Texas Medicaid

Provider Procedures Manual

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Provider Handbooks

Telecommunication Services Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

TELECOMMUNICATION SERVICES HANDBOOK

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1 General Information

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

The information in this handbook is intended for home health agencies, hospitals, nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM), licensed professional counselors (LPC), licensed marriage and family therapists (LMFT), licensed clinical social workers (LCSW), physicians, physician assistants (PA), psychologists, licensed psychological associates, provisionally licensed psychologists, and licensed dieticians.

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2 Enrollment

Providers may provide telecommunication services for Texas Medicaid clients under the provider's National Provider Identifier (NPI). No additional enrollment is required to provide telemedicine medical service or telehealth services.

Home health agency and hospital providers who wish to provide telemonitoring services must notify the Texas Medicaid & Healthcare Partnership (TMHP) as follows:

- Current providers must use the Provider Enrollment and Management System (PEMS) to indicate that they provide telemonitoring services.
- Newly enrolling or re-enrolling home health agency or outpatient hospital providers must indicate whether they provide telemonitoring services during the enrollment process.

Refer to: Subsection 3.1, "Provider Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about CNM provider enrollment.

Subsection 8.1, "Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about NP and CNS provider enrollment.

Subsection 9.1, "Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about physician provider enrollment.

Subsection 10.1, "Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about PA provider enrollment.

Subsection 4.1, "Provider Enrollment" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for information about mental health services provider enrollment.

Subsection 4.1, "Provider Enrollment" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for information about psychologist and licensed psychological associate provider enrollment.

Subsection 2.11.1, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about licensed dietitian enrollment.

3 Services, Benefits, Limitations, and Prior Authorization

Telemedicine and telehealth services must be provided in compliance with standards established by the respective licensing or certifying board of the professional providing the services.

The use of telemedicine and telehealth services within intermediate care facilities for individuals with intellectual disabilities (ICF-IID) and State Supported Living Centers is subject to the policies established by the Health and Human Services Commission (HHSC).

More than one medically necessary telemedicine service or telehealth service may be reimbursed for the same date and same place of service if the services are billed by providers of different specialties.

All confidentiality and Health Insurance Portability and Accountability Act (HIPAA) standards apply to telemedicine medical service and telehealth transmissions.

Refer to: Subsection 1.7.6, "Release of Confidential Information" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about confidentiality standards.

3.1 Patient Health Information Security

The software system used by the distant site provider must allow secure authentication of the distant site provider and the client.

The physical environments of the client and the distant site provider must ensure that the client's protected health information remains confidential. A parent or legal guardian may be physically located in the patient site or distant site environment during a telehealth or telemedicine service with a child.

A parent or legal guardian must provide written or verbal consent to the distant site provider to allow any other individual, other than the health professional as required by Texas Government Code §531.0217(c-4)(4) for school-based telemedicine, to be physically present in the distant or patient site environment during a telehealth or telemedicine service with a child.

An adult client must also provide written or verbal consent to the distant site provider to allow any other individual to be physically present in the distant or patient site environment during a telehealth or telemedicine service.

Providers of telehealth or telemedicine must maintain the confidentiality of protected health information (PHI) as required by Federal Register 42, Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164, Chapters 111 and 159 of the Texas Occupations Code, and other applicable federal and state law.

Providers of telehealth or telemedicine must also comply with the requirements for authorized disclosure of PHI relating to clients in state mental health facilities and residents in state supported living centers, which are included in, but not limited to, 42 CFR Part 2, 45 CFR Parts 160 and 164, Texas Health and Safety Code §611.004, and other applicable federal and state law.

All client health information generated or utilized during a telehealth or telemedicine service must be stored by the distant site provider in a client health record. If the distant site provider stores the patient health information in an electronic health record, the provider should use software that complies with Health Insurance Portability and Accountability Act (HIPAA) confidentiality and data encryption requirements, as well as with the United States Department of Health and Human Services (HHS) rules implementing HIPAA.

3.2 General Guidelines for Texas Medicaid MCOs

Texas Medicaid managed care organiziations (MCOs) are prohibited from denying reimbursement for covered services solely because they are delivered remotely. MCOs must consider reimbursement for all medically necessary Medicaid-covered services that are provided using telemedicine or telehealth.

Texas Medicaid MCOs must determine whether to reimburse for a telemedicine or telehealth service based on clinical and cost effectiveness, among other factors.

Texas Medicaid MCOs cannot deny, limit, or reduce reimbursement for a covered health-care service or procedure based on the provider's choice of telecommunications platform to provide the service or procedure using telemedicine or telehealth.

Providers should refer to individual MCO policies for additional coverage information.

Clinical and cost effectiveness determinations that result in prohibiting a service from being delivered using a synchronous audio-only technology, or store and forward technology in conjunction with synchronous audio-only technology are not considered denying, limiting, or reducing reimbursement for a covered health care service.

3.3 Services Provided through Telecommunications

3.3.1 Definitions of Terminology for Telemedicine and Telehealth Services

The following are definitions of terms used in telemedicine and telehealth services:

Telecommunications - The exchange of information by electronic and electrical means.

Platform - The technology, system, software, application, modality, or other method or means of delivery through which a health professional remotely interfaces with a client when providing a health care service or procedure as a telemedicine service or telehealth service.

Audiovisual - Synchronous audiovisual technology or store and forward technology in conjunction with synchronous audio-only technology.

Synchronous audiovisual technology - An interactive, two-way audio and video telecommunications platform that meets the privacy requirements of the Health Insurance Portability and Accountability Act.

Synchronous audio-only, also called synchronous telephone (audio-only), technology - An interactive, two-way audio telecommunications platform, including telephone technology, that uses only sound and meets the privacy requirements of the Health Insurance Portability and Accountability Act.

Store and forward technology - A telecommunications platform that stores and transmits or grants access to a person's clinical information for review by a health professional at a different physical location than the person that meets the privacy requirements of the Health Insurance Portability and Accountability Act.

In-person (or in person) - Within the physical presence of another person.

Not all Medicaid-covered services are authorized by HHSC for telemedicine or telehealth delivery in fee-for-service. Providers must always ensure the covered service is allowable by HHSC for telemedicine or telehealth services delivery.

Note: *For example, if a service is authorized for telemedicine or telehealth delivery only when using synchronous audiovisual technology, that service may not be delivered using store and forward technology, store and forward technology in conjunction with synchronous audio-only technology, synchronous audio-only technology, or asynchronous audio-only technology.*

Telemedicine or telehealth may be provided if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit.

3.3.2 Telemedicine and Telehealth Conditions for Reimbursement

Conditions for reimbursement applicable to telemedicine and telehealth provided using a synchronous audiovisual technology platform, or using store and forward technology in conjunction with synchronous audio-only are those that meet the following conditions:

- Must be designated for reimbursement by HHSC.
- Must be clinically effective and cost-effective, as determined and published in the benefit language by HHSC.
- May not be denied solely because an in-person medical service between a provider and client did not occur.
- May not be limited by requiring the provider to use a particular synchronous audiovisual technology platform to receive reimbursement for the service.

Other conditions for reimbursement applicable to services may vary by service type. Providers may refer to the appropriate TMPPM handbook for additional information on synchronous audiovisual technology platform coverage conditions.

Note: *Telemedicine and telehealth services that HHSC has determined are clinically effective and cost-effective when provided via a synchronous audiovisual technology platform or using store and forward technology in conjunction with synchronous audio-only technology can be found in the appropriate TMPPM handbooks.*

Conditions for reimbursement applicable to behavioral health services provided using a synchronous audio-only technology platform are those that meet the following conditions:

- Must be designated for reimbursement by HHSC.
- Provider must obtain informed consent from the client, client's parent, or the client's legally authorized representative prior to rendering a behavioral health service through a synchronous audio-only technology platform; except when doing so is not feasible or could result in death or injury to the client. Verbal consent is permissible and must be documented in the client's medical record.

- Must be clinically effective and cost-effective, as determined and published in the benefit language by HHSC.
- May not be denied solely because an in-person medical service between a provider and client did not occur.
- May not be limited by requiring the provider to use a particular synchronous audio-only technology platform to receive reimbursement for the service.
- Other conditions for reimbursement applicable to behavioral health services may vary by service type. Providers may refer to the appropriate TMPPM handbook for additional information on audio-only coverage conditions.

Conditions for reimbursement applicable to non-behavioral health services provided using a synchronous audio-only technology platform:

- Must be designated for reimbursement by HHSC.
- Clinically effective and cost-effective, as determined and published by HHSC.
- May not be denied solely because an in-person medical service between a provider and client did not occur.
- May not be limited by requiring the provider to use a particular synchronous audio-only technology platform to receive reimbursement for the service.

Note: *Behavioral or non-behavioral health services that HHSC has determined are clinically effective and cost-effective when provided via a synchronous audio-only technology platform can be found in the appropriate TMPPM handbooks.*

Telemedicine and telehealth services are reimbursed in accordance with 1 TAC §355.

In the event of a Declaration of State of Disaster, HHSC will issue direction to providers regarding the use of telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law.

Declaration of State of Disaster is when to an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Texas Government Code §418.014.

3.4 Telemedicine Services

Telemedicine medical services, also known as telemedicine, are allowable for Texas Medicaid. Telemedicine has the meaning assigned by *Texas Occupations Code* §111.001. Telemedicine services are defined as health-care services delivered by a physician licensed in Texas or a health professional who acts under the delegation and supervision of a health professional licensed in Texas and within the scope of the health professional's license to a client at a different physical location using telecommunications or information technology. Telemedicine excludes teledentistry services.

3.4.1 Distant Site

A distant site is the location of the provider rendering the service. Distant-site telemedicine benefits include services that are performed by the following providers, who must be enrolled as a Texas Medicaid provider:

- Physician
- CNS
- NP
- PA

- CNM
- Federally Qualified Health Center (FQHC)

A distant site provider is the physician, or PA, NP, CNM, FQHC, Rural Health Clinic (RHC), or CNS who is supervised by and has delegated authority from a licensed Texas physician, who uses telemedicine to provide health-care services to a client in Texas.

Distant site providers must be licensed in Texas.

An out-of-state physician who is a distant site provider may provide episodic telemedicine without a Texas medical license as outlined in *Texas Occupations Code* §151.056 and Title 22 *Texas Administrative Code* (TAC) §172.2(g)(4) and 172.12(f).

Distant site providers that provide mental health services must be appropriately licensed or certified in Texas, or be a qualified mental health professional-community services (QMHP-CS), as defined in 26 TAC §301.303(48).

A valid practitioner-patient relationship must exist between the distant site provider and the patient. A valid practitioner-patient relationship exists between the distant site provider and the patient if:

- The distant site provider meets the same standard of care required for and in-person service.
- The relationship can be established through:
  - A prior in-person service.
  - A prior telemedicine service that meets the delivery method requirements specified in *Texas Occupations Code* §111.005(a)(3).
  - The current telemedicine service that meets the delivery method requirements specified in *Texas Occupations Code* §111.005(a)(3).

A call coverage agreement established in accordance with Texas Medical Board (TMB) administrative rules in 22 TAC §177.20.

The distant site provider must obtain informed consent to treatment from the patient, patient's parent, or the patient's guardian prior to rendering a telemedicine medical service.

Distant site providers that communicate with clients using electronic communication methods other than phone or facsimile must provide clients with written notification of the physician's privacy practices prior to evaluation and treatment. A good faith effort must be made to obtain the client's written acknowledgment of the notice, including by email response.

A distant site provider should provide patients who receive a telemedicine service with guidance on the appropriate follow-up care.

Procedure codes that are reimbursed to distant site providers when billed with the 95 modifier (synchronous audiovisual technology) are included in the individual TMPPM handbooks. Procedure codes that indicate remote (telemedicine) delivery in the description do not need to be billed with the 95 modifier.

Procedure codes that are reimbursed to distant site providers when billed with the 93 modifier (audio-only services) are included in the individual TMPPM handbooks. Procedure codes that indicate telephone or audio-only delivery in their description do not need to be billed with the 93 modifier.

Behavioral health procedure codes that are reimbursed to distant site providers when billed with the FQ modifier (audio-only services) are included in the individual TMPPM handbooks. Procedure codes that indicate telephone or audio-only delivery in their description do not need to be billed with the FQ modifier.

Texas Medicaid MCOs must reimburse the following procedure codes when delivered via telemedicine services:

Procedure Codes									
G0406	G0407	G0408	G0425	G0426	G0427				

3.4.2 Telemedicine Service Delivery

The following delivery methods may be used to provide telemedicine within fee-for-service (FFS) Medicaid:

- Synchronous audiovisual technology between the distant site provider and the client in another location
- Synchronous audio-only technology between the distant site provider and the client in another location
- Store and forward technology in conjunction with synchronous audio-only technology between the distant site provider and the client in another location. The distant site provider must use one of the following:
  - Clinically relevant photographic or video images, including diagnostic images
  - The client's relevant medical records, such as medical history, laboratory and pathology results, and prescriptive histories

A Texas Medicaid managed care organization (MCO) is not required to provide reimbursement for telemedicine services that are provided through the following methods:

- A text-only email message
- A facsimile transmission

Texas Medicaid MCOs may optionally provide reimbursement for telemedicine services that are provided through asynchronous audio-only technology, such as voice mail technology. Distant site providers should contact each MCO to determine whether an MCO provides reimbursement for a specified modality.

3.4.2.1 Prescriptions Generated from a Telemedicine Medical Service

A distant site provider may issue a valid prescription as part of a telemedicine service. An electronic prescription (e-script) may be used as permitted by applicable federal and state statues and rules.

The same standards that apply for the issuance of a prescription during an in-person setting apply to prescriptions issued by a distant site provider.

The prescription must be issued for a legitimate medical purpose by the distant site provider as part of a valid practitioner-patient relationship.

The prescribing physician must be licensed in Texas. If the prescription is for a controlled substance, the prescribing physician must have a current valid U.S. Drug Enforcement Administration (DEA) registration number.

A licensed health professional acting under the delegation and supervision of a physician licensed in Texas may also issue a valid prescription. Prescribing must be in accordance with the required prescriptive authority agreement or other forms of delegation.

If the prescription is for a controlled substance, the health professional must have a current valid DEA registration number. If the prescription is for a schedule II controlled substance, the health professional must comply with DEA regulations regarding the use of electronic prescriptions. The health professional may also use the official prescription forms issued with their name, address, phone number, DEA registration number, delegating physician's name, and delegating physician's DEA registration number.

As applicable, all drug prescriptions must meet the requirements of the Texas Controlled Substance Act (*Texas Health and Safety Code* §481), the Texas Dangerous Drug Act (*Texas Health and Safety Code* §483), and any other federal or state statutes or rules.

Telemedicine medical services used for the treatment of chronic pain with scheduled drugs via audio-only is prohibited, unless a patient:

- Is an established chronic pain patient of the physician or health professional issuing the prescription;
- Is receiving a prescription that is identical to a prescription issued at the previous visit; and
- Has been seen by the prescribing physician or health professional defined under Section 111.001(1) of Texas Occupations Code, in the last 90 days either in-person or via telemedicine using audio-visual communication.

Treatment of a client for acute pain with scheduled drugs using telemedicine is permitted, as provided by 22 TAC §174.5(e). Acute pain is defined by 22 TAC §170.2(2).

All physicians must comply by 22 TAC §174.5 when issuing prescriptions through a telemedicine service.

3.4.3 Patient Site

A patient site is the place where the client is physically located. A client's home may be the patient site for telemedicine.

Patient-site providers that are enrolled in Texas Medicaid may only be reimbursed for the facility fee using procedure code Q3014. Procedure code Q3014 is payable to NP, CNS, PA, physicians, and outpatient hospital providers. Charges for other services that are performed at the patient site may be submitted separately. Procedure code Q3014 is not a benefit if the patient site is the client's home.

3.4.3.1 School-Based Setting

Telemedicine provided in a school-based setting by a physician, even if the physician is not the client's primary care physician or provider, are benefits if all of the following criteria are met:

- The physician is an authorized health-care provider enrolled in Texas Medicaid.
- The client is a child who is receiving the service in a primary or secondary school-based setting.
- The parent or legal guardian of the client provides consent before the service is provided.

Telemedicine services provided in a school-based setting are also a benefit if the physician delegates provision of services to a nurse practitioner, clinical nurse specialist, or physician assistant, as long as the nurse practitioner, clinical nurse specialist, or physician assistant is working within the scope of their professional license and within the scope of their delegation agreement with the physician.

3.4.4 Telemedicine Services for FQHCs

3.4.4.1 Distant Site

FQHCs may be reimbursed the distant-site provider fee for telemedicine services at the Prospective Payment System (PPS) rate or Alternative Prospective Payment System (APPS) rate.

FQHC practitioners may be employees of the FQHC or contracted with the FQHC.

FQHCs may be reimbursed the facility fee (procedure code Q3014) as an add-on procedure code that should not be included in any cost reporting that is used to calculate a PPS or APPS per visit encounter rate.

To receive reimbursement for more than one facility fee for the same client on the same date of service, an FQHC must submit documentation of medical necessity that indicates that the client needed multiple distant-site provider consultations. An FQHC can use a signed letter from the client's treating health-

care provider at the FQHC to document the client's medical need for receiving multiple distant-site provider consultations on the same date of service. The letter must state that the client suffered an illness or injury that required additional diagnosis or treatment by a distant-site provider.

If an FQHC is eligible for payment of both an encounter fee and a facility fee for the same client on the same date of service, the FQHC must submit a claim for the facility fee separate from the claim that was submitted for the encounter.

3.4.5 Telemedicine Services for RHCs

RHCs may be reimbursed the distant-site provider fee for telemedicine services at the PPS rate. RHC practitioners may be employees of the RHC or contracted with the RHC.

The facility fee (procedure code Q3014) may be reimbursed as an add-on procedure code that should not be included in any cost reporting that is used to calculate the RHC AIR (All Inclusive Rate) PPS per visit encounter rate.

To receive reimbursement for more than one facility fee for the same client on the same date of service, an RHC must submit documentation of medical necessity that the client needed multiple distant-site provider consultations. An RHC can use a signed letter from the client's treating health care provider at the RHC documenting that the client suffered an illness or injury requiring additional diagnosis or treatment by a distant site provider. This will suffice to document the client's medical need for purposes of receiving additional facility fee payments for the same client on the same date of service. The letter must state that the client suffered an illness or injury that required additional diagnosis or treatment by a distant-site provider.

If an RHC is eligible for payment of both an encounter fee and a facility fee for the same client on the same date of service, the RHC must submit a claim for the facility fee separate from the claim submitted for the encounter.

The facility fee should not be included in any cost reporting that is used to calculate the RHC All Inclusive Rate (AIR) prospective payment system (PPS) per-visit encounter rate.

> ***Note:*** *Telemedicine and telehealth services must be billed with modifier 95. Procedure codes that indicate remote delivery (telemedicine medical services or telehealth services) in the description do not need to be billed with modifier 95.*

3.4.6 Documentation Requirements for Telemedicine

Medical records must be maintained for all telemedicine services.

Documentation for a service provided via telemedicine must be the same as for a comparable in-person service.

If a patient has a primary care provider who is not the distant site provider and the patient or their parent or legal guardian provides consent to a release of information, a distant site provider must provide the patient's primary care provider with the following information:

- A medical record or report with an explanation of the treatment provided by the distant site provider
- The distant site provider's evaluation, analysis, or diagnosis of the patient

Unless the telemedicine services are rendered to a child in a school-based setting, distant site providers of mental health services are not required to provide the patient's primary care provider with a treatment summary.

For telemedicine provided to a child in a school-based setting, a notification provided by the telemedicine physician to the child's primary care provider must include a summary of the service, exam findings, prescribed or administered medications, and patient instructions.

If the child does not have a primary care provider, the notification must be provided to the child's parent or legal guardian. In addition to providing treatment information, the notification must include a list of primary care providers from which the child's parent or legal guardian may select a primary care provider.

3.5 Telehealth Services

Telehealth services, also known as telehealth, are allowable for Texas Medicaid. Telehealth has the meaning assigned by *Texas Occupations Code* §111.001. Telehealth services are defined as health-care services, other than telemedicine medical services or a teledentistry service, delivered by a health professional licensed, certified or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification or entitlement to a patient at a different physical location other than the health professional using telecommunications or information technology.

Telehealth services are reimbursed in accordance with 1 TAC §355.

3.5.1 Distant Site

A distant site is the location of the provider rendering the service. A distant site provider is the health professional licensed, certified, or otherwise entitled to practice in Texas who uses telehealth services to provide health care services to a patient in Texas.

Licensed psychological associates (LPAs), provisionally licensed psychologists (PLPs), post-doctoral psychology fellows, and pre-doctoral psychology interns under psychologist supervision may also deliver telehealth services. All requirements outlined in the Outpatient Mental Health Services benefit language must be met.

Distant site providers that provide mental health services must be appropriately licensed or certified in Texas or be a QMHP-CS as defined in 26 *Texas Administrative Code* §301.303(48).

A distant-site provider that is located outside of state lines while rendering services is considered an out-of-state provider.

The distant site provider must obtain informed consent to treatment from the patient, patient's parent or the patient's legal guardian prior to rendering a telehealth service.

Distant site providers should meet all other telehealth service requirements specified in Texas Occupations Code §111.

Procedure codes that are benefits for distant site providers when billed with the 95 modifier (synchronous audiovisual technology) are included in the individual TMPPM handbooks. Procedure codes that indicate remote (telehealth service) delivery in the description do not need to be billed with the 95 modifier.

Procedure codes that are a benefit for distant site providers when billed with the 93 modifier (synchronous audio-only technology) are included in the individual TMPPM handbooks. Procedure codes that indicate telephone or audio-only delivery in their description do not need to be billed with the 93 modifier.

Behavioral health procedure codes that are a benefit for the distant site providers when billed with the FQ modifier (synchronous audio-only technology) are included in the individual TMPPM handbooks. Procedure codes that indicate telephone or audio-only delivery in their description do not need to be billed with the FQ modifier.

3.5.2 Patient Site

A patient site is the place where the client is physically located while the service is rendered. Patient-site providers that are enrolled in Texas Medicaid may only be reimbursed for the facility fee using procedure code Q3014. Charges for other services that are performed at the patient site may be submitted separately.

A client's home may be the patient site for telehealth. Procedure code Q3014 is not a benefit if the patient site is the client's home.

3.5.3 Distant-Site Telehealth Services for FQHCs

FQHCs may be reimbursed the distant-site provider fee for telehealth services at the Prospective Payment System (PPS) rate or Alternative Prospective Payment System (APPS) rate.

FQHC practitioners may be employees of the FQHC or contracted with the FQHC.

The facility fee (procedure code Q3014) may be reimbursed as an add-on procedure code and should not be included in any cost reporting that is used to calculate a PPS or APPS per visit encounter rate.

To receive reimbursement for more than one facility fee for the same client on the same date of service, an FQHC must submit documentation of medical necessity indicating that the client needed multiple distant site provider consultations.

An FQHC can use a signed letter from the client's treating health care provider at the FQHC documenting that the client suffered an illness or injury requiring additional diagnosis or treatment by a distant site provider. This will suffice to document the client's medical need for purposes of receiving additional facility fee payments for the same client on the same date of service.

If an FQHC is eligible for payment of both an encounter and a facility fee for the same client on the same date of service, the FQHC must submit claims for the facility fee separate from claims submitted for the encounter.

3.5.4 Distant-Site Telehealth Services for RHCs

RHCs may be reimbursed the distant-site provider fee for telehealth services at the PPS rate.

RHC practitioners may be employees of the RHC or contracted with the RHC.

The facility fee (procedure code Q3014) may be reimbursed as an add-on procedure code that should not be included in any cost reporting that is used to calculate the RHC AIR (All Inclusive Rate) PPS per visit encounter rate.

To receive reimbursement for more than one facility fee for the same client on the same date of service, an RHC must submit documentation of medical necessity indicating that the client needed multiple distant site provider consultations.

A signed letter from the client's treating health care provider at the RHC documenting that the client suffered an illness or injury requiring additional diagnosis or treatment by a distant site provider will suffice to document the client's medical need for purposes of receiving additional facility fee payments for the same client on the same date of service.

If an RHC is eligible for payment of both an encounter and a facility fee for the same client on the same date of service, the RHC must submit claims for the facility fee separate from claims submitted for the encounter.

3.5.5 Telehealth Service Delivery

The following delivery methods may be used to provide telehealth services within FFS Medicaid:

- Synchronous audiovisual technology between the distant site provider and the client in another location
- Synchronous audio-only technology between the distant site provider and the client in another location
- Store and forward technology, in conjunction with synchronous audio-only technology between the distant site provider and the client in another location. The distant site provider must use one of the following:

- Clinically relevant photographic or video images, including diagnostic images
- The client's relevant medical records, such as medical history, laboratory and pathology results, and prescriptive histories

A Texas Medicaid MCO is not required to provide reimbursement for telehealth services that are provided through the following methods:

- A text-only email message
- A facsimile transmission

Texas Medicaid MCOs may optionally provide reimbursement for telehealth services that are provided through asynchronous audio-only technology, including voice mail technology. Distant site providers should contact each MCO to determine whether an MCO provides reimbursement for a specified modality.

3.5.6 Telehealth Service Documentation Requirements

Medical records must be maintained for all telehealth services.

Documentation for a telehealth service must be the same as a comparable in-person service.

If a client has a primary care provider, and the client or their parent or legal guardian provides consent to release information, a distant site provider must provide the client's primary care provider with the following information:

- A medical record or report with an explanation of the treatment provided by the distant site provider
- The distant site provider's evaluation, analysis, or diagnosis of the client

Providers of mental health services are not required to provide a client's primary care provider with a treatment summary.

ECI providers are not required to provide the client's primary care physician with a treatment summary.

3.6 Telemonitoring Services

Home telemonitoring is a health service that requires scheduled remote monitoring of data related to a client's health, and transmission of the data from the client's home to a licensed home health agency or a hospital. The data transmission must comply with standards set by HIPAA.

Data parameters are established as ordered by a physician's plan of care.

Data must be reviewed by a registered nurse (RN), NP, CNS, or PA, who is responsible for reporting data to the prescribing physician in the event of a measurement outside the established parameters.

Scheduled periodic reporting of the client data to the physician is required at least once every 30 days, even when there have been no readings outside the parameters established in the physician's orders. The RN, NP, CNS, or PA in a licensed home health agency or a hospital is responsible for reporting data to the prescribing physician. Telemonitoring providers must be available 24 hours a day, 7 days a week. Although transmissions are generally at scheduled times, they can occur any time of the day or any day of the week, according to the client's plan of care.

Collection and interpretation of a client's data for home telemonitoring services (procedure code 99091) is a benefit in the office or outpatient hospital setting when services are provided by a physician or other qualified health care professional. Procedure code 99091 is limited to once in a 30-day period.

Home telemonitoring is a benefit for clients who have been diagnosed with either diabetes or hypertension or both.

Home telemonitoring services are also a benefit for clients who are 20 years of age and younger, with one or more of the following conditions:

- End-stage solid organ disease
- Organ transplant recipient
- Requiring mechanical ventilation

The physician who orders home telemonitoring services has a responsibility to ensure the following:

- The client has a choice of home telemonitoring providers.
- The client has the right to discontinue home telemonitoring services at any time.

Although Texas Medicaid supports the use of home telemonitoring, clients are not required to use this service.

3.6.1 Facility Services

The provision and maintenance of home telemonitoring equipment is the responsibility of the home health agency or the hospital. The one-time initial setup and installation (procedure code S9110 with modifier U1) of the equipment in the client's home is a benefit when services are provided by a home health agency or an outpatient hospital. Monthly home monitoring services (procedure code S9110 with the appropriate modifier) are a benefit when services are provided by a home health agency or an outpatient hospital. Hospital providers must submit revenue code 780 with procedure code S9110 and one of the appropriate modifiers listed in the table within this section.

Use one of the following modifiers with monthly home monitoring services procedure code S9110 to indicate the number of transmission days per month:

Modifier	Number of Days Per Month
U2	1 through 5 days per month
U3	6 through 10 days per month
U4	11 through 15 days per month
U7	16 through 20 days per month
U8	21 through 25 days per month
U9	26 through 30 days per month

The unit of reimbursement for procedure code S9110 and the appropriate modifier is a rolling month.

Providers must bill the appropriate modifier to indicate the number of days that transmissions of data were received and reviewed for the client within a rolling month.

Providers are not required to submit modifiers U2, U3, U4, U7, U8, or U9 for telemonitoring on the prior authorization request, but are required to submit the appropriate modifier on the claim for reimbursement based on the number of days as outlined in the table.

Documentation supporting medical necessity for telemonitoring services must be maintained in the client's medical record by the entity providing the service (home health agency or hospital) and is subject to retrospective review. All paid telemonitoring services not supported by documentation of medical necessity are subject to recoupment.

3.7 Prior Authorization

Prior authorization is not required for telemedicine or telehealth services; however, it may be required for the individual procedure codes billed.

3.7.1 Prior Authorization of Telemonitoring Services

Procedure code 99091 does not require prior authorization.

Procedure code S9110 with or without modifier U1 requires prior authorization. Home telemonitoring services may be approved for up to 180 days per prior authorization request.

Procedure code S9110 with modifier U1 can only be prior authorized once per episode of care even if monitoring parameters are added after initial setup and installation, unless the provider submits documentation that extenuating circumstances require another installation of telemonitoring equipment.

Procedure code S9110 for the transmission of client data will be prior authorized no more than once per month for the duration of the prior authorization period.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

The initial request for prior authorization must be received no more than three business days from the date the home telemonitoring services are initiated. Requests received after the three-business day period will be denied for dates of service that occurred before the date the request was received.

The request must include the physician-ordered frequency of the clinical data transmission and the client's diagnoses and risk factors that qualify the client for home telemonitoring services.

Requests for additional home telemonitoring services received after the current prior authorization period ends will be denied for dates of service provided before the date the request was received.

A completed Home Telemonitoring Services Prior Authorization Request form must be submitted to request home telemonitoring services.

The Home Telemonitoring Services Prior Authorization Request form must be signed and dated within 30 days before the start of care. An RN, NP, CNS, or PA may sign the prior authorization request form on behalf of the client's physician when the physician delegates this authority to the RN, NP, CNS, or PA. The RN, NP, CNS, or PA name, NPI, signature, and date must appear on the form.

If the prior authorization form is not signed and dated by the physician or an authorized delegate, the prior authorization request must be accompanied by a written order or prescription that is signed and dated by the physician, or a complete verbal order from the physician. A complete written order or verbal order must include all of the following:

- Physician ordered home telemonitoring transmission frequency.
- The client's qualifying condition(s) and risk factors for home telemonitoring services.
- The ordered services including applicable procedure codes or descriptions.
- Dates of service matching or greater than those on the prior authorization request form.
- If prior authorization is being requested for the initial setup and installation, orders for initial requests must include the initial setup procedure code or description.

Note: *A verbal order is considered current when the date received is on, or no more than, 30 days before the start of home telemonitoring services for the requested authorization period. A written order or prescription is considered current when it is signed and dated on, or no more than, 30 days before the start of home telemonitoring services.*

A request received without a physician's or an authorized delegate's signature, documented verbal order, or written prescription will not be approved and may be denied.

Telemonitoring services will not be approved for clients of any age who have diabetes or hypertension unless they have two or more of the following risk factors:

- Two or more hospitalizations in the previous 12-month period
- Frequent or recurrent emergency department visits
- A documented history of poor adherence to medication regimens
- Documented history of falls in the previous 6-month period
- Limited or absent informal support systems
- Living alone or being home alone for extended periods of time
- A documented history of care access challenges

Prior authorization will be considered for clients who are 20 years of age and younger and have at least one of the following conditions:

- End-stage solid organ disease
- Organ transplant recipient
- Mechanical ventilation

To avoid unnecessary denials, the requesting provider must provide correct and complete information, including documentation for medical necessity of the equipment requested. The physician and telemonitoring provider must maintain documentation of medical necessity in the client's medical record.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

3.8 Documentation Requirements

Documentation for a telecommunication service must be the same as for a comparable in-person service.

3.8.1 Documentation Requirements for Telemonitoring Providers

The home health agency or hospital must maintain documentation in the client's medical record that shows:

- The telemonitoring equipment is:
  - Capable of monitoring any data parameters included in the plan of care.
  - A Food and Drug Administration (FDA) Class II hospital-grade medical device.
  - Capable of measuring and transmitting the client's weight, oxygen levels in blood, glucose levels in blood, or blood pressure data.
- The monitoring equipment is being used, which must be demonstrated with data transmission information such as the:
  - Date of transmission.
  - Frequency of transmission.
  - Clinical data that was provided to the client's primary care physician or the physician's designee.
- The provider's staff is qualified to install the telemonitoring equipment and to monitor the client's data, which will be transmitted according to the client's care plan.
- No other provider is also monitoring the client's clinical data.

- Whether the client is able to operate the equipment or has a willing and able person to assist in completing electronic transmission of data. (Not required if the equipment does not require active participation from the client.)
- There are written protocols, policies, and procedures about the provision of the home telemonitoring services that are available to HHSC or its designee upon request and that they address the:
  - Authentication and authorization of users.
  - Authentication of the origin of client data transmitted.
  - Prevention of unauthorized access to the system or information.
  - System security, including the integrity of information that is collected, program integrity, and system integrity.
  - Maintenance of documentation about system and information usage.
  - Information storage, maintenance, and transmission.
  - Synchronization and verification of patient profile data.

4 Claims Filing and Reimbursement

4.1 Claims Information

Claims for telecommunication services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills and itemized statements are not accepted as claim supplements.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

4.1.1 Telemonitoring Services

Providers submitting claims for clients who have dual eligibility for Medicaid and Medicare must first submit their claims to Medicare for procedure code 99091. Claims for procedure code S9110 with any modifier should not be submitted to Medicare. Procedure code S9110 is not payable by Medicare.

A claim submitted for a subsequent set up and installation of telemonitoring equipment (procedure code S9110 with modifier U1) will not be reimbursed unless there is a documented new episode of care.

4.2 Reimbursement

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

5 Claims Resources

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

6 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday–Friday from 7 a.m. to 7 p.m., Central Time.

7 Forms

The following linked form can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Form
Home Telemonitoring Services Prior Authorization Request