

Telehealth Questions & Answers
v.8.5.2021

General Questions

Q: Can a Provider continue to provide telehealth services from their residence, but bill from their credentialed place of service?

A Provider can provide services from any setting in which all the requirements described in the Telehealth Supplement can be met. POS for the distant site provider should indicate where the interaction would have normally taken place had it been in-person.

Q: Are we obligated to end the encounter if the patient decides to initiate the encounter in a non-secure, private setting (like a shared family room) against our recommendation?

If the telemedicine modality is found to be medically and/or clinically inappropriate, or otherwise can no longer meet the requirements stipulated in the “Reimbursable Telehealth Services” section of the Telehealth Supplement, the Provider shall provide or arrange, in a timely manner, in-person services to meet the needs of the individual.

Q: Will the reimbursement rate be the same for telehealth as face to face?

At this time, the reimbursement rate for services delivered via telemedicine is the same as for those delivered face-to-face.

Q: Is telemedicine allowable as long as the technology has audio-visual capabilities even if the patient opts to only utilize the audio functionality?

Once the federal Public Health Emergency (PHE) ends, telehealth encounters must meet all the conditions described in the Telehealth Supplement. Outside of the context of the federal PHE, telemedicine requires the synchronous use, by provider and patient, of audio and visual connections to conduct the encounter.

Q: Are these policies for federally qualified health centers (FQHCs) also?

Yes – policies described in the Telehealth Supplement are applicable to all Providers who are able to bill for services listed in Attachment A.

Q: Will the clinical provider have the option to decline the conducting of a visit via telemedicine and require the individual be seen in person due to the intensity of the symptoms or diagnosis?

Yes – Providers always have discretion on whether or not to conduct a visit via telehealth.

Q: Is Virginia following Medicare guidelines for telehealth?

DMAS aligns its definitions of telemedicine and telehealth with CMS Medicaid. Coverage of codes and billing requirements for telehealth may differ from those specified for CMS Medicare definitions.

Q: Could you please define "distant site provider"?

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A distant site Provider is a Provider – i.e., a billing provider who is either a qualified, licensed practitioner of the healing arts or a facility and who is enrolled with DMAS – who renders a covered service at a location that is different from the location of the member.

Q: If a telehealth audio-visual appointment is scheduled, and the video connection from the patient does not work properly at that time for whatever reason, can the needed appointment be conducted with audio only?

During the state of the federal Public Health Emergency, the appointment can be conducted via audio-only. After the end of the federal Public Health Emergency, use of audio-only will not be allowed unless DMAS has issued audio-only policy guidance. (At the current time, DMAS has not issued audio-only policy guidance beyond the federal Public Health Emergency)

Q: Will there be a standard form created to determine clinical appropriateness for telehealth?

Providers are expected to use their judgment on a case-by-case basis to determine whether it is clinically appropriate to deliver a service to a member via telehealth.

Billing (general)

Q: Will adding the GT/GQ codes to billing be required 60 days after the Virginia DMAS Telehealth policy goes into effect EVEN IF the Federal PHE is still in effect?

Yes – use of GT/GQ modifiers will be required within 60 days of publication of the Telehealth Supplement for services listed in Attachment A of the Supplement.

Q: Do we still use the GT modifier code for both audio-only (i.e. telephone) and audio-visual (telemedicine) methods?

During the federal PHE, the GT modifier should be used for any synchronously-delivered service that is not delivered in-person, including audio-only. After the end of the federal PHE, GT should be used for any service authorized to be delivered via telemedicine (i.e., synchronous audio-visual). At the current time, audio-only is not an allowed service outside of the context of the federal PHE.

Q: Is there any role for the 95 modifier that Medicare uses? Why did you choose to use GT instead of 95? Alignment with Medicare would seem to make it less confusing for those who are doing billing and coding.

Consistent with practice prior to the federal PHE, DMAS will continue to use the GT and GQ modifiers.

Q: Please clarify use of the Place of Service (POS) code. Pre-COVID we provided services via telemedicine and used the POS 02 – not the location where the service would "have normally been provided."

Q: When billing a modifier GT do you also need to change the place of service to 02?

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Place of Service (POS) should indicate where the service would have been provided had the client been served face-to-face (not where the client is actually located, or necessarily where the provider is actually located, when the service is received). For example, if the member would have come to a private office to receive the service outside of a telehealth modality, a POS 11 would be applied. POS 02 (“telehealth”) should not be used.

DMAS recognizes that other payers use different billing guidance, reflective of the absence of national billing standards or consensus on billing requirements.

Q: What is the difference between the GT and GQ modifier?

GT is used as a modifier to telemedicine services delivered *synchronously*. GQ is used as a modifier to telemedicine services delivered *asynchronously*.

Billing (Originating Site Fees)

Q: Can Providers bill an Originating Site Fee (Q3014) if telecommunication equipment and assistance are provided to members in an office to connect with the same Provider billing the telehealth service, who is located at a distant site (i.e. home)?

No – an Originating Site Fee (Q3014) will not be reimbursed to a Provider when the distant site Provider providing the service also provides services on an in-person basis at the same location of the entity billing the Originating Site Fee.

Q: Can a Provider bill an Originating Site Fee (Q3014) if both the member and a Provider providing the services (i.e., the distant site provider) are at the same location but, due to a possible contagion/exposure, services are delivered via telehealth?

No – an Originating Site Fee (Q3014) will not be reimbursed to a Provider when both the member and distant site Provider are located in the same location.

Q: If telecommunication equipment is provided to a member in their home (as a result of their lacking connectivity, equipment, etc.) to allow them to receive care from a provider at a distant site, could you then bill the Originating Site Fee (Q3014)?

No – Originating Site Fees may only be billed at a location where in-person services can be received, but this does not include the member’s residence.

Q: What POS should be billed for an Originating Site Fee?

POS should indicate the actual location where the Medicaid member is.

Q: Could the Originating Site Fee be billed if telecommunication equipment were provided for a member from a therapist’s home for employees of the CSB? Does this apply beyond the federal PHE as well?

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If a Provider is located with the member at a location where services can be received and all requirements specified in the Originating Site Fee section of the Telehealth Services Supplement are met, the Provider may bill an originating site fee.

General Documentation Requirements

Q: Is verbal approval documented in documents such as ISPs, etc., still acceptable as long as the consumer agrees and gives verbal permission?

For ISPs, Providers should follow documentation guidance issued by the Department of Education.

Q: Does the proposed manual include guidance on obtaining client signatures (i.e., is an "actual" signature required or a notation indicating the client consented to the treatment plan, ROI, etc.)?

Q: If someone completes a form online and emails it back, does a typed signature count?

Any signature that is considered legal and protects patient privacy under all applicable federal/state laws, statutes, regulations, etc., would be acceptable to DMAS. Providers who are unsure whether the member's signature would be considered legal and or protects patient privacy should seek advice from legal counsel.

Telehealth and federal Public Health Emergency flexibilities

Q: Will telephonic delivery be allowed after the PHE?

Q: I understand that audio-only telehealth ends with the end of the PHE and that DMAS is working on new policies around this. Will this audio-only option end with the end of the federal PHE or the state PHE or has this yet to be determined (based on DMAS policy development)?

Q: To clarify, telephonic services will be allowed post July 1st until the end of the federal PHE declaration?

During the federal PHE, use of audio-only can continue to be used as described in COVID-related Medicaid Memos (March 19, 2020; May 15, 2020; September 30, 2020). Effective July 1, 2021, DMAS has legislative authority to authorize services delivered via audio-only. When the federal PHE ends, audio-only services will only be permitted after DMAS audio-only policy is finalized. If the federal PHE ends before audio-only policy is finalized, then audio-only services will not be permitted until the policy is finalized.

Fee-for-Service vs. Managed Care

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Q: Will the MCOs follow DMAS rules around telehealth?

Q: Can the requirements for telehealth/telemedicine services be different for services billed to MCOs? Must MCOs maintain the same requirements as defined in the Telehealth Services Supplement?

MCOs must provide coverage for telemedicine and telehealth services as medically necessary, and with at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program. It is recommended that Providers contact MCOs directly with any questions regarding coverage of telehealth.

Telehealth modalities

Q: You refer to telehealth and telemedicine: is there a difference? If so can you help us distinguish the type of services that fall under each?

Telehealth means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices.

Telemedicine is a means of providing services through the use of two-way, real time interactive electronic communication between the member and the Provider located at a site distant from the member. This electronic communication must include, at a minimum, the use of audio and video equipment.

Q: What is “Store-and-Forward”?

Store-and-forward means the asynchronous transmission of a member’s medical information from an originating site to a health care Provider located at a distant site. A member’s medical information may include, but is not limited to, video clips, still images, x-rays, laboratory results, audio clips, and text. The information is reviewed at the Distant Site without the patient present with interpretation or results relayed by the distant site Provider via synchronous or asynchronous communications.

Geographic considerations

Q: In a situation where a facility is physically licensed and located in Virginia, can the telehealth provider be located out of state physically as long as they are licensed in Virginia and enrolled with Virginia Medicaid?

Providers are expected to adhere to regulations regarding licensures and locations of the patient and/or Provider issued by their Regulatory Board. Please refer to information provided by the Department of Health Professions (<https://www.dhp.virginia.gov/>)

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Q: There are circumstances when clients leave the state for a period of time, but retain a Virginia address. Would they be able to receive telemedicine in another state or country?

Providers should refer to applicable licensing authorities in Virginia and the location of the Member to ensure compliance with applicable regulations.

Behavioral Health-Related

Q: What are considered 'clinically appropriate' telehealth services for community-based mental health services? Can you give an example?

A: Individuals vary in how they respond to counseling—one size never fits all, and this includes telehealth. Clinicians must take into consideration the patient's needs, stage of treatment, experiences and environmental factors to determine if telehealth is clinically appropriate. In-person shall be considered for a variety of reasons but not limited to the following: member requests to meet in-person, members who have experienced trauma, members who are experiencing psychosis, experiencing significant dysregulation, telehealth equipment is unavailable/unreliable/broken, inadequate space in home leading to privacy concerns.

Q: Will individual therapy, group and family still be covered?

A: Psychotherapy (individual, family and couples) and group therapy are covered by the telemedicine policy. Refer to Table 2 in the Telemedicine supplement for specific covered CPT and HCPCS codes.

Q: Can psychologists, LPCs or LCSWs who hold a Virginia license but live in another state, provide services to Virginia residents via telehealth?

A: Providers are expected to adhere to regulations regarding licensures and locations of the patient and/or Provider issued by their Regulatory Board. Please refer to information provided by the Department of Health Professions (<https://www.dhp.virginia.gov/>). Providers located outside of Virginia may need to adhere to additional regulations applicable to that location.

Q: Can you provide clarity regarding Psychologists located in Virginia who provide telehealth services to residents of other states via Psychology Interjurisdictional Compact (PSYPACT)?

A: PSYPACT has 2 different credentials; one is for telepsychology and one is the authority to physically practice temporarily in a PSYPACT state for up to 30 days. In order to practice in another PSYPACT state, the individual must hold an active, unrestricted license as a Psychologist in a PSYPACT state and must be credentialed by the Association of State and Provincial Psychology Boards (ASPPB) with the E.Passport/APIT. As long as they meet both of those requirements, and the client is located within a PSYPACT state, they can practice. For more information about PSYPACT, contact the Virginia Board of Psychology at: psy@dhp.virginia.gov.

Q: Will outpatient therapists have to take a training to provide telehealth?

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A: DMAS does not require additional trainings to deliver services via telehealth. DMAS does require that services delivered via telemedicine are provided with the same standard of care as in-person. It is the responsibility of Providers to ensure that they have the training needed to ensure that this is accomplished.

Q: According to the new ACT Billing Guidance, "To bill the per diem unit, a qualified ACT team member must provide a face-to-face covered service with the individual or a face-to-face care coordination". Is telehealth allowed for this?

A: ACT is approved for service delivery via telehealth as noted in the DMAS Telehealth Provider Supplemental Manual. The face-to-face service requirement may be met through telehealth.

Q: Does fifteen minutes of audio-visual telehealth meet the face-to-face requirement for ACT?

A: Yes, the fifteen minutes of face –to-face service required to bill the ACT per diem can be met through telehealth.

Q: Can the originating site be the therapist home after the public health emergency?

A: The originating site is the location of the member at the time the service is rendered, or the site where the asynchronous store-and-forward service originates. The distant site is the location of the Provider rendering the covered service via telehealth. Providers are also expected to adhere to regulations regarding licensures and locations of the patient and/or Provider issued by their Regulatory Board and as applicable, their licensing agency. Please refer to information provided by the Department of Health Professions (<https://www.dhp.virginia.gov/>) and the Department of Behavioral Health and Developmental Services (<https://www.dbhds.virginia.gov/>).

Q: Is there a modifier for telehealth services delivered by a licensed eligible clinician under the supervision of a licensed credentialed staff?

A: There are no specific modifiers for Residents in Psychology, Residents in Counseling, nor Supervisees in Social Work. Services are billed under the supervising clinician's or agency NPI, as appropriate for the service, and appropriate telehealth modifiers should be used depending on the delivery of the service.

Q: Are the new Behavioral Health Enhancement (BHE) codes going into effect 07/01/2021 being reviewed for inclusion, as appropriate?

A: The new BHE codes effective 7/1/2021 are approved for service delivery via telehealth as noted in the DMAS Telehealth Provider Supplemental Manual.

Q: Can the flexibility of allowing one unit of billing for TDT, IHH, MHSS, ICT and PSR be extended if services are provided but time spent in billable activities does not reach the full unit of time required to bill?

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A: The flexibilities allowing one unit on days when a billable service is provided but does not reach the time requirements to bill for a service unit continues through the duration of the federal Public Health Emergency.

Q: Is telemedicine limited to licensed professionals?

A: Staff requirements for services allowed through telehealth remain the same as if the service is delivered in person. For services allowed through telehealth, such as but not limited to TDT, MHSS, Intensive In-Home, Behavioral Therapy, PSR and relevant ASAM Levels of Care, whereas staff who are not licensed may provide the service under supervision, the unlicensed staff who meet staff qualifications for the service may provide services through telehealth. Supervision requirements remain the same as when those services are delivered in person. Supervision may be provided through telehealth as allowed by the relevant licensing board.

Q: What will the service limits be for psychosocial rehabilitation via telehealth?

A: The service limits are as defined in the Mental Health Services Provider manual regardless of whether the service is delivered in-person or via telehealth.

Q: Is Mental Health Skill-building Services (MHSS) included in telehealth?

A: DMAS has received feedback to include MHSS and is taking this into consideration for the policy updates post the public health emergency.

Q: Are the assessment billing codes [H0031, H0032] in Community Mental Health Rehabilitation Services (CMHRS) services allowed to be conducted via telehealth?

A: No – the assessments for CMHRS must be done in-person.

Q: When does the long term policy go into effect and how does that impact the existing flexibilities in CMHRS services?

A: The current CMHRS flexibilities are allowed through the federal and state public health emergency. Some flexibilities will end with the end of the state public health emergency and will be noted in an upcoming DMAS memo. Telehealth and telephonic flexibilities are allowed through the federal public health emergency.

Q: Will CMHRS and outpatient psychiatric services be able to be delivered via audio-only (i.e. telephonic) modalities after 7/1?

A: During the federal PHE, use of audio-only can continue to be used as described in COVID-related Medicaid Memos (March 19, 2020; May 15, 2020; September 30, 2020). Effective July 1, 2021, DMAS has legislative authority to authorize services delivered via audio-only. When the federal PHE ends, audio-only services will only be permitted after DMAS audio-only policy is finalized. If the federal PHE ends before audio-only policy is finalized, then audio-only services will not be permitted until the policy is finalized.

Q: Is Psychosocial Rehabilitation H2017 approved for telehealth beyond the end of the federal PHE?

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A: Psychosocial Rehabilitation (H2017) is approved for synchronous audio-visual (i.e. telemedicine) service delivery beyond the end of the federal-PHE, as noted in the DMAS Telehealth Provider Supplemental Manual.

Q: Will there be a max unit billed for Psychosocial Rehab services delivered via telehealth post PHE?

A: Limits for services delivered via telehealth will be the same as any limits for in-person services as described in the Mental Health Services Manual.

Q: Is Crisis Stabilization and the initial assessment allowable via telehealth?

A: DMAS has received feedback to include Crisis Stabilization and is taking this into consideration for the policy updates post the public health emergency. Assessments for Mental Health Services must take place in-person.

Q: Would a provider be allowed to have a virtual psychosocial rehabilitation program? How would DBHDS Licensing view that?

A: Psychosocial Rehabilitation services may be delivered through telemedicine. See Appendix requirements around the ability to provide services in-person, should clinical needs not be able to be met via remote telehealth delivery. Providers should refer to DBHDS Office of Licensing or their licensing specialist for licensing questions.

Q: Will a telehealth session be considered adequate to meet the requirement for a face-to-face session every 90 days for targeted case management services?

A: The face-to-face requirement every 90 calendar days for Mental Health, Substance Use Disorder and Treatment Foster Care Targeted Case Management may be met if delivered through telehealth and clinically appropriate for the particular member's situation.

Q: Can telehealth services be delivered during Therapeutic Day Treatment (TDT) services to a child under the age of 14 when a parent may be at work or another adult is not in the home?

A: TDT services may be provided to youth under the age of 14 through telehealth when a parent is not home if clinically appropriate.

Q: Is the service code H2012 eligible for telehealth delivery beyond the end of the federal PHE under the label of Intensive In-Home in the Behavioral Health category of the Appendix?

A: Yes – Intensive In-Home (H2012) is approved for service delivery via synchronous audio-visual (i.e. telemedicine) delivery beyond the end of the federal PHE as noted in the DMAS Telehealth Provider Supplemental Manual.

Intellectual / Developmental Delay Related

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Q: Which DD waiver services are reimbursable via telehealth, if any?

Q: Would a synchronous telehealth ID/DD CM service count as a F2F service, especially if the client refuses an inpatient F2F due to COVID?

Currently, none of the telemedicine-eligible services listed in Attachment A of the Telehealth Supplement is a waiver service covered by the Community Living (CL) and Family and Individual Support (FIS) waivers. Note that waived individuals may receive services via telehealth listed in Attachment A.

School-Based Service Related

Q: Are schools eligible to be reimbursed for the originating site facility fee when telehealth visits originate at the school building, and either a school nurse, school counselor or designated school staff present the student and assist with set-up and use of the telecommunication equipment?

Schools are eligible to bill for the originating site facility fee if the school or school division is enrolled as a billing provider with the student's MCO or with DMAS (for services billed as fee-for-service) and they provide and facilitate use of telecommunication equipment for delivery of a covered telehealth service.

Early Intervention Service Related

Q: Will TCM for Early Intervention continued to be covered if completed via a telehealth platform?

Yes – TCM (T2022) is listed in Attachment A of the Telehealth Supplement. Note that Service Limitation requirements specific to Early Intervention codes must be met when delivering services via telemedicine.

Q: Regarding Early Intervention services how are you defining the clinical team? Does this have to be someone with the same credential as the telehealth provider? Could the clinical team include a case manager?

Yes – a Service Coordinator/Case Manager would be considered a member of the team. Other examples of members of the clinical team could include physical therapists, occupational therapists, developmental specialists, and speech language therapists.

Q: In terms of Early Intervention, a "member's residence" would be the originating site, correct?

Yes – if the member receiving the service is located at home, their residence is considered the originating site. Note that when the originating site is the member's residence, Providers should not bill for an Originating Site Fee.

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Q: For early intervention, why is the initial visit required to be in person?

An initial in-person visit is required to ensure clinical appropriateness of the first instance that that service is provided. Note that DMAS policies allows for the visit to be conducted via telehealth in limited circumstances (i.e., cases of documented exception circumstances to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery.)

Speech and Language Pathology Service Related

Q: The list of reimbursable codes doesn't show speech-language therapy services. Is it included?

All speech language therapy codes eligible for reimbursement if delivered via telehealth are listed in Attachment A of the Telehealth Supplement.