State of New Mexico
Medical Assistance Program Manual

Supplement

DATE: April 6, 2020

Number: **SPECIAL COVID-19 SUPPLEMENT #3 – GUIDANCE FOR NEW MEXICO MEDICAID PROVIDERS**

TO: MEDICAID PROVIDERS

FROM: NICOLE COMEAUX, J.D., M.P.H., MEDICAL ASSISTANCE DIVISION DIRECTOR

SUBJECT: COVID-19 GUIDANCE FOR NEW MEXICO MEDICAID PROVIDERS

The purpose of this Supplement is to provide guidance and directives to providers for modification of services and program standards related to the national public health emergency associated with the 2019 Novel Coronavirus (COVID-19) outbreak. The purpose of these changes is to assure the continuation of essential services to Medicaid patients without disruption or delay while following Centers for Disease Control and Prevention (CDC) direction to maximize social distancing for the duration of the public health emergency. This document is a companion document to Letter of Direction #30 which outlines these changes for the Medicaid Managed Care Organizations (MCOs) and was first released March 18, 2020. All New Mexico Medicaid Guidance and information related to COVID-19 is being posted at: www.nmmedicaid.portal.conduent.com

The Centers for Medicare and Medicaid Services (CMS) issued a Disaster Toolkit and an Inventory of Medicaid and CHIP Flexibilities and Authorities that states may exercise in the event of a disaster. At this time, we have submitted waivers to exercise these authorities and CMS has indicated that they will provide flexibility in Medicaid and CHIP programs, so states can respond effectively to this virus. Therefore, effective immediately, HSD directs providers to implement the following strategies for all Medicaid clients:

1. **Medicaid Client Communication:**

    a. To ensure clear and consistent messaging regarding COVID-19 updates, HSD requests that all providers utilize the NM Department of Health (DOH) coronavirus web site (www.cv.nmhealth.org) for the most up to date information to be used in Medicaid client communications. The DOH web site provides New Mexico specific details about the pandemic and is in full alignment with our federal partners at the CDC.

b. **Website and Medicaid Client Materials:**

NM Department of Health Coronavirus: www.cv.nmhealth.org
NM Medicaid Provider Portal: www.nmmedicaid.portal.conduent.com
Centers for Disease Control and Prevention: www.cdc.gov/coronavirus
World Health Organization: www.who.int
NM DOH Developmental Disabilities Support Division: www.nmhealth.org/about/DDSD

Coronavirus Posters for Print
Stop the Spread of Germs
Wash Your Hands

2. **COVID-19 Testing and Treatment Services:**

a. **New Billing Codes for Testing –** HSD has added three new laboratory billing codes as directed by the Centers for Medicare and Medicaid Services (CMS) for COVID-19 lab testing. These codes are identified in Table 1 of this Supplement.

b. **Drive-Through Testing/Screening –** Providers are encouraged to coordinate with Department of Health (DOH) to develop "drive-up" or "drive-through" testing and screening services, including the use of this strategy in rural/frontier areas to the greatest possible extent. This strategy will help to alleviate the impact of crowding in medical clinics and facilities and mitigate the spread of COVID-19. Drive-Through testing will be billed in accordance with current rules dependent on provider type and the associated facility where the testing is done.

HSD is committed to working collaboratively with the New Mexico Licensure Board to clarify and confirm that, for the duration of the emergency, conducting an online exam for a patient that has not yet been established with the practice is not considered "unprofessional or dishonorable conduct" per 16.10.8.8 NMAC.

HSD is submitting a 1135 waiver that would permit us to provide payments to facilities for providing services in alternative settings.

c. **Prior Authorizations for Testing and Treatment –** HSD will waive prior authorizations for Medicaid clients to obtain COVID-19 testing and treatment services (including inpatient and outpatient). Additionally, HSD reminds providers that coverage of all medically necessary emergency care is required without prior authorization. A provider does not have to be a Medicaid enrolled provider to bill for testing and treatment services of COVID-19.

d. **Prohibition Against Cost-Sharing for Testing or Treatment –** Consistent with current Medicaid regulations, Medicaid clients are exempt from all cost-sharing including for COVID-19 screening, testing and treatment services. Medicaid clients may not be held liable for unlawful balance bills from providers for these or other services provided to Medicaid clients.

e. **Prior Authorizations for Other Services –** HSD will waive prior authorization requirements as well as extend all existing prior authorizations through the termination of the existing emergency declaration. Please contact Conduent Provider Relations Help Desk if a service that is currently approved is denied for prior authorization. Medically necessary emergency care can be provided without prior authorization if the service is required to be rendered out-of-state (services provided beyond 100 miles of the border).

f. **Coverage for Durable Medicaid Equipment -** HSD is waiving the face-to-face requirement for obtaining a new physician's order and new medical necessity documentation for replacement of DME, prosthetics, orthotics, and supplies (DMEPOS) when DMEPOS are lost, destroyed, irreparably damaged, or otherwise rendered unusable.

3. New Codes for Telephonic Visits and E-Visits:

Effective March 1, 2020 and for the duration of the COVID-19 Public Health Emergency, HSD has broadened access to Medicaid telehealth services so that patients can receive a wider range of services from their doctors without having to travel to a healthcare facility. Providers must maintain appropriate documentation of all services rendered.

HSD is directing the MCOs to direct providers to render telehealth services in all settings, including member's home, through the termination of the declaration of the emergency in lieu of in-person care to reduce the risk of spreading COVID-19 through face-to-face contact.

a. **Physical Health/Telehealth:** HSD has activated/added new codes (CPT, HCPCS or Revenue Code) to encourage the use of telephonic visits and e-visits in lieu of in-person care. These codes will remain an option for all provider types for the duration of the emergency. These codes and rates can be found in Table 1.

The providers have (should be given) two options to bill their services:

- as they are currently doing using one of the modifiers listed in Table 1. The use of modifier will identify the service was rendered via telehealth. Reimbursement will not be affected by the use of modifier and will be reimbursed with the same rates as face-to-face that are currently established for such services.

or

- bill using one of the telehealth codes listed in Table 1.

b. **For Telehealth rendered in Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Hospital-Based RHCs (HBRHCs), and the Indian Health Service (IHS)** – Please refer to Table 1 of this Supplement.

c. **Behavioral Health -** Behavioral health providers should bill for telephonic visits using the same codes and rates that are currently established for such services. Authorized codes can be found in Table 1 of this Supplement.

These services will be paid as if the member received services onsite and in person. This will remain an option for providers through the termination of the emergency declaration

and applies to both initiation of care as well as treatment of established patients. Initiation of care can be for any reason, including member self-referral.

Providers are directed to bill for BH Telephonic Visits using Location Code 02 – Telephonic Visit on the claim form. If Location Code 02 is on the claim form, the services are billable and will be paid at the normal rate for the service. All other normal modifiers should be included on the claim if otherwise required. The originating site HCPCS code Q3014 is not billable for these services since the normal office visit payment is to be made instead. FQHCs and other facilities that are not able to use Location Code 02 on the claim may use revenue code 0780 on the claim in accordance with paragraph 3d above.

These visits will be considered as equivalent to in-person visits through the termination of the emergency declaration. In accordance with existing policy, providers are expected to maintain all appropriate medical records. Any medical records requiring in person presence (e.g., height, weight, etc.) are to be noted in the record as "Excused per state declaration re: COVID-19".

Telephonic BH visits must be synchronous; that is, consisting of live voice conversation with the patient or family. Asynchronous or "store and forward" visits are not payable under this provision.

Services must be provided by a practitioner and within the practitioner's normally allowed scope of practice.

The existing Supportive Housing HCPC codes remain in effect at this time and will continue to be billed as previously instructed.

d. **Applied Behavior Analysis (ABA) Services:** Providers may bill for ABA services provided as telephonic visits using the authorized codes identified in Table 1 of this Supplement, with the same rates as face-to-face that are currently established for such services.

Providers are directed to bill for ABA Telephonic Visits using Location 02- Telephonic Visits on the claim form. If Location Code 02 is on the claim form, the service is billable and will be paid at the normal rate for the service.

All normal Modifiers should be included on the claim if otherwise required.

These services will follow the same protocols as section 3 (c) above.

4. Changes to Services & Benefits:

a. **Level of Care for Institutional Care (Institutional Care Facilities for Individuals with Intellectual Disabilities and the Program of All-Inclusive Care for the Elderly [PACE]) and 1915 (c) Home and Community-Based Services Waivers –** HSD will allow the Level of Care (LOC) medical assessment to be conducted using telephonic visits and e-visits in

lieu of in-person care. HSD will be suspending Level of Care (LOC) recertifications as a requirement for Medicaid eligibility through the termination of the emergency declaration for impacted Medicaid clients. However, the Medicaid Third-Party Assessor, Comagine, will continue to process LOC requests when LOC documents are able to be completed and submitted for a determination.

b. **1915 (c) Home and Community-Based Services Waivers -** Please refer to the Department of Health Developmental Disabilities Supports Division's COVID Response Memos for direction and updates regarding services under the Developmental Disabilities Waiver, Medically Fragile Waiver, and Mi Via Waiver.

5. Pharmacy Requirements:

a. **Maintenance Drugs** – In accordance with current policy, all maintenance drugs may be dispensed in amounts up to a 90-day supply (excluding controlled substances). HSD is waiving the maximum supply requirement for maintenance drugs.

Additionally, HSD is relaxing restrictions on early medication refills as follows:

i. 30-day prescriptions will allow a refill when the Medicaid client has 2 weeks of medication on-hand.
ii. 90-day prescriptions will allow a refill when the Medicaid client has 3 weeks of medication on-hand.

b. **Controlled Substances** – Drugs defined as controlled substances shall continue to be prescribed and dispensed in accordance with the requirements of the SUPPORT Act. For 30-day opioid and opioid-like prescriptions, HSD will allow a refill when the Medicaid client has 7 days of medication on-hand.

c. **Non-Maintenance Drugs -** Prescriptions for non-maintenance drugs are limited to 34-day supply.

6. Fair Hearings: HSD is temporarily extending the number of days that a recipient has to request a state fair hearing resulting from an adverse action determination. HSD will extend the number of days from the current 90-day requirement to give Medicaid clients up to 120 days for the duration of the emergency.

7. Provider Network Requirements:

a. **Network Changes –** All providers must provide immediate notification of any expected or unexpected closures and submit a notification to HSD regarding any significant changes immediately upon receipt of such notification. In addition, providers should assist all members who need immediate care with transition to a different provider/facility.

b. **Provider Site Visits and Revalidations –** HSD is temporarily suspending provider site visits and revalidation activities to the extent that such activities may pose difficulties in expediting provider contracting and credentialing.

8. Effective Date and Additional Emergency Actions Pending Federal Approval:

HSD is working with its federal partners to obtain some of the authority outlined above as well as additional authorities and regulatory waivers that will enable further flexibility while emergency conditions persist. Requested authorities will include modifications to eligibility and enrollment requirements, such as annual recertifications, eligibility thresholds, presumptive eligibility, and relaxed verification criteria with the goal of keeping members covered through the termination of the emergency declaration. The waivers and resulting authority have different effective dates dependent on emergency declarations. We have included a summary sheet in Appendix A. that outlines our current understanding of these effectives and respective authorities. HSD will provide updated information on these topics as it becomes available.

HSD values its continued collaboration and partnership with providers to implement these directives as quickly as possible to help assure the health and safety of Medicaid clients and our fellow New Mexicans. Further direction will be provided as guidance and authorities become available.

Sincerely,

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Nicole Comeaux, JD, MPH
Director

Appendix A

The Centers for Medicare and Medicaid Services (CMS) issued a Disaster Toolkit and an Inventory of Medicaid and CHIP Flexibilities and Authorities that states may exercise in the event of a disaster. At the time of the release of this Letter of Direction, we are concurrently submitting waivers to ensure we have all of the tools available to us to combat this virus and will employ them as appropriate:

In response to the COVID-19 pandemic, New Mexico Medicaid will be requesting amendments to our 1115 and 1915(c) waivers that will allow us to (Effective date January 27, 2020):

1. Provide Medicaid coverage for testing and/or treatment for COVID-19 at higher income levels for individuals who are uninsured
2. Extend hospital presumptive eligibility to aged, blind, and disabled individuals and allow all Presumptive Eligibility Determiners to conduct determinations for all categories
3. Extend time frame for filing an appeal
4. Extend Level of Care authorizations for Home and Community Based Service recipients
5. Permit payment for 1915(c) waiver services rendered by family caregivers or legally responsible individuals

With the authority permitted under section 1135 of the Social Security Act we will be requesting to (Effective Date: March 1, 2020):

6. Waive prior authorization requirements in fee-for-service and managed care, as well as extend current prior authorizations
7. Allow enrollees to have more than 120 days to request a fair hearing
8. Temporarily waive provider enrollment requirements to ensure a sufficient number of providers are available to serve Medicaid enrollees. Such requirements include site visit prior to enrollment
9. Temporarily cease the revalidation of providers who are located in- state or otherwise directly impacted by a disaster
10. Permit providers licensed out of state/territory to provide care to Medicaid members
11. Allow facilities to provide services in alternative settings, such as a temporary shelter, when a provider's facility is inaccessible
12. Temporarily delay or suspend onsite re-certification and revisit surveys, and some enforcement actions, and/or allow additional time for facilities to submit plans of correction
13. Temporarily suspend 2-week aide supervision requirement by a registered nurse for home health agencies
14. Temporarily suspend supervision of hospice aides by a registered nurse every 14 days requirement for hospice agencies
15. Temporarily suspend application of EMTALA sanctions for redirection of an individual to receive a medical screening examination in an alternative location or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency

We will also be looking to exercise existing authority under existing Code of Federal Regulations to (Effective March 1, 2020):

16. Relax restrictions on early medication refills
17. Permit telephonic visits in lieu of face-to-face requirements for behavioral health and physical health visits
18. Temporarily suspending the requirement that individuals who meet all Medicaid eligibility requirements (financial and technical) be institutionalized for 30 days before receiving benefits

We will also be implementing system changes and exercising existing authority under existing Code of Federal Regulations to (Effective date to be determined):

19. Suspend automatic redeterminations
20. Allow self-attestation for all eligibility criteria (excluding citizenship and immigration status) on a case-by-case basis for individuals subject to a disaster when documentation is not available.

Table 1 – Authorized Codes

Code	Description	Medicaid FFS Rate
Laboratory Codes		
U0001	CDC lab tests for SARS-CoV-2 (COVID-19)	$35.92
U0002	Non-CDC lab tests for SARS-CoV-2/2019-nCoV (COVID-19)	$51.33
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)	To be determined; manually price until rate is established
Physical Health Services		
	MCOs should allow all providers to continue to bill their services as they are currently doing (for example: physicians, mid-level providers, OT, PT, SLPs , providers who can bill E&M services, Emergency Department visits and others). A service provided via telehealth would be billed using one of the following modifiers. Reimbursement will not be affected by the use of a modifier. Some providers may be limited to a percentage of the rate. Reimbursement to CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service. HSD is aligning with the Medicare guidance for telehealth services for the duration of the public health emergency. For detail on the Medicare guidance, including specific codes and provider types, please refer to https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf -GQ: Telehealth store and forward (or) -GT: Interactive telecommunication (or) -95: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System	At the same reimbursement rate as face-to-face encounters/visits.

Physician Telephone Services

(i.e., provider who can bill E&M services, physicians, mid-level providers). Some providers may be limited to a percentage of the rate. Reimbursement to CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service.

Physician Telephone Services (for example: provider who can bill E&M services, physicians, mid-level providers). Some providers may be limited to a percentage of the rate. Reimbursement to CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service.

Note: During the COVID emergency, the following codes can be used for both new and established patients.

99441	Telephone Evaluation and Management (E&M) service provided by a physician 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.	$55.34
99442	Same as above - 11-20 minutes of medical discussion	$101.71
99443	Same as above - 21-30 minutes of medical discussion	$135.63
Non-physician Telephone Services (i.e. OT, PT, SLP) (for example: OT, PT, SLPs)		
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment - 5-10 minutes of medical discussion	$12.05
98967	Same as above - 11-20 minutes of medical discussion	$23.78
98968	Same as above - 21-30 minutes of medical discussion	$34.88
Interprofessional Consultation Codes		
99451	Reported by the consultant, allowing him/her to access data/information through the electronic health record, in addition to telephone or internet - 5 minutes	$33.25
99452	Reported by the requesting/treating physician or qualified health provider (i.e., provider who can bill E&M services, physicians, mid-level providers) - 30 minutes (for example: providers who can bill E&M services, physicians, mid-level providers) - 30 minutes.	$33.25

Real-Time Interactive Audio/Video		
99421	Non face-to-face online digital E&M service for an established patient, for up to 7 days cumulative time during the 7 days - 5-10 minutes	$39.59
99422	Same as above - 11-20 minutes	$65.66
99423	Same as above - 21 or more minutes	$96.31
Other Telehealth Codes – Assessing and Monitoring		
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.	$11.52
G2012	Brief communication technology - based service (e.g., virtual check -in) by a physician or other qualified health care professional who can report E&M 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 or just "brief check-in by MD/QHP" for short, used in medical care.	$13.03
G2061	Qualified nonphysician (i.e. OT, PT, SLP) *(for example: OT, PT, SLPs)* healthcare professional online assessment, for an established patient, for up to 7 days, cumulative time during the 7 days - 5-10 minutes.	$10.90
G2062	Same as above - 11-20 minutes.	$19.20
G2063	Same as above - 21 or more minutes.	$30.07
Dental Telehealth Codes		
D9995	Teledentistry synchronous real-time: when the dentist and participant interact as if they were having a face-to-face service. Services that can be provided effectively telephonically without real-time video may also be covered via telehealth. The code will be reimbursed at the same rate as D0140 - face-to-face limited oral evaluation (problem focused) service. Providers must continue to maintain appropriate documentation of all services provided and related to medical necessity.	$28.94

Telehealth Billing for Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Hospital-Based RHCs (HBRHCs), and the Indian Health Services (IHS)		
780	Telemedicine General classification: Scenario 1: A telehealth service that is rendered with the patient present should be billed using the appropriate clinic visit revenue code. The telehealth service must be reported separately using revenue code 0780 and HCPCS code Q3014-Telehealth Originating Site -Facility Fee Scenario 2: A service rendered through telehealth only should be billed as a single line of service using their current face-to-face encounter revenue code and HCPCS code Q3014 to identify this as a telehealth service. HSD is currently working with Fiscal Agent to accommodate the processing of this type of service to ensure accurate reimbursement.	Scenario 1: Reimbursed the encounter/OMB rate plus the telehealth HCPCS fee schedule rate. Scenario 2: Reimbursed at the encounter/OMB rate

Behavioral Health Telephonic Visits – Authorized Codes			
90832	90833	90834	90836
90837	90838	90839	90840
90846	90847	90849	H0049
H0050	G0175	S0220	G0444
G0443	G0406	G0407	G0408
H0015	H0025	H0031	H0038
H0039	H2000	H2011	H2015
H2033	T1001	T1007	90785
90791	90792	99201	99202
99203	99204	99205	99211
99212	99213	99214	99215
99217	99218	99219	99220
90853	90863	99241	99242
99244	99245	99406	99243
99407	Rev Code 0513	Rev Code 0912	S0201
H2010	H2014	H2017	

Applied Behavior Analysis (ABA) Authorized codes			
T1026	0362T	97156	97152
97151	97153	0373T	97155

COVID-19 Resources and Guidance

State Resources:

New Mexico COVID-19 Information http://cv.nmhealth.org/

Federal Resources:

Centers for Disease Control and Prevention
https://www.cdc.gov/coronavirus/2019-nCoV/summary.html

Centers for Medicare and Medicaid Services
https://www.cms.gov/AboutCMS/AgencyInformation/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page