Telehealth/Telemedicine Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render telehealth/telemedicine services to members of the CarePartners of Connecticut plans selected above.

Note: Audit and disclaimer information is located at the end of this document.

Policy

CarePartners of Connecticut covers medically necessary telehealth and/or telemedicine services consistent with applicable state mandates and in accordance with the member's benefit plan document. Services covered under telehealth should be clinically appropriate and not require in-person assessment and/or treatment. CarePartners of Connecticut defers to the provider to make this determination.

All CarePartners of Connecticut contracting providers, including specialists and urgent care facilities, may provide telehealth/ telemedicine services to members for medical, behavioral health, ancillary health, and home health care visits (i.e., skilled nursing, PT, OT, and ST) for new and existing patients.

Documentation Requirements

Documentation requirements for telehealth services are the same as those required for any face-to-face encounter, with the addition of the following:

A statement that the service was provided using telemedicine or telephone consult;

- The location of the patient;
- The location of the provider; and
- The names of all persons participating in the telemedicine service or telephone consultation service and their role in the encounter.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics, including cost-share, should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization, and Notification chapter of the CarePartners of Connecticut Provider Manual.

No referrals are required for in-network services. Referrals are required for out-of-network services rendered for HMO members.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Use of labs not participating in the member's applicable network(s) may have the unintended consequence of subjecting the member

to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Coding

Providers must bill the following POS and modifier combinations for telehealth/telemedicine services:

Place of Service (POS) Codes

POS	Description
02	Patient is not located in their home when receiving health services or health-related services through telecommunication technology
10	Patient is in their home (a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health-related services through telecommunication technology

Telehealth Modifiers

In addition to the guidelines in the previous section, providers should bill with the appropriate license-level modifier and all other billing guidelines, as specified in the applicable payment policies.

Modifier	Description
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunication system- Required when an audio-only service is reported (See appendix T of the CPT manual)
95	Synchronous telemedicine service rendered via a real-time interactive audio/video telecommunications system; may only be appended to services listed in Appendix P of the AMA CPT Manual
FQ	Audio-only communication technology- To be used for counseling and therapy services provided using audio-only telecommunications
FR	The supervising practitioner was present through two-way, audio/video communication technology
GQ	Asynchronous telecommunications system- Limited to federal demonstration projects in Alaska and Hawaii
GT	Interactive audio/video telecommunication systems

Other Information

- Do not append modifiers to procedure codes that are inherently telehealth services (e.g., telephonic codes), as this is indicated by the appropriate POS code. Claims incorrectly billed with these modifiers may result in a denial.
- Report facility claims with the appropriate revenue codes, CPT/HCPCS codes and modifiers.

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules.

Under CMS rules, special codes already exist for certain telephonic services and those codes will be paid at the CMS fee schedule.

Services provided outside usual office hours through interactive mechanisms are not eligible for the addition of a 99050, 990 51, 99053, 99056, 99058, or 99060 code, since interactive services are not limited to standard office hour time frames.

Communication with the member's PCP and other treating providers is expected as part of the service and is not compensated separately. Provider-to-provider discussions without the member being present are not separately compensated.

Additional Resources

- Evaluation and Management Professional Payment Policy
- Modifiers Payment Policy
- Provider Resource Center

Document History

- July 2025: Annual policy review; updated Additional Resources; administrative edits
- July 2024: Annual policy review; added existing telehealth modifiers 93, FQ, FR, GQ; administrative updates
- September 2023: Annual policy review; no changes
- September 2022: Annual policy review; no changes

- July 2022: Policy created to reflect non-COVID-state billing and coverage guidelines effective for dates of service on or after September 1, 2022

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.