



**Department of  
Medicaid**

# **Telehealth Services: Guidelines for Managed Care Entities**

Applies to dates of service on or after January 1, 2026

## **Telehealth Services: Guidelines for Managed Care Entities (version 6.0)**

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### **THE OHIO DEPARTMENT OF MEDICAID**

Medicaid Managed Care Organizations (MCOs), MyCare Ohio Plans (MCOPs) and the OhioRISE plan (hereinafter referred to collectively as managed care entities or MCEs) will use the guidelines outlined in this document to allow their Ohio Department of Medicaid (ODM) members to continue using telehealth. In addition to the guidelines within this document, billing guidance regarding how FFS handles telehealth can be found within the telehealth billing guidelines located here: [Telehealth Billing Guidelines](#).

In accordance with the MCE provider agreements, MCEs shall cover telehealth services as specified in this document. Providers are directed to contact the MCEs directly with questions about telehealth claims. This document has been developed specifically for MCEs, and outlines requirements related to payment for telehealth services as well as information regarding the provider types allowed to deliver services through telehealth. The telehealth services included in this document reiterate the requirements outlined in Ohio Administrative Code (OAC) rule 5160-1-18, Telehealth Services, effective 1/1/2026.

#### **Where can Telehealth be provided?**

There is no limitation on the patient or practitioner site except for penal facilities or public institutions in accordance with OAC rule 5160:1-1-03. In accordance with section 5121 of the Consolidated Appropriations Act of 2023, U.S.C. 1396a, screening and diagnostic services are covered for incarcerated individuals under the age of 21 in the 30 days prior to release from the public institution. The [POS code set](#) is maintained by the Centers for Medicare and Medicaid Services (CMS).

Billing guidance for behavioral health (BH) agencies certified by the Ohio Department of Behavioral Health (ODBH) (formerly known as the Ohio Department of Mental Health and Addiction Services (OhioMHAS)) can be found in the [Behavioral Health Provider Manual](#).

If the practitioner site does not bill the MCE directly (i.e., holds a contractual agreement with the practice), the patient site or practice who holds the contractual agreement may instead bill for the service delivered using telehealth.

- In such cases, ODM recommends the place of service (POS) code reported on the professional claim should reflect the location of the billing provider if the rendering practitioner's location is unknown.

#### **Important Clarifications**

- All services identified in this document and the appendix to rule 5160-1-18 may be delivered through telehealth. Other practitioners and services authorized in rules promulgated under agency 5160 of the Administrative Code may also be delivered through telehealth. This

includes procedure codes with a telehealth description added to appendix DD of rule 5160-1-60.

- ODM periodically reviews telehealth coding changes from Medicare to add/remove codes. The billing guidelines may not always have the most up-to-date coding changes and MCEs should note that providers can still provide these services to dually eligible individuals and if Medicare pays, MCEs should consider payment of cost sharing even if ODM does not cover that service in FFS. Providers should use professional judgment when delivering telehealth services and should select the appropriate procedure code that reflects the service provided.
- The place of service (POS) code reported on a professional claim must reflect the physical location of the practitioner<sup>1</sup>. The POS code set is maintained by the Centers for Medicare and Medicaid Services (CMS) and can be found here: [Place of Service Code Set | CMS](#). As of 1/1/2025, place of service code 09 may be used when services are delivered to youth under 21 prior to release in accordance with section 5122 of the Consolidated Appropriations Act (CAA).
- **Effective 1/1/2027**, POS 02 and POS 10 will no longer be accepted on professional claims where Medicaid is the **primary payer**, unless stated otherwise. Patient location modifiers should be used as applicable to identify the location of the patient, and the POS code must reflect the physical location of the practitioner.

### Eligible Rendering and Billing Providers

Provider Type Description	Provider Type Number	Rendering	Billing
Outpatient Hospitals (01) on behalf of licensed psychologists and independent practitioners not eligible to separately bill in this setting	01	N	Y
Psychiatric Hospitals	02	N	Y
Rural Health Clinic	05	N	Y
Dietitians	07	Y	Y
Federally Qualified Health Center	12	N	Y
Doula (effective 10/1/24)	09	Y	Y
Independent practitioners enrolled with the International Board-Certified Lactation Consultant (IBCLC) specialty under OAC 5160-8-42 effective 10/1/2024	30, 09, 38, 41, 69,39,40 Specialty (091)	Y	Y
Medicare Certified Home Health Agency	60	N	Y
Other Accredited Home Health Agency	16	N	Y
Physician, Psychiatrist, Ophthalmologist	20	Y	Y

<sup>1</sup> Home health services, the RN assessment service, and the RN consultation service can be provided using telehealth when clinically appropriate. The value “02” should be used to indicate telehealth as the “Place of Service” on these claims.

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Professional Medical Group	21	N	Y
Physician Assistant	24	Y	Y
Chiropractors	27	Y	Y
Medicaid School Program Provider (Carved out of managed care)	28	N	Y
Dentist	30	Y	Y
Professional Dental Group	31	N	Y
Optometrists	35	Y	Y
Podiatrist	36	Y	Y
Licensed Independent Social Worker	37	Y	Y
Non-Agency Nurses/Private Duty Nurses	38	Y	Y
Physical Therapist	39	Y	Y
Speech-language pathologist	40	Y	Y
Occupational Therapist	41	Y	Y
Psychologist	42	Y	Y
Audiologist	43	Y	Y
Licensed Professional Clinical Counselor	47	Y	Y
Ambulatory Health Care Clinics	50	N	Y
Licensed Independent Marriage and Family Therapist	52	Y	Y
Licensed Independent Chemical Dependency Counselor	54	Y	Y
Advanced Practice Registered Nurse (APRN): Clinical Nurse Specialist, Certified Nurse Midwife, and Certified Nurse Practitioner	65, 71, 72	Y	Y
Pharmacists (as of 1/17/21)	69	Y	Y
Pharmacy (as of 1/17/21 submitted on a professional claim)	70	N	Y
ODBH certified agencies (all claims must be submitted by the billing agency)	84 or 95	N	Y
Occupational or Physical therapist assistant	*	Y	N
Speech-language pathology and audiology aides	*	Y	N
Individuals holding a conditional license as described in section 4753.071 of the Revised Code	*	Y	N
Licensed health professionals providing medically necessary supportive services	*	Y	N
Private Duty Registered Nurses (RN) and Licensed Practical Nurses (LPN)	*	Y	N
For ODBH certified agencies, those practitioners that can render the service according to <a href="#">BH provider billing manual</a> may render the service via telehealth.	Multiple	Y	N
For OhioRISE services, those provider types that can render the service according to <a href="#">OhioRISE Provider Enrollment and Billing Guidance</a> may render the service via telehealth.	Multiple	Y	N
Care Management Entity	21, 45, 84, 95	N	Y
Supervised practitioners, trainees, residents, and interns as defined in rules 5160-4-05 and 5160-8-05 of the Administrative Code	Multiple, *	Y	N

\*Along with modifier GT. Modifiers GC and GE are to be used to indicate a resident performed a service under the direction of a teaching physician or that the resident has a primary care exception. These modifiers would be situational depending on who provided the service and are not specific to telehealth.

<b>Patient Location Modifiers (not applicable to ODBH certified agencies)</b>	
<b>Telehealth Modifier<sup>2</sup></b>	<b>Description</b>
U1	Patient home or place of residence at the time of service (includes homeless shelter, residential facility other than a nursing facility, temporary housing, etc.)
U2	School
U3	Inpatient Hospital
U4	Outpatient hospital
U5	Nursing Facility
U6	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICD/IID)

<b>Professional Claim Submission for Services Delivered via Telehealth<sup>3</sup></b>		
<b>Billing provider type</b>	Providers of Professional Services	FQHC and RHC (FFS or claims for wraparound payments) <sup>4</sup>
<b>Claim type</b>	Professional (Submitted via PNM portal or EDI)	
<b>Procedure code</b>	<p>CPT code for service delivered via telehealth</p> <p>When a covered telehealth procedure code is deleted due to annual CPT and HCPCS updates, ODM will adopt the replacement procedure code if a replacement is identified.</p>	<p>First detail line: T1015 encounter code and the appropriate U modifier</p> <p>Second detail line: procedure code for service delivered via telehealth</p>
<b>Telehealth Modifier</b>	GT modifier	GT modifier with the procedure code

<sup>2</sup> If the patient site is not one of these locations, a modifier identifying patient location is not needed.

<sup>3</sup> Does not apply to crossover claims from Medicare. Provider-submitted crossover claims should be submitted with the information provided by Medicare on the explanation of benefits.

<sup>4</sup> For a covered telehealth service that is also an FQHC or RHC prospective payment (PPS) service, the face-to-face requirement is waived, and payment is made in accordance with Chapter 5160-28 of the Administrative Code.

	<p>Any other required modifiers based on provider contract</p> <p>Above-mentioned U modifier to identify patient location, if applicable</p> <p>If the description of a covered procedure code in an ODM fee schedule indicates a telehealth or electronic service, the GT modifier is not required. Example: CPT code 98000 New patient <b>synchronous audio-video</b> visit with straightforward medical decision making, if using time 15 minutes or more</p>	<p>Any other required modifiers based on provider contract</p> <p>Above-mentioned U modifier to identify patient location, if applicable</p>
<b>Place of service (POS) code</b>	Physical location of the practitioner when the service was delivered	

**Service Codes Covered via Telehealth**

<b>Dental</b>	
<b>Procedure Code</b>	<b>Description</b>
D0120	Periodic oral evaluation.
D0140	Limited Oral Evaluation – problem focused.
D9995	Teledentistry - synchronous; real-time encounter; Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

<b>Long Term Services and Supports (LTSS): Private Duty Nursing (PDN) and State Plan Home Health Services As Found in OAC Chapter 5160-12</b>	
<b>Procedure Code</b>	<b>Description</b>
G0151	Physical Therapy, each 15 minutes.
G0152	Occupational Therapy, each 15 minutes.
G0153	Speech-language pathology, each 15 minutes.
G0156	Services of home health settings, each 15 minutes.
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health setting, each 15 minutes.
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health setting
T1001	RN Assessment Services prior to the provision of home health, private duty nursing,

	waiver nursing, personal care aide and home choice services, per initial base, and each 15-minute increment.
T1001 U9	RN Consultation.

<b>Medical and Behavioral Health Services (non ODBH certified providers)</b>	
<b>Procedure Code</b>	<b>Description</b>
0403T	Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day.
0488T	Diabetes prevention, online/electronic, per month.
90785	Interactive complexity.
90791	Psychiatric Diagnostic Evaluation.
90792	Psychiatric Diagnostic Evaluation with Medical services.
90832	Psychotherapy, 30 minutes with patient.
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service.
90834	Psychotherapy, 45 minutes with patient.
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service.
90837	Psychotherapy, 60 minutes with patient.
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service.
90846	Family psychotherapy without patient present.
90847	Family psychotherapy with patient present.
90849	Multiple-family group psychotherapy.
90853	Group Psychotherapy.
90951	Dialysis related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month.
90952	Dialysis related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month.
90953	Dialysis related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month.
90954	Dialysis related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month.

90955	Dialysis related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month.
90956	Dialysis related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month.
90957	Dialysis related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month.
90958	Dialysis related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month.
90959	Dialysis related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month.
90960	Dialysis related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month.
90961	Dialysis related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month.
90962	Dialysis related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month.
90963	Dialysis related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.
90964	Dialysis related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.
90965	Dialysis related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.
90966	Dialysis related services for home dialysis per full month, for patients 20 years of age and older.
90967	Dialysis related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age.
90968	Dialysis related services for dialysis less than a full month of service, per day; for patients 2-11 years of age.
90969	Dialysis related services for dialysis less than a full month of service, per day; for patients 12-19 years of age.
90970	Dialysis related services for dialysis less than a full month of service, per day; for patients 20 years of age and older.

92002	Intermediate eye exam for new patient.
92012	Eye exam, established patient (added 11/15/2020).
92065	Orthoptic/Pleoptic training (added 11/15/2020).
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour.
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes.
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour.
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour.
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour.
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour.
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes.

96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure).
97542	Wheelchair management, each 15 minutes.
97802	Medical nutrition therapy; initial assessment and intervention, each 15 minutes.
97802 TH	Lactation counseling provided by dietitian; initial assessment and intervention, each 15 minutes.
97803	Medical nutrition therapy; re-assessment and intervention, each 15 minutes.
97803 TH	Lactation counseling by dietitian; re-assessment and intervention, each 15 minutes.
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes.
97804 TH	Lactation counseling by dietitian; group (2 or more individuals), each 30 minutes.
98000	New patient synchronous audio-video visit with straightforward medical decision making, if using time 15 minutes or more.
98001	New patient synchronous audio-video visit with low medical decision making, if using time 30 minutes or more.
98002	New patient synchronous audio-video visit with moderate medical decision making, if using time 45 minutes or more.
98004	Established patient synchronous audio-video visit with straightforward medical decision making, if using time 10 minutes or more.
98005	Established patient synchronous audio-video visit with low medical decision making, if using time 20 minutes or more.
98006	Established patient synchronous audio-video visit with moderate medical decision making, if using time 30 minutes or more.
98008	New patient synchronous audio-only visit with straightforward medical decision making and 10 minutes or more of medical discussion, if using time 15 minutes or more.
98009	New patient synchronous audio-only visit with low medical decision making and 10 minutes or more of medical discussion, if using time 30 minutes or more.
98010	New patient synchronous audio-only visit with moderate medical decision making and 10 minutes or more of medical discussion, if using time 45 minutes or more.
98012	Established patient synchronous audio-only visit with straightforward medical decision making and 10 minutes or more of medical discussion, if using time 10 minutes or more.
98013	Established patient synchronous audio-only visit with low medical decision making and 10 minutes or more of medical discussion, if using time 20 minutes or more.
98014	Established patient synchronous audio-only visit with moderate medical decision making and 10 minutes or more of medical discussion, if using time 30 minutes or more.
98016	Established patient brief communication technology-based service with 5-10 minutes of medical discussion.
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); initial set-up and patient education on use of equipment.
98976	RTM monitoring, respiratory.
98977	RTM monitoring, musculoskeletal.

98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes.
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure).
99078 TH*	Group Prenatal Care.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
99252	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99253	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99254	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99255	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.
99281	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient; Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99304	Initial nursing facility care, per day, for the E/M of a patient. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99305	Initial nursing facility care, per day, for the E/M of a patient. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99306	Initial nursing facility care, per day, for the E/M of a patient. 45 minutes are spent at the bedside and on the patient's facility floor or unit.
99307	Subsequent nursing facility care, per day, for the E/M of a patient. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.

99308	Subsequent nursing facility care, per day, for the E/M of a patient. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
99309	Subsequent nursing facility care, per day, for the E/M of a patient. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the E/M of a patient. 35 minutes are spent at the bedside, on the patient's facility floor or unit.
99315	Nursing facility discharge day management; 30 minutes or less.
99316	Nursing facility discharge day management; more than 30 minutes.
99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99401	Preventive medicine counseling, first 15 minutes.
99402	Preventive medicine counseling, 15-30 minutes.
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes.
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes.
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes.
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

99445	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, 2-15 days in a 30-day period.
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.
99454	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate) initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes.
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (list separately in addition to code for primary procedure).
99470	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes.
G0011	Individual counseling for pre-exposure prophylaxis (PrEP) by physician or qualified health care professional (QHP) to prevent human immunodeficiency virus (HIV), includes HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence, 15 to 30 minutes.
G0013	Individual counseling for pre-exposure prophylaxis (PrEP) by clinical staff to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence.
G0108	Diabetes management training, individual, 30 minutes.
G0109	Diabetes management training, group, 30 minutes.
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth.
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth.
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth.
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth.
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth.
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth.

G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
H1000	Perinatal risk assessment.
H1005	Nurse Family Partnership nurse home visiting.
H2000	Child Adolescent Needs and Strengths (CANS) assessment.
S9436	Childbirth prep/Lamaze classes, non-physician.
S9437	Childbirth refresher classes, no-physician.
S9443	Lactation consulting, per session.
S9444	Baby parenting classes, non-physician provider, per session.
S9447	Infant safety (including CPR) training, non-physician provider, per session.
S9452	Prenatal nutrition classes, non-physician provider, per session.
S9453	Smoking cessation class, non-physician provider, per session.
S9470	Prenatal nutrition counseling, dietitian visit.
T1023	Report of pregnancy (ROP).
T1030	Family Connects home visiting.
T1032	Services performed by a doula birth worker, per 15 minutes.

Occupational Therapy, Physical Therapy, Speech-Language Pathology, and Audiology Services As Found in OAC 5160-8-35	
Procedure Code	Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual.
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals.
92521	Evaluation of speech fluency (e.g., stuttering, cluttering).
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria).
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language).
92524	Behavioral and qualitative analysis of voice and resonance.
92526	Treatment of swallowing dysfunction and/or oral function for feeding.
92556	Speech audiometry threshold; with speech recognition.
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming.
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming.
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming.

92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming.
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification.
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour.
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 min (list separately in addition to code for primary procedure).
92609	Therapeutic services for the use of speech-generating device, including programming and modification.
96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument.
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour.
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes.
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing).
97129	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-on-one) patient contact; initial 15 minutes.
97130	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure).
97161	Physical therapy evaluation: low complexity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care.
97164	Re-evaluation of physical therapy established plan of care. Typically, 20 minutes are spent face-to-face with the patient and/or family.

97165	Occupational therapy evaluation, low complexity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance.
97168	Re-evaluation of occupational therapy established plan of care. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes.
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes.
97535	Self-care/home management training (eg, activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes.
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes.
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes.
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes.
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes.

<b>Specialized Recovery Services (SRS) Program</b> As found in OAC Chapter 5160-43	
Procedure Code	Description
H2023	Specialized Recovery Services (SRS) program – supported employment.
H2025	Specialized Recovery Services (SRS) program – ongoing support to maintain employment.
T1016	Specialized Recovery Services (SRS) program – recovery management.

<b>OhioRISE Only Services</b> As found in OAC Chapter 5160-59	
Procedure Code	Description
H2000 TG	Initial Supplemental Assessment – per Encounter.

H2015	Intensive Home-Based Treatment (IHBT), per 15 minutes.
H2015 TF	Functional Family Therapy (FFT), per 15 minutes.
H2033	Multisystemic Therapy for Juveniles (MST), per 15 minutes.
T2023	Intensive Care Coordination (ICC) – Monthly.
T2022	Moderate Care Coordination (MCC) – Monthly.

\*See the CME Billing Guidelines for the care coordination activities where the GT modifier will be recorded: [OhioRISE CME Manual](#)

<b>Service Codes Covered via Telehealth for Applied Behavioral Analysis (ABA)</b>	
<b>Procedure Code</b>	<b>Description</b>
<b>Adaptive Behavior Assessment</b>	
97151	Behavior identification assessment.
97152	Behavior identification – supporting assessment.
0362T	Behavior identification – supporting assessment – technician.
<b>Adaptive Behavior Treatment</b>	
97153	Adaptive behavior treatment by protocol.
97154	Group adaptive behavior treatment by protocol.
97155	Adaptive behavior treatment with protocol modification.
97156	Family adaptive behavior treatment guidance.
97157	Multi-family adaptive behavior treatment guidance.
97158	Group adaptive behavior treatment with protocol modification.

Managed Care Organizations must allow Applied Behavioral Analysis (ABA) services to be available through telehealth under the current guidelines. If the provider is not enrolled with Medicaid, a single case agreement would be needed.