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 requires 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
- Behavior Analyst
- Board-Certified Assistant Behavior Analyst (BCaBA)
- 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 Procedure Look-Up Tool to identify if a procedure code is allowed to be provided via telemedicine. CMHC and SUD agency services are not included in the Look-Up Tool. CMHC and SUD agency providers should refer to their applicable fee schedule to determine if a service is covered or allowed to be provided as a telemedicine service for their provider type.

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. To ensure that a patient's care needs are assessed by a healthcare provider, the Board-Certified Behavior Analyst (BCBA) must have an in-person 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.

Behavioral Health Services
Certain Substance Use Disorder (SUD) Agency, Community Mental Health Center (CMHC), and Independent Mental Health Practitioner (IMHP) procedure codes may be provided via telemedicine.

CMHC and SUD agency providers should refer to their applicable fee schedule to determine if a service is covered is allowed to be provided as a telemedicine service for their provider type.

IMHP services not specifically identified as "allowable via telemedicine" on the Procedure Look-Up Tool are not allowed to be provided via telemedicine or audio-only technology. An IMHP cannot bill the following CPT codes: 98012-98015.

Community Health Worker Services
Community Health Worker (CHW) services may be provided face-to-face or via telemedicine. When provided via telemedicine, the service must be related to an intervention outlined in the individual's CHW Service Plan. Service may be provided via two-way audio-only when the recipient does not have access to audio/visual telemedicine technology. The limitation necessitating audio-only services must be documented in the recipient's record.

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.

Doula Services
Care coordination, prenatal, and postpartum doula service may be provided face-to-face or via telemedicine. Services may be provided via two-way audio-only when the recipient does not have access to audio/visual telemedicine technology. The limitation necessitating audio-only services must be documented in the recipient's record.

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)

South Dakota Medicaid covers 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

Remote monitoring consists of 3 main components, each building off the step before it. When providing this service, all 3 components should be accounted for as follows:

- Education and setup: Education about how to use the device and transmit the health data helps ensure that patients use the device appropriately to collect accurate data.
- Device supply: The internet-connected device, including the collection and transmission of readings (required number of readings is specified by each code) every 30 days. Examples of these devices include connected blood pressure cuffs, continuous glucose monitors, and pulse oximeters.
- Treatment and management: Treatment management ensures that you review the health data and use it to manage the patient's condition.

Services should only be billed if they meet the coding requirements.

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	• Limited to once per month. • Cannot be billed in conjunction with 99091.

	sensor under skin with provider supplied equipment.	
95251	Continuous monitoring of blood sugar level in tissue fluid using sensor under skin with interpretation and report.	• 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.	• 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	• 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	• 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	• 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 patient/caregiver; each additional 20 minutes	• Must be billed in conjunction with 99457. • Includes reimbursement for the first 20 minutes of time that clinical staff spends with a patient.
99473	Self-measured blood pressure using a device validated for	• Limited to once per month.

	clinical accuracy; patient education/training and device calibration	• 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	• 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.

Targeted Case Management for Justice Involved Youth
Targeted case management services should be provided face-to-face or via telemedicine with both audio and visual component. In limited circumstances, services may also be provided via audio-only such as a telephone. Please refer to the Targeted Case Management for Justice Involved Youth manual for additional coverage information.

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, Community Mental Health Center (CMHC), or 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 and SUD agencies may only provide two-way audio-only covered services listed in the Audio-Only Procedure Code table in the Appendix 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

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. Services are generally intended for patient-initiated requests such as discussing new or ongoing health concerns, managing prescriptions, and making decisions about follow-up care that result in at least 10 minutes of patient history and/or assessment, and some degree of decision making. The provider must document in the medical record that the use of real time video/audio technology was not possible or was unsuccessful.

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 10 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 not covered if the services was provided on the same-day as an in-person E/M.

Claim Instructions

Services must be billed using CPT codes 98012-98015. Providers should select the appropriate code based on the time associated with the service.

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 98012-98015 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
Please refer to our Billing a Recipient Manual for additional requirements a provider must meet to bill a recipient.

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
Telemedicine services not specifically identified as "allowable via telemedicine" on the Procedure Look-Up Tool or specified on the CMHC or SUD agency fee schedules 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.

Store and forward services do not meet the definition of "telemedicine" and are generally not covered with the exception of radiology services.

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.
6. "Store-and-Forward," is the asynchronous electronic transmission of medical information to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction.

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

Refer to the Procedure Look-Up Tool to identify if a procedure code is allowed to be provided as distant site telemedicine services. CMHC and SUD agency services are not included in the Look-Up Tool. CMHC and SUD agency providers should refer to their applicable fee schedule to determine if a service is covered is allowed to be provided as a telemedicine service for their provider type. Providers should refer to the provider manuals for detailed coverage information and limitations.

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)
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
98012	Collateral contact

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