

12/24/2024

Telehealth FAQs

Below are Frequently Asked Questions (FAQs) regarding telehealth services under the Connecticut Medical Assistance Program (CMAP). Please carefully review the FAQ along with all provider bulletins and other documents posted on the CMAP Web site, www.ctdssmap.com. Please check back periodically for updates, as additional guidance may be added as necessary.

1. **Is there a difference between Telehealth and Telemedicine under the Connecticut Medical Assistance Program (CMAP)?**

Response: Yes, DSS is using the term telehealth as a broad umbrella term for remote health services currently including either telemedicine or audio only. Telemedicine is defined as synchronized audio-visual two-way communication services. Audio only is defined as two-way synchronized communication services delivered via telephone. Please refer to **PB 2023-38 REVISED Guidance for Services Rendered via Telehealth**.

2. **Is there a full list of approved services allowed to be rendered via telehealth?**

Response: Yes, please see CMAP Telehealth Table for a list of services which have been approved to be rendered via either synchronized telemedicine or synchronized audio only. The CMAP Telehealth Table is located on the “Telehealth Information” page on the www.ctdssmap.com Web page.

3. **What provider types does Provider Bulletin (PB) 2023-18 pertain to? Does this PB refer only to behavioral health services, or does it also refer to all medical services for which BH is a part?**

Response: **PB 2023-38 REVISED Guidance for Services Rendered via Telehealth** applies to both medical and behavioral health providers.

4. **Do Federally Qualified Health Centers (FQHCs) need to follow the CMAP Telehealth Table?**

Response: Yes, the CMAP Telehealth Table lists all the services that are eligible to be rendered by FQHCs via telehealth. Any service not listed on the CMAP Telehealth Table is not a telehealth eligible service. As a reminder, FQHCs must continue to render services under their approved scope of services and must bill for all the services rendered during the telehealth visit on the claim, as well as HCPCS code, T1015. FQHCs will be reimbursed their encounter rate.

5. **Can federally qualified health centers (FQHCs) bill for nutritional services performed via telemedicine?**

Response: FQHCs should refer to the CMAP Telehealth Table for approved telehealth services as well as refer to question 4 above.

6. Is written informed consent signed by the member required prior to the start of telehealth services? Is it possible to do obtain verbal consent instead of written consent?

Response: Verbal consent obtained during the PHE, as evidenced by a documentation in the medical record, may remain in effect for up to six months after the end of the PHE, after which, providers must obtain informed consent per the terms in bulletin **PB 2023-38 REVISED Guidance for Services Rendered via Telehealth**.

7. For dates of service May 12, 2023, and forward what is the appropriate place of service (POS)/Facility Type Code (FTC) and modifiers to use when billing for a telehealth encounter?

Response: POS/FTC: Providers must bill the appropriate POS/FTC code that **best reflects the location where the service would have been provided if rendered in-person (i.e. provider's office - POS 11)**. **At this time, CMAP does not recognize POS 10 and 2 on Medicaid claims.**

Modifiers: One of the following telehealth modifiers should be used when submitting claims

- **Modifier 95:** Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
- **Modifier GT:** **Telehealth service rendered** via interactive audio and video telecommunication systems

CMAP does not differentiate the use of modifier 95 and GT on telemedicine claims and providers can append either modifier to the claim.

The following modifier should be used for applicable audio only behavioral health services:

- **Modifier FQ:** The **telehealth** service was furnished using **real-time** audio-only communication technology.

8. This Provider Bulletin specifies modifier FQ for audio-only for behavioral health services. Currently we use CR for audio-only for Medicaid. Please confirm that we should use FQ for audio only from 5/12/23 onwards.

Response: Yes, effective for dates of service on or after May 12, 2023, modifier FQ should be used for behavioral health services rendered audio only. The CR modifier description is "Catastrophe/Disaster related and is being sunset at the expiration of the PHE."

9. Are there additional prior authorization requirements to provide telehealth services?

Response: There is no change to existing prior authorization (PA) requirements or new requirements for services rendered via telehealth. Refer to applicable fee schedules for prior

authorization requirements. Please see **PB 2023-38 REVISED Guidance for Services Rendered via Telehealth**.

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

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 telemedicine and cannot be billed via audio-only.

11. Can hospice services be performed via telemedicine?

Response: No, services must be rendered in person. Refer to **PB 2023-38 REVISED Guidance for Services Rendered via Telehealth**.

12. Can home health services be performed via telemedicine?

Response: No, services must be rendered in person. Refer to **PB 2023-38 REVISED Guidance for Services Rendered via Telehealth**.

13. Are well visits be allowed to be performed via telemedicine?

Response: No, well visits must be performed in-person. Refer to the CMAP Telehealth Table for covered telehealth services.

14. Are sick visits for adults and children allowed to be performed via telehealth?

Response: Yes, refer to the CMAP Telehealth Table.

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

Response: If a **medical** telemedicine service cannot be completed via telemedicine for any reason and the provider switches to audio-only to complete the service, providers should bill that service in accordance with medical audio-only procedure codes. Please refer to the Telehealth Table for approved medical audio only procedure codes.

If a **behavioral health** telemedicine service cannot be completed via telemedicine for any reason and the provider switches to audio-only communication, the provider must append modifier “FQ” to the claim to show the service was completed using audio-only communication technology.

If a **behavioral health medication management** service cannot be completed via telemedicine for any reason and the provider switches to audio-only communication, the provider must bill one of the approved audio-only procedure codes listed on the Telehealth Table. Please refer to the Telehealth Table for approved audio only procedure codes.

Consistent with CMAPs requirements all services must be documented appropriately in the member's medical record. Documentation must reflect the reason the why the service was switched.

16. The new guidelines have telehealth services end date of 12/31/2023. Will telehealth codes be discontinued at the end of the year, or will the codes be extended?

Response: All approved telehealth procedure codes will be reviewed quarterly and annually and updated as necessary based on HIPAA compliant coding updates (additions, deletions, description changes) and based on CMAP telehealth policy. Providers will be notified of all updates prior to implementation.

17. Do all providers need to have an approved location within the state of CT that allows for patients to be seen in-person?

Response: Yes, all billing providers must have a physical location within the state of 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 patients in-person and can maintain the patient's privacy and confidentiality during the visit. Please refer to **PB 2023-38 REVISED Guidance for Services Rendered via Telehealth** for additional information regarding location of providers.

Examples of location scenarios:

The following examples are **appropriate** for when an in-person visit is medically necessary or requested by a HUSKY Health member:

- A location in CT (or an approved applicable border state as approved as part of enrollment) including but not limited to rented/shared/owned/WeWork space where the provider has a room or set of rooms to see the member in-person and can maintain the member's privacy and confidentiality during the visit.
- An in-state provider who does not have a home office or a rented office but has a colleague that does and is willing to let the provider utilize the space if they need to see the member in person.

The following examples are **inappropriate** for when an in-person visit is medically necessary or requested by a HUSKY Health member:

- A location in CT (or an approved applicable border state as approved as part of enrollment) where the provider does not have consistent access for on-demand use.
- A location in CT (or an approved applicable border state as approved as part of enrollment) where the provider cannot maintain the member's privacy and confidentiality.
- A scenario where a provider lives out of CT and provides 100 % telehealth services but has a friend or family in CT and uses their home or office space sporadically to provide in-person services to HUSKY Health members.

18. Do the new telehealth guidelines affect practitioners licensed via DCF or DPH?

Response: **PB 2023-38 REVISED Guidance for Services Rendered via Telehealth** does not affect licensure. PB 2023-38 is DSS payment policy for services rendered via telehealth.

19. What is the definition of freestanding clinic?

Response: Free Standing Clinic means a facility providing clinic and off-site medical services by or under the direction of a physician or dentist, in a facility that is not part of a hospital. For purpose of telehealth services and location of provider requirements the following provider types are designated as freestanding clinics: Behavioral Health Clinics, Medical Clinics, Rehabilitation Clinics, Dialysis Clinics, Family Planning Clinics, Enhanced Care Clinics, School Based Health Centers (not operated by an FQHC or outpatient hospital). For clinics providing mental health services please see question 20 and 21 below.

20. Will our practitioners only be allowed to provide telehealth services from our actual office location?

Response: Effective for dates of service May 12, 2023 and forward:

Freestanding Clinics - Mental Health Services: CMAP enrolled freestanding clinics listed in number 19 above are not required to have their practitioners be physically in person at the CMAP enrolled licensed site when rendering mental health telehealth services. Please refer to number 21 below. **Medical Services:** Pursuant to 42 CFR 440.90 CMAP enrolled freestanding clinics listed in number 19 above 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 practitioner or member is not physically in-person at the time of the telehealth service, the freestanding clinic should not bill such service to the CMAP.

Practitioners - Individual and Group Practice, Outpatient Hospitals, Federally Qualified Health Centers, School Based Child Health: CMAP enrolled practitioners are not required to be physically in person at the enrolled licensed site when rendering eligible telehealth services. Providers must ensure they are following all policy guidelines for eligible telehealth services list on the CMAP Telehealth Table. For additional information on location of practitioners see question 17 above.

Refer to **PB 2023-38 REVISED** *Guidance for Services Rendered via Telehealth*.

21. What is the implication of moving mental health services from the Medicaid clinic option to the Medicaid Rehabilitation option?

Response: The federal clinic regulation 42 CFR 440.90 requires clinic services to be provided in the clinic. A section 1135 disaster relief waiver is currently in place but ends on the last day of the federal PHE, which is May 11, 2023. Effective for dates of service May 12, 2023 and forward, DSS is taking administrative steps with the Centers of Medicare and Medicaid Services (CMS) to maintain current flexibility on the location of the practitioner and/or member when mental health telehealth services are billed by a freestanding clinic.

This will allow freestanding clinics to provide mental health telehealth services to patients even if the provider or member are outside the "four walls of the clinic". There will be no impact on billing or reimbursement rates for providers. This update is solely related to Medicaid billing and does not change anything related to DPH and/or DCF licensure requirements.

22. Does 42 C.F.R § 440.90 apply to Federally qualified health centers (FQHCs) or outpatient hospitals?

Response: No, 42 C.F.R § 440.90 does not apply to FQHCs or outpatient hospitals.

23. Will rate changes transpire for in person vs. telehealth sessions?

Response: At this time, rates will remain the same as in-person services. Refer to **PB 2023-38** *REVISED Guidance for Services Rendered via Telehealth*.

24. Can psychiatric providers still provide medication evaluation and management sessions by Phone only for established patients?

Response: Effective for dates of service January 1, 2025 and forward, if medication management is provided to an established patient via audio only, providers should bill 98012 or 98013. Please refer to the CMAP Telehealth Table. Procedure codes 99442 and 99443 are end-dated on and after 12/31/2024.

25. What practitioner licenses are authorized to render services via telehealth? Can unlicensed practitioners conduct telehealth services?

Response: Telehealth is a mode used to render services to CMAP members and requirements are the same as when the service is rendered in-person. Providers must refer to their applicable Medicaid regulations and policies for guidance regarding specific licensure and supervision requirements.

26. For out-of-state practitioners who received a license to see Husky members virtually during the federal public health emergency, must now also have an approved site within CT borders and must be within CT borders while performing a telehealth service. Correct?

Response: Out-of-state providers that have no in-state presence and solely want to provide 100% telehealth services for HUSKY Health members are not approved to enroll in CMAP or render telehealth services.

Border Providers who are enrolled with the CMAP and have a designation as a border provider may continue to render telehealth services in their border state. Border providers do not need to have an approved location within the state of Connecticut. Enrolled border providers follow the same rules as in-state CMAP enrolled providers, therefore they can perform approved telehealth services.

In-state enrolled CMAP providers may contract with out-of-state practitioners to provide 100% telehealth services to HUSKY members. The in-state provider must ensure timely access to 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.

27. Will I still be able to see my clients via telehealth if my clients sign a document that attest that it is their chosen form of therapy?

Response: Refer to **PB 2023-38** *REVISED Guidance for Services Rendered via Telehealth* including the section titled “informed consent”. Further policy guidelines for approved telehealth procedure codes are located on the CMAP Telehealth Table.

28. Are there changes to audio-only billing for dates of service January 1, 2025?

Yes, effective for dates of service 1/1/2025 and forward, new procedure codes 98012 and 98013 which are specific to audio-only telemedicine services have been added to the CMAP Telehealth Table. Procedure codes 98012 and 98013 will be used for medical audio-only visits and behavioral health medication management.

Procedure codes 99442 and 99443 are being end-dated 12/31/2024.

29. Are there changes to billing for Evaluation and Management (E/M) 99202-99215 services via synchronized telemedicine effective January 1, 2025?

Yes, effective for dates of service 1/1/2025 and forward there are new E/M CPT codes specific to audio-visual telemedicine services (98001-98007) that will be added to the CMAP Telehealth Table. Procedure codes 98001-98007 must be used in place of 99202-99215 when services are rendered via telemedicine for medical E/M and behavioral health medication management services. Procedure codes 99202-99215 will continue to be reimbursable for in-person services.

30. Are telemedicine modifiers required for procedure codes 98001-98007?

No, telehealth modifiers are not required for procedure code 98001-98007