Substance Use Disorder Information System

Communication Release

10/8/2021

Telehealth Modifier Configuration

Overview

The California Department of Health Care services (DHCS) published Behavioral Health Information Notice 21-047 regarding new telehealth modifiers required to be included on all claims for services provided via telehealth and telephone along with the corresponding place of service code no later than 11/1/2021. This is intended to allow DHCS to track access to services and measure the proportion of services delivered by telehealth, telephone or in person services.

SAPC has been working with Netsmart to configure Sage to support these requirements from DHCS and the changes will be released prior to the November 1st deadline. The details in this document are intended to support Secondary Providers in configuring their EHR to meet the requirements of the information notice. SAPC will also be providing a job aid for both Primary Providers and Secondary Providers prior to releasing the configuration in Sage for productive use. Primary providers will be able to use the job aid to navigate the changes in ProviderConnect in order to bill for telehealth or telephone services.

Requirements

All Medi-Cal covered services delivered by telehealth or telephone must be claimed using the following modifiers and place of service code, effective November 1, 2021:

- Telehealth service: GT
- Telephone service: SC
- Place of service code: 02

To further clarify, telephone and telehealth services included on 837P files must include the appropriate modifier with the CPT code for the service and must include the place of service code – 02 - to indicate the service was delivered via telehealth/telephone. If the 02 place of service code is not included on the claim when the telehealth or telephone modifiers are used, the service will be denied. The opposite is also true, if the telehealth or telephone modifier is used without the 02 place of service code, the service will be denied.

SAPC will not configure residential settings for telehealth services as these services are only allowable under current emergency order through December 2022 and are not normal levels of care that would constitute telehealth or telephone services. Additionally, services via telehealth to patients in quarantine or isolation while the patient is at the residential site should continue to be billed as regular residential services.

CPT and Modifier Combinations with Over Four Modifiers

With the addition of the telehealth/telephone service modifiers, there are certain authorization groupings where more than 4 modifiers would need to be used. All standard EDI and HIPAA transactions have a 4-modifier limit on CPT codes, where DHCS has indicated that the youth modifier – HA – should be dropped from the CPT/modifier combination to meet the 4-modifier maximum when the service is provided by telephone/telehealth and requires the new modifier. This will not impact the rate at which the service is reimbursed as all the effected codes are for PPW services, which receives the maximum allowable rate.

The authorization groupings where the youth modifier should be dropped for the new telehealth/telephone modifier are:
ASAM 1.0-WM - 12-17/Perinatal
ASAM 1.0-WM - 18-20/Perinatal
ASAM OTP - 12-17/Perinatal-PPW
ASAM OTP - 18-20/Perinatal-PPW
RSS – 12-17/Perinatal
RSS – 18-20/Perinatal

For example, a client receiving Individual Therapy (H0004) with ASAM level 1-OTP (UA + HG), age 15 (HA), pregnant (HD), and the service conducted via Telehealth (GT) would use code H0004:UA:HG:HD:GT. The youth modifier should be dropped if the Telehealth/Telephone modifier is to be used and would cause the number of modifiers to be higher than 4.

Companion Guide Updates

SAPC has updated the 837P Companion Guide to include additional information regarding the modifiers and place of service code. Updates have been made on pages 8 and 20 to address the new requirements. These changes add information regarding the order of the modifiers on the code and where the place of service code should be on the claim. The updated companion guide has been attached to this communication and has been uploaded to the Sage website on the Sage System Guides page. Email sapc_support@ph.lacounty.gov for questions or support on the companion guide changes.

Rates & Standards Matrix Updates

The Rates & Standards Matrix will be updated to also include a brief statement regarding the requirement for the modifiers and use of the 02 place of service code. The updated matrix will be released within the next 2-3 weeks.

Provider Activity Report Update

SAPC has been collecting and reviewing requests from providers regarding the Provider Activity Report in Sage and are excited to announce that these requests as well as necessary changes to support telehealth requirements are in the process of being implemented. The updated report is expected to be released by October 31, 2021. Some of the changes being made to the report:

- Formatting the report to make it easy to export without extra rows or columns
- Addition of Method of Service Delivery field from progress notes
- Addition of fields for Documentation Time and Travel Time from progress notes

When these changes are put in place, the Provider Activity Report will temporarily only be available for download as an Excel file and will not open in a window. It is expected that the ability to also view the report in a browser window will be available in November.

National Drug Codes for Medication Assisted Treatment

The Department of Health Care Services (DHCS) indicated in MHSUDS Information Notice 17-045 that Medication Assisted Treatment (MAT) claims are required to include the NDC Code for medications administered in the NTP setting. When billing for MAT services, it is required that the claim includes the National Drug Code (NDC) for the associated medication. For example, when billing CPT code S5000A for Naltrexone Generic, the required NDC code is 65757030001. SAPC has identified a high number of claims submitted by providers that did not include the required NDC code. Claims without the associated NDC code for the medication being billed will be denied by the State with the denial code CO 96 N54 or CO 26 N650.

Through SAPC's investigation of these State denial codes, it was identified that an issue with Sage was preventing claims submitted with an NDC code to be properly sent to the State with all required information. Sage is currently being updated to resolve this issue so the information will be appropriately sent to the State. If your agency received the two noted denial codes for MAT services, SAPC recommends validating if the claims sent to SAPC included the NDC code. If the NDC code was correctly added to the claim and received one of these denial codes, SAPC requests providers to resubmit the claims to SAPC so they can be sent to the State again for adjudication. If the claim did not include the NDC code, add the code to the claim and resubmit the claim to SAPC.

It is also important for secondary providers to ensure that their electronic health record systems are correctly configured to allow the agency to add the associated NDC code for MAT services. Without these codes being included on claims, they will continue to be denied by the State and recouped by SAPC. The NDC codes for each MAT CPT code can be found on the SAPC Rates and Standard Matrix, which can be located on the SAPC website at: http://publichealth.lacounty.gov/sapc/bulletins/START-ODS/21-05/StandardFY21-22RatesMatrix.pdf.

Claims for Patients with Other Health Coverage

SAPC has been working to update Sage to allow Primary Users to enter Other Health Coverage (OHC) on services for patients who have OHC. It is anticipated that the configuration of Sage for primary users should be completed within the next 2-3 months. When able, SAPC

will provide a more approximate date when able. SAPC asks that primary users continue to hold the submission of claims for patients where OHC information would need to be added until the configuration has been completed and SAPC has provided training and resources on how to submit claims with OHC information included.

For secondary providers, Sage is currently configured to accept 837 files with OHC information included and for the information to be transmitted to the State. To align your agency's electronic health record with requirements for including OHC information on an 837 file, refer to SAPC's 837 Companion Guides which can be found on SAPC's Sage website at: http://publichealth.lacounty.gov/sapc/providers/sage/system-guides.htm.

Documenting and Billing for Screening

As a reminder, all network treatment providers are required to:

1. Complete either an ASAM Co-Triage or Youth Engagement Screener for each person who comes to the facility requesting treatment services if not referred by SASH, CENS, or CORE.
2. Complete the Referral Connection Form in Sage for both admitted patients and patients who were referred out.
3. Enter diagnosis code:
    a. Enter diagnosis code Z03.89 in Sage and in provider's EHR, if applicable, for non-admitted screenings
    b. If the screening led to an admission at the same agency, providers should use the LPHA established diagnosis
4. Submit a claim using either:
    a. Provider authorization (PAuth) for patients not admitted; OR
    b. Member authorization for admitted patients

PAuths start with a "P" and are followed by a number. To obtain the PAuth numbers for your agency, providers can utilize the following resources:

- Primary providers: When entering a service on the Treatment page, the PAuth is seen in the Authorization field dropdown.
- Secondary providers: Contact the Sage Help Desk or your agency's assigned CPA to obtain the PAuth numbers.

Additional information on the requirements and how to do screening can be found on the SAPC website at: http://publichealth.lacounty.gov/sapc/providers/sage/other-training-resources.htm.

Progress Note Writing Tips

On average, SAPC receives approximately 400-500 requests to modify progress notes from Sage users on a **weekly** basis. The high volume of tickets for this scenario impedes SAPC's ability to focus more time on tickets that are highly-impactful for provider workflows or system functionality. The table below indicates the reasons why users are requesting progress note modifications and what SAPC recommends providers do to avoid these types of issues.

When a progress note modification is required, submitting accurate and complete information supports in the swift resolution of the modification and decreases processing time. It is also required that an individual ticket is submitted per progress note that needs modification. The following information is required to include on the request for the modification via the Sage Help Desk:

- PATID
- Date of Service
- Performing Provider
- Type of Service
- Duration
- Note Type (BIRP/GIRP/SIRP/SOAP/Misc.)
- Type of Misc. Note, if applicable

Note Issue Requiring Modification	Necessary Procedure Change
Staff are starting the notes before group, but patient doesn't show for group.	Notes should be written AFTER the group session has ended and not started before the group session

Full notes written for patients that did not attend the group that are being requested to be Final to Drafted to void the note.	Notes should be written AFTER the group session has ended and not started before the group session
Dates are entered incorrectly.	Before submitting the ticket for finalization, double check the service date to ensure it is accurate
If notes are written on a different date then the service, the counselor enters the documentation date rather than the service date.	If able, enter notes on the same date of the service. Always double check the service date is correct prior to finalization of the progress note

---

Avoiding Duplicate Patients in Sage

To decrease the volume of the duplicate creation of Patient IDs, SAPC encourages providers to utilize the following procedures to avoid creating a duplicate patient in Sage:

1. When admitting a patient into Sage, verify the patient's Social Security Number (SSN), date of birth, and name are entered correctly.
2. Do not enter 999-99-9999 as the search SSN if the patient does not have a SSN. The ranking of the search results is heavily weighted on the social security number. Using 999-99-9999 as the SSN will skew the search results and make it more difficult for providers to properly identify if a patient is already in Sage.
    a. Instead of using 999-99-9999, SAPC recommends using 222-22-2222, 333-33-3333, etc. in the **search only**, if the patient does not have a SSN.
    b. When completing the admission, providers should continue to utilize 999-99-9999 as the SSN in Sage.
3. Always double check the patient's SSN and DOB for all searches and when creating patients. Additionally, be careful when searching or entering patients with common names to ensure the appropriate patient is being searched for or created.

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 6, 2021

Behavioral Health Information Notice No: 21-047

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Telehealth guidance for specialty mental health services and substance use disorder treatment services in Medi-Cal

REFERENCE: DHCS telehealth policy

PURPOSE: Provide guidance on the Medi-Cal telehealth policy

BACKGROUND:
Telehealth is not a distinct service, but an allowable mechanism to provide clinical services. The standard of care is the same whether the beneficiary is seen in-person, via telehealth (synchronous audio and video) or via telephone (audio-only).

The Department is clarifying that all telehealth and telephone flexibilities available during the public health emergency will continue until December 31, 2022. A stakeholder workgroup will be convened to provide recommendations to DHCS regarding billing and utilization management protocols for telehealth and telephone modalities used in Medi-Cal; these recommendations will be used to inform the Governor's proposed 2022/23 budget.

POLICY:
Medi-Cal covered services delivered via telehealth and telephone modalities are reimbursable in Medi-Cal fee-for-service, managed care (physical health care), Specialty Mental Health Services (SMHS), the Drug Medi-Cal Organized Delivery System (DMC-ODS), and the DMC State Plan system, including initial assessments.

DHCS' coverage and reimbursement policies for services provided via telehealth and telephone modalities align with the California Telehealth Advancement Act of 2011 and federal regulations. State law defines telehealth as "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers." (Bus. & Prof. Code, § 2290.5, subd. (a)(6).

Specific guidance for providers regarding Health Insurance Portability and Accountability Act (HIPAA) and telehealth is available from the external resources listed on DHCS' Telehealth Resources page.

The U.S. Department of Health and Human Services Office of Civil Rights (HHS-OCR) has clarified that they will use enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules when providers use telehealth in good faith during the federal COVID-19 public health emergency. The HHS-OCR guidance states that providers can use any non-public facing remote communication product that is available to communicate with patients. Specifically, providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype to provide telehealth. However, public facing applications such as Facebook Live, Twitch, TikTok, and similar video communication applications should not be used in the provision of telehealth. DHCS does not impose requirements about which video chat applications can be used to provide services via telehealth beyond the guidance established by HHS-OCR. Please note that after the national public health emergency declaration expires, HHS-OCR may resume enforcement of regulatory requirements related to telehealth, including those that pertain to video chat applications. Additional guidance regarding HHS-OCR's HIPAA enforcement during the COVID-19 public health emergency can be found on HHS-OCR's webpage.

SAMHSA has also issued guidance on 42-CFR Part 2 compliance during the emergency.

More information on telehealth can be found on the DHCS Medi-Cal & Telehealth page and the DHCS Telehealth Resources page.

DHCS does not restrict the location of the provider while providing services via telehealth or telephone or of the beneficiary receiving the services. Providers may deliver services via telehealth or telephone from anywhere in the community, including outside a clinic or other provider site and beneficiaries may receive services via telehealth or telephone in their home or in other locations.

Providers are required to complete service documentation in the patient record in the same manner as in-person visit. Verbal or written consent for telehealth or telephone services shall be documented in the patient record. The fact that a service was performed by telehealth or telephone must be clearly documented in the chart and must be reflected in the claim, using the appropriate billing code and modifier, as described below.

The Short Doyle claiming system now accepts telehealth and telephone modifiers in DMC, DMC-ODS and SMHS. Use of telehealth and telephone modifiers is mandatory as of November 1, 2021, and encouraged before this date, to allow accurate tracking of telehealth and telephone usage in behavioral health. Billing codes must be consistent with the level of care provided. The following codes shall be used in DMC-ODS, DMC and SMHS:

- Telehealth (synchronous audio and video) service: GT
- Telephone (audio-only) service: SC
- Store and forward (e-consult in DMC ODS): GQ

See Mental Health Services Division Medi-Cal Billing Manual, page 87-94 for more information.

If a patient is receiving services via telehealth or via telephone, and a patient signature on the treatment/client plan is required, electronic signatures are allowable. If it is not possible to obtain an electronic signature, a written explanation in the client record is sufficient. It is not necessary to obtain a signature when the patient returns for an in-person visit.

Patient choice must be preserved: patients have the right to request in-person services.

Services provided by telehealth or telephone may be provided and reimbursed by the following programs; details for each program are described below:

Drug Medi-Cal Organized Delivery System:

- The initial clinical assessment, including any determination of diagnosis, medical necessity, and/or level of care may be conducted by telehealth, telephone, or in-person.
- Licensed providers and non-licensed staff may provide services via telehealth and telephone, as long as the service is within their scope of practice.
- Certain services, such as residential services, require a clearly established site for services and in-person contact with a beneficiary in order to be claimed. However, California's State Plan does not require that all components of these services be provided in-person. (For example, services can be provided via telephone for a patient quarantined in their room in a residential facility due to illness).
- DMC-ODS individual and group counseling services that a provider determines to be clinically appropriate can also be provided via telehealth and telephone.[1](examples include patient education, crisis intervention, case management, medication support services)
- DHCS supports the use of telehealth and telephone for DMC-ODS services when it is appropriate, and all relevant federal and state requirements are met. Additionally, DHCS supports the use of store and forward communications for DMC-ODS physician consultation services (e-consults).
- DHCS does not impose any limitations regarding telehealth flexibilities for the provision of medications for treating substance use disorder, commonly referred to as medication-assisted treatment, above and beyond applicable federal guidance. For example, SAMHSA has issued guidance describing how waivered buprenorphine prescribers working outside of the Narcotic Treatment Program (NTP) setting may prescribe buprenorphine to new and existing patients via telehealth (including telephone). The SAMHSA guidance also outlines telehealth flexibilities available to NTPs, including the ability to treat new buprenorphine patients via telehealth, to treat existing buprenorphine and methadone patients via telehealth, and to dispense take home medications with new flexibilities. Please refer to DHCS COVID-19 Frequently Asked Questions: Narcotic Treatment Programs for additional information regarding these COVID-related flexibilities for NTPs.

[1] Group counseling sessions may be conducted via telehealth and telephone if the provider obtains consent from all the participants and takes the necessary security precautions, in compliance with HIPAA and 42CFR Part 2.

DMC State Plan:

- The initial clinical assessment and determination of diagnosis and/or medical necessity can be conducted by telehealth, telephone, or in-person.
- Individual and group counseling services can be provided via telehealth and telephone in DMC State Plan counties.[2]
- Licensed providers and non-licensed staff may provide services via telehealth and telephone, as long as the service is within their scope of practice.
- DHCS supports the use of telehealth and telephone for DMC State Plan services when it is appropriate and all relevant federal and state requirements are met.
- Certain services, such as perinatal residential services, require a clearly established site for services and in-person contact with a beneficiary in order to be claimed. However, California's State Plan does not require that all components of these services be provided in-person. (For example, services can be provided via telephone for a patient quarantined in their room in a residential facility due to illness).

Specialty Mental Health Services:

- The initial clinical assessment, including any determination of diagnosis and/or medical necessity for outpatient services can be conducted by telehealth, telephone, or in-person.
- Individual or group services[3] that can be provided by telehealth or telephone are reimbursable in all counties (For example, include mental health services, crisis intervention services, targeted case management, intensive care coordination, and medication support services can be provided via telehealth, telephone, or in-person).
- Licensed providers and non-licensed staff may provide services via telehealth or telephone, as long as the service is within their scope of practice.
- Certain services, such as crisis stabilization, day rehabilitation, day treatment intensive, crisis residential treatment services, and adult residential treatment services, require a clearly established site for services and require some in-person contact between facility staff and a beneficiary to be claimed. However, California's State Plan does not require that all components of these services be provided in-person (For example, services can be provided via telephone for

[2] Group counseling sessions may be conducted via telehealth and telephone if the provider obtains consent from all the participants and takes the necessary security precautions, in compliance with HIPAA and 42CFR Part 2.

[3] Providers are still required to follow relevant privacy laws to ensure patient privacy protections.

a patient quarantined in their room due to illness).
- DHCS supports the use of telehealth and telephone for Specialty Mental Health services when it is appropriate and all relevant federal and state requirements are met.

Mental Health Services Act (MHSA): Counties may use MHSA funding to pay for services provided via telehealth or telephone as long as the services provided are consistent with the MHSA requirements and are not able to be covered by any other source of funding. Counties that use MHSA funds to pay for SMHS (and submit claims to the Department for Federal Financial Participation for the services) must follow the Medi-Cal guidance for telehealth and telephone services in this information notice and meet all applicable Medicaid and MHSA requirements.

5150 Evaluations and 5151 Assessments:
Welfare and Institutions Code Sections (W&I) 5150 evaluations and 5151 assessments may be performed by authorized providers face-to-face via telehealth as per W&I 5008(a) and W&I 5151(b). This may include releases from involuntary holds for evaluation and treatment, as appropriate. These services are billable to Medi-Cal regardless of whether they are provided in person or through telehealth as long as the individual has Medi-Cal coverage for the service and all Medi-Cal requirements are met. This assessment shall be made face-to-face either in person or by synchronous interaction through a mode of telehealth that utilizes both audio and visual components.

Telehealth Reimbursement: Rendering services via the telehealth or telephone modality does not change the payment methodologies to counties.

For any questions, please contact us at the following addresses:

Licensing and Certification Division – MHLC@dhcs.ca.gov
Mental Health Services Act – mhsa@dhcs.ca.gov
Medi-Cal Behavioral Health Division - CountySupport@dhcs.ca.gov.

Sincerely,

Shaina Zurlin, PsyD, LCSW, Chief
Medi-Cal Behavioral Health Division

Enclosure

DHCS Telehealth Frequently Asked Questions: Behavioral Health

Intake & Assessments

1. **May telehealth and telephone be used to place and release involuntary holds on individuals (5150 evaluations and 5151 assessments) and are these services billable to Medi-Cal?**

   Under existing law and with the passage of AB 3242, examinations or assessments under W&I Code sections 5150, and 5151, 5250 and 5585 may be performed by authorized providers either in-person or via telehealth (synchronous audio and video communication) as per W&I Code sections 5008(a) and 5151(b). The examination or assessment shall be consistent with the county's authority to designate facilities for evaluation and treatment, pursuant to sections 5150 and 5404 of the W&I Code. Please see Behavioral Health Information Notice 21-003 for more information regarding the passage of AB 3242.

2. **Can the consultation between an LPHA and counselor that is needed for level of care determinations also be done by telephone (and not strictly by video)?**

   Yes, for DMC-ODS counties, if the initial assessment of the beneficiary is performed by a registered or certified AOD counselor in compliance with the IA, then the medical director/licensed physician/LPHA must evaluate that assessment with the counselor to establish an SUD diagnosis, medical necessity, and a LOC placement. Nothing in the Standard Terms and Conditions (STCs) or Interagency Agreement (IA) prevents this consultation with the counselor from being conducted via telephone. Therefore, if the registered or certified counselor completed the initial assessment of the beneficiary in compliance with IA Section III.B.3.iv, then the medical director/licensed physician/LPHA can review the assessment with the counselor through a face-to-face, telehealth, or telephone discussion, including when establishing the SUD diagnosis, medical necessity, and/or level of care assignment.

Operational Requirements

3. **What services may be provided by telehealth?**

   Telehealth is not a distinct service, but an allowable mechanism to provide clinical services. The standard of care is the same whether the patient is seen in-person, by telephone, or through telehealth.

   Services delivered via telephone and telehealth are reimbursable in Drug Medi-Cal (DMC) State Plan counties, DMC-ODS and for Specialty Mental Health Services. See the DHCS telehealth website and the DHCS Telehealth FAQ.

4. **Can individual counseling services be provided via telehealth and telephone?**

   Individual counseling services can be provided via telehealth and telephone in DMC State Plan counties, DMC-ODS counties and for Specialty Mental Health Services

5. **Can group counseling services be conducted via telehealth and telephone? If so, does the 12-client limit remain in place?**

   Group counseling services can be provided via telehealth and telephone in DMC State Plan, Drug Medi-Cal Organized Delivery System and Specialty Mental Health Services. However, providers must obtain consent from all the participants and take the necessary privacy and security precautions, in compliance with HIPAA and 42 CFR Part 2 as applicable. The 12-client group size limit still applies in both DMC and DMC-ODS counties.

6. **Can Mental Health Specialists and staff who will not be licensed, but have AOD Certification, provide a billable telehealth assessment?**

   An intern, trainee, or waivered licensed professional under the supervision of a Licensed Professional of the Healing Arts (LPHA) may perform specialty mental health assessments and subsequent services by telephone, telehealth, or in-person, under supervision of a licensed professional. See MHSUDS Information Notice 17-040 for details about scope of practice.

7. Can controlled substances be prescribed over the phone?

This is a federal, not state, issue. SAMHSA released guidance that an initial evaluation by telehealth or telephone is allowed for buprenorphine during the emergency. The DEA COVID-19 website addresses all other controlled substances, which include sedatives and stimulants, under telemedicine. Practitioners can start a new controlled medication prescription by telephone for a patient who is already under their care by telephone. However, if a patient is new to the provider, controlled medications cannot be provided by telephone (other than buprenorphine). For patients new to the provider, prescribing controlled medications can only be done by telehealth (synchronous audio and video) or in-person.

Client Signatures, Consents and Privacy

8. Does DHCS have any guidance for counties on the expectation for client signatures on medication consents, release of information (ROI), consent forms, or notices of privacy practices if services are delivered exclusively by telephone or telehealth?

After the waiver of section 852 of Title 9 of the California Code of Regulations expires on September 30, 2021, providers must ask a patient to sign an informed consent document for receipt of anti-psychotic medications. If a patient consented to receive antipsychotic medication via telehealth, while section 852 was waived, and the patient returns to the provider for an in-person visit, the provider should ask the patient to sign an informed consent document for receipt of the anti-psychotic medications. Patients should date the document when the wet signature is provided, and the facility should document in the patient's medical record the reason for the late signature. Retroactive written consent is not required. If a patient does not wish to sign the consent form, the provider should make a notation in the patient's record that the patient understands the nature and effect of the antipsychotic medication and consents to the administration of such medication. Facilities are not expected to obtain signatures on these documents for patients that started and discontinued services during the COVID-19 public health emergency, or who discontinued services during the emergency period. During the COVID-19 public health emergency, Facilities must document in the patient's medical record the reason for the missing or late signature. This requirement only applies to anti-psychotic medications, not psychotropic medications generally.

DHCS does not have direct enforcement authority for HIPAA, the Confidentiality of Medical Information Act, the Information Practices Act. federal regulations at 42 CFR Part 2, or laws pertaining to informed consent. Consequently, DHCS has no authority to waive compliance with any of these laws. Stakeholders are urged to consult their own counsel about these issues, since DHCS' views cannot protect our stakeholders from enforcement by other authorities. To the extent that these requirements touch upon relationships with DHCS, including business associate relationships, it is DHCS's intention to support telehealth where possible. Depending on the specific circumstances, reasonable approaches to these varied requirements may include some or all of these:

- Documenting in the chart that oral consent was obtained in the course of telehealth services,
- Use of electronic signatures, such as via DocuSign or similar services, if the e-signature service has a business associate agreement with the applicable covered entity,
- Obtaining wet signatures, if necessary, when an in-person visit is made, and
- Documenting the reasons for any signatures that are late or missing.

9. When the emergency ends, does DHCS expect that counties will go back and obtain treatment or client plan signatures for clients that are still in treatment?

When a signature is required on a client plan and a beneficiary is unavailable to sign the plan, such as when the service is done by telehealth or telephone, the reason for the missing signature shall be documented in the client plan. It is not necessary to obtain the signature when the client returns to in-person care.

10. Are providers (both SMHS and SUD) required to obtain and document consent for telehealth and telephone services at each encounter or is this a onetime requirement?

California law requires a patient's consent to receive services via telehealth or via telephone to be documented in the client chart. Documentation of verbal consent is sufficient. California law does not specify the frequency a provider is required to obtain consent from a patient. For facilities that participate in Medi-Cal, the DHCS licensing and certification division will accept a one-time consent in the client file.

Documentation

11. Does DHCS have specific expectations for documentation of Medi-Cal services delivered by telephone or telehealth, including for consent?

Providers should complete service documentation in the patient treatment file in the same manner as an in-person visit. Verbal or written consent for telephone or telehealth services shall be documented in the patient record.

Additional recommendations from NHeLP:

1. Add to the FAQ and address it in the policy section that telehealth may be used to establish new patient (no prior in-person relationship is required for telehealth services to be provided), per the California Telehealth Advancement Act of 2011.

2. Add to the FAQ and address it in the policy section information about additional restrictions on the use of telehealth, if any. If no additional restrictions, it may be helpful to specify that in the FAQ. For example, “May behavioral health services be provided via telehealth to minors?” “Yes, there is no age restriction, so long that the treating provider believes that the benefits or services are clinically appropriate and are best practices to be provided via telehealth.”