

## Behavioral Health Services – Updated 11/2/2020

This document answers frequently asked questions (FAQs) specifically related to the Agency's guidance on the flexibilities available to providers to address the current Public Health Emergency (PHE) due to the COVID-19 virus. This FAQ is an update to the guidance posted in April 2020 and reflects current COVID-19 flexibilities. Guidance contained in this FAQ is summarized in the Federal and State Authorities for COVID-19 Public Health Emergencies and Update for Behavioral Health and Addiction and Recovery Treatment Services Policy Continuation and Timelines memo dated 9/30/2020 available on the DMAS website under COVID-19 Policy Updates available at <http://dmas.virginia.gov/#/emergencywaiver>.

These FAQs focus on changes for the Behavioral Health benefit. For General FAQs related to the Agency's response to COVID-19 please visit: <http://www.dmas.virginia.gov/#/emergencywaiver>

### General Questions

#### *How long will the flexibilities last?*

Most flexibilities that DMAS has implemented depend on both state and federal authorities. At the federal level, the Public Health Emergency (PHE) is being extended in 90 day increments. The current Federal PHE is set to expire on January 20, 2021 unless it is renewed. Information on the Federal PHE is located at: <https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx>

At the state level, [Virginia Executive Orders](#) (EO) 51 and 58 provide corresponding policy flexibilities associated with the state PHE declaration, which currently do not have an expiration date.

DMAS is required to unwind the flexibilities obtained when either the federal or the state PHE declarations expire. At such time that these and other flexibilities and allowances cease, providers will be notified through a DMAS Medicaid Memo noting the effective dates of those actions. DMAS will issue a memo at least 30 days in advance of these changes to allow providers to adequately prepare their process and systems.

#### *Which services do the flexibilities cover?*

DMAS is not requiring face-to-face delivery of Behavioral Health and ARTS services during the COVID-19 PHE; DMAS is allowing for telehealth (including telephonic) delivery of all Behavioral Health and ARTS services with several exceptions; these are differentiated below.

Allowable services via telehealth and telephonic delivery:

- Care coordination and case management (including Mental Health Case Management and Therapeutic Foster Care Case Management);
- Peer Recovery Support Services;
- All service needs assessments (including the Comprehensive Needs Assessment (CNA), the Independent Assessment Certification, and Coordination Team (IACCT) assessment and the American Society of Addiction Medicine (ASAM) Multidimensional Assessment) and all treatment planning activities;

- Outpatient psychiatric services (this includes both medication management and psychotherapy services);
- Community Mental Health and Rehabilitation Services (CMHRS); and
- Addiction Recovery Treatment Services (ARTS) - see ARTS FAQ for addition information.

The applicable per diem or diagnostic related groups (DRG) rates for therapeutic group homes, psychiatric residential treatment facilities, and inpatient psychiatric hospitalizations will not be billable through telehealth. The professional activities within these services including assessments, therapies (individual, group, and family), care coordination, team meetings, and treatment planning are allowable via telehealth.

### ***Can we continue to use home as the originating site?***

DMAS is allowing a member's home to serve as the originating site for members. This is particularly important for those who are quarantined, are diagnosed with and/or demonstrating symptoms of COVID-19, and/or are at high risk of serious illness from COVID-19. Clinicians shall use clinical judgment when determining the appropriate use of home as the originating site. The originating site fee is not available for reimbursement when the patient's home is the originating site.

### ***Should we start using the telehealth modifiers?***

Providers delivering services via telehealth, including telephonic (audio only) communications, shall bill and submit a claim as they normally would in their regular practice. Claims for services available through telehealth prior to the PHE can be submitted with the proper telehealth modifiers. See the DMAS memo, "Updates to Telemedicine Coverage" dated May 13, 2014 for more information. DMAS memos are available at <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/>

DMAS will issue a memo on specific billing policies for telehealth delivery at a future date.

### ***Are we required to provide services through telehealth? What about groups?***

Unless noted elsewhere, services may be provided through telehealth, face-to-face or a combination of both depending on the individual's needs and as outlined in the Individual Service Plan (ISP). Service Specific face-to-face requirements outlined in DMAS provider manuals may be delivered through telehealth unless otherwise noted.

Effective 7/1/2020, DMAS resumed reimbursement for face-to-face delivery of group-based services. DMAS advises that providers carefully weigh the vulnerabilities and benefits of resuming face-to-face group services. Group-based providers are reminded that they retain, until further notice, the ability to offer services individually or through individual or group telehealth or telephonic contact. Providers are encouraged to prioritize the health and safety of members and their staff and to consider member preferences, engagement and optimal access to care.

Providers who elect to provide face-to-face services should integrate guidance provided through the Centers for Disease Control and Prevention, the Virginia Department of Health, and any relevant licensing bodies. For

initial and continued stay reviews, a service authorization request shall be completed for those services that require a prior authorization to verify medical necessity and appropriateness of the service delivery model.

### ***Have documentation requirements changed?***

All documentation requirements remain the same with the exception of signatures (see next question). The method of service delivery must be documented in the individual's record and included in the treatment plan appropriate for the service (including interdisciplinary plans of care (IPOCs) and ISPs)). The method of service delivery must also be included in any new or subsequent service authorization requests.

### ***What are the allowances for obtaining signatures during the PHE?***

Where signatures are required, providers may note that verbal consent was obtained. Providers should make reasonable attempts to obtain appropriate physical signatures within 45 days after the end of the PHE. Providers do not need to attempt to obtain physical signatures for individuals who have been discharged prior to the end of the PHE.

In regards to obtaining clinician signatures on relevant documentation, each provider shall make reasonable attempts to obtain signatures from the clinicians or document receiving the clinician's verbal consent or sign-off, with the name of the clinician and the date of receipt. If the clinician is unable to sign-off on documentation, the clinician shall maintain documentation of verbal consent or sign-off in their files.

Provider and member electronic, including telephonically recorded, signatures are acceptable during the PHE. Providers need to ensure that the person "signing" is the intended individual, an authorized or someone acting responsibly for the individual.

### ***Are there any allowances for provider qualifications?***

Provider qualifications, licensure requirements, and the structure of the services remain the same. Agency/facility employees must be appropriately supervised as described in the DMAS manual appropriate for the service and Department of Health Professions (DHP) and DBHDS guidelines.

Earlier in the PHE, DHP allowed for temporary licensure by endorsement of behavioral health clinicians whose licenses are issued by another state. Such temporary licenses expired on September 8, 2020. Practitioners who obtained these temporary licenses will not meet DMAS requirements for reimbursement effective September 9, 2020 unless they obtain a full Virginia license.

### ***Are there any allowances for service authorizations?***

A 14-day grace period will be granted for the submission of Behavioral Health Authorizations within CMHRS Services, Outpatient Psychiatric Services, Residential Treatment Services and Inpatient Psychiatric Services:

- Medicaid managed care organizations (MCOs) and Magellan of Virginia will allow up to 14 days after the start of a new behavioral health service or after the expiration of an existing authorization for a service authorization request to be submitted from the provider to the MCO or Magellan of Virginia.
- This grace period does not waive medical necessity requirements for the services or other requirements currently set forth in policies for submissions of service authorization requests.

- This grace period does not guarantee payment.

## **Service Specific Questions – Behavioral Health**

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***Can you explain the first unit billing allowance for Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health Skill-Building Services (MHSS), Intensive Community Treatment (ICT) and Psychosocial Rehabilitation (PSR)?***

During the PHE, TDT, IIH, MHSS, ICT and PSR providers may bill for one unit on days when a billable service is provided, even if time spent in billable activities does not reach the time requirements to bill a service unit. This allowance only applies to the first service unit and does not apply to additional time spent in billable activities after the time requirements for the first service unit is reached. Providers shall bill for a maximum of one unit per day if any of the following apply:

- The provider is only providing services through telephonic communications. If only providing services through telephonic communications, the provider shall bill a maximum of one unit per member per day, regardless of the amount of time of the phone call(s).
- The provider is delivering services through telephonic communications, telehealth or face-to-face and does not reach a full unit of time spent in billable activities.
- The provider is delivering services through any combination of telephonic communications, telehealth and in-person services and does not reach a full unit of time spent in billable activities.

***Is there a minimum duration to bill?***

There is no minimum duration to bill but a billable service must be provided. For example, attempts for telehealth or telephonic contacts that were unsuccessful would not support a billable service.

***Do we need to discharge individuals if we are unable to provide services for 30 days?***

Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue. Requirements for the Comprehensive Needs Assessments, however, have not changed. If there is a lapse in services of more than 31 days, the provider will need to update or complete a new Comprehensive Needs Assessment. See Chapter IV of the CMHRS Manual for additional details.

## **Behavioral Therapy**

***Are Behavioral Therapy providers included in the maximum one unit for telephonic communication?***

DMAS removed the one unit daily limit for telephonic only services for Behavioral Therapy providers. Effective June 11, 2020, Behavioral Therapy providers do not have a one unit max limit per day for audio only communications.

*For Behavioral Therapy Services, we are having trouble obtaining the required recommendation from the child's MD, can this requirement be waived during this time period?*

For Behavioral Therapy services, a physician letter, referral, or determination is not required for submission of a prior authorization during this time. The MCO shall review the request and make a determination without the physician referral. The physician referral, letter or determination shall be completed within at least 60 days of the start of the service.

The BHSA/MCO may request an updated order or letter of recommendation from the child's primary care provider or a physician, nurse practitioner or physician assistant familiar with the child's current status if necessary to complete a continuation of service request.

**Intensive In-Home (IIH)**

**Example of billing with one unit allowance**

<b>Delivery method - IIH</b>	<b>Time spent in billable activities is less than one hour per day</b>	<b>Time spent in billable activities is more than one hour per day</b>
<p><b>Audio only</b></p> <p>This includes when providers make multiple phone calls at different times of day, including phone calls to collateral contacts.</p>	One unit	One unit
<ul style="list-style-type: none"> <li>• <b>In person; or</b></li> <li>• <b>Telehealth using a platform with both audio and visual components; or</b></li> <li>• <b>Any combination of audio only, in person and telehealth with both audio and visual components.</b></li> </ul>	One unit	Bill as normal

**Therapeutic Day Treatment**

*What is allowed as acceptable billing hours for students who receive Therapeutic Day Treatment services while schools are closed or virtual?*

TDT may be provided through telehealth or in person during various parts of the day. Services may be provided individually or through groups. Individual therapy sessions conducted by a licensed mental health professional or a resident/ supervisee are allowed to be done via telehealth or in person.

*What if the youth receives both TDT and IIH?*

If the youth is receiving both TDT and IIH services, these services shall not be duplicated and care should be coordinated between the providers. If the IIH provider is providing services in person in the home, the TDT

provider may provide telehealth services to the individual or in person services at school or provider location.

**Example of billing with one unit allowance**

<b>Delivery method - TDT</b>	<b>Total time spent in billable activities is less than one unit (less than three hours) per day</b>	<b>Total time spent in billable activities is between 3 and 4.99 hours per day</b>	<b>Total time spent in billable activities is 5 or more hours per day</b>
<b>Audio only</b>  This includes when providers make multiple phone calls at different times of day, including phone calls to collateral contacts.	One unit	One unit	One unit
<ul style="list-style-type: none"> <li>• <b>In person; or</b></li> <li>• <b>Telehealth using a platform with both audio and visual components; or</b></li> <li>• <b>Any combination of audio only, in person and telehealth with both audio and visual components.</b></li> </ul>	One unit	Two units	Three units

**Mental Health Skill-Building Services**

**Example of billing with one unit allowance**

<b>Delivery method - MHSS</b>	<b>Time spent in billable activities is less than one hour per day</b>	<b>Time spent in billable activities is more than one hour per day</b>
<b>Audio only</b>  This includes when providers make multiple phone calls at different times of day, including phone calls to collateral contacts.	One unit	One unit
<ul style="list-style-type: none"> <li>• <b>In person; or</b></li> <li>• <b>Telehealth using a platform with both audio and visual components; or</b></li> <li>• <b>Any combination of audio only, in person and telehealth with both audio and visual components.</b></li> </ul>	One unit	Bill as normal

**Psychosocial Rehabilitation (PSR)**

***Can I provide PSR to a group of individuals in person at our provider location or in an Assisted Living Facility (ALF) to members living in an ALF?***

DMAS removed restrictions related to in person groups effective 7/1/20. Providers who elect to provide face-to-face services should integrate guidance provided through the Centers for Disease Control and Prevention, the Virginia Department of Health, and any relevant licensing bodies.

**Example of billing with one unit allowance**

<b>Delivery method - PSR</b>	<b>Total time spent in billable activities is less than one unit (less than four hours) per day</b>	<b>Total time spent in billable activities is between 4 and 6.99 hours per day</b>	<b>Total time spent in billable activities is 7 or more hours.</b>
<p><b>Audio only</b></p> <p>This includes when providers make multiple phone calls at different times of day, including phone calls to collateral contacts.</p>	One unit	One unit	One unit
<ul style="list-style-type: none"> <li>• <b>In person; or</b></li> <li>• <b>Telehealth using a platform with both audio and visual components; or</b></li> <li>• <b>Any combination of audio only, in person and telehealth with both audio and visual components.</b></li> </ul>	One unit	Two units	Three units

**Crisis Services**

***Does the one unit daily limit for telephonic only communications apply to Crisis Services?***

Crisis stabilization/intervention services do not have a one unit max limit per day for audio only communications.

***Can providers use telehealth to provide crisis services?***

The appropriateness of a crisis response using telehealth (including telephonic) shall be evaluated by the clinician and a determination shall be made by the clinician responding to the crisis.

Any therapeutic interventions to include, but not limited to, therapy/counseling, assessments, care coordination, team meetings, and treatment planning can occur via telehealth.

DMAS encourages providers to use telehealth platforms with both audio and video capabilities if using telehealth is appropriate for the crisis response.

## **Outpatient Psychiatric Services**

***Can the physician visit requirement for Physician Directed clinic services for new therapy clients be suspended and the client immediately enter therapy?***

The physician requirements for Physician Directed Mental Health Clinic Services remains the same. The Physician may conduct any necessary assessment through telehealth or telephonic communications. See the Psychiatric Services Manual for additional information.

***May groups occur through telehealth where participants are each in their home/individual locations?***

Yes, groups may occur when individuals are able to participate through audio only or through a platform with both audio and visual components.

***What are the limits for the number of outpatient sessions a week?***

There are no limits to outpatient therapy services that can be given in a week but they must be clinically appropriate.

***When billing for outpatient therapy, should the individual code be billed when service is provided in a virtual group setting?***

The group therapy code should be billed when providing group therapy services in a virtual group session.

***If running a virtual group, is it still required to limit group size to no more than ten?***

DMAS has not changed the group size limit to be more than 10. However, prior to the state of emergency, policy has supported special situations where there may be a few more attendees, the goal is to not turn members away from treatment. DMAS recommends scheduling multiple group sessions to meet the needs for larger patient populations.

***How should I bill for individuals who have Medicare primary?***

Providers must first bill Medicare as they normally would. If the member has both Medicare and Medicaid, providers shall continue to follow Medicare and CMS rules for behavioral health services that are covered by Medicare and if a provider type is not recognized by Medicare, Medicaid becomes primary and the provider may follow Medicaid guidelines for behavioral health services.

CMS has also expanded the outpatient psychiatric CPT codes that are allowed to be billed for Medicare recipients through telehealth during the Public Health Emergency. More information on Medicare billing during the Public Health Emergency is available at: <https://www.cms.gov/files/document/covid-dear-clinician-letter.pdf>.

CMS announced on 4/30/2020 that Medicare will cover audio only behavioral health counseling services retroactive to 3/1/2020. Additional information including a link to covered codes is located at <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.

In addition, Medicare covers Telephone Service codes for assessment and management services:

- Codes \*99441, \*99442 and \*99443 are used by M.D.s, D.O.s, nurse practitioners and physician assistants who deliver evaluation and management services.

These Medicare telephone codes currently do not have a Virginia Medicaid rate, but they can be reimbursed by Medicare when submitted by the appropriate Medicare provider type and any crossover claims for deductibles and copays can be covered by Medicaid.

## **Facility Questions**

### ***Can an out-of-network provider complete the IACCT?***

During the PHE, IACCT Assessments may be completed by out-of-network providers, but these individuals must be an independent evaluator separate from the residential facility. IACCT Assessments completed by an out-of-network provider must be coordinated with Magellan of Virginia.

### ***Which service components can be provided via telehealth?***

Therapy, assessments, case management, team meetings, and treatment planning may occur via telehealth or telephonic consults. The plan of care should be updated to include any change in service delivery as well as any change in goals, objectives, and strategies, including impacts on the individual due to COVID-19.

### ***During the PHE, do Psychiatric Residential Treatment Facilities (PRTF) and Therapeutic Group Homes (TGH) still need to discharge a member if they have an acute or inpatient medical treatment stay of more than 7 days for TGH and more than 10 days for PRTF?***

If an individual currently in a PRTF or TGH requires acute or inpatient medical treatment (non-psychiatric) for more than 7 days for a PRTF and 10 days for a TGH, the authorization will NOT be ended and the individual does not have to be discharged from the PRTF or TGH. For any subsequent admission to a PRTF or TGH, the previous admission shall be extended. The provider shall not bill for the time where the individual is admitted into acute care.

### ***Are staff in an Assisted Living Facility (ALF), PRTF or TGH allowed to host group sessions?***

Appropriately credentialed staff hired by and are part of a home (i.e. ALF, PRTF, and/or Group Home) are allowed to host groups practicing CDC guidelines for social-distancing. For example, ALF providers who are also PSR providers may provide PSR to a group of individuals living in the facility as long as they are following Virginia Department of Social Services (VDSS) social distancing guidelines for ALFs and any guidance for groups issued by DBHDS. Staff entering facilities should be screened as appropriate and shall wear personal protective equipment (PPE).

### ***What happens if a member cannot be discharged from a residential setting due to COVID-19 or quarantine?***

DMAS recognizes there may be situations where a member is unable to discharge from the following levels of care related to COVID-19: Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), Early and Periodic Screening, Diagnosis and Treatment (EPSDT) PRTF or TGH, or Inpatient Psychiatric. Providers who are requesting service authorization for members who are unable to discharge due to barriers related to COVID-19, are asked to answer the following questions when requesting an authorization. Please submit an additional page with the information when submitting the request online or be prepared to answer the questions during phone reviews.

- What are the barriers to discharge related to COVID-19?
- Please describe attempts to overcome these barriers since the last Service Request Authorization was submitted.
- What are the restrictions and/or limitations for step-down to the identified discharge disposition?
- What aftercare services are available in their community during this pandemic?
- What agencies has this individual been referred to?
- How will the treatment plan and goals be adjusted to sustain current progress and prevent regression?

Answering all these questions when requesting authorization will expedite the review process. The answers to these questions are required each time you are requesting a continued stay for a member who has not discharged due to barriers related to COVID-19.

### ***Is there additional guidance available for TGHs and PRTFs?***

- Providers should refer to guidance from the CDC regarding best practices for facilities.
- DMAS worked with DBHDS to create recommendations for children in congregate care. This guidance is located at [http://www.dbhds.virginia.gov/assets/doc/EI/rcp\\_multi-department-letter-children-congregate-care-4.24.20.pdf](http://www.dbhds.virginia.gov/assets/doc/EI/rcp_multi-department-letter-children-congregate-care-4.24.20.pdf)
- If members are in need of quarantine because they are ill, the provider should coordinate their efforts with their department of health. More information can also be found on the Virginia Department of Health (VDH) webpage, <https://www.vdh.virginia.gov/>.
- If individuals are in need of quarantine and hospitals are attempting to step them down to a psychiatric unit or facility, DMAS would encourage providers and clinicians to evaluate the appropriateness of this transfer or step down. Service authorization requirements and medical necessity criteria will have to be met for admission into this level of care.
- Providers shall notify Magellan of Virginia and the MCO of any members or staff that have tested positive for COVID-19 within one business day.