Apple Health (Medicaid) behavioral health policy and billing during the COVID-19 pandemic (FAQ)

In this time of the COVID-19 pandemic, HCA is aware that usual and customary ways of providing and billing/reporting Apple Health (Medicaid) services may not be feasible. It is also understood that different providers will have different capabilities. Therefore, in the interest of public health, HCA is trying to be as flexible as possible and is creating new policies that will allow providers to provide medically necessary services and bill or report the encounter with the most appropriate code you determine applicable using the guidance below.

This FAQ reinforces the agency's current policies regarding telemedicine as defined in WAC 182-531-1730 and covers new telehealth policies that will only be in effect during this health care crisis. We will update this FAQ as necessary to respond to new information as it develops. This FAQ is not applicable to involuntary treatment act (ITA) evaluations by designated crisis responders (DCRs).

The FAQ below was developed after new information was released Friday, March 20, by the Centers for Medicare & Medicaid Services (CMS) in an all-state call about the use of telehealth in Medicaid.   Note: Medicaid is not subject to the same policies as Medicare.

FAQ Table of Contents

Frequently Asked Questions

General questions

Q: If I have a primary care provider in my Behavioral Health (BH) clinic, can they collect the specimen for COVID-19 testing?

A: Yes, if you have medical provider rendering physical health services in a bidirectional clinical model that provider can collect the specimen. If the office visit was conducted and being billed as an office-based evaluation and management (E&M), reimbursement is included in the E&M.

PART I: Questions specifically for a BH provider who is reporting a "higher acuity" encounter using Service Encounter Reporting Instructions (SERI)

Q: What modes of technology can I use to provide outpatient BH services to my patients?

A: Under the circumstances, Medicaid is covering a variety of technology modalities in lieu of in person visits to support evaluation, assessment and treatment of clients. These modalities include: telemedicine for HIPAA compliant, interactive, real-time audio and video telecommunications, which is already covered; and other forms of telehealth, such as online digital exchange through a patient portal; and telephone calls, Face-Time; Skype; or email. Texting may also be used, but the agency cautions as to the extent this should be used for doing assessments and providing treatment. (See Part V for how to bill for texting) These technologies can be used for all modalities described in SERI, except those described below or Involuntary Treatment Act (ITA) evaluations.

Q: How do I bill for outpatient BH services if I am using telemedicine to conduct the visit?

A: Consistent with the Instructions on page 119 of SERI, report the service modality code (CPT or HCPC code) from SERI as you would if the encounter was in person. During this crisis, you can provide any modality in SERI using telemedicine, even if SERI does not include the GT modifier in the modality narrative, except as described below. Always document the modality used for delivery in the health care record.

- If your Electronic Health Record (EHR) allows you to report the encounter as described in SERI, using the "GT" modifier and the "02" place of service (POS) code, do so.
- If your EHR doesn't allow you to use both the "GT" modifier and POS "02"code, and you cannot get your EHR modified timely to support billing in this way, you may report the service modality code (CPT or HCPC code) from SERI using:
    - just the "GT" modifier or the POS "02"; or
    - neither, if one or the other is not an option.

Q: How will I be paid for telemedicine services?

A: The agency policy is to reimburse for telemedicine services equivalent to the payment for the CPT or HCPC code billed if it were conducted in-person. The Medicaid MCOs should also follow this policy*

Q: How do I bill if I am using another telehealth technology to conduct the outpatient BH encounter (e.g. online digital exchange through a patient portal; telephone calls, Face-Time; Skype; or email;)?

A: HCA is aware that there are instances when telemedicine is not feasible and providers need to use other methods to provide care.[1] In this case, Apple Health is temporarily allowing BH services using a telephone or other means of electronic transaction, as described above, to conduct an office visit. Report the service modality code (CPT or HCPC code) from SERI as you would if the encounter was in person. During this crisis,

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[1] The provider is quarantined at home, the clinic is closed, the client lives remotely and doesn't have access to the internet or the internet does not support HIPPA compliance, or the circumstances require the provider to utilize a different technology modality to provide behavior health services.

you can provide any modality in SERI using one of these telehealth methods, except as described below. Always document the modality used for delivery in the health care record.

- If your Electronic Health Record (EHR) allows you to report the encounter as described in SERI, using the "CR" modifier and the POS indicator that best describes where the client is, for example "12" is home; "31" is skilled nursing facility, "13" is assisted living facility, do so.

- **If your EHR doesn't allow you to use both the "CR" modifier and the POS code, and you cannot get your EHR modified timely to support billing in this way, you may report the service modality code (CPT or HCPC code) from SERI using:**
    - **just the "GT" modifier or the POS "02"; or**
    - **neither, if one or the other is not an option.**

Q: How will I be paid for another telehealth technology services?

A: The agency policy is to reimburse for these services equivalent to the payment for the CPT or HCPC code billed if it were conducted in-person.

Q: Are there any outpatient BH services in SERI that can't or shouldn't be delivered using one of these technologies?

A: Yes, some outpatient modalities in SERI may not be appropriate for using one of these technologies, for example Day Support or Mental Health Clubhouse services. The delivery of these services as described in SERI doesn't lend itself to a telemedicine/telehealth delivery model. The milieu in which these services are rendered are essential to the modality. In these situations, provide care, but provide the service using a different modality; maybe use Group Therapy or Individual Treatment Therapy to meet the client's needs. Report the appropriate code under one of these modalities and follow the instructions above applicable to the technology used. Document in the health care record how services are rendered.

Q: What about reporting residential BH services delivered using one of these technologies?

A: Residential services cannot be reported as a services delivered through telemedicine or telehealth. However, the professional services rendered can be provided to the admitted person using one of these technologies. In this case, you should just report the encounter as described in SERI, as the professional services are included in the per diem code and not reported separately. Document how the services were rendered in the health care record.

PART II: Questions specifically for a BH provider who is providing and billing for BH services under the Fee for Service program as described in the "Mental Health Guide, Part II: High Acuity Services"

Q: What technology modalities can I use to provide outpatient BH services to persons covered under this program?

A: Under the circumstances, Medicaid is covering a variety of technology modalities in lieu of in person visits to support evaluation, assessment and treatment of clients. These modalities include: telemedicine for HIPAA compliant, interactive, real-time audio and video telecommunications, which is already covered; and other forms of telehealth, such as on-line digital exchange through a patient portal; telephone calls, Face-Time; Skype; or email. Texting may also be used, but the agency cautions as to the extent this should be used for doing assessments and providing treatment. (See Part V for how to bill for texting)

Q: How do I bill for outpatient BH services if I am using telemedicine to conduct the visit?

A: Always document the modality used for delivery in the health care record. Please see HCA's brief on how to bill for telemedicine services to prepare claims.

- If your EHR doesn't allow you to prepare the claim as instructed at this link, then just add the '02" Place pf service if that is an option.
- If complying with this guidance is not an option and you cannot get your EHR modified timely to support billing in this way, report the service modality code (CPT or HCPC code) from the "Mental Health Guide, Part II: High Acuity Services" and be sure to document the mode of delivery in the health record.
- Remember to also follow any specific billing instructions in this section of the "Mental Health Guide", including billing with the TG modifier as directed.

Q: How will I be paid for telemedicine services?

A: The agency policy is to reimburse for telemedicine services equivalent to the payment for the CPT/HCPC code billed if it were conducted in-person.

Q: How do I bill if I am using another telehealth technology to conduct the outpatient BH encounter, e.g. on-line digital exchange through a patient portal; telephone calls, Face-Time; Skype; or email).

A: HCA is aware that there are instances when telemedicine is not feasible and providers need to use other methods to provide care.[1] In this case, Apple Health is temporarily allowing BH services using a telephone or other means of electronic transaction, as described above, to conduct an office visit. Report the service modality code (CPT or HCPC code) from the "Mental Health Guide, Part II: High Acuity Services" as you would if the encounter was in person. During this crisis, you can provide any modality in the "Mental Health Guide, Part II: High Acuity Services" using one of these telehealth methods, except as described below. Always document the modality used for delivery in the health care record.

- If your Electronic Health Record (EHR) allows you to report the "CR" modifier and the place of service indicator that best describes where the client is, i.e. "12" is home; "31" is skilled nursing facility, "13" is assisted living facility, do so.
- If your EHR doesn't allow you to use this modifier and POS codes, and you cannot get your EHR modified timely to support billing in this way, report the service modality code (CPT or HCPC code) from the Mental Health Guide, Part II: High Acuity Services.
- Remember to also follow any specific billing instructions in this section of the billing guide, including billing with the TG modifier as directed.

Q: How will I be paid for another telehealth technology services?

A: The agency policy is to reimburse for these services equivalent to the payment for the CPT/HCPC code billed if it were conducted in-person

Q: Are there any outpatient BH services in SERI that can't or shouldn't be reported using one of these technologies?

A: Yes, some current outpatient modalities in the "Mental Health Guide, Part II: High Acuity Services" may not be appropriate for using one of these technologies, for example Day Support services. The delivery of these services doesn't lend itself to a telemedicine/telehealth delivery model. The milieu in which these services are rendered are essential to the modality. In these situations, provide care, but provide the service using a different modality; maybe use Group Therapy or Individual Treatment Therapy to meet the client's needs. Report the appropriate code under one of these modalities and follow the instructions above applicable to the technology used. Document in the health care record how services are rendered. Remember to also follow any specific billing instructions in this section of the billing guide, including billing with the TG modifier as directed.

Q: What about reporting residential BH services delivered using one of these technologies?

A: Residential services cannot be reported as a services delivered through telemedicine or telehealth. However, the professional services rendered can be provided to the admitted person using one of these technologies. In this case, you should just report the encounter as in the "Mental Health Guide, Part II: High Acuity Services", as the professional services are included in the per diem code and not reported

separately. Document how the services are rendered in the health care record. Remember to also follow any specific billing instructions in this section of the billing guide, including billing with the TG modifier as directed.

PART III: Questions specifically for a BH provider who is providing and billing for "lower-acuity" BH services under the FFS "Mental Health Guide, Part I: Services for clients enrolled in an integrated managed care plan or BHSO"; or as covered by the physical health care benefit administered by a Medicaid managed care organization.

Q: How do I bill for outpatient services if I am using telemedicine to conduct the visit?

A: A: Always document the modality used for delivery in the health care record. Please see HCA's brief on how to bill for telemedicine services. Medicaid MCOs also reimburse for telemedicine.*

Q: How will I be paid for telemedicine services?

A: The agency policy is to reimburse for telemedicine services equivalent to the payment for the CPT/HCPC code billed if it were conducted in-person. The Medicaid MCOs should also follow this policy*

Q: How do I bill if I am using another telehealth technology to conduct the outpatient encounter, e.g. on-line digital exchange through a patient portal; telephone calls, Face-Time; Skype; or email).

A: HCA is aware that there are instances when telemedicine is not feasible and providers need to use other methods to provide care.[1] In this case, Apple Health is temporarily allowing BH services using a telephone or other means of electronic transaction, as described above, to conduct an office visit. Report the service modality code (CPT or HCPC code) from the "Mental Health Guide Part I: Services for clients enrolled in an integrated managed care plan or BHSO", as you would if the encounter was in person. During this crisis, you can provide any modality in the "Mental Health Guide, Part I: Services for clients enrolled in an integrated managed care plan or BHSO" using one of these telehealth methods, except as described below. Always document the modality used for delivery in the health care record.

- If your Electronic Health Record (EHR) allows you to report the "CR" modifier and the POS indicator that best describes where the client is, i.e. "12" is home; "31" is skilled nursing facility, "13" is assisted living facility, do so.
- If your EHR doesn't allow you to use this modifier and POS codes, and you cannot get your EHR modified timely to support billing in this way, report the service modality code (CPT or HCPC code) from the "Mental Health Guide, Part I: Services for clients enrolled in an integrated managed care plan or BHSO".
- The Medicaid MCOs are also following this policy.*

Q: How will I be paid for another telehealth technology services?

A: The agency policy is to reimburse for these services equivalent to the payment for the CPT/HCPC code billed if it were conducted in-person.

PART IV: BH questions applicable to all services rendered under PART I - III above

Q: Are you following Medicare's guidance and allowing the provider to select the E&M code level based just on the MDM, OR on either the MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter? Is Medicaid removing any requirements regarding documentation of history and/or physical exam in the medical record?

A: Yes, Apple Health (Medicaid) is allowing the provider to code the E&M based on this CMS guidance. Yes, Medicaid is removing requirements regarding documentation of the history and/or physical exam in the medical record when providing services via telemedicine or telehealth. *The MCO's will follow this policy.

Q: How do I comply with the face-to-face requirements for BH services as required in the Department of Health's Chapter 246 WACs?

A: During the COVID 19 crisis, this requirement is waived by the Department of Health for all BH services for which this was required. This includes PACT team and WISE services. See https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHAWaiver.pdf for details. The MCOs will follow this policy as well.*

Q: How do I provide SUD services using these telemedicine/telehealth technologies and be compliant with 42 CFR part 2?

A: SAMSHA provided guidance on this issue. See COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance (PDF | 168 KB). Since there are providers asserting this publication is not clear about the release of information without written consent and meeting the specifications for a HIPAA compliant release of information per this CFR, HCA is seeking additional clarification from SAMSHA. HCA encourages providers to use email and scan, the mail or electronic signature functionality to obtain written consent for the release of records.

Q: Do I need to take any measures to inform the client about these technologies that may not be HIPAA compliant?

A: Yes, clients must be informed when using a non-HIPAA compliant technology. Using the mail to obtain written consent is an option, or use of an electronic signature. As the next option, consent to participate using these technologies can also be verbal, but the information provided and the verbal consent must be documented and dated. Once in-person visits are resumed, the client must sign a consent form that is communicating in writing that the client provided consent to use a platform that could not protect their personal health information. HCA is accessing training for providers on a date to be announced to support providers with this activity.

Q: If I am making the call from my house to the client that is at home, what POS do I use?

A: Place of Service (POS) *is where the client receives the behavior health service*. For example, if the client is at home or any place the client deems home, use POS "12". The MCOs will follow this policy as well.*

Q: SERI (and the MH State Plan) says that services provided by individuals without a Masters Degree must be provided under the supervision of a Mental Health Professional (MHP), how do we this when services are provided through telemedicine and practitioners are working remotely?

A: To provide these Medicaid services, providers must submit a plan to HCA describing how they will implement and operationalize clinical supervision of all staff with less than a Masters Degree in a behavioral health field. This plan must be sufficiently detailed to address when and how staff will receive clinical supervision. Submit the plan to the HCA/DBHR COVID mailbox: HCADBHRBHCOVID19@hca.wa.gov with the Subject line: "Supervision Plan". HCA/DBHR staff will review the plans and may require follow-up details, if needed. Providers will be notified when their plans have been approved. When plans are approved, the approval will be retroactive to the date of submission.

Q: Can behavioral health providers continue to provide Medicaid Peer Services to individuals experiencing mental illness or substance use disorders?

A: Yes. Peer services will still need to be ordered on the treatment plan. All Peer Services must be provided under the supervision of an appropriately credentialed senior practitioner. For Peers working with individuals with substance use disorders, supervision must be provided by a licensed Substance Use Disorder Professional (SUDP). For Peers working with individuals with a mental illness supervision must be provided by a Masters Level clinician who meets the MHP definition in the state Medicaid plan. Provider agencies must submit a clinical supervision plan to HCA describing how they will implement and operationalize clinical supervision of all staff with less than a Masters Degree in a behavioral health field. This plan must be sufficiently detailed to address when and how staff will receive clinical supervision.

Submit the plan to the HCA/DBHR COVID mailbox: HCADBHRBHCOVID19@hca.wa.gov with the Subject line: "Supervision Plan". HCA/DBHR staff will review the plans and may require follow-up details, if needed. Providers will be notified when their plans have been approved. When plans are approved, the approval will be retroactive to the date of submission.

Q: How do I provide professional services in the hospital setting?

A: FFS AND MCOs will reimburse telemedicine/telehealth for professional services in the inpatient settings. Bill the services using the appropriate inpatient hospital CPT E&M or consult code(s).

If conducted using telemedicine, please see HCA's brief on telehealth services

Please also see the COVID-19 clinical policy for billing FAQ for guidance in this setting.

Q: How do I bill for telemedicine to provide professional services within the same inpatient facility?

A: During this time, HCA wants Apple Health providers to be able to use telemedicine services to provide patient care even if it is within the same facility. When providing telemedicine services within the facility, do not submit a claim for the originating site. The MCOs will follow this same policy.*

Q: What if I am providing telemedicine or telehealth services outside of Monday - Friday 8-5 office hours?

A: The following codes are available as add-on codes for services provided via telemedicine/telehealth Monday-Friday between 5pm to 8 am; on weekends or holdays. Effective 4/24/2020.

Code	Definition	Modifier
99050	Services provided at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday, weekdays after 5pm), in addition to basic service	CR
99051	Services provided during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.	CR

See COVID-19 fee schedule for rates. *The MCO's will follow this policy as well.

Q: If I am making the call from my house to the client that is at home, what POS do I use?

A: Place of Service (POS) is where the client received the medical service. For example, the client is at home, then use POS 12. The MCOs will follow this policy as well.*

PART V: New services covered during this crisis to support providing care to clients.

Q: What other codes are available for reporting BH services delivered through these new covered technologies?

A: Below is a matrix of codes that can also be used in the rare situation that using an CPT/HCPC BH visit or procedure code as described in PART l-lll isn't applicable to the care scenario.

For codes 99441-99443, to support access to care, Medicaid allows these telephone code to:

- be used by any phsycian or other qualified provider, as defined by the policies under each benefit described in PART l-lll, to conduct a telephone call with the client; not just those who can report an E&M, as described in the official code defintion.
- be provider initiated telephone calls.

The following codes are available. Please see the COVID-19 fee schedule for rates.

Code	Description
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
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
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
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Q: How do I bill these modalities?

A: Bill the CPT code provided using the CR (catastrophe/disaster) modifier at the line level.

Q: What do I need to know to use the online digital E&M code?

A: The online digital E&M service via a patient portal must be HIPPA compliant per coding rules.

Q: What if I am trying to serve a new client, the codes listed above are for established patients?

A: Apple Health is allowing use of codes 99441-99443, 99421-99423 for new or established patients during this crisis.

Q: What will I be paid for providing services using these modalities in the chart above?

A: If billing for an FFS covered client, bill with the CR modifier. You will be paid the corresponding E&M encounter rate.

See COVID-19 Fee schedule

MCOs will following this policy, as well. However depending on your contract and reimbursed at a capitated rate, or another non fee for service methodology, their reimbursement policy may not be the same.

Q: Medicare has given guidance to use G2012, is Apple Health covering that code?
A: Yes. This code is covered and must be billed with modifier CR. Apple Health (Medicaid) considers texting a virtual check-in. If billing for texting to complete an telehealth visit with a client, bill the G 2012 code for payment of this service.

To support access to care, Medicaid allows this code to be used by any phsycian or other qualified provider, as defined by the policies under each benefit described in PART l-lll, to conduct a brief communication or participate in a texting exchange with the client; not just those who can report an E&M, as described in the official code defintion. The MCOs will follow this policy as well.

Code	Description
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

Q: What if I need to consult with another provider over the phone regarding treatment of my patient?

A: 99446 is already a covered code. This code is covered and must be billed with modifier CR. See Physician-related/professional services fee schedule. MCOs will follow this policy as well.*

PART VI: Information specific to federally qualified health centers (FQHCs), rural health clinics (RHCs), and Tribal Facilities (Direct IHS Clinics, Tribal Clinics and Tribal FQHCs)

Q: What behavior health services described above are encounter eligible for federally qualified health centers (FQHCs), rural health clinics (RHCs), and Tribal Facilities (Direct IHS Clinics, Tribal Clinics and Tribal FQHCs)

A: The CPT/HCPC code billed if it were conducted in-person; plus 99441-43, 99421-23, G2012; billed with modifier CR.

Fee For Service (FFS) Claims:

As with all FFS encounter eligible claims, the above listed CPT codes should be billed directly to ProviderOne with a T1015.

Managed Care Claims:

Encounter billers (FQHCs, RHCs, and Tribes) should bill MCOs with these codes for managed care clients. For all FQHCs and those RHCs who reconcile directly with HCA, these claims will be included in the annual reconciliation.

For those RHCs who receive the full encounter rate, MCOs will ensure these clinics receive their full encounter rate for the above listed services. As with all encounter eligible services, RHCs are required to bill a T1015 in addition the above listed CPT codes in order to get the full encounter rate through MCOs.

For Tribal Facilities (Direct IHS Clinics, Tribal Clinics, and Tribal FQHCs) – the MCO payment of the encounter rate is scheduled to begin on 04/01/2020 (AI/AN clients) and 07/01/2020 (non-AI/AN clients). Until MCO payment of the encounter rate begins – the balance of the encounter rate may be billed to P1 for encounterable services.

Q: Are FQHC's or RHC's eligible to be an originating site?

A: Yes, both FQHC's and RHC's are approved originating sites. Apple Health (Medicaid) only pays an originating site facility fee for services provided via telemedicine. The MCOs are adopting these policies as well.*