



CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services

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Provider FAQs

This document has been updated to address telehealth and MCO-related FAQs that have been received. The MCO FAQs begin on page 12 of this document.

Pursuant to 907 KAR Chapter 17 and the DMS – MCO contracts, DMS has directed the contracted MCOs to comply with and implement these FAQs.

Provider Telehealth FAQs:

The March 17, 2020 Behavioral Health Provider letter addressed multiple medical and behavioral health issues relating to telehealth. In addition, future executive orders and administrative regulations to expand telehealth services are expected. As additional guidance, DMS is offering this FAQ document for providers and recipients.

1. What behavioral health services are now allowable via telehealth that were not before?

Within 907 KAR Chapter 15, these services are restricted to face-to-face only. However, for the duration of this declared emergency, the following services are permissible as synchronous telehealth or as a telecommunication mediated health service:

- Peer support services
- Intensive outpatient program services
- Group outpatient therapy
- Service planning
- Partial hospitalization
- Targeted case management
- Mobile crisis services
- Applied Behavioral Analysis
- Comprehensive Community Support Services
- Therapeutic Rehabilitation Program

2. What services are now available via telehealth or via a telehealth-like service throughout the entire Medicaid program?

DMS is making system changes to allow for all provider types to bill for telehealth services. To the extent possible,

providers should provide all services via telehealth. If a service could have been provided via telehealth, but the individual or provider does not have the capability to deliver or participate in the service via telehealth, the service may be delivered via telephone as a “telecommunication or other electronically mediated health service”. If service delivery is audio-only but the service would normally be dependent on the exchange of visual information, the provider should facilitate appropriate electronic or other data exchanges to support any treatment delivered.

3. How should I comply with HIPAA in delivering telehealth?

For the duration of this current COVID-19 nationwide public health emergency, the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) has relaxed its enforcement of HIPAA for certain non-public facing applications. This means that OCR will not enforce penalties for the *good faith provision* of telehealth. Specifically included popular applications that are *currently exempted* include, but are not limited to, these services:

- Apple FaceTime
- Facebook Messenger video chat
- Google Hangouts video
- Skype

For current or future reference, these services advertise as being currently HIPAA-compliant video communication (providers may need to conduct additional verification with these services). DMS and CHFS are not endorsing any of these products and only include them for informational purposes:

- Skype for Business
- Zoom for Healthcare
- BlueJeans
- Vidyo
- VSee
- Doxy.me
- thera-Link
- Updox
- Google G Suite Hangouts Meet

Public facing services are specifically not allowed by OCR and should *not* be used for the provision of telehealth. These include, but are not limited to:

- Facebook Live
- Twitch
- TikTok

You may wish to further review this communication from the OCR here: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>

4. (UPDATED) How can I utilize the telephone or other audio-only technology during this emergency?

DMS has filed an emergency regulation to allow for “telecommunication or other electronically mediated health services” to be used throughout the Medicaid program. DMS envisions that these services will be utilized as a “telehealth-like” service wherever appropriate.

If they are real-time conversations, telephonic services - where it is not appropriate or possible for a visual video connection to be utilized - will be treated as synchronous telehealth. For further information about Medicare G codes, please see FAQs #8, #47, and #50 below.

If a service could have been provided via telehealth, but the individual or provider does not have the capability to deliver or participate in the service via telehealth, the service may be delivered via telephone as a “telecommunication or other electronically mediated health service”. If service delivery is audio-only but the service would normally be

dependent on the exchange of visual information, the provider should facilitate appropriate electronic or other data exchanges to support any treatment delivered.

5. Can some telehealth services be delivered by behavioral health associates under the supervision of a licensed behavioral health provider?

Yes. This will also be dependent on if the licensure board allows the practice or if the licensure board is overruled by an executive order. DMS will construe any emergency order, and the March 17 Behavioral Health letter as broadly as possible in allowing for telehealth to be provided by all behavioral health and medical providers.

6. (UPDATED CONTACT INFO) Will payers be required to honor all telehealth or telecommunication codes and modifiers?

Yes. The Medicaid MCOs will be expected to follow Medicaid policy during the state and national health emergency. Providers should report problems to ProviderMCOInquiry@ky.gov if MCOs are not complying with this direction. In addition, this form can be utilized: <https://chfs.ky.gov/agencies/dms/dpqo/mco-cmb/Documents/DMSFillableComplaintFormUpdate2017.pdf>

7. Are BHSOs and CMHCs included in the March 17 Behavioral Health Provider letter?

This phrase from the notification modifies all current Chapter 15 Behavioral Health telehealth restrictions: “Therefore, licensed behavioral health providers can deliver services via telehealth, with the exception of residential substance use disorder treatment services and residential crisis services.”

The department is interpreting this letter to include the CMHC itself as a licensed behavioral health provider that can – through its licensed behavioral health providers or provider equivalents – perform any behavioral health service via telehealth, with the exception of the letter’s limitation of residential SUD or RCSU services.

The department is assuming that BHSOs and CMHCs are hiring and utilizing licensed behavioral health providers to the extent possible.

8. (UPDATED) How should the G2012 and G2010 Services be used in relation to the ability to provide a telehealth or telecommunication service with a place of service modifier?

DMS recommends utilizing the description within the G2012 and G2010 service when providing that service. If the health service being provided is more expansive than the definition in the G2012 or G2010 code, then DMS recommends still providing the service via synchronous telehealth or via a telecommunications or electronically mediated health service but noting how that service was delivered.

DMS expects that the G code rate will reimburse less than the appropriate service code rate, and would recommend using the appropriate service code with place of service modifier instead of the G code in most circumstances.

The G codes are limited in relation to the more expanded “telehealth-like” service option that DMS is utilizing for the duration of this emergency.

These codes (G2010 and G2012) are typically limited to MDs, APRNs, and DOs or other providers who code for evaluation and management codes. DMS is reimbursing these codes the same as Medicare.

DMS, however, has attempted to go beyond the G codes in allowing the use of telephones or audio-only internet connections. DMS has done this by suspending our own documentation and service requirements in Title 907 KAR via creation of the “telecommunication or electronically mediated health service” in 907 KAR 3:300. DMS is referring to this service as a “telehealth-like service”. In lieu of the G codes, a “telehealth-like” service should be used when a video conference or more traditional telehealth service couldn’t be used due to provider or recipient Internet access or ability. These “telehealth-like” services should be billed as if they were the regular service, but with the telehealth POS of 02. If this is done, the provider should not also bill for the G code, because there is no additional reimbursement.

For additional information about G code claims submitted prior to 4/1/2020, please see #50 below.

9. Can DocuSign or similar programs be used to get e-signatures or consent releases for telehealth services?

Yes. DMS will accept electronic signatures for all purposes, and will require MCOs to comply.

10. My licensing board allows *more* telehealth than currently allowed via DMS administrative regulation, how should I proceed?

The department will construe any administrative regulations, executive orders, and provider letters as broadly as possible to allow for the most telehealth to be delivered as safely as possible to our members.

11. (UPDATED CONTACT INFO) An MCO or several MCOs will not allow a covered service for telehealth that is currently allowable via telehealth, how should I proceed?

DMS is requiring all Medicaid MCOs to cover all current services that are covered via telehealth during this time. In addition, DMS will require the MCOs to cover all services that are determined to be allowable via telehealth during this declared emergency. Providers should report problems to ProviderMCOInquiry@ky.gov if MCOs are not complying with this direction. In addition, this form can be utilized: <https://chfs.ky.gov/agencies/dms/dpqo/mco-cmb/Documents/DMSFillableComplaintFormUpdate2017.pdf>

12. What about 1915(c) waiver services and waiver providers and EPSDT Special Services?

DMS is completing changes to the 1915(c) waiver documents that will greatly expand telehealth within these services and waivers.

Pursuant to HHS' guidance, DMS will allow home health and waiver providers to provide services via telehealth as long as the provider continues to operate within their scope of practice and in compliance with licensure regulations – unless otherwise waived by state law.

13. What about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit services and telehealth?

To the extent that a service can be provided via telehealth via this benefit and to this population, DMS will allow for and facilitate that service via telehealth or telecommunications.

14. What about initial in-person meetings required for services such as occupational therapy, physical therapy, and speech and language pathology or PT 76 services?

If appropriate consistent with the guidance in these FAQs, the March 17, 2020 Provider letter, or executive orders, PT 76 can use telehealth. To the extent allowed or not restricted by executive order or licensing board action, DMS will allow for these facilities and providers to provide services via telehealth or other telecommunication method.

15. What about a MSW under billing supervision for DMS purposes?

A CSW under billing supervision can conduct their customary services – as appropriate – via telehealth if under the clinical supervision of an LCSW.

16. What about dentistry services?

DMS will expand teledentistry – when using the POS 02 code to include: screenings (CDT code D0190), assessments (D0191), and/or examinations (CDT codes D0120, D0140, D0145, and D0150) via teledentistry.

17. Will these changes be permanent?

Currently, DMS plans to restrict telehealth to previous requirements after this current emergency has ended. However, DMS will carefully consider any new developments and innovations in service delivery that occur during this time and may expand current regulations or interpretations to encourage any new efficiencies that are discovered. When

possible, DMS encourages providers to carefully document new approaches and efficiencies that improve outcomes and health of our members for future study.

New Entries as of 3-20-2020

18. What about vision services?

DMS will expand the services that can be utilized by vision services providers. When using POS 02, appropriate providers may bill using the following codes: 92002, 92012, 92004 and 92014.

19. What about any services that could be performed by telehealth within a BHSO III/residential AODE facility or a residential crisis stabilization unit?

DMS will allow for certain services provided within residential SUD or residential crisis stabilization units, clinical services provided within the residential service that are typically performed in person, to be done via telehealth.

Programs must remain compliant with licensure standards in terms of overall direct staffing. They are asked to engage in social distancing to the degree possible including limiting eliminating/reducing group activities, ending outside activities that are not therapeutically essential and restricting outside visitation. We also encourage screening of employees.

DMS would like to stress that services that are performed as part of the residential per diem are not eligible for additional reimbursement.

New Entries as of 3-23-2020:

20. What about pharmacy proof of delivery requirements or receipt of prescription requirements?

Pursuant to 907 KAR 3:300E, and the emergency declarations and orders issued during the month of March 2020, DMS is waiving enforcement of 907 KAR 23:010 Section 7 relating to signature requirements through the end of the day on March 28, 2020.

After March 28, 2020, compliance with 907 KAR 23:010 Section 7 will be considered met if the pharmacist, pharmacy intern, pharmacy tech, or delivery driver writes "COVID 19" or something of similar status to denote the delivery and receipt of prescriptions on the customary location for patient signature. Such confirmation should be documented and retrievable upon audit.

This alternative method of confirming receipt of prescription will expire 2 weeks after the expiration of the emergency declarations relating to COVID-19.

21. What about DME proof of delivery requirements or receipt requirements?

Pursuant to 907 KAR 3:300E, and the emergency declarations and orders issued during the month of March 2020, DMS is waiving enforcement of DME signature proof of delivery requirements or signature delivery requirements through the end of the day on March 28, 2020.

After March 28, 2020, compliance with DME signature proof of delivery requirements or signature delivery requirements will be considered met if the DME provider, appropriate staff person, appropriate provider, or delivery driver writes "COVID 19" or something of similar status to denote the delivery and receipt of prescriptions on the customary location for patient signature. Such confirmation should be documented and retrievable upon audit.

This alternative method of confirming receipt of DME will expire 2 weeks after the expiration of the emergency declarations relating to COVID-19.

22. What about billing supervision of providers?

DMS billing requirements relating to face-to-face supervision of staff may be done via telecommunications such as video conferencing or telephone if video conferencing is not available.

This alternative method of face-to-face supervision of staff will expire 2 weeks after the expiration of the emergency declarations relating to COVID-19.

23. What about therapeutic rehabilitation program as an allowable telehealth service?

DMS is including therapeutic rehabilitation as a service within 907 KAR Chapter 15 that may now be provided telehealth as appropriate. Please see the list on question 1 that has been updated to include this service.

24. My practice is just beginning to utilize telehealth can you provide additional guidance?

Please see the answer to #2 above. DMS also recommends reviewing information available from the CHFS Telehealth Program on their website, available here: <https://chfs.ky.gov/agencies/ohda/Pages/telehealth.aspx>

DMS has already acted to broaden the availability of telehealth over the last year. But, with the filing of 907 KAR 3:300E, the department is acting to further broaden the availability of telehealth or telehealth-like services to the extent allowed by the nature of the service itself, and the provider's licensing board.

Any provider type that is allowed by their licensure board to practice telehealth can deliver any appropriate service that is within their scope of practice via telehealth or telehealth-like services.

Any service provided via telehealth should be billed with a POS of 02.

25. Can federally qualified health centers (FQHCs) or rural health centers (RHCs) provide medical and behavioral health services via telehealth?

FQHCs and RHCs can provide every appropriate service via telehealth as long as it is an approved service that the individual provider's licensure board allows for the provider providing the service.

For an FQHC or RHC to generate the PPS rate, the appropriate provider must provide the service to trigger the payment. A zero pay services code will continue to zero pay regardless of whether it is provided in person or via telehealth or telehealth-like service. Zero pay services would continue to get recorded for data and cost reports.

New entries as of 3/24/2020

26. We are an EPSDT provider of ST, OT & PT services. With the closing of certain facilities because of the Coronavirus we are wanting to provide our services through Telehealth. Will our current authorizations on clients still be valid and sufficient for the use of the Telehealth?

Yes, DMS will require that current authorizations apply to services provided via telehealth.

27. Can a physical and occupational therapist provide services in a home setting?

Yes, with the changes made to telehealth services over the last year – including the previously existing allowances under 907 KAR 3:170 - a physical and occupational therapist can provide any service via telehealth unless that service is prohibited by the providers licensure and licensure board or if it is residential in nature.

28. Can the PASRR process described pursuant to 907 KAR 1:755 utilize telehealth?

Yes. The PASRR process is eligible to be conducted via telehealth.

29. What about prior authorizations and telehealth?

Currently, DMS has directed the suspension of all prior authorizations for medical services from 2/4/2020 forward. Therefore, no med/surg claim, including behavioral health services, can be denied payment due to lack of prior authorization from DOS 2/4/20 forward.

This suspension of prior authorizations does not include pharmacy. In addition, any claim can still have a post-payment review performed.

New questions as of 3/25/2020

30. Can a certified alcohol and drug counselor (CADC) provide telehealth services?

Yes, a CADC can provide appropriate telehealth services not otherwise limited by a licensing board. A CADC provided telehealth service should be conducted under supervision of a licensed provider. During this emergency, a licensed provider may utilize e-signatures to demonstrate supervision.

31. Will Rural Health Clinics be reimbursed at their normal rate when providing telehealth or telehealth-like services? What about phone visits?

Yes. Please see question #25 for further clarification.

For telephone visits reimbursed via the Medicare-allowed G codes, as currently understood, the G codes (Medicare telephone codes) should not be a higher reimbursement than providing the service via telehealth (or “telehealth-like” service) with a POS of 02.

32. If a telehealth service is performed as a telehealth-like service is there any need to utilize one of the G codes when billing the claim?

No. The customary claim should be billed with a POS of 02. Billing the G code will not result in additional reimbursement.

33. What about prosthetic and orthotic services?

Those prosthetic and orthotic services that can be provided via telehealth should be provided via telehealth. DMS also would point to the DME guidance in FAQ #21, and will adopt a similar guidance for prosthetic and orthotic services that require the delivery of a good and the rest of the service can be delivered via telehealth.

After March 28, 2020, compliance with any signature proof of delivery requirements or signature delivery requirements will be considered met if the prosthetic or orthotic provider, appropriate staff person, appropriate provider, or delivery driver writes “COVID 19” or something of similar status to denote the delivery and receipt of prescriptions on the customary location for patient signature. Such confirmation should be documented and retrievable upon audit.

This alternative method of confirming receipt of prosthetic and orthotic supplies will expire 2 weeks after the expiration of the emergency declarations relating to COVID-19.

New Questions as of 3/26/2020

34. What documentation requirements beyond including the POS of 02 should providers observe when providing telehealth, or telehealth-like services via telephone or audio-only internet connection?

Providers may also want to include a notation as to whether the service was a telehealth service or a telehealth-like service delivered via telephone or audio-only internet connection.

35. Will EPSDT continue to reimburse for a Physical Therapist Assistant (PTA) to perform treatments (under the supervision of a PT available by phone if needed) if the treatment is performed via telehealth?

Yes. PTAs can perform treatments as telehealth or telehealth-like services under the supervision of a licensed PT. The supervision can be delivered via video, telephone, or audio-only internet connection.

36. “I work for a Narcotic Treatment Program, complying with the Department for Behavioral Health, Developmental and Intellectual Disabilities newly announced allowances for take home doses and counseling. Can I use telehealth and social distancing to reduce in-person contacts while providing this service?”

Yes. Please refer to this guidance from the Department for Behavioral Health, Developmental and Intellectual Disabilities relating to allowances for counseling and take home doses:

“Physicians must use their own judgment and should balance the stability and needs of the patient with the steps needed to reduce the spread of COVID-19. The maximum take-homes and minimum counseling and screening

requirements are set out below. These parameters are not necessarily recommended and will not be suitable for all patients.:

- Phases 2, 3, 4 and 5
 - take-homes up to 28 doses for patients deemed stable
 - take-homes up to 14 doses for patients deemed less stable
 - monthly counseling
 - monthly screening
- Phase 1
 - take-homes up to 14 doses for patients deemed stable
 - take-homes up to 7 doses for patients deemed less stable
 - every other week counseling
 - every other week screening
- Entry Phase
 - take-homes 1 dose, for every other day
 - weekly counseling
 - weekly screening
- New Intakes are not eligible for this waiver/exception process
- Medical Directors may move a patient from Entry Phase to Phase 1 during this waiver if:
 - Patient is deemed stable by the Medical Director; and
 - Patient has been in treatment for a minimum of 60 days.
- The Medical Directors should make determinations on a case-by-case basis and, when appropriate for the patient:
 - Give a patient fewer take homes;
 - Increase the frequency of counseling; and
 - Increase the frequency of screenings.
- This waiver shall expire on May 1, 2020 and may be extended pending future analysis.”

When any counseling services or other NTP services are provided via telehealth for an NTP service, the POS of 02 should be used when billing the bundle code. Additional reimbursement beyond the bundle code for this service will not be available, but telehealth and social distancing may be used when providing this service.

Updated 1915(c) Guidance for Telehealth:

The Division of Community Alternatives within DMS has released guidance about the use of telehealth during the COVID-19 declared emergencies.

37. Can providers deliver services remotely during the COVID-19 state of emergency?

Yes, DMS is allowing providers to deliver 1915(c) HCBS waiver services remotely for certain services. This can be done in situations where a participant is quarantined due to symptoms of or having been exposed to COVID-19 or as a precaution against spreading COVID-19. Services that could be provided via telehealth include:

- Physical, Occupational or Speech Therapy,
- Supported Employment,
- Behavior supports and counseling services,
- In-home services such as Personal Care or Homemaking (cueing and prompting support only)
- Case Management.

Hands-on direct care services can only be reimbursed if performed in person. Providers should also be vigilant in following their agency's infection control policies and Centers for Disease Control (CDC) guidance while providing in-home services to waiver participants.

Please see the COVID-19: Telehealth letter available at

<https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf> for more information. All providers should work together to allow participants to receive services via telehealth when possible.

38. Should case managers/support brokers/service advisors conduct virtual visits with all waiver participants or only those who show symptoms of or have had known exposure to COVID-19?

To reduce the spread of COVID-19 in Kentucky, case managers and support brokers are allowed to conduct all visits via phone or using virtual options (**Note: Please refer to FAQ #3 above**), so long as the method used allows for direct interaction between the waiver participant and the case manager (e-mail or leaving a message is not considered interactive).

Please refer to the COVID-19: Telehealth letter available at

<https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf> for more information.

39. Can case managers/support brokers/service advisors conduct virtual visits with waiver participants and their families in lieu of face-to-face visits even when no one in the participant’s residence is showing signs of COVID-19? Some participants have a higher risk of contracting the virus due to age, health conditions or a compromised immune system and don’t want to risk unintentional exposure.

On March 13, DMS began allowing case managers/support brokers/service advisors to conduct all visits via phone or using virtual options (**Note: Please refer to FAQ #3 above**). Please refer to the COVID-19: Telehealth letter available at <https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf> for more information.

40. What should a case manager do if a waiver participant needs to have a person-centered service plan meeting, either due to their annual level of care ending or the need for an emergency modification to their plan?

On March 13, DMS began allowing case managers and support brokers to conduct all visits via phone or using virtual options (**Note: Please refer to FAQ #3 above**). DMS issued the same guidance regarding assessments on March 16. Please refer to the following letters for more information.

- COVID-19: Telehealth Letter
<https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf>
- ABI/MPW Assessments Letter
<https://chfs.ky.gov/agencies/dms/ProviderLetters/abimpwassessmentscovid19.pdf>
- Model II Assessments Letter
<https://chfs.ky.gov/agencies/dms/ProviderLetters/modeliiassessmentscovid19.pdf>.

The related case note should cite the COVID-19 state of emergency as the reason the meeting was not held face-to-face.

41. Case management providers are not required to have a license to provide services. Does the waiver stipulate only licensed case managers can bill for telehealth services?

The waiver does not require case managers to be licensed to provide services. Telehealth services are governed by KRS 205.510 (15), 205.559, 205.5591, 907 KAR 3:170, 907 KAR 3:300, and information contained in these FAQs and provider letters during the declared states of emergency.

See the COVID-19: Telehealth letter available at

<https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf> for more information.

Providers delivering services through alternative methods during the state of emergency should continue to bill under their waiver provider number as they usually do.

42. What kind of flexibility is DMS offering (1915 (c)) providers as they plan for or experience staffing shortages during the COVID-19 state of emergency? The reason for these shortages could include employees who are sick or employees who need to take time off to care for their families.

First, DMS is allowing providers to deliver services via phone and telehealth, as appropriate. Please see the COVID-19 and Telehealth letter available at

<https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf> for more information.

Other **temporary** changes DMS has made to the 1915(c) HCBS waivers include:

- Allowing employees, both agency and PDS, to begin providing services while they wait on the results of background check and pre-employment screenings.
 - If the results of a background check or other screening make the employee ineligible, services will be allowed to continue until an alternative employee is found. The only exception is in cases where the employee poses immediate jeopardy to the health, safety, and/or welfare of the participant or has a substantiated finding of past abuse, neglect or exploitation or violent felony.
- Suspending all conflict-of-interest related screening of immediate family members who wish to provide PDS. This gives providers and participants more options to cover gaps in care resulting from the COVID-19 state of emergency. More guidance on how to request an immediate family member as a PDS employee during the COVID-19 state of emergency will be forthcoming.
- Expanding the provider base by waiving requirements that out of state providers be licensed and located in Kentucky as long as they are licensed by another state's Medicaid agency.
- Expanding settings where services can be provided and opening up provider qualifications to allow different provider types to offer services outside of what they typically provide.

New Entries as of 3/27/2020

43. (UPDATED) Does the waiver of prior authorizations referenced in FAQ #29 apply to all medical services or only those related to COVID-19?

The waiver of prior authorization applies to all Medicaid behavioral and medical services. DMS is waiving these prior authorizations relating to medical services in order to enhance service delivery and system capacity for COVID-19 cases. The bulk of Medicaid prior authorization authority is permissive so that the program can address the potential for provider or recipient abuse, or governed by 907 KAR Chapter 17 via contracts with the managed care organizations. As such, DMS is not typically mandated to apply prior authorizations. DMS also received authority from the federal government to waive some Fee-for-Service prior authorizations via an 1135 waiver. Furthermore, DMS is asserting the authority under 907 KAR 3:300 Section 1(1) to waive PAs.

Prior authorizations relating to 1915(c) services are still required. However, the department is allowing services to be added to the plans 30 days retroactively.

New Entries as of 3/30/2020

44. What about those instances where a recipient fails to attend a scheduled appointment for an in-person or telehealth service?

At this time, DMS is not establishing a partial reimbursement for in-person or telehealth missed appointments.

45. Are services provided by the Ky Moms Maternal Assistance Towards Recovery (MATR) program allowable via telehealth?

Yes, DMS allows services provided by the Ky Moms MATR program to be performed via telehealth. Services in this program that are allowable telehealth services include those services that are billed via Medicaid codes H0024, H0025, and H0006.

46. Are prior authorizations suspended for all laboratory services or just those related to COVID-19?

During this public health emergency, DMS has suspended all laboratory services prior authorizations. Post payment review can still be conducted on any claim.

47. (UPDATED) Can you provide further information about the Medicare telephone "G" codes that are now allowable?

Please see FAQ #8 above and FAQ #50 below for additional information. The G codes are limited in relation to the more expanded "telehealth-like" service option that DMS is utilizing for the duration of this emergency.

These codes (G2010 and G2012) are typically limited to MDs, APRNs, and DOs or other providers who code for evaluation and management codes. DMS is reimbursing these codes the same as Medicare.

New Entries as of 3/31/2020

48. Will DMS expand telephone interactions involving CPT codes 99441, 99442, and 99443?

Yes, DMS is now allowing these CPT codes to be covered for telephone interactions.

New Entries as of 4/1/2020

49. Is texting an approved method of delivering a “telehealth-like” service?

Generally no:

- A provider and recipient cannot text as the only communication for a “telehealth-like” service or a G code.
- A text could be used to initiate a session (provide a link to a secure or allowable video or audio connection).
- A text could also be used to support or enhance a telehealth or telehealth-like service that is a telephone or video conversation. For example, a telephone call could be enhanced with a texted picture or video.

New Entries as of April 3, 2020

50. I used a G code to deliver a service that was not appropriate for the G codes as clarified on 4/1/2020 prior to 4/1/2020. How should I proceed?

The G code clarification on 4/1/2020 is not retroactive. Therefore payers are to honor G codes conducted for any medically necessary purpose from the introduction of the G codes through 4/1/2020. After that, the service can still be delivered telephonically or via audio internet connection, but should be coded as the service with a POS of 02 and an explanation as to why videoconferencing was not used (ex. Recipient does not have internet access, or recipient unable to use videoconferencing, etc.).

51. How does the suspension of PAs impact recipients who have been approved for a specific number of visits? Can a provider assume that the recipient would be approved for the same number of treatments for the next 90 day period and start a new 90 days of treatment?

DMS will construe the suspension of PAs in such a way as to result in the least amount of disruption to services to recipients. Therefore, for recipients who are existing patients for whom medical necessity criteria would dictate a continuation of the same number of treatments for the next treatment period, DMS will allow a continuation of the same number of treatments for the next period so that a new 90 days of treatment can be started.

52. Can PT and OT provide telehealth and Bill concurrently to co-treat participants requiring services?

Co-therapies for OT/PT/and SLP are not allowed at this time.

Provider MCO COVID-19 FAQs

DMS has received questions relating to managed care and provider interactions. This portion of the document reflects instructions given to MCOs relating to the implementation of emergency regulations and orders relating to the delivery of Medicaid Services. This document is numbered separately from the Telehealth Provider FAQs.

Entries as of March 31, 2020

1. What services can be waived for cost sharing?

A. Cost sharing for all services is to be waived.

2. Is prior authorization required?

A. DMS has directed the suspension of all prior authorizations for medical and behavioral services until the end of the COVID-19 crisis. If providers continue to call for PA you may review for medical necessity. Post-payment review to determine medical necessity is permitted once the emergency orders are lifted. Providers do not need to be formally notified. The suspension of prior authorizations does not include pharmacy benefits. Any claim that comes in with a DOS of 2/4/2020 that requires PA per the MCO PA list, should not be denied for no PA. If the PA was denied for medical necessity on DOS 2/4/2020 or greater, and the provider submits the claim for payment, you may deny the claim for not meeting medical necessity.

3. What lab tests are covered?

A. HCPCS code (U0001) should be used to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for COVID-19. HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for COVID-19. This second HCPCS code should be used for tests developed by these additional laboratories when submitting claims to Medicaid. HCPCS code U0002 will be reimbursed at an interim fee.

4. What is the effective date for payment of claims with COVID-19 related codes?

A. DMS will follow Medicare policy regarding reimbursement for codes U0001, U0002, G2012, and G2010. The codes will be retroactively effective on February 4, 2020 but will not be billable until after April 1, 2020.

5. Are early refill on prescriptions allowed?

A. Yes. Early refills are allowed for 30, 60 or 90 day supply of medication. Practitioners should be encouraged to prescribe 90-day supplies of long-term maintenance medications for individuals in quarantine. MCOs are to apply guidance to the practitioners for 90-day supplies.

6. Is free home delivery of medications allowed?

A. Yes. Pursuant to 907 KAR 3:300E, and the emergency declarations and orders issued during the month of March 2020, DMS is waiving enforcement of 907 KAR 23:010 Section 7 relating to signature requirements through the end of the day on March 28, 2020.

After March 28, 2020, compliance with 907 KAR 23:010 Section 7 will be considered met if the pharmacist, pharmacy intern, pharmacy tech, or delivery driver writes "COVID 19" or something of similar status to denote the delivery and receipt of prescriptions on the customary location for patient signature. Such confirmation should be documented and retrievable upon audit.

7. A non-par policy that requires all non-participating providers to receive prior authorization approvals for services with a few exceptions to include emergency services. Is it KDMS' expectation that MCOs will lift these auth requirements for non-network providers related to these diagnoses codes?

A. Yes

8. Based on the guidance provided by KDMS, does the lifting of prior authorization for the coronavirus diagnoses codes (all dx) also include air ambulance services?

A. Yes

9. Does the 30, 60 and 90 day early refill policy apply to all members or members with corresponding coronavirus diagnoses?

A. All members

10. Can you please advise if the intention for a blanket extension of all existing PAs

A. Any PA that may have a limited timeframe and would expire prior to May 31, 2020, should be extended, such as therapy. Another example could be, if someone has an elective procedure scheduled during this time period that required an authorization. The procedure was postponed due to the Governor's directive, therefore the authorization should be extended.

11. Is modifier 02 to be used with the G codes?

A. Yes

12. Within the 1135 Waiver application, the submission outlined that DMS is seeking a waiver relative to the replacement of DME equipment w/o physician's order or medical necessity determination. Would you please confirm that this is referring to the requirement that DME suppliers must have a signed certificate of need (or medical necessity) before the provider can fulfill the request?

A. Yes – flexibility to replace DME without MD order for medical necessity; continue to monitor

13. With regards to the waiver request to exempt providers from certain credentialing mandates, will you please confirm if it is the expectation that MCOs allow providers without active KY Medicaid IDs be paid for both COVID-19 and non COVID-19 services?

A. Yes

14. Does DMS expect the MCOs to adjust claims that were already paid/processed with the date of service 2/4/2020 forward?

A. No

15. Have rates for G codes been published?

A. Confirmed the rates are on the fee schedules and are published on the website:

Physician Fee Schedule can be found on pages 349-350 at

<https://chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/2020%20Physician%20Fee%20Schedule.pdf>

Clinical Lab Fee Schedule can be found on page 33 at

<https://chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/2020ClinicalLabRates.pdf>

16. For the items that normally have a limit (EX: 10 per month), do we continue to override the authorizations even though the limit has been met?

A. If you receive a request to extend, you may review for medical necessity. The claim should not deny for no PA.

17. What about drugs that are administered thru the medical benefit (physician administered and outpatient infused)? Are they exempt from the 1135 waiver PA removal requirements as well?

A. As part of the 1135 waiver, DMS has waived all prior authorizations (PAs) for all medical and behavioral services. This will include all PAs for products on the physician-administered-drug list maintained by each MCO. These are a medical benefit. The only exemption is for drug products belonging to the High Cost Drug Stop Loss Program (HCDSLPL). Products

in the HCDSL (Spinraza and Zolgensma) should have their prior authorizations remain on to ensure medical necessity and appropriate use of these products.

18. Please confirm that auth extensions should only be through 5/31/20.

A. Any PA that may have a limited timeframe and would expire prior to May 31, 2020, should be extended, such as therapy. Another example could be, if someone has an elective procedure scheduled during this time period that required an authorization. The procedure was postponed due to the Governor's directive, therefore the authorization should be extended.

19. Is it KDMS' expectation that the placing facility will bill for the services rendered in an unlicensed facility, having no impact on claims processing for the MCO?

A. Yes

20. Is the DMS proceeding with allowing members 120 days to submit a request for State Fair Hearings or will DMS chose a different timeframe?

A. We will begin with the 120 day timeframe and amend in the future, if necessary

21. Is it DMS' expectation that MCOs will be held to one day to resolve a member appeal or will you still allow 2 business days?

A. We will allow 2 business days