



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

Updated March 27, 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](#) and the [Local Health Department](#).

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 Maryland](#). Further guidance on telehealth/telemedicine may be found on [Medicaid.gov](#).

Is there service delivery support for telephonic contact?

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 screen patients, refer patients to health care services, provide treatment, and issue prescriptions. Please see guidance on telephone services authorized for [general health care services](#), [behavioral health services](#), and [psychiatric rehabilitation programs](#).

If a provider can't support intensive outpatient program (IOP) groups but are 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 minimal number of 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.

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. In keeping with Governor Hogan's emergency legislation, SB 1080/HB 1663, 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 many 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**. If services provided are

either a service admission/initial evaluation or a group service, they must be performed using video-based telehealth. 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 providers however explore services such as Zoom (paid version) or Doxy which offer a HIPAA compliant platform.

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 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?

This is a correction to a statement released by BHA earlier this morning: 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.

During this state of emergency, will Medicaid reimburse telehealth services that 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, 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](#)). However, services involving multiple participants as well as admission evaluations (e.g., 90791, 9920x) must be delivered by video telehealth.

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 many behavioral health services

using voice telephone. Another example of an eligible provider type not listed is clinical psychologists.

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. If services provided are either a service admission/initial evaluation or a group service they must be performed using video-based telehealth.

For opioid treatment programs existing patients can now receive many services via telehealth or voice telephone, including prescribing medication. However, healthcare practitioners may not use telehealth services to prescribe opioids for the treatment of pain. If prescribing for a new person, the initial evaluation requires a telehealth evaluation for buprenorphine, and for methadone an in-person evaluation.

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?

PRPs 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). Additional guidance related to

supported employment (SE), which is jointly funded by BHA and the Division of Rehabilitation Services (DORS), is forthcoming.

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 offsite 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.

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 [Follow-up Guidance on Telehealth Services](#) issued by BHA on March 24, 2020.

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?

In 2019, the state enacted [COMAR 10.58.06](#), which allows for teletherapy. 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?

This issue is under review.

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.

This issue is under review.

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.