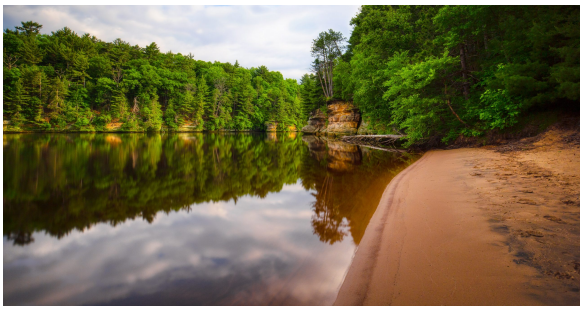
Wisconsin



At A Glance

MEDICAID REIMBURSEMENT

- Live Video: Yes
- Store-and-Forward: Yes
- Remote Patient Monitoring: Yes
- Audio Only: Yes

PRIVATE PAYER LAW

- Law Exists: No
- Payment Parity: No

PROFESSIONAL REQUIREMENTS

- Licensure Compacts: ASLP, CC, IMLC, NLC, OT, PSY, PTC
- Consent Requirements: Yes

FQHCs

- Originating sites explicitly allowed for Live Video: Yes
- Distant sites explicitly allowed for Live Video: Yes
- Store and forward explicitly reimbursed: No
- Audio-only explicitly reimbursed: No
- Allowed to collect PPS rate for telehealth: Yes

STATE RESOURCES

1. Medicaid Program: Forward Health
2. Administrator: Wisconsin Dept. of Health Services
3. Regional Telehealth Resource Center: Great Plains Telehealth Resource and Assistance Center

Private Payer

DEFINITIONS

Last updated 01/11/2024

No Reference Found

REQUIREMENTS

Last updated 01/11/2024

No Reference Found

PARITY

Last updated 01/11/2024

SERVICE PARITY

No Reference Found

PAYMENT PARITY

No Reference Found

Medicaid

OVERVIEW

Last updated 01/11/2024

Both synchronous (two-way, real-time, interactive communications) and asynchronous (information stored and forwarded to a provider for later review) services identified under permanent policy may be reimbursed when provided via telehealth (also known as “telemedicine”). ForwardHealth includes virtual check-in, e-visit options for members to connect with their providers remotely as well as telephone evaluation codes. Additionally, forward-health reimburses for audio-only when audio-visual telehealth is not possible. Certain remote patient monitoring reimbursement codes are also now

reimbursable. Interprofessional consultations (e-consults) are reimbursable by both the treating and consulting provider under the outlined policy requirements and limitations.

DEFINITIONS

Last updated 01/09/2024

Telehealth enables a provider who is located at a distant site to render the service remotely to a member located at an originating site using a combination of interactive video, audio, and externally acquired images through a networking environment.

“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 provider and a member that consists solely of an email, text, or fax transmission.

“Functionally equivalent” means that when a service is provided via telehealth, the transmission of information 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.

SOURCE: WI ForwardHealth Online Handbook. Topic #510 Telehealth & Telehealth Definitions Topic #22873. (Accessed Jan. 2024).

“In-person” refers to when the provider rendering a service and the member receiving that service are located together physically in the same space. In-person services are not considered to be delivered through telehealth, including audio-visual telehealth, unless there are applicable supervision components and requirements that are rendered through telehealth outside of the direct patient contact by the provider.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, & Telehealth Definitions Topic #22873. (Accessed Jan. 2024).

“Face-to-face” refers to requirements that can be met either in-person or through real-time, interactive audio-visual telehealth. An interactive telehealth service with face-to-face components must be functionally equivalent to an in-person service. It is delivered from outside the physical presence of a Medicaid member by using audio-visual technology, and there is no reduction in quality, safety, or effectiveness. ForwardHealth

does not consider a “face-to-face” requirement to be met by audio-only or asynchronous delivery of services.

Under telehealth policy, “direct” refers to an in-person contact between a member and a provider. Direct services often require a provider to physically touch or examine the recipient and delegation is not appropriate.

SOURCE: WI ForwardHealth Telehealth Definitions Topic #22873, WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, (Accessed Jan. 2024).

“Telehealth” means a practice of health care delivery, diagnosis, consultation, treatment, or transfer of medically relevant data by means of audio, video, or data communications that are used either during a patient visit or a consultation or are used to transfer medically relevant data about a patient. “Telehealth” does not include communications delivered solely by audio-only telephone, facsimile machine, or electronic mail unless the department specifies otherwise by rule.

“Asynchronous telehealth service” is telehealth that is used to transmit medical data about a patient to a provider when the transmission is not a 2-way, real-time, interactive communication.

“Interactive telehealth” means telehealth delivered using multimedia communication technology that permits 2-way, real-time, interactive communications between a certified provider of Medical Assistance at a distant site and the Medical Assistance recipient or the recipient’s provider.

SOURCE: WI Statute Sec. 49.45 (61). (Accessed Jan. 2024).

“Telehealth” means the use of telecommunications technology by a Medicaid-enrolled provider to deliver health care services including assessment, diagnosis, consultation, treatment, or transfer of medically relevant data in a functionally equivalent manner as that of an in-person contact:

- Telehealth may include real-time interactive audio-only communication.
- Telehealth does not include communication between a certified provider and a member (for example, a child) that consists solely of an email, text, or fax transmission.
- School documentation may use a different term to represent telehealth such as, but not limited to, teleservice, virtual learning platform, or virtual services. ForwardHealth will accept the Individual Education Program (IEP) team’s chosen term for telehealth used in documentation.

SOURCE: ForwardHealth Update, No. 2022-02, January 2022. (Accessed Jan. 2024).

“Telehealth” means the use of telecommunications technology by a certified provider to deliver services allowable under s. DHS 107.02 (5) and ss. 49.45 (61) and 49.46 (2) (b) 21. to 23., Stats., including assessment, diagnosis, consultation, treatment, or transfer of medically relevant data in a functionally equivalent manner as that of an in-person contact.

“Telehealth” may include real-time interactive audio-only communication.

“Telehealth” does not include communication between a certified provider and a recipient that consists solely of an electronic mail message, text, or facsimile transmission.

SOURCE: Department of Health Services Administrative Rules Sec. 101.03, (Accessed Jan. 2024).

Clarification of Definitions for Existing Telehealth Policy

Under permanent telehealth policy, “direct” refers to face-to-face, in-person contact between a member and a provider. This is a change from how the term “direct” has been used under temporary telehealth policy. Under temporary telehealth policy flexibilities in place during the PHE, direct telehealth services were defined to include delivery through real-time, synchronous telecommunications (such as phone, audio-only, or audio-visual interactions) that do not involve face-to-face, in-person patient contact. Refer to ForwardHealth Update 2020-15, titled “Additional Services to Be Provided Via Telehealth,” for additional information on temporary policy.

“Face-to-face” refers to requirements that can be met either in-person or through real-time, interactive audio-visual telehealth. Face-to-face equivalence for interactive telehealth services exists when a service is delivered from outside the physical presence of a Medicaid member by using audio, video, or telecommunication technology, and there is no reduction in quality, safety, or effectiveness. ForwardHealth does not consider a “face-to-face” requirement to be met by to audio-only or asynchronous delivery of services.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, (Accessed Jan. 2024).

Telehealth is audio and video contact with your doctor or health care provider using your phone, computer, or tablet. It includes:

- Health care services
- Getting a diagnosis

- Consultations to discuss your treatment
- Treatment for your medical condition

SOURCE: Wisconsin Department of Health Services, Medicaid Telehealth Expansion: Frequently Asked Questions, May 11, 2023, (Accessed Jan. 2024).

LIVE VIDEO

Last updated 01/09/2024

POLICY

The department shall provide reimbursement under the Medical Assistance program for any benefit that is a covered benefit under s. 49.46 (2) and that is delivered by a certified provider for Medical Assistance through interactive telehealth.

SOURCE: WI Statute 49.45(61), (Accessed Jan. 2024).

Both synchronous (two-way, real-time, interactive communications) and asynchronous (information stored and forwarded to a provider for later review) services identified under permanent policy may be reimbursed when provided via telehealth (also known as “telemedicine”). ForwardHealth will require providers to follow permanent billing guidelines for both synchronous and asynchronous telehealth services.

The following requirements apply to the use of telehealth:

- Both the member and the provider of the health care service must agree to the service being 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 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, 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.

Services provided via telehealth must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face visit where both the rendering provider

and member are in the same physical location. Both the distant and originating sites must have the requisite equipment and staffing necessary to provide the telehealth service.

Coverage of a service provided via telehealth is subject to the same restrictions as when the service is provided face to face (for example, allowable providers, multiple service limitations, PA).

Providers are reminded that HIPAA confidentiality requirements apply to telehealth services. When a covered entity or provider utilizes a telehealth service that involves PHI, the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each entity or provider must assess what are reasonable and appropriate security measures for their situation.

Note: Providers may not require the use of telehealth as a condition of treating a member. Providers must 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.

SOURCE: WI ForwardHealth Online Handbook. Topic #510 Telehealth (Accessed Jan. 2024).

ForwardHealth includes virtual check-in and e-visit options for members to connect with their providers remotely.

A **virtual check-in** is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed. The encounter may involve synchronous discussion over a phone or exchange of information through video or image. A provider may respond to the member's concern by phone, audio-visual communications, or a secure patient portal. Covered services include both the remote evaluation of a recorded video or image submitted by a member and the interpretation and follow-up by the provider.

An **e-visit** is a communication between a member and their provider through an online HIPAA-compliant patient portal. These patient-initiated asynchronous services involve a member having non-face-to-face communications cumulatively over a span of seven days with a provider with whom they have an established relationship. Providers who can bill E&M services may utilize online digital E&M codes while other providers may be eligible to bill online assessment and management codes.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, & Virtual Check-In, E-Visit and Telephone Evaluation and Management Services, Topic #22742. (Accessed Jan. 2024).

Behavioral Health Services

Behavioral health services should be indicated by the following modifiers.

- FQ*: A telehealth service was furnished using audio-only communication technology
- FR*: A supervising practitioner was present through a real-time two-way, audio/video communication technology
- GQ: Via asynchronous telecommunications system
- GT: Via interactive audio and video telecommunication systems

*Use for behavioral health services only.

SOURCE: WI ForwardHealth Online Handbook. Topic #22737 Behavioral Health Telehealth Services, (Accessed Jan. 2024).

ELIGIBLE SERVICES/SPECIALTIES

The department shall reimburse providers for medically necessary and appropriate health care services listed in this chapter and ss. 49.46 (2) and 49.47 (6) (a), Stats., when provided to currently eligible MA recipients via telehealth. Services provided via telehealth are subject to the same restrictions as services provided in an in-person setting unless otherwise specified in chs. DHS 101 to 109. Providers shall ensure that the locations from which they provide services via telehealth ensure privacy and confidentiality of recipient information and communications in a functionally equivalent manner to services provided in person. Benefits or services that may not be delivered via telehealth include any of the following:

- 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 when 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.

- Services provided by personal care workers, home health aides, private duty nurses, or school based service care attendants.
- Transportation.

SOURCE: Department of Health Services Administrative Rules Sec. 107.02(5), (Accessed Jan. 2024).

How does telehealth work?

Normally, you need to meet with your doctor or other health care provider in person for many health care services. Now you can get many services through telehealth if it can be securely delivered through your smartphone, computer, or tablet with the same quality and effectiveness.

Your doctor or health care provider, using guidance from the Wisconsin Department of Health Services, will decide if you can receive a service through telehealth. If you do not want to receive a service through telehealth or do not have the right technology—such as a phone, computer, or tablet—for it to be effective, you can still see your doctor in-person.

What types of services are allowed through telehealth when using Wisconsin Medicaid?

Services allowed through telehealth include:

- General health services, like seeing your provider or getting prescriptions for supplies or equipment
- Behavioral health services, like mental health screenings or treatment
- Dental consultations, like diagnosing an infected tooth and prescribing antibiotics until you can be seen in person
- Case management services
- Therapy services, like physical therapy, speech and language therapy, and occupational therapy

Are in-person services that are not covered allowed through telehealth?

No. Services that are not currently covered will not be paid when supplied through telehealth.

Families should review the HealthCheck “Other Services” benefit for services available for children under the age of 21.

See FAQ for questions related to specify covered services.

SOURCE: Wisconsin Department of Health Services, Medicaid Telehealth Expansion: Frequently Asked Questions, May 11, 2023, (Accessed Jan. 2024).

Providers should refer to the Max Fee Schedules page for a complete list of services allowed under permanent telehealth policy. Effective for dates of service on and after April 1, 2022, procedure codes for services allowed under permanent telehealth policy have POS codes 02 and 10 listed as an allowable POS in the fee schedule. Complete descriptions of these POS codes are as follows:

- POS code 02: Telehealth Provided Other Than in Patient's Home–The location where health services and health related services are provided or received through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
- POS code 10: Telehealth Provided in Patient's Home–The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

Claims for services delivered via telehealth must include all modifiers required by the existing benefit coverage policy in order to reimburse the claim correctly. Telehealth delivery of the service is shown on the claim by indicating POS code 02 or 10 and including either the GQ, GT, FQ, or 93 modifier in addition to any other required benefit-specific modifiers.

County-administered programs, school-based services, and any other programs that utilize cost reporting must include required modifiers, such as renderer credentials and group versus individual services, as well as correct details for cost reporting to ensure correct reimbursement.

Note: The GT, FQ or 93 modifiers may not be listed on the fee schedule, but it is still required on all claim submissions that use POS code 02 or 10 to indicate the telehealth service was performed synchronously. The GQ modifier is required to indicate the telehealth service was performed asynchronously.

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.

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 CDT 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.

The following cannot be billed to the member:

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

Services that are not covered when delivered in person are not covered as telehealth services. In addition, services that are not functionally equivalent to the in-person service when provided via telehealth are not covered.

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.

SOURCE: WI ForwardHealth Online Handbook. Topic #510 Telehealth (Accessed Jan. 2024).

Statute requires reimbursement for any benefit that delivered via interactive telehealth that is a covered benefit under Medicaid.

Reimbursement must be provided for a consultation pertaining to a Medicaid recipient conducted through interactive telehealth between a certified provider of Medical Assistance and the recipient's treating provider that is certified under medical assistance, except as provided by the Department by Rule.

Except as provided by the department by rule, Medicaid must cover all Medicare covered services. However, the Department may not cover or provide reimbursement for services that are first covered under the Medicare program after July 1, 2019 until the date that is one year after the date the service is covered under the Medicare program or the date the secretary explicitly approves the service as a Medical Assistance covered service, whichever is earlier.

The Department shall provide reimbursement under the Medical Assistance program for the following: Except as provided by the department by rule, services that are covered under the Medicare program under 42 USC 1395 et seq. for which the federal department of health and human services provides Medical Assistance federal financial participation and that are any of the following:

- Telehealth services, as defined under 42 USC 1395m (m) (4) (F),
- Remote physiologic monitoring,
- Remote evaluation of prerecorded patient information,
- Brief communication technology-based services,
- Care management services delivered through telehealth;
- Any other telehealth or communication technology-based services.

Any service that is not specified above that is provided through telehealth and that the department specifies by rule is a covered and reimbursable service under the Medical Assistance program.

The department shall promulgate rules specifying any services under par. (c) 4. that are reimbursable under Medical Assistance. The department may promulgate rules excluding services listed above from reimbursement under Medical Assistance. The department may promulgate rules specifying any telehealth service listed above that is provided solely by audio-only telephone, facsimile machine, or electronic mail as reimbursable under Medical Assistance.

SOURCE: WI Statute Sec. 49.45 (61). (Accessed Jan. 2024).

Telestroke Services

Telestroke, also known as stroke telemedicine, is a delivery mechanism of telehealth services that aims to improve access to recommended stroke treatment.

ForwardHealth allows providers to be reimbursed for telestroke services. Telestroke services typically consist of the member and emergency providers at an originating site consulting with a specialist located at a distant site.

Providers are required to use CPT consultation and E&M procedure codes when billing telestroke services. Telestroke services are subject to the same enrollment policy, coverage policy, and billing policy as telehealth services. All other services rendered by the provider at the originating site, and by any providers to which the member is transferred, should be billed in the same manner as visits or admissions that do not involve telehealth services.

Originating sites that have established contractual relationships for telestroke services may bill as they would for any other contracted professional services for both the professional service claim on behalf of the distant site provider and the originating site fee.

SOURCE: WI ForwardHealth Online Handbook. Topic #22741 Telestroke (Accessed Jan. 2024).

School-Based Services

ForwardHealth reimburses assessments, individual services, and group services delivered by telehealth when the service is documented in the child's IEP as an identified service and the mode of delivery is clearly described in documentation as telehealth

(using the IEP team's chosen term for telehealth delivery) and all other coverage requirements are met for the following services:

- Audiology
- Counseling service
- Nursing
- Occupational therapy
- Physical therapy
- Psychological service
- Social work service
- Speech and language therapy

The following services do not meet the definition of functionally equivalent and are not covered as a telehealth service:

- Attendant care
- Transportation

Note: School documentation may use a different term to represent telehealth such as, but not limited to, teleservice, virtual learning platform, or virtual services. ForwardHealth will accept the IEP team's chosen term for telehealth used in documentation.

As part of the IEP team meeting, the IEP team should determine if the service delivered by telehealth meets the ForwardHealth definition of functionally equivalent to be reimbursed. The decision to utilize telehealth as a delivery mode must be documented in the IEP in the section the IEP team determines appropriate.

SOURCE: ForwardHealth School-Based Services: Covered and Noncovered Services, Allowable Services via Telehealth. #22638 (Accessed Jan. 2024).

Teledentistry

ForwardHealth covers synchronous (two-way, real-time, interactive communications) and asynchronous (information stored and forwarded to a provider for subsequent review) teledentistry services.

The use of teledentistry services should be evaluated on an individual basis based on the member's individual situation and will not be required by ForwardHealth.

Providers should report code D9995 or D9996 along with the applicable allowable oral evaluation procedure codes to indicate the service was delivered via synchronous or asynchronous teledentistry.

Note: D9995 and D9996 are informational only and are not separately reimbursable.

The applicable teledentistry code is reported on a separate service line of a claim submission that also reports all the other procedures delivered during a virtual evaluation.

When providing diagnostic imaging services via teledentistry, providers should submit claims for either the interpretation or image capture of the radiograph.

All telehealth services must follow the guidelines for functional equivalency.

To maintain functional equivalency, a facilitator may be needed to assist with the teledentistry visit.

Facilitators may include dental hygienists and other appropriately trained medical or dental professionals within their scope of practice. Facilitators are allowed for teledentistry when appropriate but are not separately reimbursed.

Dental hygienists can perform and bill for an assessment (D0191) of a member via teledentistry if the service is delivered with functional equivalency and the dental hygienist is individually enrolled in Wisconsin Medicaid.

SOURCE: ForwardHealth Teledentistry Policy, Topic #22637, (Accessed Jan. 2024).

Virtual Check-In and E-Visit

Allowable procedure codes for virtual check-in and e-visit services can be found in the Attachment to this Update. These services will not require prior authorization and are patient-initiated by established patients of the provider's practice.

Virtual check-in and e-visit telehealth services are not covered or billable if they:

- Take place during an in-person visit.
- Take place within seven days after an in-person visit furnished by the same provider.
- Trigger an in-person visit within 24 hours or the soonest available appointment.
- Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service.

Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply.

See handbook for list e-visit and virtual check-in codes.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, & Virtual Check-In, E-Visit and Telephone Evaluation and Management Services, Topic #22742. (Accessed Jan. 2024).

Birth to 3 Telehealth Services

ForwardHealth reimburses therapy providers supplying services as part of the Birth to 3 Program at an enhanced rate when occupational therapy, 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 IFSP)
- Telehealth modifier: GQ, GT, FQ, or 93

SOURCE: ForwardHealth: Therapies, Physical, Occupational and Speech Language, Birth to 3 Telehealth Services, Topic #22617, (Accessed Jan. 2024).

Psychotherapy

Except as provided in par. (b), outpatient psychotherapy services shall be covered services when provided by a provider certified under s. DHS 105.22, and when the following conditions are met: ... Psychotherapy is performed only in any of the following: ...

- Via telehealth when the provider is in a location that ensures privacy and confidentiality of recipient information and communications.

The provider who performs psychotherapy shall engage in contact with the recipient in person, via real-time interactive audio-visual telehealth, or real-time interactive audio-only telehealth for at least 5/6 of the time for which reimbursement is claimed under MA.

AODA treatment services are performed only in the office of the provider, a hospital or hospital outpatient clinic, an outpatient facility, a nursing home or a school or by

telehealth when functionally equivalent to services provided in person.

The provider who performs AODA treatment services shall engage in contact with the recipient in person, via real-time interactive audio-visual telehealth, or real-time interactive audio-only telehealth for at least 5/6 of the time for which reimbursement is claimed.

SOURCE: Department of Health Services Administrative Rules Sec. 107.13, (Accessed Jan. 2024).

Interpretive Services

Interpreters may provide services either in-person or via telehealth. Services provided via telehealth must be functionally equivalent to an in-person visit, meaning that the transmission of information 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. Both the distant and originating sites must have the requisite equipment and staffing necessary to provide the telehealth service.

SOURCE: WI ForwardHealth Online Handbook. Topic #22917 Telehealth (Accessed Jan. 2024).

Mobile Crisis Teams

Wisconsin Medicaid reimburses Medicaid-enrolled crisis programs for up to three providers on a mobile crisis team who render services as part of a mobile crisis team response per DOS.

To receive reimbursement, the mobile crisis team must meet the following requirements:

- All team members must be trained and rostered with the county crisis intervention program, per Wis. Admin. Code ch. DHS 34.
- Each team includes at least one behavioral health professional who is qualified to do assessments in accordance with Wis. Admin. Code § DHS 34.22(3)(b) and at least one additional Wisconsin Medicaid provider.
- At least one team member must provide services in person. Additional team members may provide services in person or through telehealth.

SOURCE: WI ForwardHealth Online Handbook. Topic #22777 Telehealth (Accessed Jan. 2024).

Crisis Response

Covered Services – H2011 (Crisis intervention services, per 15 minutes) – this service provides a rapid response to a member experiencing behavioral health crisis, regardless of the member's location. The service is typically provided in person by going to the

member in crisis (that is, mobile crisis) but may also be provided on a walk-in basis or via telehealth according to telehealth guidelines.

SOURCE: WI Forward Health Updates 2023-34, Enhanced Reimbursement for Eligible Mobile Crisis Services, (Accessed Jan. 2024).

Medication Therapy Management Services

MTM services must be provided face-to-face with the member. Providers should attempt to provide MTM services in person whenever possible, but audio-visual telehealth delivery is allowable in cases that better fit the circumstances of the member. If the member is a child or has physical or cognitive impairments that preclude the member from managing their own medications, MTM services may be provided face-to-face to a caregiver (for example, caretaker relative, legal guardian, power of attorney, licensed health professional) on the member's behalf.

SOURCE: WI ForwardHealth Online Handbook. Topic #15199 Telehealth (Accessed Jan. 2024).

Postpartum Services

PNCC services are covered for a period after the pregnancy ends per Wis. Admin. Code § DHS 107.34(1)(a)2 if the Medicaid member was already receiving PNCC services on the last day of their pregnancy.

During the postpartum period, providers are required to:

- Make at least one face-to-face or telehealth visit with the member.
- Encourage and help the member to choose a primary health care provider for the baby.
- Discuss with the member the importance of immunizations and regular HealthCheck well-child exams for the baby. Encourage the member to have further conversations with their and/or their child's primary health care provider.
- Help the member schedule necessary postpartum appointments and adhere to their appointment schedule.
- Refer the member to additional community resources and services based on the parent and baby's individual strengths and needs.
- Follow up with the member and any providers or supportive persons as necessary to ensure that the member received all needed services and has obtained information to address any remaining needs or questions prior to the end of the PNCC benefit period.

SOURCE: WI ForwardHealth Online Handbook. Topic #944 Telehealth (Accessed Jan. 2024).

Crisis Intervention

Providers may provide crisis intervention services by the following means:

- Over the telephone
- In person at any location where a member is experiencing a crisis or receiving services to respond to a crisis (including, but not limited to, mobile crisis services, and walk-in services), but does not include jail, secure detention, or services provided to JMD members between ages 21 and 64
- Via telehealth

Providers are required to document the means and POS in the member's record.

SOURCE: WI ForwardHealth Online Handbook. Topic #6806 Telehealth (Accessed Jan. 2024).

Speech and Language Pathology, Audiology, and Hearing Services

Reimbursement of SLP Evaluations – Consistent with Wis. Admin. Code §§ DHS 107.36(b), (c), and (d), an evaluation or testing to assess the child's need for a therapy service performed in person or via audio-visual telehealth may be reimbursed when the evaluation or testing results are considered during the development or revision of an IEP. The student must qualify under IDEA in some disability category. The evaluation or testing does not need to result in that specific therapy service being added to the IEP.

Reimbursement of SLP Treatment – ForwardHealth will reimburse for coaching services when the therapist uses clinical judgment to assess student performance and the caretaker response to coaching results in direct service to the student during the therapy session. ForwardHealth confirms that speech and language therapy services rendered through telehealth may be reimbursed when a parent or caregiver is needed to assist the child during the therapy session. ForwardHealth only reimburses for services when the child is present.

SOURCE: WI ForwardHealth Online Handbook. Topic #1470 Covered Speech and Language Pathology, Audiology, and Hearing Services, (Accessed Jan. 2024).

School-Based Services – Testing and Assessment Procedures

Note: Consistent with Wis. Admin. Code §§ DHS 107.36(b),(c), and (d), an evaluation or testing to assess the child's need for a therapy service performed in person or via audio-visual telehealth may be reimbursed when the evaluation or testing results are considered during the development or revision of an IEP. The student must qualify under IDEA in some disability category. The evaluation or testing does not need to result in that specific therapy service being added to the IEP.

SOURCE: WI ForwardHealth Online Handbook. Topic #249 Testing and Assessment Procedures, (Accessed Jan. 2024).

Health Education and Nutrition Counseling

ForwardHealth covers health education and/or nutrition counseling under the PNCC benefit when: ...

- Services are provided face-to-face. Information on allowable telehealth services is available.

SOURCE: WI ForwardHealth Online Handbook. Topic #942 Health Education and Nutrition Counseling, (Accessed Jan. 2024).

Home Health

Face to Face Visit Requirement: Note: For an initial prescription, a physician or qualified healthcare professional can meet the face-to-face requirement by providing functionally equivalent synchronous audio-visual telehealth.

SOURCE: WI ForwardHealth Online Handbook. Topic #20977 Home Health, Face to Face Visit Requirement (Accessed Jan. 2024).

Postpartum Services

During the postpartum period, providers are required to:

- Make at least one face-to-face or telehealth visit with the member.

SOURCE: WI ForwardHealth Online Handbook. Topic #944 Home Health, Postpartum Services (Accessed Jan. 2024).

ELIGIBLE PROVIDERS

There is no restriction on the location of a distant site provider. In addition, there are no limitations on what provider types may be reimbursed for telehealth services.

SOURCE: WI ForwardHealth Online Handbook. Topic #510 Telehealth (Accessed Jan. 2024).

Supervision

Paraprofessional providers are subject to supervision requirements. Paraprofessional providers are providers who do not hold a license to practice independently but are providing services under the direction of a licensed provider. Providers who supervise paraprofessionals are responsible for confirming if the required components of supervision can be met through telehealth delivery.

Supervision of PCWs and home health aides must be performed on site and in person by the RN. State rules and regulations necessitate supervising providers to physically visit a member's home and directly observe the paraprofessional providing services.

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 NPI. (Nurse practitioners, nurse midwives, and anesthetists 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.

The FR modifier should be used for behavioral health services where the supervising provider is present through audio-visual means and the patient and supervised provider are in-person.

SOURCE: ForwardHealth Update, No. 2023-02, Feb. 2023, (Accessed Aug. 2023), and ForwardHealth Online Handbook, Topic #22757, (Accessed Jan. 2024).

Ancillary Providers

Claims for services provided via telehealth by distant site ancillary providers should continue to be submitted under the supervising physician's NPI using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT code for the service performed. These services must be provided under the direct on-site supervision of a physician who is located at the same physical site as the ancillary provider and must be documented in the same manner as services that are provided face to face.

Pediatric and Health Professional Shortage Area-Eligible Services

Claims for services provided via telehealth by distant site providers may additionally qualify for pediatric (services for members 18 years of age and under) or HPSA-enhanced reimbursement. Pediatric and HPSA-eligible providers are required to indicate POS code

02 or 10, along with modifier GQ, GT, FQ, or 93 and the applicable pediatric or HPSA modifier, when submitting claims that qualify for enhanced reimbursement.

SOURCE: WI ForwardHealth Online Handbook. Topic #22739 Originating and Distant Sites (Accessed Jan. 2024).

The distant site is where the provider is located during the telehealth visit. The provider who is providing health care services to the member via telehealth cannot bill the originating site fee because they are not hosting the member.

FQHCs and RHCs

For the purpose of this Online Handbook topic, FQHC refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS reimbursement.

FQHCs and RHCs may serve as originating site and distant site providers for telehealth services.

FQHCs and RHCs may report services provided via telehealth on the cost settlement report when the FQHC or RHC served as the distant site and the member is an established patient of the FQHC or RHC at the time of the telehealth service. For currently covered services, services that are considered direct when provided in-person will be considered direct when provided via telehealth for FQHCs.

Services billed with modifier GQ, GT, FQ, or 93 will be considered under the PPS reimbursement method for non-tribal FQHCs. Billing HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS rate for fee-for-service encounters. Fee-for-service claims must include HCPCS procedure code T1015 when services are provided via telehealth in order for proper reimbursement.

SOURCE: WI ForwardHealth Online Handbook. Topic #22739 Originating and Distant Sites (Accessed Jan. 2024).

Community Health Centers

Services billed with modifier GQ, GT, FQ, FR, or 93 will be considered under the PPS reimbursement. Billing HCPCS procedure codes T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS for an allowable encounter.

SOURCE: Telehealth for Community Health Centers (Accessed Jan. 2024).

Telestroke Services

ForwardHealth allows providers to be reimbursed for telestroke services. Telestroke services typically consist of the member and emergency providers at an originating site consulting with a specialist located at a distant site.

Providers are required to use CPT consultation and E&M procedure codes when billing telestroke services. Telestroke services are subject to the same enrollment policy, coverage policy, and billing policy as telehealth services. All other services rendered by the provider at the originating site, and by any providers to which the member is transferred, should be billed in the same manner as visits or admissions that do not involve telehealth services.

SOURCE: WI ForwardHealth Online Handbook. Topic #22741 Telestroke Services (Accessed Jan. 2024).

School-Based Services

Supervision of Certified Occupational Therapy and Physical Therapy Assistants

ForwardHealth accepts supervision of certified occupational therapy assistants and physical therapist assistants in schools conducted via audio-visual telehealth.

Refer to the Delegation of Physical Therapy Services topic (#1463) and the Delegation of Occupational Therapy Services topic (#1464) of the ForwardHealth Online Handbook for additional information.

SOURCE: WI ForwardHealth Online Handbook. Topic #1463 and #1464. (Accessed Jan. 2024).

Claims for telehealth services must include all modifiers required by coverage policy, in addition to POS code 02 (Telehealth Provided Other Than in Patient's Home) or 10 (Telehealth Provided in Patient's Home) and the GT, FQ, or 93 modifiers, in order to reimburse the claim correctly. The FQ or 93 modifiers should be used for any service performed via audio-only telehealth.

SOURCE: WI ForwardHealth Online Handbook. School-Based Services, School-Based Services Rate Changes and Fee Schedule, Topic #1447. (Accessed Jan. 2024).

Teledentistry

To maintain functional equivalency, a facilitator may be needed to assist with the teledentistry visit.

Facilitators may include dental hygienists and other appropriately trained medical or dental professionals within their scope of practice. Facilitators are allowed for

teledentistry when appropriate but are not separately reimbursed.

Dental hygienists can perform and bill for an assessment (D0191) of a member via teledentistry if the service is delivered with functional equivalency and the dental hygienist is individually enrolled in Wisconsin Medicaid.

SOURCE: ForwardHealth Teledentistry Policy, Topic #22637, (Accessed Jan. 2024).

Modifiers

Providers should include all applicable modifiers to identify the delivery method for telehealth services. Claims for synchronous telehealth services should be indicated by one or more
of the following applicable modifiers:

- GT (Via interactive audio and video telecommunication systems)
- 93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)
- FQ (A telehealth service was furnished using audio-only communication technology) Use this modifier when the patient is unable to use audio and video communications. (This modifier is for behavioral health services
  only.)
- FR (A supervising practitioner was present through a real-time two-way, audio/video communication technology) (This modifier is for behavioral health services only.)

Note: The FQ and FR modifiers are for behavioral health services only.

For services that include both asynchronous and synchronous components, claims should indicate that the cumulative services were rendered through both real-time interactions and store-and-forward delivery. For example, in a virtual check-in, if a provider reviews an image submitted by an established patient sent through a secure provider portal and calls the member on the phone to discuss treatment and next steps, the claim should indicate both the 93 and GQ modifiers.

Providers are required to include any additional provider, benefit, or service specific modifiers that may apply to a service code when delivered through telehealth. For example, when a service is provided by a physical therapist (PT), the codes would need to include the corresponding therapy modifier GP (Services delivered under an outpatient physical therapy plan of care) to signify the telehealth service is furnished as therapy services furnished under a PT plan of care.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, (Accessed Jan. 2024).

Physicians – Consultations

An E&M consultation requires face-to-face contact between the consultant and the member, either in person or via telehealth, where appropriate. A consultation must always result in a written report that becomes a part of the member's permanent medical record.

SOURCE: ForwardHealth Physicians, Consultations, Topic #483, (Accessed Jan. 2024).

ELIGIBLE SITES

The originating site is where the member is located during a telehealth visit. Only the provider at the originating site can bill for an originating site fee for hosting the member. The originating site should not use telehealth modifiers on the claims since all services are provided in-person. See facility fee section for sites eligible for originating site fee.

Claims for services provided via telehealth by distant site providers must be billed with the same procedure code as would be used for a face-to-face encounter along with modifiers GQ, GT, FQ, or 93.

Note: Only the service rendered from the distant site must be billed with modifier GQ. The originating site for asynchronous services is not eligible to receive an originating site fee.

Claims must also include either POS code 02 or 10. ForwardHealth reimburses the service rendered by distant site providers at the same rate as when the service is provided face-to-face.

FQHCs and RHCs

For the purpose of this Online Handbook topic, FQHC refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS reimbursement.

FQHCs and RHCs may serve as originating site and distant site providers for telehealth services.

The originating site fee is not a FQHC or RHC reportable encounter on the cost report. Any reimbursement for the originating site fee must be reported as a deductive value on the

cost report.

Although FQHCs 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.

SOURCE: WI ForwardHealth Online Handbook. Topic #22739 Originating and Distant Sites (Accessed Jan. 2024).

Community Health Centers

ForwardHealth will not separately reimburse the CHC for originating site services because all costs for providing originating site services have already been incorporated into the PPS rates for CHCs. However, claims billed by CHCs for originating site services may be used for future rate setting purposes, and CHC costs associated with telehealth services may be reported for change in scope adjustment consideration.

SOURCE: Telehealth for Community Health Centers (Accessed Jan. 2024).

The department may not limit coverage or reimbursement of a service provided under par. (b) or (c) based on the location of the Medical Assistance recipient when the service is provided.

SOURCE: WI Statute Sec. 49.45 (61). (Accessed Jan. 2024).

Do I need to be in a private location to have a telehealth visit?

Providers need to follow federal laws to ensure your privacy and security. This might include making sure you have a private space for your visit. This will help keep your health information confidential.

SOURCE: Wisconsin Department of Health Services, Medicaid Telehealth Expansion: Frequently Asked Questions, May 11, 2023, (Accessed Jan. 2024).

Telestroke Services

ForwardHealth allows providers to be reimbursed for telestroke services. Telestroke services typically consist of the member and emergency providers at an originating site consulting with a specialist located at a distant site.

SOURCE: WI ForwardHealth Online Handbook. Topic #22741 Telestroke (Accessed Jan. 2024).

Providers should refer to the Max Fee Schedules page for a complete list of services allowed under permanent telehealth policy. Effective for dates of service on and after April 1, 2022, procedure codes for services allowed under permanent telehealth policy

have POS codes 02 and 10 listed as an allowable POS in the fee schedule. Complete descriptions of these POS codes are as follows:

- POS code 02: Telehealth Provided Other Than in Patient's Home–The location where health services and health related services are provided or received through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
- POS code 10: Telehealth Provided in Patient's Home–The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

Claims for services delivered via telehealth must include all modifiers required by the existing benefit coverage policy in order to reimburse the claim correctly. Telehealth delivery of the service is shown on the claim by indicating POS code 02 or 10 and including either the GQ, GT, FQ, or 93 modifier in addition to any other required benefit-specific modifiers.

County-administered programs, school-based services, and any other programs that utilize cost reporting must include required modifiers, such as renderer credentials and group versus individual services, as well as correct details for cost reporting to ensure correct reimbursement.

Note: The GT, FQ or 93 modifiers may not be listed on the fee schedule, but it is still required on all claim submissions that use POS code 02 or 10 to indicate the telehealth service was performed synchronously. The GQ modifier is required to indicate the telehealth service was performed asynchronously.

SOURCE: WI ForwardHealth Online Handbook. Topic #510 Telehealth, (Accessed Jan. 2024).

Birth to 3 Telehealth Services

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

- 02 (Telehealth Provided Other than in Patient's Home)
- 04 (Homeless Shelter)
- 10 (Telehealth Provided in Patient's Home)
- 12 (Home)
- 99 (Other Place of Service)

SOURCE: ForwardHealth: Therapies, Physical, Occupational and Speech Language, Birth to 3 Telehealth Services, Topic #22617, (Accessed Jan. 2024).

POS codes 02 and 10 appear in a multitude of chapters in the Wisconsin Medicaid handbook. To see if they appear for you, go to the Online Wisconsin Medicaid Handbook, select your particular area and check Place of Services Codes under the "Code" chapter to see if they appear.

GEOGRAPHIC LIMITS

The originating site is where the member is located during a telehealth visit. Only the provider at the originating site can bill for an originating site fee for hosting the member. The originating site should not use telehealth modifiers on the claims since all services are provided in-person. The distant site is where the provider is located during the telehealth visit.

SOURCE: WI ForwardHealth Online Handbook. Topic #22739: Originating and Distant Sites, (Accessed Jan. 2024).

FACILITY/TRANSMISSION FEE

The following locations are eligible for the originating site fee under permanent telehealth policy:

- Office or clinic:
  - Medical
  - Dental
  - Therapies (physical therapy, occupational therapy, speech and language pathology)
  - Behavioral and mental health agencies
- Hospital
- Skilled nursing facility
- Community mental health center
- Intermediate care facility for individuals with intellectual disabilities
- Pharmacy

- Day treatment facility
- Residential substance use disorder treatment facility

In addition to reimbursement to the distant site provider, ForwardHealth reimburses an originating site fee for the staff and equipment at the originating site requisite to provide a service via telehealth. Eligible providers who serve as the originating site should bill the fee with HCPCS procedure code Q3014 (Telehealth originating site fee). Modifier GQ, GT, FQ, or 93 should not be included with procedure code Q3014.

Outpatient hospitals, including emergency departments, must bill HCPCS procedure code Q3014 on an institutional claim form as a separate line item with revenue code 0780. ForwardHealth will reimburse hospitals for the fee based on the standard hospital reimbursement methodology. ForwardHealth will reimburse these providers for the fee based on the provider's standard reimbursement methodology.

All other providers should bill HCPCS procedure code Q3014 with a POS code that represents where the member is located during the service. The POS must be a ForwardHealth-allowable originating site for HCPCS procedure code Q3014 in order to be reimbursed for the originating site fee. Billing-only provider types must include an allowable rendering provider on the claim form. The originating site fee is reimbursed based on a maximum allowable fee.

Although FQHCs 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.

To receive reimbursement, the originating site must:

- Utilize an interactive audiovisual telecommunications system that permits real-time communication between the provider at the distant site and the member at the originating site.
- Be in a physical location that ensures privacy.
- Provide access to broadband internet with sufficient bandwidth to transmit audio and video data.
- Provide access to support staff to assist with technical components of the telehealth visit.
- Be compliant with Health Insurance Portability and Accountability Act of 1996 standards.

For the purpose of this Online Handbook topic, FQHC refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS reimbursement.

FQHCs and RHCs may serve as originating site and distant site providers for telehealth services.

The originating site fee is not a FQHC or RHC reportable encounter on the cost report. Any reimbursement for the originating site fee must be reported as a deductive value on the cost report.

SOURCE: WI ForwardHealth Online Handbook. Topic #22739: Originating and Distant Sites, (Accessed Jan. 2024).

CHCs should submit claims for originating site services on a professional claim form with HCPCS procedure code Q3014 (Telehealth originating site facility fee) and a POS code that represents where the member is located during the service. Modifier GT should not be included with procedure code Q3014 for originating site services to be considered under the PPS reimbursement method. ForwardHealth will not separately reimburse the CHC for originating site services because all costs for providing originating site services have already been incorporated into the PPS rates for CHCs. However, claims billed by CHCs for originating site services may be used for future rate setting purposes, and CHC costs associated with telehealth services may be reported for change in scope adjustment consideration.

SOURCE: WI ForwardHealth Online Handbook, Telehealth for Community Health Centers. (Accessed Jan. 2024).

Dental providers should bill Q3014 (Telehealth originating site facility) with a POS code that represents where the member is located during the service on a professional claim form. The POS must be a ForwardHealth-allowable originating site for procedure code Q3014 in order to be reimbursed for the originating site fee. Billing-only provider types must include an allowable rendering provider on the claim form.

SOURCE: WI ForwardHealth Online Handbook. Topic #22637: Teledentistry Policy, (Accessed Jan. 2024).

Nursing Homes, Family Planning Only Services, and Outpatient Hospital Services may bill Q3014.

SOURCE: WI ForwardHealth Online Handbook. Topic #3219: Topic #2624; and Topic #1364. (Accessed Jan. 2024).

STORE-AND-FORWARD

Last updated 01/11/2024

POLICY

"Store and forward" is a term for asynchronous telehealth that involves the transmission of medical information to be reviewed at a later time by a provider at a distant site. The physician or practitioner at the distant site then reviews the case without the member present.

Effective January 1, 2023, ForwardHealth will begin reimbursing certain asynchronous telehealth services. Asynchronous telehealth services are defined as telehealth that is used to transmit medical data about a patient to a provider when the transmission is not a two-way, real-time, interactive communication.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, (Accessed Jan. 2024).

Both synchronous (two-way, real-time, interactive communications) and asynchronous (information stored and forwarded to a provider for later review) services identified under permanent policy may be reimbursed when provided via telehealth (also known as "telemedicine"). ForwardHealth will require providers to follow permanent billing guidelines for both synchronous and asynchronous telehealth services.

SOURCE: WI ForwardHealth Telehealth Policy, Topic #510. (Accessed Jan. 2024).

A virtual check-in is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed. The encounter may involve synchronous discussion over a phone or exchange of information through video or image. A provider may respond to the member's concern by phone, audio-visual communications, or a secure patient portal. Covered services include both the remote evaluation of a recorded video or image submitted by a member and the interpretation and follow-up by the provider.

An e-visit is a communication between a member and their provider through an online HIPAA-compliant patient portal. These patient-initiated asynchronous services involve a member having non-face-to-face communications cumulatively over a span of seven days with a provider with whom they have an established relationship. Providers who can bill evaluation and management (E&M) services may utilize online digital E&M codes while other providers may be eligible to bill online assessment and management codes.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, & Virtual Check-In, E-Visit and Telephone Evaluation and Management Services, Topic #22742. (Accessed Jan. 2024).

Modifiers

Claims for asynchronous services should be indicated using the GQ modifier.

For services that include both asynchronous and synchronous components, claims should indicate that the cumulative services were rendered through both real-time interactions and store-and-forward delivery. For example, in a virtual check-in, if a provider reviews an image submitted by an established patient sent through a secure provider portal and calls the member on the phone to discuss treatment and next steps, the claim should indicate both the 93 and GQ modifiers.

Providers are required to include any additional provider, benefit, or service specific modifiers that may apply to a service code when delivered through telehealth. For example, when a service is provided by a physical therapist (PT), the codes would need to include the corresponding therapy modifier GP (Services delivered under an outpatient physical therapy plan of care) to signify the telehealth service is furnished as therapy services furnished under a PT plan of care.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, (Accessed Jan. 2024).

Except as provided by the department by rule, asynchronous telehealth services in which the medical data pertains to a Medical Assistance recipient must be reimbursed.

Except as provided by the department by rule, services that are covered under Medicare for which the federal department of health and human services provides Medical Assistance federal financial participation and that are ... remote evaluation of prerecorded information shall be reimbursed.

SOURCE: WI Statute Sec. 49.45 (61). (Accessed Jan. 2024).

Interprofessional Consultations (E-Consults)

An interprofessional consultation or e-consult is an assessment and management service in which a member's treating provider requests the opinion and/or treatment advice of a provider with specific expertise (the consultant) to assist the treating provider in the diagnosis and/or management of the member's condition without requiring the member to have face-to-face contact with the consultant. Both the treating and consulting providers may be reimbursed for the e-consult as described below.

Consulting providers must be physicians enrolled in Wisconsin Medicaid as an eligible rendering provider. Consulting providers may bill CPT procedure codes 99446–99449 and 99451 under the following limitations:

- Services are not covered if the consultation leads to a transfer of care or other face-to-face service within the next 14 days or next available date of the consultant. Additionally, if the sole purpose of the consultation is to arrange a transfer of care or other face-to-face service, these procedure codes should not be submitted.
- Consulting services are covered once in a seven-day period.

Treating providers may be a physician, nurse practitioner, physician assistant, or podiatrist enrolled in Wisconsin Medicaid as an eligible rendering provider. Treating providers may bill CPT procedure code 99452 as a covered service once in a 14-day period.

Both the consulting and treating providers must be enrolled in Wisconsin Medicaid to receive reimbursement for the e-consult and the consultation must be medically necessary.

Providers are expected to follow CPT guidelines including that the CPT procedure codes should not be submitted if the consulting provider saw the member in a face-to-face encounter within the previous 14 days.

The following documentation requirements apply for e-consults:

- The consulting provider's opinion must be documented in the member's medical record.
- The written or verbal request for a consultation by the treating provider must be documented in the member's medical record including the reason for the request.
- Verbal consent for each consultation must be documented in the member's medical record. The member's consent must include assurance that the member is aware of any applicable cost-sharing.

SOURCE: WI ForwardHealth Online Handbook. Topic #22738, Interprofessional Consultations (E-Consults), (Accessed Jan. 2024).

Interprofessional consultations shall be covered if all of the following apply:

- The consultation is a professional service furnished to a recipient by a certified provider at the request of the treating provider.
- The consultation constitutes an evaluation and management service in which the certified provider treating a recipient requests the opinion or treatment advice of a consulting provider with specific expertise to assist the treating provider in the evaluation or management of the recipient's problem without requiring the recipient to have face–to–face contact with the consulting provider.
- The consulting provider provides a written report that becomes a part of the recipient's permanent medical record.

SOURCE: Department of Health Services Administrative Rules Sec. 107.06, (Accessed Jan. 2024).

Behavioral Health Services

Behavioral health services should be indicated by the following modifiers.

- FQ*: A telehealth service was furnished using audio-only communication technology
- FR*: A supervising practitioner was present through a real-time two-way, audio/video communication technology
- GQ: Via asynchronous telecommunications system
- GT: Via interactive audio and video telecommunication systems

*Use for behavioral health services only.

SOURCE: WI ForwardHealth Online Handbook. Topic #22737 Behavioral Health Telehealth Services, (Accessed Jan. 2024).

ELIGIBLE SERVICES

Services that are rendered asynchronously must adhere to the ForwardHealth guidelines for functional equivalency. “Functionally equivalent” means that when a service is provided via telehealth, the transmission of information 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.

Asynchronous delivery is indicated by modifier GQ (Via asynchronous telecommunications system). Modifier GQ must be used for all ForwardHealth-covered asynchronous services including, but not limited to, teleophthalmology, teledermatology, and teleradiology delivered through asynchronous telecommunications systems (for example: through e-consult and remote patient monitoring). Only the service rendered from the distant site must be billed with modifier GQ. The originating site for asynchronous services is not eligible to receive an originating site fee.

A member’s medical information may include, but is not limited to:

- Video clips
- Still images
- X-rays
- MRIs

- Laboratory results
- Audio clips
- Text documents

The transmission of protected health information must be performed in a manner compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ForwardHealth will not reimburse for any asynchronous service that does not adhere to the Healthcare Common Procedure Coding System or Current Procedural Terminology code description, meaning all the components listed in the description need to be present to be reimbursed. For example, if the code definition specifies “face-to-face” or “hands-on delivery,” this would not allow the service to be performed asynchronously. Providers must adhere to the delivery mode specified in the code description.

For dates of services on and after January 1, 2023, providers should report procedure code D9996 (Teledentistry asynchronous; information stored and forwarded to dentist for subsequent review) along with applicable dental evaluation and diagnostic imaging procedure codes to indicate the service was delivered through store and forward asynchronous teledentistry.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, (Accessed Jan. 2024).

Allowable procedure codes for virtual check-in and e-visit services can be found in the Attachment to this Update/Manual section.

These services will not require prior authorization and are patient-initiated by established patients of the provider’s practice.

Virtual check-in and e-visit telehealth services are not covered or billable if they:

- Take place during an in-person visit.
- Take place within seven days after an in-person visit furnished by the same provider.
- Trigger an in-person visit within 24 hours or the soonest available appointment.
- Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service.

Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, & Virtual Check-In, E-Visit and Telephone Evaluation and Management Services, Topic

#22742. (Accessed Jan. 2024).

ForwardHealth covers synchronous (two-way, real-time, interactive communications) and asynchronous (information stored and forwarded to a provider for subsequent review) teledentistry services.

The following code should be used on dental claims to indicate teledentistry.

- D9996 – Teledentistry asynchronous; information stored and forwarded to dentist for subsequent review

Providers should report code D9995 or D9996 along with the applicable allowable oral evaluation procedure codes to indicate the service was delivered via synchronous or asynchronous teledentistry.

SOURCE: WI ForwardHealth Online Handbook. Topic #22637: Teledentistry Policy, (Accessed Jan. 2024).

GEOGRAPHIC LIMITS

No Reference Found

TRANSMISSION FEE

Only the service rendered from the distant site must be billed with modifier GQ. The originating site for asynchronous services is not eligible to receive an originating site fee.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, (Accessed Jan. 2024).

REMOTE PATIENT MONITORING

Last updated 01/09/2024

POLICY

Except as provided by the department by rule, remote patient monitoring of a Medical Assistance recipient in which the medical data pertains to a Medical Assistance recipient must be reimbursed.

Except as provided by the department by rule, services that are covered under Medicare for which the federal department of health and human services provides Medical Assistance federal financial participation and that are ... remote physiologic monitoring shall be reimbursed.

SOURCE: WI Statute Sec. 49.45 (61). (Accessed Jan 2024).

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.

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.

SOURCE: WI ForwardHealth Online Handbook. Topic #22740 Remote Patient Monitoring. (Accessed Jan. 2024).

CONDITIONS

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.

SOURCE: WI ForwardHealth Online Handbook. Topic #22740 Remote Patient Monitoring. (Accessed Jan. 2024).

PROVIDER LIMITATIONS

Only physicians, nurse practitioners, and physician assistants enrolled in ForwardHealth are eligible to render and submit claims for remote physiologic services.

SOURCE: WI ForwardHealth Online Handbook. Topic #22740 Remote Patient Monitoring. (Accessed Jan. 2024).

OTHER RESTRICTIONS

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 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).

SOURCE: WI ForwardHealth Online Handbook. Topic #22740 Remote Patient Monitoring. (Accessed Jan. 2024).

EMAIL, PHONE & FAX

Last updated 01/09/2024

A virtual check-in is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed. The encounter may involve synchronous discussion over a phone or exchange of information through video or image. A provider may respond to the member's concern by phone, audio-visual communications, or a secure patient portal. Covered services include both the remote evaluation of a recorded video or image submitted by a member and the interpretation and follow-up by the provider.

An e-visit is a communication between a member and their provider through an online HIPAA-compliant patient portal. These patient-initiated asynchronous services involve a member having non-face-to-face communications cumulatively over a span of seven days with a provider with whom they have an established relationship. Providers who can bill evaluation and management (E&M) services may utilize online digital E&M codes while other providers may be eligible to bill online assessment and management codes.

Allowable procedure codes for virtual check-in and e-visit services can be found in the Attachment to this Update/Manual section. These services will not require prior authorization and are patient-initiated by established patients of the provider's practice.

Virtual check-in and e-visit telehealth services are not covered or billable if they:

- Take place during an in-person visit.
- Take place within seven days after an in-person visit furnished by the same provider.
- Trigger an in-person visit within 24 hours or the soonest available appointment.
- Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service.

Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply.

Telephone Evaluation and Management Services: See handbook for list of reimbursable for telephone E&M service codes.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, & Virtual Check-In, E-Visit and Telephone Evaluation and Management Services, Topic #22742. (Accessed Jan. 2024).

Can I receive services by phone (audio-only)?

Some services can be delivered over the phone with the same quality and effectiveness as an in-person service. These services can be provided by phone (audio-only). Your provider will let you know which type of technology is right for your appointment.

SOURCE: Wisconsin Department of Health Services, Medicaid Telehealth Expansion: Frequently Asked Questions, May 11, 2023, (Accessed Jan. 2024).

Modifiers

Providers should include all applicable modifiers to identify the delivery method for telehealth services. Claims for synchronous telehealth services should be indicated by one or more
of the following applicable modifiers:

- 93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)
- FQ (A telehealth service was furnished using audio-only communication technology) Use this modifier when the patient is unable to use audio and video communications. (This modifier is for behavioral health services
  only.)

Note: The FQ and FR modifiers are for behavioral health services only.

Providers are required to include any additional provider, benefit, or service specific modifiers that may apply to a service code when delivered through telehealth. For example, when a service is provided by a physical therapist (PT), the codes would need to include the corresponding therapy modifier GP (Services delivered under an outpatient physical therapy plan of care) to signify the telehealth service is furnished as therapy services furnished under a PT plan of care.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, (Accessed Jan. 2024).

The Department may promulgate rules specifying any telehealth service that is provided solely by audio-only telephone, facsimile machine or electronic mail as reimbursable under Medical Assistance.

SOURCE: WI Statute Sec. 49.45 (61). (Accessed Jan. 2024).

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.

Modifier 93 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.

SOURCE: ForwardHealth Telehealth Policy Topic #510, (Accessed Jan. 2024).

Behavioral Health Services

Behavioral health services should be indicated by the following modifiers.

- FQ*: A telehealth service was furnished using audio-only communication technology
- FR*: A supervising practitioner was present through a real-time two-way, audio/video communication technology
- GQ: Via asynchronous telecommunications system
- GT: Via interactive audio and video telecommunication systems

*Use for behavioral health services only.

SOURCE: WI ForwardHealth Online Handbook. Topic #22737 Behavioral Health Telehealth Services, (Accessed Jan. 2024).

Interprofessional Consultations (E-Consults)

An interprofessional consultation or e-consult is an assessment and management service in which a member's treating provider requests the opinion and/or treatment advice of a provider with specific expertise (the consultant) to assist the treating provider in the diagnosis and/or management of the member's condition without requiring the member to have face-to-face contact with the consultant. Both the treating and consulting providers may be reimbursed for the e-consult as described below.

Consulting providers must be physicians enrolled in Wisconsin Medicaid as an eligible rendering provider. Consulting providers may bill CPT procedure codes 99446–99449 and 99451 under the following limitations:

- Services are not covered if the consultation leads to a transfer of care or other face-to-face service within the next 14 days or next available date of the consultant. Additionally, if the sole purpose of the consultation is to arrange a transfer of care or other face-to-face service, these procedure codes should not be submitted.

- Consulting services are covered once in a seven-day period.

Treating providers may be a physician, nurse practitioner, physician assistant, or podiatrist enrolled in Wisconsin Medicaid as an eligible rendering provider. Treating providers may bill CPT procedure code 99452 as a covered service once in a 14-day period.

Both the consulting and treating providers must be enrolled in Wisconsin Medicaid to receive reimbursement for the e-consult and the consultation must be medically necessary.

Providers are expected to follow CPT guidelines including that the CPT procedure codes should not be submitted if the consulting provider saw the member in a face-to-face encounter within the previous 14 days.

SOURCE: WI ForwardHealth Online Handbook. Topic #22738, Interprofessional Consultations (E-Consults), (Accessed Jan. 2024).

Crisis Intervention, Birth to 3 Telehealth Services, School Based Services, and Community Health Centers may use the FQ (audio-only) modifier.

SOURCE: WI ForwardHealth Online Handbook, Topic #6777, Topic #22617, Topic #1447, & Topic #21997. (Accessed Jan. 2024).

Interprofessional consultations shall be covered if all of the following apply:

- The consultation is a professional service furnished to a recipient by a certified provider at the request of the treating provider.
- The consultation constitutes an evaluation and management service in which the certified provider treating a recipient requests the opinion or treatment advice of a consulting provider with specific expertise to assist the treating provider in the evaluation or management of the recipient's problem without requiring the recipient to have face-to-face contact with the consulting provider.
- The consulting provider provides a written report that becomes a part of the recipient's permanent medical record.

SOURCE: Department of Health Services Administrative Rules Sec. 107.06, (Accessed Jan. 2024).

Except as provided in par. (b), outpatient psychotherapy services shall be covered services when provided by a provider certified under s. DHS 105.22, and when the following conditions are met: ... Psychotherapy is performed only in any of the following: ...

- Via telehealth when the provider is in a location that ensures privacy and confidentiality of recipient information and communications.

The provider who performs psychotherapy shall engage in contact with the recipient in person, via real-time interactive audio-visual telehealth, or real-time interactive audio-only telehealth for at least 5/6 of the time for which reimbursement is claimed under MA.

AODA treatment services are performed only in the office of the provider, a hospital or hospital outpatient clinic, an outpatient facility, a nursing home or a school or by telehealth when functionally equivalent to services provided in person.

The provider who performs AODA treatment services shall engage in contact with the recipient in person, via real-time interactive audio-visual telehealth, or real-time interactive audio-only telehealth for at least 5/6 of the time for which reimbursement is claimed.

SOURCE: Department of Health Services Administrative Rules Sec. 107.13, (Accessed Jan. 2024).

CONSENT REQUIREMENTS

Last updated 01/09/2024

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.

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.

Note: Providers may not require the use of telehealth as a condition of treating a member. Providers must 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.

SOURCE: WI ForwardHealth Online Handbook. Topic #510 Telehealth, (Accessed Jan. 2024).

The following documentation requirements apply for e-consults:

- The consulting provider's opinion must be documented in the member's medical record.
- The written or verbal request for a consultation by the treating provider must be documented in the member's medical record including the reason for the request.
- Verbal consent for each consultation must be documented in the member's medical record. The member's consent must include assurance that the member is aware of any applicable cost-sharing.

SOURCE: WI ForwardHealth Online Handbook. Topic #22738: Interprofessional Consultations (E-Consults), (Accessed Jan. 2024).

Providers must obtain member consent for telehealth services, including informing the member of any applicable copay or cost sharing that may apply. This includes patient-initiated virtual check-in and e-visit services. For more information regarding telehealth consent guidelines, refer to the Telehealth topic (#510) of the ForwardHealth Online Handbook.

Additionally, providers are responsible for communicating with members how the delivery of a service may potentially vary between an in-person and a telehealth delivery. This includes informing a member of any potential changes they may anticipate in how a service is delivered when the temporary telehealth policy and PHE flexibilities expire and permanent policy is effective.

SOURCE: WI ForwardHealth Update: Expanded Coverage for Permanent Telehealth Policy, No. 2023-01, Jan. 2023, (Accessed Jan. 2024).

OUT OF STATE PROVIDERS

Last updated 01/09/2024

ForwardHealth policy for services provided via telehealth by out-of-state providers is the same as ForwardHealth policy for services provided face to face by out-of-state providers.

Out-of-state providers who meet the definition of a border-status provider as described in Wis. Admin. Code § DHS 101.03(19) and who provide services to Wisconsin Medicaid members only via telehealth, may apply for enrollment as Wisconsin telehealth-only border-status providers if they are licensed in Wisconsin under applicable Wisconsin statute and administrative code.

Out-of-state providers who do not have border status enrollment with Wisconsin Medicaid are required to obtain PA before providing services via telehealth to BadgerCare Plus or Medicaid members.

Note: Wisconsin Medicaid is prohibited from paying providers located outside of the United States and its territories, including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

SOURCE: WI ForwardHealth Online Handbook. Topic #510 Telehealth. (Accessed Jan. 2024).

Beginning June 1, 2023, a new telehealth-only border-status option will allow out-of-state providers located in a state that does not physically border Wisconsin to enroll in Medicaid as a telehealth-only border-status provider.

These out-of-state providers will enroll through the border-status process but will select the newly added “telehealth” option as their county. This option will distinguish these providers from regular border-status providers that may potentially also deliver in-person services to members in addition to telehealth delivery. This option is only available for providers located in the United States that:

- Provide services solely through telehealth.
- Are located in states that do not physically border Wisconsin.

In-state providers located in Wisconsin that provide services solely through telehealth should enroll in Medicaid as an in-state provider, and border-status providers located in a state that physically borders Wisconsin should enroll in Medicaid as a border-status provider.

Refer to the Attachment to this ForwardHealth Update for additional guidance on which enrollment process is most appropriate to provide telehealth-only services based on the provider’s location and status.

Note: Wisconsin Medicaid is prohibited from paying providers located outside of the United States and its territories (Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa).

Definition of Telehealth-Only Border-Status Provider

Out-of-state providers who meet the definition of a border-status provider as described in Wis. Admin. Code § DHS 101.03(19) and who provide services to Wisconsin Medicaid members via telehealth, regardless of provider location, may apply for enrollment as a telehealth-only border-status provider if they are licensed in Wisconsin under applicable statute and administrative code and are professionally licensed/certified to provide services as defined by the Wisconsin Department of Safety and Professional Services.

Enrolled border-status providers are subject to the same program requirements as in-state providers, including coverage of services, prior authorization (PA), and claim submission procedures. Out-of-state providers that do not enroll as telehealth-only border-status providers are required to obtain PA from ForwardHealth before providing a non-emergency service.

See bulletin for more on providers eligible to enroll and providers not eligible to enroll, as well as the process to become a telehealth-only border-status provider.

During the enrollment process, telehealth-only border-status providers must attest to understanding the limitations on the services they are delivering to members in Wisconsin and following all applicable policies, state and federal rules, regulations, and licensure requirements applicable to claims submitted to Wisconsin Medicaid. Providers must also acknowledge that, as a telehealth-only border-status provider, they may only submit claims for reimbursable services delivered through telehealth; any in-person services are subject to out-of-state provider requirements including PA for services.

Program limitations and requirements for telehealth-only border-status providers include the following:

- Border-status providers who are located in states that do not border Wisconsin may only deliver services via telehealth unless they have PA. Regular border-status providers (those that physically border Wisconsin – Illinois, Iowa, Michigan, and Minnesota) may deliver services via telehealth and in-person.
- Telehealth-only border-status providers must open a Portal account upon enrollment to conduct business via the Portal including submission of PA requests as necessary.

- Telehealth-only border-status providers are required to follow all applicable federal and state laws, policies, and regulations, including any related requirements from the state from which they are practicing when delivering services.

SOURCE: Wisconsin ForwardHealth Bulletin No. 2023-20, June 2023, (Accessed Jan .2024).

When a provider in a state that borders on Wisconsin documents to the department's satisfaction that it is common practice for recipients in a particular area of Wisconsin to go for medical services to the provider's locality in the neighboring state, the provider may be certified as a Wisconsin border status provider, subject to the certification requirements in this chapter and the same rules and contractual agreements that apply to Wisconsin providers, except that nursing homes are not eligible for border status.

Out-of-state independent laboratories, regardless of location, may apply for certification as Wisconsin border status providers.

Out-of-state providers who meet the definition of a border-status provider as described in s. DHS 101.03 (19) and who provide services to Wisconsin members via telehealth, regardless of provider location, may apply for certification as Wisconsin border-status providers if they are licensed in Wisconsin under applicable Wisconsin statute and administrative code.

Other out-of-state providers who do not meet the requirements of sub. (1) may be reimbursed for non-emergency services provided to a Wisconsin MA recipient upon approval by the department under s. DHS 107.04.

The department may review border status certification of a provider annually. Border status certification may be canceled by the department if it is found to be no longer warranted by medical necessity, volume or other considerations.

A provider certified in another state for services not covered in Wisconsin shall be denied border status certification for these services in the Wisconsin program.

A provider denied certification in another state shall be denied certification in Wisconsin, except that a provider denied certification in another state because the provider's services are not MA-covered in that state may be eligible for Wisconsin border status certification if the provider's services are covered in Wisconsin.

SOURCE: Department of Health Services Administrative Rules Sec. 105.48, (Accessed Jan. 2024).

Can I receive services from an out-of-state provider through telehealth?

Yes, you can receive services from an out-of-state provider if they are enrolled in Wisconsin Medicaid and follow Medicaid policy for prior authorizations (getting permission before the service occurs). Check with your provider to see if they qualify. If you are enrolled in a managed care program, you should check with them to determine who you can see.

If I am out of state, can I still receive telehealth services?

Maybe. Providers may be required to have a license to practice in the state where you are located. Check with your provider to see if they are able to provide telehealth services in the state where you are located.

SOURCE: Wisconsin Department of Health Services, Medicaid Telehealth Expansion: Frequently Asked Questions, May 11, 2023, (Accessed Jan. 2024).

MISCELLANEOUS

Last updated 01/09/2024

The department may not require a certified provider of Medical Assistance that provides a reimbursable service to obtain an additional certification or meet additional requirements solely because the service was delivered through telehealth, except that the department may require, by rule, that the transmission of information through telehealth be of sufficient quality to be functionally equivalent to face-to-face contact. The department may apply any requirement that is applicable to a covered service that is not provided through telehealth to any service telehealth service listed under statute.

SOURCE: WI Statute Sec. 49.45 (61)(e), (Accessed Jan. 2024).

The following cannot be billed to the member:

Telehealth equipment like tablets or smart devices

- Charges for mailing or delivery of telehealth equipment
- 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

Documentation Requirements

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).

As a reminder, documentation for originating sites must support the member's presence in order to submit a claim for the originating site fee. In addition, if the originating site provides and bills for services in addition to the originating site fee, documentation in the member's medical record should distinguish between the unique services provided.

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 to the member to the telehealth visit are secure.

SOURCE: WI ForwardHealth Online Handbook. Topic #510 Telehealth, (Accessed Jan. 2024).

Supervision

Supervision requirements and respective telehealth allowances vary depending on service and provider type. Some supervision requirements necessitate the physical presence of the supervising provider to meet the requirements of appropriate delivery of supervision. Such requirements cannot be met through the provision of telehealth, including audio-visual delivery.

Paraprofessional providers are subject to supervision requirements. Paraprofessional providers are providers who do not hold a license to practice independently but are providing services under the direction of a licensed provider. Providers who supervise

paraprofessionals are responsible for confirming if the required components of supervision can be met through telehealth delivery.

Personal Care/Home Health Provider Supervision Under permanent policy, supervision of PCWs and home health aides must be performed on site, in person by the RN. State rules and regulations necessitate supervising providers to physically visit a member's home and directly observe the paraprofessional providing services.

Providers are reminded that effective January 1, 2022, modifier FR should be used for behavioral health services where the supervising provider is present through audio-visual means and the patient and supervised provider are in-person.

This Update applies to telehealth services with supervision components that members receive on a fee-for-service basis and through BadgerCare Plus, Medicaid SSI, and other managed care programs. For information about managed care implementation of the updated policy, contact the appropriate managed care organization (MCO). MCOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

SOURCE: WI ForwardHealth Update, Feb. 2023, No. 2023-02, (Accessed Jan. 2024).

Supervision requirements and respective telehealth allowances vary depending on service and provider type. Some supervision requirements necessitate the physical presence of the supervising provider to meet the requirements of appropriate delivery of supervision. Such requirements cannot be met through the provision of telehealth, including audio-visual delivery.

Providers who deliver services with supervision requirements are reminded to review ForwardHealth policy, including permanent telehealth policy, and the requirements of their licensing and/or certifying authorities to determine if the supervisory components of the service can be met via telehealth.

See handbook for provider type instructions.

SOURCE: ForwardHealth Topic #22757, Supervision, (Accessed Jan. 2024).

Documentation

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 the Wisconsin Department of Health Services (DHS) upon request. Per Wis. Stat. § 49.45(3)(f), providers of services shall maintain records as

required by DHS for verification of provider claims for reimbursement. DHS may audit such records to verify actual provision of services and the appropriateness and accuracy of claims. DHS may deny or recoup payment for services that fail to meet these requirements. Refusal to produce documentation may result in denial of submitted claims, recoupment of paid claims, application of intermediate sanctions, or termination from the Medicaid program.

This Update applies to telehealth services that members receive on a fee-forservice basis and through BadgerCare Plus, Medicaid SSI, and other managed care programs. For information about managed care implementation of the updated policy, contact the appropriate managed care organization (MCO). MCOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

SOURCE: WI ForwardHealth Update, Feb. 2023, No. 2023-02, (Accessed Jan. 2024).

Teledentistry

When a dentist has performed an oral evaluation via teledentistry and a problem is found, the dentist should help refer the member to a dentist who can provide treatment if the dentist is not able to schedule the member for treatment themselves.

All telehealth services must follow the guidelines for submitting documentation for the visit and complying with audio and visual and audio-only visit guidelines.

SOURCE: ForwardHealth Teledentistry Policy, Topic #22637, (Accessed Jan. 2024).

What options are available for providing my signature or the signature of my representative?

When your signature or the signature of your representative is required, handwritten or electronic signatures are acceptable. If a handwritten signature is specified, an electronic signature will not be accepted.

The following types of signatures are accepted:

- **Handwritten signature**—This includes:
  - Signing a paper document and handing it to your provider or returning it to your provider through the mail or fax.
  - Signing a touchpad signature device.
  - Sending a statement by email giving your approval.

- Taking a picture of a signed document and electronically forwarding it to your provider using methods such as text or email.

- **Electronic signature**—The provider handles setting up a way to accept your signature electronically.

SOURCE: Wisconsin Department of Health Services, Medicaid Telehealth Expansion: Frequently Asked Questions, May 11, 2023, (Accessed Jan. 2024).

Professional Requirements

DEFINITIONS

Last updated 01/11/2024

Telemedicine means the practice of medicine when patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine does not include the provision of health care services only through an audio-only telephone, email messages, text messages, facsimile transmission, mail or parcel service, or any combination thereof.

SOURCE: WI Admin. Code MED Ch. 24.02 (Accessed Jan. 2024).

“Telehealth” means a practice of health care delivery, diagnosis, consultation, treatment, or transfer of medically relevant data by means of audio, video, or data communications that are used either during a patient visit or a consultation or are used to transfer medically relevant data about a patient. “Telehealth” includes asynchronous telehealth services, interactive telehealth, and remote patient monitoring.

SOURCE: WI Statutes 440.01. (Accessed Jan. 2024).

Veterinary Telemedicine

“Telemedicine” means the remote delivery of veterinary healthcare services, such as health assessments or consultations, over the telecommunications infrastructure, allowing a veterinarian to evaluate, diagnose and treat patients without the need for an in-person visit.

SOURCE: WI Admin. Code Ch. VE 1.50 (Accessed Jan. 2024).

CONSENT REQUIREMENTS

Last updated 01/11/2024

When a physician uses a website to communicate to a patient located in this state, the physician may not provide treatment recommendations, including issuing a prescription, unless the following requirements are met:

- The physician shall be licensed to practice medicine and surgery by the medical examining board as required under s. Med 24.04.
- The physician's name and contact information have been made available to the patient.
- Informed consent as required under s. 448.30, Stats., and ch. Med 18.
- A documented patient evaluation has been performed. A patient evaluation shall include a medical history and, to the extent required to meet or exceed the standard of minimally competent medical practice, an examination or evaluation, or both, and diagnostic tests.
- A patient health care record is prepared and maintained as required under ch. Med 21.

SOURCE: WI Admin. Code MED Ch. 24.07. (Accessed Jan. 2024).

ONLINE PRESCRIBING

Last updated 01/11/2024

A physician-patient relationship may be established through telemedicine.

SOURCE: WI Admin. Code MED Ch. 24.03 (Accessed Jan. 2024).

When a physician uses a website to communicate to a patient located in this state, the physician may not provide treatment recommendations, including issuing a prescription, unless the following requirements are met:

- The physician shall be licensed to practice medicine and surgery by the medical examining board as required under s. Med 24.04.
- The physician's name and contact information have been made available to the patient.
- Informed consent as required under s. 448.30, Stats., and ch. Med 18.
- A documented patient evaluation has been performed. A patient evaluation shall include a medical history and, to the extent required to meet or exceed the standard of minimally competent medical practice, an examination or evaluation, or both, and diagnostic tests.
- A patient health care record is prepared and maintained as required under ch. Med 21.

Providing treatment recommendations, including issuing a prescription, based only on a static electronic questionnaire does not meet the standard of minimally competent medical practice.

SOURCE: WI Admin. Code MED Ch. 24.07 (Accessed Jan. 2024).

CROSS-STATE LICENSING

Last updated 01/11/2024

WI medical license required.

SOURCE: WI Admin. Code Med Ch. 24.04 (Accessed Jan. 2024).

A psychologist who uses a telehealth visit to provide psychological services to a patient located in this state shall either be licensed as a psychologist by the board, or shall meet the requirements to exercise the authority to practice interjurisdictional telepsychology under s. 455.50 (4), Stats.

SOURCE: WI Admin Code Ch. 5.02, (Accessed Jan. 2024).

LICENSURE COMPACTS

Last updated 01/11/2024

Member of the Interstate Medical Licensure Compact.

SOURCE: Interstate Licensure Compact, Compact Map, (Accessed Jan. 2024).

Member of the Nurse Licensure Compact

SOURCE: Nurse Licensure Compact (Accessed Jan. 2024).

Member of Physical Therapy Compact.

SOURCE: PT Compact. (Accessed Jan. 2024).

Member of the Psychology Interjurisdictional Compact

SOURCE: PSYPACT Compact Map (Accessed Jan. 2024).

Member of Occupational Therapy Licensure Compact

SOURCE: OT Compact Map. (Accessed Jan. 2024).

Member of Counseling Compact

SOURCE: Counseling Compact Map, (Accessed Jan. 2024).

Member of Audiology and Speech Language Pathology Compact

SOURCE: ASLP Compact Map, (Accessed Jan. 2024).

* See Compact websites for implementation and license issuing status and other related requirements.

PROFESSIONAL BOARDS STANDARDS

Last updated 01/11/2024

Medical Examining Board

SOURCE: WI Administrative Code, Med Ch. 24, (Accessed Jan. 2024).

Veterinary Examining Board

SOURCE: WI Admin. Code Ch. VE 1 (Accessed Jan. 2024).

Psychology Board

SOURCE: WI Admin Code Ch. 5.02, (Accessed Jan. 2024).

MISCELLANEOUS

Last updated 01/11/2024

No reference found.

Federally Qualified Health Center (FQHC)

DEFINITION OF VISIT

Last updated 01/09/2024

A CHC encounter is defined as a face-to-face visit on a single DOS between a member and a Medicaid-enrolled CHC provider to provide diagnosis, treatment, or preventive service(s) at the CHC HRSA-approved location including main and off-site locations.

SOURCE: WI ForwardHealth Online Handbook Community Health Center Encounters, Topic #21958 (Accessed Jan. 2024).

For currently covered services, services that are considered direct when provided in-person will be considered direct when provided via telehealth for FQHCs.

SOURCE: WI ForwardHealth Handbook, Originating and Distant Sites, Topic #22739, (Accessed Jan. 2024).

MODALITIES ALLOWED

Last updated 01/09/2024

Live Video

FQHCs may serve as originating and distant site providers for telehealth services.

SOURCE: WI ForwardHealth Handbook, Originating and Distant Sites, Topic #22739, (Accessed Jan. 2024).

See: WI Medicaid Live Video.

Store and Forward

According to ForwardHealth Telehealth handbook, Services must be functionally equivalent to face-to-face visits. There is no indication that store-and-forward is reimbursed.

See: WI Medicaid Store and Forward.

Remote Patient Monitoring

According to statute, RPM is covered with restrictions, however there is no indication if FQHCs can bill for this.

See: WI Medicaid Remote Patient Monitoring.

Audio-Only

According to statute, there is no restriction on distant sites, and all modes of telehealth including audio-only, is supposed to covered. However, CCHP has not found an explicit reference in Medicaid manuals to whether or not FQHCs can be reimbursed for audio-only.

See: WI Medicaid Email, Phone and Fax.

SAME DAY ENCOUNTERS

Last updated 01/09/2024

ForwardHealth reimburses a CHC a maximum of one PPS rate per encounter type, per member, per DOS, unless the member, subsequent to the first encounter, suffers an illness or injury that requires additional diagnosis or treatment on the same day. A subsequent encounter is a unique situation that cannot be planned or anticipated. For example, a member sees their provider in the morning for a medical condition and later in the day has a fall and returns to the CHC. Subsequent encounters can be medical, dental, or behavioral health when the encounter satisfies the subsequent encounter requirements.

When a CHC member receives services of the same encounter type from more than one of the CHC's locations (for example, the main clinic, an off-site clinic, and/or a contracted facility) on a single day, the CHC will be reimbursed for only one encounter type, per DOS, unless the additional encounter qualifies as a subsequent encounter.

SOURCE: WI ForwardHealth Online Handbook Community Health Center Encounter Reimbursement, (Accessed Jan. 2024).

ELIGIBLE ORIGINATING SITE

Last updated 01/09/2024

For the purpose of this Online Handbook topic, FQHC refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS reimbursement.

FQHCs and RHCs may serve as originating site and distant site providers for telehealth services.

The originating site fee is not a FQHC or RHC reportable encounter on the cost report. Any reimbursement for the originating site fee must be reported as a deductive value on the cost report.

SOURCE: WI ForwardHealth Handbook, Originating and Distant Sites, Topic #22739, (Accessed Jan. 2024).

CHCs may serve as originating and distant site providers for telehealth services.

CHCs should submit claims for originating site services on a professional claim form with HCPCS procedure code Q3014 (Telehealth originating site facility fee) and a POS code that represents where the member is located during the service. Modifier GT should not be included with procedure code Q3014 for originating site services to be considered under the PPS reimbursement method. ForwardHealth will not separately reimburse the

CHC for originating site services because all costs for providing originating site services have already been incorporated into the PPS rates for CHCs. However, claims billed by CHCs for originating site services may be used for future rate setting purposes, and CHC costs associated with telehealth services may be reported for change in scope adjustment consideration.

SOURCE: WI ForwardHealth Handbook, Telehealth for Community Health Centers, Topic #21997, (Accessed Jan. 2024).

See WI Medicaid Live Video Eligible Sites.

ELIGIBLE DISTANT SITE

Last updated 01/09/2024

For the purpose of this Online Handbook topic, FQHC refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS reimbursement.

FQHCs and RHCs may serve as originating site and distant site providers for telehealth services.

FQHCs and RHCs may report services provided via telehealth on the cost settlement report when the FQHC or RHC served as the distant site and the member is an established patient of the FQHC or RHC at the time of the telehealth service. For currently covered services, services that are considered direct when provided in-person will be considered direct when provided via telehealth for FQHCs.

Services billed with modifier GQ, GT, FQ, or 93 will be considered under the PPS reimbursement method for non-tribal FQHCs. Billing HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS rate for fee-for-service encounters. Fee-for-service claims must include HCPCS procedure code T1015 when services are provided via telehealth in order for proper reimbursement.

SOURCE: WI ForwardHealth Handbook, Originating and Distant Sites, Topic #22739, (Accessed Jan. 2024).

CHCs may serve as originating and distant site providers for telehealth services.

Services billed with modifier GQ, GT, FQ, FR, or 93 will be considered under the PPS reimbursement. Billing HCPCS procedure codes T1015 (Clinic visit/encounter, all-

inclusive) with a telehealth procedure code will result in a PPS for an allowable encounter.

SOURCE: WI ForwardHealth Handbook, Telehealth for Community Health Centers, Topic #21997, (Accessed Jan. 2024).

See: WI Medicaid Live Video Distant Site

FACILITY FEE

Last updated 01/09/2024

The originating site facility fee is not a FQHC or RHC reportable encounter on the cost report. Any reimbursement for the originating site facility fee must be reported as a deductive value on the cost report.

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.

SOURCE: WI ForwardHealth Handbook, Originating and Distant Sites, Topic #22739, (Accessed Jan. 2024).

CHCs should submit claims for originating site services on a professional claim form with HCPCS procedure code Q3014 (Telehealth originating site facility fee) and a POS code that represents where the member is located during the service. Modifier GT should not be included with procedure code Q3014 for originating site services to be considered under the PPS reimbursement method. ForwardHealth will not separately reimburse the CHC for originating site services because all costs for providing originating site services have already been incorporated into the PPS rates for CHCs. However, claims billed by CHCs for originating site services may be used for future rate setting purposes, and CHC costs associated with telehealth services may be reported for change in scope adjustment consideration.

SOURCE: WI ForwardHealth Handbook, Telehealth for Community Health Centers, Topic #21997, (Accessed Jan. 2024).

See: WI Medicaid Live Video Facility/Transmission Fee

PPS RATE

Last updated 01/09/2024

For the purpose of this Online Handbook topic, FQHC refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject

to PPS reimbursement.

Services billed with modifier GQ, GT, FQ, or 93 will be considered under the PPS reimbursement method for non-tribal FQHCs. Billing HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS rate for fee-for-service encounters. Fee-for-service claims must include HCPCS procedure code T1015 when services are provided via telehealth in order for proper reimbursement.

SOURCE: WI ForwardHealth Handbook, Originating and Distant Sites, Topic #22739, (Accessed Jan. 2024).

The following apply to telehealth services:

- Telehealth services include “originating site” services and/or “distant site” services.
- Telehealth services are counted as encounters and require following PPS methodology guidelines.

CHC costs associated with telehealth services may be reported for change in scope adjustment consideration; therefore, telehealth service costs may be used for future rate setting purposes.

SOURCE: WI ForwardHealth Online Handbook Community Health Center Encounter Reimbursement, (Accessed Jan. 2024).

HOME ELIGIBLE

Last updated 01/09/2024

A service that is considered an encounter when performed in a CHC location is also considered an encounter when performed by a CHC provider in one of the following locations:

- Mobile units
- School visits
- Hospitals
- Members’ homes
- Extended care facilities
- Primary sites of identified contracted clinicians

Any services provided to CHC members through referrals to a provider with whom the CHC has no contractual relationship and in which funding for the services is not borne by the CHC is not a CHC service or encounter.

All services provided as part of the CHC encounter must meet all applicable ForwardHealth program requirements, including, but not limited to, medical necessity, PA, claims submission, prescription requirements, and documentation requirements; however, all CHC services reimbursed under the PPS rate structure are exempt from member cost share and copayment requirements.

CHCs will identify encounters by indicating HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) on claims for services rendered. ForwardHealth will assign the appropriate encounter type to the claim detail associated with procedure code T1015 based on the provider type of the rendering provider.

SOURCE: WI ForwardHealth Online Handbook Community Health Center Encounters, (Accessed Jan. 2024).

PATIENT-PROVIDER RELATIONSHIP

Last updated 01/09/2024

No reference found