COVID-19 Flexibilities Update
DMAS Behavioral Health Providers & Stakeholders

July 6, 2021

Please use the Q & A Function to ask content/service specific questions.

Hamilton Relay Transcriber (CC)

• Automated CC is available for this event with real-time captions that will run simultaneously with the presentation.
• The streaming text is available through
  ▪ https://www.streamtext.net/text.aspx?event=HamiltonRelayRCC-0706-VA2889
  ▪ We recommend opening a second window with the link provided and resizing it in such a fashion that it appears below the webinar screen. This allows the viewer to see both the webinar and its associated text/graphics while also being able to comfortably view the real-time captions.
• If you have any questions about this service please send an email to CivilRightsCoordinator@DMAS.Virginia.Gov
DMAS Behavioral Health Provider / Updates to COVID-19 Flexibilities
Meeting Agenda

Please use the Q&A Function to ask specific questions about service delivery. We will gather these questions and attempt to answer as many of these during the hour as we can.

<table>
<thead>
<tr>
<th>July 6, 2021</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Items</strong></td>
<td><strong>DMAS Lead Staff</strong></td>
</tr>
<tr>
<td>Welcome and Introductions</td>
<td>Dr. Alyssa Ward Ph.D., LCP, Behavioral Health Division Director</td>
</tr>
<tr>
<td>Purpose of today’s call and background information</td>
<td>Dr. Alyssa Ward Ph.D., LCP, Behavioral Health Division Director</td>
</tr>
<tr>
<td>Review of Specific Changes Related to Behavioral Health Services</td>
<td>Laura Reed, LCSW Behavioral Health Senior Program Advisor Ashley Harrell, LCSW ARTS Senior Program Advisor</td>
</tr>
<tr>
<td>Provider Questions (Q&amp;A Function, if time allows)</td>
<td>Dr. Alyssa Ward Ph.D., LCP Laura Reed, LCSW Ashley Harrell, LCSW</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Dr. Alyssa Ward Ph.D., LCP, Behavioral Health Division Director</td>
</tr>
</tbody>
</table>

Project BRAVO went LIVE 7/1/201

What does this mean?

- 3 Enhanced Services LIVE now:

  - Assertive Community Treatment
  - MH Partial Hospitalization
  - MH Intensive Outpatient Services

- 6 Enhanced Services LIVE **12/1/2021**

  - Multisystemic Therapy
  - Functional Family Therapy
  - Mobile Crisis Teams
  - Community Stabilization
  - Residential Crisis Stabilization
  - 23 Hour Observation Beds
Emergency Waivers for COVID-19 Updates

Emergency Waivers
The Virginia Medicaid agency implemented a variety of policies in 2020 in response to the needs of our members and providers as they confronted the COVID-19 pandemic. Policies protecting members from losing coverage remain in effect, and there is currently no official expiration date for these protections.

Some policies providing flexibility to Medicaid providers will end on June 30, 2021, with the expiration of the state Public Health Emergency executive orders. With respect to the flexibilities that end on June 30, 2021, we understand that providers need time to transition back to pre-COVID policies. DMAS is giving providers a 60-day period to make these changes where state law permits. In these cases, providers have until August 29, 2021, to revert to earlier procedures and policies. DMAS will not conduct audits or enforce any policies that are tied to this grace period until August 29, 2021. In some cases, however, flexibilities will expire at midnight June 30, 2021, and a transition period is not permitted.

In addition to the state public health emergency, Medicaid policies are also guided by the federal Public Health Emergency, which remains in effect until July 20, 2021, and the maintenance of effort (MOE) requirements associated with the Families First Coronavirus Response. As such, many policies remain in place. Please click on the links below to review charts outlining all Medicaid COVID policies, including those that have already expired, those that expire on June 30, 2021, those that will be covered by a grace period, and those that do not yet have an expiration date.

- Policies ending June 30, 2021
- Policies expiring June 30, 2021 with a 60-day grace period
- Policies remaining in effect
- Policies expired prior to June 30, 2021

www.dmas.virginia.gov/for-providers/general-information/emergency-waivers

Behavioral Health Provider Call Recordings Uploaded to YouTube

www.dmas.virginia.gov/for-providers/general-information/emergency-waivers

Today's session is being recorded and will be posted here.
Telehealth Allowances Post the Public Health Emergency

www.dmas.virginia.gov/for-providers

Coming soon! Telehealth policies and webinar will have a new landing page here!

Virginia Executive Orders Ending June 30, 2021

• The Virginia Medicaid agency implemented a variety of policies in 2020 in response to the needs of our members and providers as they confronted the COVID-19 pandemic. Policies protecting members from losing coverage remain in effect, and there is currently no official expiration date for these protections.
• Some policies providing flexibility to Medicaid providers will end on June 30, 2021, with the expiration of the Virginia state Public Health Emergency executive orders.
Virginia Executive Orders Ending June 30, 2021

- With respect to the flexibilities that end on June 30, 2021, we understand that providers need time to transition back to pre-COVID policies. DMAS is giving providers a 60-day period to make these changes where state law permits. In these cases, providers have until August 29, 2021, to revert to earlier procedures and policies.
- DMAS will not conduct audits or enforce any policies that are tied to this grace period until August 29, 2021. In some cases, however, flexibilities will expire at midnight June 30, 2021, and a transition period is not permitted.

Federal Public Health Emergency due to COVID-19

- In addition to the state public health emergency, Medicaid policies are also guided by the federal Public Health Emergency, which remains in effect until July 20, 2021, and the maintenance of effort (MOE) requirements associated with the Families First Coronavirus Response.
- As such, many policies remain in place. The link below lists charts outlining all Medicaid COVID policies, including those that have already expired, those that expire on June 30, 2021, those that will be covered by a grace period, and those that do not yet have an expiration date.
  
  www.dmas.virginia.gov/for-providers/general-information/emergency-waivers
Policies Ending June 30, 2021, no grace period

- Overall waiver of public notice requirements that would otherwise be applicable to state plan amendment submission.
- Polices relating to Nursing Facilities
- Policies relating to Durable Medical Equipment
- Does not apply to BH flexibilities


Policies Expiring June 30, 2021 and Enforcement effective 60 Days Post Expiration

www.dmas.virginia.gov/media/3593/policies-expiring-june-30-2021-with-60-day-grace-period.pdf

DMAS is allowing a **60 day grace period** before enforcing the end of the following flexibilities related to Behavioral Health:

- **Waiver of case management face-to-face requirements** behavioral health and ARTS services.
  - Face-to-face every 90 days may continue to be met via telehealth post the end of the state public health emergency per Executive Order 51 and 58.

- **Waiver of certain discharge requirements** for behavioral health
  - 1) if an individual is ready for a lower level of care and
  - 2) waive the discharge requirement if there are no services for 30 days
Policies Expiring June 30, 2021 and Enforcement effective 60 Days Post Expiration – cont.

• **Service Authorizations for Behavioral Health and ARTS that have a 14-day grace period** for the submission of Behavioral Health Authorizations within Community Mental Health Rehabilitation Services (CMHRS), Assessments, Psychotherapies, Inpatient Treatment Services, and ARTS Levels of Care
  - This flexibility allowed up to 14 days after the start of a new behavioral health or ARTS 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.

Policies Expiring June 30, 2021 and Enforcement effective 60 Days Post Expiration – cont.

• **Flexibility in Service Settings:**
  - Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health Skill Building (MHSS), and Psychosocial Rehabilitation (PSR) flexibility to provide services outside of the school setting, office setting, or clinic setting for the duration of the PHE.
  - TDT providers licensed for school-based and non-school based care flexibility to provide services outside of the school, including during the summer, with their current license. Providers are reminded that they must report to DBHDS Office of Licensing any changes to their programs that have occurred as a result of COVID-19.
Policies Expiring June 30, 2021 and Enforcement effective 60 Days Post Expiration – cont.

- 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.
- Flexibilities for Behavioral Therapy (H2033)
  - A physician letter, referral, or determination is not required for submission of a service authorization. The MCO and Magellan of Virginia 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.

DMAS Added to the Charts:

Independent Assessment Certification and Coordination Team (IACCT)

- 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.
Policies Expiring June 30, 2021 and Enforcement effective 60 Days Post Expiration – cont.

*DMAS Added to Charts:*
Psychiatric Inpatient, Facility Based Crisis Stabilization, Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH) Levels of Care

- For members in psychiatric inpatient, facility based crisis stabilization, PRTF and TGH, *medical necessity for continuation of care may be waived* if the individual is unable to transition to lower levels of care due to COVID-19 and quarantines.
  - Providers who are requesting service authorization for members who are unable to discharge due to barriers related to COVID-19, are asked to answer additional questions (see March 5, 2021 Memo) when requesting an authorization.
- Providers shall submit an additional page with the information noted in the March 5, 2021 memorandum when submitting the request online or be prepared to answer the questions during phone reviews.

Reminder!

The 60-day grace period to make these changes ends **August 29, 2021**, to revert to earlier procedures and policies.
**Flexibilities That Remain Active**

**General Flexibilities**
- Suspension of all drug co-payments
- Telehealth and telephonic policies as described in prior Medicaid Memoranda issued on March 19, 2020, May 15, 2020, and September 30, 2020 – including waiver of penalties for HIPAA non-compliance and other privacy requirements.
- Electronic signatures will be accepted for visits that are conducted through telehealth.
- Allow facilities to be fully reimbursed for services rendered to an unlicensed facility (during PHE). This rule applies to facility based providers only.
- Continuity of coverage will remain in place for Medicaid members through the end of the federal Public Health Emergency and Maintenance of Effort (MOE).

**Addiction and Recovery Treatment Services related flexibilities:**
- Opioid treatment programs may administer medication as take home dosages, up to a 28-day supply.
- Allowing a member’s home to serve as the originating site for prescription of buprenorphine. No originating site fee.
- Applies to Buprenorphine and Naltrexone!
  - Drugs dispensed for 90 days will be subject to a 75% refill “too-soon” edit. Patients will only be able to get a subsequent 90 day supply of drugs after 75% of the prescription has been used (approximately day 68).
  - Suspend all drug co-payments for Medicaid and FAMIS members
Mental Health related flexibilities:

- Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health Skill Building (MHSS), and Psychosocial Rehabilitation (PSR):
  - The service authorization request for new services will be used to track which members are continuing to receive these services, assess the appropriateness of the services being delivered via different Active, telehealth modes of treatment, and to determine if this is an appropriate service to meet the member's needs.
  - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the LMHP, LMHP-R, LMHPRP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual.

- For youth participating in both TDT and IIH, TDT should not be used in person in the home as this would be a duplication of services.
- TDT may be provided through telehealth to youth receiving IIH (in person or via telehealth) as long as services are coordinated to avoid duplication and ensure efficacy of the treatment provided.
Flexibilities That Remain Active cont.

Mental Health related flexibilities:
- During the PHE, TDT, IIH, MHSS, 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.

Behavioral Therapy related flexibilities:
- Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual’s progress and treatment needs, including changes impacting the individual to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual’s medical record as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA or LABA.
- One service unit equals 15 minutes for this level of care. Effective June 11, 2020, Behavioral Therapy providers do not have a one unit max limit per day for audio-only communications.
Flexibilities That Remain Active cont. (Added to Charts)

Crisis Stabilization/Crisis Intervention Related Flexibilities:

- 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, assessments, care coordination, team meetings, and treatment planning can occur via telehealth.
- Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP, if one is required, shall be updated to reflect any change or changes in the individual’s progress and treatment needs, including changes impacting the individual related to COVID-19 as well as any newly identified problem and documented according to the requirements in the Mental Health Provider manual.

Flexibilities That Remain Active cont. (Added to Charts)

Independent Assessment Certification and Coordination Team (IACCT)

- Assessments IACCT Assessments may occur via telehealth or telephone communication.

Psychiatric Inpatient, Facility Based Crisis Stabilization, Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH) Levels of Care

- The requirement for service authorization remains in place.
- Therapy, assessments, case management, team meetings, and treatment planning may occur via telehealth. 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.
Flexibilities That Remain Active cont.

- Many other flexibilities related to Nursing Facilities, Pharmacy, and Appeals.

Flexibilities Previously Expired

- There are policies for flexibilities that have expired prior to June 30, 2021 and are no longer in place.
- These do not apply specifically to Behavioral Health Services but could be of interest to review since related to Pharmacy, Provider Enrollment and Fair Hearings and Appeals.
- For more information, please visit: [https://www.dmas.virginia.gov/media/3592/policies-expired-prior-to-june-30-2021.pdf](https://www.dmas.virginia.gov/media/3592/policies-expired-prior-to-june-30-2021.pdf)
Frequently Asked Questions

Q: The Federal Public Health Emergency was extended until July 20, 2021 which allowed us to continue to provide telephonic services until that date. We will be allowed to continue with telephonic services with the State Public Health Emergency ending?
A: DMAS issued the attached provider memo June 30, 2021, which references the Emergency Waivers section of the DMAS public website. The telehealth flexibilities listed in the March 19, 2020 Provider Memo titled Provider Flexibilities Related to COVID-19, including those allowing audio-only connection for the delivery of services, will continue until further notice.

Frequently Asked Questions

Q: What are considered 'clinically appropriate' telehealth services for community based mental health services? Can you give an example?
A: Individuals vary in how they respond to counseling—one size never fits all, and this includes telehealth. Clinicians must take into consideration the patient’s needs, stage of treatment, experiences and environment factors to determine if telehealth is clinically appropriate.
In-person shall be considered for a variety of reasons but not limited to the following: Member requests to meet in-person, members who have experienced trauma, members who are experiencing psychosis, experiencing significant dysregulation, telehealth equipment is unavailable/unreliable/broken, inadequate space in home leading to privacy concerns.
Frequently Asked Questions

Q: How do we document the clinically appropriate requirement to reflect in the ISP that telehealth services are warranted instead of in person services?
A: Providers will need to document the rational that the services are individualized to meet the unique member’s needs. Documentation of services being delivered via telehealth must meet current standards of professional practice when utilizing telehealth technologies as a means of delivering professional services.

Frequently Asked Questions

Q: Will outpatient therapists have to take a training to provide services via telehealth?
A: DMAS does not require additional trainings to delivery services via telehealth. DMAS does require that services delivered via telehealth are provided with the same standard of care as in-person. If practitioners are needing training to ensure this is accomplished, then that would be the responsibility of the practitioner.
<table>
<thead>
<tr>
<th>Q: Can psychologists, LPCs or LCSWs who hold a Virginia license but live in another state, provide services to Virginia residents via telehealth?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Providers are expected to adhere to regulations regarding licensures and locations of the patient and/or Provider issued by their Regulatory Board. Please refer to information provided by the Department of Health Professions (<a href="https://www.dhp.virginia.gov/">https://www.dhp.virginia.gov/</a>). Providers located outside of Virginia may need to adhere to additional regulations applicable to that state/location.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q: Can you provide clarity regarding Psychologists located in Virginia who provide telehealth services to residents of other states via Psychology Interjurisdictional Compact (PSYPACT)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: PSYPACT has 2 different credentials; one is for telepsychology and one is the authority to physically practice temporarily in a PSYPACT state for up to 30 days. In order to practice in another PSYPACT state, the individual must hold an active, unrestricted license as a Psychologist in a PSYPACT state and must be credentialed by the Association of State and Provincial Psychology Boards (ASPPB) with the E.Passport/APIT. As long as they meet both of those requirements, and the client is located within a PSYPACT state, they can practice. For more information about PSYPACT, contact the Virginia Board of Psychology at: <a href="mailto:psy@dhp.virginia.gov">psy@dhp.virginia.gov</a>.</td>
</tr>
</tbody>
</table>
Frequently Asked Questions

Q: According to the new ACT Billing Guidance, "To bill the per diem unit, a qualified ACT team member must provide at a minimum a 15 minute, face-to-face covered service with the individual or a face-to-face care coordination". Is telehealth allowed for this?
A: ACT is approved for service delivery via telehealth as noted in the DMAS Telehealth Provider Supplemental Manual. The face-to-face service requirement may be met through telehealth.

Q: Does fifteen minutes of audio/visual telehealth meet the face-to-face requirement for ACT?
A: Yes, the fifteen minutes of face-to-face service required to bill the ACT per diem can be met through telehealth.

Frequently Asked Questions

Q: Can the originating site be the therapist home after the public health emergency?
A: The originating site is the location of the member at the time the service is rendered, or the site where the asynchronous store-and-forward service originates. The distance site is the location of the Provider rendering the covered service via telehealth.

Providers are also expected to adhere to regulations regarding licensure per regulatory board and location of the patient and as applicable, their licensing agency. Please refer to information provided by the Department of Health Professions (https://www.dhp.virginia.gov/) and the Department of Behavioral Health and Developmental Services (https://www.dbhds.virginia.gov/)
Frequently Asked Questions

Q: Is there a modifier for telehealth services delivered by a licensed eligible clinician under the supervision of a licensed practitioner?
A: There are no specific modifiers for Residents in Psychology, Residents in Counseling, nor Supervisees in Social Work. Services are billed under the supervising clinician’s or agency NPI, as appropriate for the service, and appropriate telehealth modifiers should be used depending on the delivery of the service.

Frequently Asked Questions

Q: Can supervision required in Chapter II of the Psychiatric Services Manual for Residents and Supervisees be done via telehealth?
A: The DMAS required supervision of Residents and Supervisees (not affiliated with their Board approved supervision) may be done via telehealth.

Q: Can Residents and Supervisees in their Board approved supervision provide services via telehealth?
A: Yes, with supporting documentation in the member’s ISP.
Frequently Asked Questions

Q: Is telemedicine limited to licensed professionals?
A: Staff requirements for services allowed through telehealth remain the same as if the service is delivered in person. For services allowed through telehealth, such as but not limited to TDT, MHSS, Intensive In-Home, Behavioral Therapy, PSR and relevant ASAM Levels of Care, whereas staff who are not licensed may provide the service under supervision, the unlicensed staff who meet staff qualifications for the service may provide services through telehealth.

Supervision requirements remain the same as when those services are delivered in person. Supervision may be provided through telehealth as allowed by the relevant licensing board.

Frequently Asked Questions

Q: Are the new Behavioral Health Enhancement (BHE) codes going into effect 07/01/2021 being reviewed for inclusion, as appropriate?
A: The new BHE codes (MH-IOP, MH-PHP and ACT) effective 7/1/2021 are approved for service delivery via telehealth as noted in the DMAS Telehealth Provider Supplemental Manual.
Frequently Asked Questions

Q: Can the flexibility of allowing one unit of billing for TDT, IIH, MHSS, and PSR be extended if services are provided but time spent in billable activities does not reach the full unit of time required to bill?

A: The flexibilities allowing one unit on days when a billable service is provided but does not reach the time requirements to bill for a service unit continues through the federal public health emergency as related to the telehealth flexibilities.

Frequently Asked Questions

Q: What will the service limits be for mental health services or ARTS via telehealth?

A: The service limits are as defined in the Mental Health Services and ARTS Provider manual regardless if the service is delivered in-person or via telehealth.
Frequently Asked Questions

Q: Are the assessment billing codes in Community Mental Health Rehabilitation Services (CMHRS) services allowed to be conducted via telehealth?
A: Yes, the comprehensive needs assessments (CNA) for CMHRS may be done via telehealth delivery through the end of the federal public health emergency.

Frequently Asked Questions

Q: Will a telehealth session be considered adequate to meet the requirement for a face-to-face session every 90 days for targeted case management services?
A: The face-to-face requirement every 90 calendar days for Mental Health, Substance Use Disorder and Treatment Foster Care Targeted Case Management may be met if delivered through telehealth and clinically appropriate for the particular member’s situation. Thus, the 60 day grace period does not apply in this case since connected to telehealth flexibilities related to the Federal Public Health Emergency. DMAS is also allowing service delivery for these case management services to continue post the Federal Public Health Emergency as clinically appropriate.
Frequently Asked Questions

Q: Does the telehealth flexibilities apply to SUD Care Coordination within a Preferred Office-Based Opioid Treatment (OBOT program) and Opioid Treatment Program?
A: The face-to-face requirement for SUD Care Coordination may be met if delivered through telehealth and clinically appropriate for the particular member’s situation.

Frequently Asked Questions

Q: Can Therapeutic Day Treatment (TDT) services be provided via telehealth to a child under the age of 14 when a parent may be at work or another adult is not in the home?
A: TDT services may be provided to youth under the age of 14 through telehealth when a parent is not home if clinically appropriate.
Frequently Asked Questions

**Q:** What is the status of the allowance for verbal consent vs. written?
**A:** Per the March 2, 2021 memo, providers shall update documentation and treatment plans (including individual service plans (ISPs), interdisciplinary plans of care (IPOCs)) with at least notation that verbal or electronic consent was obtained.

Provider and member verbal or electronic signatures are acceptable during the federal PHE. Providers need to ensure that the person “signing” is the intended individual, an authorized or someone acting responsibly for the individual. Providers are not required to obtain physical signatures of members when services are provided via telehealth or telephonic only. Patient consents provided verbally or electronically are sufficient as long as documented (noted) in the member’s record.

Frequently Asked Questions

**Q:** Will audio-only continue to be permitted during the Federal PHE (Public Health Emergency), even though the state PHE has ended?
**A:** Yes, telehealth and audio-only flexibilities are maintained through the Federal Public Health Emergency. DMAS has posted which services will continue to be allowed via telehealth post the Federal PHE in the DMAS Telehealth Supplemental Manual.

Services that had an audio-component pre-public health emergency will continue post the state and federal public health emergency. DMAS will continue to review federal policies for audio-only allowances.
Frequently Asked Questions

Q: What does the 60 day grace period mean for those flexibilities that ended with the State Public Health Emergency?
A: DMAS is giving providers a 60-day period to make these changes where flexibilities end as of June 30, 2021 with the termination of the Executive Orders authorizing the State of Emergency.

In these cases, providers have until August 29, 2021, to revert to earlier procedures and policies. DMAS will not conduct audits or enforce any policies that are tied to this grace period until August 29, 2021.

Frequently Asked Questions

Q: In regards to 14 day authorization allowance, you stated that DMAS will not enforce any policies. Are we safe to assume that the MCO's will continue to give us that 14 day grace period during this 60 day window?
A: The MCOs will follow these flexibilities as noted in the DMAS policies related to the State and Federal Public Health Emergencies.
### Frequently Asked Questions

**Q:** Will the MCOs be required to allow services via telehealth as documented in these memos and the DMAS Telehealth Supplemental Manual?

**A:** The MCOs must provide coverage for telehealth services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program.

DMAS will publish additional guidance for coverage for store-and-forward, RPM, audio-only, provider-to-provider consultations, and virtual check-ins and specific CPT Codes in upcoming Medicaid Memoranda and Provider Manuals and regulations. The Contractor will be required to provide coverage for store-and-forward, RPM, audio-only, provider-to-provider consultations, and virtual check-ins that is no more restrictive than, and is at least equal in amount, duration, and scope as is available through, the Medicaid fee-for-service program.

### Frequently Asked Questions

**Q:** Is telehealth for prescribing buprenorphine to new patients allowed via audio only?

**A:** Yes, this falls under the telehealth flexibilities and will continue through the Federal Public Health Emergency. DMAS will monitor the Drug Enforcement Agency (DEA) flexibilities that lifted the requirements under the Ryan Haight Act of 2008 for prescribing practitioner to have conducted at least one in-person medical evaluation of the patient before prescribing a controlled substance scheduled II – V, including buprenorphine and buprenorphine/naloxone for treatment of addiction. If the DEA reverts back to the in-person assessment requirement, DMAS will follow accordingly.
Frequently Asked Questions

Q: The memo states drug copays are suspended during the Federal Public Health Emergency. What about other copays?
A: Medicaid managed care enrolled members do not have copays. The copays for services for fee-for-service Medicaid and FAMIS/FAMIS MOMS will also be suspended during the Federal State of Emergency.

Frequently Asked Questions

Q: Will behavioral health/psychotherapy billing modifiers 95 and GT still need to be noted?
A: Per the DMAS Telehealth Supplemental Provider Manual, distant site providers must include the modifier GT on claims for services delivered via telehealth. Store-and-Forward Distant site Providers must include the modifier GQ.

Place of Service (POS) should reflect the location in which a telehealth service would have normally been provided, had interactions occurred in person. For example, if the member would have come to a private office to receive the service outside of a telehealth modality, a POS 11 would be applied.

While there are not specific edits to deny claims, providers should not use POS 02 or modifier 95 on telehealth claims.
**Frequently Asked Questions**

**Q:** Patients who have not been seen in person since March 2020 - do they need to be seen in person for next visit?

**A:** DMAS is not requiring providers to see individuals in person unless telehealth or audio-only is not clinically appropriate and not meeting the individual’s unique needs. Thus if service delivery via telehealth or audio-only is working for the member and the provider, they may continue.

**Frequently Asked Questions**

**Q:** The flexibility of TDT providers licensed for school-based being able to provide services outside the school ended on June 30, 2021 with a 60 day grace period. However, TDT is also listed on the services that are able to continue to be provided by telehealth. Is TDT still able to be provided outside the school?

**A:** The original allowance of "outside the school" was focused on allowing providers to do TDT at another setting if the school was closed related to COVID-19 impacts. This is separate from *allowance related to telehealth*. Thus, if the School-Based provider was able to offer TDT at a community center or clinic location, they were allowed to pivot and do that to support kids who might be doing virtual school in a program outside of the school.

TDT can still be provided via telehealth if clinically appropriate, however, the providers must be appropriately licensed through DBHDS to provide the service in the setting that is requested on the service authorization form.
Q: What about the flexibilities related to CSAC’s and CSAC Supervisees being allowed to bill psychotherapy in ARTS Intensive Outpatient and Partial Hospitalization in the March 27, 2020 Memo related to COVID flexibilities?
A: This flexibility is related to the Executive Orders for the State Public Health Emergency thus ended on June 30, 2021 with a 60 day grace period. The DMAS memo/table will be updated to reflect this change: https://www.dmas.virginia.gov/media/3593/expire-06-30-2021-60-day-offramp.pdf

Q: Is the telehealth justification portion needed for the ISP for MHSS, TDT, PSR, and IIH but not CM?
A: Providers shall document the justification of the service delivery via telehealth vs face-to-face in all ISPs regardless of the service.
### Frequently Asked Questions

**Q:** Will the federal government be considering expansion to audio only services, after the Federal Public Health Emergency, for those clients who do not have access to telehealth via web link?

**A:** DMAS will continue to monitor policies from the Center for Medicare and Medicaid Services. Current policy in the DMAS Telehealth Supplemental Manual specify the behavioral health services that will be allowed via telehealth. Only those services that had a audio only allowance pre-public health emergency may continue post the end of the Federal Public Health Emergency.

**Q:** How do these policies impact temporary detention orders?

**A:** Other than the telehealth service delivery flexibilities, there were no additional flexibilities related to temporary detention orders. Providers shall follow the requirements set forth in the DMAS Temporary Detention Order Supplemental Manual.
**Frequently Asked Questions**

**Q:** Is the waiver for vitals related to behavioral health services still in place for clients receiving services via telehealth and who remain hesitant to come in person?

**A:** Providers shall determine the clinical rationale if vitals or labs are needed. If there is clinical indication depending on service provided, pharmacotherapy prescribed, etc., vitals and/or labs may be clinically relevant to coordinate with the member. Providers should work with members to determine the most appropriate way to meet this need and support members as appropriate in these situations.

---

**Provider Questions**

**Please Use Q & A Function**

Please use the Q & A Function to ask content/service specific questions.
Training and Technical Assistance Opportunities Summer 2021

DMAS SUPPORT Act Grant: Summer 2021 Webinars

DMAS will begin offering technical assistance webinars on a variety of topics including:
• ASAM Criteria Assessment Dimensions 4
• ASAM Criteria Assessment Dimensions 5 & 6
• Co-Occurring Disorders
• Care Coordination

The complete webinar schedule can be found on the DMAS SUPPORT Act grant webpage: https://www.dmas.virginia.gov/media/3316/summer-2021-webinar-schedule.pdf

Thank you for your partnership, support and participation.

Additional Questions?

Project BRAVO and Mental Health Services Questions: enhancedbh@dmas.virginia.gov
ARTS Questions: SUD@dmas.virginia.gov