Washington State Health Care Authority

Washington Apple Health (Medicaid)

Telemedicine Policy Billing Guide

January 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this document's accuracy. If an actual or apparent conflict between this document and a Health Care Authority (HCA) rule arises, the rule applies.

HCA will update this document on an as-needed basis. Due to the nature of content change on the internet, we do not fix broken links in past versions of our documents. If you find a broken link, please check the most recent version of the document. If this is the most recent version, please notify us at askmedicaid@hca.wa.gov.

About this document

This publication takes effect **January 1, 2025,** and supersedes earlier billing guides to this program. Unless otherwise specified, the program(s) and services in this guide are governed by the rules found in WAC 182-501-0300.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by HCA.

Note: Refer to Apple Health (Medicaid) program guides on HCA's website for program-specific telemedicine policy and information.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

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Copyright disclosure

Further billing guidance

The managed care organizations also have their specific billing instructions at the links below:

- Molina Healthcare
- Coordinated Care
- United Health Care
- Community Health Plan of Washington
- Wellpoint Washington

Confidentiality toolkit for providers

The **Washington State Confidentiality Toolkit for Providers** is a resource for providers required to comply with health care privacy laws.

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Distant site—Billing	**December 23, 2024, Update:** Added requirements for: • Practitioners billing for services provided via telemedicine to a client located in Washington State, including information on interstate compacts licensure. • The service(s) being rendered, including that the service(s) must be clinically appropriate to be provided via telemedicine for that client, on the date of service.	To clarify HCA policy
Store and Forward	• Rewrote Store and Forward section by adding new policy information for e-consults including best practices, payment and billing, and documentation requirements • Deleted Teledermatology section	**Effective for dates of service on and after January 1, 2025**, HCA is replacing teledermatology with e-consults.
Does HCA cover e-consults?	Removed section	To remove duplicative information
What evaluation and management services may be provided via telephone or patient portal?	**December 23, 2024, Update:** Removed CPT® codes 99441, 99442, and 99443 from the table	These codes are being discontinued on January 1, 2025.

Subject	Change	Reason for Change
What non-evaluation and management services may be provided via a virtual check-in?	**December 23, 2024 update:** Replaced HCPCS code G2012 with CPT® code 98016	HCPCS code G2012 has been discontinued for dates of service on and after January 1, 2025. CPT® code 98016 may be used in its place.

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Definitions

This section defines terms used in this billing guide. Refer to Chapter 182-500 WAC and WAC 182-501-0300 for a complete list of definitions for Washington Apple Health.

Audio-only telemedicine – The delivery of health care services using audio-only technology, permitting real-time communication between the client at the originating site and the provider, for the purposes of diagnosis, consultation, or treatment.

Distant site – The site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine.

Established relationship – A relationship between a health care practitioner and an Apple Health (Medicaid) client in which both the following are true:

- The health care practitioner providing audio-only telemedicine has access to sufficient health care records to ensure safe, effective, and appropriate care services.
- The client meets either of the following:
    - Has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the health care practitioner providing audio-only telemedicine or with a health care practitioner employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under Chapter 48.44 or 48.46 RCW as the health care practitioner providing audio-only telemedicine.
    - Was referred to the health care practitioner providing audio-only telemedicine by another health care practitioner who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the client and has provided relevant medical information to the health care practitioner providing audio-only telemedicine.

Face-to-face – The client could be receiving the care in person or via audio-visual technology.

Facility – See the *Site-of-Service Payment Differential* section in HCA's Physician-related services/Health care professional services billing guide.

Hospital – A facility licensed under chapter 70.41, 71.12, or 72.23 RCW.

In person – The client and the provider are in the same location.

Medically necessary – See WAC 182-500-0070.

Nonfacility – See the *Site-of-Service Payment Differential* section in HCA's Physician-related services/Health care professional services billing guide.

Originating site – The physical location of a client receiving health care services through telemedicine.

Store and forward technology – Use of an asynchronous transmission of a covered person's medical or behavioral health information from an originating site to the health care provider at a distant site which results in medical or behavioral health diagnosis and management of the covered person and does not include the use of audio-only telephone, facsimile, or email.

Telemedicine – The delivery of health care services using interactive audio and video technology, permitting real-time communication between the client at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. Telemedicine includes audio-only telemedicine, but does not include any of the following services:

- Email and facsimile transmissions
- Installation or maintenance of any telecommunication devices or systems
- Purchase, rental, or repair of telemedicine equipment
- Incidental services or communications that are not billed separately, such as communicating laboratory results

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Telemedicine

Introduction to telemedicine

Before 2020, the Health Care Authority (HCA) had been encouraging and allowing healthcare providers to provide telemedicine options for HCA clients for several years. In the health care community, the words telehealth and telemedicine are often used interchangeably. However, for Apple Health, telemedicine is defined in a very specific way. See Definitions.

Best Practices

When conducting telemedicine services, it is important to ensure that the standard of care for telemedicine is the same as that for an in-person visit, providing the same health care service. Refer to the **Department of Health** for requirements from various commissions (e.g., Medical Commission, Nursing Commission, etc.).

Best practices may include, but are not limited to, the following:

- Consider the client's resources when deciding the best platform to provide telemedicine services.
- Test the process and have a back-up plan; connections can be disrupted with heavy volume. Communicate a back-up plan in the event the technology fails.
- Introduce yourself, including what your credential is and what specialty you practice. Show a badge when applicable.
- Ask the client their name and verify their identity. Consider requesting a photo ID when applicable/available.
- Inform clients of your location and obtain the location of clients. Include this information in documentation.
- Inform clients how they can see a clinician in-person in the event of an emergency or as otherwise needed.
- Inform clients they may want to be in a room or space where privacy can be preserved during the conversation. Explain that personal health information may be disclosed.
- Ask clients if they need assistive devices to participate in virtual visits.
- Include accessibility options (e.g., screen readers, closed captioning, etc.) within your telehealth programs.
- Use technology designed with equity in mind when it comes to speech recognition.

Resources

There are many resources available for providers to get started with telemedicine. The following are examples of resources:

- Telehealth Collaborative provider training (required)
- Telehealth Toolkits from NRTRC
- Washington State Department of Health's Teledentistry Guidelines
- University of Washington Behavioral Health Institute
- Washington State Department of Health

Additionally, many professional societies have telemedicine guidelines that may provide valuable care-specific information for health care professionals.

Note: Inclusion in the above list does not reflect an endorsement or verification of complete accuracy by HCA.

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care webpage for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the Client Eligibility, Benefit Packages, and Coverage Limits section in HCA's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to Step 2. If the patient is not eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program benefit packages and scope of services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to **Washington Connections** select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 1-855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCO). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained by the client through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Note: HCA continues to pay for the following through fee-for-service (FFS):

- Professional fees for dental procedures using CDT® codes
- Professional fees using CPT® codes only when the provider's taxonomy starts with 12

See the Dental-Related Services Billing Guide or the Physician-Related Services/Health Care Professional Services Billing Guide, or both, for how to bill professional fees.

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care, as a new or renewing client. Some clients may start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination. **Exception:** Apple Health Expansion clients are enrolled in MC and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's Apply for or renew coverage webpage.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:** Go to the Washington Healthplanfinder website.
- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's **Apple Health Managed Care webpage**.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the FFS program.

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care (IMC)

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support, and Alumni programs who are enrolled in Coordinated Care's (CC) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CC.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
"Coordinated Care Healthy Options Foster Care."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) Team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit Apple Health Expansion.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer?*

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

What if a client has third-party liability (TPL)?

If the client has third-party liability (TPL) coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to HCA's **ProviderOne Billing and Resource Guide**.

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Originating and Distant Sites

Introduction

Telemedicine is an interaction between a healthcare provider who is physically located at the **distant site** and a client who is physically located at the **originating site**. This section provides more information on documentation, payment, and billing requirements attributed to each type of site.

Documentation requirements

Billing site	Documentation requirement

Distant site	• Specification of the telehealth modality that was used (e.g., visit was conducted via HIPAA-compliant real-time audio/visual)
	• Verification that telemedicine was clinically appropriate for this service
	• Whether any assistive technologies (e.g., electronic stethoscopes, mobile automatic blood pressure device, etc.) were used
	• The location of the client
	• The location of the provider.-Include the following:
	  ○ The state in which the service was provided for users of the following documents:
	  ▪ Part 2 (specialized) of HCA's Mental Health Services Billing Guide
	  ▪ HCA's Substance Use Disorder Billing Guide
	  ▪ HCA's Service Encounter Reporting Instructions (SERI)
	  ○ For all others, the state in which the provider was located at the time services were provided **and** for specific service locations (e.g., facility-based), whether the provider was in a facility at the time services were provided.
	• The names and credentials (e.g., MD, ARNP, PA, etc.) of all provider personnel involved in the telemedicine visit
	• The people who attended the appointment with the client (family, friend, caregiver)
	• The start and end times of the health care service provided by telemedicine or the duration of service when billing is based on time
	• The client's consent to receive services if the services were provided via audio-only telemedicine

Billing site	Documentation requirement
Originating site	• Specification of the telehealth modality that was used (e.g., visit was conducted via HIPAA-compliant real-time audio/visual) • If there are staff involved in providing the service list the names and credentials (e.g., MD, ARNP, PA, etc.) of all provider personnel involved in the telemedicine visit • Any medical service provided (e.g., vital signs, weight, etc.) • The start and end times of the health care service provided by telemedicine

Originating site

Payment

Originating sites that are enrolled with HCA to provide services to HCA clients and bill HCA may be paid a facility fee for infrastructure and client preparation.

Note:

- An originating site must be located within the continental United States, Hawaii, District of Columbia, or any United States territory (e.g., Puerto Rico).

- HCA does not pay an originating site facility fee to the client in any setting.

Additionally, HCA does not pay an originating site facility fee in the following situations:

- Audio-only telemedicine
- Store and forward
- If the originating site is:
  - The client's home
  - A hospital (inpatient services)
  - A skilled nursing facility
  - Any location receiving payment for the client's room and board
  - The same entity as the distant site or if the provider is employed by the same entity as the distant site

Billing

To bill for an originating site facility fee for an eligible service, please use the appropriate billing codes as listed below:

Originating site	Billing
Critical access hospital	Use revenue code 0780 on the same line as HCPCS code Q3014
FQHC or RHC	Use HCPCS code Q3014
Home, or location determined appropriate by the individual receiving service	Not eligible for an originating site reimbursement
Hospital inpatient	Not eligible for an originating site reimbursement
Hospital outpatient	Use revenue code 0780 on the same line as HCPCS code Q3014
Other setting	Use HCPCS code Q3014
Physician or other healthcare professional office	Use HCPCS code Q3014
Skilled nursing facility	Not eligible for an originating site reimbursement

Distant Site

Payment

HCA reimburses medically necessary covered services through telemedicine when the service is provided by a Washington Apple Health provider and is within their scope of practice.

For kidney centers or ambulatory surgery centers to bill, either the client or the provider must be physically present at the facility at the time the service was rendered. See 42 CFR 440.90 for rules related to clinic services.

> **Note:** A distant site must be located within the continental United States, Hawaii, District of Columbia, or any United States territory (e.g., Puerto Rico).

Billing

The payment amount for the professional service provided through telemedicine by the provider at the distant site is equal to the current fee schedule amount for the service provided. Submit claims for telemedicine services using the appropriate CPT® or HCPCS code for the professional service.

To bill for services provided via telemedicine to a client located in Washington State, the practitioner must either:

- Be licensed as a provider in Washington State

  OR

- Have an interstate compact license that is recognized by Washington State. Active Washington State compacts include the following:
  - Psychology Interjurisdictional Compact
  - Physical Therapy Licensure Compact
  - Nurse Licensure Compact
  - Occupational Therapy Licensure Compact—DOH

> **Note:** Some compacts are still in the implementation process. See the Department of Health's (DOH) website for details specific to Washington State.

The service(s) rendered must be:

- Consistent with the scope of professional licensure or certification.
- Clinically appropriate to be provided via telemedicine for that client, on that date of service.

Use place of service (POS) 02 or 10 to indicate that a billed service was furnished as a telemedicine service from a distant site.

Place of service	Description
02	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
10	The location where health services and health-related services are provided or received through telecommunication technology. Patient is in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health-related services through telecommunication technology.

When billing with POS 02 or 10:

- Add modifier 95 if the distant site is designated as a nonfacility.
- Nonfacility providers must add modifier 95 to the claim to distinguish them from facility providers and ensure that they receive the nonfacility rate.

Attention licensed behavioral health agencies (BHA)—Using modifier 95 and distinguishing between facility/nonfacility are not applicable for behavioral health providers who use the following guides:

- Service encounter reporting instructions (SERI) guide
- Mental health billing guide (Part 2)
- Substance use disorder (SUD) billing guide

Attention health homes—Modifier 95 is not applicable to health home providers.

HCA discontinued the use of modifier GT for claims submitted for professional services (services billed on a CMS-1500 claim form, when submitting paper claims). Distant site practitioners billing for telemedicine services under the Critical Access Hospital (CAH) optional payment method must use modifier GT. See HCA's ProviderOne Billing and Resource Guide for more information on submitting claims to HCA. See HCA's Inpatient Hospital Services Billing Guide for more information on billing for services under the CAH optional payment method.

Follow CMS guidance for modifiers if Medicare is the primary insurance.

Audio-only telemedicine

Established relationship

Audio-only telemedicine requires an established relationship between the health care practitioner and the client. See Definitions.

Documentation requirements

In addition to the telemedicine requirements previously noted, providers must obtain consent before rendering the service per RCWs 74.09.325 and 71.24.335. Consent must be documented in the client record.

Procedure codes

Refer to HCA's Provider billing guides and fee schedules webpage, under *Telehealth*, for a complete list of audio-only telemedicine procedure codes, under *Audio-only telemedicine*.

Billing

HCA requires providers to bill audio-only services with the appropriate audio-only modifiers (93 or FQ). For services that are partially audio/visual and partially audio-only, a service is considered audio-only if 50% or more of the service was provided via audio-only telemedicine.

Modifier	Description
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-time Interactive Audio-Only Telecommunications System: Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.
FQ	For counseling and therapy provided using audio-only telecommunications

Information related to specific service areas and billing guidelines includes the following:

Billing guide/Resource	Modifier
Service Encounter Reporting Instructions (SERI) guide, Substance Use Disorder (SUD) Billing Guide, and Part II of HCA's Mental Health Services Billing Guide	FQ
Part I of HCA's Mental Health Services Billing Guide	93
All other physical health programs	93

Note: For more information, see the *Apple Health (Medicaid) FAQ for Behavioral Health Providers Billing for Services Provided via Telemedicine*, under *Telehealth* on HCA's Provider billing guides and fee schedules webpage.

Store and Forward

Store and Forward is the transmission of medical information to be reviewed later by a physician or practitioner at a distant site. A client's medical information may include but is not limited to video clips, still images, x-rays, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the client present.

Note: Transmission of protected health information must be HIPAA-compliant.

E-consults

An e-consult is a situation in which the client's treating provider requests the opinion or treatment advice, or both, of a consulting provider with specific specialty expertise to assist the treating provider with the client's care without client face-to-face contact with the consulting practitioner. The services must be directly relevant to the individual client's diagnosis and treatment, and the consulting practitioner must have specialized expertise in the health concerns of the client. The treating provider uses Store and Forward to send the request including pertinent medical information (e.g., lab results, scans, photos, etc.) to the consulting provider.

E-consults best practices

The following are some best practices for e-consults adapted from the Association of American Medical Colleges' Coordinating Optimal Referral Experiences (CORE®) document Advancing Health Care Equity Through eConsults Resource Module:

- Good e-consult questions are:
  - Focused questions that a specialist can reasonably answer without knowledge of the client's entire medical history
  - Answerable using only the information available in the electronic health record
  - Answerable within three business days, without an in-person visit
- The following are four components of a high-quality e-consult:
  - Restate the question and define the parameters to address based on the clinical question.
  - Explain the rationale and indicate the clinical or evidence-based, or both, reasons for the recommendation.
  - Provide recommendations for the next steps in management and ongoing monitoring and collaborate with the treating provider regarding the care plan.
  - Conclude with contingencies that would necessitate additional follow-up.

Payment and billing

HCA does not pay for e-consults when used as a referral for a face-to-face appointment or procedure.

When billing for e-consults, providers (e.g., physicians, physician assistants, advanced registered nurse practitioners, etc.) who may report evaluation and management (E/M) services must use the following codes:

CPT® code	Short description
99451	Ntrprof ph1/ntrnet/her 5/>
99452	Ntrprof ph1/ntrnet/her rfrl

Note: To bill the CPT® codes in the preceding table, providers must:

- Meet all elements of the procedure code
- Adhere to the American Medical Association (AMA) guidelines related to frequency of billing these codes
- Follow billing restrictions when the e-consult leads to a face-to-face encounter.

Documentation requirements

Treating providers

Treating providers must:

- Document the following:
  - The client's consent for each consultation
  - The request for the e-consult provider
- Assure the treatment plan recommendations and rationale from the consulting provider are added to the client's medical record

Consulting providers

Consulting providers must respond to the treating provider with a written treatment plan that includes the following information:

- Recommendations for treatment (e.g., plan A, plan B, etc.) and rationale
- Justification for another e-consult or to submit a referral

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Communication Technology-Based Procedure Codes

What evaluation and management services may be provided via telephone or patient portal?

HCA pays for the following procedure codes for providers (e.g., physicians, physician assistants, and advanced registered nurse practitioners) who may report evaluation and management (E/M) services provided to an established patient. Refer to the CPT® guidelines before using these procedure codes:

CPT® code	Short description
99421	OL DIG E/M SVC 5-10 MIN
99422	OL DIG E/M SVC 11-20 MIN
99423	OL DIG E/M SVC 21+ MIN

Notes:

- There are coding rules related to using these procedure codes if there is a related E/M procedure code or if the diagnosis is the same as another E/M procedure code.
- E/M procedure codes require the following components: evaluation, assessment, and management of the client.
- Online, digital E/M services may only be reported once in a 7-day period because it includes the cumulative time spent.
- CPT® codes 99421-99443 are not allowable for users of the Service Encounter Reporting Instructions (SERI) and Mental Health Services Billing Instructions.

What non-evaluation and management services may be provided via a virtual check-in?

HCA pays for the following procedure code for providers (e.g., physicians, physician assistants, and advanced registered nurse practitioners) who may report non-E/M services provided to an established patient:

CPT® code	Short description
98016	Brief communicaj tech bsd svc

Note: HCA pays for CPT® code 98016 for physical health services, but this procedure code is not allowable for behavioral health services.