

Behavioral Health Service Provision

Telemedicine and Telehealth

Facilitator:

Jennifer Hunt-Manchester

Presenters:

Melissa Sperbeck

Monica Johnson

Wendy Tiegreen

Lynn Copeland

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This document provides guidance related to service adjustments made during the COVID-19 crisis.

Telemedicine is the use of medical information exchanged from one secured site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient and the practitioner at the distant site. In response to COVID-19, Federal and State authorities are referencing the term “telehealth” which is a broad definition which encompasses phone, text, email, monitoring, and other modalities of interaction as being enabled. Very specifically, DBHDD and DCH are enabling telephonic interventions for services and all references herein qualify that process.

Telemedicine and Telephonic Allowances:

On March 14, 2020 the following allowance was provided to the field related to telemedicine:

Currently, the DBHDD Behavioral Health Provider Manual has this clause associated with several services:

To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language (one-to-one via Telemedicine versus use of interpreters). Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language.

For the specific services which have this clause, through April 30, 2020, DBHDD will waive the Service Accessibility requirement to allow for individuals to access services via Telemedicine. All other service requirements must be met (practitioner requirements, documentation, consent, adherence to IRP content, etc.), especially content defined in Part II, Section I, 1.B.16.a-c.

DBHDD will also allow Part II, Section I, 1.B.16.d. to be expanded as a part of the waiver above, allowing i. and ii. below to apply to the Telemedicine allowances defined in this guidance through April 30, 2020. Providers can apply the language in green to clearly interpret the allowance as it will be defined during this waiver period:

To promote access, providers who are using Telemedicine 1) as a tool to provide direct interventions to individuals for whom English is not their first language (one-to-one versus through use of interpreters) or 2) for the waiver period associated with COVID-19 prevention measures are exempt from:

- i. The required percent of community-based services ratios defined in the Service Definitions herein; and*
- ii. The required minimum face-to-face expectations (allowing face-to-face to be via telemedicine).*

Update as of March 19, 2020:

With a series of guidance from our federal partners in the past two days and with the DCH Banner Message dated March 17, 2020, DBHDD is able to revise the notice provided to the field on March 14, 2020 and to provide an expansion in the use of the telephone as a tool for the direct provision of service (including modes such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype as implemented and described herein: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>).

All Medicaid providers should review the DCH Banner Message posted on the MMIS website. DBHDD offers the below information related to the allowance and impact on DBHDD behavioral health services. The following excerpt from the Banner message provides the rationale for the allowances and requirements noted below.

*The codes that will be billed must be identified as “telehealth services” by utilizing a telehealth **Place of Service (POS)** code or a **telehealth modifier (e.g., GT)**.*

Services listed in Table A have a “GT” modifier code available. Therefore, these services may be provided with via telemedicine and telephonic methods The GT modifier must be used to denote either service modality.

TABLE A

Addictive Disease Services and Support	Intensive Case Management
Addictive Diseases Peer Support - IND	Intensive Family Intervention
Assertive Community Treatment*	Mental Health Peer Support - IND
Behavioral Health Assessment	Nursing Assessment and Health*
Case Management	Parent Peer Support - IND
Community Support Team*	Peer Whole Health and Wellness- IND
Crisis Intervention	Psychiatric Treatment
Community Support	Psychological Testing
Diagnostic Assessment	Psychosocial Rehab - IND
Family Counseling	Service Plan Development
Family Training	Treatment Court Services - Adult Addictive Diseases
Individual Counseling	Youth Peer Support - IND
*indicates a service-specific requirement related to telemedicine and telehealth, noted in Table C	

There are other services that are allowable via telemedicine or telephonic methods noted in Table B. However, these services do not have a GT modifier (in the Provider Manual or IT system). In order to be in compliance with Medicaid requirement noted above, providers must submit the Place of Service (POS) code “02” on **Medicaid claims** to denote the methodology.

At this time, 02 Place of Service code 02 is not activated for DBHDD state-funded claims. Therefore, **state-funded service claims** may be submitted without the Place of Service (POS) code “02”.

Table B

Assertive Community Treatment*	Psychosocial Rehabilitation – Group (no more than 6 participants)
High Utilizer Management	Peer Support Whole Health & Wellness -Group (no more than 6 participants)
Intensive Customized Care Coordination	Group Training (no more than 6 participants)
Supported Employment	Group Counseling (no more than 6 participants)
Task-Oriented Rehabilitation Services	SA Intensive Outpatient Program (no more than 6 participants)
Treatment Court Services - Adult AD	Mental Health Peer Support (no more than 6 participants)
WTRS Outpatient Services (in accordance with unbundled services named)	Parent Peer Support - Group (no more than 6 participants)
	Youth Peer Support – Group (no more than 6 participants)
	AD Peer Support Program (no more than 6 participants)
*indicates a service-specific requirement related to telemedicine and telehealth, noted in Table C	

When the telephone or telemedicine is used for the provision of one of these services, the note shall document the use of that modality.

Telemedicine and services provided via telephone must meet requirements noted in the Provider Manual. However, for this time period, DBHDD will allow documentation of verbal consent for telemedicine and telephonic services.

Please note that, for DBHDD services, originating sites may include traditional locations as well as homes, schools, and other community-based settings (see DCH *Telehealth Guidance*, page 19. This guidance is located on the GAMMIS website. Providers may locate the *Telehealth Guidance* manual by accessing the following link: www.mmis.georgia.gov. Select the “Provider Information” tab, then select “Provider Manuals.” Scroll down to the locate the *Telehealth/Telemedicine* manual).

For consistency, the provisions below applicable to state funded services mirror DCH requirements noted in their bulletin:

Expansion of the use of telehealth will be supported in the following manner:

1. Allowing telehealth services to be provided during the period of COVID-19 emergency response by the following modalities:
 - a. Telephone communication
 - b. Use of webcam or other audio and video technology
 - c. Video cell phone communication
2. All services must be deemed medically necessary
3. Qualified healthcare providers must continue to comply with state telehealth laws and regulations, including professional licensure, scope of practice, standards of care, patient consent and other payment requirements for Medicaid members.

In addition to the telemedicine allowances noted above, for effective now until April 30, 2020, the following service requirements will be adjusted as noted in Table 3

TABLE C

March 19 updates are in red font.

Service	Existing DBHDD Provider Manual Requirement	Waiver through April 30, 2020
ADSS	1. The agency providing this service must be a Tier 1 or Tier 2 provider, an Intensive Outpatient Program (IOP) specialty provider, or a WTRS provider. Contact must be made with the individual receiving ADSS services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact depending on the individual's support needs and documented preferences.	1. The agency providing this service must be a Tier 1 or Tier 2 provider, an Intensive Outpatient Program (IOP) specialty provider, or a WTRS provider. Contact must be made with the individual receiving ADSS services a minimum of twice each month.
	2. At least 50% of ADSS service units must be delivered face-to-face with the identified individual receiving the service. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month.	2. Waived completely
Assertive Community Treatment	6. At least 80% of all service units must involve face-to-face contact with individuals. Eighty percent (80%) or more of face-to-face service units must be provided outside of program offices in locations that are comfortable and convenient for individuals (including the individual's home,	6. Waived completely

	based on individual need and preference and clinical appropriateness).	
	7. During the course of ACT service delivery, the ACT Team will provide the intensity and frequency of service needed for each individual. ACT teams are expected to achieve fidelity with the DACTS Model. To achieve a score of "4" in the Frequency of Contact Measure within DACTS, ACT Teams must provide a median of 3-3.99 face-to-face contacts per week across a sample of agency's ACT individuals. This measure is calculated by determining the median of the average weekly face-to-face contacts of each individual in the sample. At least one of these monthly contacts must include symptom assessment/management and management of medications.	7. During the course of ACT service delivery, the ACT Team will provide the intensity and frequency of service needed for each individual. ACT Teams must provide a median of 3-3.99 contacts per week across a sample of agency's ACT individuals. This measure is calculated by determining the median of the average weekly contacts of each individual in the sample. At least one of these monthly contacts must include symptom assessment/management and management of medications.
	8. During discharge transition, the number of face-to-face visits per week will be determined based on the person's mental health acuity with the expectation that these individuals participating in ACT transitioning must receive a minimum of 4 face-to-face contacts per month during the documented active transition period.	8. During discharge transition, the number of contacts per week will be determined based on the person's mental health acuity with the expectation that these individuals participating in ACT transitioning must receive a minimum of 4 contacts per month during the documented active transition period.
	14. It is expected that 90% or more of the individuals have face to face contact with more than one staff member in a 2-week period."	14. It is expected that 90% or more of the individuals have contact with more than one staff member in a 2-week period."
	<p>Special Conditions:</p> <ol style="list-style-type: none"> 1) In order to utilize any telephonic direct intervention, at least to one face-to-face intervention between the ACT team and the individual must occur per week. 2) If there is any observation of decline in a person's state of wellness/recovery, the ACT team shall deploy to prevent the potential destabilization of that individual. 3) The GT Modifier is only available for U1 and U2 Practitioners; providers should bill using this modifier for these practitioner types. For other practitioner levels, POS 02 must be used for Medicaid claims. 4) The multi-disciplinary team may be held through telemedicine or telephonic technology. 	

Case Management	6. Contact must be made with the individual receiving CM a minimum of two (2) times a month. At least one of the monthly contacts must be face-to-face in non-clinic/community-based setting and the other may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the individual's identified support needs. While the minimum number of contacts is stated above, individual clinical need is always to be met and may require a level of service higher than the established minimum criteria for contact.	6. Contact must be made with the individual receiving CM a minimum of two (2) times a month. When the telephone modality is used, it is denoted by the UK modifier. While the minimum number of contacts is stated above, individual clinical/support needs are always to be met and may require a level of service higher than the established minimum criteria for contact.
	7. At least 50% of CM service units must be delivered face-to-face with the identified individual receiving the service and the majority of all face-to-face service units must be delivered in non-clinic settings over the authorization period (these units are specific to single individual records and are not aggregate across an agency/program or multiple payers).	7. At least 50% of CM units must be provided directly to the individual (with the remaining contacts allowed for collateral contacts).
	8. The majority of all face-to-face service units must be delivered in non-clinic settings (i.e. any place that is convenient for the individual such as FQHC, place of employment, community space) over the course of the authorization period (these units are specific to single individual consume records and are not aggregate across an agency/program or multiple payers).	8. Waived completely.
	9. In the absence of meeting the minimum monthly face-to-face contact and if at least two (2) unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of one (1) telephone contact in that specified month (denoted by the UK modifier). Billing for collateral contact only may not exceed 30 consecutive days.	9. Waived completely.
	10. After four (4) unsuccessful attempts at making face to face contact with an individual, the CM and members of the treatment team will re-evaluate the IRP and utilization of services.	10. After four (4) unsuccessful attempts at making contact with an individual, the CM and members of the treatment team will re-evaluate the IRP and utilization of services.
	13. When the primary focus of CM is on medication maintenance, the following allowances apply: a. These individuals are not counted in the off-site service requirement or the individual-to-staff ratio; and	13. Waived completely.

	b. These individuals are not counted in the monthly face-to-face contact requirement; however, a minimum of one (1) face-to-face contact is required every three (3) months; and monthly calls are an allowed billable service."	
Community Support Individual	<p>3. Contact must be made with youth receiving Community Support services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the youth's support needs and documented preferences of the family.</p> <p>5. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month (denoted by the UK modifier).</p>	<p>3. Contact must be made with youth receiving Community Support services a minimum of twice each month. Contacts must be face-to-face or via telephone contact (denoted by the UK modifier) depending on the youth's support needs.</p> <p>5. Waived completely</p>
Community Support Team	<p>3. At least 60% of all service units must involve face-to-face contact with individuals. The majority (51% or greater) of face-to-face service units must be provided outside of program offices in locations that are comfortable and convenient for individuals (including the individual's home, based on individual need and preference and clinical appropriateness).</p> <p>4. A minimum of four (4) face-to-face visits must be delivered monthly by the CST. Additional contacts above the monthly minimum may be either face-to-face or telephone collateral contact depending on the individual's support needs and keeping to the expected 60% of units being face-to-face.</p> <p>1. A CST shall have a minimum of 3.5 team members which must include: c. (.5 FTE) A half-time registered nurse (RN). This person will.... Nursing face-to-face time with each individual served by the team is determined based on the IRP, physician assessment, and is delivered at a frequency that is clinically and/or medically indicated."</p>	<p>3. Waived completely.</p> <p>4. A minimum of four (4) contacts must be delivered monthly by the CST. Additional contacts above the monthly minimum may be either face-to-face or telephone collateral contact depending on the individual's support needs.</p> <p>1. A CST shall have a minimum of 3.5 team members which must include: c. (.5 FTE) A half-time registered nurse (RN). This person will.... Nursing contacts with each individual served by the team is determined based on the IRP, physician assessment, and is delivered at a frequency that is clinically and/or medically indicated."</p>
<p>SPECIAL CONDITIONS: If there is any observation of decline in a person's state of wellness/recovery, the CST team shall deploy to prevent the potential destabilization of that individual.</p>		

Community Transition Planning	Community Transition Planning (CTP) is a service provided by Tier 1, Tier II and IFI providers to address the care, service, and support needs of youth to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual, family, or caregiver with a minimum of one (1) face-to-face contact with the individual prior to release from a facility.	Community Transition Planning (CTP) is a service provided by Tier 1, Tier II and IFI providers to address the care, service, and support needs of youth to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual, family, or caregiver prior to release from a facility.
Community Transition Peer Support	3. Service may be provided by phone (although 50% must be provided face to face, telephonic contacts are limited to 50%).	3. Service may be provided by phone
Psychological Testing	<p>Psychological testing consists of a face-to-face assessment of emotional functioning, personality, cognitive functioning (e.g. thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based....</p> <p>This service covers both the face-to-face administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report in accordance with CPT procedural guidance.</p>	<p>Psychological testing consists of an assessment of emotional functioning, personality, cognitive functioning (e.g. thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based....</p> <p>This service covers both the direct administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report in accordance with CPT procedural guidance.</p>
High Utilizer Management	<p>6. Using assertive engagement skills, the HUM Navigator will function to perform and report on the following 30-60-90 Day Activities:</p> <p>Within 30 days (Rapid Intensive Engagement)</p> <ul style="list-style-type: none"> • have had face-to-face contact with individual 	<p>6. Using assertive engagement skills, the HUM Navigator will function to perform and report on the following 30-60-90 Day Activities:</p> <p>Within 30 days (Rapid Intensive Engagement)</p> <ul style="list-style-type: none"> • have had contact with individual
Intensive Customized Care Coordination	<p>Intensive Customized Care Coordination is differentiated from traditional case management by:</p> <ul style="list-style-type: none"> • The frequency of the coordination: an average of one face-to-face meeting weekly. 	<p>Intensive Customized Care Coordination is differentiated from traditional case management by:</p> <ul style="list-style-type: none"> • The frequency of the coordination: an average of one meeting with the youth/family weekly.
	<p>15. The Care Coordinator will average 1 face-to-face per week per individual served.</p>	
Intensive Family Intervention	4. At least 60% of service units must be provided face-to-face with youth and their families and 80% of all face-to-face	4. Therapy intervention can be provided via Telemedicine. Coordination and skills enhancement service components may be provided telephonically.

	service units must be delivered in non-clinic settings over the authorization period.	
	ii. Meet at least twice a month with families face-to-face or more often as clinically indicated.	ii. Engage at least twice a month with the families or more often as clinically indicated.
Parent Peer Support - Individual	4. Contact must be made with the individual receiving PPS services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact depending on the individual's support needs and documented preferences.	4. Contact must be made with the individual receiving PPS services a minimum of twice each month.
	5. At least 50% of PPS service units must be delivered face-to-face with the family/youth receiving the service. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month.	5. Waived completely
	Service Accessibility: 2. PPS may be provided at a service site, in the recipient's home, or in any community setting appropriate for providing the services as specified in the recipient's behavioral health recovery plan; via phone (although 50% must be provided face to face, telephonic contacts are limited to 50%).	Service Accessibility: 2. PPS may be provided at a service site, in the recipient's home, or in any community setting appropriate for providing the services as specified in the recipient's behavioral health recovery plan; via phone
Youth Peer Support - Individual	2. YPS may be provided at a service site, in the recipient's home, or in any community setting appropriate for providing the services as specified in the recipient's behavioral health recovery plan; via phone (although 50% must be provided face to face, telephonic contacts are limited to 50%).	2. YPS may be provided at a service site, in the recipient's home, or in any community setting appropriate for providing the services as specified in the recipient's behavioral health recovery plan; via phone
Psychosocial Rehabilitation- Individual	4. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month.	4. Waived completely.
	6. When the primary focus of PSR-I is for medication maintenance, the following allowances apply: a. These individuals are not counted in the offsite service requirement or the individual-to-staff ratio; and b. These individuals are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is	6. When the primary focus of PSR-I is for medication maintenance, the following allowances applies: a. These individuals are not counted in the offsite service requirement or the individual-to-staff ratio;

	required every 3 months and monthly calls are an allowed billable service.	
Peer Support WHW - Individual	REQUIRED COMPONENTS: 3. At least 60% of all service units must involve face-to-face contact with individuals. The remainder of direct billable service includes telephonic intervention directly with the person or is contact alongside the person to navigate and engage in health and wellness systems/activities.	3. Waived completely.
Intensive Case Management	<p>6. REQUIRED COMPONENTS: Maintain face-to-face contact with individuals receiving Intensive Case Management services, providing a supportive and practical environment that promotes recovery and maintain adherence to the desired performance outcomes that have been established for individuals receiving ICM services. It is expected that frequency of face-to-face contact is increased when clinically indicated in order to achieve the performance outcomes, and the intensity of service is reflected in the individual's IRP.</p> <p>7. REQUIRED COMPONENTS: A minimum of 4 face-to-face visits must be delivered on a monthly basis to each consumer. Additional contacts may be either face-to-face or telephone collateral contact depending on the individual's support needs, 60% of total units must be face-to-face contacts with the individual.</p> <p>8. REQUIRED COMPONENTS: At least 50% of all face-to-face service units must be delivered in non-clinic/community-based settings (i.e., any place that is convenient for the individual such as a FQHC, place of employment, community space) over the authorization period (these units are specific to single individual records and are not aggregate across an agency/program or multiple payers).</p> <p>9. In the absence of monthly face-to-face contacts and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of 2 telephone contacts in that specified month (denoted by the UK modifier). This may occur for no more than 60 consecutive days.</p>	<p>6. REQUIRED COMPONENTS: Maintain engagement with individuals receiving Intensive Case Management services, providing a supportive and practical environment that promotes recovery and maintain adherence to the desired performance outcomes that have been established for individuals receiving ICM services. It is expected that frequency of face-to-face contact is increased when clinically indicated in order to achieve the performance outcomes/mitigate escalating crisis, and the intensity of service is reflected in the individual's IRP but this must at least occur 1x month.</p> <p>7. REQUIRED COMPONENTS: A minimum of 4 contacts must be delivered on a monthly basis to each consumer. At least one must be face-to-face (or more depending on the individual's support needs).</p> <p>8-10. Waived Completely.</p>

	<p>10. After 8 unsuccessful attempts at making face to face contact with an individual, the ICM and members of the treatment/support team will re-evaluate the standing IRP and utilization of services.</p>	
<p>Nursing Assessment and Health Services</p>	<p>REQUIRED COMPONENTS 3: Each nursing contact should document the checking of vital signs (Temperature, Pulse, Blood Pressure, Respiratory Rate, and weight, if medically indicated or if related to behavioral health symptom or behavioral health medication side effect) in accordance with general psychiatric nursing practice.</p>	<p>SPECIAL CONDITION: The review of vital signs is a crucial aspect of a health delivery plan for the individuals we support (especially those with significant comorbidities) and, at the same time, DBHDD is open to flexibility. We see our nursing services as key to that whole health delivery so the expectation will be that every other Nursing Assessment service can waive vitals (i.e. 50% of contact would be via telemedicine or telephonic in which a good inquiry related to health status would be expected). If there is a Medication Administration intervention provided by a nurse within your agency, this can also qualify as a documented opportunity to check with the individual on all symptoms, health indicators and vitals, counting as 50% of the Nursing face-to-face contact (which can be noted in that Progress Note).</p>