IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202071 JUNE 11, 2020

IHCP COVID-19 Response: COVID-19 policy FAQs as of June 11, 2020

The Indiana Health Coverage Programs (IHCP) hosted a live webinar on April 15, 2020, to address frequently asked questions (FAQs) concerning IHCP policies in response to the coronavirus disease 2019 (COVID-19). This bulletin includes questions and answers from the live webinar. These policies are in effect until the end of the national public health emergency.

1. ***How should providers bill for obstetric antepartum services delivered via telemedicine?***

   Providers should follow billing guidance described in *IHCP Bulletin* BT202022, BT202034 or BT202037, using the appropriate code for the service rendered. The IHCP encourages providers to use the GT modifier. Providers should use their professional discretion as to what services can and cannot be rendered via telemedicine. The IHCP acknowledges that while some antepartum procedure codes are listed in the surgical code range, fee-for-service (FFS) does not consider those services as surgeries; therefore, those services can be rendered via telemedicine.

2. ***How are Preadmission Screening and Resident Review (PASRR) requirements impacted by the 1135 waiver?***

   Section 1919(e)(7) of the 1135 waiver allows Level I and Level II assessments to be waived for 30 days. All new admissions can be treated as exempted hospital discharges. After 30 days, new admissions with mental illness (MI) or intellectual disability (ID) should receive a resident review as soon as resources become available.

   Additionally, please note that according to *Code of Federal Regulations 42 CFR 483.106(b)(4)*, new preadmission Level I and Level II screens are not required for residents who are being transferred between nursing facilities (NFs). If the NF is not certain whether a Level I had been conducted at the resident's evacuating facility, a Level I can be conducted by the admitting facility during the first few days of admission as part of intake. Transfers with positive Level I screens would require a resident review.

   The 7-to-9-day time frame for Level II completion is an annual average for all preadmission screens, not individual assessments, and only applies to the preadmission screens as indicated in *42 CFR 483.112(c)*. There is not a set time frame for when a resident review must be completed, but it should be conducted as resources become available.

3. ***For home health claims, does the nonphysician practitioner need to be enrolled in the IHCP for the claims to pay?***

   Yes, nonphysician practitioners do need to be enrolled in the IHCP to have claims paid as either an ordering, prescribing, or referring (OPR) or rendering provider. However, these providers can enroll provisionally during the public health emergency to hasten the process.

4. ***Are providers allowed to assist members with picking up prescriptions or groceries during the public health emergency?***

   The IHCP has not changed current policy for providers in regard to picking up prescriptions or groceries during the public health emergency.

5. ***Will providers be expected to provide additional documentation, such as a spreadsheet, after the public health emergency indicating which visits were rendered via telemedicine or is this only for internal provider records?***

   No, providers will not be expected to provide any additional documentation for all claims; this is only for internal records. However, if the IHCP requests documentation of the method by which a service was provided during the public health emergency, providers should be able to present documentation.

6. ***If a prior authorization (PA) was obtained for an outpatient service (for example, MRI or EKG) prior to the public health emergency but the service was not performed, will there be an extension of authorization approval dates until after elective procedures are resumed?***

   Providers should update the existing PA form. PA will not be automatically extended.

7. ***Can hospice election be done verbally during the public health emergency?***

   A signature is still required for hospice election at this time. See *IHCP Bulletin* BT202055 for additional details.

8. ***Will only provisionally enrolled providers need to revalidate after the public health emergency?***

   Provisionally enrolled providers will need to reenroll after the public health emergency. Providers will have at least 90 days to complete the full enrollment application. Already enrolled providers that were due for revalidation during the public health emergency will need to revalidate and will have at least 90 days to complete the revalidation. After the public health emergency ends, DXC Technology will indicate the enrollment or revalidation date for each provider. See *IHCP Bulletin* BT202029 for more information.

9. ***Which telephone codes are covered by Medicaid and which POS and modifiers should be included?***

   At this time, FFS Traditional Medicaid is covering telephone codes 98966, 98967, 98968, 99441, 99442, and 99443 for dually eligible members only.

   Providers may bill for a service delivered via audio-only communication using the standard code for that service with the GT modifier and POS most relevant to the member's location for members that do not have Medicare coverage as their primary insurance.

   See *IHCP Bulletins* BT202056 and BT202064 for more information on codes that are reimbursed for dually eligible members only.

10. ***Can nonphysician practitioners, such as advanced practice registered nurses (APRNs) deliver telemedicine?***

    If a provider type is allowed to perform a service face-to-face, they are allowed to perform that service via telemedicine during the public health emergency, so long as the service is not excluded from telemedicine in *IHCP Bulletin* BT202022.

11. ***What procedure codes can be used for COVID-19 specimen collection and testing? What is the allowable amount for procedure codes used for COVID-19 specimen collection?***

    Procedure codes G2023 and G2024 should be used for COVID-19 specimen collection and testing. See *IHCP Bulletins* BT202038 and BT202048.

12. How should providers bill audio-only evaluation and management (E&M) codes rendered via telemedicine?

It is the IHCP's intent to allow providers to continue any service that can be reasonably provided via telemedicine. These codes should be billed as described in *IHCP Bulletin* BT202022 with the place of service most relevant to the patient's location and the GT modifier. The IHCP may be providing additional guidance relating to well child visits. Look for more information in upcoming IHCP publications.

13. Can speech, physical, and occupational therapies be provided via telemedicine? If so, how should these therapies be billed?

Speech, physical, and occupational therapies can be provided via telemedicine; however, there must be a video component. Executive Order 20-13 excludes these services from audio-only telemedicine. Because these services are not on *Telemedicine Services Codes*, but are IHCP covered codes, providers should bill with the place of service most relevant to the patient's location and are encouraged to use the GT modifier. Providers should keep documentation of what services were rendered via telemedicine in the patient's file. Providers should use their professional discretion when deciding what services are suitable for telemedicine.

14. Can all applied behavioral analysis (ABA) therapy codes be rendered via telemedicine?

The IHCP asks that providers use their professional discretion when determining if a service can be delivered via telemedicine. ABA codes are not excluded and, therefore, may be performed via telemedicine so long as it is clinically appropriate.

Frequently asked questions (FAQs) for managed care entities (MCEs)

15. Are the MCEs allowing providers to bill under an enrolled location if patients are being seen offsite at a temporary location?

Yes, providers should bill under an existing enrolled location.

16. Can each MCE please clarify which place of service and modifier they are requiring for telemedicine visits?

Providers should bill for services with codes listed on *Telemedicine Services Codes* as normal with the place of service 02 and modifier 95, even if the service is rendered via audio-only communication. For services not listed on *Telemedicine Services Codes*, providers should use the place of service code for the patient's location with the encouraged, but not required, GT modifier. Providers should document that the service was performed via telemedicine in the patient records and be prepared to provide those records if requested. *Telemedicine Services Codes* are accessible from the *Code Sets* page at in.gov/medicaid/providers.

Note: In accordance with Executive Order 20-13, speech, occupational, and physical therapies cannot be delivered via audio-only communication.

Services that are excluded from the expanded telemedicine policy are outlined in *IHCP Bulletin* BT202022.

17. Will authorization approval dates be extended for outpatient services as many of these services had to be cancelled and rescheduled (for example, MRI or Echo)?

Providers should update the existing prior authorization (PA) form; PA will not be automatically extended.

18. Do providers need to update a PA form if the current PA does not have telemedicine listed as the place of service?

No, providers may continue to operate under a current PA even if the place of service is not listed as telemedicine. Providers should document which services are delivered via telemedicine in the patient's record.

19. Will MCEs cover Healthcare Common Procedure Coding System (HCPCS) code G2012?

HCPCS code G2012 is covered for dually eligible members only.

20. Are MCEs following the same PA relaxations as FFS?

Yes, per *IHCP Bulletins* BT202030 and BT202031, the MCEs will be following the same guidelines as the State.

Anthem: Unless identified as not requiring PA due to COVID-19, Anthem PA rules may be different from FFS. Providers may use the PLUTO tool on Anthem's website to check PA status for a Current Procedural Terminology (CPT®[1]) code.

21. Do the relaxed PA requirements for durable medical equipment (DME) products, repairs, and replacements also pertain to the MCEs?

Yes, see *IHCP Bulletin* BT202031.

QUESTIONS?

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