



Michelle Lujan Grisham, Governor
David R. Scrase, M.D., Secretary
Nicole Comeaux, J.D., M.P.H, Director

Letter of Direction #31

Date: April 3, 2020

To: Centennial Care 2.0 Managed Care Organizations

From: Nicole Comeaux, Director, Medical Assistance Division

Subject: COVID-19 Guidance for CC 2.0 MCOs Repeal & Replace LOD #30

Title: COVID-19 Guidance for CC 2.0 MCOs

HSD would like to draw attention to the following noted changes since the March 18, 2018 Letter of Direction #30 was released.

1. Addition of Telehealth. See section 3(b);
2. Addition of Teledentistry codes. See section 3(c);
3. Clarification of Revenue Code for FQHCs. See section 3(e);
4. Addition of ABA codes. See Sec. 3(f);
5. Guidance clarification of non-utilization of Community Benefits. See section 5(b);
6. Revised Nursing Facility Level of Care Requirements. See section 5(c);
7. Guidance for enrollment for Out-of-State providers. See section 7(a); and
8. Revised Reporting Requirements. See section 9(b).

The purpose of this revised Letter of Direction (LOD) is to provide guidance and directives to the Centennial Care 2.0 Managed Care Organizations (MCOs) for modification of services and program standards related to the national public health emergency associated with the 2019 Novel Coronavirus (COVID-19) outbreak. The purpose of these changes is to assure the continuation of essential services to Medicaid patients without disruption or delay while following Centers for Disease Control and Prevention (CDC) direction to maximize social distancing for the duration of the public health emergency.

The Centers for Medicare and Medicaid Services (CMS) issued a Disaster Toolkit and an Inventory of Medicaid and CHIP Flexibilities and Authorities that states may exercise in the event of a disaster. At this time, we are concurrently submitting waivers to exercise these authorities and CMS has indicated that they will provide flexibility in Medicaid and CHIP programs, so states can respond effectively to this virus. Therefore, effective immediately, HSD directs the MCOs to implement the following strategies for all Medicaid members:

1. Member and Provider Communication Protocols:

- a. **MCO Call Centers** - All MCO call center communications related to COVID-19 must align with messaging delivered by the Centers for Disease Control and Prevention (CDC), the New Mexico Department of Health (DOH), and the New Mexico Human Services Department (HSD). The MCOs are expected to work collaboratively to ensure that their messaging is consistent and in alignment with these agencies.

The MCOs are expected to assure that call center staffing is adequate to meet the volume demand of MCO members and providers. This means that staffing patterns may need to be temporarily increased through the termination of the emergency declaration. HSD is aware that the DOH COVID-19 call center may experience call volume that exceeds DOH capacity for the next several weeks and months; therefore, the ability of MCOs to assist with calls and to assure alignment with federal and state messaging will remain critical during this timeframe.

- b. **Nurse Advice Lines** - The requirements above apply to the MCOs' nurse advice lines. The MCOs are expected to assure adequate staffing and training to meet the demand for members in need of direction and advice related to COVID-19 testing and treatment. Additionally, the MCOs are required to expand their nurse advice line services to operate on a 24-hour/7-day per week basis for the duration of the emergency if such functionality does not already exist.
- c. **MCO Websites and Member Materials** – The MCOs are required to maintain up-to-date information on their websites and to develop member materials related to COVID-19. Information should include where members can obtain testing services and the symptom prompts and risks that indicate when testing is warranted. Member materials related to COVID-19 do not require HSD approval through the termination of the emergency declaration; however, as directed in paragraph 1a above, all materials must align with CDC, DOH and HSD messaging.

2. COVID-19 Testing and Treatment Services:

- a. **New Billing Codes for Testing** – HSD has added three new laboratory billing codes as directed by the Centers for Medicare and Medicaid Services (CMS) for COVID-19 lab testing. These codes are identified in Appendix A, Table 1 of this LOD.
- b. **Drive-Through Testing/Screening** – HSD requests that the MCOs work with their contracted providers and in coordination with Department of Health (DOH) to develop “drive-up” or “drive-through” testing and screening services, including the use of this strategy in rural/frontier areas to the greatest possible extent. This strategy will help to alleviate the impact of crowding in medical clinics and facilities and mitigate the spread of COVID-19. Drive-Through testing will be billed in accordance with current rules dependent on provider type and the associated facility where the testing is done.

HSD is committed to working collaboratively with the New Mexico Licensure Board to clarify and confirm that, for the duration of the emergency, conducting an online exam for a patient that has not yet been established with the practice is not considered “unprofessional or dishonorable conduct” per 16.10.8.8 NMAC.

HSD is submitting a 1135 waiver that would permit us to provide payments to facilities for providing services in alternative settings.

- c. **Prior Authorizations for Testing and Treatment** – HSD directs the MCOs to waive all prior authorizations for members to obtain COVID-19 testing and treatment services (including inpatient and outpatient), and to alert providers of this provision. Additionally, HSD reminds the MCOs that coverage of all medically necessary emergency care is required without prior authorization, whether such care is provided by an in-network or out-of-network provider.
- d. **Prohibition Against Cost-Sharing for Testing or Treatment** – Consistent with current Medicaid regulations, members are exempt from all cost-sharing including for COVID-19 screening, testing and treatment services. Members may not be held liable for unlawful balance bills from providers for these or other services provided to Medicaid members.
- e. **Prior Authorizations for All Other Services** – MCOs are directed to extend all existing prior authorizations through the termination of the emergency declaration. Additionally, the MCOs are required to maintain 24-hour/7-day per week access to individuals with the authority to authorize services. HSD must have contact information for these individuals. For direction on long-term care services, please see section 5 below.
- f. **Coverage of Durable Medical Equipment** – HSD is waiving the face-to-face requirement for obtaining a new physician’s order and new medical necessity documentation for replacement of DME, prosthetics, orthotics, and supplies (DMEPOS) when DMEPOS are lost, destroyed, irreparably damaged, or otherwise rendered unusable.

3. New Codes for Telephonic Visits and E-Visits:

Effective March 1, 2020 and for the duration of the COVID-19 Public Health Emergency, HSD has broadened access to Medicaid telehealth services so that patients can receive a wider range of services from their doctors without having to travel to a healthcare facility. Providers must maintain appropriate documentation of all services rendered.

HSD is directing the MCOs to direct providers to render telehealth services in all settings, including member’s home, through the termination of the declaration of the emergency in lieu of in-person care to reduce the risk of spreading COVID-19 through face-to-face contact.

- a. **Physical Health/Telehealth:** HSD has activated/added new codes (CPT, HCPCS or Revenue Code) to encourage the use of telephonic visits and e-visits in lieu of in-person care. These codes will remain an option for all provider types for the duration of the emergency. These codes and rates can be found in Table 1.

The providers have (should be given) two options to bill their services:

- as they are currently doing using one of the modifiers listed in Table 1. The use of modifier will identify the service was rendered via telehealth. Reimbursement will not be affected by the use of modifier and will be reimbursed with the same rates as face-to-face that are currently established for such services.
- or
- bill using one of the telehealth codes listed in Table 1.

- a. **Teledentistry** – HSD is expanding services for teledentistry. Please refer to Table 1. of this LOD.
- b. **For Telehealth rendered in Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Hospital-Based RHCs (HBRHCs), and the Indian Health Service (IHS)** – Please refer to Appendix A, Table 1 of this LOD.
- c. **Behavioral Health** - The MCOs are directed to allow behavioral health providers to bill for telephonic visits using the same codes and rates that are currently established for such services. Authorized codes can be found in Appendix A, Table 1 of this LOD.

These services will be paid as if the member received services onsite and in person. This will remain an option for providers through the termination of the emergency declaration and applies to both initiation of care as well as treatment of established patients. Initiation of care can be for any reason, including member self-referral.

Providers are directed to bill for BH Telephonic Visits using Location Code 02 – Telephonic Visit on the claim form. If Location Code 02 is on the claim form, the services are billable to the MCO and should be paid at the normal rate for the service. All other normal modifiers should be included on the claim if otherwise required. The originating site HCPCS code Q3014 is not billable for these services since the normal office visit payment is to be made instead. FQHCs and other facilities that are not able to use Location Code 02 on the claim may use revenue code 0780 on the claim in accordance with paragraph 3d above.

These visits will be considered as equivalent to in-person visits through the termination of the emergency declaration and counted toward HEDIS, NCQA, and other performance and target measures assigned by HSD. In accordance with existing policy, providers are expected to maintain all appropriate medical records. Any medical records requiring in person presence

(e.g., height, weight, etc.) are to be noted in the record as “Excused per state declaration re: COVID-19”.

Telephonic BH visits must be synchronous; that is, consisting of live voice conversation with the patient or family. Asynchronous or “store and forward” visits are not payable under this provision.

Services must be provided by a practitioner who is contracted with the MCO and within the practitioner’s normally allowed scope of practice.

For the purposes of MCO reporting and accountability, telephonic BH visits will count per the service categorization logic included in *Centennial Care MCO Financial and Utilization Reports, General Instructions for the Categorization and Reporting of Health Care Service Expenses*. This provision will apply through the termination of the emergency declaration.

The existing Supportive Housing HCPC codes remain in effect at this time and will continue to be billed as previously instructed.

- d. **Applied Behavior Analysis (ABA) Services:** The MCO’s are directed to allow ABA providers to bill for telephonic visits using the authorized codes identified in Appendix A, Table 1 of this LOD, with the same rates as face-to-face that are currently established for such services.

Providers are directed to bill for ABA Telephonic Visits using Location 02- Telephonic Visits on the claim form. If Location Code 02 is on the claim form, the services billable to the MCO and should be paid at the normal rate for the service.

All normal Modifiers should be included on the claim if otherwise required.

These services will follow the same protocols as section 3 (e) above.

4. Care Coordination:

- a. **Care Coordination** – HSD is waiving the in-person, face-to-face requirements for all care coordination home visits through the termination of the emergency declaration. The Comprehensive Needs Assessment (CNA) exception form will not be required during the emergency declaration period. The MCOs are required to continue all care coordination activities using telephonic visits or, if the capacity exists for the member and MCO, virtual visits. Care coordination activities that normally require a home visit with face-to-face member interaction include initial, annual and semi-annual CNAs; semi-annual and annual in-person touch points; transition of care three-day in-home assessments; and Nursing Facility Level of Care (NFLOC) determinations for Community Benefits. Although the face-to-face home visit requirement is waived during this emergency period, the MCOs are directed to report all

telephonic and virtual care coordination contacts with members into the Care Coordination Report (Report #6).

5. Other In-Home Services & Community Benefits:

- a. **Centennial Home Visiting (CHV)** - HSD is temporarily waiving the requirement that CHV program providers perform in-home visits. Instead, Nurse Family Partnership and Parents as Teachers home visitors will follow telehealth guidance in accordance with their curriculum standards, including the use of videoconferencing, if possible. Any activities that require an in-person visit with CHV clients will be deferred through the termination of the emergency declaration.
- b. **In-Home Community-Based Services & Personal Care Services (PCS)** – For in-home community-based services, including Personal Care Services (PCS), Respite, Support Broker and Home Health Aide services, the MCOs must obtain, review and ensure implementation of each agency’s emergency disaster plan. The agency disaster plans must include actions for in-person visits with members who have a confirmed diagnosis of COVID-19, and back-up plans for providing care when the member’s caregiver has been diagnosed with COVID-19.

PCS agencies should follow the guidance provided by the Centers for Disease Control (CDC) and Prevention on implementing Home Care of people not requiring hospitalization for Coronavirus Disease 2019 (COVID-19) located at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html> and outlining the prevention of spreading of Coronavirus Disease 2019 in Homes and Residential Communities. Guidance can be found at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html>. MCOs are required to work collaboratively to develop mutually agreed upon protocols to reduce the administrative burden for providers.

MCOs must ensure that PCS agencies are maintaining and providing back-up caregivers per Section 8.14 of the Managed Care Policy Manual. The MCOs are required to ensure that every member receiving PCS has a back-up plan and that members and caregivers are aware of such plans. Informal supports must be researched as back-up caregivers.

HSD is allowing for lapse in annual and an extension of 6 months for initial CPR and First Aid training requirements as outlined in section 8.14 of the Managed Care Policy Manual effective with this LOD.

HSD is suspending the in-home supervisory visit requirements for all in-home care services outlined in Section 8 of the Managed Care Policy Manual. Telephonic supervisory visits must be used instead of in-home supervisory visits.

The MCOs should continue their current processes for Electronic Visit Verification (EVV)

exceptions, like substitute caregivers, while working closely with PCS providers to mitigate administrative burden. The MCOs will need to continue monitoring and reporting the exceptions as directed in MCO report 35.

Additionally, MCOs are directed to not start the timeclock for non-utilization of Community Benefits for waiver recipients. Member's waiver services should continue without a break in service until further notice.

- c. **Nursing Facility Level of Care (NFLOC) Redeterminations** - HSD will be suspending NFLOC redeterminations (annual or LOC change) for impacted (COVID-19 positive) members through the termination of the emergency declaration. MCOs will continue to receive 112 files and should continue to submit 113 files as usual when NFLOC determinations are able to be completed.

MCOs must extend NF LOC determinations and setting of care (SOC) in Omnicaid and reissue prior authorizations for all long-term care services. HSD will provide the MCOs with lists of extended categories of eligibility (COEs) from ASPEN, that must be adjusted in the Omnicaid system for an additional three (3) months of long-term care eligibility.

HSD is not changing timeframes for completing initial NFLOC determinations as outlined in section 7.9 of the Managed Care Policy Manual at this time, however the in-person visit requirement is being waived and shall be replaced with a telephonic assessment as stated in the Care Coordination section above. If the MCO is not able to conduct a telephonic assessment for the NFLOC determination, the MCO may utilize the LOC packet from the existing NFLOC determination during the emergency declaration period. MCOs are required to track and report to HSD the members that fit in this category.

6. Pharmacy Requirements:

- a. **Maintenance Drugs** – In accordance with current policy, all maintenance drugs may be dispensed in amounts up to a 90-day supply (excluding controlled substances). HSD is waiving the maximum supply requirement for maintenance drugs.

Additionally, HSD is relaxing restrictions on early medication refills as follows:

- i. 30-day prescriptions will allow a refill when the member has 2 weeks of medication on-hand, or what is allowed by the MCO if least restrictive.
- ii. 90-day prescriptions will allow a refill when the member has 3 weeks of medication on-hand, or what is allowed by the MCO if least restrictive.

- b. **Controlled Substances** – Drugs defined as controlled substances shall continue to be prescribed and dispensed in accordance with the requirements of the SUPPORT Act. For 30-day opioid and opioid-like prescriptions, HSD will allow a refill when the member has 7 days of medication on-hand.
- c. **Non-Maintenance Drugs** - Prescriptions for non-maintenance drugs are limited to 34-day supply.
- d. **Monitoring and Reporting of Drug Shortages** – The MCOs are required to work closely with their Pharmacy Benefit Managers (PBMs) to monitor the potential of drug supply chain shortages, and to report this information to HSD immediately upon learning that the supply of any particular drug item may be at risk of a shortage. This information must be reported to HSD proactively and immediately at any point that the MCO becomes aware of a potential supply chain problem.

7. **Provider Network Requirements:**

- a. **Network Adequacy** – The MCO provider networks must be adequate to handle an increase in the need for health care services, including offering access to out-of-network services for Medicaid members where appropriate and required, as more COVID-19 cases emerge in New Mexico. With this directive, HSD is granting additional flexibilities to the MCOs to work with out-of-state providers as quickly as possible so they can provide care to New Mexico Medicaid members who may be traveling or currently located outside of the state. This may include relaxed or expedited credentialing requirements and criteria. MCOs may continue to register (via the online MCOR process) non-network providers located, and providing services, out of state.
 - b. **Network Changes** – All MCO contracted providers must provide immediate notification of any expected or unexpected closures. The MCOs must submit a notification to HSD regarding any significant change in their provider networks immediately upon receipt of such notification. In addition, the MCOs should assist all members who need immediate care with transition to a different provider/facility.
 - c. **Provider Site Visits and Revalidations** – HSD is temporarily suspending provider site visits and revalidation activities. The MCOs are authorized to do the same to the extent that such activities may pose difficulties in expediting provider contracting and credentialing.
8. **Fair Hearings:** HSD is temporarily extending the number of days that a member has to request a state fair hearing resulting from an adverse action determination. HSD will extend the number of days from the current 90-day requirement to give members up to 120 days for the duration of the emergency.

9. Reporting Requirements:

- a. **Reporting on Provider Rate Increases** – The MCOs should continue to submit their weekly provider rate increase reports every Monday.
- b. **Other Reporting Requirements** – HSD is suspending required program and financial reporting submissions and associated reporting penalties, with the exception of those listed below. The MCOs should continue to monitor and capture data for all required reports. Normal reporting operations are to resume once the emergency declaration is terminated.

Required Program Reports	
#2 – Call Center	#44 - Pharmacy
#3 – Network Adequacy	#55 –Geo Access
#4 – Community Benefit	#56 –Program Integrity
#6 – Care Coordination	LOD #22- TM2, TM4, TM8, and TM9 are required
#5 – Admissions and Readmissions	LFC Performance Measures
#8 – NFLOC	Pregnancy Termination Services report
#35 – EVV	Agency-Based Community Benefit Provider Contracting
Tracking Measure #4	
Ad Hoc Reports	
Behavioral Health Utilization Management	Residential Treatment Center
Behavioral Health Telemedicine	
Required Financial Reports	
FIN #28	

- 10. **Effective Date and Additional Emergency Actions Pending Federal Approval:** HSD is working with its federal partners to obtain some of the authority outlined above as well as additional authorities and regulatory waivers that will enable further flexibility while emergency

conditions persist. Requested authorities will include modifications to eligibility and enrollment requirements, such as annual recertifications, eligibility thresholds, presumptive eligibility, and relaxed verification criteria with the goal of keeping members covered through the termination of the emergency declaration. The waivers and resulting authority have different effective dates dependent on emergency declarations. We have included a summary sheet in Appendix A that outlines our current understanding of these effectives and respective authorities. HSD will provide updated information on these topics as it becomes available.

HSD values its continued collaboration and partnership with the MCOs to implement these directives as quickly as possible to help assure the health and safety of Medicaid members and our fellow New Mexicans. Further direction will be provided as guidance and authorities become available.

Sincerely,

A black rectangular redaction box covering the signature of Nicole Comeaux.

Nicole Comeaux, JD, MPH
Director

Appendix A.

Summary of Waiver Authority Requested March 18, 2020

The Centers for Medicare and Medicaid Services (CMS) issued a Disaster Toolkit and an Inventory of Medicaid and CHIP Flexibilities and Authorities that states may exercise in the event of a disaster. At the time of the release of this Letter of Direction, we are concurrently submitting waivers to ensure we have all of the tools available to us to combat this virus and will employ them as appropriate:

In response to the COVID-19 pandemic, New Mexico Medicaid will be requesting amendments to our 1115 and 1915(c) waivers that will allow us to (Effective date January 27, 2020):

1. Provide Medicaid coverage for testing and/or treatment for COVID-19 at higher income levels for individuals who are uninsured
2. Extend hospital presumptive eligibility to aged, blind, and disabled individuals and allow all Presumptive Eligibility Determiners to conduct determinations for all categories
3. Extend time frame for filing an appeal
4. Extend Level of Care authorizations for Home and Community Based Service recipients
5. Permit payment for 1915(c) waiver services rendered by family caregivers or legally responsible individuals

With the authority permitted under section 1135 of the Social Security Act we will be requesting to (Effective Date: March 1, 2020):

6. Waive prior authorization requirements in fee-for-service and managed care, as well as extend current prior authorizations
7. Allow enrollees to have more than 120 days (in the case of a managed care appeal) or 90 days (in the case of an eligibility or fee-for-service appeal) to request a fair hearing.
8. Allow enrollees to have more time to request a fair hearing
9. Temporarily waive provider enrollment requirements to ensure a sufficient number of providers are available to serve Medicaid enrollees. Such requirements include site visit prior to enrollment.
10. Temporarily cease the revalidation of providers who are located in- state or otherwise directly impacted by a disaster
11. Permit providers licensed out of state/territory to provide care to Medicaid members
12. Allow facilities to provide services in alternative settings, such as a temporary shelter, when a provider's facility is inaccessible
13. Temporarily delay or suspend onsite re-certification and revisit surveys, and some enforcement actions, and/or allow additional time for facilities to submit plans of correction
14. Temporarily suspend 2-week aide supervision requirement by a registered nurse for home health agencies
15. Temporarily suspend supervision of hospice aides by a registered nurse every 14 days requirement for hospice agencies
16. Temporarily suspend application of EMTALA sanctions for redirection of an individual to receive a medical screening examination in an alternative location or transfer of an individual

who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency

We will also be looking to exercise existing authority under existing Code of Federal Regulations to (Effective March 1, 2020):

17. Relax restrictions on early medication refills
18. Permit telephonic visits in lieu of face-to-face requirements for behavioral health and physical health visits
19. Temporarily suspending the requirement that individuals who meet all Medicaid eligibility requirements (financial and technical) be institutionalized for 30 day before receiving benefits

We will also be implementing system changes and exercising existing authority under existing Code of Federal Regulations to (Effective date to be determined):

20. Suspend automatic redeterminations
21. Allow self-attestation for all eligibility criteria (excluding citizenship and immigration status) on a case-by-case basis for individuals subject to a disaster when documentation is not available.

Appendix B. COVID-19 Resources and Guidance

State Resources:

New Mexico COVID-19 Information <http://cv.nmhealth.org/>

Federal Resources:

Centers for Disease Control and Prevention <https://www.cdc.gov/coronavirus/2019-nCoV/summary.html>

Centers for Medicare and Medicaid Services <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>

Table 1. Authorized Telehealth Codes

Code	Description	Medicaid FFS Rate
Laboratory Codes		
U0001	CDC lab tests for SARS-CoV-2 (COVID-19)	\$35.92
U0002	Non-CDC lab tests for SARS-CoV-2/2019-nCoV (COVID-19)	\$51.33
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)	To be determined; manually price until rate is established
Physical Health Services		
	<p>MCOs should allow the providers (i.e., provider who can bill E&M services, physicians, mid-level providers, OT, PT, and SLPs) to continue to bill their services as they are currently doing. A service provided via telehealth would be billed using one of the following modifiers. Reimbursement will not be affected by the use of modifier. Some providers may be limited to a percentage of the rate. Reimbursement to a CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service.</p> <p>-GQ: Telehealth store and forward (or) -GT: Interactive telecommunication (or) -95: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.</p> <p>MCOs should allow all providers to continue to bill their services as they are currently (for example: physicians, mid-level providers, OT, PT, SLPs, providers who can bill E&M services, Emergency Department visits and others). A service provided via telehealth would be billed using one of the following modifiers.</p> <p>Reimbursement will not be affected by the use of a modifier. Some providers may be limited to a percentage of the rate. Reimbursement to CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service. HSD is aligning with the Medicare guidance for telehealth services for the duration of the public health emergency. For detail on the Medicare guidance, including specific codes and</p>	<p>At the same reimbursement rate as face-to-face encounters/visits.</p>

	<p>provider types, please refer to https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf</p> <p>-GQ: Telehealth store and forward (or) -GT: Interactive telecommunication (or) -95: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.</p>	
(or) Other Telehealth Options		
<i>Physician Telephone Services</i>		
<i>Some providers (i.e., provider who can bill E&M services, physicians, mid-level providers) may be limited to a percentage of the rate. Reimbursement to a CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service.</i>		
<i>Physician Telephone Services (for example: provider who can bill E&M services, physicians, mid-level providers). Some providers may be limited to a percentage of the rate. Reimbursement to CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service.</i>		
<i>Note: During the COVID emergency, the following codes can be used for both new and established patients.</i>		
99441	Telephone Evaluation and Management (E&M) service provided by a physician to an established patient, parent or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion.	\$55.34
99442	Same as above - 11-20 minutes of medical discussion	\$101.71
99443	Same as above - 21-30 minutes of medical discussion	\$135.63
<i>Non-physician Telephone Services (i.e. OT, PT, SLP) (for example: OT, PT, SLPs)</i>		
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or	\$12.05

	soonest available appointment - 5-10 minutes of medical discussion	
98967	Same as above - 11-20 minutes of medical discussion	\$23.78
98968	Same as above - 21-30 minutes of medical discussion	\$34.88
<i>Interprofessional Consultation Codes</i>		
99451	Reported by the consultant, allowing him/her to access data/information through the electronic health record, in addition to telephone or internet - 5 minutes	\$33.25
99452	Reported by the requesting/treating physician or qualified health provider (i.e., provider who can bill E&M services, physicians, mid-level providers) - 30 minutes (for example: providers who can bill E&M services, physicians, mid-level providers)- 30 minutes.	\$33.25
<i>Real-Time Interactive Audio/Video</i>		
99421	Non face-to-face online digital E&M service for an established patient, for up to 7 days cumulative time during the 7 days - 5-10 minutes	\$39.59
99422	Same as above - 11-20 minutes	\$65.66
99423	Same as above - 21 or more minutes	\$96.31
<i>Other Telehealth Codes – Assessing and Monitoring</i>		
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment.	\$11.52
G2012	Brief communication technology - based service (e.g., virtual check -in) by a physician or other qualified health care professional who can report E&M services, provided to an	\$13.03

	established patient, not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment - 5-10 minutes of medical discussion or just "brief check-in by MD/QHP" for short, used in medical care.	
G2061	Qualified nonphysician (i.e. OT,PT,SLP) (<i>for example: OT, PT, SLPs</i>) healthcare professional online assessment, for an established patient, for up to 7 days, cumulative time during the 7 days - 5-10 minutes.	\$10.90
G2062	Same as above - 11-20 minutes.	\$19.20
G2063	Same as above - 21 or more minutes.	\$30.07
Dental Telehealth Codes		
D9995	Teledentistry synchronous real-time: when the dentist and participant interact as if they were having a face-to-face service. Services that can be provided effectively telephonically without real-time video may also be covered via telehealth. The code will be reimbursed at the same rate as D0140- face-to-face limited oral evaluation (problem focused) service. Providers must continue to maintain appropriate documentation of all services provided and related to medical necessity.	\$28.94
Telehealth Billing for Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Hospital-Based RHCs (HBRHCs), and the Indian Health Services (IHS)		
780	<p>Telemedicine General classification</p> <p>Scenario 1: A telehealth service that is rendered with the patient present should be billed using the appropriate clinic visit revenue code. The telehealth service must be reported separately using revenue code 0780 and HCPCS code Q3014- Telehealth Originating Site -Facility Fee.</p> <p>Scenario 2: A service rendered through telehealth only should be billed as a single line of service using their current face-to-face encounter revenue code and HCPCS code Q3014 to identify this as a telehealth service.</p> <p>Dental: Please continue to bill procedure code D0999 and enter a POS 02- Telehealth.</p>	<p>Scenario 1: Reimbursed the encounter/OMB rate plus the telehealth HCPCS fee schedule rate.</p> <p>Scenario 2: Reimbursed at the encounter/OMB rate</p> <p>Dental: Reimbursed at the encounter/OMB rate</p>

Entering revenue code 0780 is not necessary.

<i>Behavioral Health Telephonic Visits – Authorized Codes</i>			
90832	90833	90834	90836
90837	90838	90839	90840
90846	90847	90849	H0049
H0050	G0175	S0220	G0444
G0443	G0406	G0407	G0408
H0015	H0025	H0031	H0038
H0039	H2000	H2011	H2015
H2033	T1001	T1007	90785
90791	90792	99201	99202
99203	99204	99205	99211
99212	99213	99214	99215
99217	99218	99219	99220
90853	90863	99241	99242
99244	99245	99406	99243
99407	Rev Code 0513	Rev Code 0912	S0201
H2010	H2014	H2017	
<i>Applied Behavior Analysis (ABA) Authorized codes</i>			
T1026	0362T	97156	97152
97151	97153	0373T	97155