



Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

**Maryland Medical Assistance Program
General Provider Transmittal No. 92
May 30, 2023**

TO: All Providers
Tricia Roddy
 FROM: Tricia Roddy, Deputy Medicaid Director
 Maryland Medicaid
 RE: Public Health Emergency Unwinding
 NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this memorandum.

1. End of the PHE

The national Public Health Emergency (PHE) ended on [May 11, 2023](#). Most of the flexibilities permitted by MDH during the PHE have already ended, see [COVID-19 Provider Updates](#) for more information. The following addresses the flexibilities and policies that remained in place after August 15, 2021 and supersedes previous guidance. Additional information on the Medicaid Check-In Campaign, resumption of renewals and disenrollments, and opportunities to communicate with participants are addressed in item 2 of this transmittal.

A. COVID-19 Vaccines, Tests, and Treatments

1. COVID-19 vaccines: MDH will continue to cover COVID-19 vaccinations without cost sharing for participants until at least September 30, 2024. MDH will provide further guidance on whether copays will be required beginning October 1, 2024.

MDH will issue additional guidance on billing for vaccinations once the supply of vaccines purchased by the federal government is exhausted. Providers may continue to bill for vaccine administration through September 30, 2024.

2. COVID-19 tests: MDH will continue to cover both over-the-counter and laboratory testing ordered by a provider without cost sharing for participants until at least September 30, 2024. MDH will provide further guidance on whether copays will be required beginning October 1, 2024.
3. COVID-19 treatments: MDH will continue to cover COVID-19 treatments without cost sharing for participants until at least September 2024. MDH will provide further guidance on whether copays will be required beginning October 1, 2024.

B. PREP Act Additional Guidance

The US Department of Health and Human Services (HHS) has announced that certain amendments to the PREP Act are forthcoming. For additional information, please see the current [HHS Fact Sheet](#).

C. Balance Billing Medicaid Participants for Personal Protective Equipment (PPE) Is Prohibited

In accordance with COMAR 10.09.36, in order to participate in the Program, providers must accept payment by the Program as payment in full for covered services rendered and make no additional charge to any person for covered services. This requirement applies to both fee-for-service (FFS) and managed care organization providers. Any Medicaid provider that practices balance billing is in violation of its agreement with the Program and is thus subject to sanctions, including termination from the Program. A provider is responsible for educating and supervising staff on this prohibition so that balance billing does not occur. For additional information, see [PT 39-15](#) dated June 25, 2015.

D. Long Term Services and Supports (LTSS)

Home-Delivered Meals

MDH reminds providers that they have a responsibility to abide by and follow the Medicaid provider agreement, State and federal regulations, and laws. The approved plan of service authorizes providers to render and be reimbursed for services in accordance with the outlined quantities and frequencies of services.

Per COMAR 10.09.84 and 10.09.36, as well as the Maryland Medicaid Provider Agreement, only services which have been preauthorized by the Department in the participant's plan of service should be provided and billed. It is the provider's responsibility to ensure that requests for reimbursements are appropriate and accurate.

Please be advised that providers who bill inappropriately for unauthorized services are subject to disciplinary actions including but not limited to sanctions, recovery, suspension, or termination per 10.09.84, 10.09.36, and the Maryland Medicaid Provider Agreement.

E. Non-Emergency Medical Transportation (NEMT)

Coverage for NEMT services for purposes of transport to COVID-19 vaccinations as described in [previous guidance](#) will continue to be permitted after the end of the PHE.

Medicaid NEMT can be used to transport participants to vaccination appointments. This is subject to the same screening procedures employed for regular appointments. The transport must be to the closest appropriate provider that can administer the vaccinations, as the administrative fee is being considered as Fee-for-Service.

F. Premium Payments for Employed Individuals with Disabilities (EID) Program and Maryland Children's Health Program Premium (MCHP Premium)

The Program continues to suspend monthly premium payments for EID Program and MCHP Premium enrollees. The Program will not disenroll individuals for failure to pay premiums for the EID Program until January 1, 2024. The Program will not disenroll individuals for failure to pay premiums for MCHP Premium until May 1, 2024.

G. Telehealth

In accordance with *SB 534, Preserve Telehealth Access Act of 2023 (Ch. 382 of the Acts of 2023)*, telehealth flexibilities, including coverage of audio-only phone conversations, will continue through at least June 30, 2025. As such, Medicaid will continue to provide coverage for health care services delivered through telehealth regardless of the participant's location at the time services are rendered and to allow a distant-site provider to provide services to a participant from any location at which the services may be delivered through telehealth. Additionally, Medicaid will permit services to be rendered via audio-only telehealth through June 30, 2025. Note that the Act requires that MDH not reimburse facility, room, or board charges for telehealth visits unless a professional fee cannot be billed separately.

In addition, please note that the use of non-HIPAA compliant technology products authorized through the end of the federal public health emergency at the discretion of the federal Office of Civil Rights (OCR) is also ending. OCR is providing a 90-calendar day transition period for covered health care providers to come into compliance with the HIPAA Rules with respect to their provision of telehealth. The transition period will be in effect beginning on May 12, 2023 and will expire at 11:59 p.m. on August 9, 2023. For more information, visit HHS's [HIPAA and Telehealth webpage](#). OCR has previously issued guidance on HIPAA compliance in the provision of telehealth services on an audio-only basis, contained on [this webpage](#).

Dental Services Delivered via Telehealth (Teledentistry)

Coverage for teledentistry as described in [previous guidance](#) will continue to be permitted after the end of the PHE.

Below is a list of procedure codes for teledentistry. Services delivered via telehealth using two way audio-visual technology assisted communication should be billed using the Place of Service “02” to indicate use of telecommunication technology. For these services, audio-only or telephonic services are not reimbursable. This code does not require prior authorization from Maryland Medicaid.

Procedure Code	Description	Medicaid Reimbursement Rate
D0140	Limited oral evaluation - problem focused	\$47.26

School-Based Health Center Services (SBHC)

Provisions granting flexibilities regarding compliance with 42 C.F.R. § 440.90(a) have sunset effective May 11, 2023. This guidance clarifies SBHC sponsoring agencies should bill Medicaid for covered services delivered via telehealth to eligible Medicaid participants.

When billing for services rendered via audio-video or audio-only modalities, SBHC sponsoring agencies must adhere to the following:

1. Federal Rules (Clinic Services): SBHCs must adhere to federal Medicaid regulations governing clinics (42 CFR § 440.90 - Clinic Services). Medicaid may not reimburse SBHCs or other clinics if neither the practitioner nor patient is physically located within the clinic. This requirement applies to all freestanding clinics participating in the Maryland Medicaid program, regardless of whether they are community-based clinics or SBHCs.

During the PHE, CMS granted MDH an 1135 waiver permitting services provided via telehealth from clinic practitioners’ homes (or another location) to be considered to be provided at the clinic for purposes of 42 C.F.R. § 440.90(a). Under this authority, SBHCs were permitted to receive Medicaid reimbursement for services rendered if both the practitioner and the patient are in their homes for the duration of the federal government’s declared public health emergency. The waiver has a retroactive effective date of March 1, 2020, and will terminate when the federal public health emergency ends on May 11, 2023.

2. Modifiers: When billing Medicaid or a HealthChoice MCO for an audio-video telehealth visit or an audio-only visit, sponsoring agencies should bill using the usual procedure code with the appropriate modifier.

- To bill for services delivered via two-way audio-visual telehealth technology assisted communication, providers must bill for the appropriate service code and use the “-GT” modifier.

- To bill for audio-only telephonic services, providers must bill for the appropriate service code and use the “-UB” modifier to identify the claim as a telephonically delivered service.

3. Place of Service (POS): SBHC sponsoring agencies should bill using the same POS code that would be appropriate for a non-telehealth claim.

- **If conducting a telehealth visit with a student enrolled with a SBHC (or family member who is also enrolled) who would normally be eligible to receive in-person care at the SBHC, sponsoring agencies should use POS code 03 (School).** Sponsoring agencies should use POS code 03 for such visits regardless of the physical location of the student.
- **If a SBHC location adds or maintains telehealth services and wishes to use their telehealth service model to see patients they would not normally see (i.e., patients that are not associated with the student population), the sponsoring agency should not bill for the services as a SBHC. For such visits, sponsoring agencies should use POS code 11 (Office).** Services to these recipients are not considered to be self-referred under COMAR 10.67.06.28. SBHCs should not use the 03 (School) POS when billing for services rendered to patients who would otherwise not be able to receive in-person care at the SBHC. MCOs also are not required to reimburse for such services if the sponsoring agency has not contracted with the MCO.
- **SBHCs may NOT bill using the 02 (Telehealth) code in the POS field.**

Well-Child Visits Delivered via Telehealth

Coverage for well-child visits delivered via telehealth as described in [previous guidance](#) will continue to be permitted after the end of the PHE. **This guidance does not apply to sick visits or chronic care appointments.** Specifically:

For children 24 months and younger:

- Well-child visits should continue in the primary care office setting in order to assess the child’s development, provide timely referrals for additional services as appropriate, and remain up-to-date with immunization schedules. Newborns, infants, and children under 24 months should receive priority for in-person office visits.

For children older than 24 months:

- A telehealth visit may be offered to provide timely EPSDT services; however, this service does not replace the necessary components of a well-child visit that must take place in an office setting, such as immunizations, vision and hearing screening tests, oral health screening and fluoride varnish, and laboratory testing. Providers should clearly document any visit limitations in the child’s medical record.
- Providers must notify patient families of all required preventive service components that cannot occur in the course of the telehealth visit, and that such services will need to be completed at a

later time. An in-person visit is encouraged within 6 months from the date of the telehealth visit to conduct the remaining components of the well-child exam.

- Any concerns raised during the telehealth visit should be clearly documented and addressed as soon as possible during an in-person visit.
- Providers should use their professional judgment and experience with families to determine how telehealth would best be utilized in their practice. In order to establish and maintain a medical home, providers should give special consideration to offering in-office appointments for new patients.
- In order to avoid delays in necessary referrals and services, priority for office visits should be given to those patients who may have missed previously scheduled well-child visits, those who are following a catch-up immunization schedule, and younger children.

Coverage for telehealth and office visits:

- Refer to Table 1 for a full description of CPT codes for preventive services and any restrictions.
- Telehealth services for well-child visits for children older than 24 months will be covered at the same rates as an office visit. Providers must document which elements of preventive care were provided and indicate the setting and module.
- Providers must bill the appropriate service code using the “-GT” modifier to identify the claim as a service delivered via telehealth and using the place of service code that would be appropriate as if it were a non-telehealth claim. The distant site must bill using the location of the doctor as the place of service code. Place of Service Code 02 (Telehealth) is not recognized for Maryland Medicaid participants except for use on Medicare crossover claims to specify services rendered through a telecommunication system for dually eligible participants.
- Coverage includes an additional in-person visit to complete the necessary components of the well-child visit on a later date. Providers should bill a follow-up visit using the same code without the -GT modifier.

TABLE 1: Well-Child Visit Telehealth Coding Guide for the COVID-19 State of Emergency

CPT Code	Code Description	Maryland Medicaid Coverage for Telehealth Visits	
		Children 24 months and younger	Children older than 24 months
99381	Preventive medicine services*; Infant (younger than 1 year); New patient	X	-
99382	Preventive medicine services*; Early childhood (age 1-4 years); New patient	X	✓

99383	Preventive medicine services*; Late childhood (age 5-11 years); New patient	-	✓
99384	Preventive medicine services*; Adolescent (age 12-17 years); New patient	-	✓
99385	Preventive medicine services*; 18 years and older; New patient	-	✓
99391	Preventive medicine services**; Infant (Younger than 1 year); Established patient	X	-
99392	Preventive medicine services**; Early childhood (age 1–4 years); Established patient	X	✓
99393	Preventive medicine services**; Late childhood (age 5–11); Established patient	-	✓
99394	Preventive medicine services**; Adolescent (age 12–17 years); Established patient	-	✓
99395	Preventive medicine services**; 18 years and older; Established patient	-	✓
96110	Developmental screening, per instrument, scoring and documentation	X	✓
96127	Brief emotional/behavioral assessment (e.g, depression inventory) with scoring and documentation, per standardized instrument	X	✓
96160, 96161	Administration of health risk assessment instrument	X	✓

X Not covered for telehealth services; ✓ - Covered for telehealth services; * - Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures (Pap smears and pelvic exam as age and gender appropriate), new patient; ** - Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures (Pap smears and pelvic exam as age and gender appropriate), established patient.

2. Medicaid Check in Campaign 2023

Changes are coming to Maryland Medicaid

MDH asks for your partnership during this time to spread the word about our Medicaid Check-In campaign. During the COVID-19 public health emergency, Marylanders who were enrolled in Medicaid (also called Medical Assistance) continued to be covered, even if they were no longer eligible.

Medicaid renewals will not be automatic this year. As of April 2023, Maryland has begun making Medicaid eligibility reviews again. Not everyone will be up for renewal at the same time. These renewals will take place over 12 months.

Medicaid participants must make sure their contact information is up to date. This way, participants are able to be contacted when it is their time to renew.

The Maryland Department of Health (MDH), along with our partners, including HealthChoice Managed Care Organizations (MCOs), the Maryland Department of Human Services (DHS), and the Maryland Health Connection (MHC), recently launched a statewide communications campaign to alert participants of the upcoming changes.

Provider Partnership

To reduce the number of qualified members that could lose their coverage, MDH created an outreach [toolkit](#) to support providers, advocates, and partners with key messaging and resources to make sure participants know how to renew their coverage and are aware of other affordable health coverage options if needed. MDH will update this throughout the unwinding period, April 2023 through April 2024.

MDH encourages partners to use the messages, templates, and other informational resources available in this toolkit in their own outreach and ask that you help us in sharing consistent messages to ensure participants get the information they need while minimizing potential confusion.

Watch this short, informational video to learn more about Medicaid Check-In and how to help our participants [here](#). MDH will upload this video to the provider toolkit as well.

Participant Redetermination Dates

Providers can find out when a participant is due for redetermination by checking the Eligibility Verification System (EVS). Please call 1-866-710-1447 or visit www.emdhealthchoice.org. This functionality will go-live in early April 2023.

Please note, MDH is also working with the Chesapeake Regional Information System for our Patients (CRISP) Health Information Exchange (HIE) to provide healthcare delivery organizations with a secure report of all their participants who will face redetermination within the next 90 days. While currently in a testing phase, CRISP aims to have this information available to all interested providers by the end of June

2023. Interested providers will receive a monthly managed file transfer (MFT) via CRISP. The file will include information for the current month and ninety (90) days into the future at a given time.

The Medicaid Check-In [Provider Page](#) includes additional information and instructions on checking EVS or working with CRISP to find redetermination dates.

Additional Resources

Please find more provider information and provider toolkit at this link:

<https://health.maryland.gov/mmcp/Pages/MedicaidCheckIn-Providers.aspx>.

Please find participant specific information at this link:

<https://health.maryland.gov/mmcp/Pages/MedicaidCheckIn-Participants.aspx>.

For questions or to suggest FAQs, please reach out to: mdh.medicheckin@maryland.gov.