



Telehealth Guidance for SUD Residential Treatment Services During the COVID-19 Outbreak

April 15, 2020

Introduction

On March 5, 2020, Governor Lawrence J. Hogan, Jr., declared a state of emergency due to disease (“COVID-19”) caused by the novel coronavirus. On April 1 Governor Hogan issued the first of several emergency orders expanding the provision of telehealth services by behavioral health providers, and on March 30 a stay at home order went into effect.

The Maryland Department of Health (MDH) recognizes the difficulties of the provider community to continue to provide services during this State of Emergency, especially the provision of residential substance use disorder (SUD) treatment.

Providers are expected to incorporate both a clinical and a public health approach to ensure individuals are able to access appropriate treatment and services while also addressing the individuals’ and staff’ health and safety and minimizing the transmission of the virus.

Resources for residential providers include:

National Council for Behavioral Health COVID-19 Guidance for Behavioral Health Residential Facilities:

https://www.thenationalcouncil.org/wp-content/uploads/2020/03/NCBH_COVID19_Guidance_for_BH_Facilities.pdf?dof=375ateTbd56

ASAM Recommendations for Infection Control in Residential Treatment Facilities:

<https://www.asam.org/Quality-Science/covid-19-coronavirus/infection-mitigation-in-residential-treatment-facilities>

To assist residential facilities to provide services in a safe manner, especially where social distancing is not possible, MDH has issued guidance to temporarily expand Medicaid telehealth

regulations to permit the home as an originating site.¹ Pursuant to the Governor’s Executive Order and in recognition of the fact that certain Medicaid and qualified (or eligible) uninsured Marylanders participants are still unable to access needed services, BHA is issuing the following guidance to relax certain requirements around the use of telephones to provide SUD.

Residential Treatment Services

While telehealth services are not normally permitted for Residential Treatment Programs, MDH is taking the following steps in order to ensure that participants continue to receive necessary services and that any measures taken can be integrated into existing business practices without causing further disruption during the COVID-19 crisis.

Because providers will not be able to meet in person with many participants, they should make every effort to use the following technology, in order of priority:

1. Traditional telehealth technology which meets all formal requirements is strongly preferred. (These services remain unaffected by the measures in this guidance).
2. If Medicaid participants are unable to access originating sites possessing fully qualified technology (ability to pan/focus camera, multiple views, etc.) this emergency policy will permit use of notebook computers, smartphones or audio-only phones. Apps used on televideo devices must be restricted to non-public facing products which cannot be shared to a larger audience, such as Zoom, Doxy, Skype, Whats App or other similar products. Public-facing apps such as Facebook Live, Tic-Toc, Snapchat etc., should not be used.
3. If service participants cannot access cellphone based video technology, audio-only telephone calls will be permitted. Group therapy may be by telephone if all the participants are residents of the same licensed site.

General Conditions

1. The measures outlined in this document are restricted to use during the emergency declared by Governor Hogan to deal with the threat of COVID-19 and will expire immediately at the end of the declared emergency, unless Executive Order No. 20-03-20-01 is rescinded or superseded, amended, or revised by additional orders such that the Secretary’s authority to issue this guidance no longer exists.
2. The measures address only those services delivered in SUD Residential Treatment

¹ COVID-19 #1: Temporary Expansion of Medicaid Regulations to Permit Delivery of Telehealth Services to the Home to Mitigate Possible Spread of Novel Coronavirus (“COVID-19”), https://phpa.health.maryland.gov/Documents/COVID-19.1_Telehealth%20Guidance_Neall.pdf.

Programs through Medical Assistance and the Public Behavioral Health System. This document does not address the eligibility of Medicare-funded or commercial services; clarification on whether these payers will allow for audio-only telephone services should be obtained directly from the payers in question.

3. Audio-only telephone services, or services using video applications that do not meet State regulations, may only be delivered **with the explicit informed consent of the participant**. Consent shall be obtained from the recipient's parent or guardian if such consent is legally required. Participants must be provided with a clear explanation of the telehealth or voice service and its confidentiality limitations, including the use of non-HIPAA compliant technology. Providers must ensure that this is documented in the Medicaid participant's medical record. Attention to ensuring that participants' confidentiality is protected in terms of private space, etc., must be a priority. The provider shall abide by all laws regarding a participant's rights and health information.
4. The provider shall verify the identity of the participant receiving services, and shall provide the provider's name and contact information.
5. SUD Residential Treatment Services provided telephonically are subject to the same program restrictions, preauthorizations, limitations and coverage that exist for the service when provided in-person.

Measures to be implemented:

1. Effective immediately, a licensed SUD Residential Treatment Program will be reimbursed for delivering services using various telehealth technologies.
2. Telehealth services will be considered directly equivalent to existing in-person services for the purpose of SUD Residential Treatment Program billing and compliance during this state of emergency. As with all other Medicaid reimbursed services, providers are required to document services fully:
 - (1) COMAR 10.09.59.03 includes the date of service with service start and end times;
 - (2) Includes the participant's primary behavioral health complaint or reason for the visit;
 - (3) Includes a brief description of the service provided, including progress notes;
 - (4) Includes an official e-Signature, or a legible signature, along with the printed or typed name of the individual providing care, with the appropriate title.
3. 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).
4. Providers must be willing to provide telephone records of services, if requested for an audit.
5. Providers should try to ensure that they have Business Agreements with any telehealth

provider involved.

6. Initial Assessments may be billed for services delivered by telehealth or televideo, but not by voice telephone.

Measures affecting all Residential Treatment Programs:

1. Organizations must consider discharging an individual who is less in need of the service it is providing, if the provider is confident that the individual is able to return to a living situation which enhances their ability to maintain physical distance and safety. If individuals can be served through IOP services or individual telehealth and stay at home this may help reduce disease exposure.
2. Staff who are able to work from home rather than in the facility should do so. Facilities are, however, obliged to ensure that a sufficient number of staff remain on-site to ensure proper oversight of the program, and to deliver services, such as withdrawal management, which require in-person involvement. Telehealth qualified staff (LCSW-C, LCPC, LMSW, LGPC, and addiction counselors) may deliver services into the facility, including group services through telehealth technology that meets the current HIPAA requirements.
3. On-site face to face groups shall be no larger than 10 and must provide at least six feet of spacing between participants. If space is not available, then group size must be reduced. Organizations are encouraged to use telehealth technology, even internally to a facility to enhance physical distancing.
4. All individuals, not just service participants, should be regarded as potentially infected, and everything possible should be done to maximize physical distancing. Visitors and guests should not be permitted in the residence. Testing is helpful, as is temperature taking, review of recent history, and alertness to symptoms such as loss of taste/smell. However, given the symptom-free incubation period of COVID-19, it is simply impossible to know at this juncture whether any individual is carrying the disease and liable to infect others.
5. If an individual is discovered, or seriously suspected, to be infected with COVID 19, it is critical to minimize exposure of other residents and staff to that individual. **The local health department must be contacted immediately for guidance.**
6. Staff who must work with an infected individual must take the most stringent available precautions. Some basic measures that should be considered are:
 - a. Isolate the area in which the individual is staying.
 - b. Isolate the bathroom that the individual is using.
 - c. Maintain physical distance.
 - d. Use of PPE, if available.

- e. Ensuring that all areas in which the individual has been are disinfected.
 - f. Keeping the individual's laundry, utensils and dishes separated.
 - g. Consider the need to quarantine the whole facility, or portions thereof. (All measures should be implemented in consultation with the local health department).
7. Organizations may be forced to self-isolate, close admissions, or ultimately even suspend operations in the event of an outbreak. In this unfortunate situation, the organization must coordinate a proactive plan with both their Local Behavioral Health Authority/s and BHA Licensing (bha.regulations@maryland.gov). The plan must then be implemented as approved. Licensed providers are considered essential medical services and are required to ensure that proper referrals are made for individuals needing services. Failure to do this will be considered grounds for further action including disciplinary action from professional boards, and future denial of BHA licensure.
 8. For billing purposes, organizations may drop the resident to a lower ASAM level of service if necessary, if this does not endanger the individual concerned.

The Medicaid Program has agreed to the following minimum requirements:

For all the following levels of service, clinical services by appropriately licensed or certified staff, or peer support staff may be provided by telehealth (televideo).

Individual clinical sessions, including assessments and medication management, may be provided by telephonic services.

Group sessions may be provided by telephone, if all the participants are in the same licensed site.

Level 3.1 requirements

1. At minimum Level 3.1 must have 24-hour onsite coverage by at least one individual, including sufficient on-site staff to coordinate telehealth interventions by other staff, and ensure physical safety.
2. Clinical treatment services may be provided entirely by telehealth if provided by telehealth qualified staff (see COMAR 10.58.06.01) (see rules on individual vs. group services).
3. Therapeutic substance use disorder services for a minimum of three hours per week.
4. The Clinical Director, Program Director, Licensed or Certified Counselor and Peer Support Staff may perform responsibilities by telehealth, as clinically appropriate.
5. Overnight coverage requirements do not change.

Level 3.3 requirements

1. At minimum Level 3.1 must have 24-hour onsite coverage by at least one individual,

including sufficient on-site staff to coordinate telehealth interventions by other staff and ensure physical safety.

2. Clinical treatment services may be provided by telehealth if provided by telehealth qualified staff (see COMAR 10.58.06.01), Peer Support Services may be by telehealth (see rules on individual versus group services).
3. Provide therapeutic activities a minimum of 10 hours per week.
4. Overnight coverage requirements do not change.

Level 3.5 requirements

1. At minimum Level 3.5 must have 24-hour onsite coverage by at least one individual, including sufficient onsite staff to coordinate telehealth interventions by other staff and ensure physical safety.
2. Clinical treatment services may be provided by telehealth if provided by telehealth qualified staff (see COMAR 10.58.06.01).
3. Provide clinically managed substance use disorder treatment at least 28 hours per week.
4. Facility Director may perform responsibilities via telehealth as clinically and administratively appropriate.
5. Overnight coverage requirements do not change.

Level 3.7 requirements

1. The physician nurse practitioner, physician assistant, psychiatrist or psychiatric nurse requirements may be performed by telehealth or telephone as clinically appropriate
2. The requirements for a nurse onsite has not changed.
3. Facility Director may perform responsibilities via telehealth as clinically and administratively appropriate.
4. Provide clinically managed substance use disorder treatment at least 28 hours per week.
5. Overnight coverage requirements do not change.

Withdrawal Management

Withdrawal Management services, wherever they occur, must have clinical staff onsite.

Service Reimbursement

Telehealth and telephonic services may be implemented immediately.

Telehealth service claims should be submitted to the ASO as they are today but must use modifiers to denote that telehealth services were provided. If a service claim is for a monthly or daily rate in which multiple services of different types were offered, that claim shall have the "lowest" applicable modifier. (Face to face have no special modifier. Telehealth video have the GT modifier and telephone the UB modifier).

Service Authorizations

Services will be authorized using the regular Optum Maryland process for SUD Residential Treatment. No special authorization is needed for telephone services.

Providers must contact the behavioral health ASO with questions regarding prior authorization requirements for services rendered via audio-only telephone or telehealth.

No special authorization will be needed for providing services by telehealth or audio-only telephone.

Service Volume Monitoring

Providers may not use the telephone service option to expand services. Service volumes will be monitored, and outliers will be audited.

Providers must maintain documentation in the same manner as for an in-person visit or consultation, using either electronic or paper medical records, per the Health-General Article, §4-403, Annotated Code of Maryland. The provider should document the participant's consent to receive telehealth services in their medical record. Consent may be given verbally by the participant.

MDH may revoke a provider's telephonic telehealth privileges under this emergency authority at any time due to fraud and abuse issues. The provider will not be able to appeal this decision.

C. A residential, low-intensity level 3.1 provider shall:

- (1) Provide therapeutic services for a minimum of 5 hours per week;
- (2) Coordinate aftercare services through:
 - (a) Peer support; or
 - (b) A licensed provider;
- (3) At a minimum, maintain the following staff:
 - (a) A part-time program director on-site 20 hours per week;
 - (b) A clinical director serving the program 20 hours per week who:
 - (i) May also be the program director;
 - (ii) Is responsible for the supervision of the program's clinical services, counselors, peer support staff, and coordination of all care provided by outside programs; and
 - (iii) Is identified under COMAR 10.09.59.04 as an individual practitioner

provider or certified and approved by the Board of Professional Counselors and Therapists as a supervisor;

- (c) A licensed or certified counselor on-site 40 hours per week;
- (d) Peer support staff; and
- (e) At least one staff member on duty between 11 p.m. and 7 a.m. who is:
 - (i) Certified in cardiopulmonary resuscitation;
 - (ii) Certified in Narcan administration; and
 - (iii) Trained in crisis intervention.

D. A residential, medium intensity level 3.3 provider shall:

- (1) Have sufficient physician, physician assistant, or nurse practitioner services to:
 - (a) Provide initial diagnostic work-up;
 - (b) Provide identification of medical and surgical problems for referral; and
 - (c) Handle medical emergencies when necessary;
- (2) Provide therapeutic activities from 20 to 35 hours per week;
- (3) Coordinate aftercare services through:
 - (a) Peer support; or
 - (b) Licensed provider;
- (4) Have at least one staff member:
 - (a) Certified in cardiopulmonary resuscitation;
 - (b) Trained in crisis intervention; and
 - (c) On duty between 11 p.m. and 7 a.m.;
- (5) Have a part-time facility director on-site 20 hours per week; and
- (6) At a minimum, maintain the following staff:
 - (a) A physician, nurse practitioner, or physician assistant on-site 4 hours per week and 1 hour on call;
 - (b) A psychiatrist or psychiatric nurse practitioner available 3 hours per week;
 - (c) A registered nurse or licensed practical nurse on-site 40 hours per week; and
 - (d) An on-site multi-disciplinary team consisting of:

- (i) A clinical supervisor;
- (ii) A licensed mental health clinician;
- (iii) A certified counselor under direct supervision of a counselor approved by the Board of Professional Counselors and Therapists as a supervisor; and
- (iv) Peer support staff.

E. A residential, high intensity level 3.5 provider shall:

- (1) Have sufficient physician, physician assistant, or nurse practitioner services to:
 - (a) Provide initial diagnostic work-up;
 - (b) Provide identification of medical and surgical problems for referral; and
 - (c) Handle medical emergencies when necessary;
- (2) Provide a minimum of 36 hours of therapeutic activities per week;
- (3) Coordinate aftercare services through:
 - (a) Peer support; or
 - (b) A licensed provider;
- (4) Have at least one staff member:
 - (a) Certified in cardiopulmonary resuscitation;
 - (b) Trained in crisis intervention; and
 - (c) On duty between 11 p.m. and 7 a.m.;
- (5) Have a part-time facility director on-site 20 hours per week; and
- (6) At a minimum, have the following staff:
 - (a) A physician, nurse practitioner, or physician assistant on-site 1 hour per week;
 - (b) A psychiatrist or psychiatric nurse practitioner available 1 hour per week;
 - (c) An on-site multi-disciplinary team consisting of:
 - (i) A clinical supervisor;
 - (ii) A licensed mental health clinician;
 - (iii) Certified counselors under direct supervision of a counselor approved by the Board of Professional Counselors and Therapists as a supervisor;

and

(iv) Peer support staff.

F. A residential, intensive level 3.7 provider shall:

- (1) Have sufficient physician, physician assistant, or nurse practitioner services to:
 - (a) Provide initial diagnostic work-up;
 - (b) Provide identification of medical and surgical problems for referral; and
 - (c) Handle medical emergencies when necessary;
- (2) Provide a minimum of 36 hours of therapeutic activities per week;
- (3) Coordinate aftercare services through:
 - (a) Peer support; or
 - (b) Licensed provider;
- (4) Have at least two staff members:
 - (a) Certified in cardiopulmonary resuscitation;
 - (b) Trained in crisis management; and
 - (c) On duty between 11 p.m. and 7 a.m.;
- (5) Have a part-time facility director on-site 20 hours per week; and
- (6) At a minimum, have on staff a:
 - (a) Physician, nurse practitioner, or physician assistant on-site 5 hours per week and 2 hours on call;
 - (b) Psychiatrist or psychiatric nurse practitioner available 10 hours per week;
 - (c) Nurse on-site 168 hours per week, with a minimum of 56 hours provided by a registered nurse;
 - (d) On-site multi-disciplinary team consisting of:
 - (i) A clinical supervisor;
 - (ii) A licensed mental health clinician;
 - (iii) Certified counselors under direct supervision of a counselor approved by the Board of Professional Counselors and Therapists as a supervisor; and
 - (iv) Peer support staff.

G. A withdrawal management service level 3.7-WM provider shall:

- (1) Have a part-time facility director on-site 20 hours per week;
- (2) Coordinate aftercare services through:
 - (a) Peer support; or
 - (b) Licensed provider; and
- (3) At a minimum, have on staff:
 - (a) A physician, nurse practitioner, or physician assistant on-site 20 hours per week and 4 hours on call;
 - (b) A psychiatrist or psychiatric nurse practitioner available 8 hours per week;
 - (c) A registered nurse on-site 56 hours per week;
 - (d) A licensed practical nurse on-site 112 hours per week; and
 - (e) An on-site multi-disciplinary team consisting of:
 - (i) A clinical supervisor;
 - (ii) A licensed mental health clinician;
 - (iii) Certified counselors under direct supervision of a counselor approved by the Board of Professional Counselors and Therapists as a supervisor; and
 - (iv) Peer support staff.