

TELEMEDICINE AND AUDIO-ONLY SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the [provider enrollment chart](#) for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the [South Dakota Medicaid Provider Agreement](#).

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's [online portal](#).

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

| Coverage Type | Coverage Limitations |
|--|--|
| Medicaid/CHIP Full Coverage | Medically necessary services covered in accordance with the limitations described in this chapter. |
| Qualified Medicare Beneficiary – Coverage Limited (73) | Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services. |
| Unborn Children Prenatal Care Program (79) | Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby. |
| Medicaid Renal Coverage up to \$5,000 (80) | Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to renal failure, prescription drugs necessary for dialysis or transplants not covered by other sources and non-emergency medical travel reimbursement to renal failure related appointments. |

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility including information regarding limited coverage aid categories.

TELEMEDICINE COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the [General Coverage Principles](#) manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Telemedicine Overview

Services provided via telemedicine are subject to the same service requirements and limitations as in-person services. Providers must have and utilize appropriate equipment to provide a service via telemedicine. Telemedicine services always involve an originating site and a distant site. An originating site is the physical location of the Medicaid recipient at the time the service is provided. The distant site is the physical location of the practitioner providing the service via telemedicine.

HIPAA Compliant Platform

South Dakota Medicaid requires telemedicine services are in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations as enforced by The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS).

Originating Sites

Telemedicine originating sites for services provided via telemedicine include any site in the U.S. where the patient is at the time of the telemedicine service, including a person's home. Originating sites listed below are eligible to receive a facility fee for each completed telemedicine transaction for a covered distant site telemedicine service. Sites not listed may also serve as an originating site but are not eligible for a facility fee reimbursement. Originating sites are not reimbursed for any additional costs associated with equipment, technicians, technology, or personnel utilized in the performance of the telemedicine service. The originating site fee is not reimbursable for audio-only services and should not be billed for these services. An originating site fee also is not reimbursable if the service could be provided onsite at the originating site, but the service is being provided via telemedicine solely due to patient preference to see a provider that is not located at the originating site.

Originating sites must be an enrolled provider to be reimbursed by South Dakota Medicaid. The following providers are eligible to be reimbursed a facility fee for serving as an originating site:

- Office of a physician or practitioner;
- Outpatient Hospital;
- Inpatient Hospital;
- Critical Access Hospital;
- Rural Health Clinic (RHC);

- Federally Qualified Health Center (FQHC);
- Indian Health Service Clinic;
- A Hospital-Based or Critical Access Hospital-Based Renal Dialysis Center
- Community Mental Health Center (CMHC);
- Substance Use Disorder Agency;
- Nursing Facilities; and
- Schools.

Distant Site

Distant site locations must be in the United States. The physician or practitioner at the distant site must be licensed to provide the service in both the state of the originating site and state of the distant site. Services should be provided at a location consistent with any applicable laws or regulations regarding where services may be provided. The distant site and the originating site cannot be the same clinic/facility location. Unless prohibited by law or regulation the distant site location may be a provider's home. South Dakota Medicaid does not require the distant site location be listed on their provider enrollment record. All services provided via telemedicine at a distant site must be billed with the GT modifier in the first modifier position to indicate the service was provided via telemedicine.

The following providers can provide services via telemedicine at a distant site:

- Audiologists
- Certified Nurse Anesthetist
- Certified Social Worker – PIP
- Certified Social Worker – PIP Candidate
- Clinical Nurse Specialists
- Community Health Worker (CHW)
- Community Mental Health Centers
- Dentists
- Diabetes Education Program
- Dieticians
- Federally Qualified Health Center (FQHC)
- Indian Health Services (IHS) Clinics
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor – MH
- Licensed Professional Counselor – working toward MH designation
- Nurse-midwife
- Nurse Practitioners
- Nutritionists
- Occupational Therapists
- Physical Therapists
- Physicians
- Physician Assistants
- Podiatrists
- Psychologists

- Radiologists
- Rural Health Clinic (RHC)
- Speech Language Pathologists
- Substance Use Disorder Agencies
- Tribal 638 facilities

Same Community Services

South Dakota Medicaid covers telemedicine services even if the recipient and the provider are located in the same community. The decision of whether it is appropriate to deliver the service via telemedicine should be determined by the provider and the recipient.

Covered Procedure Codes

Only certain procedure codes may be provided via telemedicine. Refer to the Appendix for a list of procedure codes allowed to be provided via telemedicine.

Applied Behavioral Analysis (ABA) Services

ABA services may be provided via telemedicine. The service must be provided by means of “real-time” interactive telecommunications system and the provider must have a face-to-face visit within the first 30 days and every 90 days thereafter. Please refer to the [Applied Behavioral Analysis \(ABA\) Services](#) manual for additional coverage information.

Audiology Services

Limited fitting and programming audiology services may be provided via telemedicine. The service must be provided by means of “real-time” interactive telecommunications system and the provider must have a face-to-face visit within the first 30 days and every 90 days thereafter. The following services may be performed when the patient is in any setting, including the patient’s home:

- Cochlear Implant Follow-Up/Reprogramming (CPT codes 92601-92604);
- Hearing Aid Checks (CPT codes 92592-92593), and
- Auditory Function Evaluation (CPT codes 92620, 92621, 92626, and 92627).

In addition, the following services can be provided via telemedicine when the patient is located in a clinic or other setting with a qualified health professional present:

- Tympanometry (CPT code 92550 and 92567); and
- Evoked Auditory Tests (CPT codes 92585-92588).

Please refer to the [Audiology Services](#) manual for additional coverage information.

Diabetes Self-Management Training (DSMT)

When applicable, the distant site practitioner must confirm that the recipient has received or will receive 1 hour of in-person DSMT services for purposes of injection training when it is indicated during the year following the initial DSMT service or any calendar year’s 2 hours of follow-up training.

Please refer to the [Diabetes Self-Management Training Services](#) manual for additional coverage information.

End-Stage Renal Disease (ESRD) Services

ESRD services must include at least 1 visit per month be furnished face-to-face “hands on” to examine the vascular access site by a physician other licensed practitioner. Telemedicine may be used for providing additional visits

Emergency Department or Initial Inpatient Consultation

The intent of an inpatient or emergency department telemedicine consultation service is that a physician or other licensed practitioner or other appropriate source is asking another physician or other licensed practitioner for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge.

A request for an inpatient or emergency department telemedicine consultation from an appropriate source and the need for an inpatient or emergency department telemedicine consultation (i.e., the reason for a consultation service) shall be documented by the consultant in the patient's medical record and included in the requesting physician or other licensed practitioner plan of care in the patient's medical record.

Inpatient and Nursing Facility Telemedicine

Inpatient telemedicine consultations furnished to recipients in hospitals or skilled nursing facilities via telemedicine must be at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telemedicine cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telemedicine consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs.

Teledentistry Services

Please refer to the [Teledentistry Services](#) manual for information regarding coverage of teledentistry services.

Therapy Services

Physical therapy, occupational therapy, and speech language therapy services may be provided via telemedicine. The service must be provided by means of “real-time” interactive telecommunications system and the provider must have a face-to-face visit within the first 30 days and every 90 days thereafter.

Telemedicine service for electric stimulation attended, code 97032, is limited to one unit. Providers must document any treatment modifications used to support delivering services via telemedicine. Please refer to the [Therapy Services](#) manual for additional coverage information.

Remote Patient Monitoring (RPM)

Effective October 1, 2023, South Dakota Medicaid added permanent coverage of remote patient monitoring of physiologic functions when medically necessary for recipients with acute or chronic conditions when ordered and billed by providers who are eligible to bill Medicaid for E/M services. The following criteria must be met in order for coverage:

- The recipient must be diagnosed with at least one of the following conditions:
 - Asthma
 - Congestive Heart Failure
 - Cardiac monitoring
 - Hypertension or Hypotension
 - Chronic Obstructive Pulmonary Disease
 - Diabetes
 - Gestational Diabetes
 - COVID-19 post infection monitoring
- The recipient must be cognitively capable of operating the remote monitoring equipment or must be assisted by a caregiver capable of operating the equipment.
- The recipient's condition must be unmanaged or require frequent and on-going monitoring during a period where:
 - The recipient is newly diagnosed with the condition in the last 6 months and is learning to manage the condition;
 - The recipient has a chronic condition that has become difficult to manage in the last 6 months; or
 - The recipient has had 2 or more episodes that required either emergency department care, hospitalization, or emergency intervention in the last 6 months.
- The medical device supplied to a recipient as part of RPM services must be a medical device as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act, that the device must be reliable and valid, and that the data must be electronically (i.e., automatically) collected and transmitted rather than self-reported.
- Only a physician, physician assistant, nurse practitioner, or certified nurse midwife are allowed to order RPM and bill for the services.
- RPM is only allowed for established recipients who are under the active care of a provider.
- The provider must document the medical necessity of the service.
- The provider must obtain consent from the recipient to furnish RPM services.
- The provider must prescribe a care plan that denotes the need for remote monitoring and the impact on treatment and management of the recipient. The care plan must also address actions taken by the provider and/or care team to improve or address the recipient's ability to self-manage the condition including patient education.

Billing Guidance

The table below provides the covered CPT codes and billing guidance for remote patient monitoring services:

| CPT | Description | Billing Guidance |
|------------|--|--|
| 95250 | Continuous monitoring of blood sugar level in tissue fluid using sensor under skin with provider supplied equipment. | <ul style="list-style-type: none"> Limited to once per month. Cannot be billed in conjunction with 99091. |
| 95251 | Continuous monitoring of blood sugar level in tissue fluid using sensor under skin with interpretation and report. | <ul style="list-style-type: none"> Limited to once per month. Cannot be billed in conjunction with 99091. |
| 99091 | The provider interprets medical information, such as ECG recordings, blood pressure records, and home glucose monitoring results, received in digital form from a patient or his caregiver requiring at least 30 minutes of the provider's time. | <ul style="list-style-type: none"> Limited to once per month. Can only be billed by a physician or qualified health professional (QHP) — not general clinical staff. Includes 30 minutes of RPM clinical time between a patient and a physician per month, and also requires at least one instance of communication, which can be a call, video visit or even email exchange. Cannot be billed in conjunction with 95251, 99457, or 99458 and is intended for stand-alone treatment. |
| 99453 | Remote monitoring of physiologic parameters, initial set-up and patient education on use of equipment | <ul style="list-style-type: none"> One-time reimbursement per episode of care (service initiations through attainment of targeted treatment goal). Cannot bill until the patient has taken 16 separate days of readings within 30 days for (code 99454). Cannot be billed in conjunction with 95250. |
| 99454 | Remote monitoring of physiologic parameters, initial supply of devices with daily recordings or programmed alerts transmission, when recipient is using device 16 out of 30 days each month | <ul style="list-style-type: none"> Limited to once per month no matter how many devices the patient is using. Must be billed in conjunction with 99453, and requires the transmission of data from a remote device for a minimum of 16 days within a 30-day period. Cannot be billed in conjunction with 95250. |
| 99457 | Remote physiologic monitoring treatment management services, healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver; first 20 minutes | <ul style="list-style-type: none"> Covers the initial time spent by the physician or qualified clinician in actual treatment of the patient's condition. Limited to once per month no matter how many devices the patient is using. Can be administered remotely, including a telephone or video connection. Cannot be billed in conjunction with 99091. |
| 99458 | Remote physiologic monitoring treatment management services, healthcare professional time in a calendar month requiring interactive communication with the | <ul style="list-style-type: none"> Must be billed in conjunction with 99457. Includes reimbursement for the first 20 minutes of time that clinical staff spends with a patient. |

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|-------|--|--|
| | patient/caregiver; each additional 20 minutes | |
| 99473 | Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration | <ul style="list-style-type: none"> Limited to once per month. Covers patient training and calibration of a home blood pressure monitoring device. Device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. Do not report in the same calendar month as 93784, 93786, 93788, 93790, 99091, 99424, 99425, 99426, 99427, 99437, 99439, 99453, 99454, 99457, 99487, 99489, 99490, or 99491. |
| 99474 | Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient | <ul style="list-style-type: none"> Limited to once per month. Do not report in the same calendar month as 93784, 93786, 93788, 93790, 99091, 99424, 99425, 99426, 99427, 99437, 99439, 99453, 99454, 99457, 99487, 99489, 99490, or 99491. Not billable on the same day as the patient presents for an evaluation and management (E/M) service to the same provider |

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

FQHC/RHC providers may bill for these services on a fee for service basis using their non-Prospective Payment System (PPS) NPI if the service is ordered by one of the allowable practitioner types.

Indian Health Services (IHS) and Tribal 638 Facilities

IHS and Tribal 638 facilities can bill the encounter rate for remote patient monitoring CPT codes 99091, 99457, and 99458 as long as these services meet the definition of an encounter and are in accordance with the “Four Walls” requirement under 42 CFR 440.90 as provided in the IHS and Tribal 638 Facilities manual.

School District Services

School district providers may provide physical and occupational therapy via telemedicine using CPT code 97799 for physical therapy and CPT code 97139 for occupational therapy. Speech-language pathology services continue to be allowed when provided via telemedicine and should be billed using

CPT code 92507. The service must be provided by means of “real-time” interactive telecommunications system and the provider must have a face-to-face visit within the first 30 days and every 90 days thereafter.

Psychology services may also be provided via telemedicine or real time, two-way audio-only using CPT code 90899. Audio-only services must be provided in accordance with the independent mental health practitioner coverage criteria stated in this manual.

Please refer to the [School District Services](#) manual for additional coverage information.

Prior Authorization

The out-of-state prior authorization requirement does not apply if the recipient is located in South Dakota at the time of the service and the provider is located outside of the State. If the service otherwise requires a prior authorization, the provider is still required to obtain prior authorization prior to providing the service.

AUDIO-ONLY COVERED SERVICES AND LIMITS

Audio-Only Behavioral Health Services

South Dakota Medicaid covers real time, two-way audio-only behavioral health services delivered by a Substance Use Disorder (SUD) Agency or a Community Mental Health Center (CMHC) when the recipient does not have access to face-to-face audio/visual telemedicine technology.

South Dakota Medicaid covers real-time, two-way audio-only behavioral health services delivered by an Independent Mental Health Practitioner (IMHP) when the recipient does not have access to face-to-face audio/visual telemedicine technology.

SUD agencies and CMHCs, and IMHPs must utilize traditional audio/visual telemedicine technology when possible. Audio-only services are not covered when used for the convenience of the provider or recipient. The provider must document in the medical record that the use real time video/audio technology was not possible or was unsuccessful.

Covered Services

CMHCs may provide all covered services via audio-only technology when coverage requirements are met. SUD agencies may only provide covered SUD agency services listed in the Audio-Only Procedure Code table in the Appendix via audio-only technology when the coverage requirements are met. Contact the Division of Behavioral Health for questions regarding unlisted codes.

For the purpose of this manual, an IMHP includes mental health providers who meet the requirements in [ARSD 67:16:41:03](#) and licensed physicians or psychiatrists that provide behavioral health services. IMHPs may provide applicable services listed in the Audio-Only Procedure Code table in the Appendix via audio-only technology when the coverage requirements are met. Services not listed in the table are not allowed to be provided via telemedicine or audio-only technology. An IMHP cannot bill the following CPT codes: 98966, 98967, and 98968.

FQHCs/RHCs and IHS/Tribal 638 Providers

SUD agency services may also be provided via audio-only if the provider is an accredited and enrolled agency. Audio-only behavioral health services are reimbursed at the encounter rate.

Non-covered Services

Services other than those specifically stated as covered when provided via an audio-only modality are considered non-covered if provided via an audio-only modality and must not be billed to South Dakota Medicaid.

Claim Instructions

Audio-only services will need the GT modifier and place of service 77. Any additional modifiers must be coded alphabetically as shown on the [CMHC](#) and [SUD](#) fee schedules.

Audio-Only Evaluation and Management Services

Audio-only evaluation and management services are covered for established patients if the recipient does not have access to face-to-face audio/visual telemedicine technology. The provider must document in the medical record that the use of real time video/audio technology was not possible or was unsuccessful.

The service must be initiated by the recipient. The service should include patient history and/or assessment, and some degree of decision making. Telephonic evaluation and management services are only allowed to be provided by a physician, podiatrist, nurse practitioner, physician assistant, or optometrist. The service must be 5 minutes or longer. Services may be provided via telephone or via another device or service that allows real-time audio communication.

Audio-only evaluation and management services are not to be billed if clinical decision-making dictates a need to see the patient for an office visit, including a telemedicine office visit, within 24 hours or at the next available appointment time. In those circumstances, the telephone service is considered a part of the subsequent office visit. If the telephone call follows a billable office visit performed in the past seven calendar days for the same or a related diagnosis, then the telephone services are considered part of the previous office visit and are not separately billable. Telephone services provided by an RN or LPN are not billable.

Non-covered Services

Audio-only services are only covered if initiated by a recipient and the recipient did not have access to face-to-face audio/visual telemedicine technology.

Claim Instructions

Services must be billed using CPT codes 98966, 98967, and 98968. Providers should select the appropriate code based on the time associated with the service. Do not bill for these services using CPT codes 99441, 99442, or 99443 even if you believe the code description is more applicable. Billing with 99441, 99442, or 99443 will result in your claim being denied.

Reimbursement

Payment for services is limited to the lesser of the provider's usual and customary charge or the fee contained on South Dakota Medicaid's Physician Services [fee schedule](#). FQHC/RHC and IHS/Tribal 638 providers may bill for audio-only evaluation and management services using codes 98966, 98967, and 98968 and be reimbursed at the fee schedule rate. These services must be submitted using the FQHC/RHCs non-PPS billing NPI. For more information regarding billing with a non-PPS NPI please refer to the [FQHC/RHC Service Manual](#).

Billing a Recipient

There is no cost share for this service. Please refer to our [Billing a Recipient Manual](#) for additional requirements a provider must meet to bill a recipient.

DISCONTINUED COVID-19 PUBLIC HEALTH EMERGENCY FLEXIBILITIES

The COVID-19 Public Health Emergency ended on May 11, 2023. This section of the manual provides the temporary coverage flexibilities that are discontinued and no longer in effect as of May 11, 2023.

Well Child Check-ups

South Dakota Medicaid added temporary coverage of well child check-ups for recipients and providers at high risk for COVID-19, under quarantine, or social distancing during the declared emergency for COVID-19. Effective May 11, 2023, codes associated with well-child check-ups and listed in the Appendix will no longer be eligible for coverage via telemedicine.

Originating Site Facility Fee

During the public health emergency, South Dakota Medicaid followed Medicare's billing guidance allowing providers to bill the originating site fee if a hospital received approval to make a recipient's home a "hospital location" known to and approved by Medicare. Effective May 11, 2023, providers will no longer be allowed make a recipient's home a "hospital location" for the purpose of billing an originating site fee.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to [ARSD 67:16:01:08](#) or the [General Coverage Principles](#) manual for a general list of services that are not covered by South Dakota Medicaid.

Non-covered Telemedicine Services

Services not specifically listed as covered in the procedure code table in the Appendix are considered non-covered. Claims submitted by a non-eligible originating site will be denied. Birth to Three services do not qualify for an originating site reimbursement unless provided at an eligible originating site location. Distant sites located outside of the United States are not covered.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the [Documentation and Record Keeping](#) manual for additional requirements.

Telemedicine Documentation

Originating Site

Originating site documentation is required for originating sites that are eligible for reimbursement. South Dakota Medicaid does not require documentation to be maintained for originating sites that are not eligible for reimbursement. The originating site must document the physical location of the recipient and provider at the time the services were provided. The originating site must also document if a nurse or other health care professionals were present and provided any services such as checking vitals.

Distant Site

The distant site must document the physical location of the recipient and provider at the time the services were provided. The distant site provider must document all services rendered in accordance with the requirements in the [Documentation and Record Keeping](#) manual.

REIMBURSEMENT AND CLAIMS INSTRUCTIONS

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Reimbursement

Providers must bill for services at their usual and customary charge. Providers are reimbursed the lesser of their usual and customary charge or the fee schedule rate. Reimbursement for distant site telemedicine services is limited to the individual practitioner's professional fees or the encounter rate if the service qualifies as an FQHC/RHC or IHS/Tribal 638 clinic service. The maximum allowable reimbursement for distant site services is listed on the applicable [fee schedule](#). The maximum allowable amount for services provided via telemedicine is the same as services provided in-person. Facility related charges for distant site telemedicine providers are not reimbursable.

Originating Site

The maximum rate for originating site facility fee is listed on the physician fee schedule under procedure code Q3014. The facility fee is reimbursed on a fee for service basis including for providers paid at an encounter rate or other methodology. providers. There is no additional reimbursement for equipment, technicians, technology, or personnel utilized in the performance of telemedicine services. The originating site fee is not reimbursable for audio-only services and should not be billed for these services.

Claim Instructions

Providers should bill for telemedicine services on the same claim form they use when billing for services rendered in person. Detailed claim instructions are available on our [website](#).

Place of Services

For distant site services billed on a CMS 1500 or 837P providers must bill;

- “02” for telemedicine services provided other than in patient’s home;
- “10” for telemedicine services provided in the patient’s home; or
- “77” for audio-only services.

Telemedicine Modifiers

Telemedicine provided at a distant site must be billed with the GT modifier in the first modifier position to indicate the service was provided via telemedicine/audio-only. Failure to comply with this requirement may lead to payment recoupment or other action as decided by South Dakota Medicaid.

Audio-Only Modifiers

- CMHC and SUD Agencies: Bill modifier GT in addition to the POS code 77.
- All other providers allowed to bill audio only services: Bill modifier 93 in addition to the POS code 77.

Originating Site

An originating site eligible for reimbursement must bill for the service using the HCPCS code Q3014 for CMS 1500 Claims or Revenue code 780 for UB-04 Claims. For group services with multiple recipients in the same originating site location, only one originating site fee is billable per physical location of the recipients. For Division of Behavioral Health block grant contract providers, the originating site fee should only be billed to Medicaid if the group includes both Medicaid recipients and individuals ineligible for Medicaid.

DEFINITIONS

1. “Telemedicine,” The use of an interactive telecommunications system to provide two-way, real-time, interactive communication between a provider and a Medicaid recipient across a distance.
2. “Telehealth,” A method of delivering services, including interactive audio-visual or audio-only technology, in accordance with SDCL chapter 34-52.
3. “Distant site,” The physical location of the practitioner providing the service via telemedicine.

4. "Originating site," The physical location of the Medicaid recipient at the time the service is provided.
5. "Interactive telecommunications system," Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the Medicaid recipient and distant site practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

QUICK ANSWERS

1. **Does South Dakota Medicaid require providers to use a specific real-time, interactive communication platform?**

No, South Dakota Medicaid does not regulate what platform providers use. The platform the provider chooses to use must be HIPPA compliant.

2. **My site is not listed as an originating site in the Eligible Providers section. Can we be an originating site?**

Yes, this section refers to originating sites eligible for reimbursement. Other sites can act as originating sites but are not eligible for reimbursement.

3. **An originating site is located in South Dakota, but the distant site is an enrolled provider located out-of-state, does the distant site provider need an out of state prior authorization?**

No, the distant site provider does not need an out-of-state prior authorization for services delivered via telemedicine. If the service otherwise requires a prior authorization, the provider is still required to obtain prior authorization prior to providing the service.

4. **Can a home be an originating site?**

Yes, a home can be an originating site but is not eligible for reimbursement.

APPENDIX: COVERED TELEMEDICINE PROCEDURE CODES

Covered Procedure Codes

The following services are covered distant site telemedicine services. Providers should refer to their applicable fee schedule to determine if a service is covered for their provider type:

| CPT Code | Description |
|----------|--|
| 77427 | Radiation treatment management, 5 treatments |
| 90791 | Psychiatric diagnostic evaluation |
| 90792 | Psychiatric diagnostic evaluation with medical services |
| 90832 | Psychotherapy, 30 minutes |
| 90833 | Psychotherapy, 30 minutes |
| 90834 | Psychotherapy, 45 minutes |
| 90836 | Psychotherapy, 45 minutes |
| 90837 | Psychotherapy, 60 minutes |
| 90838 | Psychotherapy, 60 minutes |
| 90839 | Psychotherapy for crisis, first 60 minutes |
| 90840 | Psychotherapy for crisis, each additional 30 minutes |
| 90845 | Medical psychoanalysis |
| 90846 | Family psychotherapy without the patient present, 50 minutes |
| 90847 | Family psychotherapy including patient, 50 minutes |
| 90849 | Multiple family group psychotherapy including patient, 50 minutes |
| 90863 | Pharmacologic management, including prescription and review of medication (CMHCs only) |
| 90899 | School district psychology services |
| 90951 | Dialysis services (4 or more physician visits per month), for patients younger than 2 |
| 90952 | Dialysis services (2-3 physician visits per month), for patients younger than 2 |
| 90953 | Dialysis services (1 physician visit per month), for patients younger than 2 |
| 90954 | Dialysis services (4 or more physician visits per month), for patients 2-11 |
| 90955 | Dialysis services (2-3 physician visits per month), for patients 2-11 |
| 90956 | Dialysis services (1 physician visit per month), patient 2-11 years of age |
| 90957 | Dialysis services (4 or more physician visits per month), for patients 12-19 |
| 90958 | Dialysis services (4 or more physician visits per month), for patients 12-19 |
| 90960 | Dialysis services (4 or more physician visits per month), for patients 20 and older |
| 90959 | Dialysis services (1 physician visit per month), for patients 12-19 |
| 90961 | Dialysis services (2-3 physician visits per month), for patients 20 and older |
| 90962 | Dialysis services (1 physician visit per month), for patients 20 and older |
| 90963 | Home dialysis services per month, for patients younger than 2 |
| 90964 | Home dialysis services per month, for patients 2-11 |
| 90965 | Home dialysis services per month, for patients 12-19 |
| 90966 | Home dialysis services per month, for patients 20 and older |
| 90967 | Dialysis services, per day (less than full month service), patient younger than 2 years of age |

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| 90968 | Dialysis services, per day (less than full month service), patient 2-11 years of age |
| 90969 | Dialysis services, per day (less than full month service), patient 12-19 years of age |
| 90970 | Dialysis services, per day (less than full month service), patient 20 years of age or older |
| 92002 | Eye and medical examination for diagnosis and treatment, new patient |
| 92004 | Eye and medical examination for diagnosis and treatment, new patient, 1 or more visits |
| 92012 | Eye and medical examination for diagnosis and treatment, established patient |
| 92014 | Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits |
| 92507 | Treatment of speech. Language, voice, communication, and/or auditory processing disorder; individual each 15 minutes (also used for school district speech-language pathology services) |
| 92508 | Group treatment of speech, language, voice, communication, and/or hearing processing disorder |
| 92521 | Evaluation of speech fluency |
| 92522 | Evaluation of speech sound production |
| 92523 | Evaluation of speech sound production with evaluation of language comprehension and expression |
| 92524 | Behavioral and qualitative analysis of voice and resonance |
| 92526 | Treatment of swallowing dysfunction and/or oral function for feeding |
| 92550 | Tympanometry and reflex threshold measurements |
| 92551 | Air tone conduction hearing assessment screening |
| 92552 | Pure tone air conduction threshold hearing assessment |
| 92553 | Pure tone air and bone conduction hearing assessment |
| 92555 | Assessment of speech hearing loss |
| 92556 | Assessment of hearing loss and speech recognition |
| 92557 | Air and bone conduction assessment of hearing loss and speech recognition |
| 92563 | Hearing test using earphones |
| 92565 | Assessment of simultaneous but different hearing tones in same ear |
| 92567 | Tympanometry (impedance testing) |
| 92568 | Assessment of hearing loss with placement of probe in ear to assess ear bone contraction |
| 92570 | Detection of middle ear fluid with assessment of eardrum and muscle function |
| 92585 | Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive |
| 92586 | Placement of scalp electrodes for assessment and recording of responses from several areas of the nerve-brain hearing system, infant |
| 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 |
| 92588 | Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation, with interpretation and report |
| 92592 | Hearing aid check; Monaural |

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| 92593 | Hearing aid check; Binaural |
| 92601 | Analysis and programming of inner ear (cochlear) implant, patient younger than 7 years of age |
| 92602 | Analysis and reprogramming of inner ear (cochlear) implant, patient younger than 7 years of age |
| 92603 | Analysis and programming of inner ear (cochlear) implant, patient age 7 years or older |
| 92604 | Analysis and reprogramming of inner ear (cochlear) implant, patient age 7 years or older |
| 92607 | Evaluation of patient with prescription of speech-generating and alternative communication device |
| 92608 | Evaluation and prescription of speech-generating and alternative communication device |
| 92609 | Therapeutic services for use of speech-generating device with programming |
| 92610 | Evaluation of swallowing function |
| 92620 | Evaluation of central auditory function, with report; initial 60 minutes |
| 92621 | Evaluation of central auditory function, with report; each additional 15 minutes |
| 92625 | Hearing assessment of abnormal sounds |
| 92626 | Evaluation of hearing function to determine candidacy for, or postoperative status of surgically implanted hearing device; first hour |
| 92627 | Evaluation of hearing function to determine candidacy for, or postoperative status of, surgically implanted hearing device; additional 15 minutes |
| 93750 | Interrogation ventricular assist device in person |
| 93797 | Cardiac rehab |
| 93798 | Cardiac rehab/monitor |
| 94002 | Ventilation assistance and management, hospital inpatient or observation, initial day |
| 94003 | Ventilation assistance and management, hospital inpatient or observation, each subsequent day |
| 94005 | Evaluation of home ventilator management care plan, 30 minutes or more |
| 94664 | Demonstration and/or evaluation of patient use of aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device |
| 95970 | Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional; w/o programming |
| 95971 | Simple Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional |
| 95972 | Complex Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional |
| 95983 | Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional; w/ programming 15 min |
| 95984 | Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional; w/ programming 15 min additional 15 |

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| 96105 | Assessment of expressive and receptive speech with interpretation and report per hour |
| 96112 | Developmental test administration by qualified health care professional with interpretation and report, first 60 minutes |
| 96113 | Developmental test administration by qualified health care professional with interpretation and report, additional 30 minutes |
| 96116 | Neurobehavioral status exam, interpretation, and report by psychologist or physician per hour |
| 96121 | Neurobehavioral status examination by qualified health care professional with interpretation and report, additional 60 minutes |
| 96125 | Standardized thought processing testing, interpretation, and report per hour |
| 97032 | Electric Stimulation Attended |
| 97535 | Self care / Home management training |
| 96130 | Psychological testing evaluation by qualified health care professional, first 60 minutes |
| 96131 | Psychological testing evaluation by qualified health care professional, additional 60 minutes |
| 96132 | Neuropsychological testing evaluation by qualified health care professional, first 60 minutes |
| 96133 | Neuropsychological testing evaluation by qualified health care professional, additional 60 minutes |
| 96136 | Psychological or neuropsychological test administration and scoring by qualified health care professional, first 30 minutes |
| 96137 | Psychological or neuropsychological test administration and scoring by qualified health care professional, additional 30 minutes |
| 97802 | Medical nutrition therapy, initial assessment and intervention, individual face-to-face, each 15 minutes |
| 97110 | Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes |
| 97112 | Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes |
| 97116 | Walking training to 1 or more areas, each 15 minutes |
| 97139 | School district occupational therapy services |
| 97150 | Therapeutic procedures in a group setting |
| 97151 | Behavior identification assessment by qualified health care professional, each 15 minutes |
| 97152 | Behavior identification assessment by technician under direction of qualified health care professional, each 15 minutes |
| 97153 | Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient, each 15 minutes |
| 97154 | Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to multiple patients, each 15 minutes |

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| 97155 | Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient, each 15 minutes |
| 97156 | Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present), each 15 minutes |
| 97157 | Family adaptive behavior treatment guidance by qualified health care professional without patient present, each 15 minutes |
| 97158 | Group adaptive behavior treatment with protocol modification administered by qualified health care professional to multiple patients, each 15 minutes |
| 97161 | Evaluation of physical therapy, typically 20 minutes |
| 97162 | Evaluation of physical therapy, typically 30 minutes |
| 97163 | Evaluation of physical therapy, typically 45 minutes |
| 97164 | Re-evaluation of physical therapy, typically 20 minutes |
| 97165 | Evaluation of occupational therapy, typically 30 minutes |
| 97166 | Evaluation of occupational therapy, typically 45 minutes |
| 97167 | Evaluation of occupational therapy established plan of care, typically 60 minutes |
| 97168 | Re-evaluation of occupational therapy established plan of care, typically 30 minutes |
| 97530 | Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes |
| 97750 | Physical performance test or measurement with report, each 15 minutes |
| 97755 | Assistive technology assessment to enhance functional performance, each 15 minutes |
| 97760 | Training in use of orthotics (supports, braces, or splints) for arms, legs and/or trunk, per 15 minutes |
| 97799 | School district physical therapy services |
| 97803 | Medical nutrition therapy, re-assessment and intervention, individual, face-to-face, each 15 minutes |
| 97804 | Medical nutrition therapy, group (2 or more individuals), each 30 minutes |
| 98960 | Self-management education & training 1 patient - 30 minutes |
| 98961 | Self-management education & training 2-4 patient - 30 minutes |
| 98962 | Self-management education & training 5-8 patient - 30 minutes |
| 98966 | Hc pro phone call 5-10 min |
| 98967 | Hc pro phone call 11-20 min |
| 98968 | Hc pro phone call 21-30 min |
| 99201 | New patient office or other outpatient visit, typically 10 minutes |
| 99202 | New patient office or other outpatient visit, typically 20 minutes |
| 99203 | New patient office or other outpatient visit, typically 30 minutes |
| 99204 | New patient office or other outpatient visit, typically 45 minutes |
| 99205 | New patient office or other outpatient visit, typically 60 minutes |
| 99211 | Established patient office or other outpatient visit, typically 5 minutes |
| 99212 | Established patient office or other outpatient visit, typically 10 minutes |
| 99213 | Established patient office or other outpatient visit, typically 15 minutes |
| 99214 | Established patient office or other outpatient visit, typically 25 minutes |

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| 99215 | Established patient office or other outpatient visit, typically 40 minutes |
| 99221 | Initial hospital inpatient care, typically 30 minutes per day |
| 99222 | Initial hospital inpatient care, typically 50 minutes per day |
| 99223 | Initial hospital inpatient care, typically 70 minutes per day |
| 99231 | Subsequent hospital inpatient care, typically 15 minutes per day |
| 99232 | Subsequent hospital inpatient care, typically 25 minutes per day |
| 99233 | Subsequent hospital inpatient care, typically 35 minutes per day |
| 99234 | Hospital observation or inpatient care low severity, 40 minutes per day |
| 99235 | Hospital observation or inpatient care moderate severity, 50 minutes per day |
| 99236 | Hospital observation or inpatient care high severity, 55 minutes per day |
| 99238 | Hospital discharge day management, 30 minutes or less |
| 99239 | Hospital discharge day management, more than 30 minutes |
| 99241 | Patient office consultation, typically 15 minutes |
| 99242 | Patient office consultation, typically 30 minutes |
| 99243 | Patient office consultation, typically 40 minutes |
| 99244 | Patient office consultation, typically 60 minutes |
| 99245 | Patient office consultation, typically 80 minutes |
| 99251 | Inpatient hospital consultation, typically 20 minutes |
| 99252 | Inpatient hospital consultation, typically 40 minutes |
| 99253 | Inpatient hospital consultation, typically 55 minutes |
| 99254 | Inpatient hospital consultation, typically 80 minutes |
| 99255 | Inpatient hospital consultation, typically 110 minutes |
| 99281 | Emergency department visit, self limited or minor problem |
| 99282 | Emergency department visit, low to moderately severe problem visit |
| 99283 | Emergency department visit, moderately severe problem |
| 99284 | Emergency department visit, problem of high severity |
| 99285 | Emergency department visit, problem with significant threat to life or function |
| 99291 | Critical care delivery critically ill or injured patient, first 30-74 minutes |
| 99292 | Critical care delivery critically ill or injured patient, additional 30 minutes |
| 99304 | Initial nursing facility visit, typically 25 minutes per day |
| 99305 | Initial nursing facility visit, typically 35 minutes per day |
| 99306 | Initial nursing facility visit, typically 45 minutes per day |
| 99307 | Subsequent nursing facility visit, typically 10 minutes per day |
| 99308 | Subsequent nursing facility visit, typically 15 minutes per day |
| 99309 | Subsequent nursing facility visit, typically 25 minutes per day |
| 99310 | Subsequent nursing facility visit, typically 35 minutes per day |
| 99354 | Prolonged office or other outpatient service first hour |
| 99315 | Nursing facility discharge day management, 30 minutes or less |
| 99316 | Nursing facility discharge management, more than 30 minutes |
| 99341 | Home visit new patient, typically 20 minutes |
| 99342 | Home visit new patient, typically 30 minutes |
| 99344 | Home visit new patient, typically 60 minutes |

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| 99345 | Home visit new patient, typically 75 minutes |
| 99347 | Established patient home visit, typically 15 minutes |
| 99348 | Established patient home visit, typically 25 minutes |
| 99349 | Established patient home visit, typically 40 minutes |
| 99350 | Established patient home visit, typically 60 minutes |
| 99355 | Prolonged office or other outpatient service each additional 30 minutes |
| 99356 | Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service, first hour |
| 99357 | Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service, each additional 30 minutes |
| 99406 | Smoking and tobacco use cessation counseling visit, 3-10 minutes |
| 99407 | Smoking and tobacco use cessation counseling visit, greater than 10 minutes |
| 99412 | Preventative counseling – group (CMHCs only) |
| 99468 | Initial inpatient hospital critical care of newborn, 28 days of age or younger, per day |
| 99469 | Subsequent inpatient hospital critical care of newborn, 28 days of age or younger, per day |
| 99471 | Initial inpatient hospital critical care of infant or young child, 29 days through 24 months, per day |
| 99472 | Subsequent inpatient hospital critical care of infant or young child, 29 days through 24 months, per day |
| 99475 | Initial inpatient hospital critical care of infant or young child, 2 through 5 years, per day |
| 99476 | Subsequent inpatient hospital critical care of infant or young child, 2 through 5 years, per day |
| 99477 | Initial intensive care of newborn, 28 days of age or younger, per day |
| 99478 | Subsequent intensive care of recovering low birth weight infant < 1500 grams, per day |
| 99479 | Subsequent intensive care of recovering low birth weight infant 1500-2500 grams, per day |
| 99480 | Subsequent intensive care of recovering low birth weight infant 2501-5000 grams, per day |
| 99497 | Advanced care planning 30 min |
| 99498 | Advanced care planning additional 30 min |
| G0108 | Diabetes outpatient self-management educations services, individual |
| G0109 | Diabetes outpatient self-management educations services, group |
| G0312 | Immunization counseling < 21yr 5-15 m |
| G0313 | Immunization counseling < 21yr 16-30 m |
| G0314 | COVID-19 pediatric vaccine counseling, under age 21 16-30 minutes |
| G0315 | COVID-19 pediatric vaccine counseling, under age 21 5-15 minutes |
| G0316 | Prolonged hospital inpatient or observation care evaluation and management service(s) |
| G0317 | Prolonged nursing facility evaluation and management service(s) |

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| G0318 | Prolonged home or residence evaluation and management service(s) |
| G0445 | High intensity behavioral counseling to prevent sexually transmitted disease, 30 minutes |
| H0001 | Assessments via telemedicine (SUD treatment agencies only) |
| H0004 | Local individual counseling via telemedicine (SUD treatment agencies only) |
| H0005 | Local/group counseling via telemedicine (SUD treatment agencies only) |
| H0039 | Assertive community treatment, face-to-face, per 15 minutes |
| H0050 | Alcohol and/or drug services, brief intervention, per 15 minutes |
| H2011 | Crisis intervention via telemedicine (SUD treatment agencies only) |
| H2012 | Functional family therapy (FFT) per session (CMHCs only) |
| H2016 | Comprehensive community support services (CMHCs only) |
| H2021 | CYF group provided via telehealth (Community-based wrap-around services) (CMHCs only) |
| S9455 | Diabetes education, follow-up, group, per 60 minutes |
| S9460 | Diabetes education, follow-up, individual, per 60 minutes |
| T1006 | Local/HB family counseling via telemedicine (SUD treatment agencies only) |
| T1007 | Alcohol and/or substance abuse services, treatment plan development and/or modification |
| T1012 | Cognitive behavioral intervention for substance abuse (SUD treatment agencies only) |

Substance Use Disorder (SUD) Audio-only Covered Procedure Codes

The following services are covered when provided as audio-only behavioral health services delivered by a Substance Use Disorder (SUD) Agency when the recipient does not have access to face-to-face audio/visual telemedicine technology (including smart phone, tablet, computer, or WIFI/internet access). Providers should refer to their applicable fee schedule to determine if the service is covered for their provider type:

| CPT Code | Description |
|-----------------|---|
| 99412 | Group preventive medicine counseling, typically 1 hour |
| H0001 | Assessments via telemedicine (SUD treatment agencies only) |
| H0004 | Local individual counseling via telemedicine (SUD treatment agencies only) |
| H0005 | Local/group counseling via telemedicine (SUD treatment agencies only) |
| H0015 | Alcohol and/or Drug Services Intensive Outpatient (SUD treatment agencies only) |
| H0050 | Alcohol and/or drug services, brief intervention, per 15 minutes |
| H2011 | Crisis intervention via telemedicine (SUD treatment agencies only) |
| T1006 | Local/HB family counseling via telemedicine (SUD treatment agencies only) |
| T1007 | Alcohol and/or substance abuse services, treatment plan development and/or modification |
| T1012 | Cognitive behavioral intervention for substance abuse (SUD treatment agencies only) |

Community Mental Health Center (CMHC) Audio-only Covered Procedure Codes

The following services are covered when provided as audio-only behavioral health services delivered by a Community Mental Health Center (CMHC) when the recipient does not have access to face-to-face audio/visual telemedicine technology (including smart phone, tablet, computer, or WIFI/internet access). Providers should refer to their applicable fee schedule to determine if the service is covered for their provider type:

| CPT Code | Description |
|-----------------|---|
| 90791 | Psychiatric diagnostic evaluation |
| 90832 | Psychotherapy, 30 minutes |
| 90846 | Family psychotherapy without the patient present, 50 minutes |
| 90847 | Family psychotherapy including patient, 50 minutes |
| 90853 | Group psychotherapy |
| 90863 | Pharmacologic management, including prescription and review of medication |
| 99412 | Preventative counseling – group |
| 99442 | Collateral contact |
| H0039 | Assertive community treatment, face-to-face, per 15 minutes |
| H2012 | Functional family therapy (FFT) per session |
| H2016 | Comprehensive community support services |
| H2021 | CYF group provided via telehealth (Community-based wrap-around services) |

Independent Mental Health Provider (IMHP) Audio-only Covered Procedure Codes

The following services are covered when provided as audio-only behavioral health services delivered by an Independent Mental Health Provider (IMHP) when the recipient does not have access to face-to-face audio/visual telemedicine technology (including smart phone, tablet, computer, or WIFI/internet access). Providers should refer to their applicable fee schedule to determine if the service is covered for their provider type.

| CPT Code | Description |
|-----------------|---|
| 90791 | Psychiatric diagnostic evaluation |
| 90832 | Psychotherapy, 30 minutes |
| 90834 | Psychotherapy, 45 minutes |
| 90837 | Psychotherapy, 60 minutes |
| 90839 | Psychotherapy for crisis, first 60 minutes |
| 90840 | Psychotherapy for crisis, each additional 30 minutes |
| 90847 | Family psychotherapy including patient, 50 minutes |
| 90849 | Multiple family group psychotherapy including patient, 50 minutes |
| 90853 | Group psychotherapy |
| 96116 | Neurobehavioral status exam, interpretation, and report by psychologist or physician per hour |
| 96130 | Psychological testing evaluation by qualified health care professional, first 60 minutes |
| 96131 | Psychological testing evaluation by qualified health care professional, additional 60 minutes |
| H0046 | Collateral Contacts |

Discontinued COVID-19 Temporarily Covered Procedure Codes

Effective May 11, 2023, the following services are no longer covered distant site telemedicine services. Providers should refer to their applicable fee schedule to determine if the service is covered for their provider type.

| CPT Code | Description |
|-----------------|--|
| 92065 | Orthoptic and/or pleoptic training, with continuing medical direction and evaluation |
| 92584 | Testing of nerve from ear to brain (cochlear) |
| 92605 | Evaluation and prescription of non-speech-generating and alternative communication device first hour |
| 92606 | Therapeutic services for use of non-speech-generating device with programming |
| 92618 | Evaluation and prescription of non-speech-generating and alternative communication device |
| 96110 | Developmental screen or autism screening |
| 96127 | Depression screening |
| 96161 | Maternal depression screening |
| 99217 | Hospital observation care on day of discharge |
| 99218 | Hospital observation care, typically 30 minutes |
| 99219 | Hospital observation care, typically 50 minutes |
| 99220 | Hospital observation care, typically 70 minutes |
| 99224 | Subsequent observation care, typically 15 minutes per day |
| 99225 | Subsequent observation care, typically 25 minutes per day |
| 99226 | Subsequent observation care, typically 35 minutes per day |
| 99324 | New patient assisted living visit, typically 20 minutes |
| 99325 | New patient assisted living visit, typically 30 minutes |
| 99326 | New patient assisted living visit, typically 45 minutes |
| 99327 | New patient assisted living visit, typically 60 minutes |
| 99328 | New patient assisted living visit, typically 75 minutes |
| 99334 | Established patient assisted living visit, typically 15 minutes |
| 99335 | Established patient assisted living visit, typically 25 minutes |
| 99336 | Established patient assisted living visit, typically 40 minutes |
| 99337 | Established patient assisted living visit, typically 60 minutes |
| 99343 | Home visit new patient, typically 40 minutes |
| 99381 | Init pm e/m new pat infant |
| 99382 | Init pm e/m new pat 1-4 yrs |
| 99383 | Prev visit new age 5-11 |
| 99384 | Prev visit new age 12-17 |
| 99385 | Prev visit new age 18-39 |
| 99391 | Per pm reeval est pat infant |
| 99392 | Prev visit est age 1-4 |
| 99393 | Prev visit est age 5-11 |

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| 99394 | Prev visit est age 12-17 |
| 99395 | Prev visit est age 18-39 |
| 99402 | Prev med cnsl indiv apprx 30 |
| 99403 | Prev med cnsl indiv apprx 45 |