Connecticut Medical Assistance Program Provider Bulletin 2023-38
Policy Transmittal 2023-23 May 2023

Andrea Barton Reeves, J.D, Commissioner Effective Date: May 12, 2023
Contact: See below

TO: All Providers

RE: REVISED Guidance for Services Rendered via Telehealth

Effective for dates of service on and after **May 12, 2023,** which is the first day after the federal COVID-19 public health emergency declaration ends, in accordance with sections 17b-245e and 17b-245g of the Connecticut General Statutes, the Department of Social Services (DSS) is issuing new guidance for services eligible for reimbursement under the Connecticut Medical Assistance Program (CMAP) when rendered via telehealth. Provider Bulletin (PB) 2023-38 **supersedes** *PB 2023-18* "*New Guidance for Services Rendered via Telehealth under the Connecticut Medical Assistance Program (CMAP)"*, and all other telehealth guidance issued under the COVID-19 response bulletins during the Public Health Emergency (PHE) period.

Telehealth includes (1) telemedicine (synchronized audio-visual two-way communication services) and, where specified by DSS, (2) audio-only two-way synchronized communication services delivered via telephone. This guidance applies to services rendered under CMAP for all HUSKY Health members.

Telehealth Services

Effective for dates of service **May 12, 2023** and forward, DSS will continue to reimburse for specified services when rendered via telehealth as detailed below and on the CMAP Telehealth Table.

DSS' continued expectation is that enrolled CMAP providers will perform clinically appropriate services including, but not limited to, ensuring timely access to in-person services when medically necessary or requested by the HUSKY Health member for optimum quality of care. Therefore, all enrolled billing entities must have the capacity to deliver services in-person and must provide services in-person to the full extent that is clinically appropriate for their patients and to the full extent necessary if the HUSKY Health member does not consent to receiving one or more services via telehealth. Having the capacity means that the provider must have a physical location in CT, (or an approved applicable border state as approved as part of enrollment) where the provider has a room or set of rooms to see members in-person and can maintain the member's privacy and confidentiality during the visit. See the Telehealth Frequently Asked Questions (FAQs) for more guidance.

Comprehensive information regarding the specific procedure codes eligible to be billed via telehealth is posted on the Connecticut Medical Assistance Program (CMAP) www.ctdssmap.com Web site, select the "Telehealth Information" page. This web page will provide information on telehealth requirements, approved procedure codes, required modifiers, specific policy criteria and/or limitations, effective dates, and other telehealth policy information, including the Telehealth FAQs. **CMAP will notify** providers of pertinent updates to the telehealth policy via provider bulletins and/or important messages (IM). **Providers must monitor the CMAP Web site periodically for updates.**

Notwithstanding federal or state statutes, DSS reserves the right to update and/or amend the telehealth policy going forward based on relevant research on this topic and/or based on

feedback the Departments solicits from HUSKY members and providers.

Providers are responsible for verifying coverage of a specific procedure code as a telehealth service as well as a covered service on their applicable fee schedule **prior** to delivering and billing CMAP for the service. Billing for a service via telehealth that is not listed as an approved service on the CMAP Telehealth Table or listed as a covered service on the applicable fee schedule or failure to adhere to the policy and applicable telehealth criteria/limitations, may result in a denied claim or may be at-risk for a financial adjustment during a post-payment review.

All applicable federal and state requirements for the equivalent in-person service apply to telehealth services. Therefore, consistent with all services billed to CMAP, all telehealth services must meet the statutory definition of medical necessity in section 17b-259b of the Connecticut General Statutes and all other applicable federal and state statutes, regulations, requirements, and guidance. Each provider is responsible for ensuring that the provision of a service performed via telehealth complies with all applicable requirements, including, but not limited to Department of Public Health (DPH) practitioner licensing and scope of practice requirements, DSS regulations, provider bulletins/Important Messages, Frequently Asked Questions (FAQs), billing and documentation requirements and any other applicable State or Federal statute, regulation, or any other requirement. Note that, in accordance with sections 17b-245e and 17b-245g of the Connecticut General Statutes, services detailed in this bulletin as covered via telehealth are authorized by DSS under that authority, notwithstanding any DSS regulations or policies that may otherwise have prohibited those services to be rendered via telehealth.

Specifically, section 17b-245e of the Connecticut General Statutes provides that the audiovisual telehealth services covered under CMAP pursuant to this bulletin are "(1) clinically appropriate to be provided by means of telemedicine, (2) cost-effective for the state, and (3) likely to expand access to medically necessary services where there is a clinical need for those services to be provided by telehealth or for HUSKY Health members for whom accessing appropriate in-person health care services poses an undue hardship."

Similarly, section 17b-245g of the Connecticut General Statutes provides that the audio-only telephone services covered under CMAP pursuant to this bulletin are "(1) clinically appropriate, as determined by the Commissioner, (2) it is not possible to provide comparable covered audiovisual telehealth services, and (3) provided to individuals who are unable to use or access comparable, covered audiovisual telehealth services."

Reimbursement for Services Rendered via Telehealth

Services rendered via telehealth will be reimbursed at the same rate as if the service was rendered in-person. Providers must refer to their applicable reimbursement methodology or fee schedule to ensure that the service identified as eligible to be rendered as a telehealth service is payable for their specific provider type and the reimbursement rate.

HIPAA and Privacy Related Requirements

Information and data related to telehealth services are protected health information (PHI) to the same extent as in-person services and to the full extent applicable, fall under the scope of the federal Health Insurance Portability and Accountability Act (HIPAA) and all other applicable federal and state health information privacy and security requirements.

Providers must ensure they comply with all applicable requirements, including, but not limited to, using telehealth software, protocols, and procedures that fully comply with HIPAA

and all other applicable requirements. Popular social media and telecommunications applications with video capabilities may not comply with HIPAA requirements and in those instances should not be used. Providers must ensure that they fully comply with such requirements, including researching applicable federal HIPAA requirements and, as appropriate, using only HIPAA compliant software to provide audio-visual or audio-only telephone telehealth services. Providers should check with their telehealth vendor to determine if the software is HIPAA compliant.

Providers must develop and implement procedures to verify provider and patient identity prior to provision of a telehealth service. Additionally, providers must ensure that an appropriate, secure, and private location is available for all HUSKY Health members participating in telehealth services.

Informed Consent

In a method as determined by providers, informed consent must be obtained in writing (electronic consent is acceptable) from each HUSKY Health member before providing telehealth services and annually thereafter. DSS is not requiring the use of a specific form and providers may use their own form or format for obtaining informed consent. In addition, the provider must ensure each HUSKY Health member is aware they can opt-out or refuse telehealth services at any time.

Services Rendered to Minors

If the HUSKY Health member is a minor child under age 18, a parent or legal guardian must be present for services to the same extent as it would be required for comparable in-person services unless exempted by state or federal law. In addition, informed consent for telehealth services must be obtained by the parent or legal guardian prior to the provision of such services and obtained annually thereafter.

Location of Practitioner – Providers

Independent Practitioners/Group Practitioners/Federally Qualified Health Centers/Outpatient Hospitals

Except as otherwise specifically stated in subsequent provider guidance issued by DSS, stated as part of telehealth policy criteria for a specific service as outlined on the CMAP Telehealth Table, or for coverage of out-of-state services that are not available in-state or from a border provider as required under 42 CFR §431.52, a practitioner who is enrolled with CMAP as an independent provider or as part of an independent provider group, or as a FQHC or outpatient hospital and maintains an approved service location as part of the CMAP enrollment, has the flexibility to perform eligible telehealth services even when the performing/rendering practitioner is not physically in-person at one of the enrolled CT or border service locations at the time of the service, so long as the practitioner complies with all applicable state and federal requirements. Enrolled border providers and out-of-state providers rendering services as approved in 42 CFR 431.52, are encouraged to research applicable licensing and scope of practice requirements that may apply specifically to their location at the time of the telehealth service.

In-state enrolled CMAP providers (facility/billing provider/parent company etc.) who contract with out-of-state practitioners to provide 100% telehealth services to HUSKY members must ensure that the billing provider can provide in-person services when medically necessary or when the member requests it. Consistent with current CMAP requirements, the out-of-state practitioner must hold an active CT license. The billing provider is responsible for providing the Department with supporting documentation for services during any audit review or investigation. If documentation is not provided, or if it is not sufficient to support the services billed, the billing provider will be responsible for any

calculated overpayment that needs to be returned to the Department.

Except for providers meeting the requirements under 42 CFR §431.52, out-of-state practitioners who are not contracted with an in-state CMAP provider are not eligible to enroll and bill for telehealth services.

Freestanding Clinics

Effective for dates of service May 12, 2023, and forward, due to the end of the federal COVID-19 public health emergency and the associated expiration of the state's federally approved disaster relief waivers under section 1135 of the Social Security Act, the requirements for services billed by freestanding clinics to be performed at the clinic, as established by federal regulations in 42 C.F.R. § 440.90 will be reinstated. CMAP enrolled freestanding clinics must ensure that either the performing practitioner rendering the telehealth service and/or the HUSKY Health member receiving the telehealth service is physically in-person at one of the enrolled clinic's licensed sites at the time of the telehealth service*. If the freestanding clinic's practitioner or the HUSKY Health member is not physically in-person at the time of the telehealth service, the freestanding clinic should not bill such service to the CMAP. Clinics must maintain documentation supporting compliance with this requirement and in the absence of such documentation, may be at-risk for a financial adjustment during a post-payment review.

For these purposes of compliance with 42 CFR §440.90, free-standing clinics include providers enrolled with CMAP as a clinic provider type and are not licensed as part of an outpatient hospital license, nor are they Federally Qualified Health Centers. Accordingly, please note that services rendered and reimbursed to Federally Qualified Health Centers and outpatient clinics that are licensed under an outpatient hospital license are not subject to compliance with 42 CFR §440.90.

** Behavioral Health Services Provided by Freestanding Clinics licensed by the Department of Public Health and/or Department of Children and Families:*
Effective for dates of service May 12, 2023, and forward, mental health services billed by freestanding clinics will be categorized and reported to the Centers for Medicare and Medicaid Services under the rehabilitation federal services benefit category. This change is already in effect for substance use disorder services. This move is specific to mental health services provided by the freestanding clinic and maintains the flexibility regarding the location of the performing practitioner associated with the freestanding clinic and/or the HUSKY Health member when the freestanding clinic provides mental health services via telehealth. This is the same flexibility that was in effect during the public health emergency. This move will not impact reimbursement rates, covered services, or any rules other than those specifically detailed in this bulletin regarding telehealth and does not modify any DPH and/or DCF licensing requirements. Additional details will be forthcoming. This change applies only to mental health services provided by freestanding clinics and does not apply to any other service that eligible for reimbursement to the freestanding clinic.

Outpatient Hospitals

Medical telehealth services are considered professional services only unless otherwise stated on the CMAP Telehealth Table and as such no payment will be issued to the hospital for the provision of telehealth services. Consistent with the current reimbursement methodology, behavioral health telehealth services are considered an all-inclusive rate reimbursed to the hospital and therefore professional fees will not be paid separately.

Prior Authorization

There is no change to existing prior authorization (PA) requirements or new requirements for services rendered via telehealth. All PA requirements are the same as for equivalent in-person services. All PAs must follow the established PA processes and must be obtained through the appropriate DSS' Administrative Service Organization.

Accessing Telehealth Policies and Covered Services

Comprehensive information on telehealth can be found on the www.ctdssmap.com Web page by selecting "Telehealth Information." This page will provide details such as the CMAP Telehealth Table, FAQs, Provider Bulletins, IMs, and all other telehealth communications. Please refer to this page periodically for updates.

Accessing the Fee Schedule

The fee schedules can be accessed and downloaded by accessing the Connecticut Medical Assistance Program (CMAP) Web site: www.ctdssmap.com. From this Web page, go to "Provider", then to "Provider Fee Schedule Download". Next click on the "I accept" button and proceed to click on the appropriate fee schedule, then select "Open file".

Accessing CMAP Addendum B:

CMAP's Addendum B (which includes various details regarding payment for outpatient hospital services) can be accessed via the www.ctdssmap.com Web site by selecting the "Hospital Modernization" Web page. CMAP's Addendum B (Excel) is located under "Important Messages – Connecticut Hospital Modernization".

For questions about billing or if further assistance is needed to access the fee schedule, on the 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 Gainwell Technologies.

Responsible Unit

DSS, Division of Health Services:

Dental Services (including FQHC-Dental Services): Please contact Donna Balaski, D.M.D., Health Services, Integrated Care Unit at donna.balaksi@ct.gov or (860) 967-8545.

Hospital - Medical (facility only): Please contact Colleen Johnson, Medical Policy Consultant at colleen.johnson@ct.gov.

Physician, Home Health, FQHC-Medical Services: Please contact Dana Robinson-Rush, Medical Policy Consultant at dana.robinson-rush@ct.gov.

Behavioral Health Services including FQHC-Behavioral Health Services: Please contact Donaicis Alers, Behavioral Health Consultant and Program Coordinator in the Integrated Care at donaicis.alers@ct.gov

Family Planning Clinics, Dialysis Clinics, Physical & Occupational Therapy, Speech and Language Pathology and Rehabilitation Clinic Services: Please contact Catherine Holt, Medical Policy Consultant at catherine.holt@ct.gov.

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