



Connecticut Medical Assistance Program
Policy Transmittal 2020-07

Provider Bulletin 2020-09
March 2020

Deidre S. Gifford, MD, MPH, Commissioner

Effective Date: March 13, 2020
Contact: Contact Person: see below

TO: All Providers

RE: New Coverage of Specified Telemedicine Services Under the Connecticut Medical Assistance Program (CMAP)

Effective for dates of service March 13, 2020 and forward, in accordance with section 17b-245e of the 2020 supplement to the Connecticut General Statutes, the Department of Social Services (DSS or Department) will implement full coverage of specified synchronized telemedicine, which is defined as an audio and video telecommunication system with real-time communication between the patient and practitioner. The coverage of specified synchronized telemedicine services will be covered under both Connecticut's Medicaid Program and Children's Health Insurance Program (CHIP).

The Commissioner of the Department has determined in accordance with that statute referenced above that all of the telemedicine services listed in this bulletin as covered under CMAP "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 Medicaid members for whom accessing appropriate health care services poses an undue hardship." Therefore, in accordance with that statute, telemedicine services are fully covered under this bulletin as described herein "notwithstanding any provision of the regulations of Connecticut state agencies that would otherwise prohibit coverage of telehealth services."

All other requirements applicable to these services remain in effect. Therefore, the following telemedicine services are covered under CMAP only when they:

- Are medically necessary, in accordance with the statutory definition of medical

necessity in section 17b-259b of the Connecticut General Statutes;

- Are rendered via a HIPAA-compliant, real time audio and video communication system (but note that certain popular video chatting software programs are not HIPAA-compliant); and
- Comply with all CMAP requirements that would otherwise apply to the same service performed face-to-face (in-person), including, but not limited to, enrollment, scope of practice, licensure, documentation, and other applicable requirements.

Providers: Please review this entire bulletin carefully as there are many important details that apply to this new coverage.

Please refer to **Addendum A – "Definitions"** attached to this bulletin for a list of applicable telemedicine definitions.

Please refer to **Table 1 - "Approved Procedure Codes for Telehealth Services"** attached to this bulletin for a list of permissible services.

BEHAVIORAL HEALTH SERVICES

The following behavioral health services may be rendered via telemedicine:

1. Psychotherapy Services

The following individual psychotherapy, family psychotherapy, and psychotherapy with medication management services may be rendered via telemedicine:

Procedure Code	Description
90832	Psytx pt &/family 30 minutes
90833	Psytx pt &/fam w/e&m 30 min
90834	Psytx pt &/family 45 minutes
90836	Psytx pt &/fam w/e&m 45 min
90837	Psytx pt &/family 60 minutes
90838	Psytx pt &/fam w/e&m 60 min
90847	Family psytx w/patient

Please Note: There is no limitation on the originating site (location of the member at the time of the telemedicine call) for a member receiving individual therapy, family therapy, or psychotherapy with medication management.

Eligible Providers: Same as those eligible to provide psychiatric diagnostic evaluations under telemedicine, listed below.

2. Psychiatric Diagnostic Evaluations

Psychiatric diagnostic evaluations may be rendered via telemedicine **only** if the member is located at a CMAP-enrolled originating site (healthcare office/facility).

Procedure Code	Description
90791	Psych diag eval
90792	Psych diag eval w/E&M

Eligible Providers: Only the following categories of CMAP-enrolled providers may provide and bill for such **psychotherapy services** or **psychiatric diagnostic evaluations** within their scope of practice via telemedicine:

- Physicians
- Physician Assistants (PAs)
- Advanced Practice Registered Nurses (APRNs)

- Licensed Behavioral Health Clinicians (defined below and which includes only the following: Licensed Psychologists, Licensed Clinical Social Workers, Licensed Marital and Family Therapists, Licensed Professional Counselors, and Licensed Alcohol and Drug Counselors)
- Behavioral Health Clinics – including Enhanced Care Clinics (ECCs)
- Behavioral Health Federally Qualified Health Centers (FQHCs)
- Medical Clinics – excluding School Based Health Centers (SBHCs)
- Rehabilitation Clinics
- Outpatient Hospital Behavioral Health (BH) Clinics
- Outpatient Psychiatric Hospitals
- Outpatient Chronic Disease Hospitals (CDHs)

Please Note: Prior Authorization for behavioral health services rendered by a physician assistant must be obtained and billed under the physician/physician group provider ID. The physician assistant must be listed as the rendering provider on claims.

3. Medication Assisted Treatment (MAT)

All of the following criteria; in addition to all other applicable requirements, including, but not limited to, state and federal requirements and limitations specific to the prescribing and of controlled substances via telemedicine (including applicable requirements pursuant to the federal Ryan Haight Act), as well as state and federal requirements specific to methadone maintenance services, must all be met when rendering MAT services via telemedicine.

A. Opioid Treatment Programs (Methadone Maintenance Clinics)

Opioid Treatment Programs (Methadone Maintenance Clinics) are required to perform a complete, fully documented physical evaluation, as defined in federal regulations in

42 CFR 8.12(f), prior to admission. The program physician may render the physical evaluation component of MAT services via telemedicine only when all of the following criteria are met:

- The CMAP member's originating site is another CMAP-enrolled Opioid Treatment Program (Methadone Maintenance Clinic) that is part of the same billing entity as the originating site;
- The originating site is providing all the other required components of MAT services including the intake and psychiatric evaluation;
- As required by 42 CFR 8.12(f), an authorized healthcare professional under the supervision of a program physician is present with the member at the originating site; and
- The distant site provider must be located at a different service location/address than the originating site.

Due to Opioid Treatment Programs (Methadone Maintenance Clinics) receiving a daily payment rate for all MAT services provided, the daily payment rate will continue to be paid to the originating site only. The distant site provider cannot bill for the physical evaluation component rendered via telemedicine.

Induction services must always be rendered face-to-face (in-person) and only after the physical and psychiatric evaluation has been performed. Once a CMAP member has been inducted, routine psychotherapy services may be rendered via telemedicine. All current payment, billing and documentation guidelines for Opioid Treatment Programs (Methadone Maintenance Clinics) remain in effect.

Please refer to **Table 1-Approved Procedure Codes for Telehealth Services** for a list of permissible services.

B. MAT Services – Office-Based Opioid Treatment Providers

The following MAT services may be rendered via telemedicine in Office-Based Opioid Treatment Providers only if all of the following criteria are met in addition to all other applicable requirements, including, but not limited to, state and federal requirements specific to MAT services:

- Medication Management
- Psychotherapy Services

Please Note: Induction services must always be rendered face-to-face (in-person) and only after the physical and psychiatric evaluation has been performed.

Eligible Providers: Only the following categories of CMAP-enrolled providers may provide and bill for such services within their scope of practice requirements via telemedicine:

- Physicians
- APRNs
- PAs
- Behavioral Health Clinics

Please Note: Prior Authorization for behavioral health services rendered by a physician assistant must be obtained and billed under the physician/physician group provider ID. The physician assistant must be listed as the rendering provider on claims.

4. Medication Management Services

When Medication Management is the only psychiatric service being rendered to a CMAP member on the date of service, one of the following Office and Other Outpatient Visit procedure codes must be billed:

Procedure Code	Description
99211	Office/outpatient visit est

99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est

Eligible Providers: Only the following categories of CMAP-enrolled providers may provide and bill for such services within their scope of practice requirements via telemedicine:

- Physicians
- PAs
- APRNs
- Medical Clinics – excluding SBHCs
- Behavioral Health Clinics – including ECCs
- Behavioral Health FQHCs
- Outpatient Hospital BH Clinics
- Outpatient Chronic Disease Hospitals

Please Note: Prior Authorization for behavioral health services rendered by a physician assistant must be obtained and billed under the physician/physician group provider ID. The physician assistant must be listed as the rendering provider on claims.

MEDICAL SERVICES

The following categories of medical services described below are eligible for payment when rendered via telemedicine:

- Select Established Patient Evaluation and Management (E/M) Services

The select established patient E/M services listed in Table 1 may be rendered via telemedicine only if the following criteria are met (each as described in more detail below):

- The CMAP member has been approved to have or has received surgery from a provider in a non-contiguous state; or

- The CMAP member has been determined to be homebound by a CMAP-enrolled physician, APRN, Certified Nurse Midwife (CNM), PA, or podiatrist.

1. Out-of-State Surgery

Inpatient Surgery

Physicians rendering inpatient surgical services for a CMAP member must ensure the hospital has submitted and obtained an approved prior authorization for the inpatient surgery. Once the hospital has an approved authorization on file for the CMAP member, the member is eligible to receive their pre-and/or post-surgical consultations via telemedicine. Any telemedicine service related to the surgery must be rendered by the Out-of-State (OOS) provider who will be performing the surgery. All telemedicine services must be clinically appropriate and medically necessary. Pre/Post surgery instructions are not eligible for reimbursement via telemedicine. There are no changes or new authorization requirements for OOS hospitals to obtain an inpatient authorization for CMAP members.

There is no limitation on the originating site location for a member receiving telemedicine services related to their inpatient hospital surgery.

Please Note: OOS practitioners must be licensed in the State of Connecticut in order to render a telemedicine service to a member who is physically located in Connecticut at the time the service is rendered. Claims billed by OOS practitioners who are not licensed in the State of Connecticut, but who render telemedicine services to a CMAP member who is physically located in Connecticut at the time the service is provided, may be recouped on post payment audit.

Outpatient Surgery

Physicians rendering outpatient surgical services for a CMAP member must ensure the

hospital has submitted and obtained an approved prior authorization for the outpatient surgery. Once an approved authorization is on file for the outpatient surgery, the member is eligible to receive their pre- and/or post-surgical consultations via telemedicine. Any telemedicine services related to the surgery must be rendered by the OOS provider who will be performing the surgery. There are no changes or new authorization requirements for OOS hospitals to obtain an outpatient authorization for CMAP members.

OOS practitioners must be licensed in the State of Connecticut in order to render a telemedicine service to a member who is physically located in Connecticut at the time the service is rendered.

Please Note: There is no limitation on the originating site location for a member receiving telemedicine services related to their outpatient hospital surgery.

Eligible Providers: Only the following categories of CMAP-enrolled providers may provide and bill for such services within their scope of practice requirements via telemedicine:

- Physicians
- PAs
- APRNs
- CNMs
- Podiatrists

2. Homebound Telemedicine

Members must meet the criteria listed on **Addendum A – Definitions** in order to be eligible for homebound telemedicine services. Please see **Addendum A – Definitions** attached to this document for homebound criteria.

Each practitioner wishing to render telemedicine services to a CMAP member they have determined to be homebound must clearly document in the member's medical record or office visit notes that the member has

met CMAP's telemedicine homebound criteria and the reason the member is being determined homebound. This documentation must support the medical necessity of the homebound services, as well as the time frame in which the member will be considered homebound for purposes of receiving telemedicine services. Providers that cannot meet the documentation requirements should not render telemedicine services or submit claims for services rendered via telemedicine.

Eligible Providers: Only the following categories of CMAP-enrolled providers may determine a CMAP member to be homebound and/or provide and bill for such services within their scope of practice requirements via telemedicine:

- Physicians
- PAs
- APRNs
- CNMs
- Podiatrists

FEDERALLY QUALIFIED HEALTH CENTERS

Medical and Behavioral Health Federally Qualified Health Centers (FQHCs) are eligible to bill their encounter rate when an approved, medically necessary telemedicine service is rendered. Medical and Behavioral Health FQHCs cannot bill their encounter rate when serving as an originating site only; meaning no other services were rendered to the member on that date of service outside of facilitating the telemedicine call by providing the space and technology.

All existing requirements for FQHCs billing their encounter rate remain in effect, including the requirements described in this bulletin. Please refer to **Table 1-Approved Procedure Codes for Telehealth Services** for a list of permissible services.

GENERAL TELEMEDICINE POLICIES

All applicable federal and state requirements for the equivalent in-person services apply for telemedicine services. Each provider is responsible for ensuring that provision of telemedicine services complies with all applicable requirements, including, but not limited to: DSS regulations, scope of practice requirements, medical necessity and all other billing and documentation requirements. (The only exception is that, as stated at the top of this bulletin, in accordance with section 17b-245e of the 2020 supplement to the Connecticut General Statutes, services detailed in this bulletin as covered via telemedicine are authorized notwithstanding any DSS regulations that would otherwise prohibit telemedicine.)

HIPAA and Related Requirements:
Information and data related to synchronized telemedicine services are protected health information (PHI) to the same extent as for in-person services and to the full extent applicable, fall under the scope of the federal Health Insurance Portability and Accountability Act (HIPAA) and 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 telemedicine software, protocols, and procedures that fully comply with HIPAA and all other applicable requirements. Certain popular video chatting software programs do not comply with HIPAA requirements. Providers must ensure that they fully comply with such requirements, including using only HIPAA compliant software to provide synchronized telemedicine services.

General Requirements:

The following specific requirements apply to all services delivered via telemedicine:

- Providers are prohibited from saving recordings of telehealth video-conferencing sessions;

- Providers must obtain informed consent in writing from each member before providing telehealth services and annually thereafter. The provider must ensure each patient is aware they can opt-out or refuse telehealth services at any time;
- If the member is a minor child, a parent or legal guardian must be present for services to the same extent as would be required for comparable in-person services unless exempted by state or federal law;
- Under post payment review, DSS may take adjustments for services that are billed and not documented in accordance with all applicable telemedicine guidelines;
- Originating site must ensure that an appropriate, secure and private location is available for all members participating in telehealth services;
- Both originating site providers and distant site providers must develop and implement procedures to verify provider and patient identity; and.
- A telemedicine service may not be billed for the sole purpose of the CMAP member obtaining a prescription where the provider has previously determined the need for a prescription.

PRIOR AUTHORIZATION

There is no change or new prior authorization (PA) requirements for services rendered via telemedicine. All PA requirements are the same as for equivalent in-person services.

Any medical telemedicine service that requires prior authorization must be obtained from the Department's medical Administrative Services Organization (ASO), Community Health Network of Connecticut (CHNCT), prior to rendering the telemedicine service. PA request forms are available on the HUSKY Health Web site at: www.ct.gov/husky. To access the forms, click on **For Providers**, followed by

Prior Authorization Forms and Manuals
under the ***Prior Authorization*** menu item.

Any behavioral health service that requires PA/registration must be obtained from the Department's behavioral health ASO – Beacon Health Options prior to rendering the telemedicine service. To receive PA or to obtain further information regarding behavioral health, please contact CT BHP (Beacon Health Options) at 1-877-552-8247 or visit the CTBHP Web site at www.ctbhp.com.

BILLING AND DOCUMENTATION GUIDELINES

Subject to all other applicable requirements for reimbursement under the CMAP, the following guidelines apply to all services rendered via telemedicine:

- Reimbursement/payment rates are the same as for equivalent in-person services;
- Documentation must be maintained by both the originating site provider and the distant site provider to substantiate the services provided. Originating site documentation must indicate the member received or has been referred for telehealth services;
- If a telehealth service cannot be provided or completed for any reason, such as due to technical difficulty, providers shall not submit a claim.

Modifiers

All distant site providers billing for telemedicine services must append the applicable telemedicine modifier to the claim.

The following modifier(s) must be appended to all claims submitted for services rendered via telehealth:

- 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.

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.

Responsible Units:

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Addendum A - Definitions

- (1) *Distant Site*: the physical location of the CMAP practitioner/provider who is performing the telemedicine service.
- (2) *Originating Site*: the physical location of the CMAP member when the member receives telemedicine services.
- (3) *Homebound*: The patient must meet one or more of the following criteria as specified by a CMAP-enrolled physician, APRN, CNM, physician assistant or podiatrist in order to receive telemedicine services at home under this category (which is a determination specific to the requested provision of applicable telemedicine services and not necessarily related to a determination of homebound status for any other purpose):
- Leaving home to be able to receive relevant in-person health services must require a considerable and taxing effort because of illness or injury, such as severe morbid obesity, require the aid of supportive devices such as wheelchairs or walkers; the use of special transportation; or the assistance of persons in order to leave their place of residence; OR
 - Have a condition such that leaving his or her home in order to be able to receive relevant in-person health services is medically contraindicated, such as immune suppression; OR
 - Have a condition such that leaving his or her home in order to receive relevant in-person health services would be detrimental to the individual's mental health and/or physical health.
- (4) *Medicaid billing entity*: means a practitioner, provider, or provider entity who share any of the following:
- a. Medicaid provider Identification Number;
 - b. National Provider Identifier (NPI); **or**
 - c. Tax Identification (ID) Number (TIN).
- (5) *Licensed behavioral health clinician*: means a licensed psychologist, licensed alcohol and drug counselor, licensed marital and family therapist, licensed clinical social worker or licensed professional counselor.

Table 1 - Approved Procedure Codes for Telemedicine Services

The following procedure codes are eligible for payment when rendered via telehealth and billed with the applicable telehealth modifier. All applicable requirements, including those described above, remain in effect. Providers may bill for the applicable code(s) only in compliance with all applicable requirements. Additions and/or deletions to CMAP telehealth services will be made annually in conjunction with fee schedule/HIPAA compliant updates.

Procedure Code	Short Descriptor
90791*	Psych diag eval
90792*	Psych diag eval w/E&M
90832*	Psychotherapy 30 minutes
90833*	Psychotherapy w/e&m 30 min
90834*	Psychotherapy 45 minutes
90836*	Psychotherapy w/e&m 45 min
90837*	Psychotherapy 60 minutes
90838*	Psychotherapy w/e&m 60 min
90847*	Family psytch w/patient
99211**	Office/outpatient visit est
99212**	Office/outpatient visit est
99213**	Office/outpatient visit est
99214**	Office/outpatient visit est
99215**	Office/outpatient visit est

PLEASE NOTE: procedure codes marked with an * indicates the service is designated as a behavioral health only telehealth service. Procedure codes marked with ** indicates the procedure can be either medical or behavioral health. Procedure codes marked with *** indicates the service is designated as a medical only telehealth service.