:

- Services shall be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession, as evidenced by the credentialing and licensing requirements of Sanford Health Plan
- The extent of services provided via telemedicine modality includes at least a problem focused history and straight forward medical decision making
- Services should not be billed more than once within 7 days for the same episode of care or be related to an evaluation and management service performed within 7day
- E-visits billed within the post-operative period of a previously completed major or minor surgical procedure will be considered part of the global payment for the procedure and not paid separately

Telemonitoring:

Telemonitoring is covered for patients who have a history of cardiac conditions including heart failure (HF) and hypertension, COPD, uncontrolled diabetes, and mental health and/or substance use disorders (MH/SUD):

- Recent hospitalized or hospitalization(s) with a primary diagnosis of HF/COPD/CV conditions/Diabetes/MH/SUD
- A history of failing to adhere to their treatment plan and are at risk for an acute episode
- ED visits in the recent past for treatment of cardiac conditions including heart failure and hypertension, COPD, uncontrolled diabetes, mental health and/or substance use disorders
- The above conditions along with renal failure as defined as GFR<30, hepatic failure or coronary disease that puts the patient at risk for myocardial function compromise
- Major system co-morbid conditions that complicate their chronic disease status (i.e. heart failure, renal failure, diabetes and respiratory illness)

Telehealth:

Allowable Services:

Telehealth E/M services provided over an audio/visual connection are covered when all the following are met:

- Services are medically appropriate and necessary
- Patient is present at time of consultation
- The consultation takes place via interactive audio and/or video
- Permanent record of the telemedicine communications relevant to the ongoing medical care of the patient is maintained as part of the medical record
- Services delivered through a telemedicine modality shall be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located
- Appropriate informed consent is obtained

Controlled substances may be prescribed through a telehealth encounter but are subject to certain limitations:

- Controlled substances may be prescribed by a provider so long as a bona-fide
- relationship with the patient is established. Opioids can only be prescribed through telehealth as

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

- medication-assisted treatment (MAT) as approved by the FDA, or the patient is a patient in a hospital
- or long-term care facility. The provider must be enrolled in the North Dakota prescription drug
- monitoring program
- The medical examination of the patient must be under the control of the consulting provider
- A permanent record of online communications relevant to the ongoing medical care of the patient should be maintained as part of the patient medical record

Examples of Telehealth Services: Office or outpatient visits, consultations (office, Internet-based, outpatient, emergency room), follow-up inpatient consultations, subsequent hospital care services, subsequent nursing facility services, pharmacologic management, treatment services for mental health and/or substance use disorders, neurobehavioral status exam, end stage renal disease (ESRD) related services, individual and group medical nutrition therapy, individual and group health and behavior assessment and intervention, individual and group kidney disease education (KDE) services, individual and group diabetes self-management training, smoking cessation services, high-intensity behavioral counseling to prevent sexually transmitted infections, annual face-to-face intensive behavioral therapy for cardiovascular disease or face-to-face behavioral counseling for obesity

Audio Only Services:
Refer to Sanford Telehealth Policy for additional information regarding audio only services

Modifiers/POS:
- **POS** 02 or 10
- **Modifier** GT, FR, GQ, 93 or 95

Non-Covered
Services for excluded benefits or diagnoses excluded from policy, services not medically necessary, services that cannot be performed adequately via telehealth for the medical condition, telecommunication devices or systems (including installation or maintenance), provider-initiated e-mail, appointment scheduling, a service that would similarly not be charged for in a regular office visit, reminders for scheduled office visits, referral requests, consultative message exchanges with an individual seen in the provider's office on the same day as a telehealth visit for the same condition, clarification of simple instructions, naturopaths/homeopaths, services furnished using audio-only communication technology, dental care, acupuncture, chiropractic care, telephone, remote in-home visits, transmission fees, supplies

Provider-Patient Relationship
As a prerequisite to providing telehealth services to a patient, a provider-patient relationship must be established. A provider-patient relationship encompasses several parameters:
- Verify and authenticate the location and identity of the patient
- Disclosing and validating provider's identity and applicable credentials
- Obtaining consent for treatment
- Establishing a diagnosis through review of patient history, mental status, and appropriate diagnostic/laboratory testing
- Discussing the diagnosis and its evidentiary basis to the patient, including the risks and benefits of different treatment options
- Ensure appropriate follow-up care for the patient
- Providing a visit summary to the patient

However, a provider-patient relationship need not be established when the patient is seeking urgent or emergent care, care is given through cross-coverage, or when the patient's primary care physician agrees to monitor the patient's care and emergency treatment

ruralMED REVENUE CYCLE RESOURCES
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Originating Site: The office of a physician or practitioner, hospitals (inpatient or outpatient), critical access hospitals (CAHs), rural health clinics (RHCs), federally qualified health centers (FQHCs), hospital- or CAH-based renal dialysis centers (including satellites), skilled nursing facilities (SNFs), ambulatory surgical centers (ASCs), laboratories, and community mental health centers (CMHCs). Additionally, Sanford Health Plan allows Video Visits via internet initiated by patient or group homes

- Sanford Health defines a "Video Visit" as: video interactions between a patient and provider, where the patient is at home or work on a web camera speaking with a provider. Access points may include mobile smart phones, tablets, or computers.
- The originating site of the patient is determinative of whether the provider may continue care. If the originating site is a state where the provider is licensed, the call may continue. However, should it become known that the originating site is somewhere other than where the provider is licensed, the telehealth/telemedicine call must be terminated.

Reimbursement
Refer to contracted feel schedule

Transmission & Originating Site Fees:
An originating site fee is eligible for reimbursement if allowable originating healthcare site. Transmission fees are not allowable

Reference:

- Sanford Policy Health Plan Telehealth Benefit Reimbursement

Note: Sanford's telehealth policy is not publicly available. Therefore, the information provided above reflects prior policy information referenced in 2024. For the most current policy details, including billing requirements and reimbursement guidance, please refer to the Sanford Telehealth Policy available through the Sanford provider portal.

ruralMED REVENUE CYCLE RESOURCES
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Payor Specific Key Points:

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 98970-98972, 99421-99423
- **Virtual Check-In**: 98016, G2010, G2250-G2252

POS/Modifier:
POS utilized if visit would have in person and no modifier

Remote Patient Monitoring Codes:

Allowable Codes:

- 98975-98978, 98980-98981, 99091, 99457, 99458, 99473-99474

POS/Modifier:
POS utilized if visit would have in person and no modifier

Interprofessional Assessment Codes:

Allowable Codes:

- 99446-99449, 99451-99454, G0546-G0551

POS/Modifier:
POS utilized if visit would have in person and no modifier

Telehealth:

Allowable Codes:
UHC will allow any services on the below lists:

- Services recognized by the Centers for Medicare and Medicaid Services (CMS)
- Services recognized by the American Medical Association (AMA) included in Appendix P of the CPT code set
- Additional services identified by UnitedHealthcare that can be effectively performed via Telehealth
    - See Telehealth Allowable Codes table below for UHC specified codes
- Consistent with CMS, UHC will not recognize CPT 98000-98015, as they are assigned to status code “I” on the NPFS Relative Value File, indicating another code (replacement code) is used to report the procedure or service and that replacement code has an assigned RVU

Physical Health, Occupational, and Speech Therapy:
UHC will reimburse certain physical, occupational, and speech therapy (PT/OT/ST) Telehealth services provided by QHPs rendered via interactive audio and video technology.
Services submitted on a CMS 1500 form should include:

- Code(s) from the list of specific physical, occupational and speech therapy Telehealth services (see the PT/OT/ST Telehealth Eligible Services Code List in the Attachments section)
- The appropriate place of service code 02 or 10 in Box 24B

All PT/OT/ST Telehealth visits must be performed using live, interactive video conferencing that involves the presence of both parties at the same time and a communication link between them that allows a real-time audio and visual interaction to take place. E-mailing “stored” exercise videos and discussing or reviewing by phone is not reimbursable.

ruralMED REVENUE CYCLE RESOURCES
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Modifiers/POS:

- **POS** 02 or 10
- **Modifiers**
    - **Audio Visual:** 95, GT, GQ, and G0 are not required to identify telehealth services but are accepted as informational if reported on claims
    - **Audio-Only**: 93

Provider Type:

Physician, nurse practitioner, physician assistant, nurse-midwife, clinical nurse specialist, registered dietitian or nutrition professional, clinical psychologist, clinical social worker, certified registered nurse anesthetists, physical therapists, occupational therapists, and speech therapists.

Patient Location:

UHC will recognize CMS designated originating sites considered eligible for furnishing telehealth services to a patient located in an originating site.

- Examples of CMS originating sites with a telepresenter: the office of a physician or practitioner, hospital, critical access hospital (CAH), rural health clinic (RHC), federally qualified health center (FQHC), hospital based renal dialysis center, skilled nursing facility (SNF), community mental health center (CMHC), mobile stroke unit, patient home-for monthly end stage renal, ESRD-related clinical assessments, for purposes of treatment of a substance use disorder or a co-occurring mental health disorder.
- UHC will also recognize home as an originating site for telehealth services (no telepresenter present)

Reimbursement:

Refer to contracted fee schedule

Transmission & Originating Site Fees:

Claims for Originating Site services may be reported using HCPCS code Q3014 (Telehealth Originating Site facility fee) on either a professional (CMS-1500) or a facility (UB-04) claim when a Telepresenter is present at an Originating Site location other than the patient's home. Q3014 is not reimbursable when the Distant Site claim is reported with a POS 10 indicating the patient is located at home and not receiving any Originating Site services from a Telepresenter. T1014 is not eligible for payment, UHC considers these services as incidental to the charges associated with the E/M.

Audio Only Services:

Telehealth services must be performed over an audiovisual connection, unless an audio-only allowable code is utilized

- UHC will align with the AMA and will consider for reimbursement the services included in Appendix T of the CPT code set, which are appropriate for reporting real-time, interactive audio-only telehealth, when appended with modifier 93, and reported with POS 02 or 10.

UHC ELIGIBLE TELEHEALTH CODES											
0362T	0373T	0591T	0592T	0593T	77427	90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	90845	90846	90847	90853	90863	90875	90901
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962
90963	90964	90965	90966	90967	90968	90969	90970	92002	92004	92012	92014
92227	92228	92507	92508	92521	92522	92523	92524	92526	92550	92552	92553
92555	92556	92557	92563	92565	92567	92568	92570	92587	92588	92601	92602
92603	92604	92607	92608	92609	92610	92625	92626	92627	93228	93229	93268
93270	93271	93272	93750	93797	93798	94002	94003	94004	94005	94625	94626
94664	95970	95971	95972	95983	95984	96105	96110	96112	96113	96116	96121
96125	96127	96130	96131	96132	96133	96136	96137	96138	96139	96156	96158
96159	96160	96161	96164	96165	96167	96168	96170	96171	96202	96203	97110
97112	97129	97130	97150	97151	97152	97153	97154	97155	97156	97157	97158

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

97161	97162	97163	97164	97165	97166	97167	97168	97530	97535	97537	97542
97550	97551	97552	97750	97755	97760	97761	97763	97802	97803	97804	98960
98961	98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213
99214	99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238
99239	99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307
99308	99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349
99350	99406	99407	99408	99409	99417	99418	99468	99469	99471	99472	99473
99475	99476	99477	99478	99479	99480	99483	99495	99496	99497	99498	G0011
G0013	G0108	G0109	G0136	G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406
G0407	G0408	G0410	G0420	G0421	G0422	G0423	G0425	G0426	G0427	G0438	G0439
G0442	G0443	G0444	G0445	G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514
G0539	G0540	G0541	G0542	G0543	G0560	G2086	G2087	G2088	G2211	G2212	G3002
G3003	G9685	90482	90483	90484	90849	92622	92623	96041	97116	99497	99498
G0473	G0545										

PT/OT/ST											
92507	92521	92522	92523	92524	97110	97112	97116	97161	97162	97163	97164
97165	97166	97167	97168	97535	97750	97755	97760	97761			

AUDIO ONLY CODES											
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845
90846	90847	92507	92508	92521	92522	92523	92524	96041	96110	96116	96121
96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171	97802
97803	97804	99406	99407	99408	99409	99497	99498	90482	90483	90484	90853
96130	96131	96132	96133	96136	96137	96138	96139	96202	96203		

Reference:

- Reimbursement Policy-Telehealth/Virtual Health Policy, Professional

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Payor Specific Key Points:

Virtual Communication Services:

Effective Jan 1, 2026, RHCs are required to report the individual remote evaluation service codes previously billed under G0071 (G0071 is no longer reportable)

Allowable Codes:

Virtual Check-In: G2010, 98016, G2250

Care Coordination Services

Starting Jan 1, 2025, CMS required RHCs & FQHCs to report the individual CPT/HCPCS care coordination codes instead of G0511; CMS allowed billing G0511 during a transition period, but G0511 was no longer billable after Sept 30, 2025

Telehealth:

RHC/FQHC Distant Site Provider Extension:

RHCs and FQHCs may continue to bill for non-behavioral health services furnished through interactive telehealth through December 31st, 2027, utilizing G2025

Allowable Codes:

RHCs and FQHCs may furnish allowable RHC/FQHC services via telehealth utilizing G2025 for medical telehealth claims and the appropriate behavioral health CPT/HCPCS for behavioral health claims.

Audio Only:

Beneficiaries may continue to receive audio-only telehealth services in their homes through December 31, 2027

- Audio-only can be used for both new and established patients
- Utilized when the patient is not capable of or does not consent to using audio-video communication technology
- Provider must be technically capable of using audio-video communication technology
- Beneficiaries who are receiving remote mental health services, as defined in the CY 2023 and 2024 OPPS Final Rules, furnished by hospital-employed staff in their homes may also receive these services via audio-only communication technology
- Starting January 1, 2028, providers may only use audio-only communication technology for behavioral health services furnished to a patient in their home

Billing:

- **Medical Claims**
  - **HCPCS**: G2025
  - **UB**: 52X revenue code
  - **Modifier:**
    - **Audio/Video:** None Required
    - **Audio Only:** FQ
- **Mental Health Claims**:
  - **CPT/HCPCS**: Appropriate Behavioral Health CPT/HCPCS
  - **UB**: 900 revenue code
  - **Modifier:**
    - **Audio/Video:** CG & 95
    - **Audio Only:** FQ

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Mental Health Services:

- CMS will permanently allow mental health telehealth services performed by an RHC/FQHC
- The service must be either audio visual OR
- Audio-only if the following are present:
    - The patient is incapable of, or fails to consent to, the use of video technology for the service
    - The provider has conducted an in-person visit within the last 6 months of the initial tele-mental service
    - The services are medically necessary
    - After the initial telehealth visit, the provider conducts an in-person visit at least once every 12 months of each tele-mental visit.
        - However, if the patient and provider consider the risks of an in person service and agree that these risks outweigh the benefits, then the annual visit may be skipped.
        - Providers must document the decision
    - Until December 31st, 2027, the initial 6 month visit and the in person visit every 12 month requirement is waived

Provider Type:

Physicians, Nurse practitioners (NPs), Physician assistants (PAs), Certified nurse-midwives (CNMs), Clinical psychologists (CPs), Clinical social workers (CSWs), Marriage and family therapists (MFTs), Mental health counselors ((MHCs)

Reimbursement:

Medical:

- The RHC/FQHC telehealth payment rate is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. For 2026 the rate is $97.53

Mental Health:

- RHC AIR rate or FQHC PPS rate

Supervision:

CMS permanently adopted a definition of direct supervision, for RHC and FQHC services, that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only)

Transmission/ Originating Site Fees:

Medicare will reimburse an originating site fee (HCPCS Q3014) if the patient is present at a healthcare facility. Medicare does not reimburse for transmission fees.

References:

MLN Matters-Telehealth Services
SE22001 Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
CMS Telehealth FAQ 2026
Consolidated Appropriations Act, 2026
CMS Telehealth Services List

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423
- **Virtual Check-In**: Not allowable

Digital E/M Services: Cumulative online digital evaluation and management (E/M) services occurring within a seven-day period beginning with the health care professional's review of the patient generated inquiry. Included services not separately billable:

- For the same or a related problem within seven days of a previous E/M service
- Related to a surgical procedure occurring within the postoperative period of a previously completed procedure
- Any subsequent online communication that does not include a separately reported E/M service.
- E/M services related to the patient's inquiry provided by qualified health care professionals in the same group practice.

Separate reimbursement may be allowed for:

- Online digital inquiries initiated for a new problem within seven days of a previous online digital E/M service.

Permanent documentation storage (electronic or hard copy) of the encounter is required.

Interprofessional Telephone/Internet/Electronic Record Assessment & Management Services:

Allows treating providers to consult with a specialist to assist the treating provider in diagnosis and/or management of a patient's health condition without requiring the patient to have face-to-face contact with the specialist. Specialists bill their consultation time with these codes. These services are limited to four per member per year.

Codes:

- 99447, 99448, 99451, 99452

Service Requirements:

- Both the treating practitioner and the consultant must be enrolled in ND Medicaid
- Consultations must directly related to the patient's diagnosis and treatment; for the patient's direct benefit, and documented
- Review of patient records and reports is included in this service

Treating practitioners and consultants must follow all state and federal privacy laws regarding patient privacy and the exchange of patient information.

Non-Reportable Service:

Do not report this service if:

- Direct specialty care is clinically indicated
- Consultant has seen the patient in a face-to-face encounter in the last 14 days
- The consultation leads to a transfer of care or other face-to-face service within the next 14 days or the next available appointment date of the consultant
- Greater than 50% of the service time is devoted to data review and/or analysis (for codes 99446-99449 only)

Telehealth:

Allowable Codes:

When providing telehealth services to patients located in their homes or another facility, FQHCs and RHCs should continue to bill the revenue codes listed in the FQHC and RHC policies, along with the CPT or HCPCS code for the service rendered, appended with modifier GT or 95.

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

Synchronous Audio-Video Outpatient E/M Services: Utilize CPT 98000-98007

- Do not report CPT E/M services 99202-99215 when the service was performed via telehealth
  - The only exception is for claims that Medicare has processed as the primary payer. Medicare does not recognize CPT 98000-98015 and requires them to be billed under regular E/M codes.

The Procedure Code Look-up Tool should be utilized to verify if specific codes can be delivered via telehealth

Audio Only Services:

Synchronous Audio-only E/M Services: Utilize 98008-98015

Use the Procedure Code Look-up Tool to verify if a service can be rendered audio-only

General Provider Policies:

All qualified telehealth services must:

- Meet the same standard of care as in-person care
- Be medically appropriate and necessary, with supporting documentation included in the patient's clinical medical record
- Be provided with secure and appropriate equipment to ensure confidentiality and quality in the delivery of the service. The service must be provided using a HIPAA-compliant platform
- Health care professionals must follow CPT coding guidelines
- A telecommunications system may include two-way, real-time, audio-only communication technology for any Medicaid telehealth service furnished to a member in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology. The reason for audio-only must be documented in the medical record for the service. Use the Procedure Code Look-up Tool to verify if a service can be rendered audio-only.

Documentation:

Originating site documentation is required for originating sites that are eligible for reimbursement. North Dakota Medicaid does not require documentation to be maintained for originating sites that are not eligible for reimbursement. The originating site must document the physical location of the recipient and provider at the time the services were provided. The originating site must also document if a nurse or other healthcare professionals were present and provided any services, such as checking vitals. The distant site must document the physical location of the recipient and provider at the time the services were provided. The distant site provider must follow the documentation requirements in the Provider Requirements Policy.

Modifiers/POS:

- **Modifier**
  - **Audio-Visual**: GT or 95
  - **Audio Only**: 93

Non-Covered Services:

- Store and Forward – G2010
- Virtual Check-In – 98016
- Interprofessional services – 99446, 99499
- Digital Assessment and Management Services – 98970-98972

Reimbursement

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement. Payment will be made only to the distant health care professional during the telehealth session. No payment is allowed to a professional at the originating site if their sole purpose is the presentation of the patient to the professional at the distant site

Transmission & Originating Site Fees:

Payment will be made to the originating site as a facility fee only in the following places of service: office, inpatient hospital, outpatient hospital, or skilled nursing facility/nursing facility. There is no additional payment for equipment, technicians, or other technology or personnel utilized in the performance of the telehealth service.

ruralMED REVENUE CYCLE RESOURCES

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

- **Facility (UB) Claims**: HCPCS Q3014 with revenue code 780

Reference:

- ND Telehealth Policy

Document Prepared By: Hayley Prosser, ruralMED Executive Director of Revenue Cycle Services, hprosser@ruralmed.net

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.