Maryland
DEPARTMENT OF HEALTH

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

Updated April 3, 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.

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.

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 loosened the rules regarding telehealth and telephonic services so that many 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, Tic-Toc, and Snapchat, which can easily be shared to a broader audience. Specific guidance is available on the HHS website.

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 the standards for the use of telehealth be relaxed during the COVID-19 crisis to allow the use of telehealth via smartphone so long as the transmission is secure and HIPAA compliant?

The standards have been relaxed for providing telehealth services. However, if providing a group service, the transmission must be HIPAA compliant.

As the federal authorities have relaxed the rules regarding HIPAA compliant technology, the BHA and Medicaid program have also relaxed the rules. BHA recommends that providers follow the guidance in the HHS memo referenced above.

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 not able to bill for services provided by telehealth.

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?

BHA is working with Medicaid to determine if a provider with an IOP authorization can bill an OP service without changing authorization.

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.

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

No. Group services must be done using video telehealth technology.

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

At this time, BHA has no further guidance on this matter. Please defer to the Boards and Commissions for guidance on ADTs.

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.

UPDATED 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. If the behavioral health services provided are a group service, they must be performed using video-based telehealth. Initial evaluations of new OTP patients prescribed methadone still require an in-person evaluation.

Medical healthcare practitioners may not use telehealth or audio-only telephone services to prescribe opioids for the treatment of pain.

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 Behavioral Health Authority. 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 & 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.

UPDATED 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 perform clinical evaluations, 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 with client is regarded in the same light as a group service. It will require the use of a video telehealth technology, not telephone.

If we are doing phone 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.

NEW 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 an /s 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.

NEW 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.

NEW 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.

NEW 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).

NEW 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.

NEW 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.

NEW 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.

NEW 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.

NEW 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.

NEW 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.

NEW 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.