Frequently Asked Questions:
Coronavirus Disease 2019 (COVID-19) and Telehealth

Updated July 31, 2020

The Maryland Department of Health (MDH) Behavioral Health Administration (BHA) continues to develop coordinated prevention and response plans for COVID-19. BHA will provide COVID-19 updates as they become available and accurate information for behavioral health providers, partners, and the greater community. For the latest COVID-19 information and resources, visit the BHA website or coronavirus.maryland.gov. If you have a behavioral health question related to COVID-19 that has not been addressed, please submit it here. For additional questions or concerns, contact your Local Behavioral Health Authority.

NEW What is the status of the federal public health emergency?

On July 23, 2020, the Secretary of Health and Human Services renewed the public health emergency due to COVID-19. As with the previous April 21 renewal, this extension will expire after 90 days.

Does this mean that telehealth services provided using HIPAA compliant technology will continue to be permitted after July 25?

In March 2020, the Office of Civil Rights (OCR) at the Department of Health and Human Services issued a statement that OCR would exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. However, if the public health emergency expires, OCR may begin enforcing the HIPAA regulations.

Maryland regulations, including Medicaid regulations require telehealth transmissions to be HIPAA compliant. If the Governor rescinds Executive Order 20-04-01-01, services may no longer be provided by telephone or audio only calls. Telehealth services would need to be HIPAA compliant to be in compliance with Maryland regulations.

Is there a difference in rates for telehealth versus face-to-face visits?

No. The fee structure is the same whether care is delivered in-person or by telehealth or audio-only telephone. They are designed for the care provided to be of sufficient clinical benefit. Further guidance on telehealth/telemedicine may be found under the telehealth section of BHA's COVID-19 website and on Medicaid.gov.

When a provider is on the phone with a consumer getting their consent, does a provider need to have a witness (another staff person on the phone) to "witness" consent?

No, the provider is not required to have another staff member witness the consent. The provider however may choose to have a witness if there are concerns with the consumer later not remembering giving consent, questionable capacity to understand, etc.

Will the State consider relaxing some of the time requirements for telehealth/telephonic group and/or individual sessions (15 minutes for individual; 60 minutes for group)?

No. Time requirement minimums are the same whether care is delivered in-person or by telehealth or audio-only telephone. They are designed for the care provided to be of sufficient clinical benefit. The minimum for individual therapy is 15 minutes but for group therapy it is 45 minutes.

Additionally telehealth and audio-only telephone care present unique challenges for engaging patients, as discussed in the Benefits and Challenges of Conducting Psychotherapy by Telephone, and in Learning To Do Telemental Health from the APA Telepsychiatry Toolkit.

For programs that previously provided buprenorphine services in a mobile van, can we offer initiation of buprenorphine to new patients via telemedicine-audio only if the patient doesn't have the means to make a video call?

Yes. DATA-waived practitioners and OTPs can prescribe buprenorphine to new patients with an opioid use disorder for maintenance treatment or detoxification treatment following an evaluation via audio-only telephone, if telehealth is not possible. This may only be done if the evaluating practitioner determines that an adequate evaluation of the patient can be accomplished via the use of telehealth or audio-only telephone, due to the complexity of the case, balanced against the risk for infection COVID-19. If it is determined that an in-person evaluation is instead indicated, and the provider cannot provide this, they should refer to an office based or OTP provider who can perform an in-person evaluation. DEA guidance is informative and is found at DEA Policy: Use of Telephone Evaluations to Initiate Buprenorphine Prescribing. Initial evaluations of new OTP patients prescribed methadone still require an in-person evaluation.

With the use of telehealth increasing what are resources for low-income consumers on phone and internet service, and for computers?

A federal government resource is provided by the FCC's Lifeline Program, which provides a monthly $9.25 discount on either phone or internet service to qualifying low-income consumers. Eligible are those who are enrolled in federal assistance programs (or if someone in their household is enrolled) such as Medicaid, SSI, SNAP, and public housing assistance. If not enrolled, someone also qualifies if their income is 135% or less than the federal poverty guidelines.

A non-profit connects eligible individuals to low-cost home internet service, affordable computers and tablets, and digital literacy training. Go to the Everyoneon.org Finder.

Can phone or internet service be terminated during the state of emergency?

On April 20, 2020, Governor Hogan amended his executive order, Prohibiting Termination of Residential Services and Late Fees, to extend it to June 1. Besides telephone and internet services, other residential services that cannot be terminated or have late fees applied are electric, gas, sewage disposal, telegraph, water, and cable television.

Where can providers find more financial support to accommodate growing telehealth demands?

The Federal Communications Commission (FCC) has a COVID-19 telehealth program to provide immediate support to eligible health care providers responding to the COVID-19 pandemic by fully funding their telecommunications services, and more. This and other funding opportunities are listed by the Mid-Atlantic Telehealth Resource Center: Telehealth Funding Opportunities Available.

Garrett County Center for Behavioral Health has a distant site telehealth provider. However, the psychiatrist is through University of MD Psychiatry and the child age group is only served. Will the GC Center for Behavioral Health be able to provide outpatient therapy via telehealth to all age groups, without having the psychiatrist set up through telehealth?

Providers are no longer required to enroll in Telehealth in order to provide telehealth services as long as they are enrolled as a Medicaid provider. The provider does not need to obtain a separate authorization to provide telehealth services

Can hospital-based outpatient mental health clinics deliver and bill for telehealth visits? Doctors? Therapy visits?

Yes. Individual behavioral health evaluations can also be conducted by voice-only telephone if telehealth is not available, with the exception that initial evaluations of new OTP patients prescribed methadone still require an in-person evaluation. Family therapy with or without patients can occur via telephone in the absence of telehealth.

Group services must still be offered through telehealth, not telephone, with the exception of services offered within a specific residential treatment site. In this case, telephone services are permitted if telehealth is not viable.

For PRP, if group telehealth services are conducted via video platform, is there any limit to the number of participants in each group?

There are no further restrictions on group size. Group size should be the same as would be the case if the service were delivered in-person on-site. This should not be viewed as an opportunity to expand group size.

If PRP provides a client with a combination of telehealth audio and telehealth video services throughout the month, we would bill all services with the lowest modifier (UB), correct?

Yes.

What are the latest CMS Medicare actions on telehealth?

On April 30th CMS expanded access to telehealth services for people with Medicare. This means they can receive care where they are: at home or in a nursing or assisted living facility.

CMS will now pay for more than 80 additional services when furnished via telehealth. These include emergency department visits, initial nursing facility and discharge visits, and home visits, which must be provided by a clinician that is allowed to provide telehealth.

Providers also can evaluate beneficiaries who have audio phones only.

CMS is allowing telehealth to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice and home health. During the pandemic, individuals can use commonly available interactive apps with audio and video capabilities to visit with their clinician.

If a physician determines that a Medicare beneficiary should not leave home because of a medical contraindication or due to suspected or confirmed COVID-19, and the beneficiary needs skilled services, he or she will be considered homebound and qualify for the Medicare Home Health Benefit. As a result, the beneficiary can receive services at home.

Virtual Check-In services, or brief check-ins between a patient and their doctor by audio or video device, could previously only be offered to patients that had an established relationship with their doctor. Now, doctors can provide these services to both new and established patients.

In addition to these flexibilities, there is also new guidance for additional healthcare settings such as ambulatory surgery centers, community mental health centers, outpatient physical therapy and other settings of care.

For information please go to CMS COVID-19 flexibilities webpage.

For individual outpatient services using telehealth, is the 15-minute minimum still a requirement? Am I allowed to bill for any lesser amount of time?

Service minimums in individual outpatient remain as they would outside of telehealth.

Is there any consideration to allow TCM to utilize unit pay structure (like MHCC) to assist clients with basic needs, but not necessarily meeting for one hour or utilizing the telephonic to check on some clients?

BHA does not have approval from the Centers for Medicare and Medicaid Services (CMS) to alter the mechanism by which Targeted Case Management (TCM) services are reimbursed.

We need clarification on the Telehealth, Telemedicine, and Teleconsultation, for OMT services. When communicating via the telephone can we submit a claim for reimbursement if an ADT is the one making the call and having the session?

Yes, you can submit a claim for ADTs to conduct telehealth/telephonic.

In the Governor's statement on April 1, 2020, he said that behavioral health services could be initiated telephonically. Does this mean that in a situation where face-to-face and telehealth intake/assessment is not possible, that we can complete a psychiatric rehabilitation program intake via telephone?

Yes, you may do a psychiatric rehabilitation intake by phone if no telehealth option is viable. This must be clearly documented, along with the consumer’s informed consent. Documentation

requirements are the same as they are for traditional services. Providers may be required on audit to present telephone service bills/data use statements to support billing claims.

Regarding financial stability and billing, are there reserve funding limitations?

No additional limitations have been placed.

Exceptions for telephonic assessment? We are receiving referrals for PRP and CM services from hospitals, but they are not allowing us in the hospital and they don't have the technology available to allow for video assessments. Once the consumer is released, many times the consumer has no resources for telehealth or video conferencing. Is there any circumstance where we could complete a telephone-only assessment while the consumer is still in the hospital in order to initiate services? (The discharging social worker could provide feedback verifying the identity of the person, mental status, affect, etc.) My concern is that those consumers being discharged are at high risk for rehospitalization if we can't connect with them.

In the event that telehealth (video-based) options are not available, a psychiatric rehabilitation program may do an initial evaluation by telephone with documented informed participant consent. Programs must document why the use of a telephone was necessary and confirm the identity of the participant.

Would you mind shedding some light on the telehealth option for providers? Do you know if any provider can offer this during this time?

Telehealth for the purpose of this question means use of videoconferencing technology. Clients may remain in their home. Clinicians do not need to be in the office. BHA prefers the technology to be HIPAA compliant technology. Clients must consent to the use of telehealth, and if the technology (on both ends: provider and consumer) is not HIPAA compliant the provider must advise that the technology is not HIPAA compliant, thus not necessarily secured. Consent must be documented by the provider. Providers able to use telehealth within their normal scope of practice will be able to use audio-only telephone for individual service codes if telehealth is not possible. Group services have to be delivered by video telehealth unless they occur in the context of Residential Treatment.

The following providers can use telehealth within their scope of practice:

Individual Therapy:

- Individual providers (includes group practices), Psychiatrists, PMH certified CRNP, and APRN, psychologists, LCSW-C, LCPC, LCADC, LCMFT

- OMHC (including LMSW, LGPC, etc.), PHPs, Level 1 SUD (including CAC-AD, CSC-AD), IOP (SUD and MH)
- ADTs (during the emergency, with specific supervision requirements)

Medication Management Services (New OTP patients started on methadone require an in-person evaluation)

- Psychiatrists, Non-Psychiatric MDs, PMH certified CRNP, APRNs, Physician Assistants

For ASAM Level 3.5 and 3.1 LoC, can we conduct therapeutic services via audio-visual telehealth? Room and Board services will be rendered as usual with a CPR licensed staff present at the facility at all times.

Individual and group therapy sessions may be provided by telehealth, and if not available, by telephone in residential SUD programs.

When should we initiate our telecommute procedure?

Telecommuting should be strongly considered now for those employees where it would not adversely impact patient care, and should happen immediately for employees where there is suspicion of COVID-19 infection, as per guidance issued by the CDC.

Is there service delivery support on telehealth?

MDH recently provided new guidance regarding the use of telehealth through the State's administrative service organization (ASO) Optum. Further guidance on telehealth/telemedicine may be found under the telehealth section of BHA's COVID-19 website and on Medicaid.gov.

Would Medicaid reimburse for group therapy via conference call? What if a practitioner has individuals who are not allowed to have internet access?

Group services in non-residential settings must be done using video telehealth technology. Within residential settings group therapy may be provided by audio-only telephone if telehealth is not available.

If a provider can't support intensive outpatient program (IOP) groups but is able to do individual telehealth, are they able to bill? Currently, IOP is all bundled together and can only bill for groups to do two individual sessions a month and random urine screens.

MDH recognizes the financial burden placed on all Marylanders, not only providers, by this crisis. MDH and Centers for Medicare and Medicaid Services (CMS) have relaxed the rules regarding telehealth and telephonic services so that most services may be provided through audio-only calls. MDH is reviewing whether other regulatory requirements may be waived, e.g., the minimum required hours of service, or whether the provider may bill for a lower level of service than was authorized.

Does BHA have a preference with FaceTime or use of Zoom for HIPAA compliant practices?

The U.S. Department of Health and Human Services (HHS) announced, effective immediately, that it will exercise its enforcement discretion and will waive potential penalties for HIPAA violations against health care providers that serve patients through everyday communications technologies during the COVID-19 nationwide public health emergency. It would be preferable to use HIPAA and State compliant technology to the extent possible. However, HHS has made clear that this relaxation applies to non-public facing technology such as Skype, Zoom, Doxy, WhatsApp and similar apps, rather than public-facing applications such as FaceBook Live, Tik-Tok, and Snapchat, which can easily be shared to a broader audience. Specific guidance is available on the HHS website.

Technological services hold inherent privacy risks. For example, Zoom recently experienced security issues. It is the recommendation of MDH that providers utilize HIPAA compliant telehealth platforms. Ultimately, prior to utilizing the telephone or telehealth to provide a clinical service, it is the responsibility of the provider to inform the service recipient whether the telehealth platform is HIPAA compliant and of the security/confidentiality risks when engaging in remote health services. The form of transmission (e.g., HIPAA-compliant Zoom software) should be documented in the medical record and that the individual consented to the particular method of remote health services with the understanding that it may not be fully compliant.

Are there updates regarding BHA staffing plans and initiation of telecommuting allowance?

BHA is not considering any telecommuting allowance.

Can we clarify the terminology?

We use the term "telehealth" as a mode of delivering health care services through the use of telecommunications technology by a health care practitioner to a patient in a different physical location from a health care practitioner. Telehealth may include both synchronous and asynchronous interactions. It does not include audio-only messages, emails, or fax transmissions.

"Telephonic communication" refers to audio-only interactions between a health care practitioner and a recipient.

During the state of emergency, BHA has allowed for providers who would normally be eligible for telehealth as well as PRP providers to drop to using audio telephone for almost all clinical services, although audio telephone would not normally be considered telehealth. This must be done with informed consent by the participant. (Specific requirements are outlined in the Secretary of Health's memorandum of March 21, 2020, which is on the COVID 19 section of the BHA website.) A general principle is that **voice telephone may be used during the emergency only if the participant is not able to access true telehealth services**. The Department of Health and Human Services has put out a memo concerning the relaxation of enforcement of certain HIPAA Security Rules for telehealth during the emergency.

Will a provider be able to provide outpatient therapy via telehealth to all age groups, without having the psychiatrist set up through telehealth?

Providers are no longer required to enroll in Telehealth in order to provide telehealth services as long as they are enrolled as a Medicaid provider. The provider does not need to obtain a separate authorization to provide telehealth services.

Do you have any idea if Medicare is expanding its telehealth like Medicaid?

Yes, however one needs to check with Medicare as to the extent of the expansion.

For persons in IOP and PHP – will telehealth be expanded to allow persons who are quarantined to receive some type of telehealth service since IOP and PHP aren't covered since they are provided in group settings?

IOP and PHP may provide group therapy by telehealth only if the platform is HIPAA compliant. Please see HHS guidance referred to above. The provider must ensure that each client consents to the service by telehealth and understands and accepts that the provision of service is less secure and possibly confidential than an in-person service. Each client should attest that they are in a private space where no other family members or friends can overhear the therapy sessions.

Is there guidance on certified recovery residences–for levels 1 and 2 where there is no organizational hierarchy?

Certified recovery residences are not treatment facilities and are the individual's residence. An outpatient program may provide individual therapy via telehealth or telephone into a residence

with participant consent. Confidentiality must be maintained. Group Therapy may only be provided using HIPAA/COMAR 10.49.09 compliant technology.

Secretary Neall's memo regarding the extension of telehealth services stated to reach out to our CSA for information about whether our services are a part of this extension. Do you know if MH TCM is considered one of the Behavioral Health services that can be done via telehealth?

Mental Health TCM visits can be delivered by telephone, if necessary.

We are concerned that if groups are further limited in size and/or staff is quarantined, is a provider allowed to provide telehealth and still be eligible to bill for the services under provider type 50 (IOP/OP) with the modifier "GT" and use place of service code 11 since 02 is not recognized for Maryland Medicaid. In addition, we have the same question for provider type 54 (3.3 level care).

IOP and OP may bill for telehealth services. Group services can only be offered with HIPAA compliant technology. Telehealth services should be billed with a -GT modifier. Optum will program their systems accordingly.

Level 3.3 Residential SUD is able to bill for services provided by telehealth. Within residential settings, group therapy may be provided by audio-only telephone if telehealth is not available, but outside of residential settings audio-only groups are not authorized.

Does the new telehealth information/expanded regulation apply to clinical group settings? For SUD IOP, how does that impact the client's nine weekly hours of IOP? Especially if we have to move clients from group to individual sessions, either in person or via telehealth. Then do we have to switch them to an OP auth, then back to an IOP auth?

The expansion of telehealth applies to SUD IOPs. Telehealth may be used for group and individual therapy. The telephone may be used on individual therapy, if telehealth is not available. The service rules have been reduced for IOP.

<u>Billing Requirements Only During This Emergency Situation</u>: IOP services are based on a per diem requiring a minimum of two hours per day with a weekly minimum of nine hours per week. During this time period only, these requirements will be relaxed as follows:

1. To bill a service a minimum of two hours of clinical care must be provided. During the emergency, the two hours may be extended over the course of two days. However, in such a case, only one claim for H0015 (daily rate) may be submitted.

- For Example: Two hours each are provided on Monday, one hour on Tuesday, one hour on Wednesday
    - Claims would be: Monday H0015, and Wednesday H0015.

2. IOPs are encouraged to provide as many hours of service as the individual requires. However, there is no minimum number of hours a week required. If an individual is receiving less than four hours a week, the provider should consider a Level 1 outpatient level of care for the patient.

3. IOP Providers may bill up to a maximum of four days per week.

There are recent problems with the telehealth platforms crashing because everyone is using them. There is a concern that it might go to a total shut down in the next couple of days which would further complicate things. Will a limited time of phone call sessions or at least the use of different platforms like FaceTime and other options be considered?

The Federal Government has already reduced the requirements for telehealth technology for the duration of the emergency. Services must still be delivered in compliance with CPT code requirements for duration, etc.

Can you please advise if Alcohol and Drug Trainees (ADTs) are approved for telehealth?

Per Secretary Neall's order of April 6, 2020, an Alcohol and Drug Trainee ("ADT") may provide counseling services via teletherapy in accordance with COMAR 10.58.06 and subject to the following terms and conditions:

a) During the state of emergency as declared by the Governor;
b) Using IT equipment owned by a facility, clinic, or office;
c) At a facility, clinic, office, or alternate location as determined to be appropriate by the ADT's Board of Professional Counselors and Therapists ("Board")-approved supervisor; and
d) Under the supervision of a Board-approved supervisor who is physically, electronically, or otherwise immediately available.

Do we need a written consent or is an oral consent satisfactory?

Written consent is not required; however, the provider should document in the client's record that the individual was advised that the session is being conducted by telehealth/telephone, and that the transmission may not be HIPAA compliant, etc.

If a provider type is not listed in the Governor's March 20, 2020 executive order (COVID-19 #4b: Temporary Authorization of Audio-Only Health Care Services to Mitigate Possible Spread of Novel Coronavirus ("COVID-19") Executive Order No. 20-03-20-01), does this mean the provider type is automatically excluded?

No. The order did not include an exhaustive list of eligible provider types, and the section pasted below from the order is broader in its scope and is applicable. For example, although non-psychiatric physicians and nurse practitioners were not specifically listed in the order, they are provider types already authorized for telehealth behavioral health services in the area of addiction medicine. The order authorizes them to now deliver behavioral health services using audio-only telephone. Another example of an eligible provider type not listed is clinical psychologists.

A general principle is that audio-only telephone may be used during the emergency only if the participant is not able to access true telehealth services. There are behavioral health exceptions. Within residential settings group therapy may be provided by audio-only telephone if telehealth is not available, but outside of residential settings audio-only groups are not authorized. Initial evaluations of new OTP patients prescribed methadone still require an in-person evaluation.

The Department of Health and Human Services has put out a memo concerning the relaxation of enforcement of certain HIPAA Security Rules for telehealth during the emergency.

> "Providers who may deliver behavioral health services using voice telephone
> Only those provider types already authorized by existing State regulations to use telehealth technology may deliver public behavioral health system (PBHS) funded telephone services. To bill Medicaid, a provider must be a current Medicaid provider. There is no longer a separate telehealth registration process.
>
> "Providers may only deliver services that fall within their normal scope of practice as authorized by the relevant professional board.
>
> "Providers may not deliver services for which they would not normally be eligible as Medicaid providers." See Executive Order No. 20-03-20-01.

What if services are being provided by telehealth or telephonically, but written patient consent for disclosure of substance use disorder records has not been obtained?

See SAMHSA's COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance.

The clinician should document in the record that the individual was advised that the service was being done via telehealth or telephone, and the possible security and confidentiality issues that exist, and the option to opt out, and that the individual consented to the service.

Can an emergency petition be done based on my telephone or telehealth contact with a patient?

Yes. This is a situation suicide hotlines have to deal with. If the criteria for an emergency petition are met, there is nothing in statute or regulation mandating an in-person evaluation by the person to whom the danger to self or others was verbalized, if not verbalized in-person. You would not directly complete the emergency petition, but initiate the process for an in-person evaluation that would be done by either the police or a mobile crisis team, depending on whichever you contact and provide the information about the danger.

In addition to the questions regarding whether the UB modifier should really be on the encounter/visit (H2016) for PRP, we need to know the order for the modifiers for billing purposes.

The UB modifier should be on the H2018, not the H2016. If a participant has had even one voice telephone service during the month, this would be reflected as a H2018-UB. The order of the modifiers does not matter. For further clarification refer to BHA's Follow-up Guidance on Temporary Telehealth Services.

Because the governor has ordered nonessential businesses to close, are PRP offices considered "essential" under Maryland guidelines?

PRP are health care programs and are not required to close under the Governor's executive order. PRPs, as well as other health care programs provide an essential service especially during this crisis. PRP's are encouraged to follow CDC guidelines for the provision of health care services. To assist in the provision of services, the Medicaid Program has issued guidance regarding general health care services, behavioral health services, and psychiatric rehabilitation programs.

Please be advised that licensed programs may not close without seeking approval from the Local Behavioral Health Authority and informing the BHA Office of Licensing. If a program closes without obtaining approval, it may be sanctioned if it seeks to reopen. Programs seeking to close must comply with COMAR 10.63.06.10.

For clarity, if the organization was considering opting to use Zoom for IOP services, based on the memorandum, is it correct that only a CAC or LCADC could be the group facilitator?

The licensing regulations that were in place still apply, so staff members who were qualified under 10.63 remain qualified.

What guidance can the State provide regarding telehealth/telephone ACT, Mobile Treatment and SE services?

On March 25, 2020, BHA provided guidance on the use of telephone services authorized during the State of Emergency for mobile treatment and ACT services. If providers would like additional considerations for these additional levels of service a formal request will need to be levied with the appropriate parties (BHA and Medicaid). On April 1, 2020, BHA provided guidance on the use of telephone services authorized during the state of emergency for SE services.

What is the place of service code for telehealth and telephone services? (for example, Medicare doesn't add any modifiers to the billing codes, but changes the place of service to "02")

Providers should bill using the same place of service code that would be appropriate for a non-telehealth claim. The distant site should bill using the location of the doctor. If a distant site provider is rendering services at an off-site office, the provider should bill using the Place of Service Code 11 for "Office." Place of Service Code 02 (Telehealth) is not recognized for Maryland Medicaid participants except for use on Medicare crossover claims to specify services rendered through a telecommunication system for dual eligible participants.

Is there any specific documentation that has to be used alongside with the progress notes for telephonic only services or can all activities be documented on the agency's progress note?

Providers must maintain documentation in the same manner as an in-person visit or consultation, using either an electronic or paper medical record. Providers must also reflect in their records whether the service was delivered using telehealth or telephone.

Providers must also be willing to provide telephone billing records to State auditors to justify services provided by telephone.

Per the PRP telehealth policy, the group sessions can only happen with telehealth providers that you have a business agreement with, or, is this a suggestion?

While providers are strongly encouraged to obtain a business agreement with the vendor if at all possible, the Office of Civil Rights (OCR) at the Department of Health and Human Services (HHS) has stated it will not enforce this requirement for the duration of the national public health emergency. Popular platforms like Zoom sometimes do have business agreements available, but often only to paid customers.

Several clients do not have access to sign and return signed telehealth consent. The revised guidelines received Saturday states, to explicitly "document" consent for Non-HIPAA compliant sources. Is the guideline referring to the clinician documenting the explicit understanding in the EMR that they have discussed and reviewed this with clients, or is the guideline indicating an additional signed consent form completed by patient for this format?

Clarification is contained in the Guidance Clarification issued by BHA on March 24, 2020. It can be found on the BHA homepage.

During this state of emergency will Medicaid reimburse telehealth services which are audio-only calls or conversations?

Yes. On March 20, 2020, the Governor signed an executive order for Medicaid to reimburse health care providers for audio-only calls or conversations used to refer patients to health care services, provide treatment, and issue prescriptions (COVID-19 #4b: Temporary Authorization of Audio-Only Health Care Services to Mitigate Possible Spread of Novel Coronavirus ("COVID-19") Executive Order No. 20-03-20-01).

What if services are being provided by telehealth or telephonically, but written patient consent for disclosure of substance use disorder records has not been obtained?

See SAMHSA's COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance.

The clinician should document in the record that the individual was advised that the service was being done via telehealth or telephone, and the possible security and confidentiality issues that exist, and the option to opt out, and that the individual consented to the service.

COMAR 10.58.06 allows for audio/visual consultations with patients. What is MDH's stance and recommendation on teletherapy?

Most Professional Boards covering behavioral health providers have enacted regulations allowing for teletherapy. Providers are referred to the regulations of the specific boards or, for Medicaid, to COMAR 10.09.49.

Teletherapy is the use of interactive audio, video, or other telecommunications or electronic media by a counselor or therapist to deliver counseling services within the scope of practice of the counselor or therapist and at a location other than the location of the patient. As a means to limit person-to-person contact, MDH supports those who are able to provide teletherapy and telehealth services.

Please see the BHA website for additional information about new executive orders about telehealth, including when voice telephone services are now permissible during this pandemic.

Modifier on encounter or case rate - My question is about the UB modifier: The H2018 is the case rate code for PRP. The individual visits or encounters are coded H2016. So, for example, if we provided four face-to-face encounters (H2016) and two audio-only encounters (also H2016), do we use the UB modifier on the monthly case rate for six encounters? Should the modifier be used on the H2016 rather than the H2018?

The modifier is correctly placed on the H2018. A major reason for this is that it will be easier to do manual edits on the limited number of H2018 claims, rather than the H2016 claims, which are far more numerous, but are often themselves "roll-ups" of multiple visits of different types in a single day. It is unrealistic to expect many agencies to modify their EHRs for the short time frame likely to be involved in the use of telehealth in PRP. The H2018 claim with modifier will enable the State to identify which individuals were served during the month with at least some telephone service. Rules for used of the modifier are:

If encounters are all by telehealth (audio+video) or some by telehealth and some in person, the –GT modifier is used.

If encounters are some or all telephonic (audio only) (any combination that includes telephonic), the –UB modifier is used

Modifier order: In addition to the questions regarding whether the UB modifier should really be on the encounter/visit (H2016) for PRP, we need to know the order for the modifiers for billing purposes.

The order of the modifiers does not matter

Exceptions for telephonic assessment: We are receiving referrals for PRP and CM services from hospitals, but they are not allowing us in the hospital and they don't have the technology available to allow for video assessments. Once the consumer is released, many times the consumer has no resources for telehealth or video conferencing. Is there any circumstance where we could complete a telephone-only assessment while the consumer is still in the hospital in order to initiate services? (The discharging social worker could provide feedback verifying the identity of the person, mental status, affect, etc.) My concern is that those consumers being discharged are at high risk for rehospitalization if we can't connect with them.

This issue is under review.

Do you have more information about CMS telehealth regulations for Medicare patients? I know CMS dropped geographic restrictions, but I am unsure about billing Medicare patients, it seems a GT suffix is not required?

Please refer to the Medicare website.

Our Day Program normally serves a large number of clients from other agencies' RRPs. Our authorization for these is onsite only because they receive offsite from the RRP. Now that the day program is closed and onsite PRP services can only be delivered virtually, we are wondering how to deliver one-to-one virtual PRP services for clients whom we can only bill for onsite. I presume if we do virtual group with two or more there would be no problem billing onsite. But if we want to provide virtual service to just one such client, would MDH permit billing that as onsite service, or alternately, allow us to temporarily bill for offsite during the governor's emergency period?

This issue remains under review and will be answered in a forthcoming FAQ. However, as long as you bill the full duration for the single service, it will be acceptable.

One of the alerts said "90847 - family with clients" was not covered with the phone therapy. Can we have clarity on why not? It could be really helpful in some cases.

Family therapy can now also be performed by audio-only telephone, but as with other services only if a telehealth option is not possible.

If we are doing phone calls for PRP, does it have to be a minimum of one hour for on-site, as it is now? Would BHA consider reducing the 60-minute requirement?

BHA is reviewing this matter. At present, the 60-minute requirement remains.

How do individuals seeking recovery supports connect with online and other digital resources during the COVID-19 pandemic?

BHA has developed an extensive document titled, "Recovery and Wellness Support Resources for the COVID-19 Outbreak" which details available online resources for individuals utilizing multiple pathways of recovery. These supports span the behavioral health spectrum and can be accessed via smartphone, tablet, or computer.

Guidelines sent out on Saturday, March 21, state that clinicians need to explicitly "document" consent for non-HIPAA compliant sources. Clients may not have the ability to sign and return telehealth consent forms. What constitutes "explicit consent of the participant"?

Maryland law requires signed written consent to services; thus, staff should make a good faith effort to secure some form of signed consent. The following options are available:

1. Email or mail the consent to an individual for them to sign and return. This can also include using a program like DocuSign so the individual can sign electronically. If the individual does not have the ability to print the document, the individual can electronically sign the consent with a signature and their name and email it back.

2. Have employees sign up for a Google Voice account that they can use to text consumers from their computers. They can then text a copy of the consent to the consumers, who can download it as well as the free Adobe Fill and Sign app to sign the consent with their phone, or who can just use their phone's built in photo editing tool to sign the document.

3. If the customer does not have email access or a smartphone to be able to access a form to sign, then in those limited situations, after reading the release over the phone and documenting that the release was read and verbally consented to, a verbal release will be accepted in these limited circumstances, since it is consistent with the executive order aimed at reducing congregating in public waiting rooms. It should be followed up with an attempt to mail a written consent form for the individual to sign as soon as possible.

Telehealth service encounters will be considered directly equivalent to existing in-person encounters for the purpose of PRP billing during this state of emergency. As with all other Medicaid reimbursed services, COMAR 10.09.59.03 requires providers to document services fully by:

1. including the date of service with service start and end times;

2. including the participant's primary behavioral health complaint or reason for the visit;

3. including a brief description of the service provided, including progress notes; and

4. including an official e-Signature, or a legible signature, along with the printed or typed name of the individual providing care, with the appropriate title.

In addition to the information above, providers must include a clear indication of how the service was delivered (e.g., office, telehealth, televideo, or voice telephone). Providers must be willing to provide telephone records of services, if requested for an audit. Phone records may

be in the form of phone billing records or call records available from the telephone provider. Staff call logs, in and of themselves, are insufficient documentary evidence.

Is there a uniform consent that MDH would like for providers to utilize?

No.

Is there a possibility of authorizing the reimbursement of telephonic encounters for PRP or RRP encounters as most of our population does have some kind of access to a cell phone?

To assist in the provision of services, the Medicaid Program has issued guidance regarding telehealth, televideo, and telephonic encounters: general health care services, behavioral health services, and psychiatric rehabilitation programs.

Knowing that "Place of Service" is an important aspect of billing, can you clarify whether telephonic counseling conducted from a counselor's home is permitted and billable in the same manner as when provided in the treatment center?

Yes. In addition to the information in other areas of this FAQ, further information is available on BHA's COVID-19 website in the telehealth section.

Some clients who have severe and persistent mental illness, also have children who will be home from school. These clients are experiencing heightened anxiety and need routine checks as they are quite vulnerable and so are their children. Will telehealth be expanded for PRP? Will PRPs be able to conduct home visits to clients who claim they are symptom free? Will phone call sessions be reimbursable?

Telehealth eligibility has been expanded to allow for the use of televideo devices such as cell phones and, failing availability of those, telephones. Information concerning this may be found on the BHA's COVID-19 website under Telehealth. Specifically, look at Telehealth Services Authorized for Psychiatric Rehabilitation Programs (PRP) and Follow Up Guidance on Temporary Telehealth Services (March 24, 2020).

Are the reimbursement rates of telehealth services the same as normal rates? Are PRP rates the same too?

PRP service delivery by various telehealth technologies to individuals will be treated as offsite services, subject to the same medical necessity, time and documentation rules as face to face services. Group PRP services will be considered onsite services, requiring a minimum 60-

minutes duration for billing. Service encounters involving telehealth should be totaled and submitted as daily offsite visits in the same manner as is done for face-to-face visits. They may be combined with face-to-face visits.

Now that PRP services can utilize telehealth model, RCs will need to keep a call log visit for auditing purposes?

Providers must be willing to provide telephone records of services, if requested for an audit. Phone records may be in the form of phone billing records or call records available from the telephone provider. Staff call logs, in and of themselves, are insufficient documentary evidence of service provision.

On what date of services will MDH begin reimbursement for telephonic services? When providers were first urged by state officials to provide remote care via telephone (3/12/2020) or the date of the PRP guidance (3/21/2020)?

PRP services delivered by various telehealth technologies may count as a reimbursable encounter for March 2020 monthly billing submissions.

The Optum Maryland Team emailed the MD DOH document concerning Telehealth Services Authorization. I did not see Licensed Clinical Psychologists listed under the provider types who may deliver behavioral health services using telehealth.

Licensed Clinical Psychologists may deliver services by telehealth.

The difficulty with the Optum transition has already taxed providers financially and this pandemic is putting a lot of jobs and organizations at risk. How are we going to get through this without losing a large quantity of providers, and thus putting PBHS consumers in jeopardy?

BHA and Medicaid have suspended many rules governing the provision of services, to permit providers to continue serving clients by telehealth and telephone.

Please provide clarification on the policy relating to government phone minutes for those clients who can only be reached by phone. Are there still currently restrictions on minutes for these phones?

The Lifeline Program for Low Income Consumers is operated by the federal government.

Are Provider Type 50 (Certified Addiction Program) eligible to provide telehealth? ***(The memo references "In ASAM Level 1 outpatient SUD program, State licensed providers only – CAC-AD, CSC-AD", but doesn't specifically reference Provider Type 50.)*** **Are Provider Type 54 (Residential Treatment Program) eligible to provide telehealth?** ***(The memo does not specifically mention Provider Type 54.)*** **Are Provider Type 32 (Opioid Treatment Program) eligible to provide telehealth?** ***(The memo does not specifically mention Provider Type 32.)***

Type 50 covers many types of outpatient SUD programs. The Medicaid Program and BHA are providing guidance on specific types of programs. The rules governing your program are based upon your license and not your provider type. At this time, the rules governing residential SUD programs are under review. OTPs are permitted to use telehealth as set forth in other guidance by MDH.

Are there any specific telehealth explanation forms that the Maryland Department of Health wants us to utilize when explaining the service to clients/members?

MDH has not adopted a specific form.

I have reviewed the details included in the March 21, 2020, provider alert and have a question regarding the location of the provider when conducting telehealth services. Can nurse practitioners and clinicians provide medication management and psychotherapy to clients with Medicaid from their homes or is it still a requirement that they be at the office to conduct these services?

The provider may be in a location other than their office.

When will Optum's system be ready to adjudicate the claims with the new modifiers?

The computers are being programmed. BHA recommends that claims not be submitted for at least two weeks.

Is it suggested or recommended to discontinue OTP and IOP groups?

If services cannot be provided in a manner that complies with social distancing, in person services should be discontinued. Groups may be provided by telehealth. Convert to telehealth instead.

If both locations have HIPAA compliant platforms, are telehealth services covered when the patient is located in an ER or psychiatry inpatient ward and the psychiatrist is located in his/her home?

Yes.

What should we do if clients are unable to participate in video-based telehealth group sessions and are only able to call in using a landline?

Medicaid will not reimburse for audio only groups in non-residential settings, although video telehealth is covered. Within residential settings groups are reimbursed for audio-only telephone services if telehealth is not available. Individual sessions should be considered for individuals in non-residential settings who are otherwise unable to participate in group services through approved telehealth technology.

I manage operations for four HSCRC regulated BEH clinics and the services performed by the LCPCs and LCSWc's are only billed via facility billing on a UB04, no professional fees. How will we be reimbursed for the telehealth or telephone visits that we complete?

I also manage a non-HSCRC clinic that only bills professional fees. While the State of Maryland and Gov. Hogan have indicated that patient homes are now an approved service site, will providers be able to bill for their services if the provider is calling or video-calling patients from their own homes?

Yes.

Can you provide any clarification on whether Psychiatric/Mental Health Nurse Practitioners in Maryland are now allowed to do new client intakes for Medication Management via Telehealth?

PMH certified CRNP and APRN- Yes.

Can the group service be in the form of a conference call where several clients live in the same residence? Or does it have to be an actual webinar call-in type of call?

Yes, if the service is a PRP service to individuals in a single RRP setting. Yes, if the group service is to individuals in a single SUD residential location (namely, all of the participants reside in the same house).

With COVID-19 #4b: Temporary Authorization of Audio-Only Health Care Services to Mitigate Possible Spread of Novel Coronavirus ("COVID-19") Executive Order No. 20-03-20-01, are counseling trainees allowed to continue to provide group therapy?

On April 6, 2020, the Secretary of Health issued an order temporarily allowing alcohol and drug trainees (ADT) to provide counseling services via teletherapy during the state of emergency. However, the services must be performed in accordance with COMAR 10.58.06 and subject to the following terms and conditions:

a) During the state of emergency as declared by the Governor;
b) Using IT equipment owned by a facility, clinic, or office;
c) At a facility, clinic, office, or alternate location as determined to be appropriate by the ADT's Board of Professional Counselors and Therapists ("Board")-approved supervisor; and
d) Under the supervision of a Board-approved supervisor who is physically, electronically, or otherwise immediately available.

Please refer to the Board of Professional Counselors for additional guidance on alcohol and drug trainees (ADTs).

In light of so many hospitals implementing telepsychiatry and psychiatrists being remote rather than onsite at Maryland hospitals (and patient assessments completed by video due to COVID-19), will the courts allow the psychiatrist to e-sign and/or fax back the signed voluntary and involuntary forms? Or will the courts continue to only accept original signed forms?

BHA believes the courts will accept e-signatures, however, this is a question for the Office of Administrative Hearings.

For provider type SE- are we also adding the modifier SE followed by GT or UB modifier for telehealth and telephone?

On April 1, 2020, BHA issued guidance related to the telephone services authorized during the state of emergency for supported employment (SE) services. Please consult the SE guidance document for clarification as to the service codes that are eligible for reimbursement by telehealth and telephone. On the claim submission, the provider shall include the SE service modifier, as applicable, and the GT or UB modifier, as applicable. The order of the modifiers does not matter. Please note that only BHA designated EBP SE programs with a current letter of EBP eligibility on file may submit claims for the EBP SE reimbursement codes.

My employees are working from home providing telehealth, do I need a physical office open?

No. However, clients and new patients must have notice of how to reach the program during working hours. Clients and other clinicians must be able to contact the program and receive a reply back within a reasonable time period.

We are an approved SUD IOP/OP provider at our main location. We have several members who reside at another location in our housing program. Can we bill for OP group as we do for those clients at the housing location?

Yes.

Does the Governor's latest order on telehealth allow for group counseling/therapy using non-HIPAA compliant platforms?

If HIPAA compliant tele-video platforms are not available, group counseling/therapy may be conducted utilizing non-HIPAA compliant platforms. The individual must give consent to the telehealth service and be on notice that the platform is not-HIPAA compliant, and thus security/confidentiality may be at risk.

Has there been any literature during this public health emergency for providers in providing telehealth services to new clients? Should new clients be treated the same as established clients?

There are numerous resources on the web regarding telehealth. For example, the National Council for Behavioral Health released Best Practices for Telehealth During COVID-19 Public Health Emergency.

How do the executive orders issued by Governor Hogan impact the treatment process for outpatient mental health agencies in any way?

Outpatient programs, if providing onsite services, are required to utilize social distancing and other recommendations from the CDC and State. Programs may utilize telehealth and telephonic means to provide services to individuals in their homes.

Are 3.7 level services approved for telehealth services?

Level 3.7 SUD housing is a medically monitored intensive level of service. It is important that a staff member appropriately trained to address immediate clinical needs of the residents be present in the residence at all times. Clinicians providing individual therapy may provide the

service via telehealth, or voice-only telephone, if telehealth is not available. Within residential settings group therapy may also be provided by voice-only telephone, but outside of residential settings voice-only groups are not authorized.

For a Psychiatric Rehabilitation Intake Assessment, do we use the GT modifier when we bill for that service?

Yes, the claim is to be submitted with the GT modifier if the service is performed by telehealth using accepted video protocols.

May a provider use Zoom given new issues that have arisen regarding the security of the Platform?

Providers should use every effort to utilize a HIPAA compliant platform to conduct therapy with their clients. If a HIPAA compliant platform is not available (client lacks technology), then the Provider may utilize a non-compliant platform. The provider must obtain informed consent from the individual prior to initiating the clinical service. The individual must be advised that the clinical session will be transmitted over a non-secured technology, and the confidentiality or security of the session cannot be guaranteed. The form of the transmission (HIPAA compliant telehealth, telephonic, etc.) must be documented in the medical record as well as the individual's consent to the technology.

Has there been official guidance on whether LGPC or LGSW can receive supervision via telehealth?

Please contact the appropriate licensure board for requirements for supervision.

We have several PRP consumers without video or smart phone options. The guidance is a bit conflicting about the use of Telehealth and Telephonic allowances. Are telephonic groups an approved method for services rendered in PRP groups?

Groups in residential settings are approved only if the PRP service is being provided in a RRP home and all the participants of the group session reside in the home. Otherwise, PRP groups may not be provided via telephone.

In regard to call logs, is our EMR notating the type of telehealth service provided (video with type of platform or phone) an acceptable form of a log for our records? Or do we need a separate log kept (ex. Zoom calendar detail of the type of meeting to match the billing

records or phone logs with times and dates of calls in addition to the information in the billing records)?

It is recommended that if you have a calendar or other documentation to support the telehealth service, that the provider maintain the documentation.

Has telehealth and telephone been approved for RRP services? If not, how are staff to provide services when the extent of staff and/or client illness and/or lack of appropriate PPE prohibits face to face contact?

In the absence of video telehealth, and with the informed consent of the participant, telephone services may be used. For billing purposes, the normal rules of medical necessity, documentation and duration apply. Providers must also be willing to furnish telephone billing/data records to auditors on request to justify the services in question.

Will we need to separate billing codes by clients who received all face-to-face services (before the crisis) and those who received a combination of telehealth and face-to-face services?

Yes. You will need to bill the code for the specific type of service. If offered face to face, there would not be any special modifier. If video telehealth, you will need to bill a GT modifier, and if telephone, a UB modifier.

What CPT codes are reimbursable for OMHCs providing Telehealth audio/video and telephonic?

Most codes normally used by OMHC's are reimbursable for telehealth and telephone. There are limitations on groups, which must be offered through video telehealth unless in a residential treatment site in which video proves non-viable. In this case telephone may be used.

Under what circumstances can clinicians, group practices and OMHCs do evaluations (90791 and 90792) telephonically? Is there a process for requesting exemptions to allow telephonic evaluation?

In the event that it is not possible to do these evaluations by telehealth, and with the informed consent of the participant, these codes may be performed telephonically.

Where regs require a face-to-face interview (such as RCS or SE clinical interview), can providers now use telehealth? Telephonic?

Requirements for initial evaluations have been relaxed to allow for telehealth, and, if not viable, telephone interviews with informed participant consent.

Can we obtain both an onsite (group) and off site (telephonic service) in 1 day with the same client?

In PRP this would certainly be possible if you have the correct authorizations. For other clinical programs this would not be applicable.

Are all CPT codes listed in the memo eligible to be provided via telephone (audio-only) except for the ones that specifically state "not covered for voice telephone"? *We assume the following CPT codes are allowed to be provided via telephone (audio-only): 99211, 99212, 99213, 99214, 99215, 90832, 90834, 90846, 90833, 90836, 90837, 90839, 90840, H0004). The following CPT codes are carved out as "not covered for voice telephone": 90847, H0016, H0001, and all Group Treatment Codes (90853, H0005, H0015, H2036, S9480, H0032). We assume that all of these services are only eligible to be provided via telehealth (video and audio).*

The guidance has been updated to allow for all individual evaluations to be conducted by telephone if telehealth is not available, with the exception of initial methadone induction, which must still be face to face. Conditions for Family Therapy with or without patients have also been relaxed to allow for telephone service in the absence of telehealth.

Group services must still be offered through telehealth, not telephone, with the exception of services offered within a specific residential treatment site. In this case, telephone services are permitted if telehealth is not viable.

For clarity, audio services are not allowable for 90847 and 90847-52? This is a family session service code.

Yes, audio only is now allowed in circumstances in which video telehealth technology is not viable. This must be documented, and the participant must provide informed consent.

Now that PRP services can utilize telehealth model, the call would count as a typical off-site visit for billing, correct?

Yes, this is correct, with the same duration, medical necessity and documentation requirements. In addition, providers using telephone must be willing to provide telephone billing/data use records to auditors to validate that services were provided.

Can you please elaborate on the "time span" provided in the provider alert on 3/21/20 for expanded telehealth services for behavioral health. It states a 90832 has a time span of 16-37 and a 90834 has a time span of 38-52. Are these the minimum and maximum minutes allowed per session?

The exact timespans for specific services are set in the CPT coding system.

What are the explicit telehealth regulations?

Telehealth is provided under a number of different regulations, including those of the specific professional boards. Medicaid regulations are in COMAR 10.09.49. The variances from these regulations which permit the broadened use of telehealth and telephone are contained in guidance from HHS, as well as the Governor's and Secretary of Health's orders on the topic. These may be found on the BHA or Medicaid websites.