Connecticut Department of Social Services (DSS)
Connecticut Medical Assistance Program (CMAP)

Responses to Frequently Asked Questions (FAQs) About CMAP's Response to COVID-19 (Coronavirus)

Updated: May 11, 2020

Below are responses to frequently asked questions about CMAP's response to the outbreak of COVID-19 (Coronavirus). Please carefully review all provider bulletins and other documents posted on the CMAP Web site, www.ctdssmap.com and check for updates, as we intend to continue providing updated guidance as necessary.

1. Does the provider need to use a software program with both video and telephone for telemedicine visit or can they just speak with the patient over the phone?

   Response: Provider Bulletins 2020-09 and 2020-10 do not authorize audio only telephone as telemedicine services. Telemedicine must be an audio and video system with real-time communication between the patient and practitioner. Provider Bulletin 2020-14 does authorize telephone services (audio only) under specific circumstances.

2. The bulletin requires a written informed consent to be signed by the member prior to the start of telemedicine services. Is it possible to do obtain verbal consent instead of written consent?

   Response: Yes, for the time period that PB 2020-10 is in effect (as part of CMAP's response to COVID-19), for CMAP purposes, the Department is waiving the requirement of written consent prior to starting telemedicine services. Providers must document that they obtained verbal consent from the member to provide telemedicine services and document that consent in the medical record. One potential alternative to obtaining traditional written informed consent is that providers include, as part of the software program used to provide telemedicine services, that the member affirmatively agrees to receive services by telemedicine as a condition of opening the telemedicine software encounter and the provider. If the provider chooses this option for obtaining written informed consent, the provider should maintain documentation on file that its telemedicine software program includes this disclaimer and consent. These options are permissible for CMAP purposes but do not supersede any other requirements that may apply to the provider, such as scope of practice or professional standards.

3. What is the appropriate place of service (POS) to use when billing for a telemedicine encounter?

   Response: Providers should use POS 02 which will indicate that the service was rendered via telemedicine.

4. Is the CMAP Medicaid Management Information System (MMIS) billing system, operated by DXC Technology, system ready to process and pay claims billed with POS-02?

   Response: Yes, the MMIS is ready to accept claims with POS 02.

5. Is there a full list of approved billing codes?

   Response: Yes, please refer to Table 1 - "Approved Procedure Codes for Telehealth Services" attached to provider bulletin 2020-09 for a list of permissible services. Please refer to provider bulletin 2020-10 for a list of temporary services which have been expanded due to COVID-19.

6. What medical telemedicine services are currently covered by CMAP?

   Response: PB 2020-09 authorizes coverage of telemedicine for out-of-state surgeries and homebound individuals. PB 2020-10 temporarily expands telemedicine coverage to a much broader category of medical evaluation and management services effective for dates of service March 13, 2020 through the date that DSS notifies providers in writing that the COVID-19 public health emergency in Connecticut has ended. Provider Bulletin 2020-14 does authorize telephone services (audio only) under specific circumstances.

7. Are independent behavioral health practitioners required to physically be in the office when they render a telemedicine or telephone service to a member?

   Response: No, independent practitioners in solo practices or in group practices are not required to be in the office when rendering a telemedicine or telephone service to a member.

8. As an independent practitioner, do I still need to add my provider specific modifier that I used prior to telemedicine in addition to the telemedicine modifier to the claim?

   Response: Yes, independent behavioral health practitioners must still use the billing modifiers that were in place prior to the telemedicine policy. For telemedicine services, there will be two modifiers on a claim, the previous billing modifier and the telemedicine modifier. Clinical social workers use the modifier "AJ" and Licensed Marriage and Family Therapists, Licensed Professional Counselors, and Licensed Alcohol and Drug Counselors use the modifier "HO".

9. Regarding behavioral health services, as a DPH licensed behavioral health clinic, non-licensed and non-certified staff could provide services under the direction of a licensed behavioral health practitioner. Is that still the case for telemedicine and telephone services?

   Response: Yes, only in behavioral health clinics that are licensed by DPH.

10. Regarding the physical location of the practitioner who works for a DPH licensed healthcare facility, does the practitioner still need to be in the clinic when rendering telemedicine or telephone services?

    Response: DSS is waiving the DSS regulations regarding any limitation to the physical location of the practitioner when rendering telemedicine or telephone services.

11. For methadone maintenance services, providers are required to provide at least one counseling session per month. Can we do the required monthly counseling session via telemedicine or telephone?

    Response: Yes.

12. Are there additional authorization requirements in order to provide services via telemedicine or telephone?

    Response: No additional or different authorization procedures are required beyond the authorization requirements in place prior to issuing new policy on telemedicine.

13. As an FQHC, we were providing group psychotherapy and IOP on a face to face basis. Does PB 2020-25 allow us to provide group psychotherapy and IOP via telemedicine?

    Response: Yes. Any practitioner or provider type that was rendering group psychotherapy, adult day treatment, intensive outpatient treatment and partial hospital treatment on a face to face (in-person) basis prior to PB 2020-25 may now conduct those group sessions via telemedicine (audio and video), but not audio-only telephone.

14. I understand that the codes for medication administration are hands-on care service codes. Under the current public health emergency, is DSS allowing licensed home health providers to perform these services via telemedicine or telephone?

    Response: Correct, during the temporary effective period, until DSS notifies providers differently, the medication administration codes listed on the bulletin, that are normally done in the home with the patient, may now be done via telemedicine (audio and video) or telephonically (audio only). The Department is aware that the T1502 and T1503 codes are both for direct face to face administration of medications including intramuscular and subcutaneous injections. In an effort to reduce the transmission of the coronavirus, the Department is allowing these codes to be done via telemedicine or telephonically for prompting of oral medication by a nurse and not for any other medication administration. The expectation is that the home health nurse will pre-pour patients' oral medications ahead of time and use telemedicine, or telephone call to conduct a brief assessment and prompt patients to take their already pre-poured medications. Please refer to provider bulletins, PB 2020-28 CMAP COVID-19 Response – Bulletin 13: Emergency Temporary Telemedicine Coverage/Telephonic Coverage for Specified Home Health Services and Hospice

Services and PB 2015-07 Clarification of Billing Medication Administration Visit Code and Skilled Nursing Visit Code Related to Pre-pouring of Medication for additional guidance.

15. The nurse will be the one pre-pouring the medications; are home health aides able to call patients and prompt them to take their medications after it has been pre-poured by the nurse?

    Response: No, medication prompting services performed by home health aides are not eligible to be performed under the temporary emergency telemedicine or telephone coverage. HCPCS codes T1502 and T1503 include a brief assessment performed by a nurse who will also prompt the HUSKY Health member to take their medications.

16. If the home health aides cannot call patients and prompt them to take their medications, why is there a home health prompting code?

    Response: The Department is not advising home health agencies to not perform medication prompting by home health aides service that were prior authorized as part of the care plan. Home health agencies are advised to perform authorized services in the safest manner possible during this public health crisis.

17. Will the Department of Social Services (DSS) follow the CARES Act allowing other health professionals to sign off on home health orders?

    Response: Effective immediately, **only** physicians can sign off on home health orders. The request for the state to allow additional health professionals based on the federal CARES Act adding flexibility to *federal* requirements, specifically APRN and PA to be allowed to sign off on home health orders, is currently under consideration, and updated guidance will be posted if there are any changes. Unless otherwise notified, all current state payment and licensure requirements remain in effect.

18. Has DSS waived prior authorization requirements for outpatient hospital radiology services that are billed using a "C" procedure code?

    Response: Yes, during the COVID-19 Temporary Effective Period, prior authorization has been waived on the following "C" procedure codes:

C8900	C8908	C8914	C8933
C8901	C8909	C8918	C8934
C8902	C8910	C8919	C8935

C8903	C8911	C8920	C8936
C8905	C8912	C8931	
C8906	C8913	C8932	

19. Can DSS clarify the use of telemedicine modifiers and Place of Service (POS) requirements when billing for telemedicine or telephonic services?

    Response: The following modifiers are required on all claims when services are rendered via telemedicine:
    - 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.

    Providers should continue to append all other appropriate modifiers on the claim in conjunction with the applicable telemedicine modifier. When services are rendered via telemedicine POS 02 – Telehealth must be appended on the claim. At this time, telephonic services do not require a specific modifier and there is no specific POS requirement when services are rendered telephonically (audio only).

20. How will inpatient behavioral health admissions be reimbursed for admission dates April 1, 2020 until the Temporary Effective Period is over?

    Response: As described in *PB 20-33 - CMAP COVID-19 Response – Bulletin 23: Changes to the Prior Authorization Requirements for Specified Services,* any BH inpatient admission that is 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. If you have any problems with billing and reimbursement you can send an email to DXC via the hospital email address ctxixhosppay@dxc.com.

    Any BH inpatient admission approved prior to 4/1/2020 must continue to have the authorization updated through Beacon Health Options, in order to receive the per diem payment.

    Please note: All inpatient behavioral health services continue to remain an all-inclusive payment to the hospital; therefore, professional services cannot be billed separately.

21. How will inpatient rehab admissions be reimbursed for admission dates April 1, 2020 until the Temporary Effective Period is over?

    Response: As described in *PB 20-33 - CMAP COVID-19 Response – Bulletin 23: Changes to the Prior Authorization Requirements for Specified Service,* any Rehabilitation 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. If you have any problems with billing and reimbursement you can send an email to DXC via the hospital email address ctxixhosppay@dxc.com .

Any Rehab inpatient admission approved prior to 4/1/2020 must continue to have the authorization updated through Community Health Network of CT (CHNCT), in order to receive the per diem payment.
Please Note: All inpatient rehabilitation services continue to remain an all-inclusive payment to the hospital; therefore, professional services cannot be billed separately.

22. Our in-state group practice has multiple service locations. Due to the COVID-19 health crisis, we have had to close facilities and have moved physicians to some of our other locations that they normally wouldn't work at. We have also had to move physicians around to different locations to cover for sick physicians. Do we have to update the physicians location in their enrollment every time they change locations in order to bill correctly?

    Response: No Providers are to bill using the providers "home" location during the COVID-19 health crisis. Providers will not be required to update their location if they are moving around from location to location treating patients until the state has no longer declared a health emergency.

Provider Bulletins:

PB 2020-10 - CMAP COVID-19 Response – Bulletin 1: Emergency Temporary Telemedicine Coverage
PB 2020-12 – CMAP COVID-19 Response – Bulletin 2: Laboratory Testing Coverage
PB 2020-13 – CMAP COVID-19 Response – Bulletin 3: Emergency Pharmacy Program Changes
PB 2020-14 – CMAP COVID-19 Response – Bulletin 4: Expanded Telemedicine and New Audio-Only (Telephonic) Services
PB 2020-15 – CMAP COVID-19 Response – Bulletin 5: Elimination of Copayments for Services Rendered to HUSKY B Members
PB 2020-17 – CMAP COVID 19 Response – Bulletin 6: – Emergency Remote Early Intervention Services
PB 2020-19 – CMAP COVID-19 Response – Bulletin 7: Enhanced Care Clinic (ECC) Access Requirements
PB 2020-23 – CMAP COVID-19 Response – Bulletin 8: Emergency Temporary Telemedicine Coverage for Physical Therapy, Occupational Therapy & Speech Therapy Services
PB 2020-24 – CMAP COVID-19 Response – Bulletin 9: Emergency Temporary Telemedicine Coverage for Specified Therapy Services Rendered at Rehabilitation Clinics
PB 2020-25 – CMAP COVID-19 Response – Bulletin 10: Expanded Use of Synchronized Telemedicine for Specified Behavioral Health Group Therapy Services and Autism Spectrum Disorder Services
PB 2020-26 – CMAP COVID-19 Response – Bulletin 11: Emergency School Based Child Health (SBCH) Program Changes
PB 2020-27 – CMAP COVID-19 Response – Bulletin 12: Waiver of Certain Requirements and Temporary Procedural Changes for Home and Community-Based Waiver Programs
PB 2020-28 - CMAP COVID-19 Response - Bulletin 13: Emergency Temporary Telemedicine Coverage/Telephonic Coverage for Specified Home Health Services and Hospice Services
PB 2020-18 – CMAP COVID-19 Response – Bulletin 15: Emergency MEDS Program Changes
PB 2020-29 – CMAP COVID-19 Response – Bulletin 16: Emergency Durable Medical Equipment Changes Pertaining to Customized Wheelchairs

PB 2020-30 – CMAP COVID-19 Response – Bulletin 17: Temporary Changes to Claim Submission for Coagulation Factor Drugs
PB 2020-32 – CMAP COVID-19 Response – Bulletin 18: Temporary Changes to Signature Requirement for Prescription Medications
PB 2020-31 - CMAP COVID-19 Response - Bulletin 19: Emergency ICF-IID Leave Day Changes
PB 2020-35 – CMAP COVID-19 Response – Bulletin 20: TU Modifier – Overtime
PB 2020-34 – CMAP COVID-19 Response – Bulletin 21: Select Added Services to the Emergency Temporary Telemedicine Coverage/Telephonic Coverage for Specified Home Health Services
PB 2020-36 – CMAP COVID-19 Response – Bulletin 22: Meals on Wheels Changes
PB 2020-33 – CMAP COVID-19 Response – Bulletin 23: Changes to the Prior Authorization Requirements for Specified Services
PB 2020-39 – CMAP COVID-19 Response – Bulletin 25: Non-Emergency Medical Transportation and Non-Emergency Ambulance Transportation
PB 2020-38 – CMAP COVID-19 Response – Bulletin 26: Additional Changes to the Synchronized Telemedicine Program
PB 2020-42 – CMAP COVID-19 Response – Bulletin 27: New COVID-19 Coverage Group for Uninsured Residents
PB 2020-43 – CMAP COVID-19 Response – Bulletin 28: Emergency Medicaid for Non-Citizens
PB 2020-45 – CMAP COVID-19 Response – Bulletin 29: Updated Guidance Regarding Audio-Only Telephone Services and Guidance Regarding the Use of Synchronized Telemedicine Services for Supervision of Resident Services
PB 2020-44 – CMAP COVID-19 Response – Bulletin 31: Updated Audio-Only Behavioral Health (Telephonic) Services - NEW Billing Guidance

Important Messages:

Attention Autism Waiver Service Providers: COVID-19 Response Bulletin 12 (Posted 3/30/20)

COVID-19 Response DXC Technology Alternate Call Center and Provider Enrollment Contact Information:

Provider Assistance Center:

If providers are experiencing extended call wait times, providers may email the provider assistance call center with their question at ctdssmap-provideremail@dxc.com. Please be sure to include your name and phone number with your inquiry.

Please note, The provider assistance center does not verify client eligibility for current dates of serice. Providers need to log into their secure web portal account at www.ctdssmap.com in order to verify a client's eligibility. Providers are reminded that the self service functions including Client eligibility, Web Claim Submission, Claims Status Inquiry, Paid Claim Adjustments, Pharmacy Prior Authorization Request Submissions and Prior Authorization status requests are available to providers through their secure Web portal account.

Client Assistance Center

If clients are experiencing extended call wait times, clients may email the client assistance call center with their question at webmaster-ctmedprog@dxc.com. Please be sure to include your name and phone number with your inquiry.

Clients inquiring about a claim denial due to third party liability on their client record that is outdated should contact Health Management Systems at 1-866-277-4271.

Clients inquiring about a claim denial due to the client not being eligible, will need to contact the DSS Client Information Line and Benefits Center at 1-855-626-6632 (TTD/TTY 1-800-842-4524).

Clients requesting a replacement ID card will need to call Husky Health at 1-800-859-9889 or visit the www.ctgov/husky Web site.

Pharmacy Prior Authorization Assistance Center

Providers with access to the secure web portal can submit pharmacy prior authorization requests electronically as well as check prior authorization status. Please refer to provider bulletin (2019-70) titled Pharmacy Web Prior Authorization for further instructions on how to submit pharmacy prior authorizations via the secure web portal. As a reminder, please access www.ctdssmap.com and click on pharmacy for information including the preferred drug listing and prior authorization forms.

Provider Enrollment

Providers with questions related to a provider enrollment matter are encouraged to email their question to the provider enrollment email box at ctproviderenrollment@dxc.com, or providers may fax their question to 1-877-899-5401.

Providers who are submitting follow on documents to DXC Technology for current enrollment or re-enrollment ATNs may fax the documents to 1-877-899-5401 or email them to ctproviderenrollment@dxc.com. Please be sure to include your ATN on each document page.

Claims/Financial Team

Providers who wish to submit Hysterectomy Consent Forms, Sterilization Consent Forms or Electronic Claim Attachments may fax the documents to 1-860-986-7995 or email them to ctxix-claimattachments@dxc.com.

Providers who wish to submit Trauma Questionnaire Responses may fax them to 1-833-577-3519 or email them to CTXIX-TraumaMailbox@dxc.com.