IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202239 MAY 19, 2022

IHCP announces final 2022 telehealth and virtual services code set

The Indiana Health Coverage Programs (IHCP) will be using an updated telehealth and virtual services code set for the remainder of 2022 (first proposed in *IHCP Bulletin* BT2021112). Effective for dates of service on and after July 21, 2022, the following changes will be made to the originally proposed code set:

- For certain telehealth services, an audio-only modifier (93) can be used to signify when a service is delivered via audio-only telehealth. Services eligible for reimbursement when billed with this new modifier are identified within this finalized code set. All other codes must be delivered via video and audio telehealth.
- Intensive Outpatient Treatment (IOT) services (H0015, S9480)-will be reimbursed when rendered via telehealth. For more details on telehealth IOT, see the *Intensive Outpatient Treatment Services via Telehealth* section of this bulletin.
- The following discharge or evaluation and management codes were added for telehealth coverage:
  - Hospital discharge day management (99238–99239)
  - Initial evaluation and management of a patient in a nursing facility (99304–99306)
  - Evaluation and management of a new or established patient in a domiciliary or rest home (99324–99328, 99334, 99335)
  - Evaluation and management of a new or established patient in their home (99341–99345, 99347–99350)

For the remainder of 2022, services that are delivered via telehealth will continue to be reimbursed at the same reimbursement rates as if the service were delivered in person.

The new code set is in effect for dates of service on or after July 21, 2022, and will expire at the end of 2022. It will be reevaluated for 2023. This coverage and PA policy apply to all IHCP programs that offer such services – including but not limited to Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise and Traditional Medicaid. The new code set will be used by fee-for-service (FFS) and managed care delivery systems.

For DOS on or after July 21, 2022, practitioners will be reimbursed only for services featured on the telehealth and virtual services code set when rendering services via telehealth, with the appropriate place of service (POS) codes and modifiers included on the claim submission. For dates of service prior to July 21, 2022, practitioners are required to continue to bill for services using the same protocols established during the public health emergency (PHE) announced in BT2020106.

This information will be included in *Telehealth Service Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers, and the *Telemedicine and Telehealth Services* provider reference module.

Telehealth and virtual services

The codes listed are separated into three categories: telehealth medical services, nonhealthcare virtual services and telehealth dental services. All three tables listed in this bulletin are to be used in the delivery for virtual/telehealth services that make up the overall telehealth and virtual services code set. Specific billing guidance under each service category are provided in this bulletin, along with special billing considerations for specific providers.

Remote patient monitoring (RPM) services also fall under IHCP's interpretation of telehealth services. See IHCP Bulletin BT202238 for details on service coverage and billing.

The code set is to be used for the remainder of 2022; however, the Office of Medicaid Policy and Planning (OMPP) is aware that *Senate Enrolled Act (SEA) 284* (Public Law 109) may allow some providers or programs to offer additional services using telehealth in rendering care. Clarification bulletins will be published by the IHCP prior to the bill's effective date of July 1, 2022.

Telehealth medical services

Telehealth medical services follow the definition listed in *Indiana Code IC 25-1-9.5-6*: "the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA)." For a provider to be reimbursed for telehealth services under the IHCP, the provider must be enrolled with the IHCP and be a licensed practitioner listed in *IC 25-1-9.5-3.5*. Providers rendering services in state are also encouraged to have a telehealth provider certification filed with the Indiana Professional Licensing Agency. Providers rendering services out of state are required to have a telehealth provider certification under *IC 25-1-9.5-9*.

For the reimbursement of telehealth medical services, the service code billed must be a procedure code listed in Table 1, and must be a service for which the member is eligible under their IHCP coverage. Additionally, the claim must have:

- An appropriate place of service (POS) code of one of the following:
  - 02 – *Telehealth provided other than in patient's home*
  - 10 – *Telehealth provided in the patient's home*
- An appropriate modifier of one of the following:
  - 95 – *Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system*
  - *93 – Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system*

Nonhealthcare virtual services

Nonhealthcare virtual services take place between a patient and a provider via interactive electronic communications technology. These services do not require a licensed practitioner listed in *IC 25-1-9.5-3.5* to perform the service virtually, as the services are not considered healthcare services under the definition listed in *IC 25-1-9.5-2.5* and, therefore, do not fall under the definition of telehealth by the IHCP. As specified in Table 2, nonhealthcare virtual services must be billed with a POS of 02 or 10, and do not require modifiers 93 or 95. All services in this category can be provided via audio only.

Note that the nonhealthcare virtual service codes in Table 2 do not include all Home- and Community-Based Services (HCBS) waiver services currently allowed to be delivered virtually per Appendix K authority. For more information on virtual services allowed for HCBS waiver providers under Appendix K authority, see IHCP Bulletin BT202188.

Telehealth dental services

Dental services listed in Table 3 are covered when provided through telehealth. These services must be billed with POS code 02 or 10, and do not require modifiers 93 or 95. These services cannot be billed via audio-only telehealth.

Special billing considerations

Special billing considerations apply for federally qualified health center (FQHC) and rural health clinic (RHC) providers as well as for intensive outpatient treatment (IOT) services.

FQHC and RHC providers

FQHC and RHC providers may continue to bill for telehealth services if the service rendered is considered a valid FQHC or RHC encounter and a covered telehealth service (as defined by the code set featured in this bulletin). Subject to the following criteria, reimbursement is available to FQHCs and RHCS when they are serving as either the distant site or the originating site for telehealth services.

When the FQHC or RHC is the **distant site**, the service provided by the FQHC or RHC must meet the requirements both for a valid encounter and for an approved telehealth service. The claim must include the following:

- An encounter code T1015 (or D9999 for valid dental encounters), billed with POS code 02, 03, 04, 10, 11, 12, 31, 32, 50 or 72
- One or more appropriate procedure codes for the specific services rendered, billed with modifier 93 or 95, and a POS code of either 02 or 10, depending on the originating site/location of the patient

  Note: The procedure code must appear on one of the code tables in this bulletin, and must be on the list of procedure codes allowable for an FQHC/RHC medical or dental encounter.

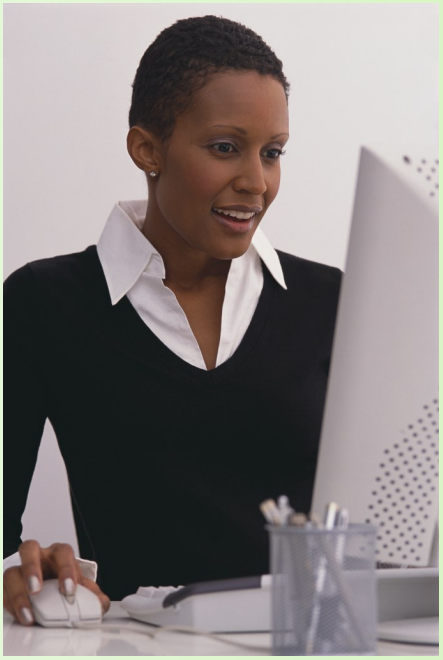
When the FQHC or RHC is the **originating site** (the location where the patient is physically located), the FQHC or RHC may be reimbursed if it is medically necessary for a medical professional to be present with the member, and the service provided includes all components of a valid encounter code. The claim must include the following:

- Encounter code T1015 (or D9999 for valid dental encounters), billed with POS code 02, 03, 04, 11, 12, 31, 32, 50 or 72
- Procedure code Q3014 – *Telehealth originating site facility fee*, billed with POS code 02 and modifier 95
- One or more appropriate procedure codes for the specific services rendered, billed with modifier 93 or 95, and a POS code of either 02 or 10, depending on the originating site/location of the patient

  Note: The procedure code must appear on one of the code tables in this bulletin, and must be on the list of procedure codes allowable for an FQHC/RHC medical or dental encounter.

Intensive outpatient treatment via telehealth

After receiving feedback from providers over an allotted 30-day period, the IHCP has determined that IOT services (procedure codes H0015 and S9480) will be reimbursable when delivered via telehealth. This service will be added to the 2022 telehealth and virtual services code set.



The-IHCP is approaching this temporary policy expansion as a pilot initiative, where any healthcare provider engaging in telehealth IOT will be opting in to the analysis of the efficacy of this model through data collection and analysis. This data collection and analysis will be administered through the state and is intended to have a minimal administrative impact on providers. All providers submitting claims for telehealth IOT will automatically be included in the study and are expected to participate by providing data if requested. Telehealth IOT will be available for 12 months after which the data collected will be analyzed by the Division of Mental Health and Addiction (DMHA). To confirm participation in this pilot, email dmhadata@fssa.in.gov with the following information: your organization's name and a contact's name, phone number, and email address.

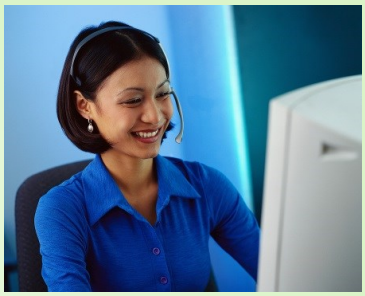
IOT currently requires prior authorization (PA) for medical necessity for these services, and the IHCP will maintain the same PA requirement for IOT when it is delivered via telehealth. Additionally, the IHCP will require the following criteria are met when performing IOT via telehealth:

- The intake process for telehealth IOT must be conducted in person, such as at the IOT provider location or at another location with an appropriately licensed service provider contracted by or otherwise approved by the IOT provider.
- The patient chart must include a record of the call/check-in by a staff member (case manager or peer) prior to IOT session to confirm that the patient is still eligible and appropriate for telehealth IOT.
- A maximum of eight patients per group can participate in IOT via telehealth. If a provider uses a hybrid model that includes both telehealth and in person, a maximum of eight patients per group may participate via telehealth, and the total group size may not exceed 12 people.

- A physician, psychiatric nurse practitioner or physician assistant assessment of the appropriateness and potential risks of telehealth IOT care for each patient must be documented in the patient's medical record.
- Each patient log-in and log-off time and total time on the call/meeting for each three-hour session must be documented.

- The individualized treatment plan for each virtual patient must indicate who will be in the home with them during telehealth IOT in the event that an emergency takes place:
  - For minors or individuals under guardianship, an adult caregiver must be present in the home during telehealth IOT.
  - For adults, if there is no one in the home, an emergency contact must be documented. Additionally, there must be a release of information for the emergency contact that allows disclosure of the nature of the emergency event.
- Documented protocols must be in place to address risk behaviors and decompensation in the individual's home.
- A crisis plan must be completed and documented in the patient chart prior to start of the IOT service and must contain, at minimum:
  - An emergency contact
  - A plan with multiple options for who the client may contact and/or what the client may do to deescalate if they experience a mental health or substance use crisis and/or suicidal or homicidal ideation.

  One copy of this plan should be given to the client and another copy kept in the chart.
- IOT delivered via telehealth must have a video component. Telehealth IOT cannot be audio-only (for example, via telephone). Telehealth IOT cannot be billed with modifier 93. Cameras must be on and used by IOT participants for the entire duration of the session, with camera-off time documented and not billable.
- The standard practice of routine discharge processes must be followed, including after-care appointment expectations regarding continuity of care for psychiatric medication monitoring within a specific time frame.
- At least one one-on-one meeting must occur every seven days between staff (case manager, peer) and patient – via telehealth or in community or office. For minors or individuals under guardianship, this meeting is required one time every seven days between staff member, client, and parent or guardian. Every 14 days, the one-on-one meeting between staff (case manager, peer) and patient (and parent or guardian for minors or individuals under guardianship) is required to be in person.
- To the extent required by the patient's individual treatment plan, drug screens must be completed in person at the IOT provider location or other location approved by the IOT provider. Those with a primary or secondary substance use disorder (SUD) diagnosis must have a drug screen at least once every seven days. Those without an SUD diagnosis must receive a random drug screen at least monthly to maintain an objective analysis of any new substance use issues that may occur.



- To the extent required by the patient's individual treatment plan, verification of compliance with prescribed medication must be conducted every seven days, at the IOT provider location or other location approved by the IOT provider. This verification could include pill counts, a report from the client, a report from the client, a report from a parent or guardian, and/or laboratory monitoring.
- Every virtual program must also have an in-person option available for people who are not complying with the rules of the telehealth care model or who are not stable enough or interested in the virtual care option.

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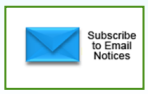

2022 Telehealth and Virtual Services Code Set

Table 1 – Covered Procedure Codes for Telehealth Medical Services

When the services in this table are delivered as telehealth, claims require place of service (POS) code 02 or 10 and modifier 95 or, if indicated as allowable, 93.

The preceding guidance applies to all programs that include coverage for these codes, including Medicaid Rehabilitation Option (MRO), with the exception of Home- and Community-Based Services (HCBS) and Money Follows the Person (MFP) programs. Modifiers 95 and 93 should not be used for HCBS or MFP claims – including any HCBS waiver plan or MFP plan as well as Adult Mental Health and Habilitation, Behavioral and Primary Healthcare Coordination Service, or Child Mental Health Wraparound.

Note: Codes marked with a single asterisk (*) are billable only for certain IHCP members/programs. If a member does not have eligibility to receive these services in person through the IHCP, then they are not eligible to receive these services via telehealth.

This table does not include the remote patient monitoring (RPM) codes covered for telehealth. For information about covered RPM codes, see IHCP Bulletin BT202238.

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
59425	Antepartum care only; 4-6 visits	Yes
59426	Antepartum care only; 7 or more visits	Yes
59430	Postpartum care only (separate procedure)	Yes
90785	Interactive complexity	Yes
90791	Psychiatric diagnostic evaluation	No
90792	Psychiatric diagnostic evaluation with medical services	No
90832	Psychotherapy with patient, 30 minutes	Yes
90833	Psychotherapy with patient with E/M, 30 minutes	Yes
90834	Psychotherapy with patient, 45 minutes	Yes
90836	Psychotherapy with patient with E/M, 45 minutes	Yes
90837	Psychotherapy with patient, 60 minutes	Yes
90838	Psychotherapy with patient with E/M, 60 minutes	Yes
90839	Psychotherapy for crisis, first 60 minutes	Yes
90840	Psychotherapy for crisis	Yes
90845	Psychoanalysis	Yes
90846	Family psychotherapy without patient, 50 minutes	Yes
90847	Family psychotherapy including patient, 50 minutes	Yes
90849	Multiple-family group psychotherapy	No
90853	Group psychotherapy (other than of a multiple-family group)	Yes
90951	Dialysis services (4 or more physician visits per month), patient younger than 2 years of age	No
90952	Dialysis services (2-3 physician visits per month), patient younger than 2 years of age	No
90954	Dialysis services (4 or more physician visits per month), patient 2-11 years of age	No
90955	Dialysis services (2-3 physician visits per month), patient 2-11 years of age	No
90957	Dialysis services (4 or more physician visits per month), patient 12-19 years of age	No
90958	Dialysis services (2-3 physician visits per month), patient 12-19 years of age	No
90960	Dialysis services (4 or more physician visits per month), patient 20 years of age and older	No
90961	Dialysis services (2-3 physician visits per month), patient 20 years of age and older	No
90963	Home dialysis services per month, patient younger than 2 years of age	No
90964	Home dialysis services per month, patient 2-11 years of age	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
90965	Home dialysis services per month, patient 12-19 years of age	No
90966	Home dialysis services per month, patient 20 years of age or older	No
90967	Dialysis services, per day (less than full month service), patient younger than 2 years of age	No
90968	Dialysis services, per day (less than full month service), patient 2-11 years of age	No
90969	Dialysis services, per day (less than full month service), patient 12-19 years of age	No
90970	Dialysis services, per day (less than full month service), patient 20 years of age or older	No
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	No
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits	No
92012	Eye exam, established patient	No
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits	No
92227	Diagnostic imaging of retina	No
92228	Diagnostic imaging of retina management	No
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	No
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	No
92521	Evaluation of speech fluency (e.g. stuttering, cluttering)	No
92522	Evaluation of speech sound production (e.g. articulation, phonological process, apraxia, dysarthria)	No
92523	Evaluation of speech sound production (e.g. articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (eg, receptive and expressive language)	No
92524	Behavioral and qualitative analysis of voice resonance	No
92526	Treatment of swallowing dysfunction and/or oral function for feeding	No
92550	Tympanometry and reflex threshold measurements	No
92551	Screening test, pure tone, air only	No
92552	Pure tone audiometry (threshold); air only	No
92553	Pure tone audiometry (threshold); air and bone	No
92555	Speech audiometry threshold;	No
92556	Speech audiometry threshold; with speech recognition	No
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	No
92560	Bekesy audiometry; screening	No
92561	Diagnostic hearing loss test	No
92563	Tone decay test	No
92565	Stenger test, pure tone	No
92567	Tympanometry (impedance testing)	No
92568	Acoustic reflex testing, threshold	No
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	No
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	No
92590	Hearing aid examination and selection; monaural	No
92591	Hearing aid examination and selection; binaural	No
92592	Hearing aid check; monaural	No
92593	Hearing aid check; binaural	No
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	No
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	No
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	No
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	No
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	No
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	No
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	No
92609	Therapeutic services for the use of speech-generating device, including programming and modification	No
92610	Evaluation of oral and pharyngeal swallowing function	No
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	No
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	No
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)	No
92630	Auditory rehabilitation; prelingual hearing loss	No
92633	Auditory rehabilitation; postlingual hearing loss	No
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	No
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	No
93750	Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report	No
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	No
96040	Medical genetic patient or family counseling services each 30 minutes	Yes
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	No
96110	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	Yes

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	Yes
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)	Yes
96116	Neurobehavioral status examination by qualified health care professional with interpretation and report, first 60 minutes	No
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)	No
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	No
96156	Health behavior assessment, or re-assessment	Yes
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	Yes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	Yes
96160	Administration and interpretation of patient-focused health risk assessment	Yes
96161	Administration and interpretation of caregiver-focused health risk assessment	Yes
96164	Health behavior intervention, group, face-to-face; initial 30 minutes	Yes
96165	Health behavior intervention, group, face-to-face; each additional 15 minutes	Yes
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	Yes
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	Yes
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	Yes
96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes	Yes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	No
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	No
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	No
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)	No
97150	Therapeutic procedure(s), group (2 or more individuals)	No
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	No
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	No
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	No
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.	No
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.	No
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.	No
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family	No
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	No
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	No
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	Yes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	No
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	No
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	No
97802	Medical nutrition therapy, assessment and intervention, each 15 minutes	Yes
97803	Medical nutrition therapy re-assessment and intervention, each 15 minutes	Yes
97804	Medical nutrition therapy performed in a group setting, each 30 minutes	Yes

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
98960	Education and training for patient self-management, each 30 minutes	Yes
98961	Education and training for patient self-management, 2-4 patients, each 30 minutes	Yes
98962	Education and training for patient self-management, 5-8 patients, each 30 minutes	Yes
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straight forward medical decision making. When using time for code selection 15-29 minutes of total time is spent on the date of the encounter.	No
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	No
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	No
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	No
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	No
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	No
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	No
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	No
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	No
99217	Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
99218	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	No
99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	No
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	No
99221	Initial hospital inpatient care, typically 30 minutes per day	No
99222	Initial hospital inpatient care, typically 50 minutes per day	No
99223	Initial hospital inpatient care, typically 70 minutes per day	No
99224	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	No
99225	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
99226	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	No
99231	Subsequent hospital inpatient care, typically 15 minutes per day	No
99232	Subsequent hospital inpatient care, typically 25 minutes per day	No
99233	Subsequent hospital inpatient care, typically 35 minutes per day	No
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.	No
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	No
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.	No
99238	Hospital discharge day management; 30 minutes or less	No
99239	Hospital discharge day management; more than 30 minutes	No
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	No
99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	No
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.	No
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	No
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	No
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)	No
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	No
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit	No
99307	Subsequent nursing facility visit, typically 10 minutes per day	No
99308	Subsequent nursing facility visit, typically 15 minutes per day	No
99309	Subsequent nursing facility visit, typically 25 minutes per day	No
99310	Subsequent nursing facility visit, typically 35 minutes per day	No
99324	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent with the patient and/or family or caregiver.	No
99325	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient and/or family or caregiver.	No
99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.	No
99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
99328	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.	No
99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.	No
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.	No
99341	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	No
99342	Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	No
99343	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
99344	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	No
99345	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.	No
99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.	No
99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	No
99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	No
99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.	No
99354	Prolonged office or other outpatient service first hour	No
99355	Prolonged office or other outpatient service each 30 minutes beyond first hour	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
99356	Prolonged inpatient or observation hospital service first hour	No
99357	Prolonged inpatient or observation hospital service each 30 minutes beyond first hour	No
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)	No
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)	No
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)	No
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)	No
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)	No
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)	No
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)	No
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)	No
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years	No
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years	No

Procedure code	Description	Audio-Only (Can be billed with the 93 modifier)
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older	No
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	Yes
99406	Smoking and tobacco use intensive counseling, < 10 minutes	Yes
99407	Smoking and tobacco use intensive counseling, greater than 10 minutes	Yes
99408	Alcohol and/or substance abuse screening and intervention, 15-30 minutes	Yes
99409	Alcohol and/or substance abuse screening and intervention, greater than 30 minutes	Yes
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	Yes
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes	Yes
G0444	Annual depression screening, 15 minutes	Yes
H0004*	Behavioral health counseling and therapy, per 15 minutes	No
H0005*	Alcohol and/or drug services; group counseling by a clinician	No
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	No
H0031	Mental health assessment, by nonphysician	No
H0034*	Medication training and support, per 15 minutes	No
H2011	Crisis intervention service, per 15 minutes	Yes
H2035*	Alcohol and/or other drug treatment program, per hour	No
Q3014**	Telehealth originating site facility fee	No
S9480	Intensive outpatient psychiatric services, per diem	No

* *Codes marked with a single asterisk (*) are billable only for certain IHCP members/programs. If a member does not have eligibility to receive these services in person through the IHCP, then they are not eligible to receive these services via telehealth.*

** *Code Q3014, signifying the telehealth originating site facility fee, can only use POS code 02 and modifier 95. Q3014 is not eligible for reimbursement when billed with POS code 10 or modifier 93.*

Table 2 – Procedure Codes for Nonhealthcare Virtual Services

*When the services in this table are delivered as virtual, claims require POS code 02 or 10, and **do not require** modifiers 93 or 95.*

All services in this category can be provided via audio only.

Procedure code	Description
T1016*	Case management, each 15 minutes
T2022*	Case management, per month
A9279*	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)

* *Codes marked with an asterisk (*)are billable only for certain members/programs under the IHCP. If a member does not have eligibility to receive these services in person through the IHCP, then they are not eligible to receive these services via telehealth.*

Table 3 – Procedure Codes for Telehealth Dental Services

*When the services in this table are delivered as telehealth, claims require POS code 02 or 10, and **do not require** modifiers 93 or 95.*

These services cannot be billed via audio-only telehealth.

Procedure code	Description
D0140	Limited oral evaluation - problem focused
D1320	Tobacco counseling for the control and prevention of oral disease