Ohio Department of Medicaid

Telehealth Billing Guidelines

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

Amendment History

Version	Date	Modifications
1.0	July 2022	Creation of guidance document. Updated eligible service HCPCS codes including pregnancy education and diabetes management. Removed retired HCPCS codes.
2.0	January 2025	Updates to reflect yearly CPT & HCPCS coding updates (additions, deletions, modifications); added clarification on place of service code 09 in response to the Consolidated Appropriations Act; removed table with codes for OhioMHAS-certified providers and referenced those billing manuals; rearranged codes to be in sequential order; added doulas and doula services; added lactation consulting service code S9443 and practitioners with IBCLC specialty; removed references to MITS and updated with provider network management (PNM) module; end-dated hospice flexibilities under the PHE; removed outpatient hospital behavioral health (OPHBH) information as this is no longer applicable.
3.0	January 2026	Updates to reflect yearly CPT & HCPCS coding updates (additions, deletions, modifications); removal of Hospice aides and Private duty registered nurses or licensed practical nurses in a hospice setting; clarification of medically necessary health care services delivered through telehealth that are eligible for payment; removed references to rules 5160-28-03.1 and 5160-28-03.3 as they have been consolidated under 5160-28-3 of the OAC; added the exception of "eligible juveniles" as defined in 5160:1-1-03 of the OAC for being eligible for telehealth services under this rule; addition of eligible codes for payment under Medical and Behavioral Health Services;

Telehealth Billing Guidelines

THE OHIO DEPARTMENT OF MEDICAID

These billing guidelines, pursuant to rule 5160-1-18 of the Ohio Administrative Code (OAC), apply to **fee-for-service claims** submitted by Ohio Medicaid providers and are applicable for dates of service on or after January 1, 2026.

The Managed Care Organizations (MCOs) and Managed Care Entities (MCEs) cover the same telehealth services as in fee-for-service but may have different billing requirements. For questions about submitting claims for telehealth to the MCOs and MCEs, providers should contact the plans directly. ODM has posted telehealth guidelines for managed care organizations at https://medicaid.ohio.gov/resources-for-providers/managed-care/mc-policy/covid-19/telehealth-services-guidelines-for-mcos-ver3.

If you are a behavioral health agency certified by the Ohio Department of Behavioral Health (ODBH) (formerly known as the Ohio Department of Mental Health and Addiction Services (OhioMHAS)), please refer to the billing guidance for telehealth approved services found at https://medicaid.ohio.gov/resources-for-providers/bh.

This guide provides general information about Ohio Medicaid's fee-for-service policy and includes specific instructions for the following program areas:

- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Outpatient Hospitals
- Dental
- Long Term Services and Supports:
    - Hospice
    - Private Duty Nursing
    - State Plan Home Health services
    - Nursing Facilities
- Pre-Admission Screening and Resident Review (PASRR)

What is Telehealth?

Under rule 5160-1-18 effective 1/1/2026, the following is considered telehealth:

- The direct delivery of health care services to a patient related to the diagnosis, treatment, and management of a condition.

- Telehealth is the interaction with a patient via synchronous, interactive, real-time electronic communication that includes both audio and video elements; **OR**
- The following activities that are asynchronous or do not have both audio and video elements:
  - Telephone calls
  - Remote patient monitoring
  - Communication with a patient through secure electronic mail or a secure patient portal
- For services rendered by behavioral health providers as defined in rule 5160-27-01 of the Administrative Code, telehealth is further defined in rule 5122-29-31 of the Administrative Code.

- Medicaid covered individuals can access telehealth services wherever they are located. Locations include, but are not limited to:
  - Home
  - School
  - Temporary housing
  - Homeless shelter
  - Nursing Facility
  - Hospital
  - Group home
  - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)

Service Site Guidance:

	Practitioner Site	Patient Site
Definition	» Physical location of the treating practitioner when the service was delivered » There is no limitation on practitioner site	» Physical location of the patient when the service was delivered » There is no limitation on patient site
Rendering providers (PNM Provider Type)	» Physician, Psychiatrist, Ophthalmologist (20) » Podiatrist (36) » Psychologist (42) » Physician Assistant (24) » Dentist (30) » Advanced Practice Registered Nurses: ○ Clinical Nurse Specialist (65) ○ Certified Nurse Midwife (71) ○ Certified Nurse Practitioner (72) » Licensed Independent Social Worker (37) » Licensed Independent Chemical Dependency Counselor (54) » Licensed Independent Marriage and Family Therapist (52)	» Not applicable

	» Licensed Professional Clinical Counselor (47) » Dietitians (07) » Audiologist (43) » Occupational Therapist (41) » Physical Therapist (39) » Speech-language pathologist (40) » Practitioners who are supervised or cannot practice independently: » Supervised practitioners, trainees, residents, and interns as defined in OAC rules 5160-4-05 and 5160-8-05 » Occupational therapy assistant » Physical therapist assistant » Speech-language pathology aide » Audiology Aide » Individuals holding a conditional license as described in section 4753.071 of the Revised Code » Registered Nurses (RN) and Licensed Practical Nurses (LPN) working in a home health setting. » Non-Agency Nurses (38) » Medicaid School Program (MSP) practitioners described in 5160-35 of the Administrative Code (28) » Optometrists (35) » Pharmacists (69) » Chiropractors (27) effective 7/15/2022 » Doula (09) under OAC 5160-8-43 effective 10/3/2024 Practitioners enrolled with the International Board-Certified Lactation Consultant (IBCLC) specialty under OAC 5160-8-42 » Other practitioners if specifically authorized in rule under Agency 5160 of the Administrative Code	
Billing (pay-to) providers (PNM Provider Type)	» Rendering practitioners listed above except: ○ Supervised practitioners defined in 5160-4-05 and 5160-8-05 ○ Occupational therapy assistant ○ Physical therapist assistant ○ Speech-language pathology and audiology aides ○ Individuals holding a conditional license ○ Registered Nurses (RN) and Licensed Practical Nurses (LPN) working in a home health setting » Professional Medical Group (21) » Professional Dental Group (31) » Federally Qualified Health Center (12) » Rural Health Clinic (05) » Ambulatory Health Care Clinics (50)	» Not applicable

	» Outpatient Hospitals (01) on behalf of licensed psychologists and independent practitioners not eligible to separately bill in this setting » Psychiatric Hospitals providing BH services (02) » Medicaid School Program Provider (28) » Private Duty or non-Agency Nurses (38) » Pharmacies (70) (submitted on a professional claim) » Chiropractors (27) » Doula (09) under OAC 5160-8-43 » Independent practitioners enrolled with the International Board-Certified Lactation Consultant (IBCLC) specialty under OAC 5160-8-42 » Other practitioners if specifically authorized in rule promulgated under Agency 5160 of the Administrative Code	
Excluded place of service (POS)	» Penal facility or public institution such as jail or prison (09), per federal exclusion » 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). » Place of service codes (02) and (10) will not be accepted on claims where Medicaid is the primary payer unless specified in provider specific billing guidelines	» Not applicable, the patient site can be anywhere. » If applicable, a modifier indicating the patient site location must be reported. See provider specific billing guidelines.

Professional Claims

When billing for professional services:

- In most cases, the "GT" modifier is required to identify the service delivery through telehealth. 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. See instructions for your specific program area or provider type for further clarification.
  - Example: CPT code 98000 New patient **synchronous audio-video** visit with straightforward medical decision making, if using time 15 minutes or more
- 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.
- In most cases, the place of service code reported on the claim must be the location of the practitioner. See instructions for your specific program area or provider type for further clarification.
- Telehealth place of service codes 02 and 10 will not be accepted on claims where Medicaid is the primary payer unless stated otherwise in provider specific billing guidelines.
- If the patient is at one of the following locations, a specific modifier identifying the type of location is required:

- The patient's home
- School
- Inpatient hospital
- Outpatient hospital
- Nursing facility
- Intermediate care facility for individuals with an intellectual disability

Patient Location Modifiers

(Not applicable to OhioMHAS certified behavioral health agencies)

If the patient site is not one of these locations, a modifier identifying patient location is not required

Telehealth Modifier	Description
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 (ICF/IID)

Professional Claim Submission for Services Delivered via Telehealth*

Billing provider type	Providers of Professional Services	FQHC and RHC (FFS or claims for wraparound payments)
Claim type	» Professional (Submitted via PNM portal or EDI)	» Professional (Submitted via PNM portal or EDI)
Procedure code	» CPT code for service delivered via telehealth	» First detail line: T1015 encounter code and the appropriate U modifier » Second detail line: procedure code for service delivered via telehealth
Telehealth Modifier	» GT modifier » Any other required modifiers based on provider contract » Above-mentioned U modifier to identify patient location, if applicable	» GT modifier with the procedure code » Any other required modifiers based on provider contract » Above-mentioned U modifier to identify patient location, if applicable
Place of service (POS) code	Physical location of the practitioner when the service was delivered	Physical location of the practitioner when the service was delivered

*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

Institutional Claims

Outpatient hospital billing:

Hospital providers are eligible to bill for telehealth services provided by licensed psychologists and independent practitioners not eligible to separately bill a professional claim. Telehealth services are covered to the extent they appear with a telehealth note on the EAPG covered code list, located on our website: https://www.medicaid.ohio.gov/provider/feescheduleandrates.

To bill outpatient hospital telehealth services, please append modifier "GT" to the procedure code.

Outpatient hospital telehealth services will pay according to the Enhanced Ambulatory Patient Grouping (EAPG) pricing methodology as described in OAC rule 5160-2-75.

Instructions for Specific Providers and Program Areas

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) billing:

- For a covered telehealth service that is also an FQHC or RHC prospective payment system (PPS) service, the face-to-face requirement is waived, and payment is made in accordance with Chapter 5160-28 of the Administrative Code.
- Medical nutrition therapy and lactation services rendered by eligible FQHC and RHC practitioners will be paid under the PPS.
    - When these services are rendered by a practitioner not listed in Chapter 5160-28 of the Administrative Code, these services shall be paid through FFS under the clinic provider type 50 (using ODM's fee schedules).
- Remote patient monitoring will be paid through FFS as a covered non-PPS service under the clinic provider type 50 (using ODM's fee schedules).
- Group therapy will continue to be paid through FFS as a covered non-PPS service under the clinic provider type 50 (using ODM's fee schedules).
- Services under the Specialized Recovery Services (SRS) program are not currently covered FQHC or RHC services.
- When the FQHC or RHC is billing as the practitioner site:
    - The T1015 encounter code must be reported in the first detail line of the claim with the appropriate U modifier indicating the type of visit.
    - The next detail line reported on the claim must be the service (procedure code) provided via telehealth. Modifier "GT" must be reported with the procedure code in addition to any other required modifiers. If there is more than one modifier, the GT modifier should be reported first.
    - The place of service code reported on the claim must reflect the physical location of the practitioner.

For more information regarding payment for covered pharmacist services in an FQHC or RHC, please refer to Medicaid Advisory Letter (MAL) number 653 found here: https://medicaid.ohio.gov/static/About+Us/PoliciesGuidelines/MAL/MAL-653.pdf

Dental

Dentists may provide a limited problem-focused oral exam (CDT D0140) or periodic oral evaluation (D0120) through telehealth under this rule.

- When billing for the procedure on a **professional claim**, providers should use the GT modifier to indicate the service was provided through telehealth. There is no need to report D9995.
- When billing for the procedure on a **dental claim**, providers should include procedure code D9995 to indicate the service was provided through telehealth.
- Dental services **furnished through telehealth at FQHCs** are covered under 5160-1-18 and are paid as covered FQHC dental services.
    - On the first service line of the claim, the provider should report T1015 with the appropriate modifier to identify the type of visit (in this case U2).
    - The procedure code (D0140 or D0120) should be reported in the next detail line of the claim representing the service that was provided along with a GT modifier to identify the service as a telehealth service. There is no need to report D9995.
    - The place of service code should reflect the practitioner's physical location.

Home Health Services, RN Assessment and RN Consultation

Home health services, the RN assessment service and the RN consultation service can be provided using telehealth when clinically appropriate. These services should be billed using the procedure codes below. The value "02" should be used to indicate telehealth as the "Place of Service" on all claims for services provided using telehealth.

- G0156 Home Health Aide
- G0299 Home Health Nursing – RN
- G0300 Home Health Nursing – LPN
- T1001 RN Assessment
- T1001 w/U9 Modifier – RN Consultation
- G0151 Physical Therapy
- G0152 Occupational Therapy
- G0153 Speech-Language Pathology

Nursing Facilities

Nursing facilities (NF) are reimbursed for all telehealth related services through the NF per diem rate. Nursing Facilities do not bill for the telehealth related services they provide. Per the telehealth rule 5160-1-18, physicians and other eligible providers may bill for the services they provide to nursing facility residents from the practitioner's site in accordance with the rule.

When nursing facilities provide telehealth related services to their residents, they report the costs they incur for those services on the Medicaid NF cost report using the following cost center codes:

- **DIRECT CARE COSTS**
  - 6110 – RN Charge Nurse
  - 6115 – LPN Charge Nurse
  - 6120 – Registered Nurse
  - 6125 – Licensed Practical Nurse
  - 6210 – Consulting and Management Fees
  - 6401 – Registered Nurse Purchased Nursing
  - 6411 – Licensed Practical Nurse Purchased Nursing
  - 6600 – Physical Therapist
  - 6610 – Occupational Therapist
  - 6620 – Speech Therapist
  - 6630 – Audiologist

- **ANCILLARY/SUPPORT COSTS**
  - 7000 – Dietitian
  - 7231 – Psychologist
  - 7251 – Social Work/Counseling
  - 7261 – Social Services/Pastoral Care
  - 7302 – Medical Minor Equipment Non-Billable to Medicare

- **CAPITAL COSTS**
  - 8040 – Depreciation – Equipment
  - 8065 – Lease and Rent – Equipment

No system changes, Administrative Code rules, or the Medicaid State Plan are necessary to implement telehealth in nursing facilities.

Pre-admission Screening and Resident Review

Pre-admission Screenings and Resident Reviews (PASRR) should be completed via the electronic HENS system as they are today as these screenings are primarily via desk review. In instances where a face-to-face is required, a telephonic and/or desk review is permissible.

Level II evaluations can be provided either by telephone or desk review when appropriate. There is no system or reimbursement impact as these functions are supported by the level II entities and the applicable contractor.

Important Clarifications

- If the practitioner site does not bill the Ohio Department of Medicaid (ODM) 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.
    - If the physical location of the practitioner at the time of service is not known, the POS code reported on the claim should reflect the location of the billing provider.
- In most cases, the "GT" modifier is required to identify the service delivery through telehealth. 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. See instructions for your specific program area or provider type for further clarification.
- All services identified in this document and the appendix to rule 5160-1-18 may be delivered through telehealth for dates of service on or after January 1, 2026. 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 or another ODM Fee Schedule.
    - Example: CPT code 98000 New patient **synchronous audio-video** visit with straightforward medical decision making, if using time 15 minutes or more.
- 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.
- 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. The POS code set is maintained by the Centers for Medicare and Medicaid Services (CMS) and can be found here: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_service_code_set
    - Place of service code 02 (Telehealth not provided in patient's home) and 10 (Telehealth provided in patient's home) will not be accepted on claims where Medicaid is the primary payer, unless otherwise stated in these billing guidelines.
- Similar to what CMS allows for Medicare services provided during the public health emergency, ODM adopts the following workforce flexibility: For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology.

Covered Telehealth Services

Enhanced Ambulatory Patient Groups (EAPG)	
Procedure Code	**Description**
Refer to link in Description	EAPG covered telehealth-eligible codes as identified on the ODM Website: https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support/provider-types/hospital-provider-information/eapg-covered-codes-telehealth

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

Long Term Services and Supports: Private Duty Nursing, State Plan Home Health	
Procedure Code	**Description**
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health setting, each 15 minutes.
G0155	Services of clinical social worker in home health settings, each 15 minutes.
G0156	Services of home health/hospice aide in home health settings, each 15 minutes.
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health setting, each 15 minutes.
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.
G0151	Physical Therapy, each 15 minutes.
G0152	Occupational Therapy, each 15 minutes.
G0153	Speech-language Pathology, each 15 minutes.

Medical and Behavioral Health Services (non-OhioMHAS certified behavioral health agencies)	
Procedure Code	**Description**
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.
92012	Eye exam, established patient.
92065	Orthoptic/Pleoptic training.
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).
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.
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.

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.
97542	Wheelchair management, each 15 minutes.
97802	Medical nutrition therapy; initial assessment and intervention, each 15 minutes.
97803	Medical nutrition therapy; re-assessment and intervention, each 15 minutes.
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes.
97802 TH	Lactation counseling by dietitian; initial assessment and intervention, each 15 minutes.
97803 TH	Lactation counseling by dietitian; re-assessment and intervention, each 15 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	Remote therapeutic monitoring, respiratory.
98977	Remote therapeutic 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 evaluation and management 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 evaluation and management 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 evaluation and management of a patient. Typically, 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 evaluation and management 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 evaluation and management 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 evaluation and management 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 evaluation and management of a patient. Typically, 35 minutes are spent at the bedside and 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.
99345	Home or residence visit for the evaluation and management of a new 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, 75 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	Preventative medicine counseling, first 15 minutes.
99402	Preventative 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.
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.
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).
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.
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.
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.

H2000	Child Adolescent Needs and Strengths (CANS) assessment.
S9436	Childbirth prep/Lamaze classes, non-physician provider, per session.
S9437	Childbirth refresher classes, non-physician provider, per session.
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, dietician visit.
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.
T1023	Report of pregnancy (ROP).
T1032	Services performed by a doula birth worker, per 15 minutes.
T1030	Family Connects home visiting.

Occupational Therapy, Physical Therapy, Speech-Language Pathology, and Audiology Services
As Found in OAC 5160-8-35

Procedure Code	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 minutes (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).
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.
97129	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, sequencing tasks), 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 (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure).
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 (eg, 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.

Specialized Recovery Services (SRS) Program As found in Chapter 5160-43 of the OAC	
Procedure Code	**Description**
H0038	Specialized Recovery Services (SRS) program – peer recovery support services.
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.

Questions?

Contact: medicaid@medicaid.ohio.gov
For more information go to: Medicaid.Ohio.gov

Are you an agency certified by OhioMHAS?
Contact: BHPolicy@medicaid.ohio.gov
For more information go to: Behavioral Health | Medicaid