

Connecticut Department of Social Services (DSS)
Connecticut Medical Assistance Program (CMAP)

Responses to Frequently Asked Questions (FAQs) About CMAP's Response to COVID-19 (Coronavirus)

Updated: June 30, 2023

Below are responses to frequently asked questions about CMAP's response to the outbreak of COVID-19 (Coronavirus). Please carefully review all provider bulletins and other documents posted on the CMAP Web site, www.ctdssmap.com and check for updates, as we intend to continue providing updated guidance as necessary.

1. Does the provider need to use a software program with both video and telephone for telemedicine visit or can they just speak with the patient over the phone?

Response: Provider Bulletins 2020-09 and 2020-10 do not authorize audio only telephone as telemedicine services. Telemedicine must be an audio and video system with real-time communication between the patient and practitioner. Provider Bulletin 2020-14 does authorize telephone services (audio only) under specific circumstances.

2. Provider Bulletin PB 2020-10 requires a written informed consent to be signed by the member prior to the start of telemedicine services. Is it possible to do obtain verbal consent instead of written consent?

Response: Yes, for the time period that PB 2020-10 is in effect (as part of CMAP's response to COVID-19), for CMAP purposes, the Department is waiving the requirement of written consent prior to starting telemedicine services. Providers must document that they obtained verbal consent from the member to provide telemedicine services and document that consent in the medical record. One potential alternative to obtaining traditional written informed consent is that providers include, as part of the software program used to provide telemedicine services, that the member affirmatively agrees to receive services by telemedicine as a condition of opening the telemedicine software encounter and the provider. If the provider chooses this option for obtaining written informed consent, the provider should maintain documentation on file that its telemedicine software program includes this disclaimer and consent. These options are permissible for CMAP purposes but do not supersede any other requirements that may apply to the provider, such as scope of practice or professional standards.

3. What is the appropriate place of service (POS) to use when billing for a telemedicine encounter? For dates of service 1/2/2021 and forward: Please click [here](#) for updated guidance.

Response: Providers should use POS 02 which will indicate that the service was rendered via telemedicine.

4. Is the CMAP Medicaid Management Information System (MMIS) billing system, operated by Gainwell Technologies, system ready to process and pay claims billed with POS-02? Please click [here](#) for updated guidance.

Response: Yes, the MMIS is ready to accept claims with POS 02.

5. Is there a full list of approved billing codes?

Response Updated on 5/22/20: Please click on APPENDIX 1: ELIGIBLE PROCEDURE CODES UNDER COVID 19 TELEMEDICINE/TELEPHONIC COVERAGE for a list of all services that can be performed via synchronized telemedicine and /or telephonically. [APPENDIX 1 \(Revised\)](#)

6. What medical telemedicine services are currently covered by CMAP?

Response: PB 2020-09 authorizes coverage of telemedicine for out-of-state surgeries and homebound individuals. PB 2020-10 temporarily expands telemedicine coverage to a much broader category of medical evaluation and management services effective for dates of service March 13, 2020 through the date that DSS notifies providers in writing that the COVID-19 public health emergency in Connecticut has ended. Provider Bulletin 2020-14 does authorize telephone services (audio only) under specific circumstances. Please refer to [question 5](#) above for additional details.

7. Are independent behavioral health practitioners required to physically be in the office when they render a telemedicine or telephone service to a member?

Response: No, independent practitioners in solo practices or in group practices are not required to be in the office when rendering a telemedicine or telephone service to a member.

8. As an independent practitioner, do I still need to add my provider specific modifier that I used prior to telemedicine in addition to the telemedicine modifier to the claim?

Response: Yes, independent behavioral health practitioners must still use the billing modifiers that were in place prior to the telemedicine policy. For telemedicine services, there will be two modifiers on a claim, the previous billing modifier and the telemedicine modifier. Clinical social workers use the modifier "AJ" and Licensed Marriage and Family Therapists, Licensed Professional Counselors, and Licensed Alcohol and Drug Counselors use the modifier "HO".

9. Regarding behavioral health services, as a DPH licensed behavioral health clinic, non-licensed and non-certified staff could provide services under the direction of a licensed behavioral health practitioner. Is that still the case for telemedicine and telephone services?

Response: Yes, only in behavioral health clinics that are licensed by DPH.

10. Regarding the physical location of the practitioner who works for a DPH licensed healthcare facility, does the practitioner still need to be in the clinic when rendering telemedicine or telephone services?

Response: DSS is waiving the DSS regulations regarding any limitation to the physical location of the practitioner when rendering telemedicine or telephone services.

11. For methadone maintenance services, providers are required to provide at least one counseling session per month. Can we do the required monthly counseling session via telemedicine or telephone?

Response: Yes.

12. Are there additional authorization requirements in order to provide services via telemedicine or telephone?

Response: No additional or different authorization procedures are required beyond the authorization requirements in place prior to issuing new policy on telemedicine.

13. As an FQHC, we were providing group psychotherapy and IOP on a face-to-face basis. Does PB 2020-25 allow us to provide group psychotherapy and IOP via telemedicine?

Response: Yes. Any practitioner or provider type that was rendering group psychotherapy, adult day treatment, intensive outpatient treatment and partial hospital treatment on a face to face (in-person) basis prior to PB 2020-25 may now conduct those group sessions via telemedicine (audio and video), but not audio-only telephone.

14. I understand that the codes for medication administration are hands-on care service codes. Under the current public health emergency, is DSS allowing licensed home health providers to perform these services via telemedicine or telephone?

Response: Correct, during the temporary effective period, until DSS notifies providers differently, the medication administration codes listed on the bulletin, that are normally done in the home with the patient, may now be done via telemedicine (audio and video) or telephonically (audio only). The Department is aware that the T1502 and T1503 codes are both for direct face to face administration of medications including intramuscular and subcutaneous injections. In an effort to reduce the transmission of the coronavirus, the Department is allowing these codes to be done via telemedicine or telephonically for prompting of oral medication by a nurse and not for any other medication administration. The expectation is that the home health nurse will pre-pour patients' oral medications ahead of time and use telemedicine, or telephone call to conduct a brief assessment and prompt patients to take their already pre-poured medications. Please refer to provider bulletins, PB 2020-28 CMAP COVID-19 Response – Bulletin 13: Emergency Temporary

Telemedicine Coverage/Telephonic Coverage for Specified Home Health Services and Hospice Services and PB 2015-07 Clarification of Billing Medication Administration Visit Code and Skilled Nursing Visit Code Related to Pre-pouring of Medication for additional guidance.

15. The nurse will be the one pre-pouring the medications; are home health aides able to call patients and prompt them to take their medications after it has been pre-poured by the nurse?

Response: No, medication prompting services performed by home health aides are not eligible to be performed under the temporary emergency telemedicine or telephone coverage. HCPCS codes T1502 and T1503 include a brief assessment performed by a nurse who will also prompt the HUSKY Health member to take their medications.

16. If the home health aides cannot call patients and prompt them to take their medications, why is there a home health prompting code?

Response: The Department is not advising home health agencies to not perform medication prompting by home health aides service that were prior authorized as part of the care plan. Home health agencies are advised to perform authorized services in the safest manner possible during this public health crisis.

17. Will the Department of Social Services (DSS) follow the CARES Act allowing other health professionals to sign off on home health orders?

Updated Response: In accordance with state law as amended by sections 1 and 2 of Public 21-133, advanced practice registered nurses (APRNs) and physician assistants, for the purposes of scope of practice, are authorized to issue orders for home health services under the Connecticut Medical Assistance Program (CMAP). This state law will make the signing authority originally granted under the CARES Act to APRNs and physician assistants permanent (Please refer to provider bulletin, *PB 21-81 Advance Practice Registered Nurses and Physician Assistants Authorized to Order Home Health Services*).

Response: Effective April 27, 2020 (or such other effective date of the Connecticut Department of Public Health (DPH) order on the same topic), until the end of the officially declared public health and civil preparedness emergency, Medicaid payment is authorized for otherwise covered home health services that are ordered by advanced practice registered nurses and physician assistants (an expansion of the current requirements, which are limited to orders issued by physicians). This expansion of practitioners is consistent with DPH's order to broaden the scope of practitioners authorized to issue orders for home health services under its home health licensing regulations. DSS will review updates from DPH about the expansion of practitioners authorized to sign home health orders to determine if DSS needs to make any further updates.

18. Has DSS waived prior authorization requirements for outpatient hospital radiology services that are billed using a "C" procedure code?

Response: Yes, during the COVID-19 Temporary Effective Period, prior authorization has been waived on the following "C" procedure codes:

C8900	C8908	C8914	C8933
C8901	C8909	C8918	C8934
C8902	C8910	C8919	C8935
C8903	C8911	C8920	C8936
C8905	C8912	C8931	
C8906	C8913	C8932	

REVISED Response: Provider Bulletin PB21-26 was published advising providers of the reinstatement of Prior Authorization (PA) requirements for Outpatient Hospital Services. Please refer to [PB21-26](#) for additional information.

19. Can DSS clarify the use of telemedicine modifiers and Place of Service (POS) requirements when billing for telemedicine or telephonic services? Click [HERE](#) for updated guidance related to POS requirements.

Response: The following modifiers are required on all claims when services are rendered via telemedicine:

- Modifier "GT" is used when the member's originating site is located in a healthcare facility or office; or
- Modifier "95" is used when the member is located in the home.

Providers should continue to append all other appropriate modifiers on the claim in conjunction with the applicable telemedicine modifier. When services are rendered via telemedicine POS 02 – Telehealth must be appended on the claim. At this time, telephonic services billed with CPT codes 99442 and 99443 do not require a specific modifier and there is no specific POS requirement when services are rendered telephonically (audio only). For dates of service, May 7, 2020 and forward, behavioral health services rendered as telephonic services must include the CR modifier as specified by PB 2020-44.

20. How will inpatient behavioral health admissions be reimbursed for admission dates April 1, 2020 until the Temporary Effective Period is over?

Response: As described in *PB 20-33 - CMAP COVID-19 Response – Bulletin 23: Changes to the Prior Authorization Requirements for Specified Services*, any BH inpatient admission that is billed with Revenue Center Code (RCC) 124 or 126 and/or assigned a DRG of 740-776 (behavioral health) will pay at the hospital's behavioral health per-diem rate. If you have any problems with billing and reimbursement you can send an email to Gainwell Technologies via the hospital email address ctxixhosppay@gainwelltechnologies.com.

Any BH inpatient admission approved prior to 4/1/2020 must continue to have the authorization updated through Beacon Health Options, in order to receive the per diem payment.

Please note: All inpatient behavioral health services continue to remain an all-inclusive payment to the hospital; therefore, professional services cannot be billed separately.

21. How will inpatient rehab admissions be reimbursed for admission dates April 1, 2020 until the Temporary Effective Period is over?

Response: As described in *PB 20-33 - CMAP COVID-19 Response – Bulletin 23: Changes to the Prior Authorization Requirements for Specified Service*, any Rehabilitation inpatient admission billed with Revenue Center Code (RCC) 128 and/or assigned a DRG 860 (rehabilitation) will be paid the hospital's Rehab per diem rate. If you have any problems with billing and reimbursement you can send an email to Gainwell Technologies via the hospital email address ctxixhosppay@gainwelltechnologies.com.

Any Rehab inpatient admission approved prior to 4/1/2020 must continue to have the authorization updated through Community Health Network of CT (CHNCT), in order to receive the per diem payment.

Please Note: All inpatient rehabilitation services continue to remain an all-inclusive payment to the hospital; therefore, professional services cannot be billed separately.

22. Our in-state group practice has multiple service locations. Due to the COVID-19 health crisis, we have had to close facilities and have moved physicians to some of our other locations that they normally wouldn't work at. We have also had to move physicians around to different locations to cover for sick physicians. Do we have to update the physicians' location in their enrollment every time they change locations in order to bill correctly?

Response: No Providers are to bill using the providers "home" location during the COVID-19 health crisis. Providers will not be required to update their location if they are moving around from location to location treating patients until the state has no longer declared a health emergency.

23. Can providers bill E/M visit based on time limits or MDM limits as covered by Medicare as part of their COVID-19 response?

Response: 6/4/2020 UPDATE: Please see response to FAQ 24 below.

24. Is DSS following Medicare's guidance regarding the Level Selection for Office/Outpatient Evaluation and Management (E/M) Visits When Furnished via Telemedicine?

Response: Yes, during the Temporary Effective Period, DSS will follow Medicare's policy regarding office/outpatient E/M level selection for services furnished via telehealth. On an interim basis, office and outpatient E/M services can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter. Providers should refer to section "W" of the Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency IFR for additional information:

<https://www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public>

25. Related to PB 2020-44, the Department issued this bulletin on May 12th with an effective date of sun setting or terminating the use of procedure codes 98967 and 98968 of May 6th. As a provider we had no way of knowing not to bill these codes from May 7th through May 12th, the date of issuance of the provider bulletin. Do providers need to go back and resubmit claims using the new procedure codes for the period between May 7th and May 12th?

Response: In an Important Message issued on May 18, 2020, the Department modified the end dates of procedure codes 98967 and 98968 for behavioral health services from May 6th to May 12th. Providers do not need to modify or resubmit claims for the period of May 7th through May 12th.

26. How should providers bill for a behavioral health telemedicine service that switched to audio-only due to technical difficulties?

Response: If a telemedicine service cannot be completed for any reason and the provider switches to audio-only to complete the service, providers should bill that service in accordance to CMAP's audio-only billing guidance – please see PB 2020-44. Providers may roll up the time spent on telemedicine before the disconnection with the time spent on audio-only to bill the applicable procedure code. A telemedicine claim should not be submitted for these services.

For example: BH Session started as telemedicine was provided for 23 mins, the session could not be completed via telemedicine due to issues with video and went to audio-only for the remaining 37 minutes of the session. The total service that was provided was for 60 minutes. Since the service was completed via audio-only, the provider should bill with 90837 CR modifier.

27. According to PB20-33, During the Temporary Effective Period, all in-state and border hospital admissions do not require PA, after submitting the inpatient behavioral health claims, I received the following Explanation of Benefits (EOB) code 3000 "Prior Authorization Services are Cutback or Exhausted". How should I submit inpatient claims and why did this EOB post?

Response: Any hospital that has requested and received an inpatient behavioral health authorization from Beacon Health Options for admissions after to April 1, 2020 must continue to have the authorization updated with Beacon Health Options for the entire admission. For any claims that hit EOB 3000 between April 1, 2020 and June 1, 2020 or the hospital only received

partial payment for the inpatient stay, Gainwell Technologies and Beacon Health Options are working on updating the current authorizations on file. We will notify providers with an important message (IM) when that occurs. As a reminder Prior authorization is not required during the Temporary effective period and hospitals do not need to reach out to request an authorization for the admission.

28. Can a provider amend a patient's medical record after 30 days from the original date of service?

Response: Per provider bulletin (PB) 2014-23: *Timely Completion of Medical Records in the Hospital Setting* and PB 2018-11: *Timely Completion of Medical Records in the Office and Outpatient Settings* medical records must be completed (including authentication by the provider) in as timely a manner as possible but no later than 30 days after a billable inpatient or outpatient visit or procedure. The medical record must be completed sooner if required by any other policy, statute, regulation, or requirement. Effective for dates of service retroactive to March 18, 2020 until the state declares to no longer be in a public health emergency, medical records that have been completed and signed within the 30 day time period may be amended to include additional documentation related to the services rendered on the documented date of service by the provider after the 30 day time period has passed. Examples of additional documentation include but are not limited to, the mode in which the service was rendered (audio-visual telemedicine or audio-only telephonic services).

29. Can residents render audio only services under the primary care exception?

Response: Similar to the guidance referenced in section "M" - Additional Flexibility under the Teaching Physician Regulations regarding the provision of services furnished by a resident without the presence of a teaching physician under the primary care exception - CMS-5531-IFC <https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf>, during the Temporary Effective Period, residents may render audio-only services under the primary care exception to CMAP members. It should be noted that CMAP currently covers procedure codes 99442 and 99443 and providers should refer to Provider Bulletin (PB) 2020-14 and PB 2020-45 for further guidance on billing for audio only services. Subject to all other applicable requirements for reimbursement under the CMAP and unless otherwise noted in the Department's regulations, subsequent Provider Bulletins or below, the CMAP follows Medicare's requirements regarding the primary care exception.

30. Does CMAP reimburse providers for the cost of purchasing personal protective equipment (PPE)?

Response: No, PPE is a necessary component of rendering covered services and is part of the cost of doing business. Therefore, PPE is included as part of the standard CMAP payment and is not separately reimbursable under CMAP. In addition, because PPE is part of CMAP covered services, CMAP providers are prohibited by state and federal requirements from charging members for PPE or any other component of covered services.

Separately, Medicaid providers may be eligible to receive support payments through one or more federal programs, such as the federal Provider Relief Fund available through the federal

Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Fund, the Paycheck Protection Program, and/or Health Care Enhancement Act. Providers must comply with applicable federal requirements in order to be eligible for such payments.

For more information on the Provider Relief Fund, please select the following HHS links and the CMAP Important Message which includes instructions for submission of an application.

Overview:

<https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html>,

FAQs:

<https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html#medicaid-targeted>

CMAP IM:

[https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=CARES+Act+Relief+Fund.pdf&URI=Important Message%20CARES+Act+Relief+Fund.pdf](https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=CARES+Act+Relief+Fund.pdf&URI=Important%20Message%20CARES+Act+Relief+Fund.pdf)

31. What needs to be done when an out-of-state provider that enrolled/joined my group/facility is no longer rendering in-person services to Connecticut Medical Assistance Program (CMAP) members during the public health emergency?

Response: PB 2020-40 - COVID-19 Response Bulletin 34 – Enrollment of CMAP Out-of-State Providers – issued guidance on the enrollment of out-of-state providers who are joining in-state practices and who will be physically rendering in-person services to Connecticut Medical Assistance Program (CMAP) members during the public health emergency.

DSS would like to remind providers that, when those out-of-state providers return to their home states they must 1) be dis-associated from the in-state group/facility and 2) be dis-enrolled.

- 1) To dis-associate a provider, the group/facility may log on to their Secure Web portal account at www.ctdssmap.com, and navigate to the "Maintain Organization Members" panel to dis-associate (i.e. end date) that provider from the group/facility.
- 2) To dis-enroll a provider, submit a signed request on letterhead via email or fax to the Gainwell Technologies Provider Enrollment Unit stating that the out-of-state provider is no longer rendering in-person services to CMAP members and so should be dis-enrolled. Email address: ctproviderenrollment@gainwelltechnologies.com Fax number: 1-877-899-5401.

32. Effective January 1, 2021 and forward is Place of Service (POS) 02 acceptable to use when billing for a telemedicine encounter?

Response: Effective for dates of service January 1, 2021 and forward, telemedicine claims should no longer be billed using Place of Service (POS) 02. Providers must indicate the POS that best

describes where the service was performed if it was rendered in person. This response updates the guidance provided in FAQ numbers 3 and 4.

33. What are the Vaccine Administration billing requirements for the Hospitals?

Response: (Updated 11/15/2022) An outpatient hospital claim submitted for the administration of a COVID-19 vaccine must include both the procedure code for the COVID-19 vaccine administration with Revenue Center Code 770 "Prevent Care Svcs" and the procedure code for the vaccine product with the national drug code - NDC. Please refer to provider bulletins [PB21-05](#), [PB21-63](#), and [PB21-89](#) for additional guidance.

For administration of the pediatric COVID-19 vaccine, submitted claims must include both the procedure code (0071A or 0072A) for the administration with Revenue Center Code 770 "Prevent Care Svcs" and the procedure code for the vaccine product administered 91307 (including the national drug code - NDC). Please refer to provider bulletin [PB21-91](#) for additional guidance.

34. REVISED guidance issued on 1-12-2022 and is retroactive to February 18, 2021. How should Federally Qualified Health Centers (FQHCs) pursue reimbursement for administration of COVID vaccines?

Response: Please note that DSS, DPH and OPM are pursuing guidance from federal agencies including, but not limited to, FEMA, on options for federal funding of COVID vaccine administration. As further information is received, the information below, which is effective as of February 18, 2021, may be updated and re-released.

For HUSKY Health members: Provider Bulletin [PB21-05](#) provides that, subject to all of the requirements that are articulated in the bulletin, "**Medical Federally Qualified Health Centers (FQHC)**" that have registered with CT DPH may provide the COVID-19 vaccine and will be eligible for reimbursement at the FQHC's current encounter rate. DSS is confirming that FQHCs are eligible for reimbursement at the FQHC's encounter rate for vaccine administration on premises, at community "congregate" sites, and any other service site that is not on the premises of the FQHC that is approved by HRSA for which the FQHC has not already been compensated (or will not be seeking reimbursement) via a methodology other than under the HUSKY Health program. All current FQHC regulations and policies apply to reimbursement for COVID-19 vaccine administration billed to DSS. FQHCs must follow all guidance as issued by the Health Resources Services Administration (HRSA) regarding service site locations. Please refer to [PB21-05](#) for additional guidance. Please note that for dates of service May 1, 2021 and forward, Federally Qualified Health Centers (FQHC) – Dental can also follow this guidance.

For commercially insured people: FQHCs should submit claims to private payers for reimbursement.

For uninsured people: FQHCs are asked to pursue reimbursement from the federal Health Resources Services Administration (HRSA). Federal coverage of testing, treatment and **vaccine administration for uninsured individuals** was authorized by the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act through a Provider Relief Fund that was established to cover

both direct treatment and also health care provider financial relief. This initiative is reimbursing health care providers, including physicians and hospitals, for testing, treatment and vaccine administration for uninsured individuals with a primary diagnosis of COVID-19 that occurred on or after February 18, 2020.

Per the information provided by the federal Health Resources & Services Administration (HRSA) eligible patients are, "individuals in the U.S. without health care coverage." Further, "health care providers are not required to confirm immigration status prior to submitting claims for reimbursement." Covered services include, among others, administration of FDA-licensed or authorized vaccines as they become available.

To qualify to be paid for these services, health care providers are required to attest that:

- they have confirmed that the involved individual does not have insurance coverage through an individual or employer-sponsored plan, a federal healthcare program, or the Federal Employees Health Benefits Program at the time services were provided;
- no other payer will cover the service, reimburse for the service and/or care for the involved patient;
- they will accept Provider Relief Fund payment, generally at Medicare rates for services, as payment in full for the care that is provided; and
- they will not bill the involved patients over and above payment received.

Extensive guidance is provided via FAQ at this link:
<https://www.hrsa.gov/coviduninsuredclaim/frequently-asked-questions>

35. Please note that for dates of service May 1, 2021 and forward, Federally Qualified Health Centers (FQHC) – Dental can also follow this guidance.

Response: The Department will reimburse claims/encounters when eligible provider types administer the COVID-19 vaccination. It is advised to review the "Approved COVID-19 Vaccination Training Programs" Webpage found on the State of CT-Department of Public Health, <https://portal.ct.gov/DPH/Practitioner-Licensing--Investigations/PLIS/Approved-COVID-19-Vaccination-Training-Programs> for the list of eligible providers and additional guidance.

36. Does the Connecticut Medical Assistance Program (CMAP) reimburse for COVID testing for asymptomatic individuals including testing required for work, school or travel purposes?

Response: Yes, during the federal PHE and subsequent periods of active surveillance, CMAP will reimburse for all diagnostic and screening COVID-19 testing that is consistent with CDC recommendations. This coverage includes, but is not limited to, reimbursement for COVID screening testing to return to school or work or to meet travel requirements. Providers must continue to refer to their applicable fee schedule and Medicaid regulations for the procedure codes that are reimbursed and the applicable rates. Current reimbursement methodologies continue to apply for each specific provider category.

37. [PB 2020-48](#) – **REVISED** CMAP COVID-19 Response – Bulletin 32: Services Covered under the Optional Medicaid Coverage Group “COVID-19 Testing Group” for Uninsured Connecticut Residents states that emergency department (ED) services would be covered under Tier level CPT codes 99281-99285. Should services also be covered if the location is at a Type B ED where the Tier level CPT code is G0380-G0384?

Response: Yes, retroactive to dates of service March 18, 2020, DSS has added those CPT codes as covered services for the “COVID-19 Testing Group”.

38. Are Dialysis Clinics eligible for reimbursement for clinical diagnostic laboratory tests (CDLTs) that utilize high-throughput technology for the detection of SARS-CoV2 or for the diagnosis of the virus that causes COVID-19?

Response: Yes, The Department of Social Services (DSS) has added CDLTs for the detection of SARS-CoV2 or for the diagnosis of the virus that causes COVID-19 when using high-throughput technologies to the Dialysis Clinic (DC) fee schedule effective for dates of service (DOS) retroactive to 4/14/2020 and forward. For DOS 1/1/2021 and forward CDLT U0005 will also be added to the DC fee schedule and DC must follow the guidance issued in Provider Bulletin [PB 2020-102](#): CMAP COVID-19 Response – Bulletin 47: Updated Billing Guidance Regarding High-Throughput Technology Billed Under Procedure Codes U0003 and U0004.

The following procedure codes are being added to the dialysis clinic fee schedule:

Codes	Description	Rate	Effective Date
U0003	Cov-19 amp prb hgh thruput	\$100.00	4/14/2020
		\$75.00	1/1/2021
U0004	Cov-19 test non-cdc hgh thru	\$100.00	4/14/2020
		\$75.00	1/1/2021
U0005*	Infec agen detec ampli probe	\$25.00	1/1/2021

39. How should outpatient hospitals bill for nutritional counseling services when rendered via telemedicine (audio-visual telecommunication)?

Response: Outpatient hospitals may bill for nutritional counseling services when rendered via telemedicine under procedure code G0463 – “clinic visit”. It should be noted that procedure code G0463 is approved for telemedicine for nutritional counseling services only and that nutritional counseling can only be billed via audio-visual telecommunication and cannot be billed via audio-only).

Provider Bulletins:

[PB 2020-10](#) - CMAP COVID-19 Response – Bulletin 1: Emergency Temporary Telemedicine Coverage
[PB 2020-12](#) – CMAP COVID-19 Response – Bulletin 2: Laboratory Testing Coverage
[PB 2020-13](#) – CMAP COVID-19 Response – Bulletin 3: Emergency Pharmacy Program Changes
[PB 2020-14](#) – CMAP COVID-19 Response – Bulletin 4: Expanded Telemedicine and New Audio-Only (Telephonic) Services
[PB 2020-15](#) – CMAP COVID-19 Response – Bulletin 5: Elimination of Copayments for Services Rendered to HUSKY B Members
[PB 2020-17](#) – CMAP COVID 19 Response – Bulletin 6: Emergency Remote Early Intervention Services
[PB 2020-19](#) – CMAP COVID-19 Response – Bulletin 7: Enhanced Care Clinic (ECC) Access Requirements
[PB 2020-21](#) – CMAP COVID-19 Response - Bulletin 14: Emergency Temporary Telehealth Coverage for Specified Dental Services
[PB 2020-23](#) – CMAP COVID-19 Response – Bulletin 8: Emergency Temporary Telemedicine Coverage for Physical Therapy, Occupational Therapy & Speech Therapy Services
[PB 2020-24](#) – CMAP COVID-19 Response – Bulletin 9: Emergency Temporary Telemedicine Coverage for Specified Therapy Services Rendered at Rehabilitation Clinics
[PB 2020-25](#) – CMAP COVID-19 Response – Bulletin 10: Expanded Use of Synchronized Telemedicine for Specified Behavioral Health Group Therapy Services and Autism Spectrum Disorder Services
[PB 2020-26](#) – CMAP COVID-19 Response – Bulletin 11: Emergency School Based Child Health (SBCH) Program Changes
[PB 2020-27](#) – CMAP COVID-19 Response – Bulletin 12: Waiver of Certain Requirements and Temporary Procedural Changes for Home and Community-Based Waiver Programs
[PB 2020-28](#) - CMAP COVID-19 Response - Bulletin 13: Emergency Temporary Telemedicine Coverage/Telephonic Coverage for Specified Home Health Services and Hospice Services
[PB 2020-18](#) – CMAP COVID-19 Response – Bulletin 15: Emergency MEDS Program Changes
[PB 2020-29](#) – CMAP COVID-19 Response – Bulletin 16: Emergency Durable Medical Equipment Changes Pertaining to Customized Wheelchairs
[PB 2020-30](#) – CMAP COVID-19 Response – Bulletin 17: Temporary Changes to Claim Submission for Coagulation Factor Drugs
[PB 2020-32](#) – CMAP COVID-19 Response – Bulletin 18: Temporary Changes to Signature Requirement for Prescription Medications
[PB 2020-31](#) - CMAP COVID-19 Response - Bulletin 19: Emergency ICF-IID Leave Day Changes
[PB 2020-35](#) – CMAP COVID-19 Response – Bulletin 20: TU Modifier – Overtime
[PB 2020-34](#) – CMAP COVID-19 Response – Bulletin 21: Select Added Services to the Emergency Temporary Telemedicine Coverage/Telephonic Coverage for Specified Home Health Services
[PB 2020-36](#) – CMAP COVID-19 Response – Bulletin 22: Meals on Wheels Changes
[PB 2020-33](#) – CMAP COVID-19 Response – Bulletin 23: Changes to the Prior Authorization Requirements for Specified Services
[PB 2020-37](#) – CMAP COVID-19 Response – Bulletin 24: Addition of Laboratory Procedure Codes to the Independent Laboratory Fee Schedule
[PB 2020-39](#) – CMAP COVID-19 Response – Bulletin 25: Non-Emergency Medical Transportation and Non-Emergency Ambulance Transportation
[PB 2020-38](#) – CMAP COVID-19 Response – Bulletin 26: Additional Changes to the Synchronized Telemedicine Program
[PB 2020-40](#) – CMAP COVID-19 Response – Bulletin 34 – Enrollment of CMAP Out-of-State Providers

[PB 2020-42](#) – CMAP COVID-19 Response – Bulletin 27: New COVID-19 Coverage Group for Uninsured Residents

[PB 2020-43](#) – CMAP COVID-19 Response – Bulletin 28: Emergency Medicaid for Non-Citizens

[PB 2020-45](#) – CMAP COVID-19 Response – Bulletin 29: Updated Guidance Regarding Audio-Only Telephone Services and Guidance Regarding the Use of Synchronized Telemedicine Services for Supervision of Resident Services

[PB 2020-44](#) – CMAP COVID-19 Response – Bulletin 30: Updated Audio-Only Behavioral Health (Telephonic) Services - NEW Billing Guidance

[PB 2020-47](#) – CMAP COVID-19 Response – Bulletin 31: Updated Synchronized Telemedicine (Audio and Video) Services – for Autism Spectrum Disorder Providers

[PB 2020-48](#) – **REVISED** CMAP COVID-19 Response – Bulletin 32: Services Covered under the Optional Medicaid Coverage Group “COVID-19 Testing Group” for Uninsured Connecticut Residents

[PB 2020-49](#) – CMAP COVID-19 Response – Bulletin 33: Addition of Laboratory Procedure Codes to Various Fee Schedules and Updating the Effective Date of Procedure Code U0001 and U002 Previously Added to the Consolidated Laboratory Fee Schedule

[PB 2020-40](#) – CMAP COVID-19 Response – Bulletin 34: Enrollment of CMAP Out-of-State Providers

[PB 2020-46](#) – CMAP COVID-19 Response – Bulletin 35: Emergency Updated Telemedicine Guidance Pertaining to Customized Wheelchairs

[PB 2020-50](#) – CMAP COVID-19 Response – Bulletin 36: Wheelchair Assessments Rendered Via Synchronized Telemedicine by Physical and Occupational Therapists

[PB 2020-53](#) – CMAP COVID-19 Response – Bulletin 37: Reauthorizations of Home Health Services During the Temporary Effective Period as a Result of the COVID-19 Public Health Emergency

[PB 2020-54](#) – CMAP COVID-19 Response – Bulletin 38: Increase in Inpatient Hospital Reimbursement for COVID-19 Claims Paid under the All Patient Refined-Diagnosis Related Group (DRG)

[PB 2020-60](#) – CMAP COVID-19 Response – Bulletin 39: Modification of Minimum Weekly Hour and Time Study Requirements for Adult Mental Health Private Non-Medical Institutions (PNMIs)

[PB 2020-66](#) – CMAP COVID-19 Response – Bulletin 40: Temporary Rate Increase for Non-Sterile Gloves

[PB 2020-68](#) – CMAP COVID-19 Response – Bulletin 41: Temporary Flexibility of Face-to-Face Requirements for Home Health Evaluations/Assessments

[PB 2020-84](#) – CMAP COVID-19 Response - Bulletin 42: Clarifying Guidance for Speech and Language Pathology Telemedicine Services Stated in PB 2020-23 and 2020-24

[PB 2020-80](#) – CMAP COVID-19 Response – Bulletin 45: Emergency SBCH Program Changes

[PB 2020-85](#) – CMAP COVID-19 Response – Bulletin 43: Updates to the Temporary Telemedicine Coverage for Therapy Services Billed by Home Health Agencies/Access Agencies

[PB 2020-87](#) – CMAP COVID-19 Response – Bulletin 44: Updated Telemedicine Guidance for Physical Therapy and Occupational Therapy Services

[PB 2020-90](#) – CMAP COVID-19 Response - Bulletin 46: Clarifying Guidance for Expanded Use of Synchronized Telemedicine for Specified Behavioral Health Services Stated in PB 2020-14 and 2020-44

[PB 2020-102](#) – CMAP COVID-19 Response – Bulletin 47: Updated Billing Guidance Regarding High-Throughput Technology Billed Under Procedure Codes U0003 and U0004

[PB 2021-05](#) – CMAP COVID-19 Response - Bulletin 48: COVID-19 Vaccine Administration - Medical Practitioners

[PB 2021-06](#) – CMAP COVID-19 Response - Bulletin 49: COVID-19 Vaccine Administration – Provided by Pharmacists, Pharmacy Interns and Pharmacy Technicians

[PB 2021-12](#) – CMAP COVID-19 Response – Bulletin 50: Telemedicine Guidance for Respiratory Care Services

[PB 2021-19](#) - Reinstating Standard Requirements - Medical Equipment, Devices and Supplies (MEDS) Signed Delivery Receipts Requirement and Prior Authorization Extensions

[PB 2021-21](#) – RESCINDED Intermediate Care Facilities for Individuals with Intellectual Disabilities Leave Day Changes

[PB 2021-23](#) - CMAP COVID-19 Response Bulletin 51: Updated Guidance - COVID-19 Vaccine Administration - Medical Practitioners

[PB 2021-24](#) - CMAP COVID-19 Response Bulletin 53: Reinstating Pharmacy Requirements – Quantity Limits and Days' Supply, and Refill Criteria

[PB 2021-25](#) - CMAP COVID-19 Response - Bulletin 52: UPDATED GUIDANCE COVID-19 Vaccine Administration – Provided by Pharmacists, Pharmacy Interns and Pharmacy Technicians

[PB 2021-26](#) – REVISED Reinstating Prior Authorization Requirements that were Suspended During the Public Health Emergency

[PB 2021-29](#) – Intermediate Care Facilities for Individuals with Intellectual Disabilities Leave Day Changes (REVISED)

[PB 2021-30](#) – Reinstating Standard Requirements for Minimum Service Hours and Time Study Requirements for Adult Mental Health Private Non-Medical Institutions (PNMIs)

[PB 2021-32](#) - Reinstatement of Copayments for Medical Services Rendered to HUSKY B Members

[PB 2021-33](#) - Reinstating Standard Requirements for Medical Equipment, Devices and Supplies (MEDS): Prescriptions for Repairs of Durable Medical Equipment (DME), Completion/Filing Deadline for Customized Wheelchairs and 30-Day Supplies

[PB 2021-34](#) - CMAP COVID-19 Response – Bulletin 54: ADDITIONAL Services Covered under the “COVID-19 Testing Group”

[PB 2021-63](#) – CMAP COVID-19 Response – Bulletin 55: ADDITIONAL DOSE COVID-19 Vaccine Administration for Individuals who are Immunocompromised

[PB 2021-89](#) – CMAP COVID-19 Response Bulletin 56: Booster Doses COVID-19 Vaccine Administration

[PB 2021-91](#) – CMAP COVID-19 Response Bulletin 57: Authorization of Pfizer-BioNTech COVID-19 Vaccine for Pediatric Administration (ages 5-11 years)

[PB 2022-12](#) – CMAP COVID-19 Response Bulletin 58: COVID-19 Vaccine Counseling-Only for Pediatric Members

[PB 2022-15](#) - CMAP COVID-19 Response - Bulletin 59: Coverage of At Home COVID-19 Over-the-Counter (OTC) Test Kits

[PB 2022-19](#) - Reinstatement of Multi-Loading for NEMT Transportation

[PB 2022-24](#) - CMAP COVID-19 Response Bulletin 60: Administration of the Pfizer-BioNTech COVID-19 Pre-Diluted Vaccine

[PB 2022-60](#) - CMAP COVID-19 Response Bulletin 61: COVID-19 Vaccine Administration: Additional Adult and Pediatric Booster Codes and Vaccinations for Members 6 Months to Four Years of Age

[PB 2023-11](#) - Reinstating Enhanced Care Clinic (ECC) Access Requirements that were Temporarily Suspended during the Federal COVID-19 Public Health Emergency

[PB 2023-17](#) - Coverage of At Home COVID-19 Over the Counter (OTC) Test Kits

[PB 2023-20](#) - COVID-19 Laboratory Testing Coverage

[PB 2023-22](#) - Updated Billing Guidance Regarding COVID-19 High-Throughput Technology Billed Under Procedure Codes U0003, U0004 and U0005

[PB 2023-30](#) - COVID-19 Vaccine Administration Guidance

[PB 2023-31](#) - Sunsetting Provider Bulletins Issued in Response to the COVID-19 Public Health Emergency – UPDATED

[PB 2023-32](#) - Discontinuation of the Optional COVID-19 Testing Group - Effective May 12, 2023

[PB 2023-35](#) - Sunsetting Home and Community Based Waiver Program Provider Bulletins Issued in Response to the COVID-19 Public Health Emergency

Important Messages:

[Attention Autism Waiver Service Providers: COVID-19 Response Bulletin 12 \(Posted 3/30/20\)](#)
[Attention All Providers: Clarification of Provider Bulletin 2020-44 \(Posted 5/18/20\)](#)
[Attention Primary Care Providers: Upcoming Provider Training Supporting Primary Care Clinicians to Address COVID-19 Behavioral Health Issues \(Posted 6/2/20\)](#)
[Attention All Providers: Diagnosis Code Requirement for COVID-19 Testing Group Claims \(Posted 6/26/20\)](#)
[Attention Providers: Pre-Registration for Providers Interested in Receiving and Administering COVID-19 Vaccines \(Posted 9/21/20\)](#)
[Attention All Providers: Telemedicine: Update to Place of Service Requirements \(Posted 12/23/20\)](#)
[Attention Providers: HHS Announces Provider Relief Fund Reporting Update \(Posted 1/22/21\)](#)
[Attention Providers: Janssen COVID-19 Vaccine Notification \(Posted 3/3/21\)](#)
[Attention Providers: Reinstatement of Prior Authorization Requirements \(Posted 3/26/21\)](#)
[Attention: Medical Equipment, Devices and Supplies \(MEDS\) Providers: Reinstating Standard Medical Equipment, Devices and Supplies \(MEDS\) Requirements: Signed Delivery Receipts and Prior Authorization Extensions \(Posted 3/30/21\)](#)
[Attention Dentists, Dental Hygienists and Dental FQHCs: Eligible Dental Providers who can Administer the COVID-19 Vaccinations \(Posted 4/29/21\)](#)
[Attention All Providers: CMAP COVID-19 Telehealth \(audio-visual and telephone-only\) Policies \(Posted 5/18/21\)](#)
[Attention Pharmacy Providers: COVID-19 Vaccine Claim ID & Reprocess for HUSKY B Beneficiaries \(Posted 5/27/21\)](#)
[Attention All Providers: Reminder: Prior Authorization \(PA\) Requirements Reinstated: PB 2021-26: REVISED Reinstating PA Requirements that were Suspended During the PHE \(Posted 6/14/21\)](#)
[Attention: Dentists, Dental Hygienists and Dental FQHCs: Termination of Commissioner of Public Health's Order Allowing Dental Hygienists to Administer COVID-19 Vaccinations \(Posted 4/27/22\)](#)

COVID-19 Response Gainwell Technologies Alternate Call Center and Provider Enrollment Contact Information:

Provider Assistance Center:

If providers are experiencing extended call wait times, providers may email the provider assistance call center with their question at ctdssmap-provideremail@gainwelltechnologies.com. Please be sure to include your name and phone number with your inquiry.

Please note, The provider assistance center does not verify client eligibility for current dates of service. Providers need to log into their secure web portal account at www.ctdssmap.com in order to verify a client's eligibility. Providers are reminded that the self-service functions including Client eligibility, Web Claim Submission, Claims Status Inquiry, Paid Claim Adjustments, Pharmacy Prior Authorization Request

Submissions and Prior Authorization status requests are available to providers through their secure Web portal account.

Client Assistance Center

If clients are experiencing extended call wait times, clients may email the client assistance call center with their question at webmaster-ctmedprog@gainwelltechnologies.com. Please be sure to include your name and phone number with your inquiry.

Clients inquiring about a claim denial due to third party liability on their client record that is outdated should contact Health Management Systems at 1-866-277-4271.

Clients inquiring about a claim denial due to the client not being eligible, will need to contact the DSS Client Information Line and Benefits Center at 1-855-626-6632 (TTD/TTY 1-800-842-4524).

Clients requesting a replacement ID card will need to call Husky Health at 1-800-859-9889 or visit the www.ctgov/husky Web site.

Pharmacy Prior Authorization Assistance Center

Providers with access to the secure web portal can submit pharmacy prior authorization requests electronically as well as check prior authorization status. Please refer to provider bulletin (2019-70) titled Pharmacy Web Prior Authorization for further instructions on how to submit pharmacy prior authorizations via the secure web portal. As a reminder, please access www.ctdssmap.com and click on pharmacy for information including the preferred drug listing and prior authorization forms.

Provider Enrollment

Providers with questions related to a provider enrollment matter are encouraged to email their question to the provider enrollment email box at ctproviderenrollment@gainwelltechnologies.com, or providers may fax their question to 1-877-899-5401.

Providers who are submitting follow on documents to Gainwell Technologies for current enrollment or re-enrollment ATNs may fax the documents to 1-877-899-5401 or email them to ctproviderenrollment@gainwelltechnologies.com. Please be sure to include your ATN on each document page.

Claims/Financial Team

Providers who wish to submit Hysterectomy Consent Forms, Sterilization Consent Forms or Electronic Claim Attachments may fax the documents to 1-860-986-7995 or email them to ctxix-claimattachments@gainwelltechnologies.com.

Connecticut Department of Social Services
Responses to FAQs About CMAP's Response to COVID-19 (Coronavirus)
Updated June 30, 2023

Providers who wish to submit Trauma Questionnaire Responses may fax them to 1-833-577-3519 or email them to CTXIX-TraumaMailbox@gainwelltechnologies.com.