

# ForwardHealth **UPDATE**

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## **PERMANENT TELEHEALTH COVERAGE POLICY AND BILLING GUIDELINES**

Only synchronous (two-way, real-time, interactive communications) and remote physiological monitoring services identified under permanent policy may be reimbursed when provided via telehealth effective on the first day of the first month after the federal public health emergency related to the COVID-19 pandemic expires. For example, if the public health emergency ends on April 12, 2022, permanent policy would become effective for dates of service on and after May 1, 2022.

Temporary telehealth policy will remain in effect until the switch to permanent policy occurs when ForwardHealth will require providers to follow permanent billing guidelines for synchronous telehealth and remote physiological monitoring services. Telehealth-related updates to the ForwardHealth Online Handbook will be available following the implementation of permanent policy.

Providers are reminded that they are responsible for keeping current with ForwardHealth policy and billing information as indicated in the Online Handbook.

## **AFFECTED PROGRAMS**

BadgerCare Plus, Medicaid

## **TO**

All Providers, HMOs and Other  
Managed Care Programs

## **QUICK LINKS**

- [Telehealth topic \(#510\)](#)
- [Max fee schedule](#)
- [ForwardHealth Online Handbook](#)

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The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(61).

The following temporary federal allowances and coverage policies will continue through the end of the federal public health emergency, unless providers are notified otherwise in writing prior to that time:

- Remote supervision of personal care workers by registered nurses (Refer to Alert [051](#), “Temporary Policy Changes for Personal Care Providers to Continue Through the Public Health Emergency”)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) temporary flexibilities provided by the Office of Civil Rights (Refer to Alert [052](#), “Continuation of HIPAA Flexibilities Through the Public Health Emergency”)
- Narcotic treatment services telephonic communication including opioid treatment for less than five minutes using modifier 52 (Refer to Alert [053](#), “Temporary Changes to Narcotic Treatment Services to Continue Through the Public Health Emergency”)

Temporary billing guidelines will end when permanent policy goes into effect. ForwardHealth is allowing providers to submit claims for services identified as permanent telehealth procedure codes under either the temporary or permanent telehealth billing guidelines (per this Update) until the first day of the first month after the federal public health emergency related to the COVID-19 pandemic expires. Refer to ForwardHealth Update [2021-21](#), titled “Transition From Temporary to Permanent Synchronous Telehealth Coverage Policy and Billing Guidelines,” for additional information.

Permanent telehealth policy for asynchronous telehealth services is still in development and will be published in a future publication. Temporary policy for interprofessional consults will remain in effect until permanent policy is implemented.

Refer to the [Telehealth Expansion and Related Resources for Providers webpage](#) for additional information.

The following terms are defined for the purposes of this Update:

- “Telehealth” means the use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services including: assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. Telehealth may include real-time interactive audio-only communication. Telehealth does **not** include communication between a certified provider and a member that consists solely of an email, text, or fax transmission.
- “Functionally equivalent” means a service provided via telehealth must meet both of the following criteria:

## TEMPORARY ALLOWANCES

The following ForwardHealth Alerts include information about temporary allowances that will continue through the end of the public health emergency:

- Alert [051](#), “Temporary Policy Changes for Personal Care Providers to Continue Through the Public Health Emergency”
- Alert [052](#), “Continuation of HIPAA Flexibilities Through the Public Health Emergency”
- Alert [053](#), “Temporary Changes to Narcotic Treatment Services to Continue Through the Public Health Emergency”

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- The quality, effectiveness, and delivery mode of the service provided must be clinically appropriate to be delivered via telehealth.
- The service must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable.

This ForwardHealth Update covers the following topics related to the implementation of permanent telehealth policy:

- [Permanent Telehealth Policy Requirements](#)
- [Allowable Services Under Telehealth](#)
  - [Services Not Appropriate Via Telehealth](#)
  - [Reimbursement for Covered Services](#)
  - [Documentation](#)
  - [Audio-Only Guidelines](#)
  - [Member Consent Guidelines for Telehealth](#)
  - [Privacy and Security](#)
  - [Costs Member Cannot Be Billed For](#)
  - [Direct Supervision for Ancillary Care Providers](#)
  - [Remote Physiologic Monitoring](#)
  - [Birth to 3 Program](#)
  - [Clarifications for Federally Qualified Health Centers](#)
- [Policy Reminders](#)
- [Future Updates](#)

## Permanent Telehealth Policy Requirements

The following requirements apply to the use of telehealth:

- Both the member and the provider of the health care service must agree in order for a service to be performed via telehealth. If either the member or provider decline the use of telehealth for any reason, the service should be performed in-person.
- The member retains the option to refuse the delivery of health care services via telehealth at any time without affecting their right to future care or treatment and without risking the loss or withdrawal of any program benefits to which they would otherwise be entitled.
- Medicaid-enrolled providers must be able and willing to refer members to another provider if necessary, such as when telehealth services are not appropriate or cannot be functionally equivalent or if the member declines a telehealth visit.
- [Title VI](#) of the Civil Rights Act of 1964 requires recipients of federal financial assistance to take reasonable steps to make their programs,

# RESOURCES

For the latest information regarding telehealth policy, providers can refer to the [Telehealth Expansion and Related Resources for Providers](#) page of the ForwardHealth Portal and the [Wisconsin Department of Health Services Medicaid Telehealth Expansion webpage](#).

These pages include general information as well as links to other important information and pages including the following:

- The [Stakeholder Engagement webpage](#) includes information on input sessions and workgroups.
- FAQs include questions and answers to questions from [providers](#) and [members](#) about telehealth policy changes.
- The [Telehealth Information for You and Your Family member brochure](#) provides general information about telehealth that providers can use to share with members.

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services, and activities accessible by eligible persons with limited English proficiency.

- The Americans with Disabilities Act requires that health care entities provide full and equal access for people with disabilities.

## Allowable Services Under Telehealth

Providers should refer to the [maximum allowable fee schedule](#) for a complete list of services allowed under permanent telehealth policy. Procedure codes for services allowed under permanent telehealth policy have place of service code 02 (Telehealth) listed as an allowable place of service in the fee schedule. Refer to the Telehealth topic ([#510](#)) for general claim submission requirements.

Providers can submit a request to the Department of Health Services for review of additional functionally equivalent services that should be allowed via telehealth under permanent policy that are not identified on the fee schedule.

Providers should email telehealth coverage requests to [DHStelehealth@dhs.wisconsin.gov](mailto:DHStelehealth@dhs.wisconsin.gov). Include the following information in the email request:

- Use the subject line “Telehealth Code Consideration.”
- Provide a description of the service and any applicable Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure codes.
- Include a summary of how providing the service via telehealth is functionally equivalent to the in-person service. Provide any rationale and references to support the request, if applicable.

## Services Not Appropriate Via Telehealth

Certain types of benefits or services that are not appropriately delivered via telehealth include:

- Services that are not covered when provided in-person.
- Services that do not meet applicable laws, regulations, licensure requirements, or procedure code definitions if delivered via telehealth.
- Services where a provider is required to physically touch or examine the recipient and delegation is not appropriate.
- Services the provider declines to deliver via telehealth.
- Services the recipient declines to receive via telehealth.
- Transportation services.
- Services provided by personal care workers, home health aides, private duty nurses, or school-based service care attendants.

## Reimbursement for Covered Services

The health care provider at the distant site must determine the following:

- The service delivered via telehealth meets the procedural definition and components of the CPT or HCPCS procedure code, as defined by the American Medical Association, or the Current Dental Terminology procedure code, as defined by the American Dental Association.
- The service is functionally equivalent to an in-person service for the individual member and circumstances.

Reimbursement is not available for services that cannot be provided via telehealth due to technical or equipment limitations.

## Documentation

Documentation requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the service rendered. Documentation must identify the delivery mode of the service when provided via telehealth and document the following:

- Whether the service was provided via audio-visual telehealth, audio-only telehealth, or via telehealth externally acquired images
- Whether the service was provided synchronously or asynchronously
- Additional information for which documentation is recommended, but not required, includes:
  - Provider location (for example, clinic [city/name], home, other)
  - Member location (for example, clinic [city/name], home)
  - All clinical participants, as well as their roles and actions during the encounter (This could apply if, for example, a member presents at a clinic and receives telehealth services from a provider at a different location.)

## Audio-Only Guidelines

When possible, telehealth services should include both an audio and visual component. In circumstances where audio-visual telehealth is not possible due to member preference or technology limitations, telehealth may include real-time interactive audio-only communication if the provider feels the service is functionally equivalent to the in-person service and there are no face-to-face or in-person restrictions listed in the procedural definition of the service.

Documentation should include that the service was provided via interactive synchronous audio-only telehealth.

The FQ modifier should be used for any service performed via audio-only telehealth. The GT modifier should only be used to indicate services that were performed using audio-visual technology.

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## Member Consent Guidelines for Telehealth

On at least an annual basis, providers should supply and document that:

- The member expressed an understanding of their right to decline services provided via telehealth.
- Providers should develop and implement their own methods of informed consent to verify that a member agrees to receive services via telehealth. These methods must comply with all federal and state regulations and guidelines.
- Providers have flexibility in determining the most appropriate method to capture member consent for telehealth services. Examples of allowable methods include educating the member and obtaining verbal consent prior to the start of treatment or telehealth consent and privacy considerations as part of the notice of privacy practices.

## Privacy and Security

Providers are required to follow federal laws to ensure member privacy and security. This may include ensuring that:

- The location from which the service is delivered via telehealth protects privacy and confidentiality of member information and communications.
- The platforms used to connect the member to the telehealth visit are secure.

## Group Treatment

Additional privacy considerations apply to members participating in group treatment via telehealth. Group leaders should provide members with information on the risks, benefits, and limits to confidentiality related to group telehealth and document the member's consent prior to the first session. Group leaders should adhere to and uphold the highest privacy standards possible for the group.

Group members should be instructed to respect the privacy of others by not disclosing group members' images, names, screenshots, identifying details, or circumstances. Group members should also be reminded to prevent non-group members from seeing or overhearing telehealth sessions.

Providers may not compel members to participate in telehealth-based group treatment and should make alternative services available for members who elect not to participate in telehealth-based group treatment.

## Costs Member Cannot Be Billed For

The following cannot be billed to the member:

- Telehealth equipment like tablets or smart devices
- Charges for mailing or delivery of telehealth equipment

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- Charges for shipping and handling of:
  - Diagnostic tools
  - Equipment to allow the provider to assess, diagnose, repair, or set up medical supplies online such as hearing aids, cochlear implants, power wheelchairs, or other equipment

### **Direct Supervision for Ancillary Care Providers**

Ancillary providers have specific requirements when providing care via telehealth. These providers are health care professionals that are not enrolled in Wisconsin Medicaid, such as staff nurses, dietician counselors, nutritionists, health educators, genetic counselors, and some nurse practitioners who practice under the direct supervision of a physician and bill under the supervising physician's National Provider Identifier. (Nurse practitioners, nurse midwives, and anesthesiologists who are Medicaid-enrolled should refer to their service-specific area of the Online Handbook for billing information.)

For telehealth services, the supervising physician is not required to be onsite, but they must be able to interact with the member using real-time audio or audiovisual communication, if needed. For supervision of ancillary providers, remote supervision is allowed in circumstances where the physician feels the member is not at risk of an adverse event that would require hands-on intervention from the physician.

All providers are required to act within their scope of practice and follow all appropriate licensure and certification requirements of the provider's supervising body or other regulatory authorities.

For additional information, refer to the Ancillary Providers topic ([#647](#)) of the Online Handbook.

### **Remote Physiologic Monitoring**

Remote physiologic monitoring is the collection and interpretation of a member's physiologic data, such as blood pressure or weight checks, that are digitally transmitted to a physician, nurse practitioner, or physician assistant for use in the treatment and management of medical conditions that require frequent monitoring. Such conditions include congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, and mental or behavioral problems. It is also used for members receiving technology-dependent care, such as continuous oxygen, ventilator care, total parenteral nutrition, or enteral feeding.

### **Eligible Devices**

The device used to capture a member's physiologic data must meet the Food and Drug Administration definition of a medical device. To submit claims for

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CPT procedure codes 99453–99458, the members’ physiologic data must be wirelessly synced so it can be evaluated by the physician, nurse practitioner, or physician assistant. Transmission can be synchronous or asynchronous. (Data does not have to be transmitted in real time as long as it is automatically updated on an ongoing basis for the provider to review.)

### ***Policy Requirements***

The following policy requirements apply for remote physiologic monitoring services:

- Only physicians, nurse practitioners, and physician assistants enrolled in ForwardHealth are eligible to render and submit claims for remote physiologic services.
- The member’s consent for remote physiologic monitoring services must be documented in the member’s medical record.
- The provider must document how remote physiologic monitoring is tied to the member-specific needs and will assist the member to achieve the goals of treatment.
- Services are not separately reimbursable if the services are bundled or covered by other procedure codes (for example, continuous glucose monitoring is covered under CPT procedure code 95250 and should not be submitted under CPT procedure codes 99453–99454).
- CPT procedure codes 99453 and 99454 can be used for blood pressure remote physiologic monitoring if the device used to measure blood pressure meets remote physiologic monitoring requirements. If the member self-reports blood pressure readings, the provider must instead submit self-measured blood pressure monitoring CPT procedure codes 99473–99474.
- CPT procedure code 99457 should be used when the physician, nurse practitioner, or physician assistant uses medical decision making based on interpreted data received from a remote physiologic monitoring device to assess the member’s clinical stability, communicate the results to the member, and oversee the management and/or coordination of services as needed.
- Providers are expected to follow CPT guidelines.

### ***Claim Submission***

Special modifiers are not required or requested for remote physiologic monitoring services. Providers should follow appropriate claim submission requirements as outlined in the Online Handbook.

### ***Birth to 3 Program***

ForwardHealth will reimburse therapy providers supplying services as part of the Birth to 3 Program at an enhanced rate when occupational therapy,

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physical therapy, and/or speech therapy is performed using telehealth and the member is located in their natural environment as defined in both 34 C.F.R. Part 303 and Wis. Admin. Code § [DHS 90.03\(25\)](#).

To receive this reimbursement, therapy providers must meet all other requirements and indicate the following modifier types when submitting a claim:

- Therapy type modifier: GN (Services delivered under an outpatient speech language pathology plan of care), GO (Services delivered under an outpatient occupational therapy plan of care), or GP (Services delivered under an outpatient physical therapy plan of care)
- Birth to 3 enhanced rate modifier: TL (Early intervention/individualized family service plan [IFSP])
- Telehealth modifier: GT or FQ

Therapy providers must also indicate the place of service where the therapy is performed. Allowable place of service codes are as follows:

- 02 (Telehealth)
- 04 (Homeless Shelter)
- 12 (Home)
- 99 (Other Place of Service)

### Clarifications for Federally Qualified Health Centers

The following are clarifications for federally qualified health centers:

- For currently covered services, services that are considered direct when provided in-person will be considered direct when provided via telehealth.
- Although federally qualified health centers are not directly reimbursed an originating site fee, HCPCS procedure code Q3014 should be billed for tracking purposes and for consideration in any potential future changes in scope.
- Fee-for-service claims must include HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) when services are provided via telehealth in order for proper reimbursement.
- Refer to the Federally Qualified Health Centers and Rural Health Clinics section of the Telehealth topic ([#510](#)) for additional guidance.

### Policy Reminders

Providers are reminded of the following:

- There are no limitations on which provider types may be reimbursed for telehealth services.
- ForwardHealth does not limit where members can receive telehealth services.

## REMINDERS

Providers are reminded of the following:

- There are no limitations on which provider types may be reimbursed for telehealth services.
- There are no limits on where members can receive telehealth services.

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- If the member is located outside the State of Wisconsin during a telehealth visit, the provider of the service must follow all applicable state laws and practice standards for the state in which the member is located during the telehealth visit.

## Future Updates

School-based services and teledentistry policy information will be available in future publications. Asynchronous telehealth policy is still in development. Sign up to receive the latest updates by joining the [Medicaid Telehealth Expansion email list](#).

## Documentation Retention

Providers are reminded that they must follow the documentation retention requirements per Wis. Admin. Code § [DHS 106.02\(9\)](#). Providers are required to produce or submit documentation, or both, to ForwardHealth upon request. Per Wis. Stat. § [49.45\(3\)\(f\)](#), providers of services shall maintain records as required by the Department of Health Services for verification of provider claims for reimbursement. The Department of Health Services may audit such records to verify actual provision of services and the appropriateness and accuracy of claims. ForwardHealth may deny or recoup payment for services that fail to meet these requirements. Refusal to produce documentation may result in sanctions including, but not limited to, termination from the Medicaid program.

## Information Regarding Managed Care Organizations

This Update contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

# FUTURE UPDATES

School-based services and teledentistry policy information will be available in future publications.

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The ForwardHealth Update is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Medicaid Services within the Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health within DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/).