Connecticut Medical Assistance Program
Policy Transmittal 2020-12

Provider Bulletin 2020-14
March 2020

Deidre S. Gifford, MD, MPH, Commissioner

Effective Date: March 18, 2020
Contact: See below

TO: **All Providers**

RE: **CMAP COVID-19 Response – Bulletin 4: Expanded Telemedicine and New Audio-Only (Telephonic) Services**

In response to the declaration of a public health emergency as the result of COVID-19 (coronavirus) in Connecticut, DSS is taking several temporary steps to address the needs of our shared members as well as the provider community in order to facilitate prompt testing for the virus when medically necessary, help reduce unnecessary exposure to health care workers and the general public, and generally help address and contain the spreading of the virus.

The following measures are being implemented under various authorities permitted to states during a public health emergency. The following policies are in effect until the state has deemed that COVID-19 is no longer a public health emergency or the Department otherwise determines that some or all of these specific measures are no longer needed, as communicated in writing through subsequent provider communications disseminated by DSS.

EXPANSION OF TELEMEDICINE PROVISIONS

DSS issued guidance under PB 2020-09 and PB 2020-10 regarding coverage of telemedicine under CMAP. In order to address public health concerns and limit the probability of the transmission of COVID-19, DSS is temporarily further expanding the CMAP coverage of telemedicine in multiple ways outlined below. Please continue to use and refer to PB 2020-09 and PB 2020-10 for all telemedicine requirements that are not superseded by the provisions below.

Effective for dates of service March 18, 2020 and forward, the following services may be provided via telemedicine by providers that are currently authorized to perform these services in accordance with all existing CMAP and other federal and state requirements. All of these services will be paid at the same rate as the equivalent in-person services when rendered as a telemedicine service:

- All of the following children's behavioral health (BH) rehabilitation services:
  - Home-based models (codes H2019 & T1017 and modifiers for Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS));
  - Emergency Mobile Psychiatric Services (EMPS) (codes S9484 & S9485); and
  - Extended Day Treatment (EDT), non-group services (code H2012)
- Autism spectrum disorder treatment services (97153 & H2014)
- Targeted case management (T1017)
- Case management (T1016)
- Family therapy without the patient (90846)

Also effective for dates of service March 18, 2020 and forward, to the extent permitted by other applicable federal and state requirements, Opioid Treatment Programs (OTPs) can fulfill the face-to-face requirement with a physician, Advanced

Practice Registered Nurse (APRN) or Physician Assistant (PA) seeing the individual via telemedicine as part of the induction services, as long as there is a Registered Nurse in the same location as the individual when the telemedicine service is initiated and the qualified healthcare professional and the physician, APRN or PA are employed by the same OTP.

AUDIO-ONLY TELEPHONE SERVICES

In response to concerns over the spread of COVID-19 from both the member and provider communities, effective for dates of service **March 18, 2020** and until otherwise notified by DSS in writing, select evaluation and management services and identified behavioral health services for established patients rendered via the telephone or other audio only modalities will be covered by CMAP under the circumstances described below. A member does not need the diagnosis or symptoms of COVID-19 to access these services via the telephone. To the extent applicable, providers must comply with applicable state laws regarding telehealth and scope of practice.

Select Evaluation and Management (E&M) Services Rendered to Established Patients via the Telephone:

The following Current Procedural Terminology (CPT) codes should be used to bill for otherwise coverable E&M services rendered to established patients via the telephone. The initial induction of medication for the purposes of Medication Assisted Treatment (MAT) may not be done via audio-only telephone.

Code	Description	Rate
99442	Physician telephone patient service, 11-20 minutes of medical discussion	Physician Office: $42.93 Medical Clinic: $52.15 Family Planning Clinic: $52.15 BH Clinic/ Outpatient Hospital: $74.72 Enhanced Care Clinic (ECC) BH Clinic/ ECC Outpatient Hospital: $78.65
99443	Physician telephone patient service, 21-30 minutes of medical discussion	Physician Office: $64.99 Medical Clinic: $78.94 Family Planning Clinic: $78.94 BH Clinic/ Outpatient Hospital: $110.02 ECC BH Clinic/ ECC Outpatient Hospital: $115.81

Please note, consistent with CPT guidance and the National Correct Coding Initiative, providers may only bill one unit of service per day per member for one of the codes identified above. The code selection should represent the total length of time spent performing the medically necessary service for the member.

The codes listed above are not eligible for increased reimbursement under the HUSKY Health Increased Payments for Primary Care policy or under Person-Centered Medical Homes (PCMH). The current reimbursement methodology for APRNs, certified nurse midwives (CNMs) and PAs remain in effect for the codes listed above.

Providers Eligible to Bill Select E&M Services via the Telephone:

These services may only be billed by the following categories of CMAP enrolled providers: physicians, APRNs, PAs, CNMs, free-standing medical clinics (not school-based health centers), behavioral health clinics (including enhanced care clinics), outpatient hospital behavioral health clinics, public and private psychiatric outpatient hospital clinics, federally qualified health centers (FQHCs), and family planning clinics.

FQHCs are reminded that payment is limited to one medical encounter rate per member per date of service.

Behavioral Health Services Rendered to Established Patients via the Telephone:

The following CPT codes should be used to bill for behavioral health services rendered to established patients via the telephone.

Code	Description	Rate
98967	Telephone assessment and management service, 11-20 minutes of medical discussion *(to be used for BH services outlined above rendered via telephone)*	BH Clinician: $43.06 BH Clinic/ Hospital: $50.95 Medical Clinic: $41.15 Psychologist: $52.28 Rehab Clinic: $50.95 Physician Office: $61.51 ECC: $67.67
98968	Telephone assessment and management service, 21-30 minutes of medical discussion (*to be used for BH services outlined above rendered via telephone)*	BH Clinician: $46.56 BH Clinic/ Hospital: $55.95 Medical Clinic: $46.15 Psychologist: $56.53 Rehab clinic: $55.95 Physician office: $66.51 ECC BH Clinic/ECC Outpatient Hospital: $72.67

All otherwise coverable behavioral health services referenced in PB 2020-09 and 2020-10 and the additional behavioral health services referenced above in the telemedicine section may be done via telephone (audio only) for established patients only under this policy using the CPT codes listed above to indicate that the service was done via the telephone.

When submitting claims for the CPT codes identified for use when billing behavioral health services please note the following:

- CPT codes 98967 and 98968 may be billed together on the same date of service for the same member by the same provider, but only if the duration of the telephone call **exceeds** 41 minutes;
- only one unit of service may be billed for each code; and
- independent licensed behavioral health practitioners must continue to use the applicable billing modifier on their claims (AJ or HO);
- independent behavioral health practitioners are not required to be in an office when rendering services to members via telemedicine or telephone; and
- the current reimbursement methodology using the AJ or HO modifiers for BH Clinicians remains in effect for the codes listed above.

Providers Eligible to Bill BH Services via the Telephone:

These services may only be billed by the following categories of CMAP enrolled providers: independent licensed behavioral health clinicians (licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), and licensed alcohol and drug counselors (LADCs)), behavioral health clinics (including enhanced care clinics), outpatient hospital behavioral health clinics, public and private psychiatric outpatient hospital clinics, free-standing medical clinics (not school-based health centers), rehabilitation clinics, behavioral health FQHCs, physicians, advanced practice registered nurses, and physician assistants.

FQHCs are reminded that payment is limited to one behavioral health encounter rate per member per date of service.

For both the E&M and behavioral health services rendered to established patients via the telephone: providers shall only bill for services that, but for the emergency, would be covered if the service was rendered in person. At a minimum, providers must adhere to the following:

- a service that is otherwise covered and currently reimbursable under Medicaid if provided in-person must be provided in order to bill for services delivered by audio-only telephone;
- providers are required to follow the applicable CPT guidance when billing for the service;
- providers must obtain verbal informed consent from the member before providing services via the telephone and document such consent in the medical record. The provider must ensure each member is aware they can opt-out or refuse services at any time;
    - If the member is a minor child, a parent or legal guardian must provide verbal informed consent before providing services via the telephone;
- providers must develop and implement procedures to verify provider and patient identity;
- providers must adhere to all coding requirements, federal and state regulations that govern provision of the service billed;
- providers must document completely for the service billed, including a notation that the service was rendered via the telephone and follow current documentation requirements for the type of service being billed;
- telephone communication previously not reimbursable under Medicaid including, but not limited to, routine follow-up for laboratory and other results, provider to provider discussions and/or communication, scheduling visits or other administrative communication between the provider and member are not reimbursable under this policy; and

- if a service cannot be provided or completed for any reason, such as due to technical difficulty, providers shall not submit a claim.

LOCATION OF PRACTITIONER

For CMAP purposes, except as otherwise specifically stated in any of the various bulletins regarding telemedicine, including this bulletin, prior bulletins, and future bulletins that may be issued, there is no restriction on the location of the provider while providing covered CMAP telehealth services, so long as the provider complies with all applicable requirements. To the extent that any DSS regulation would otherwise impose a specific location requirement, in accordance with DSS' authority to implement specified telemedicine services under section 17b-245e of the 2020 supplement to the Connecticut General Statutes, that requirement does not apply with respect to CMAP-covered telemedicine services. Providers are encouraged to research applicable licensing and scope of requirements that may apply.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):

In a notice issued on March 17, 2020 (posted at this link: https:// https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html), the U.S. Department of Health and Human Services, Office of Civil Rights (OCR) posted updated guidance on the enforcement discretion for telehealth remote communications during the COVID-19 public health emergency. Providers should consult with this communication and future communications from OCR regarding their obligations under HIPAA.

Providers must continue to ensure that they comply with all applicable federal requirements and guidance. While the COVID-19 national public health emergency may result in exceptions issued by OCR, the Department still recommends that, whenever possible, providers should fully comply with all details of HIPAA privacy and security rule provisions as written in order to best safeguard the privacy and security of protected health information. For more information: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html and any other federal guidance that may be issued in the future.

Billing Questions

For questions about billing or if further assistance is needed to access the fee schedules on the Connecticut Medical Assistance Program Web site, please contact the Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p.m. at 1-800-842-8440.

Posting Instructions:

Policy transmittals can be downloaded from the Web site at www.ctdssmap.com.

Distribution:

This policy transmittal is being distributed to providers of the Connecticut Medical Assistance Program by DXC Technology.

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