MISSISSIPPI DIVISION OF
MEDICAID

Emergency Telehealth Policy

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(Original Version)

Revisions as of April 10, 2020

The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

Contents

Emergency Telehealth Policy

In response to the coronavirus outbreak, the Mississippi Division of Medicaid (DOM) is expanding its coverage of telehealth services throughout the state in alignment with Governor Tate Reeves' recommendations on leveraging telemedicine to care for patients while limiting unnecessary travel, clinic visits and possible exposure. For a complete reference to DOM's updated telehealth policy, that includes procedures during States of Emergency, see the Administrative Code section: https://medicaid.ms.gov/administrative-code/emergency-administrative-code-filings/

DOM defines telehealth services as the delivery of health care by an enrolled Mississippi Medicaid provider, through a real-time audio and/or visual communication method, to a beneficiary who is located at a different site. DOM defines the distant site as the physical location of the provider delivering the telehealth service. The beneficiary's physical location at the time the telehealth service is provided is the originating site. During a State of Emergency, a beneficiary's residence is approved as an originating site.

Temporary Telehealth Services

Effective immediately through May 31, 2020, DOM's Emergency Telehealth Policy will allow additional use of telehealth services to combat the spread of Coronavirus Disease 2019 (COVID-19). Details of enhanced services include the following:

Improved Access for Beneficiaries

- A beneficiary may seek telehealth:
  - From the beneficiary's home with no telepresenter present,
  - From an originating site approved in the State Plan as listed below with a telepresenter present, or
  - From a temporarily approved originating as listed below with a telepresenter present.
- A beneficiary may use his or her personal cellular device, computer, tablet, or other web camera-enabled device to seek and receive medical care in a synchronous format with a DOM approved distant-site provider.
- Telehealth services do not include service delivery through text messages, email, a web portal, or other formats that do not include audio and/or visual components.

Requirements for the Provision of Temporary Telehealth Services

Temporary telehealth services provided during this period must meet the following criteria:

- The service rendered from the distant site must be safe and medically appropriate for delivery in the originating site.
- Any services provided through telehealth must meet the same standard of care as if provided in person.
- The beneficiary must give either verbal or written consent to receive telehealth services. Providers must document this consent.
- Providers may only bill:

    - Procedure codes that they are already eligible to bill, and/or
    - The temporary telehealth procedure codes.
- Services not otherwise covered by the Mississippi Division of Medicaid are not covered when delivered via telehealth.
- The availability of services through telehealth does not alter the scope of practice of any health care provider, nor does it authorize the delivery of health care services in a setting or manner not otherwise authorized by law.
- The GT modifier should be used in addition to service/program required modifiers and is not intended to take the place of other modifiers.

Telehealth Provider Approval Process

- Provider types not included in the State Plan as an originating site or the Administrative Code as a distant site should contact DOM for approval to serve as a telehealth provider. As provider types are approved, this document will be updated under Approved Provider Types (below) to reflect newly-approved provider types that will not require further approval.
- If you are a provider type that has not been approved, or you are a provider type approved as either a distant site or an originating site, but not both, and you wish to render both types of services, please submit your request to Jennifer Grant (Jennifer.Grant@medicaid.ms.gov). Please include the following details:
    - Service Provider Name,
    - Service Provider Type,
    - Current Medicaid Provider Number,
    - A brief description for how telehealth can be used to serve your patient population,
    - Specific telecommunication equipment to be used (personal cellular device, computer, tablet, or other web camera-enabled device) and
    - Whether you are seeking to serve as an originating site, a distant site, or both.

Billing Information for Approved and Temporary Distant Site Providers (where the provider is located)

- Non-Face-to-Face Telehealth Services
    - Audio Only Consultation
        - CPT Codes 99441, 99442, and 99443
            - Audio only consultation initiated by an established patient or guardian of an established patient.
            - Professional claims (CMS 1500) should be billed with place of service (POS) 02 and do not require a modifier.
    - Virtual Audio Check-In
        - HCPCS Code G2012
            - Brief, audio-only medical discussions with an established patient with a physician or other qualified healthcare professional.
            - Professional claims (CMS 1500) should be billed with POS 02 and do not require a modifier.

- Store-and-Forward
  - HCPCS Code G2010
    - Remote evaluation of recorded video and/or images submitted by an established patient, including interpretation and follow up with the patient within a 24-hour period. This service cannot be related to an E&M visit that took place within seven (7) days prior to the virtual check in, and must not lead to the medical visit within the next 24 hours (or the soonest appointment available).
    - Professional claims (CMS 1500) should be billed with place of service POS 02. No modifier is required for the use of these codes.

- Face-to-Face Telehealth Services
  - Distant site telehealth providers should bill the appropriate procedure code as if the service is rendered in person and attach the GT modifier and bill with POS 02. Please refer to the Medicaid Fee Schedule page to view FFS reimbursement rates.

Temporary Telehealth Procedure Codes		
Code	**Code Description**	**Z1 Fee on File Medicaid Rate**
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.	$10.19
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an 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.	$12.35

99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided 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.	$12.07
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided 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; 11-20 minutes of medical discussion.	$23.48
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided 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; 21-30 minutes of medical discussion.	$34.55

Billing Information for Approved and Temporary Originating Site Providers (where the beneficiary is located)

- HCPCS code Q3014
  - Originating site providers will only be reimbursed for the Telehealth Originating Site Facility Fee if no other services are rendered.
  - Originating site providers may only bill for an additional service if the provider conducted a separate identifiable E&M visit while the beneficiary was present in the originating site.
  - Inpatient hospitals are not eligible to receive an originating site fee. The originating site fee is included in the hospital's APR-DRG.

Billing Information for Providers Acting Simultaneously as Originating and Distant Sites

- Providers acting simultaneously as both a telehealth distant and originating site to deliver services to a beneficiary can only bill either the originating or distant site fee-for-service rate, not both.

Approved Administrative Code Distant Site Providers	Approved Temporary Telehealth Distant Site Providers
Physicians	MYPAC providers
Physician Assistants	Speech Therapists may render services to established patients
Nurse Practitioners	Occupational Therapists may render services to established patients
Psychologists	Physical Therapists may render services to established patients
Licensed Clinical Social Workers (LCSWs)	Rural Health Clinics (RHCs)
Licensed Professional Counselors (LPCs)	Federally Qualified Health Centers (FQHCs)
Board Certified Behavior Analysts (BCBAs) or Board Certified Behavior Analyst-Doctorals (BCBA-Ds)	
Community Mental Health Centers (CMHCs)*	
Private Mental Health Centers (PMHCs)*	

**CMHCs/PMHCs acting as a distant site provider should refer to additional billing information found on pages 8-9 of this document.*

Approved State Plan Originating Site Providers	Approved Temporary Telehealth Originating Site Providers
Office of a physician or practitioner	Prescribed Pediatric Extended Care (PPEC) Centers
Outpatient Hospital (including a Critical Access Hospital (CAH))	Inpatient hospital, provided the telepresenter is authorized to carry out the orders of the distant site provider
Rural Health Clinics (RHCs)	
Federally Qualified Health Centers (FQHCs)	
Community Mental Health Centers (CMHCs)	
Private Mental Health Centers	
Therapeutic Group Homes	
Indian Health Service Clinic	
School-based clinics	

Guidelines for Community Mental Health Centers (CMHCS and Private Mental Health Centers (PMHCs) Acting as Distant Site Providers

SERVICE NAME	PROCEDURE CODES
Psychiatric Diagnostic Evaluation	90791 90792
Assessment	H0031
Brief Behavioral Health Assessment (Screening)	96127
Evaluation & Management (E/M)	99201-99205 99211-99215
Nursing Facility Evaluation & Management (E/M)	99304-99310
Assisted Living Evaluation & Management (E/M)	99324-99337
Psychotherapy with E/M (must also bill E/M code on separate line)	90833 90836 90838
Prolonged Service 60 min.	99354
Prolonged Service 30 min add on	99355
Treatment Plan Development & Review	H0032
Psychotherapy	90832 90834 90837
Nursing Assessment	T1002
Family Therapy	90846 90847
Group Therapy	90853
Multi-Family Group Therapy	90849
Interactive Complexity	90785
Psychological Evaluation (First Hour)	96130
(Each Additional Hour)	96131
Psychological Evaluation (First 30 Minutes)	96136
(Each Additional 30 Minutes	96137
Targeted Case Management - (management of the case record)	T1017
Assertive Community Treatment (ACT)	H0039
Psychosocial Rehabilitation	H2030
Crisis Response (Phone rate $21.88)	H2011
Acute Partial Hospitalization	H0035
Community Support Services (management of the individual)	H0036

Peer Support	H0038
Wraparound Facilitation	H2021
Intensive Outpatient Psychiatric	S9480
MYPAC	H2022
NOTE: *All Mental Health procedure codes must be billed with the required modifiers used during face-to-face services, as outlined on the appropriate fee schedules. In addition to the required Mental Health modifiers, providers should also append the GT modifier to identify the service was rendered via Telehealth.*	

Psychosocial Rehabilitation Services (PSR)

Psychosocial Rehabilitation is an active treatment program designed to support and restore community functioning and well-being of an adult Medicaid beneficiary who has been diagnosed with a serious and persistent mental disorder. Psychosocial rehabilitation programs must use systematic, curriculum based interventions for skills development for participants. Its purpose is to promote recovery in the individual's community by alleviating psychiatric decompensation, confusion, anxiety, feelings of low self-worth, isolation and withdrawal. Program activities aim to improve reality orientation, social adaptation, physical coordination, daily living skills, coping skills, effective management of time and resources, task completion and activities to incorporate the individual into independent community living. It is oriented toward empowerment, recovery and competency. It is designed to support individuals who require extensive clinical services to support community inclusion and prevent re-hospitalization.

Recognizing that individuals with Serious Mental Illness (SMI) receive significant benefits from PSR, especially in this time of social distancing related to COVID-19, DOM is issuing telehealth guidance to allow the PSR (H2030) per fifteen minute code to be submitted with POS 02.

DOM prefers telehealth options that would permit actual visual connection with the member but will accept telephonic sessions. Additionally:

- Extra steps are to be taken at the beginning of the telehealth session to review confidentiality and privacy concerns.
- The members should have the opportunity to participate in at least one hour-long group per day on PSR appropriate topics. One hour PSR groups can be offered throughout the day and do not have to be consecutive hours. When using the telehealth format, PSR participants are only required to participate as long as the individual is able.
- Telehealth only Psychosocial Rehabilitation must be provided by at least one (1) clinical staff member present during the time of program operation/presentation.