DEPARTMENT OF MENTAL HEALTH

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March 19, 2020

TO: All Legal Entity Providers

FROM: Jonathan E. Sherin, M.D., Ph.D.
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SUBJECT: **DEPARTMENT OF MENTAL HEALTH (DMH) COVID-19 RESPONSE**

I reach out to you and our entire provider community to reassure you of our relentless efforts and the ongoing planning taking place for many weeks to address the mounting new challenges we face as a County and Local Mental Health Plan (MHP) due to the Coronavirus (COVID-19) pandemic. The Board of Supervisors and County Department Heads have been working around the clock with a range of partners at the local, state, and federal levels to be as proactive as possible in our actions, to respond in real time to changes in conditions that present literally each day, and to plan for contingencies we can and cannot predict.

In the context of "Social Distancing" as the new norm and a defining practice, we are challenged as a system. Our Governor has ordered business closures, home confinement, and other actions in an effort to mitigate the spread of the virus. Just this week our Board of Supervisors ordered that all County facilities to be closed to the public, and the Centers for Disease Control and Prevention (CDC) ordered any gatherings be limited to no more than 10 persons (this is down from the 250 person limit announced only days earlier). That said, we as a department and network must maintain our capacity to deliver essential services.

With essential services as our priority, DMH will remain fully operational and open for business to the best of our ability. Our Emergency Outreach and Triage Division (EOTD) services, including 24/7 response, law enforcement mental health teams as well as our countywide street engagement services to the homeless will be continued at capacity. In addition, our crisis services to children in the child welfare system and beyond must continue at capacity. It is expected that Legal Entity (LE) providers will continue their vital role in our MHP of providing field-based services to high need individuals, children and families (e.g., FSP, urgent/crisis services to children and adults, services to home-bound

clients and historically isolated clients) as well as ensuring that clients discharged from hospitals are prioritized for appointments with their service provider.

As this public health crisis continues to evolve, we recognize that the agencies which make up our provider network and partner with us to provide mental health services and support to the most vulnerable individuals, families, and communities are themselves experiencing significant impacts to their service delivery operations. It has come to our attention that our LE network has experienced significant service disruptions, decreased service delivery levels, client cancellations, school closures, and fiscal pressures. Across our MHP the top priority is to support the health and wellbeing of our most vulnerable clients and the agency staff without whom delivering mission-critical services would not be possible. We trust that agencies, especially during the current pandemic, are ensuring that staff delivering in-person and field-based services to clients are being provided with the proper tools and safety items recommended by the local, state, and federal public health authorities.

We have received many questions from agencies and hope that the information below will provide some clarity of our intent and provides some safeguards for client's access to care and for the agencies that serve them for at least the near future. As this situation unfolds, we will be sending weekly updates to all providers beginning the week of March 23, 2020.

Financial Matters

There will be significant and immediate financial supports for agencies that continue to deliver on our highest priority services exampled above, which will include direct face-to-face client services (and acceptable alternatives) whether delivered in the field, home, or clinic settings. Along these lines, services to high need individuals and families, particularly through intensive care programs, are key to the wellbeing of the vulnerable populations we serve and much of which cannot be met solely through telehealth-based interventions. In the spirit of collaboration and customer service DMH has decided to implement the following changes to assist providers in meeting expectations consistent with those expected of our directly operated clinics. Providers must commit to delivering these services as outlined above.

Payments

- DMH will provide a Cash Flow Advance (CFA) for the May payment equal to 1/12th of the current Maximum Contract Amount. The CFA should be received around April 3, 2020.
- The CFA balance will be held constant after the April payment. Additional guidance regarding the reconciliation of the CFA balance will be provided.

- DMH will issue the April payment as scheduled by April 1, 2020.
- Updates will be provided regarding the June payment.

Rates

- DMH will temporarily increase the Provisional Rates for Crisis Intervention (Mode/SFC 15:70-79) and Community Outreach Services by 10 percent for all LEs who currently have these rates in their contract for non Medi-Cal related services/clients. LEs should determine the appropriate rate to claim to DMH that is consistent with their projected/actual cost. The provisional rates will be updated in IBHIS by the end of next week.
- DMH will temporarily increase the CMA by 10 percent for all rates, except Mode 05. The CMA will increase by the end of next week for non Medi-Cal services. The increase for Medi-Cal services will follow as soon as the State updates their system. DMH will send updates to the LE regarding the Medi-Cal rates.
- Updates regarding increasing individual LE rates will be provided.

Telehealth Services

Our Quality Assurance (QA) Division has prepared QA Bulletin No. 20-01, *Providing Specialty Mental Health Services During the COVID-19 Crisis* (see Attached), which includes useful information and links for telehealth activities.

Psychiatric Mobile Response and Individuals Needing 5150/5585 Holds

We have developed the *COVID-19 Screening Form* (see Attached), that contract agencies evaluating individuals for involuntary holds may find useful in screening for COVID-19 risk.

Contract Amendments

DMH will continue to process contract amendments on a flow basis as contract actions are approved. We are not expecting any interruptions in this process. We will use our weekly updates to communicate any changes.

School Based Services

As previously noted, the closure of most schools in Los Angeles County will have a significant programmatic and financial impact on some LE providers. DMH School Based Division is working on a short-term solution to address referrals to this program. Please refer to *School Based Services* (see Attached) for additional information.

Within the next week we will convene a small group of provider agencies via tele/video conference to discuss DMH plans. We will continue to develop contingencies for the go-forward as this pandemic evolves.

DMH has established a COVID-19 email address, DMHCovid19@dmh.lacounty.gov, where we invite you to submit any questions regarding this pandemic. Also, the County of Los Angeles Department of Public Health (DPH) now has a designated Novel Coronavirus website, http://publichealth.lacounty.gov/media/coronavirus/ with daily updates.

Please continue to contact your DMH Lead Manager should you have questions. In the event that your manager is not available please forward those question to Terri Boykins, LCSW, the CMMD Deputy Director at Tboykins@dmh.lacounty.gov; or 213.738.2408. Clinical care related questions should be forwarded to Lisa Wong, Psy.D. at Lwong@dmh.lacounty.gov and financial related questions should be forwarded to our Financial Services Bureau at fsb@dmh.lacounty.gov.

JES:GP:tb

Attachments:

- QA Bulletin No. 20-01, *Providing Specialty Mental Health Services During the COVID-19 Crisis*
- *COVID-19 Screening Form*
- *School Based Services*

Quality Assurance Bulletin

Quality Assurance Unit
County of Los Angeles – Department of Mental Health
Jonathan E. Sherin, M.D., Ph.D., Director

March 18, 2020 **No. 20-01**

PROVIDING SPECIALTY MENTAL HEALTH SERVICES DURING THE COVID-19 CRISIS

This bulletin serves as interim guidance to assist practitioners in ensuring beneficiaries can access all medically necessary specialty mental health services (SMHS) while minimizing the community spread of COVID-19. In accord with State Department of Health Care Services (DHCS) Information Notice No.: 20-009 and Los Angeles County Department of Mental Health (LACDMH) interim protocols, providers should maximize the use of services that can be provided by telephone and/or telehealth methods of delivery.

What SMHS may be provided over the telephone or telehealth?
The Guide to Procedure Codes (Guide) provides a list of services that may be provided by telephone and telehealth. The "Method of Delivery" column identifies the allowable ways in which a practitioner may deliver the respective activity. In the Guide, the term "telepsych" is used to refer to telehealth. The following set of examples is not exhaustive.

Examples of services allowable by telephone:
- Plan Development (H0032)
- Psychotherapy (H0046)
- Individual Rehabilitation (H2015)
- Collateral (90887)
- Targeted Case Management (T1017)
- Crisis Intervention (H2011)
- Comprehensive Medication Services (H2010)

Examples of services allowable by telehealth:
- Assessment (90791/90792)
- Plan Development (H0032)
- Psychotherapy (H0046, 90832, 90834, 90837)
- Individual Rehabilitation (H2015)
- Collateral (90887)
- Crisis Intervention (H2011)
- Evaluation and Management Medication Services (99201, 99212, etc.)

During the COVID-19 crisis, there is a need to increase the services provided by telephone and/or telehealth in order to ensure that clients continue to receive medically necessary services. What follows are interim instructions on completing assessments over the telephone and providing group/family services over the telephone or through telehealth.

Can a provider conduct a mental health assessment over the telephone?
Yes. While LACDMH Policy 312.02 - Opening & Closing of Service Episodes allows assessments to be initiated without a face-to-face contact, it requires a face-to-face contact prior to finalizing the assessment. During the COVID-19 crisis, LACDMH is allowing assessments to be completed and finalized over the telephone. All other requirements of LACDMH Policy 312.02 must be adhered to including conducting financial screening, obtaining client identification and obtaining informed consent. Verbal informed consent may be obtained and documented on the Consent for Services form (MH 500) along with a statement that verbal consent was accepted due to the COVID-19 crisis. Likewise, verbal financial screening and client identification is acceptable at this time, but should be followed-up with in-person screening including the presentation of required documentation should

that opportunity become available during the course of treatment. The progress note should state the client's agreement to receive the assessment over the telephone as well as that the service was provided via non-standard means due to the COVID-19 crisis. Practitioners may verify the client's identity and address verbally and obtain proof of the client's identification when the client can be seen in-person. The LACDMH Central Business Office (CBO) will be issuing a Bulletin within the next few days related to financial screening requirements during the COVID-19 crisis.

The choice of assessment forms to use in these situations is up to the provider and practitioner. However, if the Immediate/Same Day Assessment form is chosen, the Full Assessment should be completed if and when the client presents for in-person services, if needed. When certain information cannot be obtained during a telephone contact (e.g. some observational data included in the mental status exam), it should be obtained upon the first in-person encounter with the client. A primary diagnosis must be provided at the point of finalizing the assessment based on the information that has been gathered. As with any other case, the diagnosis is subject to revision in light of additional information being obtained.

Can group and family services be provided over the telephone or telehealth?
Yes, LACDMH has expanded the use of the procedure codes for group (90853, 90847HEHQ, H2015HEHQ, and 90887HEHQ) and family sessions (90847 and 90849) to allow for telephone and telehealth methods of delivery (refer to instructions for claiming telephone and telehealth services below). However, these services should be provided with caution and all clients involved in such services must be advised of the privacy risks inherent in conducting group/family sessions over the telephone or through telehealth. Prior to conducting any group or family session in this manner, the practitioner or provider should contact the Quality Assurance (QA) Unit at (qualityassurance@dmh.lacounty.gov) to obtain additional instructions and reference materials. In addition, the QA Unit can provide instructions on the use of alternative equipment for conducting group or family sessions by directly-operated providers (e.g. Skype for Business).

Are there any special documentation requirements to consider during the COVID-19 crisis?
If a service is delivered in a nonstandard manner (e.g. an assessment completed over the telephone as referenced above), this should be stated at the beginning of the progress note and that the client agreed to the method in which the service was delivered (i.e. telephone or telehealth). In addition, the note should indicate that the service was provided during the COVID-19 crisis. This guidance applies to any other nonstandard procedures used in response to the COVID-19 crisis in addition to those specifically mentioned in this Bulletin.

Sample progress note language:

> *This session was provided via [HIPAA-compliant video conferencing or telephone] due to recommendations from public health agencies regarding face-to-face contact related to COVID-19. This client agreed to be treated via [telehealth or telephone] and provided verbal consent. The plan for dealing with an emergency during the session is that the clinician will [call 911 or contact an identified emergency contact], depending on the nature of the situation. The client is aware of this plan.*

How do we handle medication consents if the client is not physically present to sign, or it is not safe to pass pens and paper between the client and practitioner?
For directly-operated providers providing services during the COVID-19 crisis, verbal consent for medications may be obtained whether the client is present or not present. All items on the medication consent form shall be reviewed with the client, whether in-person, over the telephone or via telehealth. The client's understanding of the information and verbal agreement with it shall be documented both on the progress note and the medication consent form. For directly-operated providers, this is done on the Medication Consent and MSS Treatment Plan under Signatures by marking the "Parties Refused/Unable to Sign", then documenting in the Justification/Explanation field that the client/legal representative verbally agreed and affirmed understanding of the information. Whether the client was not present and therefore unavailable to sign, or present but did not sign due to social distancing practices, the specific situation leading to the verbal consent should be

documented on the Medication Consent and within the progress note along with a statement that the consent process was conducted in a nonstandard manner due to the COVID-19 crisis. Contract providers may choose to follow the directly-operated process or consult with their legal counsel to develop an alternate approach.

How do we handle client treatment plans if the client is not physically present to sign, or it is not safe to pass pens and paper between the client and practitioner?
Client treatment plans may be completed over the telephone or via telehealth, and verbal approval for the treatment plan may be obtained. The client/legal representative's verbal agreement to the treatment plan should be documented on the client treatment plan. For directly-operated providers, this is done by marking the "Client/Other Refused/Unable to Sign" or "Client/Other is Unavailable to Sign" box, then documenting in the comments field that the client agreed verbally to the plan but was not able to sign due to the COVID-19 crisis. In addition, the practitioner should document in the progress note that this process was done due to the COVID-19 crisis.

How are telephone services claimed?
Telephone services are a reimbursable method of providing services to Medi-Cal beneficiaries. Telephone services are not considered face-to-face activities and, therefore, no "face-to-face" time will be documented (i.e. face-to-face time will always be zero). For psychotherapy services provided over the telephone, the procedure code will always be H0046SC, and the entire amount of time spent providing the service will be included as "other" time. The SC modifier must be added to the procedure code for all telephone services, and the place of service will be wherever the practitioner is located. If the practitioner is providing telephone services from his/her own residence, the place of service should be "99 – unlisted facility" and the cross streets nearest the practitioner's home location, as well as home ZIP code, will be listed as the address where the service was provided.

How are telehealth (also referred to as telemental health or telepsychiatry) services claimed?
While telephone services are not considered face-to-face, telehealth services are considered face-to-face because the client is visually present. Telehealth services include the use of video teleconferencing solutions (e.g., HIPAABridge) in order to provide services to a client via interactive audio and video telecommunication. The GT modifier must be added to the procedure code for all telehealth services, and the place of service will be "02 – telehealth". The location of where the practitioner is located should be listed for the address. As with telephone services, if the practitioner is providing telehealth services from his/her own residence, the cross streets of the practitioner's home location, as well as the home ZIP code, must be listed as the address where the service was provided.

Does a provider need to be certified or pre-approved for telehealth services?
No. There is no Medi-Cal requirement that a provider be specifically certified or pre-approved for telehealth services.

Does a practitioner need to be present with the client for telehealth services?
No. There is no Medi-Cal requirement that a practitioner or other staff be physically present with a client in order for the client to receive services via telehealth. For directly-operated providers, the standard practice has been for the practitioner to be physically present with the client; however, as an interim procedure in order to support social distancing protocols, the presence of the practitioner will not be required.

What are the allowable types of telehealth equipment for <u>individual</u> services?
Telehealth must be provided using HIPAA compliant videoconferencing/video chat tools. For directly-operated providers, the approved types of equipment for individual telehealth services are Cisco Jabber and HIPAABridge. HIPAABridge supports a free mobile application that clients can download on their telephone. HIPAABridge can also be used via a computer browser, allowing the client to participate in telehealth services from his/her own residence. Directly-operated providers should refer to the CIO Teleworking Toolkit for

additional information regarding accessing this equipment. Contract providers should refer to the notification (linked here) from the U.S. Department of Health & Human Services (HSS) entitled discretion for telehealth remote communications during the COVID-19 crisis. Notably, the HHS notice states that under certain conditions, as long as telehealth services are provided in good faith, the Office of Civil Rights will exercise its enforcement discretion to not impose penalties for noncompliance with regulatory requirements under the HIPAA Rules.

How do we handle consents for telehealth if the client is not physically present to sign, or if it is not safe to pass pens and paper between the client and practitioner?
As with other forms of consent, the consent for telehealth may be done verbally and documented on the appropriate consent form. For directly-operated providers, use form MH 652 - Consent for Telemental Health Services for services using Cisco Jabber or form MH 732 - Consent for Secure Test Messaging/Video Chat for services using HIPAABridge.

How is timely access to care accounted for during the COVID-19 crisis? Do new clients have to be assessed?
At this time, there is no guidance from DHCS that relaxes the timeframes for access to care during the COVID-19 crisis. However, DHCS does allow for timeframes to be extended if there is determination by an Authorized Mental Health Discipline (AMHD) acting within his/her scope of practice and consistent with professionally recognized standards of practice that a longer wait time will not have a detrimental impact on the health of the client. Documentation of this determination may be done within the Service Request Log or Mental Health Triage form.

Can we claim for telephone check-ins on existing clients during the COVID-19 crisis?
As is the case at any other time, it depends on the specific activity the provider performs. If the contact addresses the client's identified mental health symptoms, behaviors, and/or impairments, the activity may be claimable as a direct treatment service such as individual rehabilitation (H2015) or plan development (H0032). If the contact is to outreach to the client, or reengage the client into treatment, the activity may be claimable as a Community Outreach Service (COS). And if the activity represents no service, such as leaving a voicemail, then the "never-billable" procedure code (00000) should be used.

Final Note:
DHCS has submitted to the federal Centers for Medicare and Medicaid Services (CMS) a request for section 1135 (Social Security Act) waiver flexibilities related to the COVID-19 national/public health emergency. This waiver, if granted, may impact the access to care and other requirements mentioned in this Bulletin. The QA Unit will update providers as additional information becomes available.

If directly-operated or contract providers have questions related to this Bulletin, please contact the Quality Assurance Unit at QualityAssurance@dmh.lacounty.gov.

cc: DMH Executive Management
DMH Administration Managers
DMH QA Liaisons
Legal Entity Executive Management
DMH Clinical Operations Managers
DMH Quality Management Unit
DMH CIOB Managers
Legal Entity QA contacts

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

COVID-19 SCREENING FROM

PLEASE CIRCLE

1. In the last 72 hours, has the client or any family member had any signs or symptoms of fever, cough, or shortness of breath?

   YES NO

2. Has the client or any family member traveled in the last 14 days to: China, Japan, Italy, Iran, South Korea?

   YES NO

3. Has the client or any family member been in contact with anyone who has tested positive for COVID-19 or is suspected of having COVID-19?

   YES NO

MARQUE CON UN CIRCULO

1. ¿En las últimas 72 horas, usted o un miembro de su familia ha tenido síntomas de fiebre, toz, o falta de respiración?

   SI NO

2. ¿En los últimos 14 días, usted of un miembro de su familia ha viajado a China, Japón, Italia, Irán o Corea del Sur? ¿Tiene usted o un miembro de su familia contacto con alguien que ha viajado a estos lugares?

   SI NO

3. ¿Usted o un miembro de su familia ha tenido contacto con alguien que ha sido diagnosticado positive con el Coronavirus o sospecha que está infectado (a) con el Coronavirus?

   SI NO

LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH

School Based Services

Current Issue	All 80 school districts in Los Angeles closed starting on 3/16/20 with an unknown re-open date. In FY 19-20, there are approximately 61 LE school mental health providers who serve approximately 1211 schools.
Impact of School Closures	Students who were receiving school mental health services are not being seen in the school setting. These students are either seen at the clinic or via telehealth if they are unable to go to the clinic. However, not all providers have a strong telehealth infrastructure. Students with mental health needs are not being identified by school staff to be referred to school mental health services.
Options for Providers	-Triage and complete intakes on students being referred from the DMH SBCAP Regional Team who are receiving referrals from the 80 school districts. -Increase telehealth options for clients unable to go to the clinic -Increase crisis support via expanding access to their after-hours line to all clients, including parents/caregivers -Develop activities that parents/caregivers can do with their children that would support all their mental health -Develop outreach materials tailored to their community that educates on how to support your mental health

ktate@dmh.lacounty.gov