

# Connecticut



## At A Glance

### MEDICAID REIMBURSEMENT

- Live Video: Yes
- Store-and-Forward: Yes\* (e-consult codes)
- Remote Patient Monitoring: No
- Audio Only: Yes

### PRIVATE PAYER LAW

- Law Exists: Yes
- Payment Parity: Yes

### PROFESSIONAL REQUIREMENTS

- Licensure Compacts: CC, IMLC, NLC, PSYPACT, PTC, SW
- Consent Requirements: Yes

### STATE RESOURCES

1. Medicaid Program: CT Medical Assistance Program (CMAP)
2. Administrator: Connecticut Department of Social Services
3. Regional Telehealth Resource Center: Northeast Telehealth Resource Center

# Private Payer

## DEFINITIONS

*Last updated 05/17/2025*

“Telehealth” means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store-and-forward transfers or remote patient monitoring. Telehealth does not include the use of facsimile, texting or electronic mail.

SOURCE: CT General Statute 19a, Sec. 906(a)(11). (Accessed May 2025).

## REQUIREMENTS

*Last updated 05/17/2025*

No health carrier shall reduce the amount of a reimbursement paid to a telehealth provider for covered health care or health services that the telehealth provider appropriately provided to an insured through telehealth because the telehealth provider provided such health care or health services to the patient through telehealth and not in person.

SOURCE: HB 5198 (Public Act 24-110 – 2024 Session), Sec. 3. (Accessed May 2025).

Each individual health insurance policy and group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall provide coverage for medical advice, diagnosis, care or treatment provided via telehealth to the extent coverage is provided for such advice, diagnosis, care or treatment when provided through in-person consultation between the insured and a health care provider licensed in the state. Such coverage shall be subject to the same terms and conditions of the policy.

No such policy shall: (1) Exclude a service for coverage solely because such service is provided only through telehealth and not through in-person consultation between the insured and a health care provider licensed in the state, provided telehealth is appropriate for the provision of such service; or (2) be required to reimburse a treating or

consulting health care provider for the technical fees or technical costs for the provision of telehealth services.

Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service corporation or other entity from conducting utilization review for telehealth services, provided such utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service.

SOURCE: CT General Statute 38a, Sec. 499a. & 38a, Sec. 526a. (Accessed May 2025).

Telehealth provider means any physician licensed under chapter 370, physical therapist licensed under chapter 376, chiropractor licensed under chapter 372, naturopath licensed under chapter 373, podiatrist licensed under chapter 375, occupational therapist licensed under chapter 376a, optometrist licensed under chapter 380, registered nurse or advanced practice registered nurse licensed under chapter 378, physician assistant licensed under chapter 370, psychologist licensed under chapter 383, marital and family therapist licensed under chapter 383a, clinical social worker or master social worker licensed under chapter 383b, alcohol and drug counselor licensed under chapter 376b, professional counselor licensed under chapter 383c, dietitian-nutritionist certified under chapter 384b, speech and language pathologist licensed under chapter 399, respiratory care practitioner licensed under chapter 381a, audiologist licensed under chapter 397a, pharmacist licensed under chapter 400j or paramedic licensed pursuant to chapter 384d who is providing health care or other health services through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to the profession.

SOURCE: CT General Statute 38a, Sec. 499a. & 38a, Sec. 526a. (Accessed May 2025).

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## PARITY

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*Last updated 05/17/2025*

### SERVICE PARITY

Coverage must be provided for telehealth if it would be covered in-person, subject to the terms and conditions of all other benefits under such policy.

SOURCE: CT General Statute 38a, Sec. 499a. & 38a, Sec. 526a. (Accessed May 2025).

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## PAYMENT PARITY

No health carrier shall reduce the amount of a reimbursement paid to a telehealth provider for covered health care or health services that the telehealth provider appropriately provided to an insured through telehealth because the telehealth provider provided such health care or health services to the patient through telehealth and not in person.

SOURCE: HB 5198 (Public Act 24-110 – 2024 Session), Sec. 3. (Accessed May 2025).

# Medicaid

## OVERVIEW

*Last updated 05/17/2025*

Connecticut Medicaid is required to cover telemedicine services for categories of health care that the commissioner determines are appropriate, cost effective and likely to expand access to medically necessary services where there is a clinical need for those services to be provided by telehealth or for Medicaid recipients for whom accessing appropriate health care services poses an undue hardship. An additional law requires reimbursement of audio-only telehealth under certain circumstances and reimbursement for services provided by means of telehealth to the same extent as if the service was provided in person.

The CT Medicaid Program manuals do not mention reimbursement for telemedicine though provider bulletins do indicate coverage and reimbursement for some services, including those rendered via audio-visual and audio-only modalities. At the beginning of 2025, DSS also added procedure codes to the physician office and outpatient fee schedule for billing e-consults. CT Medicaid has created a Telehealth Information page with FAQs and a CMAP Telehealth Table, which includes a list of procedure codes approved to be rendered via telehealth.

SOURCE: CT Statute 17b-245e; CT Statute 17b-245g; CT Dept. of Social Services Provider Bulletin 2023-38. REVISED Guidance for Services Rendered via Telehealth. May 2023 & CT Policy – Provider Bulletin 2024-81. Dec. 2024. (Accessed May 2025).

## DEFINITIONS

*Last updated 05/17/2025*

Telehealth includes (1) telemedicine (synchronized audio-visual two-way communication services) and, where specified by DSS, (2) audio-only two-way synchronized communication services delivered via telephone.

SOURCE: CT Policy – Provider Bulletin 2023-38. May 2023. (Accessed May 2025).

“Telehealth” means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical, oral and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store and forward transfers or remote patient monitoring. “Telehealth” does not include the use of facsimile, texting or electronic mail.

SOURCE: CT General Statute 17b, Sec. 245g. (Accessed May 2025).

Definition for Telemedicine Demonstration Program for FQHCs: “Telemedicine means the use of interactive audio, interactive video or interactive data communication in the delivery of medical advice, diagnosis, care or treatment and includes services described in subsection (d) of section 20-9 and 42 CFR 410.78(a)(3). Telemedicine does not include the use of facsimile or audio-only telephone.”

SOURCE: CT General Statute 17b, Sec. 245c. (Accessed May 2025).

## Telehealth FAQs

Is there a difference between Telehealth and Telemedicine under the Connecticut Medical Assistance Program (CMAP)?

Yes, DSS is using the term telehealth as a broad umbrella term for remote health services currently including either telemedicine or audio only. Telemedicine is defined as synchronized audio-visual two-way communication services. Audio only is defined as a two-way synchronized communication services delivered via telephone.

SOURCE: CT Medical Assistance Program (CMAP) Telehealth FAQs (12/24/24). (Accessed May 2025).

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## LIVE VIDEO

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*Last updated 05/17/2025*

## POLICY

CT Medicaid is required to provide coverage for telehealth services for categories of health care services that the commissioner determines are clinically appropriate to be

provided through telehealth, cost effective for the state and likely to expand access to medically necessary services where there is a clinical need for those services to be provided by telehealth or for Medicaid recipients whom accessing healthcare poses an undue hardship.

The commissioner may provide coverage of telehealth services pursuant to this section notwithstanding any provision of the regulations of Connecticut state agencies that would otherwise prohibit coverage of telehealth services. The commissioner may implement policies and procedures as necessary to carry out the provisions of this section while in the process of adopting the policies and procedures as regulations.

SOURCE: CT General Statute 17b, Sec. 245e. (Accessed May 2025).

To the extent permissible under federal law, the commissioner shall provide Medicaid reimbursement for services provided by means of telehealth to the same extent as if the service was provided in person.

SOURCE: CT General Statute 17b, Sec. 245g. (Accessed May 2025).

Effective for dates of service on and after May 12, 2023, which is the first day after the federal COVID-19 public health emergency declaration ends, in accordance with sections 17b-245e and 17b-245g of the Connecticut General Statutes, the Department of Social Services (DSS) is issuing new guidance for services eligible for reimbursement under the Connecticut Medical Assistance Program (CMAP) when rendered via telehealth. DSS will continue to reimburse for specified services when rendered via telehealth as detailed in Provider Bulletin 2023-38 and on the CMAP Telehealth Table. This guidance applies to services rendered under CMAP for all HUSKY Health members.

Telehealth includes:

- telemedicine (synchronized audio-visual two-way communication services) and,
- where specified by DSS, audio-only two-way synchronized communication services delivered via telephone.

DSS' continued expectation is that enrolled CMAP providers will perform clinically appropriate services including, but not limited to, ensuring timely access to in-person services when medically necessary or requested by the HUSKY Health member for optimum quality of care. Therefore, all enrolled billing entities must have the capacity to deliver services in-person and must provide services in-person to the full extent that is clinically appropriate for their patients and to the full extent necessary if the HUSKY Health member does not consent to receiving one or more services via telehealth. Having



the capacity means that the provider must have a physical location in CT, (or an approved applicable border state as approved as part of enrollment) where the provider has a room or set of rooms to see members in-person and can maintain the member's privacy and confidentiality during the visit.

All applicable federal and state requirements for the equivalent in-person service apply to telehealth services. Therefore, consistent with all services billed to CMAP, all telehealth services must meet the statutory definition of medical necessity in section 17b-259b of the Connecticut General Statutes and all other applicable federal and state statutes, regulations, requirements, and guidance.

SOURCE: CT Policy – Provider Bulletin 2023-38. May 2023. (Accessed May 2025).

Connecticut's Medical Assistance Program will not pay for information or services provided to a client by a provider electronically or over the telephone. However, there is an exception for case management behavioral health services for clients age eighteen and under.

SOURCE: CT Provider Manual. Physicians and Psychiatrists. Sec. 17b-262-342. Pg. 9, Oct. 2020; CT Provider Manual. Psychologists. Sec. 17b-262-472. Oct. 2020. Pg. 7; & CT Provider Manual. Behavioral Health. Sec. 17b-262-918. Oct. 2020. Pg. 6. (Accessed May 2025).

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## ELIGIBLE SERVICES/SPECIALTIES

See specified services reimbursed when rendered via telehealth as detailed in Provider Bulletin 2023-38 and on the CMAP Telehealth Table. Comprehensive information regarding the specific procedure codes eligible are posted on the CMAP Telehealth Webpage as well. This web page will provide information on telehealth requirements, approved procedure codes, required modifiers, specific policy criteria and/or limitations, effective dates, and other telehealth policy information, including the Telehealth FAQs.

Providers are responsible for verifying coverage of a specific procedure code as a telehealth service as well as a covered service on their applicable fee schedule prior to delivering and billing CMAP for the service. Billing for a service via telehealth that is not listed as an approved service on the CMAP Telehealth Table or listed as a covered service on the applicable fee schedule or failure to adhere to the policy and applicable telehealth criteria/limitations, may result in a denied claim or may be at-risk for a financial adjustment during a post-payment review.

Services rendered via telehealth will be reimbursed at the same rate as if the service was rendered in-person. Providers must refer to their applicable reimbursement methodology or fee schedule to ensure that the service identified as eligible to be rendered as a telehealth service is payable for their specific provider type and the reimbursement rate.

SOURCE: CT Policy – Provider Bulletin 2023-38. May 2023. (Accessed May 2025).

Are there changes to billing for Evaluation and Management (E/M) 99202-99215 services via synchronized telemedicine effective January 1, 2025?

Yes, effective for dates of service 1/1/2025 and forward there are new E/M CPT codes specific to audio-visual telemedicine services (98001-98007) that will be added to the CMAP Telehealth Table. Procedure codes 98001-98007 must be used in place of 99202-99215 when services are rendered via telemedicine for medical E/M and behavioral health medication management services. Procedure codes 99202-99215 will continue to be reimbursable for in-person services. Telehealth modifiers are not required for procedure code 98001-98007.

SOURCE: CT Medicaid Assistance Program Telehealth FAQ (Dec. 2024), p. 7. (Accessed May 2025).

Modifiers: One of the following telehealth modifiers should be used when submitting claims:

- Modifier GT: Via interactive audio and video telecommunication systems
- Modifier 95: Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
- Modifier FQ: This service was furnished using audio-only communication technology (use with applicable behavioral health services )

Modifier GT and 95 not required for procedure codes 98400-98407 and 98012-98013. Continue to use modifier FQ with applicable behavioral health services including medication management services.

Effective January 1, 2025, for evaluation and management services:

- New patient office/outpatient visit codes 99202-99205 are end-dated 12/31/2024 for telemedicine only.
- In addition to medical providers, BH Clinics and Outpatient Hospitals can bill new patient synchronous audio-video office/outpatient visit codes 98000-98003 for medication management TM services.



- Established patient office/outpatient visit codes 99211-99215 are end-dated 12/31/2024 for telemedicine only.
- In addition to medical providers, BH Clinics and Outpatient Hospitals can bill established patient synchronous audio-video office/outpatient visit codes 98004-98007 for medication management TM services.

SOURCE: CMAP Telehealth Table. (Accessed May 2025).

Effective for dates of service January 1, 2025, and forward, the procedure codes 98000-98007 are being added to the CMAP Telehealth Table for select E/M services rendered via synchronized telemedicine and for behavioral health medication management services. DSS is making this update based on the January 2025 HCPCS changes. The new synchronized telemedicine specific E/M codes will replace the current E/M procedure codes 99202-99215 only when services are rendered via telemedicine. Procedure codes 99202-99215 must still be billed for all in-person E/M services. Please Note: No changes have been made to policy guidelines or payment methodology for telehealth services. Please continue to refer to the CMAP Telehealth table, FAQs, PB 23-38 and applicable fee schedules for further guidance.

SOURCE: CT Policy – Provider Bulletin 2024-78. Dec. 2024. (Accessed May 2025).

Effective June 12, 2023, providers must ensure that the provision of 90853 (group psychotherapy) is performed via telemedicine (synchronized audio-visual) only. Providers are encouraged to monitor the CMAP website ([www.ctdssmap.com](http://www.ctdssmap.com)) frequently for updates to the DSS Telehealth policy and to ensure that you are accessing the most current version of the CMAP Telehealth Table.

SOURCE: CT Dept. of Social Services. Provider Message. June 2023. (Accessed May 2025).

Effective June 21, 2023, and forward, providers eligible for reimbursement for procedure code T1017 (Targeted case management, 15 minutes) may perform this service via audio-only or telemedicine under the CMAP Telehealth policy.

SOURCE: CT Dept. of Social Services. Provider Message. June 2023. (Accessed May 2025).

Effective for dates of service May 12, 2023, and forward, Medical Equipment Devices (MEDS) providers must comply with the face-to-face (F2F) requirements for certain DME as specified by 42 CFR 440.70. Compliance with this requirement includes the provision of the F2F encounter via telehealth as specified by 42 CFR 440.70(f)(6) when the service billed complies with the telehealth policies as outlined and specified by DSS.

Effective for dates of service May 12, 2023, and forward, physicians can conduct assessments for complex rehabilitative technology (CRT) equipment either in person or via synchronized telemedicine with the assistance of the physical therapist (PT) or occupational therapist (OT) which must be in person with the HUSKY Health member. The requirement of the PT or OT in-person with the member is to ensure the demonstration of the equipment and any features on a customized wheelchair will meet the clinical needs of members residing in skilled nursing facilities.

SOURCE: CT Policy – Provider Bulletin 2023-33. Apr. 2023. (Accessed May 2025).

Effective for dates of service October 16, 2023, and forward, providers eligible for reimbursement for procedure code S0199 (Med abortion inc all ex drug) may perform this service via telemedicine only (synchronized audio-visual), under the CMAP Telehealth policy.

SOURCE: CT Policy – Provider Important Message. Oct. 2023. (Accessed May 2025).

In addition to procedure code S0199, providers are permitted to provide & bill for the MAB medications (S0190 & S0191) as part of the overall MAB service.

SOURCE: CMAP Telehealth Table. (Accessed May 2025).

Opioid Treatment Programs are required to perform a complete, fully documented physical evaluation prior to admission. The program physician may render the physical evaluation component of MAT services via telemedicine only when all of the following are met:

- The CMAP member's originating site is another CMAP-enrolled Opioid Treatment Program (Methadone Maintenance Clinic) that is part of the same billing entity as the originating site;
- The originating site is providing all the other required components of MAT services including the intake and psychiatric evaluation;
- As required by 42 CFR 8.12(f), an authorized healthcare professional under the supervision of a program physician is present with the member at the originating site; and
- The distant site provider must be located at a different service location/address than the originating site.

Induction services must always be rendered face-to-face (in-person) and only after the physical and psychiatric evaluation has been performed. Once a CMAP member has been inducted, routine psychotherapy services may be rendered via telemedicine.

MAT services that may be rendered via telemedicine include medication management and psychotherapy services.

SOURCE: CT Policy – Provider Bulletin 2020-09. March 2020. (Accessed May 2025).

CT does not pay for information or services furnished by a licensed behavioral health clinician to the client electronically or over the telephone, except for case management behavioral health services for clients age eighteen and under.

SOURCE: CT Provider Manual. Behavioral Health. Sec. 17b-262-918. Oct. 2020. Pg. 6. (Accessed May 2025).

## **Outpatient Hospitals**

With the exception of nutritional counseling and PT/OT/SLP services, medical telehealth services are considered professional services and therefore no reimbursement will be provided to the hospital. Behavioral health telehealth services, including medication management, are considered an all-inclusive rate to the hospital and therefore professional fees will not be paid separately.

SOURCE: CT Policy – Provider Bulletin 2023-38. May 2023. & CMAP Telehealth Table. (Accessed May 2025).

Outpatient hospitals may bill for nutritional counseling services when rendered via telemedicine under procedure code G0463 – “clinic visit”. It should be noted that procedure code G0463 is approved for telemedicine nutritional counseling services only and that nutritional counseling can only be billed via telemedicine and cannot be billed via audio-only.

SOURCE: CT Medicaid Assistance Program Telehealth FAQ (Dec. 2024), p. 3. (Accessed May 2025).

## **Nursing Facility and Hospital Care**

Subsequent nursing facility care services are limited to one telemedicine visit every 30 days. Subsequent hospital care services are limited to one telemedicine visit every 3 days.

## **End-State Renal Disease Services (ERSD)**

ESRD services with multiple visits per month (two or more) may be reimbursed when rendered as telemedicine, however; at least one (1) visit must be rendered in-person to examine the vascular access site.

SOURCE: CMAP Telehealth Table. (Accessed May 2025).

## **School Based Child Health Providers**

School Based Child Health Providers are limited to the following services: 90791, 90832, 90847, 90853, H0031, H2014, 92507, 92521, 92522, 92523, 97110 – Refer to the policy guidelines in the CMAP Telehealth Table.

SOURCE: CT Policy – Provider Bulletin 2023-23. March 2023. & CMAP Telehealth Table. (Accessed May 2025).

### **Targeted Case Management for Integrated Care for Kids (InCK) in New Haven**

Monitoring and follow-up activities include making necessary adjustments in the care plan and related changes in the services performed by the provider, which may be performed by staff face-to-face, telehealth, or telephone contact with the individual; by chart review; by case conference; by collateral contact with individuals, family members, providers, legal representatives, or other persons or entities for the benefit of the Medicaid member; or any combination thereof. The care plan must be reviewed every 90 days and adjusted if needed. See bulletin for more information.

SOURCE: CT Policy – Provider Bulletin 2023-55. Jul. 2023. (Accessed May 2025).

### **Sick Visits**

Sick Visits for adults and children are allowed to be performed via telehealth. Refer to CMAP Telehealth Table.

### **Hospice and Home Health Services, and Well Visits**

Hospice and home health services, in addition to Well Visits, cannot be performed via telemedicine. These services must be rendered in person. Refer to Provider Bulletin 2023-38.

SOURCE: CT Medicaid Assistance Program Telehealth FAQ (Dec. 2024), p. 3. (Accessed May 2025).

### **Children’s Mental Health Urgent Crisis Centers Services**

Effective April 1, 2024, DSS will enroll and pay certified providers to deliver children’s mental health urgent crisis services. Claims submitted from DCF certified service location that is enrolled as a CMAP provider will be reimbursed for in-person or services performed via telehealth when billing identified billing/procedure codes listed in Provider Bulletin 2024-16.

SOURCE: CMAP Provider Bulletin 2024-16. Mar. 2024. (Accessed May 2025).

## ELIGIBLE PROVIDERS

Only the following categories of CMAP-enrolled providers may provide and bill for such psychotherapy services or psychiatric diagnostic evaluations within their scope of practice via telemedicine:

- Physician
- Physician Assistant
- Advanced Practice Registered Nurses
- Licensed Behavioral Health Clinicians (defined below and which includes only the following: Licensed Psychologists, Licensed Clinical Social Workers, Licensed Marital and Family Therapists, Licensed Professional Counselors, and Licensed Alcohol and Drug Counselors)
- Behavioral Health Clinics – including Enhanced Care Clinics (ECCs)
- Behavioral Health Federally Qualified Health Centers (FQHCs)
- Medical Clinics – excluding School Based Health Centers (SBHCs)
- Rehabilitation Clinics
- Outpatient Hospital Behavioral Health (BH) Clinics
- Outpatient Psychiatric Hospitals
- Outpatient Chronic Disease Hospitals (CDHs)

Modifiers GT is used when the member's originating site is located in a healthcare facility or office; or modifier 95 is used when the member is located at home.

SOURCE: CT Policy – Provider Bulletin 2020-09. March 2020. (Accessed May 2025).

## Medication Assisted Treatment

Eligible providers:

- Physician
- APRNs
- PAs
- Behavioral Health Clinics

## Medication Management

Eligible Providers:

- Physicians

- PAs
- APRNs
- Medical Clinics – excluding SBHCs
- Behavioral Health Clinics – including ECCs
- Behavioral Health FQHCs
- Outpatient Hospital BH Clinics
- Outpatient Chronic Disease Hospitals

**Eligible providers for out of state surgery and homebound patients include:**

- Physicians
- PAs
- APRNs
- CNMs
- Podiatrists

**Eligible providers to determine if patient to be homebound and/or provide and bill for such service:**

- Physicians
- PAs
- APRNs
- CNMs
- Podiatrists

For homebound patients, provider must document the reason the member is being determined homebound.

Documentation must be maintained by both the originating site provider and the distant site provider to substantiate the services provided. Originating site documentation must indicate the member received or has been referred for telehealth services.

SOURCE: CT Policy – Provider Bulletin 2020-09. March 2020. (Accessed May 2025).

**Medication Assisted Treatment – Opioid Treatment Program**



The distant site provider cannot bill for the physical evaluation component rendered via telemedicine.

SOURCE: CT Policy – Provider Bulletin 2020-09. March 2020. (Accessed May 2025).

## FQHCs

Federally Qualified Health Centers (FQHCs) are eligible to bill their encounter rate when an approved, medically necessary telehealth service is rendered. FQHCs must use the services identified on the Telehealth Table in combination with their approved scope of service to identify the services eligible to be rendered using telehealth. FQHCs must continue to bill HCPCS code, T1015 and all eligible telehealth procedure codes to reflect all of the services rendered during the telehealth visit.

SOURCE: CMAP Telehealth Table. (Accessed May 2025).

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## ELIGIBLE SITES

There is no limitation on the originating site for a member receiving individual therapy, family therapy or psychotherapy with medication management.

Psychiatric diagnostic evaluations may be rendered via telemedicine only if the member is located at a CMAP-enrolled originating site.

Modifiers GT is used when the member's originating site is located in a healthcare facility or office; or modifier 95 is used when the member is located at home.

Documentation must be maintained by both the originating site provider and the distant site provider to substantiate the services provided. Originating site documentation must indicate the member received or has been referred for telehealth services.

SOURCE: CT Policy – Provider Bulletin 2020-09. March 2020, (Accessed May 2025).

Place of Service/Facility Type Code – Providers must bill the appropriate POS/FTC code that best reflects the location where the service would have been provided if rendered in-person (i.e. provider's office – POS 11). At this time, CMAP does not recognize POS 10 and 2 on Medicaid claims.

Will practitioners only be allowed to provide telehealth services from actual office locations?

Response: Effective for dates of service May 12, 2023 and forward:

- Freestanding Clinics
  - Mental Health Services: CMAP enrolled freestanding clinics listed in number 19 above are not required to have their practitioners be physically in person at the CMAP enrolled licensed site when rendering mental health telehealth services. Please refer to number 21 below.
  - Medical Services: Pursuant to 42 CFR 440.90 CMAP enrolled freestanding clinics listed in number 19 above must ensure that either the performing practitioner rendering the telehealth service and/or the HUSKY Health member receiving the telehealth service is physically in-person at one of the enrolled clinic's licensed sites at the time of the telehealth service. If the practitioner or member is not physically in-person at the time of the telehealth service, the freestanding clinic should not bill such service to the CMAP.
- Practitioners – Individual and Group Practice, Outpatient Hospitals, Federally Qualified Health Centers, School Based Child Health:
  - CMAP enrolled practitioners are not required to be physically in person at the enrolled licensed site when rendering eligible telehealth services. Providers must ensure they are following all policy guidelines for eligible telehealth services list on the CMAP Telehealth Table. For additional information on location of practitioners see question 17 above. Refer to PB 2023-38 REVISED Guidance for Services Rendered via Telehealth.

What is the implication of moving mental health services from the Medicaid clinic option to the Medicaid Rehabilitation option?

- The federal clinic regulation 42 CFR 440.90 requires clinic services to be provided in the clinic. A section 1135 disaster relief waiver is currently in place but ends on the last day of the federal PHE, which is May 11, 2023. Effective for dates of service May 12, 2023 and forward, DSS is taking administrative steps with the Centers of Medicare and Medicaid Services (CMS) to maintain current flexibility on the location of the practitioner and/or member when mental health telehealth services are billed by a freestanding clinic.
- This will allow freestanding clinics to provide mental health telehealth services to patients even if the provider or member are outside the “four walls of the clinic”. There will be no impact on billing or reimbursement rates for providers. This update is solely related to Medicaid billing and does not change anything related to DPH and/or DCF licensure requirements.

SOURCE: CT Medicaid Assistance Program Telehealth FAQ (Dec. 2024), p. 2, 5. (Accessed May 2025).

A practitioner who is enrolled with CMAP as an independent provider or as part of an independent provider group, or as a FQHC or outpatient hospital and maintains an approved service location as part of the CMAP enrollment, has the flexibility to perform eligible telehealth services even when the performing/rendering practitioner is not physically in-person at one of the enrolled CT or border service locations at the time of

the service, so long as the practitioner complies with all applicable state and federal requirements.

SOURCE: CT Policy – Provider Bulletin 2023-38. May 2023. (Accessed May 2025).

## Medication Assisted Treatment

Due to Opioid Treatment Programs (Methadone Maintenance Clinics) receiving a daily payment rate for all MAT services provided, the daily payment rate will continue to be paid to the originating site only. The distant site provider must be located at a different service location/address than the originating site.

SOURCE: CT Policy – Provider Bulletin 2020-09. March 2020. (Accessed May 2025).

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## GEOGRAPHIC LIMITS

No Reference Found

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## FACILITY/TRANSMISSION FEE

The code (Q3014) for an originating site facility fee is not listed as eligible on the CMAP Telehealth Table.

SOURCE: CMAP Telehealth Table. (Accessed May 2025).

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## STORE-AND-FORWARD

*Last updated 05/17/2025*

## POLICY

Telehealth includes (1) telemedicine (synchronized audio-visual two-way communication services) and, where specified by DSS, (2) audio-only two-way synchronized communication services delivered via telephone.

SOURCE: CT Policy – Provider Bulletin 2023-38. May 2023. (Accessed May 2025).

“Telehealth” means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical, oral and mental health, and includes (A) interaction between the patient at the

originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store and forward transfers or remote patient monitoring. “Telehealth” does not include the use of facsimile, texting or electronic mail.

SOURCE: CT General Statute 17b, Sec. 245g. (Accessed May 2025).

## Telehealth FAQs

Is there a difference between Telehealth and Telemedicine under the Connecticut Medical Assistance Program (CMAP)?

Yes, DSS is using the term telehealth as a broad umbrella term for remote health services currently including either telemedicine or audio only. Telemedicine is defined as synchronized audio-visual two-way communication services. Audio only is defined as a two-way synchronized communication services delivered via telephone.

SOURCE: CT Medical Assistance Program (CMAP) Telehealth FAQs (Dec. 2024). (Accessed May 2025).

## E-Consults

Effective for dates of service January 1, 2025, and forward, the Department of Social Services (DSS) is adding procedure codes 99451 and 99452 to the physician office and outpatient fee schedule for billing electronic consultations (e-consults).

Based on the 2025 Current Procedural Terminology (CPT) manual, DSS defines an e-consult as a consultation service through which a member’s primary care practitioner or treating practitioner (defined as a physician, advanced practice registered nurses (APRN), certified nurse midwife (CNM), and physician assistant) requests the opinion and/or treatment advice of a physician/psychiatrist, APRN, CNM or physician assistant with a specific specialty, to assist the primary care or treating practitioner in the diagnosis and/or management of the member’s presenting complaint.

E-consult services are typically provided in cases where a timely face-to-face visit with a specialist is not necessary or may not be feasible due to, factors including but not limited to, time and distance. DSS is expanding this measure as part of an effort to increase access to medically necessary specialist services covered under the Connecticut Medical Assistance Program (CMAP).

See bulletin for list of eligible codes, specialists, and requirements for the electronic systems used, as well as consent and documentation requirements.

SOURCE: CT Policy – Provider Bulletin 2024-81. Dec. 2024. (Accessed May 2025).

## ELIGIBLE SERVICES/SPECIALTIES

### E-Consults

#### Guidance for E-Consults Procedure Codes – Referring Provider:

- CPT code 99452 should be billed by the primary care or treating practitioner within an office setting, if 16-30 minutes in the service day is spent preparing for the referral and/or communicating with the specialist performing the e-consult. The primary care or treating practitioner may not report this CPT code more than once in a 14-day period for each individual HUSKY Health member per specialty.

#### Guidance for E-Consults Procedure Codes – Consulting Provider:

- CPT code 99451 should be billed when an econsult for an evaluation/management (E/M) visit performed by a specialist occurs in place of a face-to-face (F2F) visit with that same specialist. E-consult codes are not reimbursable if there has been an F2F visit with the specialist 14 days prior to or 14 days after the e-consult occurs (or at the next available appointment date with the specialist if that date is greater than 14 days) when:
  - the F2F visit was/is related to the original complaint; and,
  - the F2F visit is with the same specialist (or specialist group) and was completed in addition to the e-consult.
- In this circumstance, the e-consult codes should not be billed when the specialist will bill for an F2F visit.
- Please note if a F2F visit and e-consult are billed by the same specialist or specialist group as outlined above, claims will be subject to denial via the claims processing system or subject to recoupment based on a post-payment audit review by DSS Quality Assurance division.

#### Guidance for Federally Qualified Health Centers:

- E-consults that are performed in the FQHC setting are reimbursed as part of the overall encounter for the date of service. Separate reimbursement from the encounter received for e-consults is not permitted.
- Case management or follow-up services to an econsult performed by FQHCs will be considered part of the initial visit and no additional payments will be made to the FQHCs for this follow-up care rendered on the same date of service.

#### Requirements of the Specialists:

- As is required for all services reimbursed under CMAP, all providers, including the specialist performing the e-consult, must be enrolled in the CMAP provider network. Providers must enroll as the provider type and specialty that they are licensed/certified with the State of Connecticut Department of Public Health.

An “e-consult” is not eligible for reimbursement under CMAP if the “e-consult” is performed as a split or shared medical or behavioral health visit (see PB 22-35 Updated Guidance Regarding Shared/Split Medical Visits for more information). It is DSS’ expectation that the appropriate level of specialist performs the e-consult and bills accordingly.

See bulletin for list of eligible specialists.

SOURCE: CT Policy – Provider Bulletin 2024-81. Dec. 2024. (Accessed May 2025).

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## GEOGRAPHIC LIMITS

No Reference Found

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## TRANSMISSION FEE

No Reference Found

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# REMOTE PATIENT MONITORING

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*Last updated 05/17/2025*

## POLICY

Telehealth includes (1) telemedicine (synchronized audio-visual two-way communication services) and, where specified by DSS, (2) audio-only two-way synchronized communication services delivered via telephone.

SOURCE: CT Policy – Provider Bulletin 2023-38. May 2023. (Accessed May 2025).

“Telehealth” means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical, oral and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store and forward transfers or remote patient monitoring. “Telehealth” does not include the use of facsimile, texting or electronic mail.

SOURCE: CT General Statute 17b, Sec. 245g. (Accessed May 2025).



## Telehealth FAQs

Is there a difference between Telehealth and Telemedicine under the Connecticut Medical Assistance Program (CMAP)?

Yes, DSS is using the term telehealth as a broad umbrella term for remote health services currently including either telemedicine or audio only. Telemedicine is defined as synchronized audio-visual two-way communication services. Audio only is defined as a two-way synchronized communication services delivered via telephone.

SOURCE: CT Medical Assistance Program (CMAP) Telehealth FAQs (Dec. 24, 2024). (Accessed May 2025).

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## TRANSMISSION FEE

No Reference Found

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## CONDITIONS

No Reference Found

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## PROVIDER LIMITATIONS

No Reference Found

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## OTHER RESTRICTIONS

No Reference Found

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## EMAIL, PHONE & FAX

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*Last updated 05/17/2025*

Effective for dates of service on and after May 12, 2023, which is the first day after the federal COVID-19 public health emergency declaration ends, in accordance with sections

17b-245e and 17b-245g of the Connecticut General Statutes, the Department of Social Services (DSS) is issuing new guidance for services eligible for reimbursement under the Connecticut Medical Assistance Program (CMAP) when rendered via telehealth. DSS will continue to reimburse for specified services when rendered via telehealth as detailed in Provider Bulletin 2023-38 and on the CMAP Telehealth Table. This guidance applies to services rendered under CMAP for all HUSKY Health members.

Telehealth includes:

- telemedicine (synchronized audio-visual two-way communication services) and,
- where specified by DSS, audio-only two-way synchronized communication services delivered via telephone.

Comprehensive information regarding the specific procedure codes eligible are posted on the CMAP Telehealth Webpage. This web page will provide information on telehealth requirements, approved procedure codes, required modifiers, specific policy criteria and/or limitations, effective dates, and other telehealth policy information, including the Telehealth FAQs. Providers are responsible for verifying coverage of a specific procedure code as a telehealth service as well as a covered service on their applicable fee schedule prior to delivering and billing CMAP for the service.

SOURCE: CT Policy – Provider Bulletin 2023-38. May 2023. (Accessed May 2025).

Notwithstanding the provisions of section 17b-245c, 17b-245e or 19a-906 of the general statutes, as amended by this act, or any other section of the general statutes, regulation, rule, policy or procedure governing the Connecticut medical assistance program, the Commissioner of Social Services shall, to the extent permissible under federal law, provide coverage under the Connecticut medical assistance program for audio-only telehealth services when (1) clinically appropriate, as determined by the commissioner, (2) it is not possible to provide comparable covered audiovisual telehealth services, and (3) provided to individuals who are unable to use or access comparable, covered audiovisual telehealth services.

SOURCE: CT Statute Sec. 17b-245g. (Accessed May 2025).

Based on the January 2025 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions, and description changes) the following procedure codes are being end-dated effective for dates of services on and after December 31, 2024:

- 99442 – Telephone medical discussion with physician 11-20 minutes and
- 99443 – Telephone medical discussion with physician 21-30 minutes

Effective for dates of service January 1, 2025 and forward the following procedure codes will be used for medical audio-only services and audio-only behavioral health medication management services:

- 98012 – Established patient synchronous audio-only visit with straightforward medical decision making and 10 minutes or more of medical discussion, if using time 10 minutes or more
- 98013 – Established patient synchronous audio-only visit with low medical decision making and 10 minutes or more of medical discussion, if using time 20 minutes or more

SOURCE: CT Policy – Provider Bulletin 2024-78. Dec. 2024. (Accessed May 2025).

Medical audio-only services for HUSKY Health members who lack the ability to present in-person for a visit or utilize audio-visual telemedicine services, such as insufficient internet access, insufficient equipment to support a telemedicine visit or at the member's request to utilize audio-only (when clinically appropriate).

1. Established patients only
2. An in-person visit must have occurred within the previous 12 months prior to the audio-only visit
3. Must be a scheduled visit and the provider must document that an in-person or TM appt was offered and declined

In addition to medical providers, BH Clinics & Outpatient hospitals may bill 98012 – 98013 for audio-only med mgmt.

Modifier GT and 95 not required for procedure codes 98012-98013. Continue to use modifier FQ with applicable behavioral health services including medication management services.

Please refer to the CMAP Telehealth Table.

The following modifier should be used for applicable audio only behavioral health services:

- Modifier FQ: The telehealth service was furnished using real-time audio-only communication technology.

Are there changes to audio-only billing for dates of service January 1, 2025?

- Yes, effective for dates of service 1/1/2025 and forward, new procedure codes 98012 and 98013 which are specific to audio only telemedicine services have been added to the CMAP Telehealth Table. Procedure codes 98012 and 98013 will be used for medical audio-only visits and behavioral health medication management.

- Procedure codes 99442 and 99443 are being end-dated 12/31/2024.

How should providers bill for a telemedicine service that switched to audio-only due to technical difficulties?

- If a medical telemedicine service cannot be completed via telemedicine for any reason and the provider switches to audio-only to complete the service, providers should bill that service in accordance with medical audio-only procedure codes. Please refer to the Telehealth Table for approved medical audio only procedure codes.
- If a behavioral health telemedicine service cannot be completed via telemedicine for any reason and the provider switches to audio-only communication, the provider must append modifier “FQ” to the claim to show the service was completed using audio-only communication technology.
- If a behavioral health medication management service cannot be completed via telemedicine for any reason and the provider switches to audio-only communication, the provider must bill one of the approved audio-only procedure codes listed on the Telehealth Table. Please refer to the Telehealth Table for approved audio only procedure codes.
- Consistent with CMAPs requirements all services must be documented appropriately in the member’s medical record. Documentation must reflect the reason the why the service was switched.

Can psychiatric providers still provide medication evaluation and management sessions by Phone only for established patients?

- Effective for dates of service January 1, 2025 and forward, if medication management is provided to an established patient via audio only, providers should bill 98012 or 98013. Please refer to the CMAP Telehealth Table. Procedure codes 99442 and 99443 are end-dated on and after 12/31/2024.

SOURCE: CT Medicaid Assistance Program Telehealth FAQ (Dec. 2024), p. 2-4, 6-7. (Accessed May 2025).

Effective June 21, 2023, and forward, providers eligible for reimbursement for procedure code T1017 (Targeted case management, 15 minutes) may perform this service via audio-only or telemedicine under the CMAP Telehealth policy.

SOURCE: CT Dept. of Social Services. Provider Message. June 2023. (Accessed May 2025).

The department shall not pay for information or services provided to a client over the telephone except for case management behavioral health services for patients aged 18 and under.

SOURCE: CT Provider Manual. Clinic. Sec. 17b-262-823. Oct. 1, 2020. Ch. 7, pg. 20; Behavioral Health. Sec. 17b-262-918. Oct. 2020 Ch. 7, Pg. 6; CT Provider Manual. Physician and Psychiatrist. Sec. 17b-262-342 & 17b-262-456. Oct. 2020 Pg. 9 & 20; CT Provider Manual. Psychologist. Sec. 17b-262-472. Oct.

2020. Ch. 7, pg. 7; CT Provider Manual. Hospital Inpatient Services. Sec. 150.2(E)(III)(I). Oct. 2020. Ch. 7, pg. 44; CT Provider Manual. Chiropractic. Sec. 17b-262-540. Oct. 2020. Ch. 7, pg. 6; CT Provider Manual. Dental. Sec. 17b-262-698. Oct. 2020. Ch. 7, Pg. 44; CT Provider Manual. Home Health. Sec. 17b-262-729. Oct. 2020. Ch. 7, pg. 12; CT Provider Manual. Naturopath. Sec. 17b-262-552. Oct. 2020. Ch. 7, pg. 6; CT Provider Manual. Nurse Practitioner/Midwife. Sec. 17b-262-578. Oct. 2020. Ch. 7, pg. 7; CT Provider Manual. Podiatry. Sec. 17b-262-624. Oct. 2020. Ch. 7, pg. 6; CT Provider Manual. Vision Care. Sec. 17b-262-564. Oct. 2020. Ch. 7, pg. 4. (Accessed May 2025).

The price for any supply listed in the fee schedule published by the department shall include and the department shall pay the lowest: ... information furnished by the provider to the client over the telephone.

SOURCE: CT Provider Manual. Medical Services, Sec. 17b-262-720. Oct. 2020, p. 7. (Accessed May 2025).

### Person-Centered Medical Home (PCMH) Program

Effective for April 1, 2024 and forward, specific to the Person-Centered Medical Home (PCMH) Program, the Department of Social Services (DSS) will update the list of procedure codes eligible for the PCMH add-on payment. The following Evaluation/Management (E/M) codes have been added to the PCMH add-on payment list: Procedure Code Description 99442 – Telephone medical discussion with physician 11-20 minutes; 99443 – Telephone medical discussion with physician 21-30 minutes. PCMH providers should refer to the PCMH Codes for Enhanced Reimbursement chart at HUSKY Health Program | Providers | PCMH Codes for Enhanced Reimbursement ([huskyhealthct.org](https://huskyhealthct.org)) for a complete list of eligible procedure codes for the PCMH add-on payment.

SOURCE: CMAP Policy Bulletin 2024-21. Mar. 2024. (Accessed May 2025).

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## CONSENT REQUIREMENTS

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*Last updated 05/17/2025*

### Informed Consent

In a method as determined by providers, informed consent must be obtained in writing (electronic consent is acceptable) from each HUSKY Health member before providing telehealth services and annually thereafter. DSS is not requiring the use of a specific form and providers may use their own form or format for obtaining informed consent. In addition, the provider must ensure each HUSKY Health member is aware they can optout or refuse telehealth services at any time.

### Services Rendered to Minors

If the HUSKY Health member is a minor child under age 18, a parent or legal guardian must be present for services to the same extent as it would be required for comparable in-person services unless exempted by state or federal law. In addition, informed consent for telehealth services must be obtained by the parent or legal guardian prior to the provision of such services and obtained annually thereafter.

SOURCE: CT Medicaid Assistance Program Provider Bulletin 2023-38 (May 2023), p. 3. (Accessed May 2025).

### **Verbal Consent Allowance Expired**

Verbal consent obtained during the PHE, as evidenced by a documentation in the medical record, may remain in effect for up to six months after the end of the PHE, after which, providers must obtain informed consent per the terms found in Provider Bulletin 2023-38 (cited above).

SOURCE: CT Medicaid Assistance Program Telehealth FAQ (Dec. 2024), p. 2. (Accessed May 2025).

### **E-Consults**

Consent from the HUSKY Health member is required prior to the e-consult request being sent to the consulting specialist. The consent must include permission to consult with eligible specialists. Consent may be verbal or written (including electronic) and the consent must be clearly documented in the HUSKY Health member's patient record.

SOURCE: CT Policy – Provider Bulletin 2024-81. Dec. 2024. (Accessed May 2025).

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## **OUT OF STATE PROVIDERS**

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*Last updated 05/17/2025*

DSS' continued expectation is that enrolled CMAP providers will perform clinically appropriate services including, but not limited to, ensuring timely access to in-person services when medically necessary or requested by the HUSKY Health member for optimum quality of care. Therefore, all enrolled billing entities must have the capacity to deliver services in-person and must provide services in-person to the full extent that is clinically appropriate for their patients and to the full extent necessary if the HUSKY Health member does not consent to receiving one or more services via telehealth. Having the capacity means that the provider must have a physical location in CT, (or an approved applicable border state as approved as part of enrollment) where the provider has a room or set of rooms to see members in-person and can maintain the member's privacy and confidentiality during the visit.



## Location of Practitioner – Providers

### *Independent Practitioners/Group Practitioners/Federally Qualified Health Centers/Outpatient Hospitals*

Except as otherwise specifically stated in subsequent provider guidance issued by DSS, stated as part of telehealth policy criteria for a specific service as outlined on the CMAP Telehealth Table, or for coverage of out-of-state services that are not available in-state or from a border provider as required under 42 CFR §431.52, a practitioner who is enrolled with CMAP as an independent provider or as part of an independent provider group, or as a FQHC or outpatient hospital and maintains an approved service location as part of the CMAP enrollment, has the flexibility to perform eligible telehealth services even when the performing/rendering practitioner is not physically in-person at one of the enrolled CT or border service locations at the time of the service, so long as the practitioner complies with all applicable state and federal requirements. Enrolled border providers and out-of-state providers rendering services as approved in 42 CFR 431.52, are encouraged to research applicable licensing and scope of practice requirements that may apply specifically to their location at the time of the telehealth service.

In-state enrolled CMAP providers (facility/billing provider/parent company etc.) who contract with out-of-state practitioners to provide 100% telehealth services to HUSKY members must ensure that the billing provider can provide in-person services when medically necessary or when the member requests it. Consistent with current CMAP requirements, the out-of-state practitioner must hold an active CT license. The billing provider is responsible for providing the Department with supporting documentation for services during any audit review or investigation. If documentation is not provided, or if it is not sufficient to support the services billed, the billing provider will be responsible for any calculated overpayment that needs to be returned to the Department. Except for providers meeting the requirements under 42 CFR §431.52, out-of-state practitioners who are not contracted with an in-state CMAP provider are not eligible to enroll and bill for telehealth services.

SOURCE: CT Dept. of Social Services. Provider Bulletin 2023-38 REVISED Guidance for Services Rendered via Telehealth (May 2023). (Accessed May 2025).

Do all providers need to have an approved location within the state of CT that allows for patients to be seen in-person?

Response: Yes, all billing providers must have a physical location within the state of CT (or an approved applicable border state as approved as part of enrollment) where the

provider has a room or set of rooms to see patients in-person and can maintain the patient's privacy and confidentiality during the visit. Please refer to PB 2023-38 REVISED Guidance for Services Rendered via Telehealth for additional information regarding location of providers.

#### Examples of location scenarios:

The following examples are appropriate for when an in-person visit is medically necessary or requested by a HUSKY Health member:

- A location in CT (or an approved applicable border state as approved as part of enrollment) including but not limited to rented/shared/owned/WeWork space where the provider has a room or set of rooms to see the member in-person and can maintain the member's privacy and confidentiality during the visit.
- An in-state provider who does not have a home office or a rented office but has a colleague that does and is willing to let the provider utilize the space if they need to see the member in person.

The following examples are inappropriate for when an in-person visit is medically necessary or requested by a HUSKY Health member:

- A location in CT (or an approved applicable border state as approved as part of enrollment) where the provider does not have consistent access for on-demand use.
- A location in CT (or an approved applicable border state as approved as part of enrollment) where the provider cannot maintain the member's privacy and confidentiality.
- A scenario where a provider lives out of CT and provides 100 % telehealth services but has a friend or family in CT and uses their home or office space sporadically to provide in-person services to HUSKY Health members.

For out-of-state practitioners who received a license to see Husky members virtually during the federal public health emergency, must now also have an approved site within CT borders and must be within CT borders while performing a telehealth service.

Correct?

Response: Out-of-state providers that have no in-state presence and solely want to provide 100% telehealth services for HUSKY Health members are not approved to enroll in CMAP or render telehealth services.

Border Providers who are enrolled with the CMAP and have a designation as a border provider may continue to render telehealth services in their border state. Border providers do not need to have an approved location within the state of Connecticut.

Enrolled border providers follow the same rules as in-state CMAP enrolled providers, therefore they can perform approved telehealth services.

In-state enrolled CMAP providers may contract with out-of-state practitioners to provide 100% telehealth services to HUSKY members. The in-state provider must ensure timely access to in-person services when medically necessary or when the member requests it. Consistent with current CMAP requirements, the out-of-state practitioner must hold an active CT license.

SOURCE: CT Medicaid Assistance Program Telehealth FAQ (Dec. 2024), p. 4-6. (Accessed May 2025).

### **Out-of-State Surgery**

Physicians rendering inpatient surgical services for a CMAP member must ensure the hospital has submitted and obtained an approved prior authorization for the inpatient surgery. Once the hospital has an approved authorization on file for the CMAP member, the member is eligible to receive their pre- and/or post-surgical consultations via telemedicine. Any telemedicine service related to the surgery must be rendered by the Out-of-State (OOS) provider who will be performing the surgery. All telemedicine services must be clinically appropriate and medically necessary. Pre/Post surgery instructions are not eligible for reimbursement via telemedicine.

SOURCE: CT Medical Assistance Program, Provider Bulletin 2020-09 (March 2020), p. 4. (Accessed May 2025).

### **Border Hospital Reimbursement**

The Department of Social Services (DSS) is notifying border and out-of-state (OOS) hospitals that the rates and parameters for reimbursement of inpatient and outpatient hospital services, provided to Connecticut Medicaid members, have been updated effective for dates of discharges on or after January 1, 2025.

SOURCE: CT Medical Assistance Program, Provider Bulletin 2024-77 (Dec. 2024), p. 1. (Accessed May 2025).

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## **MISCELLANEOUS**

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*Last updated 05/17/2025*

DSS' continued expectation is that enrolled CMAP providers will perform clinically appropriate services including, but not limited to, ensuring timely access to in-person services when medically necessary or requested by the HUSKY Health member for optimum quality of care. Therefore, all enrolled billing entities must have the capacity to

deliver services inperson and must provide services in-person to the full extent that is clinically appropriate for their patients and to the full extent necessary if the HUSKY Health member does not consent to receiving one or more services via telehealth. Having the capacity means that the provider must have a physical location in CT, (or an approved applicable border state as approved as part of enrollment) where the provider has a room or set of rooms to see members in-person and can maintain the member's privacy and confidentiality during the visit.

Each provider is responsible for ensuring that the provision of a service performed via telehealth complies with all applicable requirements, including, but not limited to Department of Public Health (DPH) practitioner licensing and scope of practice requirements, DSS regulations, provider bulletins/Important Messages, Frequently Asked Questions (FAQs), billing and documentation requirements and any other applicable State or Federal statute, regulation, or any other requirement. Note that, in accordance with sections 17b-245e and 17b-245g of the Connecticut General Statutes, services detailed in this bulletin as covered via telehealth are authorized by DSS under that authority, notwithstanding any DSS regulations or policies that may otherwise have prohibited those services to be rendered via telehealth.

## **HIPAA and Privacy Related Requirements**

Information and data related to telehealth services are protected health information (PHI) to the same extent as in-person services and to the full extent applicable, fall under the scope of the federal Health Insurance Portability and Accountability Act (HIPAA) and all other applicable federal and state health information privacy and security requirements.

Providers must ensure they comply with all applicable requirements, including, but not limited to, using telehealth software, protocols, and procedures that fully comply with HIPAA and all other applicable requirements. Popular social media and telecommunications applications with video capabilities may not comply with HIPAA requirements and in those instances should not be used. Providers must ensure that they fully comply with such requirements, including researching applicable federal HIPAA requirements and, as appropriate, using only HIPAA compliant software to provide audio-visual or audio-only telephone telehealth services. Providers should check with their telehealth vendor to determine if the software is HIPAA compliant.

Providers must develop and implement procedures to verify provider and patient identity prior to provision of a telehealth service. Additionally, providers must ensure

that an appropriate, secure, and private location is available for all HUSKY Health members participating in telehealth services.

SOURCE: CT Policy – Provider Bulletin 2023-38. May 2023. (Accessed May 2025).

## E-Consults

### Requirements of E-consult's Electronic System:

- All e-consults must be conducted through a secure internet exchange between the primary care or treating practitioner and the specialist. Telephonic consultations are not reimbursable under CMAP.
- The system used to complete the e-consult must, at a minimum, comply with the following requirements. The system must:
  - be in compliance with Health Insurance Portability and Accountability Act (HIPAA) and other applicable security and privacy requirements.
  - enable transmission through electronic communication systems to a specialist who uses the information to evaluate the cases for the type of e-consults for which it is used.
  - be compatible with the primary care or treating practitioners' electronic health records (EHR) system.

### Documentation Requirements:

- All documentation for encounters and the corresponding e-consults must be in compliance with Section 17b-262-349 and Section 17b-262- 1004 of the regulations of Connecticut state agencies. The documentation should include the medical/behavioral health reasoning for the econsult along with any documentation of medical/behavioral health conclusions and any recommendations for treatment written by the specialist.
- Also, as defined in Section 17b-262-349 and Section 17b-262-1004(a) of the regulations of Connecticut state agencies, all required documentation for encounters and the e-consults must be retained in the HUSKY Health member's medical and/or behavioral health file and it must be available to DSS upon request.

SOURCE: CT Policy – Provider Bulletin 2024-81. Dec. 2024. (Accessed May 2025).

The Commissioner is required to submit a report by Aug. 1, 2020 to the joint standing committees of the General Assembly on the categories of health care services in which the department is utilizing telehealth services, in what cities or regions of the state such services are being offered and any cost savings realized by the state by providing telehealth services.

SOURCE: CT General Statute 17b, Sec. 245e. (Accessed May 2025).



Effective for dates of service January 1, 2021 and forward, telemedicine claims should no longer be billed with POS 02.

SOURCE: CT Department of Social Services, Medical Assistance Program, Provider Bulletin 2020-100, Dec. 2020. (Accessed May 2025).

The Commissioner of Public Health, in consultation with the Commissioner of Early Childhood, shall develop and implement a plan to establish licensure by reciprocity or endorsement of a person who (1) is (A) a speech and language pathologist licensed or certified to provide speech and language pathology services, or entitled to provide speech and language pathology services under a different designation, in another state having requirements for practicing in such capacity that are substantially similar to or higher than the requirements in force in this state, or (B) an occupational therapist licensed or certified to provide occupational therapy services, or entitled to provide occupational therapy services under a different designation, in another state having requirements for practicing in such capacity that are substantially similar to or higher than the requirements in force in this state, (2) has no disciplinary action or unresolved complaint pending against such person, and (3) intends to provide early intervention services under the employment of an early intervention service program participating in the birth-to-three program established pursuant to section 17a-248b of the general statutes.

When developing and implementing such plan, the Commissioner of Public Health shall consider eliminating barriers to the expedient licensure of such persons in order to immediately address the needs of children receiving early intervention services under the birth-to-three program. The provisions of any interstate licensure compact regarding a speech and language pathologist or occupational therapist adopted by the state shall supersede any program of licensure by reciprocity or endorsement implemented under this section for such speech and language pathologist or occupational therapist.

On or before January 1, 2023, the Commissioner of Public Health shall (1) implement the plan to establish licensure by reciprocity or endorsement, and (2) report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and children regarding such plan and recommendations for any necessary legislative changes related to such plan.

SOURCE: SB 2 (2022 Session), Sec. 26. (Accessed May 2025).



The executive director of the Office of Health Strategy, established under section 19a-754a of the general statutes, shall conduct a study regarding the provision of, and coverage for, telehealth services in this state. Such study shall include, but need not be limited to, an examination of (1) the feasibility and impact of expanding access to telehealth services, telehealth providers and coverage for telehealth services in this state beginning on July 1, 2024, and (2) any means available to reduce or eliminate obstacles to patient access to telehealth services, telehealth providers and coverage for telehealth services in this state, including, but not limited to, any means available to reduce patient costs for telehealth services and coverage for telehealth services in this state. Not later than January 1, 2023, the executive director shall submit a report on the findings of such study, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and insurance.

SOURCE: SB 2 (2022 Session), sec. 41. (Accessed May 2025).

### **Hospice Hospital at Home Pilot Program**

Recently passed legislation provides that not later than Jan. 1, 2024, the CT Department of Public Health shall establish, in collaboration with a hospital in the state and the CT Department of Social Services, a Hospice Hospital at Home pilot program to provide hospice care to patients in the home through a combination of in-person visits and telehealth.

SOURCE: CT SB 1075 (2023 Session). (Accessed May 2025).

## **Professional Requirements**

### **DEFINITIONS**

*Last updated 05/17/2025*

“Telehealth” means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store-and-forward transfers or remote patient monitoring. Telehealth does not include the use of facsimile, texting or electronic mail.

SOURCE: CT General Statute 19a, Sec. 906(a)(11). (Accessed May 2025).

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## CONSENT REQUIREMENTS

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*Last updated 05/17/2025*

At the time of the telehealth provider's first telehealth interaction with a patient, the telehealth provider shall inform the patient concerning the treatment methods and limitations of treatment using a telehealth platform and, after providing the patient with such information, obtain the patient's consent to provide telehealth services. The telehealth provider shall document such notice and consent in the patient's health record. If a patient later revokes such consent, the telehealth provider shall document the revocation in the patient's health record.

Each telehealth provider shall, at the time of the initial telehealth interaction, ask the patient whether the patient consents to the telehealth provider's disclosure of records concerning the telehealth interaction to the patient's primary care provider. If the patient consents to such disclosure, the telehealth provider shall provide records of all telehealth interactions to the patient's primary care provider, in a timely manner, in accordance with the provisions of sections 20-7b to 20-7e, inclusive.

Any consent required under this section shall be obtained from the patient, or the patient's legal guardian, conservator or other authorized representative, as applicable.

SOURCE: CT Gen. Statutes Sec. 19a-906(b)(2), (d) & (e). (Accessed May 2025).

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## ONLINE PRESCRIBING

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*Last updated 05/17/2025*

No telehealth provider shall prescribe any schedule I, II or III controlled substance through the use of telehealth, except a schedule II or III controlled substance other than an opioid drug, as defined in section 20-14o, in a manner fully consistent with the Ryan Haight Online Pharmacy Consumer Protection Act, 21 USC 829(e), as amended from time to time, for the treatment of a person with a psychiatric disability or substance use disorder, as defined in section 17a-458, including, but not limited to, medication-assisted treatment. A telehealth provider using telehealth to prescribe a schedule II or III controlled substance pursuant to this subsection shall electronically submit the prescription pursuant to section 21a-249, as amended by this act.

SOURCE: CT General Statute 19a, Sec. 906(c). (Accessed May 2025).

Notwithstanding any provision of the general statutes or any regulation of Connecticut state agencies concerning the certification of qualifying patients through telehealth services, a physician, physician assistant or advanced practice registered nurse may issue a written certification to a qualifying patient and provide any follow-up care utilizing telehealth services, provided all other requirements for issuing such written certification to the qualifying patient, including, but not limited to, all recordkeeping requirements, are satisfied.

SOURCE: CT General Statute 21a-408c (f). (Accessed May 2025).

A licensed practitioner shall not be required to electronically transmit a prescription when:

- Electronic transmission is not available due to a temporary technological or electrical failure. In the event of a temporary technological or electrical failure, the practitioner shall, without undue delay, reasonably attempt to correct any cause for the failure that is within his or her control. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection, shall document the reason for the practitioner's failure to electronically transmit the prescription in the patient's medical record as soon as practicable, but in no instance more than seventy-two hours following the end of the temporary technological or electrical failure that prevented the electronic transmittal of the prescription. For purposes of this subdivision, "temporary technological or electrical failure" means failure of a computer system, application or device or the loss of electrical power to such system, application or device, or any other service interruption to such system, application or device that reasonably prevents the practitioner from utilizing his or her certified application to electronically transmit the prescription in accordance with subsection (b) of this section;
- The practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by an electronically transmitted prescription in a timely manner and that such delay would adversely impact the patient's medical condition, provided if such prescription is for a controlled substance, the quantity of such controlled substance does not exceed a five-day supply for the patient, if the controlled substance was used in accordance with the directions for use. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection, shall document the reason for the practitioner's failure to electronically transmit the prescription in the patient's medical record;
- The prescription is to be dispensed by a pharmacy located outside this state. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection, shall document the reason for the practitioner's failure to electronically transmit the prescription in the patient's medical record;
- Use of an electronically transmitted prescription may negatively impact patient care, such as a prescription containing two or more products to be compounded by a pharmacist, a prescription for direct administration to a patient by parenteral, intravenous, intramuscular,

subcutaneous or intraspinal infusion, a prescription that contains long or complicated directions, a prescription that requires certain elements to be included by the federal Food and Drug and Administration, or an oral prescription communicated to a pharmacist by a health care practitioner for a patient in a chronic and convalescent nursing home, licensed pursuant to chapter 368v; or

- The practitioner demonstrates, in a form and manner prescribed by the commissioner, that such practitioner does not have the technological capacity to issue an electronically transmitted prescription. For the purposes of this subsection, “technological capacity” means possession of a computer system, hardware or device that can be used to electronically transmit controlled substance prescriptions consistent with the requirements of the federal Controlled Substances Act, 21 USC 801, as amended from time to time. The provisions of this subdivision shall not apply to a practitioner when such practitioner is prescribing as a telehealth provider, as defined in section 19a-906, as amended by this act, pursuant to subsection (c) of said section.

SOURCE: CT General Statute 21a-249 (c). (Accessed May 2025).

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## CROSS-STATE LICENSING

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*Last updated 05/17/2025*

### Registration for Out-of-State Mental or Behavioral Health Providers Seeking to Provide Services via Telehealth Prior to Licensure in Connecticut

Public Act 24-110, An Act Concerning Telehealth, allows certain mental or behavioral health providers currently licensed in another US state to provide mental or behavioral health care in Connecticut via telehealth while seeking a Connecticut license.

A provider seeking to practice in Connecticut via telehealth prior to licensure must:

- Be licensed in another US state, territory, or the District of Columbia in the profession for which the provider seeks a license in Connecticut;
- Register with the Department of Public Health as a “telehealth registrant”;
- Apply for a Connecticut license no later than 60 days after registering; and
- Complete the application process no later than 60 days after applying.

The registration and application process must be completed online. The Department of Public Health must receive the provider’s telehealth registrant application prior to June 30, 2025.

See the CT Department of Public Health Telehealth Registrant Behavioral Health website for additional information and licensure categories eligible to provide mental or behavioral health care via telehealth while seeking a Connecticut license.

SOURCE: CT Department of Public Health Telehealth Registrant Behavioral Health. (Accessed May 2025).

A telehealth provider includes, on or before June 30, 2025, an appropriately licensed, certified or registered physician, naturopath, registered nurse, advanced practice registered nurse, physician assistant, psychologist, marital and family therapist, clinical social worker, master social worker, alcohol and drug counselor, professional counselor, dietitian-nutritionist, nurse-midwife, behavior analyst, music therapist or art therapist, in another state or territory of the United States or the District of Columbia who:

- provides mental or behavioral health care through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to the profession
- maintains professional liability insurance, or other indemnity against liability for professional malpractice, in an amount that is equal to or greater than that required for similarly licensed, certified or registered Connecticut mental or behavioral health care providers
- registers with the Department of Public Health, in a form and manner prescribed by the Commissioner of Public Health, as a provider of mental or behavioral health care in the state through the use of telehealth prior to providing telehealth to a patient in the state, and
- submits an application to the Department of Public Health for a license, certificate or registration as a mental or behavioral health care provider pursuant to title 20 not later than sixty days after registering with the department pursuant to clause (iii) of this subparagraph and completes the application process for such license, certificate or registration not later than sixty days after submitting such application.

Subject to compliance with all applicable federal requirements, state licensing standards, state telehealth laws or any regulation adopted thereunder, a telehealth provider may provide telehealth services pursuant to the provisions of this section from any location to a patient in any location.

Any Connecticut entity, institution or health care provider, that engages or contracts with a telehealth provider who is licensed, certified or registered in another state or territory of the United States or the District of Columbia to provide health care or other health services, but who is not licensed, certified or registered by the Department of Public Health to provide such care or services, shall verify that the telehealth provider has registered with the Department of Public Health pursuant to subparagraph (B)(iii) of subdivision (12) of subsection (a) of this section. The department shall (1) verify the credentials of such telehealth provider in the state in which such provider is licensed, certified or registered, (2) ensure that such telehealth provider is in good standing in such state, and (3) confirm that such telehealth provider maintains professional liability insurance or other indemnity against liability for professional malpractice in an amount



that is equal to or greater than that required for similarly licensed, certified or registered health care or other services health provider in the state.

The Commissioner of Public Health shall issue a decision on each application for a license, certificate or registration made by a health care provider pursuant to subparagraph (B)(iv) of subdivision (12) of subsection (a) of this section not later than forty-five days after the completion of the application process for such provider. Notwithstanding any provision of this section, a health care provider who is not licensed, certified or registered as a health care provider by the Department of Public Health pursuant to title 20 shall not provide mental or behavioral health care through telehealth in the state if such provider is on the list of excluded individuals or entities posted in the federal online database maintained by the United States Department of Health and Human Services Office of Inspector General. The commissioner may prohibit a health care provider who is not licensed, certified or registered as a health care provider by the Department of Public Health pursuant to title 20 from registering with the department pursuant to subparagraph (B)(iii) of subdivision (12) of subsection (a) of this section or suspend or revoke a provider's registration made pursuant to said subparagraph, if such provider does not meet any of the requirements set forth in this section or act in accordance with the provisions of subdivision (6) of subsection (a) of section 19a-14.

SOURCE: CT General Statute 19a, Sec. 906. (Accessed May 2025).

The Department of Public Health may establish a process of accepting an applicant's license from another state and may issue that applicant a license to practice medicine in the state without examination, if certain conditions are met.

SOURCE: CT General Statutes Chapter 370, 20-12. (Accessed May 2025).

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## LICENSURE COMPACTS

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*Last updated 05/17/2025*

Enacted the Counseling Compact.

SOURCE: CC Map. (Accessed May 2025).

Enacted the Interstate Medical Licensure Compact.

SOURCE: SB 2 (2022 Session), sec. 43. IMLC Map. (Accessed May 2025).

Enacted the Nurse Licensure Compact.

SOURCE: HB 5058 (2024 Session), NLC Map. (Accessed May 2025).



Enacted the Psychology Interjurisdictional Compact.

SOURCE: SB 2 (2022 Session), sec. 42. PSYPACT Map. (Accessed May 2025).

Enacted the Physical Therapy Compact.

SOURCE: PTC Map. (Accessed May 2025).

Enacted the Social Worker Compact.

SOURCE: HB 5197 (2024 Session), SW Compact Map. (Accessed May 2025).

\* See Compact websites for implementation and license issuing status and other related requirements.

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## PROFESSIONAL BOARDS STANDARDS

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*Last updated 05/17/2025*

No Reference Found

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## MISCELLANEOUS

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*Last updated 05/17/2025*

“Telehealth provider” means any health care provider licensed pursuant to title 20 and any pharmacist licensed by the Department of Consumer Protection pursuant to title 20 who is providing health care or other health services through the use of telehealth within such provider’s scope of practice and in accordance with the standard of care applicable to the profession.

See CT Cross-State Licensure category for out-of-state providers also included as part of the definition of telehealth provider, subject to in-state registration and additional requirements.

A telehealth provider shall only provide telehealth services to a patient when the telehealth provider:

- Is communicating through real-time, interactive, two-way communication technology or store and forward technologies;
- has access to, or knowledge of, the patient’s medical history, as provided by the patient, and the patient’s health record, including the name and address of the patient’s primary care provider, if any;
- conforms to the standard of care applicable to the telehealth provider’s profession and expected for in-person care as appropriate to the patient’s age and presenting condition,

except when the standard of care requires the use of diagnostic testing and performance of a physical examination, such testing or examination may be carried out through the use of peripheral devices appropriate to the patient's condition; and

- provides the patient with the telehealth's provider license number and contact information

At the time of the telehealth provider's first telehealth interaction with a patient, the telehealth provider shall inform the patient concerning the treatment methods and limitations of treatment using a telehealth platform and, after providing the patient with such information, obtain the patient's consent to provide telehealth services. The telehealth provider shall document such notice and consent in the patient's health record. If a patient later revokes such consent, the telehealth provider shall document the revocation in the patient's health record.

Each telehealth provider shall, at the time of the initial telehealth interaction, ask the patient whether the patient consents to the telehealth provider's disclosure of records concerning the telehealth interaction to the patient's primary care provider. If the patient consents to such disclosure, the telehealth provider shall provide records of all telehealth interactions to the patient's primary care provider, in a timely manner, in accordance with the provisions of sections 20-7b to 20-7e, inclusive.

The provision of telehealth services and health records maintained and disclosed as part of a telehealth interaction shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 P.L 104-191, as amended from time to time.

Nothing in this section shall prohibit:

- A health care provider from providing on-call coverage pursuant to an agreement with another health care provider or such health care provider's professional entity or employer;
- a health care provider from consulting with another health care provider concerning a patient's care;
- orders of health care providers for hospital outpatients or inpatients; or
- the use of telehealth for a hospital inpatient, including for the purpose of ordering any medication or treatment for such patient in accordance with Ryan Haight Online Pharmacy Consumer Protection Act, 21 USC 829(e), as amended from time to time.

For purposes of this subsection, "health care provider" means a person or entity licensed or certified pursuant to chapter 370, 372, 373, 375 to 376b, inclusive, 377, 378, 379, 380, 381a, 382, 382a, 383 to 383d, inclusive, 383f, 383g, 384b, 384d, 397a, 399 or 400j, or licensed or certified pursuant to chapter 368d or 384d.

No telehealth provider or hospital shall charge a facility fee for telehealth services. Such prohibition shall apply to hospital telehealth services whether provided on campus or otherwise. For purposes of this subsection, “hospital” has the same meaning as provided in section 19a490 and “campus” has the same meaning as provided in section 19a508c.

No telehealth provider shall provide health care or health services to a patient through telehealth unless the telehealth provider:

- has determined whether the patient has health coverage for such health care or health services, and, if the patient has such health coverage, whether the patient elects to either use such health coverage to pay for such health care or health services, in whole or in part, or pay the telehealth provider directly for such health care or health services without using such coverage, and
- prior to providing such health care or health services to any patient who elects to pay the telehealth provider in part using such coverage or directly without using such coverage, discloses the cost of such health care or health services to the patient.

Notwithstanding any provision of the general statutes, a telehealth provider who agrees to provide health care or health services to a patient through telehealth shall accept as full payment for such health care or health services:

- An amount that is equal to the amount that Medicare reimburses for such health care or health services if the telehealth provider determines that the patient does not have health coverage for such health care or health services;
- The amount that the patient’s health coverage reimburses and any coinsurance, copayment, deductible or other out-of-pocket expense imposed by the patient’s health coverage for such health care or health services if the telehealth provider determines that the patient has health coverage for such health care or health services, unless the patient has explicitly elected to pay the provider directly without using such coverage pursuant to subparagraph (A) of subdivision (1) of this subsection, in which case the patient and provider may mutually agree to a different amount; or
- An amount mutually agreed to by the patient and telehealth provider

If a telehealth provider determines that a patient is unable to pay for any health care or health services described in subdivisions (1) and (2) of this subsection, the provider shall offer to the patient financial assistance if such provider is required to offer to the patient such financial assistance under any applicable state or federal law.

Nothing in this subsection shall be construed to prohibit a patient from paying a telehealth provider directly for health care or health services without seeking coverage from a health carrier for such health care or health services.

SOURCE: CT General Statute 19a, Sec. 906. (Accessed May 2025).

The Department of Public Health shall collect the following data regarding each telehealth provider who registers with the department pursuant to subparagraph (B)(iii) of subdivision (12) of subsection (a) of section 19a-906 of the general statutes, as amended by this act, and each out-of-state health care provider who applies to the department for a license pursuant to title 20 of the general statutes on and after the effective date of this section. Not later than January 1, 2025, and, thereafter, not later than July 1, 2025, the Commissioner of Public Health shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health regarding the following:

- The number of such telehealth providers who registered with the department on or after the effective date of this section;
- The number of such telehealth providers who applied to the department for a license pursuant to subparagraph (B)(iv) of subdivision (12) of subsection (a) of section 19a-906 of the general statutes, as amended by this act, on or after the effective date of this section;
- The number of such telehealth providers who receive a license from the department on or after the effective date of this section; and
- The number of such out-of-state health care providers who apply for a license with the department pursuant to title 20 of the general statutes on or after the effective date of this section.

SOURCE: HB 5198 (Public Act 24-110 – 2024 Session), Sec. 8. (Accessed May 2025).

## Family and Medical Leave Act

Recent regulations expanded the right to Family and Medical leave under the law to most workers in the state. Amendments include references to allowing telemedicine for the required continuing treatment and periodic visits by a health care provider in certain instances.

SOURCE: Regulations of CT State Agencies Section 31-51qq-1. (Accessed May 2025).