Connecticut Medical Assistance Program Provider Bulletin 2020-33
Policy Transmittal 2020-28 April 2020

Deidre S Gifford, MD, MPH, Commissioner

Effective Date: April 1, 2020
Contact: See Below

TO: All Providers

RE: CMAP COVID-19 Response – Bulletin 23: Changes to the Prior Authorization Requirements for Specified Services

As an interim measure in response to the Governor's recent declaration of a public health emergency as the result of the outbreak of COVID-19 (coronavirus), the Department of Social Services (DSS) is temporarily changing the prior authorization (PA) requirements for specified services effective for dates of service April 1, 2020 until DSS has notified providers in writing that the state has deemed COVID-19 to no longer to be a public health emergency (the "Temporary Effective Period").

Note: Please carefully review the entirety of this bulletin along with all other provider bulletins and documents (i.e. FAQs) found on the Connecticut Medical Assistance Program (CMAP) Web site, www.ctdssmap.com.

Inpatient Hospital Admissions:

During the Temporary Effective Period, all in-state and border hospital admissions will not require PA. This applies to all inpatient general acute care hospitals, children's hospitals, chronic disease hospitals and freestanding psychiatric hospitals. Please note that Out-of-State inpatient hospital admissions continue to require prior authorization from the applicable administrative service organization.

Hospitals reimbursed via the All Patient Refined-Diagnostic Related Groups (APR-DRGs) will continue to receive the assigned DRG payment for all medical inpatient admissions. During the Temporary Effective Period, when a member is admitted medically and requires further behavioral health or rehabilitation care, the separate per diem PA will no longer be required in order for the hospital to receive the inpatient per diem rate.

When a member is admitted medically and requires further inpatient behavioral health care, hospitals must continue to administratively discharge the member from inpatient medical status and readmit the member to the appropriate behavioral health status. During the Temporary Effective Period, DSS will identify a process for hospitals in order to apply the behavioral health per diem rate for inpatient behavioral health admissions. DSS will issue a separate provider bulletin with claims submission instructions.

When a member is admitted medically and requires further rehabilitation care, the hospital must continue to administratively discharge the patient from medical status and re-admit into the appropriate rehabilitation status. DSS will work directly with the hospitals to identify a process in order to ensure the appropriate reimbursement for the days that the patient is designated under rehabilitation. DSS will issue a separate provider bulletin with claims submission instructions.

Please Note: All inpatient behavioral health and rehabilitation services continue to remain an all-inclusive payment to the hospital;

therefore, professional services cannot be billed separately. Any inpatient admission that is either 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.

Any 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.

- Any BH or Rehab inpatient admissions and inpatient chronic disease hospital admissions approved prior to 4/1/2020 must continue to have the authorization updated through Beacon Health Options for behavioral health services or Community Health Network of CT (CHNCT) for rehabilitation services.. Please note that for chronic disease admissions that were authorized prior to 4/1/2020 and the PA needs to be updated for continued stay, CHNCT will update the PA and send the provider a new authorization letter.

Inpatient Hospice Services:

During the Temporary Effective Period, general inpatient hospice days beyond the fifth day will not require PA. Providers must continue to provide general inpatient hospice level of care as described under Sec. 17b-262-838(d)(3) of the Regulations of Connecticut State Agencies.

Outpatient Behavioral Health Services:

During the Temporary Effective Period, PA and registration requirements will be waived for the following outpatient behavioral health services:

Behavioral Health Service	Procedure Code(s)
Psychiatric Diagnostic Evaluation	90791-90792, 90785
Electroconvulsive Therapy	90870
Intensive Outpatient Program (IOP) - MH	S9480
Intensive Outpatient Program (IOP) - SA	H0015
Partial Hospitalization Program (PHP)	H0035
Extended Day Treatment (EDT)	H2012
Individual Therapy	90832 - 90838
Group Therapy	90853
Family Therapy	90846, 90847, 90849
Other BH (Medication Management)	99201 - 99205, 99211 - 99215
Other Behavioral Health Services (Targeted Case Management and Home Based Services)	H2019 and T1017
Psychological & Neurological Testing	96116, 96121, 96130-96133, 96136-96137 – Psychological Testing 96136 TF and 96137 TF – Neuropsychological Testing Only
Methadone Maintenance	H0020
Case Management	T1016
Adult Day Treatment	H2013
MRO Group Homes	2074Y

Eligible Providers:

PA and registration requirements for the above services are being waived for the following providers:

- Physicians
- Advanced Practice Registered Nurses (APRN)
- Physician Assistants
- Outpatient Hospitals
- Outpatient Chronic Disease Hospitals (CDH)
- Freestanding Psychiatric Hospitals

- Opioid Treatment Programs (Methadone Maintenance Clinics)
- Freestanding Behavioral Health Clinics
- Federally Qualified Health Centers
- Independent Behavioral Health Clinicians (Licensed Clinical Social Workers (LCSWs), Licensed Alcohol & Drug Counselors (LADCs), Licensed Marital and Family Therapists (LMFTs), Licensed Professional Counselors (LPC), Psychologist)

Please Note: Behavioral health services rendered by a physician assistant must be billed under the physician/physician group provider ID. The physician assistant must be listed as the rendering provider on claims.

Advanced Radiology and Imaging Services:

During the Temporary Effective Period, PA will be waived for advanced radiology/imaging services for the following providers and services:

- Physicians
- APRNs
- Physician Assistants
- Independent Radiology
- Outpatient Hospitals

70336	70546	72128	72195	73719	74263	77084
70450	70547	72129	72196	73720	74712	78608
70460	70548	72130	72197	73721	74713	78609
70470	70549	72131	72198	73722	75557	78811
70480	70551	72132	73200	73723	75559	78812
70481	70552	72133	73201	73725	75561	78813
70482	70553	72141	73202	74150	75563	78814
70486	70554	72142	73206	74160	75565	78815
70487	70555	72146	73218	74170	75571	78816
70488	71250	72147	73219	74174	75572	G0297
70490	71260	72148	73220	74175	75573	
70491	71270	72149	73221	74176	75574	
70492	71275	72156	73222	74177	75635	
70496	71550	72157	73223	74178	76380	
70498	71551	72158	73225	74181	76390	
70540	71552	72159	73700	74182	77046	
70542	71555	72191	73701	74183	77047	
70543	72125	72192	73702	74185	77048	
70544	72126	72193	73706	74261	77049	
70545	72127	72194	73718	74262	77078	

PA is being waived for both the global and technical components of advanced radiology/imaging services.

Home Health Services:

During the Temporary Effective Period, the following PA changes will be made for home health services:

- Authorizations that are set to end in the months of April 2020 and May 2020 will be identified by Community Health Network of CT and Beacon Health Options and automatically extended for 90 days from the date the current authorization is set to end. Providers do not need to request this extension; instead CHNCT and Beacon will send a new authorization letter outlining the new end date and units authorized.
- The PA thresholds for the following home health services will be increased to minimize the need for home health agencies to request PA:
  - Nursing Services – PA will be required for skilled nursing in excess of the initial evaluation and **five (5)** visits per week
  - Pregnancy-related preventive prenatal nursing care services in excess of **five (5)** visits during the prenatal period
  - Pregnancy-related preventive postpartum nursing care services in excess of **five (5)** visits during the postpartum period

- Physical therapy services in excess of the initial evaluation and **four (4) visits** per week
- Speech therapy services in excess of the initial evaluation and **four (4) visits** per week
- Occupational therapy in excess of the initial evaluation and **two (2)** visits per week

Please note that there are **no** changes to the PA requirements for the following categories of service and home health providers must continue to request PA as designated by the applicable provision of the home health regulation:

- Extended nursing services – Sec. 17b-262-732(2)
- home health aide services - Sec. 17b-262-732(5)
- PT, OT, or SLP greater than nine visits per calendar year per provider per member for specified diagnoses – Sec. 17b-262-732(b)(9)
- Early and Periodic Screening, Diagnostic and Treatment services – Sec. 17b-262-732(10)

Dental Services:

During the Temporary Effective Period, PA will be waived for the following dental procedures:

- D3310 Endodontic therapy, anterior tooth (excluding final restoration)
- D3320 Endodontic therapy, bicuspid tooth (excluding final restoration)
- D3330 Endodontic therapy, molar (excluding final restoration)

Medical Equipment, Devices and Supplies:

For information related to temporary changes for specific Medical Equipment, Devices and Supplies, please refer to PB 2020-18 CMAP COVID-19 Response – Bulletin 15: Emergency MEDS Program Changes and PB 20-29 CMAP COVID-19 Response – Bulletin 16: Emergency Durable Medical Equipment Changes Pertaining to Customized Wheelchairs.

Prior Authorization:

If the PA requirement for a specific service is not identified as changed in this provider bulletin or a subsequent provider bulletin, the current authorization requirements remain in effect and providers are expected to continue to follow those requirements in order to be eligible for reimbursement. For services for which PA has not been waived or changed, providers must continue to submit PA requests to the appropriate administrative service organization:

Medical Authorizations

Community Health Network of CT (CHNCT) at 1-800-440-5071, between the hours of 8:00 a.m. to 6:00 p.m.

Behavioral Health Authorizations

Beacon Health Options at 1-877-552-8247

Dental Authorizations

BeneCare Provider Relations at 1-888-445-6665

Non-Emergency Medical Transportation Authorizations

Veyo at 1-855-478-7350

For questions about billing or if further assistance is needed to access the fee schedules on the Connecticut Medical Assistance Program (CMAP) 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.

Responsible Unit:
DSS, Division of Health Services:

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