Los Angeles County Department of Mental Health
Quality Assurance Unit

Frequently Asked Questions Related to COVID-19

Updated as of 6/10/20

Intakes and Assessments

1. **Are clinicians allowed to conduct initial and triannual mental health assessments over the telephone? If the mental health assessment is conducted solely via telephone, can it be completed/finalized or does the 'final' session need to be in-person?**

   During the COVID-19 crisis, LACDMH is allowing assessments to be completed and finalized over the telephone. Therefore, there is no need to have a 'final' session in-person. Refer to QA Bulletin 20-01R.

   (NOTE: This interim COVID-19 protocol is temporarily waiving the requirement in LACDMH Policy 312.02 - Opening & Closing of Service Episodes, for a face-to-face contact prior to finalizing the assessment.)

2. **How do we claim for Initial Medication Evaluations and Medication Follow-Up appointments conducted via telephone or telehealth?**

   For telephone sessions with the client related to medications, use H2010SC as the procedure code. Evaluation & Management (E&M) codes require a Face-to-Face contact and therefore are not eligible to be used when providing the above services via telephone. The SC modifier on the code signifies that the service was provided by telephone.

   For telehealth sessions with the client (client visually presents via video conferencing platform), use the appropriate E&M code with the GT modifier.

3. **Is it a problem if the admission date does not match the date of the first Assessment contact? Currently, our intake coordinator is opening new clients by obtaining required verbal consents, financials, and opening the admission episode, and the first Assessment contact occurs on a subsequent date. Please clarify which dates need to match.** (Added 4/28/20)

   The consent for services should be on or before the date of the admission episode as consumers should be aware of and agree to being entered into our DMH system before an admission episode is opened. The date of the admission episode, financials, and verbal consents may be earlier than the date of the first Assessment contact.

4. **For directly-operated providers, at telehealth or telephone intake, we have been obtaining and documenting verbal consent for the consent/acknowledgement forms, as well as any other needed consents (e.g., Authorization to Release PHI). How do we provide clients with some of the information that we are required to give them (e.g., Notice of Privacy Practices, booklet, and list of providers)?** (Added 4/28/20)

When conducting intakes via telephone or telehealth, providers would still offer the Notice of Privacy Practices (NPP), the Guide to Medi-Cal Mental Health Services booklet, and the Provider Directory. For clients who want copies of these documents, providers can electronically send them via encrypted email or mail them hard copies. When completing the NPP Acknowledgement of Receipt form (MH 610) in these situations, staff would complete the "Inability to Obtain Acknowledgement" section by signing and dating the form as well as checking off "Other Reasons or Comments" and entering: "Unable to obtain client signature due to COVID-19 and Safer at Home guidance." Providers can also add that the NPP was either emailed or mailed to the client.

Below are the links to the English-versions of these documents:

Guide to Medi-Cal Mental Health Services:
http://file.lacounty.gov/SDSInter/dmh/159129_MediCalGuide_English_July2013.pdf

Provider Directory:
http://file.lacounty.gov/SDSInter/dmh/1051448_CountywideProviderDirectory2018.pdf

Notice of Privacy Practices: https://dmh.lacounty.gov/our-services/consumer-and-family-affairs/privacy/

5. **For directly-operated providers who are conducting intakes in-person in the field (e.g., in the homeless shelters), how do they provide the Notice of Privacy Practices (NPP) to new clients?** (Added 4/28/20)

For new clients who are being assessed in person during this time, providers will continue to offer a physical copy of the NPP. Clients can make the decision to either accept or decline it. As a reminder, for clients who choose to accept the NPP and sign MH 610, all signed copies must be kept in a protected and secure location as these signed forms contain client protected health information (PHI). If clients decline a copy of the NPP, staff would complete the "Inability to Obtain Acknowledgement" section by signing and dating the form as well as checking off "Patient refused to sign."

6. **If a face-to-face contact is not an option for practitioners and families, can a child age 0-5, be assessed and diagnosed over the telephone?** ***(Added 6/10/20)***

For the 0-5 population, assessments completed and finalized over the telephone should only be provided as a last resort in cases where triage determines that the referral is urgent, and the child must be assessed immediately. For all other routine referrals, assessments should be completed and finalized by providers who are able to assess via telehealth. Per the Prevention Services Division, telehealth is the preferred method for completing assessments with the 0-5 population during the COVID-19 public health emergency if an in-person face-to-face contact is not possible.

For more information, refer to this document: Clinical Guidance Re Assessing and Treating the 0-5 Population during COVID-19

7. If face-to-face assessment contacts were not available due to the current COVID-19 crisis, can a practitioner determine that a child age 0-5 does not meet medical necessity? ***(Added 6/10/20)***

Determining that a child does not meet medical necessity without any face-to-face assessment contacts should be done with extreme caution since face-to-face contact (whether in-person or via telehealth) and the ability to observe a child is crucial in accurately assessing and diagnosing the 0-5 population. As telehealth is the preferred medium over telephone for completing assessments with the 0-5 population, practitioners should make every effort to have face-to-face assessment contacts, especially if no medical necessity is being considered. Agencies may want to consider using PCIT rooms (if an in-person assessment is being conducted) in order to provide face-to-face contacts, if these rooms are available and can adhere to social distancing and sanitation guidelines.

Before a practitioner determines that a young child does not meet medical necessity, that practitioner should consult with his/her supervisor(s) and ensure that key assessment information was gathered from other significant support persons in the child's life. For example, information provided by DCFS social workers, teachers/child care providers, the child's attorney, and previous clinicians can help provide different perspectives of the child and family. Utilizing other assessment and screening tools such as the Ages and Stages Questionnaires (ASQ) or the Child Behavioral Checklist (CBCL) can also assist in providing information about a child's development and functioning.

If no medical necessity is determined after consultation and gathering all key assessment information without face-to-face contact with the child, practitioners may want to consider asking the family to participate in Stepped Care under PEI expansion which allows for services without medical necessity.

For any further clinical questions regarding the clinical assessment and treatment of the 0-5 population, please contact the Prevention Services Division at FCPTrainings@dmh.lacounty.gov. In the subject line of the email, enter in "Birth to Five."

Questions Related to Telehealth

8. For group and family services, it indicates that directly-operated practitioners can use Skype for Business, but I thought only HIPAABridge can be used?

HIPAABridge is designed for individual sessions and does not work for group and family services because you cannot have multiple participants on it at the same time; therefore, Skype for Business is the current preferred telehealth platform. For additional guidance for DO providers, please refer to the following links:

Telephone and Telehealth Guidance for Group and Family Services

MH739 Consent for Groups or Family Sessions conducted via Telehealth or Telephone

9. Can we claim TCM for assisting clients with the 'setting up for telehealth' process (e.g., creating email accounts, talking them through how to download apps)?

Activities related to setting clients up for telehealth are non-billable clerical/administrative activities.

10. When we provide collateral sessions via telehealth, in which the client is not present, do we enter '0' (zero) for Face-to-Face time?

Yes. Collateral is never considered Face-to-Face even when provided via telehealth. As a reminder, Face-to-Face time indicates Face-to-Face time with the client.

11. We are a <u>Legal Entity agency</u> in the process of implementing a HIPAA-compliant telehealth platform, but in the meantime could we use our internal video conferencing system, which is not HIPAA compliant? We were advised that we will not be penalized for using platforms that are not HIPAA compliant during COVID-19.

This decision is up to your agency. We recommend following the guidance from the Office for Civil Rights (OCR), the agency that enforces HIPAA. In response to the COVID-19 crisis, on March 17, 2020, the OCR issued a notice stating that effective as of that date, the OCR will not impose penalties against covered providers for their lack of a Business Associate Agreement (BAA) or for any other noncompliance with the HIPAA rules that relate to the provision of Telehealth during this time. That means that a provider who needs to provide Telehealth services to their patients during this time may use platforms that would otherwise not be "HIPAA-compliant" such as FaceTime or Skype. Providers may use other popular applications that allow video chat to provide Telehealth without risk that they will be penalized by the OCR.

(NOTE: For Directly-Operated providers, practitioners must utilize applications identified in the CIO Teleworking Toolkit)

12. Can an existing practitioner who needs to go out of state or cannot travel back to California, provide services from out of state via telehealth for LACDMH?

Yes. There are no Medi-Cal rules that would prohibit existing practitioners who are out of state from providing services to LACDMH clients.

13. **May telehealth and telephone be used to place and release involuntary holds on individuals (5150/5585 evaluations)?** (Added 4/28/20) ***(Updated 6/10/20)***

For telehealth, yes; for telephone, no. WIC 5150/5585 evaluations may be performed by authorized providers face-to-face via telehealth, <u>not via telephone</u>. However, DHCS has not put out any guidance regarding the process for conducting 5150/5585 via telehealth. It is up to providers to determine a process that works for them.

Refer to the following document that addresses items to consider when developing a process for 5150/5585 Evaluations provided via telehealth: 5150/5585 Evaluations via Telehealth

14. **Is it acceptable to electronically sign the 5150/5585 form and submit it to the hospital via email or eFax?** ***(Added 6/10/20)***

Yes, this is acceptable for most hospitals, however, providers should contact each hospital to determine if they will accept the 5150/5585 form via HIPAA compliant encrypted email or fax. For directly-operated practitioners, refer to DMH Policy 557.02 regarding sending encrypted emails (i.e. adding [secure] at front of subject line).

DHCS has recently acknowledged DocuSign as a permissible HIPAA-compliant app, if a Business Associate Agreement (BAA) is in place with the electronic signature vendor. When using an electronic signature platform for 5150/5585 submission, providers must ensure compliance with all applicable privacy laws, including HIPAA, 42 CFR Part 2, and the Information Practices Act (IPA), whenever they transfer PHI through a secure electronic signature platform.

Regarding transmission via eFax, DHCS does not require a specific medium; however, providers must be compliant with HIPAA and all applicable State and Federal privacy requirements when electronically transmitting PHI.

Providing Services from Home (updated 4/15/20)

15. Our teleworking practitioners are providing services via telephone and telehealth and are concerned about putting their home zip code and MAJOR cross streets as the location of service on the progress notes because they believe this too closely identifies where they live, and clients requesting their records would see it. Is there another way to meet the location of service requirement that better protects the practitioners' privacy?

Entering the home zip code and major cross streets of the practitioner's home is no longer required. Based on guidance issued by the Centers for Medicare and Medicaid Services (CMS) in early April 2020, services provided during the current COVID-19 Public Health Emergency should indicate the location of service of where the service would have been most likely provided prior to the COVID-19 crisis. Practitioners no longer need to enter the address of where the service was actually provided (e.g., for services being rendered at the practitioner's home, do not need to enter the major cross-streets of their home location). Practitioners providing these services via telehealth or telephone will still need to enter the appropriate procedure code modifiers (GT for telehealth; SC for telephone

NOTE: Providers do NOT need to go back and change Location of Service on prior progress notes. This updated instruction is to be applied upon being informed of it.

Directly-operated providers should refer to this document: COVID-19 Interim Practice: Update Regarding Entering Location of Service on Progress Notes

16. For services that practitioners are providing from their home, they are to enter the MAJOR cross streets closest to their home as the location of service. If they don't know the exact MAJOR cross streets closest to their home, is best judgment sufficient?

This no longer applies. See above response.

17. We are a Legal Entity agency and our practitioners are providing telephone and telehealth services from their homes. Is the location of service "office" since the practitioners are technically in their home "office" when providing the service?

Practitioners who are working from home should now enter the location of where the service would have been prior to the current COVID-19 crisis. See above response.

Questions Related to Indirect Services (COS and MAA)

18. **Are COS (DO & LE) and MAA (DO only) services allowable via telehealth?** (Updated 4/28/20)

Yes, LACDMH added the telehealth modifiers to the procedure codes for COS and MAA. Please refer the updated Allowable Telephone and Telehealth Procedure Codes during COVID-19 for Directly Operated or Legal Entity list.

19. For COS outreach, we are doing educational presentations on mental health via different platforms (e.g., ZOOM, Skype for Business). Can we claim for the time it takes to convert in-person presentations into virtual presentations?

Converting the training to virtual mode is an administrative task that is not claimable. However, you can claim for the time spent developing the original training and providing it via telehealth. This type of COS service is claimed as:

COS – Mental Health Promotion (200)

Service Type – Education/Training

Procedure Codes / Claiming Information

20. When will the updates to the codes associated with the temporary COVID-19 practice changes be made on the claims/billing side?

LACDMH ensures new codes are available for claiming prior to including the code on the Allowable Telephone and Telehealth Procedure Codes during COVID-19 for Directly Operated or Legal Entity list. Legal Entity providers should submit a DMH HEAT ticket if a claim is denied with a code identified on the list. Directly Operated should contact DMH IBHIS Error Correction (IBHISerrorcorrection@dmh.lacounty.gov) if they are unable to select one of the codes identified on the list.

21. I noticed in the bulletin that TBS is not allowable via telephone or telehealth. Why not?

The TBS codes for both telephone and telehealth have been added as of 3/23/20. QA Bulletin 20-01 did not provide an exhaustive list of telephone and telehealth codes. During the COVID-19 crisis, providers should refer to the *Allowable Telephone and Telehealth Procedure Codes during COVID-19 for Directly Operated or Legal Entity* for the most up-to-date list of allowable procedure codes on the QA COVID-19 webpage.

22. During COVID-19, I'm predominantly seeing clients via telehealth from my residence. If I need to see clients in person at the clinic, can I claim travel time (from my residence to the clinic and back to my residence)? ***(Added 6/10/20)***

No, you cannot claim travel time for travelling from your residence to a provider site. Here is the QA Bulletin for further information http://file.lacounty.gov/SDSInter/dmh/1021450_17-08ClaimingforTravelTime.pdf

23. **For Medication Support Services, do Medi-Cal reimbursement rates vary by method of delivery (e.g., are rates higher for in-person versus phone)?** ***(Added 6/10/20)***

No. For Medi-Cal, there is no difference in payment for services provided via phone, in-person, or telehealth. The reimbursement for medication support services is the same regardless of the method of delivery or procedure code (e.g., H2010 vs 99201).

Mode 10 Services

24. For Day Treatment Intensive (DTI) / Day Rehabilitation (DR), has the pre-authorization for concurrent MHS been removed? If so, do we need to create a new mental health objective and MHS intervention on the client's treatment plan or will the DTI/DR objective and intervention suffice? Will the services then only be limited to telephone or telehealth or will in-person services also be available as needed?

During the COVID-19 crisis, LACDMH recognizes that some Day Treatment Intensive (DTI) or Day Rehabilitation (DR) programs may need to quickly switch over to providing telehealth/telephone outpatient Mental Health Services to clients currently approved for a DTI/DR program. For this reason, and based upon updated authorization requirements by the State Department of Health Care Services, LACDMH has removed the pre-authorization requirement for concurrent Mental Health Services for clients receiving DTI or DR services. As of March 23, 2020, providers will no longer need prior authorization to provide concurrent MHS to clients receiving DTI/DR services. The Intensive Care Division Authorization Unit has modified all current DTI/DR authorizations to allow for concurrent MHS.

Minimally, new MHS interventions must be added to the client's treatment plan because MHS are different than DTI/DR. The delivery of MHS can be done in-person, or through telephone/telehealth. If the DTI/DR program remains ongoing, then the MHS must be delivered outside of the hours of the DTI/DR program.

Medical Record Requests

25. For directly-operated providers, has there been any discussion on how to handle medical records requests? Can we send the records to clients based on their verbal authorization to release?

Verbal authorizations can be accepted. Providers executing these authorizations should document on the MH602 or MH603 that a "verbal authorization was accepted due to the COVID-19 crisis" and have staff scan the form into the client's chart.

Receiving Information from Clients

26. *Are directly-operated providers allowed to receive emails from clients and legal representatives with information that contains Personal Health Information (PHI) (e.g., report cards, IEPs)?* (Added 4/28/20)

Yes, providers are allowed to receive emails from clients and legal representatives that contain PHI. In order to ensure that the entire email communication is secure, providers can initiate the email by sending a secure email to the client and having the client reply back to the encrypted email. Ideally, DMH would like providers to do their due diligence to ensure that all email communication is adequately secured. DMH also acknowledges that during this crisis, it may not be a top priority for our clients. Should providers receive any unsecured emails from clients, providers should respond to these emails through secure email to ensure that the ongoing email trail is secure and protected.