Chapter 38

Physician and Professional Services

NOTE: *Please review the following detail for specific processes and expectations with South Country Health Alliance (South Country). South Country may vary from the MHCP Manual and Minnesota Department of Human Services Guidelines. For additional detail on this chapter, please go to the Minnesota Health Care Programs Provider Manual at* MHCP Provider Manual.

Billing Information – *Please review the* South Country Provider Manual Chapter 4 Provider Billing *for general billing processes and procedures.*

Allergy Immunotherapy–Allergy Testing

Antigen: The raw form of pollen, (venom, stinging insect, etc.) prior to refinement for administration to humans.

Allergenic Extract: The refined injectable form of antigen either commercially prepared or refined in the physician's office under his or her supervision.

Immunotherapy: The parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy.

Covered Allergy Immunotherapy Services

South Country covers the following allergy immunotherapy or allergy testing services:

- Professional services to prepare raw antigen to a refined state that will become an allergenic extract;
- Professional services to administer the allergenic extract;
- Providing the injectable allergenic extract;
- Physician ordered allergen immunotherapy and services performed by the physician or qualified personnel under the direction of a physician;
- Professional services to monitor the member's injection site and observe for anaphylactic reaction;
- Allergy testing when clinically significant symptoms exist and conservative therapy has failed; and
- Provision of inhalants (a pharmaceutical). Refer to South Country Provider Manual Chapter 21 Pharmacy Services.

Evaluation and Management services are eligible for separate payment on the same day as allergen immunotherapy only when a significant, separately identifiable service is performed.

Noncovered Allergy Immunotherapy Services

Testing
Allergy testing includes the performance, evaluation, and reading of cutaneous and mucous membrane testing.

The physician work of taking a history, performing the physical examination, deciding on the antigens to be used, interpretation of results, counseling and prescribing treatment should be reported using an evaluation and management code.

The following allergy testing procedures are considered investigative, and therefore are not covered:

- Cytotoxic leukocyte testing (Brian's test);
- Leukocyte histamine release testing;
- Provocation-neutralization testing (sublingual, subcutaneous, intradermal, or intracutaneous);
- Rebuck skin window test;
- Passive transfer or P-K Test (Prausnitz-Kustner);
- Candidiasis hypersensitivity syndrome testing;
- IgG level testing general volatile organic screening test (volatile aliphatic panel);
- ELISA/ACT immunotherapy (Serammune Physician Lab, Reston VA); and
- Antigen Leukocyte Cellular Antibody Test (ALCAT).

Treatment

The following allergy treatments are considered investigative and therefore are not covered:

- Provocation-neutralization treatment (sublingual, subcutaneous, intradermal or intracutaneous);
- Oral and sublingual immunotherapy (includes oral drops, solutions, oral capsules and tablets);
- Rinkel immunotherapy;
- Autologous urine immunizations;
- Clinical ecology urine immunizations;
- Candidiasis hypersensitivity syndrome treatment and related services;
- IV vitamin C therapy;
- Enzyme potentiated desensitization;
- Rhinophototherapy;
- Poison ivy or poison oak extracts for immunotherapy; and
- T.O.E. (trichophyton, oidiomycetes and epidermophyton) immunotherapy for chronic otitis media.

Coverage Limitations

Allergenic extracts may be administered with either one or multiple injections. Documentation in the medical record must support the number of injections administered.

Preparation of raw antigen to allergenic extract: Only physicians who perform the refinement of raw antigens to allergenic extract may bill for this service. This service involves:

- Sterile preparation of an allergenic extract by titration, filters, etc.
- Checking the integrity of the extract by cultures or other qualitative methods.

Neither purchasing refined antigens, measuring dosages nor adding diluent is considered "refining raw antigens."

Adding diluent: As in any other medication administration, it is not a separately covered service. This service is an integral part of the professional services for providing an allergenic extract.

Identifiable services not included in an office visit may be billed separately.

Services with a gender or procedure code conflict

The KX modifier is required on professional claims (837P) in order to identify services that are gender specific (services that are considered female or male only). The KX modifier will allow gender specific edits to be bypassed.

Institutional providers should report condition code 45 (Ambiguous Gender Category) to identify claims for inpatient or outpatient services that can be subjected to gender specific editing. This condition code will allow gender specific edits to be bypassed.

Education and Counseling

Eligible Providers

Eligible providers include: enrolled physicians, physician clinics, community clinics, outpatient hospitals, public health clinics, family planning agencies, certified nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives, community mental health centers and physician extenders.

Covered education or counseling services

Reason for education or counseling	HCPCS code(s)	Eligible providers	Billing directions
Education or counseling is the primary reason for the visit: Services to healthy individuals for the purpose of promoting health and anticipatory guidance (for example, family planning, smoking cessation, infant safety, etc.).	99401–99409 (individual) 99411–99412 (group)	• Physicians • Enrolled physician assistants (PAs), advanced practice registered nurses (APRNs), nurse practitioners (NPs), clinical nurses (CNSs) and certified nurse-midwives (CNMs) • Physician extenders: non-enrolled APRNs, registered nurses (RNs), genetic counselors, licensed acupuncturists, tobacco cessation counselors and pharmacists	Use modifier U7 when a physician extender provides the service.
Education or counseling is the primary reason for the visit: services to patients with symptoms, a diagnosis or an established illness (for example, prenatal, joint care, pain, HIV, asthma). Refer also to nutritional,	98960 (individual) 98961–62 (group)	• Enrolled PAs and APRNS (NPs, CNSs, CNMs) • Physician extenders (non-enrolled APRNs, RNs, genetic counselors, licensed acupuncturists)	Use modifier U7 when a physician extender provides the service.

Reason for education or counseling	HCPCS code(s)	Eligible providers	Billing directions
diabetic and weight reduction guidelines.			
Education or counseling is an add-on to the office visit (for example, if provided as part of the regular office visit and dominating more than 50% of the clinician and patient visit, then time may be considered the key or controlling factor to qualify for a particular level of E/M service).	99201–99205 (new patient) 99211–99215 (established patient)	• Physicians • Enrolled PAs and APRNs (NPs, CNSs, CNMs)	
Asthma education, per session. Asthma education may be reported outside of the office visit when a clinician writes an asthma action plan (AAP) and discusses it with the patient or family, documents in the medical record and gives a copy to the asthma educator.	S9441	Report asthma education with S9441 by using the supervising clinicians' NPI for one of the following: • Non-enrolled APRNs (NPs, CNSs, CNMs) • RNs • Pharmacists • Certified Asthma Educators (CAE)	Bill one unit for each class.
Birthing classes per session.	S9442	Clinics and outpatient hospitals whose prenatal education program is directed by a South Country enrolled provider may report S9442, S9443 and H1003 with one of the following: • Non-enrolled APRNs (NPs, CNSs, CNMs) • RNs • Health educators with at least a baccalaureate level degree in health education or national certification with the International Childbirth Education Association (ICEA), Lamaze or the National Commission for Health Education	Bill one unit for each time the class meets.
Lactation classes per session.	S9443		Bill one unit for each time the class meets.
Enhanced prenatal services provided to "at-risk" pregnant women only. An at-risk determination is based on the results of a prenatal risk assessment (for example, ACOG's Obstetric Medical history).	H1003		Bill one unit for the entire class: 3 weeks of nutrition education = 1 unit.

Reason for education or counseling	HCPCS code(s)	Eligible providers	Billing directions
		Credentialing (NCHEC) for prenatal certification or international board-certified lactation consultant (IBCLC) for lactation certification	
Counseling to assess and minimize problems hindering normal nutrition, and to improve the patient's nutritional status.	97802 – initial individual 97803 – reassess individual 97804 – group	• Physicians • Licensed dieticians • Licensed nutritionist	Bill 15 minute unit. Medical nutritional therapy (MNT) is reimbursed when a licensed dietician or nutritionist is under the supervision of a physician.
Reassessment due to change in diagnosis, medical condition or treatment regimen requiring a second referral in the same year.	G0270 – individual G0271 – group	• Physicians • RNs • Licensed dieticians • Licensed nutritionist	Bill 15 minute unit. MNT is reimbursed when a licensed dietician or nutritionist is under the supervision of a physician.
Diabetic Outpatient Self-Management Training services (DSMT) including education about self-monitoring blood glucose, diet, exercise and sliding scale insulin treatment for the patient who is insulin dependent.	G0108 – individual G0109 – group	• Physicians • RNs • Licensed dieticians • Licensed nutritionist • A provider of dually eligible Medicare and South Country members must be a certified provider according to the National Diabetes Advisory Board Standards.	Bill 30 minute unit. Initial training 10-hour limit per 12 months Additional training limited to 1 hour per year.

Noncovered Education and Counseling Services

Services provided as part of a day treatment program, partial hospitalization or other similar health care programs may not be billed as physician services provided in an educational or counseling setting.

Documentation

A physician order for educational or counseling services is required. Documentation of the member's participation, number of participants in the educational or counseling group, name

and credentials of person who provided the service and topic content must be in the medical record or class record.

Education and Counseling Services Billing

Refer to the following billing guidelines:

- The cost of educational materials is included in the payment; no additional payment will be made for handouts, textbooks or other materials.
- Physician extenders must modify their services using the appropriate modifier. (Refer to the Physician Extender section.)

Enhanced Asthma Care Services

As of Jan. 1, 2022, the Minnesota legislature has amended Minnesota statutes, section 256B.0625, to allow South Country to cover enhanced asthma care services and related products in the homes of children with poorly controlled asthma.

A child is defined as having poorly controlled asthma when they have received emergency care services or hospitalization for the treatment of asthma within the past year and they have received a referral and standing orders from a qualified health care provider listed under Eligible Providers in this section. A referral must be written from the provider stating enhanced asthma care services are needed which gives the county the authority to provide these services.

A home assessment is required to determine if there are asthma triggering agents in the home, thus identifying what the child needs in regards to education and supplies. A home assessment is not required for a provider to order supplies as long as there is documentation of medical necessity for product use kept in the member's record.

A home assessment is defined as a home visit to identify asthma triggers in children's homes and provide education on trigger-reducing agents. A child is limited to two home assessments for the year, except when a child moves to a new home, a new asthma trigger (including tobacco smoke) enters the home, or if the child's primary provider identifies a new allergy for the child (including mold, pests, pets, or dust mites).

Eligible Providers

Asthma services must be referred and ordered by one of the following providers:

- Physician;
- Physician assistant; and
- Advanced practice nurse.

Home assessment must be provided by the following credentialed local public health workers:

- Healthy homes specialist defined and credentialed as a healthy home evaluator by the Building Performance Institute;
- Lead risk assessor as credentialed and defined by the Minnesota Department of Health;
- Registered environmental health specialist as defined and credentialed by the Minnesota Department of Health; and

Local public health workers and the public health agencies they work for cannot bill South Country for home assessments because they are not MHCP-enrolled providers.

Eligible Members

All South Country members under the age of 21 for MA and under the age of 19 for MinnesotaCare members.

Billing

The following providers may bill for a home assessment:

- Community health clinics;
- County human services agencies;
- Federally qualified health centers;
- Hospitals;
- Indian health services;
- Physician clinics;
- Public health nursing clinics;
- Rehabilitation center; and
- Rural health clinics.

To bill for asthma services:

- Use the (837P) Professional transaction;
- Bill for these services using service code T1028 with UA modifier; and
- Bill using the National Provider Identifier (NPI) from one of the MHCP-enrolled eligible providers that may bill for a home assessment.

No service authorization is required for the T1028 code when providing enhanced asthma care services.

Documentation

Counties are required to have a physician's order and the order must be part of the member's records.

Documentation in the member's record must also include the name of the healthy homes specialist, lead risk assessor, or the registered environmental health specialist who completed the service.

Gender-Affirming Surgery

Gender-Affirming surgery (GAS) is considered medically necessary when a person has been diagnosed as having gender dysphoria and meets the established criteria. Treatment for gender dysphoria does not consist of a single procedure but is part of a process involving multiple medical and surgical methods.

Eligible Providers

Physicians enrolled with Minnesota Health Care Programs (MHCP) may provide and bill South Country for covered services.

Eligible Members

All members enrolled with South Country may be eligible for covered services. Member must be 18 years of age or older to be eligible for genital surgery.

Covered Services

South Country covers the following services when medically necessary:

- Hysterectomy and salpingo-oophorectomy;
- Vaginectomy (including colpectomy, metoidioplasty, phalloplasty, urethoplasty, urethromeatoplasty);
- Mastectomy, breast reduction, chest reconstruction;
- Penile prosthesis (noninflatable or inflatable);
- Orchiectomy;
- Vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introittus, construction of vagina with graft, coloproctostomy);
- Voice therapy;
- Breast augmentation surgery for male-to-female GAS is covered upon completion of 6 months of hormone therapy (12 months for adolescents) unless hormone therapy is medically contraindicated or not desired; and
- Scrotoplasty, testicular expanders, and testicular prostheses for female-to-male gender-affirming surgery.
- Facial surgery may be considered for coverage on a case-by-case basis. Factors that may be considered in the case-by-case analysis include:
    - How each requested procedure has a direct link to alleviating the documented symptoms of the gender dysphoria;
    - Documentation showing that no other physical or behavioral health condition could be causing the distress that the facial surgery attempts to address; and
    - Explanation of how the symptoms will be alleviated through each requested procedure and how improvement will be measured and monitored.
- Electrolysis or laser hair preoperatively is covered and hair removal from the face, body, and genital areas for gender affirmation will be reviewed for medical necessity on a case-by-case basis that may include:
    - Physician recommends hair removal prior to genital reconstruction for the treatment of gender dysphoria.
    - Documentation explaining excessive hair growth and a letter from the clinician performing hair removal that supports the medical necessity of hair removal as it relates to gender dysphoria treatment.
- Voice modification surgery is covered on a case-by-case basis when medically necessary. Provider must document medical necessity. An example is by recommendation of a voice therapist because voice therapy has had an inadequate reduction in voice dysphoria, existing vocal presentation significantly varies from the normal for the gender, and vocal therapy has been exhausted.

Hormone therapy is not a pre-requisite for covered services unless specified within this document.

Noncovered Services

The following procedures are considered cosmetic and not medically necessary; therefore, these services are excluded from South Country coverage:

- Abdominoplasty;
- Blepharoplasty;

- Calf implants;
- Collagen injections;
- Gluteal augmentation;
- Hair transplantation;
- Laryngoplasty;
- Lipofilling or collagen injections;
- Liposuction;
- Mastopexy;
- Neck tightening;
- Pectoral implants;
- Removal of redundant skin;
- Skin resurfacing (dermabrasion, chemical peels); and

  Trachea shave or thyroid cartilage reduction (chondroplasty).

Authorization Requirements

All of the following criteria for the requested services must be met before coverage of GAS can be authorized:

- Member must meet diagnostic criteria of gender incongruence (inconsistent).
- Provider has submitted documentation supporting that the member has experienced marked and sustained gender dysphoria over time.
- The member must demonstrate the emotional and cognitive maturity required to provide informed consent and approval for the treatment.
- Provider has submitted written referrals from clinicians qualified in the behavioral aspects of gender dysphoria. The referral letters must meet the following requirements:
  - Adults: One written referral from a healthcare professional who has competencies in the assessment of transgender or gender diverse people; and
  - Adolescents (less than 18 years of age): One written referral from a multidisciplinary team reflecting the assessment and opinion from the team that involves both medical and mental health professionals; or separate letters collectively including assessments from both a medical and mental health professional.
- If the referral letter is from a behavioral health provider, it must include a recent diagnostic assessment.
- If the referral letter is from the member's treating provider (physician, nurse practitioner, clinical nurse specialist), a psychosocial assessment must be completed. Include the psychosocial assessment components.

Psychosocial assessment components

A psychosocial assessment must include the following:

- Client's current life situation;
- Age;
- Current living situation, including household membership and housing status;

- Basic needs status including economic status;
- Education level and employment status;
- Significant personal relationships, including the member's evaluation of relationship quality;
- Strengths and resources including the extent and quality of social networks;
- Belief systems;
- Contextual nonpersonal factors;
- General physical health and relationship to member's culture;
- Current medications;
- Reason for assessment;
- Description of symptoms including reason for referral;
- Perception of his or her condition;
- History of mental health treatment including review of records;
- Developmental incidents;
- Maltreatment or abuse;
- History of alcohol or drug abuse;
- Health history and family health history;
- Cultural influences and impact on diagnosis and possibly on treatment;
- Mental status exam;
- Assessment of the member's need based on baseline measurements, symptoms, behaviors, skills, abilities, resources, vulnerabilities and safety needs;
- Screening used to determine substance abuse and other standardized screening instruments (CAGE-AID, GAIN-SS);
- Clinical summary;
- Prioritization of needed mental health, ancillary or other services;
- Member and family participation in assessment;
- Referrals to services and service preferences by individual;
- Cause, prognosis, likely consequences of symptoms;
- How the criteria for a diagnosis of gender dysphoria is met: symptoms, duration and functional impairment;
- Strengths, cultural influences, life situations, relationships, health concerns and how gender dysphoria diagnosis interacts with or impacts member's life; and
- Primary diagnosis of gender dysphoria. If any other mental health or substance use disorders are present, make a referral to a mental health professional or a substance use treatment specialist.

Clinician attestation

In addition to a diagnostic or psychosocial assessment, the referral letter must include the clinician's attestation about each of the following:

- The person's general identifying characteristics;
- The duration of the referring provider's relationship with the person, including the type of evaluation and therapy or counseling that the person underwent;
- An explanation that the person has met criteria for surgery and a brief description of the clinical rationale for supporting the request for surgery;
- A statement that the clinician obtained informed consent;
- A statement that the treating provider is available for coordination of care;
- Affirmation of gender dysphoria diagnosis; and
- If significant medical or mental health concerns are present, documentation must support that these concerns are reasonably well controlled in addition to the person's adherence to recommended medical and behavioral treatment plans. This includes the following:
    - Behavioral health therapy: recipient is receiving treatment, is in recovery, or is in stable remission of any co-morbid behavioral health conditions that are not attributed to dysphoria (for example, psychosis, trauma, substance use disorder) for 12 continuous months. Stable remission is defined as lack of hospitalization, day treatment or emergent care for any co-morbid behavioral health conditions during the 12-month period before surgery.
- No medical contraindications for surgery.

Billing

Bill using the 837I or 837P claim forms.

Refer to South Country Provider Manual Chapter 4 Provider Billing for general billing processes and procedures.

Locum Tenens Physicians

South Country recognizes that physicians often retain a substitute physician to take over their professional practices while they are absent for reasons such as illness, vacations, continuing medical education and pregnancy.

South Country further recognizes locum tenens arrangements and pays the regular physician for the services provided by the substitute physician if the following are established:

- The regular physician is unavailable to provide services;
- The member has arranged or seeks to receive the services from the regular physician;
- The regular physician pays the locum tenens physician on a per diem or a fee-for-service basis; and
- The locum tenens physician does not provide services over a continuous period of longer than 60 days.

Covered Locum Tenens Services

South Country covers locum tenens physician services using Medicare guidelines. Locum tenens services provided by an APRN are covered. Current licensure is required.

Documentation

The regular physician must keep a record of each service provided by the locum tenens physician along with the substitute physician's NPI.

Locum Tenens Billing

Refer to the following billing guidelines for locum tenens physicians:

- The member's regular physician submits bills and receives payment for locum tenens physician covered services. Compensation paid by a medical group is considered paid by the physician;
- The locum tenens physician does not have to be identified on the claim or need to enroll with DHS;
- Bill with modifier Q6; and
- Postoperative services performed by the locum tenens physician during the global surgery period do not require a Q6 modifier (if the services are only in connection with the surgery).

Physician Services in Teaching Settings

South Country follows Medicare guidelines for teaching physicians, interns and residents.

Substitute Physicians

A member's regular physician may submit a claim for a covered service that the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if:

- The regular physician is unavailable to provide the visit services;
- The member has arranged or seeks to receive services from the regular physician; and
- The substitute does not provide services over a continuous period of longer than 60 days.

These requirements do not apply to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the services must be identified as the rendering physician.

Covered Services for Substitute Physicians

South Country covers substitute physician services using Medicare guidelines.

Documentation

The regular physician must keep a record of each service provided by the substitute physician along with the substitute physician's unique physician identification number (UPIN) found in the Centers for Medicare & Medicaid Services System of Records.

Substitute Physician Billing

Refer to the following billing guidelines for reciprocal billing:

- The regular physician submits bills and receives payment for substitute physician covered services;
- The substitute physician does not have to be identified on the claim nor enrolled with DHS;
- Bill with modifier Q5; and
- Postoperative services performed by the substitute physician during the global surgery period do not require a Q5 modifier (if the services are in connection with the surgery).

Outpatient Physician-Administered Drugs

Bill drugs that are administered to a patient as part of a clinic or other outpatient visit to South Country using the appropriate HCPCS code(s). Do not bill drugs administered during an outpatient visit through the pharmacy point of sale (POS) system. South Country does not allow "brown-bagging" (patient obtains prescription drug from a pharmacy and takes it to physician's office to be administered) or "white-bagging" (provider obtains prescription drug from a pharmacy and patient visits the physician's office for administration).

Pharmacies, including mail order pharmacies, who are providing the drugs for a clinic visit, must bill the clinic and not South Country for the drugs dispensed. South Country will make an exception only if a member has third party liability and the third-party payer requires that the drugs be billed through the pharmacy benefit.

Pharmacies should not dispense drugs directly to a patient if the drugs are intended for use during a clinic or other outpatient visit.

For injections that involve multiple national drug codes (NDCs), bill the initial line item with the HCPC code, units and NDC with modifier KP (first drug of a multiple drug unit dose formulation). Bill the second, and any subsequent line item(s) of the same HCPC code with modifier KQ (second or subsequent drug of a multiple drug unit dose formulation). If billing the same HCPC code on more than two lines, the KQ modifier and an additional modifier are needed on each subsequent line.

Outpatient Physician-Administered Drugs NDC Reporting

The federal Deficit Reduction Act of 2005 (DRA) requires states to collect rebates for covered outpatient drugs administered by physicians. To comply, states must gather utilization data including the NDC, quantity and unit of measure from claims submitted for physician-administered drugs.

Include the correct NDC information on all claims, including Medicare and other third-party claims, when billing non-vaccine drugs using HCPCS codes. Participants in the 340B Drug Pricing Program are included in the NDC reporting requirements. Add the UD modifier to drugs purchased through the 340B program. Refer to the HCPCS Codes Requiring NDC when submitting claims for reimbursement.

NDC Reporting of Outpatient Physician-Administered Compound Drug

Multiple service lines are necessary to report a compound drug. One NDC is allowed per line. Report the HCPC code as a separate line for each associated NDC.

Reporting the Discarded Portion of Administered Drugs

When a provider must discard the remainder of a single use vial or other single use package after administering a dose or quantity of the drug or biological, report the amount of the unused and discarded drug on a separate claim line using the JW modifier. Providers are expected to use the package size that minimizes the amount of waste billed to South Country. For example, if a patient needs 50 mg of drug and the product comes in 50 mg and 100 mg vials, use the 50 mg vial.

The JW modifier is not permitted when the actual dose of the drug or biological administered is less than the billing unit. The JW modifier is not appropriate for drugs that are from multiple dose vials or packages.

Telemonitoring (Remote Physiological Monitoring Services)

Telemonitoring services are the remote monitoring of data related to a member's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a

provider for analysis. Telemonitoring is a tool that can assist the provider in managing a member's complex health needs.

Eligible Members

South Country covers telemonitoring services for South Country members.

Eligible Providers

The assessment and monitoring of the health data transmitted by telemonitoring must be performed by the following licensed health care professionals:

- Advanced practice registered nurse;
- Physician;
- Physician assistant;
- Podiatrist;
- Registered nurse;
- Respiratory therapist;
- A licensed professional working under the supervision of a medical director (for example, an LPN).

Covered Telemonitoring Services

South Country covers telemonitoring services for members in high-risk, medically complex patient populations. These members have medical conditions like congestive heart failure, chronic obstructive pulmonary disease (COPD) or diabetes.

South Country covers telemonitoring services based on the following medical necessity criteria:

- the telemonitoring service is medically appropriate based on the member's medical condition or status;
- the member is cognitively and physically capable of operating the monitoring device or equipment, or the member has a caregiver who is willing and able to assist with the monitoring device or equipment;
- the member resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site;
- the prescribing provider has identified and documented how telemonitoring services would likely prevent the member's admission or readmission to a hospital, emergency room or nursing facility; and
- the results of the telemonitoring services are directly used to impact the plan of care.

Noncovered Telemonitored Services

Any service that does not meet medical necessity criteria will not be covered.

Billing Telemonitoring Services

- Bill on 837P claim format;
- Submit claims for telemonitoring services using the CPT or HCPC code that describes the services rendered. Prior authorization is not needed;
- You must bill for at least 16 days of data collection within a 30-day period;
- the data must be collected and transmitted rather than self-reported to the provider. The device must be defined by the FDA as a medical device;

- Only MDs and practitioners may bill for remote patient monitoring (RPM) services; and
- Independent diagnostic testing facilities are not able to bill for RPM services.