ProviderAlert

Select Health of South Carolina

Healthy Connections

To: Select Health of South Carolina Participating Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

From: Select Health Provider Network Management

Date: April 27, 2020

Subject: FQHC and RHC COVID-19 Telephonic Care Update

The information provided herein is reflective of the applicable South Carolina Department of Health and Human Services (SCDHHS) guidance as of the date of issuance. Providers should continue to check the SCDHHS COVID-19 website at: https://msp.scdhhs.gov/covid19/ for further updates and modifications to practice and billing requirements given the evolving situation surrounding this pandemic.

During the COVID-19 state of emergency, Select Health participating FQHCs and RHCs will be allowed to provide telehealth/telemedicine services, in accordance with the guidelines outlined by SCDHHS.

For FQHCs and RHCs, telehealth/telemedicine claims will be submitted in lieu of the encounter code and reimbursement will be based on the applicable SCDHHS fee schedule. Standard place of service coding still applies. RHC claims should be billed under the GP NPI number.

Effective for claims with dates of service on and after March 15, 2020, the following policy changes will apply:

Telephonic care provided by a Physician, Nurse Practitioner, or Physician Assistant

- The telephonic care codes in the chart below should not be billed if the telephonic encounter originates from a related evaluation and management (E/M) service provided within the preceding seven days or if it leads to an E/M service or procedure within the subsequent 24 hours.
- A total of three encounters will be allowed every 30 days, and services may be provided regardless of the member's location.
- Telephonic care codes should be billed with the 'GT' modifier.

Billable telephonic care codes for medical professionals (during the COVID-19 health emergency:

Code	Description
G2010	Remote image submitted by patient
G2012	Brief check in by provider
99441	Telephonic E/M; 5-10 minutes of medical discussion
99442	Telephonic E/M; 11-20 minutes of medical discussion
99443	Telephonic E/M; 21-30 minutes of medical discussion

The standard telemedicine benefit, which includes consultation, office visits, individual psychotherapy and psychiatric diagnostic interview examinations, and testing and pharmacologic management provided to members in a variety of referring sites by physicians, nurse practitioners and physician assistants, will continue to apply.

E/M services in the range of Current Procedural Terminology (CPT) codes **99201-99204** and **99212-99214**, billed with a GT modifier, may be provided regardless of the member's location.

- Initial guidance for provision of these telehealth services was limited to established patients only. Effective April 16, 2020, these codes are reimbursable to new and established patients. Standards for authorization, referral, service limits and standards of medical necessity must be satisfied prior to initiation of care for a new patient.

- Standard requirements related to the referring site, the presence of a certified or licensed professional and specific technology are waived.

In addition, psychological testing and management, crisis intervention, and case management provided telephonically are currently reimbursed. Providers can find more details about this benefit in the state plan or the relevant provider manuals located on the SCDHHS website at: scdhhs.gov/provider-manual-list.

Telephonic care provided by Licensed Independent Practitioners (LIPs)

To help ensure continuity of care within patient-provider relationships, licensed psychologists and other LIP providers (LPC, LPC-S, LMFT, LMFT-S, LISW-CP, LISW-AP, and LPES), who are enrolled in the Medicaid program, will be allowed to

provide periodic check-ins and assessments and telehealth video conferences with new and established patients.

During the COVID-19 public health emergency and response, the provision of telemedicine services will also be extended to associate-level providers, individuals who have met the educational and testing requirements to be licensed for a profession, but have not met the experience hours or case requirements for full licensure. During the period of associate licensure, associates practice with limited supervision under the guidance of a fully licensed supervising professional, who is responsible for the associate's professional activities during the period of limited licensure. The following associate types may render services and receive reimbursement under the registration of their supervising providers:

- Licensed Professional Counselor – Associates
- Licensed Marriage and Family Therapist – Associates
- Licensed Master Social Worker
- Psychologist – Postdoctoral Pending Licensure

Billable telephonic care codes for LIPs (during the COVID-19 health emergency):

Code	Description
98966	Telephonic Assess/Mgmt; 5-10 minutes, non-physician
98967	Telephonic Assess/Mgmt; 11-20 minutes, non-physician
98968	Telephonic Assess/Mgmt; 21-30 minutes, non-physician

- Telephonic care codes should not be billed if the telephonic encounter originates from a related assessment and management service provided within the preceding seven days or if it leads to an assessment and management service or procedure within the subsequent 24 hours.
- A total of three encounters will be allowed every 30 days, and services may be provided regardless of the Medicaid member's location.
- Use current modifiers (AH, HO) as the first modifier and a "GT" modifier as the second modifier when billing these codes.
- Telephonic crisis management continues to be available through the community mental health, LIPs, and rehabilitative behavioral health services benefits. The three encounter limitation does not apply to crisis management.

- Notification and medical necessity requirements related to the provision of crisis management continue to apply.

Billable telemedicine codes for LIPs (during the COVID-19 health emergency):

Code	Description	Limitation
90832	Individual Psychotherapy, 30 Minutes	1/day, 6/month
90834	Individual Psychotherapy, 45 Minutes	1/day, 6/month
90837	Individual Psychotherapy, 60 minutes	1/day, 6/month
90846	Family Psychotherapy, without client, 50 minutes	1/day, 4/month
90847	Family Psychotherapy, Including Client, 50 minutes	1/day, 4/month
90791	Psychiatric Diagnostic Evaluation without Medical	1 per 6 months
H2014	Behavior Modification	4 units/day
H2017	Psychosocial Rehabilitation Service (individual)	4 units/day
S9482	Family Support	4 units/day

Note: These limitations and billing guidelines apply only when these services are provided via telehealth.

- Initial guidance for these telehealth flexibilities was limited to established patients only. Effective April 16, 2020, these codes are reimbursable to <u>new</u> and established patients. Standards for authorization, referral, service limits and standards of medical necessity must be satisfied prior to initiation of care for a new patient.
- The services and limitations listed may be delivered without regard to the patient's location.
- A synchronous audio-visual, telehealth delivery platform must be used.
- Use current modifiers (AH, HO) as the first modifier and a "GT" modifier as the second modifier when billing these codes.
- Providers engaging in telemedicine services are required to ensure that the quality of care delivered is the same as if engaging the patient in a face-to-face format.
- Only individual services are eligible for telemedicine. <u>Group or multi-family interventions are not reimbursable, nor are services with staff-to-member ratio less than one-to-one.</u>
- Providers may not conduct interventions remotely with more than one individual concurrently and must conclude any intervention or visit with one patient before commencing an intervention or visit with the next.

- Providers must still follow the course of therapy and limitations detailed in the member's individual plan of care (IPOC).
- Since services are not being conducted face-to-face, signature requirements for service plan development (SPD), IPOCs and written consents for treatment are being waived.
- In lieu of the wet-ink signature, providers must document verbal consent for treatment of all parties present during the telephone/video conference and include a time stamp.

Prior authorizations:

For services that normally require prior authorization, Select Health will continue to review for medical necessity, exercising discretionary flexibility warranted by the current COVID-19 public health emergency. Providers should continue to submit prior authorization requests by completing the applicable form found on the Select Health website, http://www.selecthealthofsc.com/provider/resources/forms.aspx, through the NaviNet provider portal or by calling Population Health Utilization Management at **1-888-559-1010**. Current authorizations that are scheduled to expire will be reviewed for possible extension upon request for the duration of the COVID-19 health emergency.

Authorization for members in Foster Care:

During the COVID-19 pandemic, medical necessity reviews will be waived for behavioral health services for children in foster care. However, notification of the services to be rendered is still required by calling Population Health Management at **1-888-559-1010**.

Members who are unable to self-direct or engage with a telephone or audio-visual device without a provider's presence may require face-to-face interactions to receive the therapeutic effect of the interventions.

When services are provided in a manner consistent with standard SCDHHS policy, such as care delivered face-to-face or through the therapeutic foster care system, existing limitations and billing requirements apply.

General Information

Several exclusions remain in place during the COVID-19 response to ensure that Medicaid reimbursement is available only when the quality of patient care remains at a clinically appropriate level and may not be provided via telemedicine, including:

- Administration of injectable medication.
- Inpatient services administered in a hospital inpatient psychiatric setting or Psychiatric Residential Treatment Facility (PRTF) cannot be provided in alternate settings and monitored remotely.
- Services provided by providers who are not licensed or credentialed to practice independently are also excluded (unless otherwise noted).

Families and members should be given every opportunity to make informed decisions about the receipt of services via telemedicine, including the clinical appropriateness of the intervention, its limitations, privacy and confidentiality, and the effect the provider's setting has on each of these issues.

Reimbursement for the telephonic services is available if the interaction with the member includes telephone and/or video interactions. Other forms of electronic communication, such as email and instant and text messaging, are not eligible for reimbursement.

For all telemedicine services, the audio and visual components of the interaction must include sufficient quality and/or resolution for the provider to effectively deliver the care being administered.

SCDHHS has also published the fee schedule for telehealth codes that have been created during the public health emergency and further guidance for providers through a newly launched COVID-19 frequently asked questions (FAQs) page. Both resources are available on the Agency's COVID-19 website, the fee schedule is located at: www.scdhhs.gov/resource/fee-schedules and the FAQ can be found at: https://msp.scdhhs.gov/covid19/faq-resources. Additional questions or concerns may be submitted directly to SCDHHS by emailing: covid@scdhhs.gov.

Thank you for your cooperation during this challenging time and for the valuable services you provide our First Choice members.