Quality Assurance Bulletin

Quality Assurance Unit

County of Los Angeles – Department of Mental Health

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PROVIDING SPECIALTY MENTAL HEALTH SERVICES DURING THE COVID-19 CRISIS

(Revised 4/17/20)

This bulletin serves as interim guidance to assist practitioners in ensuring beneficiaries can access all medically necessary specialty mental health services (SMHS) while minimizing the community spread of COVID-19. In accord with State Department of Health Care Services (DHCS) Information Notice No.: 20-009 and Los Angeles County Department of Mental Health (LACDMH) interim protocols, providers should maximize the use of services that can be provided by telephone and/or telehealth methods of delivery.

What SMHS may be provided over the telephone or telehealth?

The Guide to Procedure Codes (Guide) provides a list of services that may be provided by telephone and telehealth. The "Method of Delivery" column identifies the allowable ways in which a practitioner may deliver the respective activity. In the Guide, the term "telepsych" is used to refer to telehealth. The following set of examples is not exhaustive.

Examples of services allowable by telephone:

- Plan Development (H0032)
- Psychotherapy (H0046)
- Individual Rehabilitation (H2015)
- Collateral (90887)
- Targeted Case Management (T1017)
- Crisis Intervention (H2011)
- Comprehensive Medication Services (H2010)

Examples of services allowable by telehealth:

- Assessment (90791/90792)
- Plan Development (H0032)
- Psychotherapy (H0046, 90832, 90834, 90837)
- Individual Rehabilitation (H2015)
- Collateral (90887)
- Crisis Intervention (H2011)
- Evaluation and Management Medication Services (99201, 99212, etc.)

During the COVID-19 crisis, there is a need to increase the services provided by telephone and/or telehealth in order to ensure that clients continue to receive medically necessary services. What follows are interim instructions on completing assessments over the telephone and providing group/family services over the telephone or through telehealth.

Can a provider conduct a mental health assessment over the telephone?

Yes. While LACDMH Policy 312.02 - Opening & Closing of Service Episodes allows assessments to be initiated without a face-to-face contact, it requires a face-to-face contact prior to finalizing the assessment. During the COVID-19 crisis, LACDMH is allowing assessments to be completed and finalized over the telephone. All other requirements of LACDMH Policy 312.02 must be adhered to including conducting financial screening, obtaining client identification and obtaining informed consent. Verbal informed consent may be obtained and documented on the Consent for Services form (MH 500) along with a statement that verbal consent was accepted due to the COVID-19 crisis. Likewise, verbal financial screening and client identification is acceptable at this time, but should be followed-up with in-person screening including the presentation of required documentation should that opportunity become available during the course of treatment. The progress note should state the client's agreement to receive the assessment over the telephone as well as that the service was provided via non-standard means due to the COVID-19 crisis. Practitioners may verify the client's identity and address verbally

and obtain proof of the client's identification when the client can be seen in-person. The LACDMH Central Business Office (CBO) will be issuing a Bulletin within the next few days related to financial screening requirements during the COVID-19 crisis.

The choice of assessment forms to use in these situations is up to the provider and practitioner. However, if the Immediate/Same Day Assessment form is chosen, the Full Assessment should be completed if and when the client presents for in-person services, if needed. When certain information cannot be obtained during a telephone contact (e.g. some observational data included in the mental status exam), it should be obtained upon the first in-person encounter with the client. A primary diagnosis must be provided at the point of finalizing the assessment based on the information that has been gathered. As with any other case, the diagnosis is subject to revision in light of additional information being obtained.

Can group and family services be provided over the telephone or telehealth?
Yes, LACDMH has expanded the use of the procedure codes for group (90853, 90847HEHQ, H2015HEHQ, and 90887HEHQ) and family sessions (90847 and 90849) to allow for telephone and telehealth methods of delivery (refer to instructions for claiming telephone and telehealth services below). However, these services should be provided with caution and all clients involved in such services must be advised of the privacy risks inherent in conducting group/family sessions over the telephone or through telehealth. Prior to conducting any group or family session in this manner, the practitioner or provider should contact the Quality Assurance (QA) Unit at (qualityassurance@dmh.lacounty.gov) to obtain additional instructions and reference materials. In addition, the QA Unit can provide instructions on the use of alternative equipment for conducting group or family sessions by directly-operated providers (e.g. Skype for Business).

Are there any special documentation requirements to consider during the COVID-19 crisis?
If a service is delivered in a nonstandard manner (e.g. an assessment completed over the telephone as referenced above), this should be stated at the beginning of the progress note and that the client agreed to the method in which the service was delivered (i.e. telephone or telehealth). In addition, the note should indicate that the service was provided during the COVID-19 crisis. This guidance applies to any other nonstandard procedures used in response to the COVID-19 crisis in addition to those specifically mentioned in this Bulletin.

Sample progress note language:

> *This session was provided via [HIPAA-compliant video conferencing or telephone] due to recommendations from public health agencies regarding face-to-face contact related to COVID-19. This client agreed to be treated via [telehealth or telephone] and provided verbal consent. The plan for dealing with an emergency during the session is that the clinician will [call 911 or contact an identified emergency contact], depending on the nature of the situation. The client is aware of this plan.*

How do we handle medication consents if the client is not physically present to sign, or it is not safe to pass pens and paper between the client and practitioner?
For directly-operated providers providing services during the COVID-19 crisis, verbal consent for medications may be obtained whether the client is present or not present. All items on the medication consent form shall be reviewed with the client, whether in-person, over the telephone or via telehealth. The client's understanding of the information and verbal agreement with it shall be documented both on the progress note and the medication consent form. For directly-operated providers, this is done on the Medication Consent and MSS Treatment Plan under Signatures by marking the "Parties Refused/Unable to Sign", then documenting in the Justification/Explanation field that the client/legal representative verbally agreed and affirmed understanding of the information. Whether the client was not present and therefore unavailable to sign, or present but did not sign due to social distancing practices, the specific situation leading to the verbal consent should be documented on the Medication Consent and within the progress note along with a statement that the consent process was conducted in a nonstandard manner due to the COVID-19 crisis. Contract providers may choose to follow the directly-operated process or consult with their legal counsel to develop an alternate approach.

How do we handle client treatment plans if the client is not physically present to sign, or it is not safe to pass pens and paper between the client and practitioner?
Client treatment plans may be completed over the telephone or via telehealth, and verbal approval for the treatment plan may be obtained. The client/legal representative's verbal agreement to the treatment plan should be documented on the client treatment plan. For directly-operated providers, this is done by marking the "Client/Other Refused/Unable to Sign" or "Client/Other is Unavailable to Sign" box, then documenting in the comments field that the client agreed verbally to the plan but was not able to sign due to the COVID-19 crisis. In addition, the practitioner should document in the progress note that this process was done due to the COVID-19 crisis.

How are telephone services claimed?
Telephone services are a reimbursable method of providing services to Medi-Cal beneficiaries. Telephone services are not considered face-to-face activities and, therefore, no "face-to-face" time will be documented (i.e. face-to-face time will always be zero). For psychotherapy services provided over the telephone, the procedure code will always be H0046SC, and the entire amount of time spent providing the service will be included as "other" time. The SC modifier must be added to the procedure code for all telephone services, and the place of service will be wherever the practitioner is located. As an interim practice during the current COVID-19 crisis, if a practitioner is providing telephone services from his/her own residence, the place of service will be the location of where that service would have most likely been provided if not for the current COVID-19 crisis (e.g. office).

NOTE: This information regarding the place of service is different from what was originally provided on 3/18/20. *Providers do NOT need to go back and change Location of Service on any prior progress notes.*

How are telehealth (also referred to as telemental health or telepsychiatry) services claimed?
While telephone services are not considered face-to-face, telehealth services are considered face-to-face because the client is visually present. Telehealth services include the use of video teleconferencing solutions (e.g., HIPAABridge) in order to provide services to a client via interactive audio and video telecommunication. The GT modifier must be added to the procedure code for all telehealth services, and the place of service will be "02 – telehealth." As an interim practice during the current COVID-19 crisis, if a practitioner is providing telehealth services from his/her own residence, the place of service will be the location of where that service would have mostly likely been provided if not for the current COVID-19 crisis (e.g. office). If the service would have been provided via telehealth regardless of the COVID-19 crisis, then the place of service will continue to be "02 –telehealth."

NOTE: This information regarding the place of service is different from what was originally provided on 3/18/20. *Providers do NOT need to go back and change Location of Service on any prior progress notes.*

Does a provider need to be certified or pre-approved for telehealth services?
No. There is no Medi-Cal requirement that a provider be specifically certified or pre-approved for telehealth services.

Does a practitioner need to be present with the client for telehealth services?
No. There is no Medi-Cal requirement that a practitioner or other staff be physically present with a client in order for the client to receive services via telehealth. For directly-operated providers, the standard practice has been for the practitioner to be physically present with the client; however, as an interim procedure in order to support social distancing protocols, the presence of the practitioner will not be required.

What are the allowable types of telehealth equipment for individual services?
Telehealth must be provided using HIPAA compliant videoconferencing/video chat tools. For directly-operated providers, the approved types of equipment for individual telehealth services are Cisco Jabber and HIPAABridge. HIPAABridge supports a free mobile application that clients can download on their telephone. HIPAABridge can also be used via a computer browser, allowing the client to participate in telehealth services from his/her own residence. Directly-operated providers should refer to the CIO Teleworking Toolkit for

additional information regarding accessing this equipment. Contract providers should refer to the notification (linked here) from the U.S. Department of Health & Human Services (HSS) entitled discretion for telehealth remote communications during the COVID-19 crisis. Notably, the HHS notice states that under certain conditions, as long as telehealth services are provided in good faith, the Office of Civil Rights will exercise its enforcement discretion to not impose penalties for noncompliance with regulatory requirements under the HIPAA Rules.

How do we handle consents for telehealth if the client is not physically present to sign, or if it is not safe to pass pens and paper between the client and practitioner?
Due to Executive Order N-43-40, obtaining verbal or written consent for telehealth services prior to the use of this method of providing services is temporarily suspended during the current COVID-19 crisis. However, LACDMH recommends that practitioners continue to review elements of telehealth with clients when applicable and reasonable to do so. Providers can refer to the "Temporary Suspension of Consent for Telehealth" document posted on the QA COVID-19 site.

How is timely access to care accounted for during the COVID-19 crisis? Do new clients have to be assessed?
At this time, there is no guidance from DHCS that relaxes the timeframes for access to care during the COVID-19 crisis. However, DHCS does allow for timeframes to be extended if there is determination by an Authorized Mental Health Discipline (AMHD) acting within his/her scope of practice and consistent with professionally recognized standards of practice that a longer wait time will not have a detrimental impact on the health of the client. Documentation of this determination may be done within the Service Request Log or Mental Health Triage form.

Can we claim for telephone check-ins on existing clients during the COVID-19 crisis?
As is the case at any other time, it depends on the specific activity the provider performs. If the contact addresses the client's identified mental health symptoms, behaviors, and/or impairments, the activity may be claimable as a direct treatment service such as individual rehabilitation (H2015) or plan development (H0032). If the contact is to outreach to the client, or reengage the client into treatment, the activity may be claimable as a Community Outreach Service (COS). And if the activity represents no service, such as leaving a voicemail, then the "never-billable" procedure code (00000) should be used.

Final Note:
DHCS has submitted to the federal Centers for Medicare and Medicaid Services (CMS) a request for section 1135 (Social Security Act) waiver flexibilities related to the COVID-19 national/public health emergency. This waiver, if granted, may impact the access to care and other requirements mentioned in this Bulletin. The QA Unit will update providers as additional information becomes available.

If directly-operated or contract providers have questions related to this Bulletin, please contact the Quality Assurance Unit at QualityAssurance@dmh.lacounty.gov.

cc: DMH Executive Management
DMH Administration Managers
DMH QA Liaisons
Legal Entity Executive Management
DMH Clinical Operations Managers
DMH Quality Management Unit
DMH CIOB Managers
Legal Entity QA contacts