April 16, 2020

Up-To-The-Minute Notice To Substance Use (SU) Treatment Providers

DHCS Response to Frequently Asked Questions for Behavioral Health

During State of Emergency Because of COVID-19

Effective April 16, 2020

Please see below for an updated list of Frequently Asked Questions related to the COVID-19 public health emergency. The below reflects a comprehensive list of the FAQs that are currently posted to DHCS’ COVID-19 Response website, as well as new FAQs that have been received for which responses have been completed. An updated Behavioral Health FAQ document reflecting this information will be posted to the DHCS COVID-19 website in the coming days, but we are sending these out via email to disseminate the information to you as quickly as possible.

We appreciate the time you have taken to submit these questions, and your patience as we worked to research the responses. We hope you find this information helpful, and please continue to submit additional questions to CountySupport@dhcs.ca.gov, as needed, as DHCS is continuing to work to address the questions submitted to date.

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?** (New 4/9/20)

WIC 5150 evaluations may be performed by authorized providers face-to-face via telehealth as per WIC 5008(a). This may include releases from involuntary 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. That said, assessments required by WIC 5151 are to be completed “in person” and, as such, shall not be provided using telehealth.
2. Can DHCS clarify that assessment and medical necessity and level of care may also be done by telephone for Drug Medi-Cal Organized Delivery System (DMC-ODS) counties? (New 4/9/20)

Yes. In anticipation of CMS’ approval of DHCS’s 1135 Waiver request, beginning on March 1, 2020 and for the duration of the emergency, the initial assessment of the beneficiary may be performed by telephone by a medical director, a licensed physician, a licensed practitioner of the healing arts (LPHA), or a certified alcohol or other drug (AOD) counselor. Outside of and during the emergency, this initial assessment can also be performed either face-to-face or via telehealth (STC 132.e; IA Section III.B.3.iv). The medical director, licensed physician, or LPHA must then use the information gathered in that face-to-face or telehealth assessment to establish a substance use disorder (SUD) diagnosis, medical necessity, and level of care (LOC) placement.

3. 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)? (New 4/9/20)

Yes, for DMC-ODS counties, if the initial assessment of the beneficiary is performed by a 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 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 when establishing the SUD diagnosis, medical necessity, and level of care assignment.

Operational Requirements

4. What services may be provided by telehealth? (Updated 4/9/20)

DHCS encourages all counties to permit telehealth services within state and federal requirements, given the importance of minimizing COVID-19 spread. In anticipation of CMS’ approval of DHCS’s 1135 Waiver request, beginning on March 1, 2020, and for the duration of the emergency, services via telephone and telehealth are now reimbursable in Drug Medi-Cal State Plan counties. Services via telephone and telehealth are available in DMC-ODS and for Specialty Mental Health Services, independent of the emergency. See the COVID-19 Behavioral Health Information Notice 20-009, the DHCS telehealth website and the DHCS Telehealth FAQ.

5. Can individual counseling services be provided via telehealth and telephone? (New 4/9/20)
Yes. In anticipation of CMS’ approval of DHCS’s 1135 Waiver request, beginning on March 1, 2020, and for the duration of the public health emergency, individual counseling services can be provided via telehealth and telephone in DMC State Plan counties. Individual counseling may be provided in DMC-ODS counties and for Specialty Mental Health Services, independent of the emergency.

6. Can group counseling services be conducted via telehealth and telephone? If so, does the 12-client limit remain in place? (New 4/9/20)

Yes. In anticipation of CMS’ approval of DHCS’s 1135 Waiver request, beginning on March 1, 2020, and for the duration of the public health emergency, group counseling services can be provided via telehealth and telephone in DMC State Plan counties. Group counseling services may be provided in Drug Medi-Cal Organized Delivery System and for Specialty Mental Health Services, independent of the emergency. 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.

The 12-client group size limit still applies in both DMC and DMC-ODS counties.

7. Can Mental Health Specialists and staff who will not be licensed, but have AOD Certification, provide a billable telehealth assessment? (New 4/9/20)

An intern, trainee, or waived 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.

8. How can providers ensure their patients do not run out of medications?

Medi-Cal allows patients to fill up to 100 days of non-controlled medications. Narcotic treatment programs can receive exemptions to provide take-home medications for patients who are sick or quarantined. See COVID-19 FAQ: Narcotic Treatment Programs for more detail. Patients receiving buprenorphine products can currently receive 30-day supplies on Medi-Cal.

Utilization limits on quantity, frequency, and duration of medications may be waived by means of an approved Treatment Authorization Request (TAR) if there is a documented medical necessity to do so. See DHCS pharmacy guidance.

Some medications are anticipated to be in short supply due to supply-chain challenges. The FDA keeps a list of medications in short supply, including some medications for behavioral health conditions. DHCS recommends that providers prescribe 100-day supplies of all chronic medications, and patients may obtain early refills if 75% of the estimated duration of the supply dispensed has elapsed (other
than certain medications with quantity/frequency limitations). Pharmacies are required to supply up to 72 hours of prescribed medications in an emergency and may provide the emergency supply without an approved TAR.

Medi-Cal allows for, and reimburses, mail order pharmacy providers enrolled as pharmacy providers in the Medi-Cal program.

9. Can controlled substances be prescribed over the phone? (New 4/9/20)

This is a federal, not a state, issue. SAMHSA has released guidance that an initial evaluation by telehealth or telephone is now allowed for buprenorphine. The DEA COVID website addresses all other controlled substances, which includes sedatives and stimulants, under telemedicine. Practitioners can start a new prescription for a patient who is already under their care by telephone, but cannot do so for a new patient without a telemedicine or in-person visit. For more information, see https://www.deadiversion.usdoj.gov/coronavirus.html.

10. How can providers maintain services in the face of staff shortages?

DHCS anticipates that staff illness and quarantine may create challenges for provider organizations. DHCS encourages providers to do contingency planning to ensure that patients are able to access needed care. DHCS provides specific guidance in the COVID-19 Behavioral Health Information Notice 20-009.

11. How do counties access the American Society of Addiction Medicine (ASAM) training modules referenced in the Intergovernmental Agreement? (New 4/9/20)

All ASAM trainings funded by DHCS include the required modules. Counties may, however, purchase the modules from ASAM to facilitate provider training.

Client Signatures, Consents and Privacy

12. Does DHCS have any guidance for counties on the expectation for client signatures on release of information (ROI), consent forms, or notices of privacy practices if services are delivered exclusively by telephone or telehealth? (New 4/9/20)

DHCS did not specifically request waivers of signatures on these items; therefore, we do not have specific guidance at this time. DHCS expects providers to document client consent in other ways if an in-person visit is not possible. That said, DHCS will continue to work to include information relevant to client signatures in Behavioral Health Information Notice 20-009 and/or these FAQs as more information becomes available.
13. May providers share SUD diagnosis information during this emergency? (New 4/9/20)

Yes. The Substance Abuse and Mental Health Services Administration (SAMHSA) issued [new guidance](#) which allows providers to share patient SUD diagnosis information that would normally be protected under 42 CFR Part 2 in instances of a bona fide medical emergency. Usage of the medical emergency exception must be documented by providers.

14. 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? (New 4/9/20)

Counties are not expected to get signatures from beneficiaries who receive DMC State Plan and DMC-ODS services during the time period of the COVID-19 public health emergency. For Specialty Mental Health Services, MHPs may provide services through telehealth and telephone during the COVID-19 public health emergency and if beneficiaries are unavailable to sign their client plans, Section 1810.440(c)(2)(B) of Title 9 of the California Code of Regulations applies, which gives an exception to the signature requirement when the client is unavailable. When the public emergency ends, counties shall resume compliance with all requirements for obtaining treatment plan signatures on a “go-forward” basis. This means that following the COVID-19 public health emergency, counties shall obtain a treatment or client plan signature from all new beneficiaries and from existing beneficiaries when they resume in-person services following the emergency. Counties are not expected to obtain beneficiary signatures on treatment or client plans for beneficiaries 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, Counties must document in the beneficiary’s medical record the reason for the missing signature.

**Documentation**

15. Does DHCS have specific expectations for documentation of services delivered by telephone or telehealth? (New 4/9/20)

Counties should continue following current documentation requirements unless informed otherwise by DHCS. The IA (specifically, Exhibit A, Attachment I A2 15. “Progress Notes”) specifies the documentation requirements in the DMC-ODS.

16. Is documentation of patient consent for telehealth or telephone services required during the emergency? (New 4/9/20)

No. [Executive Order N-43-20](#) states that the requirements specified in Business and Professions Code section 2290.5(b) related to the responsibility of a health care
provider to obtain verbal or written consent before using telehealth to deliver services and to document that consent is suspended.

17. **What about required signatures on other intake requirements, like admission agreements or consent for treatment forms?** (New 4/9/20)

Counties are not expected to get required signatures from beneficiaries who receive DMC State Plan and DMC-ODS services during the time period of the COVID-19 public health emergency. For Specialty Mental Health Services during the COVID-19 public health emergency, MHPs may follow the guidance in #4 above regarding signatures on client plans. MHPs may suspend the requirement for patient signature for receipt of psychiatric medication during this time of emergency (Cal. Code. Regs. tit. 9 § 852). When the public emergency ends, Counties shall obtain signatures from all beneficiaries. Signatures should not be backdated. Beneficiaries should date the document when the wet signature is provided, and counties must document in the beneficiary’s medical record the reason for the late signature. Counties are not expected to obtain signatures on these documents for beneficiaries 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, Counties must document in the beneficiary’s medical record the reason for the missing or late signature.

**Data Reporting**

18. **Can DHCS clarify current expectation for the various county data reporting requirements?** (New 4/9/20)

Reporting requirements during the COVID-19 public health emergency are as follows:

- **Consumer Perception Survey** - The next scheduled survey period is May 2020. Due to the COVID-19 emergency, DHCS is extending the survey collection period to June 2020.

- **Client and Services Information System (CSI), Data Collection and Reporting System (DCR), California Outcomes Management System (CalOMS) and American Society of Addiction Medicine (ASAM) Level of Care** - DHCS recognizes that there may be delays in submitting data. However, due to federal reporting requirements, DHCS is not able to waive data reporting requirements for CSI, DCR, CalOMS and ASAM Level of Care Data.

- **Child and Adolescent Needs and Strengths (CANS) & Pediatric Symptoms Checklist – 35 (PSC 35)** - During this time of COVID-19, DHCS recognizes that there may be limitations in staff time as some staff are being redirected due to the emergency. If necessary, counties may temporarily utilize alternative tools to CANS or PSC-35 through April 30, 2020. However, counties opting to use
these alternative tools should resume use of CANS and PSC-35, as well as resume submissions for the May 2020 reporting month. Furthermore, although IN 20-003 requires counties to include the CIN number with CANS and PSC-35 submissions to the FAST system, due to COVID-19, DHCS will extend the implementation of the mandatory CIN requirement to July 1, 2020.

Provider Enrollment

19. Can DHCS issue written clarification explaining whether and how the Provider Enrollment Division (PED) emergency bulletin, which outlines an expedited emergency enrollment process for Medi-Cal FFS providers, applies to DMC providers with pending applications for DMC site certification? Can providers with pending DMC certifications begin claiming for DMC/DMC-ODS services if they follow the procedure in the bulletin for FFS providers? If so, how does this impact the status of their existing DMC application? Are there specific steps they’d need to take after the emergency enrollment period passes? (New 4/9/20)

DMC providers with DMC applications currently under review with PED can additionally apply for emergency enrollment pursuant to the Guidance for Emergency Medi-Cal Provider Enrollment. Their pending non-emergency enrollment DMC applications will not be impacted. Moreover, providers enrolled pursuant to the provider bulletin will be automatically deactivated at a later date based on the duration of the emergency. If a provider would like to continue their enrollment as a DMC provider, they will need to submit a completed DMC provider application. If a provider currently has a pending non-emergency DMC application, it will continue to be reviewed in the order it was received, separately from any DMC application received pursuant to the emergency provider bulletin.


Pursuant to section 1135 of the Social Security Act (1135 Waiver) CMS has waived the enrollment requirement for SMHS providers to undergo an onsite visits per Code of Federal Regulations (CFR), title 42, section 455.432(a). Moreover, part of the enrollment process for SMHS providers includes the requirement for the provider to obtain a fire clearance prior to the onsite visit, as specified in the county Mental Health Plan (MHP) contract. As stated under the MHP contract, Exhibit E, page 12 of 16, Paragraph 7(B), DHCS may use policy letters to provide clarification and instructions to its contactors regarding implementation of mandated obligations pursuant to State and federal statutes and regulations.

In light of the many challenges counties are facing due to the COVID-19 crisis, including the inability to obtain a fire clearance, the DHCS is waiving the Medi-Cal Certification requirements for an onsite review and a fire clearance, during the approved 1135 Waiver period. During this time, providers may be certified using the
streamlined procedures. See updated Behavioral Health Information Notice 20-009 for more details.

21. Counties and providers have asked about fingerprinting requirements and noted that they can’t do fingerprinting right now as facilities are closed. Is fingerprinting part of the provider enrollment background check process that can be waived? Is it also something that DHCS monitors outside of provider enrollment? If so, can DHCS clarify the expectation for providers who are still trying to obtain fingerprints from staff? (New 4/9/20)

As the provider bulletin states, providers who enroll using this method will not be subject to the following requirements: submission of an application fee, designation of screening levels, and submission of a completed Medi-Cal Provider e-Form Application, which includes a completed Medi-Cal Disclosure Information Section and Medi-Cal Provider Agreement. This includes application requirements such as fingerprints required for providers with moderate or high risk designations. However, this only applies to emergency enrollment pursuant to the provider bulletin. If a provider seeks regular enrollment in Medi-Cal, they are subject to the existing statutory and regulatory requirements for their provider type.

The requirements of Welfare and Institutions Code §5405 that individuals employed in MHRCs and PHFs undergo criminal background checks, including fingerprinting, remain in effect; however, DHCS may grant program flexibility when a provider proposes to use alternate concepts to comply with existing MHRC and PHF staffing regulations. Facilities requesting program flexibility should describe the alternate concepts needed to meet the intent of the above requirement and submit it to MHLC@dhcs.ca.gov for consideration.

Additionally, to facilitate processing of CBC clearances during the COVID-19 pandemic, DHCS has instituted the following:

- DHCS Mental Health Licensing Section will work collaboratively with facilities to process a Criminal Record Approval Transfer Notification (CRATN). An additional criminal background check (CBC) is not required if an individual or licensee has received a prior CBC clearance while working in a licensed facility and wishes to transfer to another similar facility. The individual or licensee who wishes to obtain a CRATN shall complete the DHCS Form 1818.

- An online criminal background check may be considered with the submission of the DHCS Form 3007 and DHCS Form 3085.

- Once the DHCS Form 1818 has been submitted to DHCS, the individual with a DHCS-issued CBC clearance is allowed to start working in a PHF or MHRC.
• As was the case before the COVID-19 crisis, a new employee who has submitted fingerprint images/live scans can start working in a PHF or a MHRC while awaiting the CBC clearance as long as the employee is under constant supervision.

• If the individual will solely be providing services through telehealth, and will have no direct contact with the patient, then a criminal background check will not be required.

**Licensing and Certification**

22. Can DHCS waive the requirement that SUD treatment programs maintain a minimum of 30% licensed staff? (New 4/9/20)

DHCS does not require AOD treatment programs to maintain a minimum of 30% of licensed staff. Pursuant to California Code of Regulations Title 9 Chapter 8 Section 13010, at least 30% of staff providing counseling services in all AOD programs shall be licensed or certified.

23. Can individual providers receive a waiver to operate above their licensed capacity? (New 4/9/20)

To address the issue of insufficient AOD/SUD treatment bed capacity, the Licensing & Certification Division will expedite review and approvals of requests for increases in treatment bed capacity. Residential SUD treatment facilities seeking to increase treatment bed capacity shall electronically submit a Supplemental Application (DHCS 5255) along with a Facility Staffing Data form (DHCS 5050) for review to LCDQuestions@dhcs.ca.gov. DHCS shall also review and approve facility requests to temporarily operate above their licensed treatment bed capacity as long as the total bed capacity does not exceed the capacity allowed in the approved facility fire clearance.

For any specific operational flexibilities, including the need to operate above the licensed capacity for MHRCs and PHFs, requests may be made by email to: MHLG@dhcs.ca.gov. The request shall include the following written components:

• Description of alternate concepts, methods, procedures, techniques, equipment, and personnel qualifications.

• The reasons for the program flexibility request and justification that the goal or purpose of the regulations would be satisfied.

• The time period for which the program flexibility is requested.
• Policies and Procedures to implement the provisions of the program flexibility which demonstrate that this flexibility meets or exceeds provisions for patient care and safety.

24. What are the licensure requirements to allow SUD residential programs to relocate into new locations on an emergency basis? (New 4/9/20)

In accordance with California Code of Regulations Title 9 Chapter 5 Section 10527(c), facilities that move operations to new locations shall submit a Supplemental Application (DHCS 5255) within 60 days from the date of the move.

25. Are facilities able to provide treatment or recovery services outside the facility service location if there are concerns about providing treatment at the location due to COVID-19? (New 4/9/20)

In some circumstances, DHCS shall consider and may allow facilities to provide treatment or recovery services off-site for any concerns related to COVID-19. Providers should contact their Licensing Analyst for questions. See COVID-19 Response website for information notices for treatment facilities.

General COVID-19 Information

26. Where are up-to-date resources on COVID-19?

California Department of Public Health – COVID-19 Updates

CDPH Gathering/Meeting Guidance

CDC COVID-19 webpage

Guidance for the Elderly

Guidance for Employers

What to do if you are sick

Guidance for Workplace/School/Home Document

Steps to Prevent Illness

Guidance for use of Certain Industrial Respirators by Health Care Personnel

Medicaid.gov, COVID-19 resource page
27. How should behavioral health programs reduce transmission of COVID-19?

The CDC has provided interim infection prevention and control recommendations in health care settings. Recommendations include:

- Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer, tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc.
- Wash hands often with soap and water for at least 20 seconds.
- Cover mouth and nose with a tissue when coughing or sneezing and immediately dispose of the tissue.
- Avoid touching your eyes, nose and mouth with unwashed hands.
- Clean all surfaces and knobs several times each day with sanitizers.
- Anyone with a respiratory illness (e.g., cough, runny nose) should be given a mask before entering the space.
- Stay home and away from others when sick.

28. How should behavioral health providers manage patients presenting with upper respiratory symptoms?

DHCS strongly encourages use of telehealth or telephone services to minimize infection spread. See COVID-19 Behavioral Health Information Notice 20-009 for information about how specialty mental health and substance use disorder services can be delivered by telehealth or telephone, including in facilities where patients may want to access services by telephone even when needing to be isolated in their room.

When telehealth is not available, providers should develop procedures to minimize the risk that symptomatic patients will infect staff or other patients. Patients with cough should wear a mask if available.
Programs should follow infection prevention and control recommendations in health care settings published by the CDC (please see #35 below for more details).

29. When should programs refer a patient to medical care?

There is currently no treatment for COVID-19, only supportive care for severe illness. Mildly symptomatic patients should stay home. See CDC guidelines for health care professionals on when patients with suspected COVID-19 should seek medical care.

30. What should SUD facilities do in the event a client is diagnosed with COVID-19?

If a client of an outpatient facility is confirmed to be positive for COVID-19, the client should be instructed to stay home. Services may be provided by telephone or telehealth (see question 8). Residential or inpatient facilities with a patient or resident diagnosed with COVID-19 should ensure the patient is isolated in a room, has a mask for use when leaving the room, and should contact their local public health department for guidance. Inpatient and residential facilities must also report to DHCS, within one (1) working day, any events identified in California Code of Regulations Title 9 Chapter 5 Section 10561(b)(1), which would include cases of communicable diseases such as COVID-19.

31. If a former client is later found to have been diagnosed with COVID-19, what action should be taken?

Staff should inform possible contacts of their possible exposure, but must protect and maintain the participant’s confidentiality as required by law. Clients exposed to a person with confirmed COVID-19 should refer to CDC guidance on how to address their potential exposure, as recommendations are evolving over time.

32. What should SUD facilities do in the event a staff member is diagnosed with COVID-19?

Staff members who have symptoms of a respiratory illness should stay home until symptoms completely resolve. Staff members with confirmed COVID-19 infection, or who are under investigation (testing pending), should stay home and the facility should contact their local public health department for guidance. Inpatient and residential facilities must also report to DHCS, within one (1) working day, any events identified in California Code of Regulations Title 9 Chapter 5 Section 10561(b)(1), which would include cases of communicable diseases such as COVID-19.

33. What else can behavioral health programs do to prepare for or respond to COVID-19?
DHCS encourages providers to adhere to the CDC's and CDPH's recommendations to prepare for COVID-19. Some helpful preparedness strategies include but are not limited to the following:

- **Screen patients and visitors for symptoms of acute respiratory illness (e.g., fever, cough, difficulty breathing) before entering your healthcare facility.** Providers can refer to the following resources on the CDC's Guidelines for patient screening and Infection Prevention and Control Recommendations for more information.

- **Ensure proper use of personal protection equipment (PPE)**

  Healthcare personnel who come in close contact with confirmed or possible patients with COVID-19 should wear the appropriate personal protective equipment.

- **Encourage sick employees to stay home**

  Personnel who develop respiratory symptoms (e.g., cough, shortness of breath) should be instructed not to report to work. Ensure that your sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

- **Encourage adherence to the CDC's recommendations**, including but not limited to the following steps, to prevent the spread of illness:
  - Avoid close contact with people who are sick.
  - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
  - Avoid touching your eyes, nose, and mouth.
  - Clean and disinfect frequently touched objects and surfaces.
  - Stay home when you are sick, except to get medical care.
  - Wash your hands often with soap and water for at least 20 seconds.

- **Ensure up-to-date emergency contacts** for employees and patients.

- **Reach out to patients** through phone calls, emails, and onsite signs to contact the treatment program before coming on-site if they develop symptoms, so alternatives (such as phone or telehealth visits) can be discussed.

- **Change seating in waiting room and group visit sessions** to maintain a six-foot distance between patients.

- **Limit group visits**, especially for those at high risk (e.g., over age 60). If you hold group visits, set up chairs six feet apart.

- **Protect the health of high-risk staff**. For example, staff over the age of 60 or with health conditions should consider conducting all or most visits by telephone and telehealth visits, where appropriate.