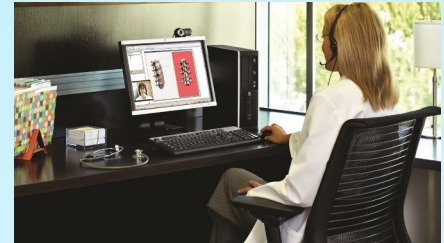




IHCP COVID-19 Response: IHCP responds to telemedicine FAQs as of April 1, 2020

The Indiana Health Coverage Programs (IHCP) is providing this frequently asked question (FAQ) bulletin to providers due to the change in telemedicine and telehealth during the current coronavirus disease 2019 (COVID-19) public health emergency. The following definitions have been revised to accommodate this current situation:



- **Telemedicine** – The use of technology which allows a healthcare provider to render an exam or other service to a patient at another location.
- **Telehealth** – The scheduled remote monitoring of clinical data through technologic equipment in the member's home. The IHCP covers telehealth services provided by home health agencies to members who are approved for other home health services.

1. Are there any changes regarding prior authorization (PA) requests or timely filing?

Some changes related to PA and specific services have been made; see *IHCP Bulletins* [BT202030](#) and [BT202031](#) for additional details. Please continue to check IHCP publications for updated information regarding COVID-19-related policy changes.

2. Can telemedicine be provided via audio-only communication?

Any IHCP-covered service – aside from the exclusions listed in [BT202022](#) and speech, occupational, and physical therapies – can be provided through audio-only, given that the service can reasonably be provided through audio-only communication. Some services may be better provided through video; however, the IHCP acknowledges some patients may not have access to video communication. [Executive Order 2020-13](#) excludes speech, occupational, and physical therapies from audio-only telemedicine.

3. What services cannot be provided via telemedicine?

According to [BT202022](#), surgical procedures, radiological services, laboratory services, anesthesia services, audiological services, chiropractor services, care coordination without the member present (unless this service is covered under the member's benefit plan or package), durable medical equipment (DME)/home medical equipment (HME) providers, and provider-to-provider consultation cannot be provided via telemedicine. Procedure codes that include physical interaction in the service definition, for example chiropractic services, which cannot be replicated via video or audio, are not reimbursable via telemedicine. IHCP expects providers to use their professional discretion when determining if a service can be provided via telemedicine.

4. Is the GT modifier required for codes not listed on the telemedicine code set?

The GT modifier is strongly encouraged, but is not required. If the GT modifier is not used on the claim, the provider must maintain and be prepared to provide documentation that notes that the service was provided via telemedicine. For information about billing for services listed on *Telemedicine Services Codes* (accessible from the [Codes Sets](#) page at in.gov/medicaid/providers), refer to the [Telemedicine and Telehealth Services](#) provider reference module.

5. Should the GT modifier be used in addition to the modifiers providers are already using?

Yes, however, the GT modifier is preferred, but not required. If you are already using four modifiers, there is no additional space for the GT modifier. In this case, ensure you document that the service was performed via telemedicine in the patient records and be prepared to provide those records if requested. Exceptions for home and community-based services (HCBS) are listed in next question response.

6. Does telemedicine apply to HCBS waiver services?

At this time, HCBS providers can provide services via telemedicine; however, CoreMMIS does not allow modifier GT to be billed with HCBS claims. Providers will need to record that the service was performed via telemedicine in the patient records. At this time we do not see this changing; however, the Office of Medicaid Policy and Planning (OMPP) will notify providers of any changes being made.

**7. Can providers prescribe controlled substances via telemedicine?**

Yes. In accordance with Executive Order 2020-13, a prescriber who is a Drug Enforcement Agency (DEA)-registered practitioner may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person evaluation so long as all the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his or her professional practice.
- The telemedicine communication is conducted using a real-time, two-way interactive communication system.
- All other applicable federal and state laws are followed.

This provision supersedes the provision in [Executive Order 20-12](#), paragraph 4.D. These visits may be done through either audio-only or audio and video telemedicine visits. See [Executive Order 2020-13](#) for additional details.

8. Are there any geographic limitations?

No, the IHCP does not apply geographic restrictions to telemedicine.

9. Will the managed care entities (MCEs) be following the same telemedicine guidance as fee-for-service (FFS) Medicaid?

The MCEs will be covering the same services via telemedicine as FFS Medicaid. However, the MCEs may have different rules regarding prior authorization (PA) and billing. Be sure to communicate with your MCE provider representatives for further guidance.

10. Which place of service code should be used?

For codes included in *Telemedicine Services Codes* (accessible from the [Codes Sets](#) page at [in.gov/Medicaid/providers](#)), use place of service (POS) code 02. For IHCP covered codes not on *Telemedicine Services Codes*, use the POS code most relevant to the member's location. If the member is located in his or her home, use POS code 12. For a complete list of codes, visit the [Place of Service Code Set](#) page at [cms.gov](#).

11. Is there a reduction in payment for providing services via telemedicine?

No, telemedicine pays at the normal rate for the procedure code.

12. What guidance is there for billing for Medicaid Rehabilitation Option (MRO) services on a roll-up claim?

The IHCP encourages providers to have separate line items for services performed via telemedicine with the GT modifier and services that were performed face-to-face. We expect providers to be reasonable in determining what can be billed via telemedicine and what cannot. An MRO service can be billed with a GT modifier, and there will be no difference in payment.

13. Will care coordination without the member present be covered for MRO beneficiaries?

There are no changes to current service definitions, except to allow telemedicine when reasonably able to do so. If care coordination without the member present is included in the member's benefit plan, then this service can be done via telemedicine.

14. Can Child and Adolescent Needs and Strengths Assessment (CANS), Adult Needs and Strengths Assessment (ANSA), and Child/Family Team Meetings (CFTM) be completed via telemedicine?

Yes. It is the IHCP's intent to allow providers to continue any service that can be reasonably provided via telemedicine.

15. What Clubhouse services can be delivered through telemedicine?

We ask that providers use their professional discretion when deciding if a service can be rendered via telemedicine and what kind of communication is most appropriate (video or audio-only).

16. Will HAF and facility fees be covered for services rendered via telemedicine?

There will be a future publication to address facility fee billing. Facility fees will still be covered via telemedicine, even if not at the facility. If submitted, the HAF adjustment factor will be applied per usual. We ask that providers are reasonable when determining what services can be performed via telemedicine. For example, behavioral health can be rendered via telemedicine, but an x-ray cannot.

17. What documentation is required for telemedicine visits?

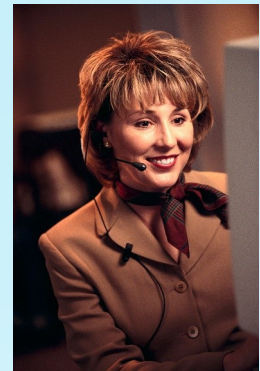
Patient consent for receiving a service through telemedicine and the location of the patient should both be documented. Patient consent may be received verbally or by electronic signature, and should be documented as such. Uploading the visit documents with the claim is not required.

18. Is IHCP making any changes to provider signature requirements?

The IHCP is following federal Centers for Medicare & Medicaid Services (CMS) guidance, which waives signature and proof of delivery requirements for Part B drugs and durable medical equipment (DME) when a signature cannot be obtained because of the inability to collect signatures. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19. See the [Durable Medical Equipment, Prosthetics, Orthotics and Supplies: CMS Flexibilities to Fight COVID-19](#) at [cms.gov](https://www.cms.gov) for additional information.

19. Can providers continue to operate under a current PA if the place of service is not listed as telemedicine?

For fee-for-service Medicaid members, yes. For members in managed care plans, please reach out to your provider representative for further clarification.



20. Do technologies need to be HIPAA compliant?

Health Insurance Portability and Accountability Act (HIPAA) federal guidance has been waived during this public health emergency. For additional information, see the [FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency](#) at hhs.gov. We ask that providers take steps to protect confidential information to the best of their abilities.

**21. What type of technology can be used for telemedicine?**

Any technology that allows for real-time interactive communication between the patient and provider is acceptable. This can be done either in a video format or audio-only communication. Services provided via email and text message formats are not reimbursable.

22. Can the patient/provider relationship be established via telemedicine?

Yes.

23. What is the specific guidance for federally qualified health centers (FQHCs) and rural health clinics (RHCs) when billing telemedicine?

When acting as the distant site:

- If billing FFS, bill the T1015 code with the appropriate place of service (POS) code (11, 12, 31, 32, 50, or 72). T1015 is not needed when billing claims to managed care entities.
- Bill procedure codes for the services rendered.
 - If the procedure code is on the existing *Telemedicine Services Codes* (accessible from the [Codes Sets](#) page at in.gov/Medicaid/providers), bill POS 02 and modifier 95 on the claim details.
 - If the procedure code is not on the existing *Telemedicine Services Codes*, bill the most appropriate place of service for where the member is located. It is strongly encouraged to also bill the GT modifier on the claim details.

It is still required that at least one service provided must meet the definition of a valid encounter. If the claim has no valid encounter procedure codes on the claim, it will deny.

When acting as the originating site, follow the instructions in the [Telemedicine and Telehealth Services](#) provider reference module. No changes have been made to this guidance when acting as the originating site.

QUESTIONS?

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