This is the second formal correspondence from the DBH to behavioral health treatment providers regarding our response to the COVID-19 pandemic. It includes more specific guidance related to billing parameters and service delivery.

To help mitigate the clinical and fiscal impacts of the COVID-19 pandemic on our community behavioral health providers, the following policies and billing parameters are effective March 9, 2020, until otherwise determined by the Division of Behavioral Health, Department of Mental Health. We recognize these may not address all programs and potential scenarios; we expect to add to this over time. Please let us know as soon as possible of any obvious issues or oversights.

GUIDING PRINCIPLES

- Prevent or minimize clients’ and staff’s exposure to contagious illness.
- Focus on maintaining the clinical stability of clients in the community to avoid unnecessary burdens on the general and acute healthcare system.
- Reduce barriers to providing necessary clinical interventions in atypical circumstances via alternative means of communication.
- Simplify, to the degree possible, the process for billing services while simultaneously capturing data that may be relevant and valuable post-pandemic.
- Continue billing services to the appropriate fund source when possible.
- Provide fiscal stability to agencies during this period of unpredictable revenues, expenditures, service disruptions, and workforce availability.
- Establish a time frame for providers to assure EMR compliance with coding changes made
for the purposes of COVID-19-related tracking.

FISCAL GUIDANCE

CCBHO Providers: CCBHOs will continue to receive a PPS for DBH-funded services that previously triggered visits. In addition, services typically not considered billable via non-face-to-face methods (i.e. telephone, video, text, e-mail) will also be reimbursed via PPS. To assess the impacts of COVID-19, DBH is adding the modifier “CR” to the T1040 code (T1040 CR Q2). Shadow claims will continue to be captured as they are now. You should only use the CR-modified code if you are delivering services differently due to COVID-19.

Telehealth is an approved medium for all current billable services. Services delivered via telehealth should be billed normally unless this medium was specifically used due to COVID-19 circumstances.

MHD Clinic Services - The CR modifier is only being added to DBH-funded services. Services provided under the MHD “clinic” option may be delivered via telehealth, telephone, or other means as described in the “Relevant References to Current Parameters of ‘Telehealth”’ (below).

Non-CCBHO Fee for Service (FFS) Providers: The DBH is adding the modifier “CR” on several service codes so providers can be reimbursed for services delivered via non-traditional, electronic methods (i.e., telephone, video, text, e-mail). All existing modifiers for FFS billings remain with CR added to the end. The exception is for sign language fluent services; this can be amended later if providers determine the need. Services delivered via telehealth should be billed normally unless this medium was specifically used because of COVID-19 circumstances. If telehealth was only due to COVID-19, the CR modifier in combination with the telehealth modifier (GT) is requested.

Time Frame for Providers to Utilize CR Modified Codes – We recognize that it may take some time for providers to make changes to their EMR systems to accommodate the CR modifier which will enable us to better track COVID-19-related impacts to service provision. The providers will have 15 business days (starting from March 20, 2020) to begin using the CR-modified codes. Until providers can begin using the CR-modified codes, they should generally keep track of services delivered during that time.

At this time, the following programs will have CR codes added:

- CSTAR W&C, W&C Enhanced, W&C AltCare
- CSTAR Adolescent
- CSTAR General Adult Enhanced
- Adult and Youth CPR
- Adult and Youth Community Services

The “next round” of programs that will have the CR modifier added to codes include:

- CSTAR Opioid
- CSTAR General Adult
- State Opioid Response (SOR)
• Justice Reinvestment Initiative (JRI)
• Primary Recovery Plus (PR+)
• DOC Free & Clean and Community Restoration

The following FFS codes are approved for the CR modifier (more may be added as determined appropriate, except for sign language fluent service codes). A more detailed list will be sent to providers when complete.

CPS Services
• Community Support
• Professional PSR (individual psychotherapy)
• Crisis Intervention
• Family and Peer Support
• Physician Services (E&M codes)
• Medication Administration (nursing)

SUD Services
• Community Support
• Individual Counseling (including specialty
• Family and Peer Support
• Physician Services (E&M codes)
• Medication Administration (nursing)

Clinical Outreach - There will be one outreach code with the new modifier available for both CPR and CSTAR programs. You may use the code for both specific and non-consumer specific outreach within the program. This code shall be used in place of community support when no contact by any means is made with client (ex: dropping something off on a porch). Suggested uses of these codes are below.

CPS - H0023
Code is consumer specific

CSTAR - 15010
Code is non-consumer specific – please place documentation in client chart when used for a specific consumer

Recommended use of both codes:
• Engagement of individuals referred from other entities
• Delivery of basic needs
• Transporting of a device that allows for tele-health appointment to occur in the home
• Well checks to ensure stabilization during COVID-19
• Aid to continue work with client regarding medication adherence
• Contact and stabilization of individuals without community support services
• Increasing check-ins due to inability to obtain preferred face-to-face services due to COVID-19
• Allow community support key service functions under this code by staff that would not qualify to deliver them pre-COVID-19
• Assessment of basic needs
Consultation  
Coordination  
Referrals  

Loss of Revenues: The DBH understands there could be potential loss of revenue due to a decline in new admissions and office visits; closing and/or reduced utilization of residential or other congregate treatment settings; staff shortages or reduced billings of some professionals, etc. due to COVID-19. To support fiscal stability and agency sustainability, the DBH will allow agencies to invoice for COVID-19 associated loss of revenues (services only) for FFS providers, effective March 9, 2020. We will continue to evaluate the need for such support for CCBHO providers.

The invoice must include the following information (Appendix B for template):
- Lost revenues by
  1. Contract
  2. Service Category
  3. Amount
- Brief explanation of the loss (i.e., staff shortages, closed offices, interrupted programs, reduced census, etc.)
- Timeframe during which the revenue was lost.

The invoice for loss of revenues will be paid from your current non-Medicaid allocation. If there is no funding remaining in your allocation, the invoice will not be paid unless you request to move funding (normal transfer rules apply).

The invoices are submitted at the providers’ discretion. Loss of revenue will affect all providers differently. Providers will be given at least 30 days notice before all invoices are due and will no longer be accepted.

Additional Points to Remember:
- The DBH understands the federal government is considering an infusion of financial resources to assist state budgets in addressing the expected economic decline within states due to COVID-19. We will advocate on your behalf for those funds, just as we have during past recession events.
- The DBH understands the Governor’s office, the Missouri Coalition for Community Behavioral Healthcare, and others are working with the Missouri Health Foundations to identify additional resources that could assist in covering some of the extraordinary costs you may incur during this pandemic.

Relevant References to Current Parameters of “Telehealth”: The DBH has been reviewing many of the relevant documents being issued around this topic, having conversations with the MO HealthNet Division (MHD), as well as seeking outside consultation.

“COVID-19 FAQs for State Medicaid and CHIP Agencies” (published 3.12.2020): #2. What flexibilities are available to provide care via telehealth for individuals who are quarantined or self-isolated to limit risk of exposure? “States have broad flexibility to cover telehealth through Medicaid, including the methods of communication (such as telephonic, video technology commonly available on smart phones and other devices) to use. Telehealth is important not just for people who are unable to go to the doctor, but also for when it is not advisable to go in person. No federal approval is needed for state
Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services…”

**MHD Provider Hot Tip on Telehealth** (issued 3.16.2020) refers to prior Telehealth bulletin ([https://dss.mo.gov/mhd/providers/pdf/bulletin41-20-2018.pdf](https://dss.mo.gov/mhd/providers/pdf/bulletin41-20-2018.pdf)), cites state statutes pertaining to telehealth (191.1145, 191.1146, 208.670, and 208.677), and the following narrative: “During this event, the MHD is waiving the requirement that physicians must have an established relationship with the patient before providing services via telehealth. **Telehealth services may be provided to a MHD participant, while at home, using their telephone.** There is not a separate telehealth fee schedule. Reimbursement to health care providers delivering the medical service at the distant site is equal to the current fee schedule amount for the service provided. This Hot Tip also applies to providers that are contracted with the Managed Care Organizations.”

**HHS.gov site on Notification of Enforcement Discretion** (posted 3.17.2020) offers guidance for telehealth remote communications during the COVID-19 nationwide public health emergency: [https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html](https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html). You will find in this link the following statement: “Under this Notice, covered health care 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 without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.”

**PROGRAM POLICY GUIDANCE**

We recognize that certain rules typically associated with program administration may need to be temporarily relaxed and some timelines extended. The following policy changes are effective March 9, 2020. For all staff interacting with consumers, in any way, the normal background checks must be completed. Standard program rules and procedures will be reinstated following the identified end to this public health crisis.

**Service Documentation:**

- Client signatures on required documents will be waived. Please obtain verbal consent/approval and ensure that this consent is documented.
- Time frame allowed for the completion of general progress notes will be extended from five (5) business days to 15 business days.
- Timelines associated with the completion of assessments/treatment plans will be extended from 30/45 days to 60/90 days.

**Staff Qualifications and Training:**

- Outreach may be delivered by any staff that provides any form of direct care to consumers.
- Community support may be delivered by all clinical staff with appropriate training, as determined by the agency, to perform this function.
• Certain training requirements for new employees may be waived in order to expedite their ability to provide services to consumers:
  o Community Support – See Appendix A
  o Peer Support – see Appendix A
  o Family Support – see Appendix A
Training requirements for the following staff position during the COVID-19 pandemic crisis have been adjusted to reflect minimal requirements to assist providers in addressing individuals’ needs more quickly. The following reflects these minimal requirements. Once the COVID-19 pandemic has been determined to no longer be a crisis situation, training requirements will resume.

Training Requirements during COVID-19:
- A background screening shall be conducted for all staff in accordance with 9 CSR 10-5.190.
- Know the organization’s population served, scope of program, mission, vision, and policies and procedures;
- Abide by applicable regulations for rights, ethics, confidentiality, corporate compliance, and abuse and neglect;
- Know agency protocols for responding to emergencies at the program or while providing services in the community, including protocols for infection control and agency procedures to maximize safety for individuals served, staff members, and the public.
- Be knowledgeable of mandated reporting requirements for abuse and neglect of children and reporting requirements related to abuse, neglect, or financial exploitation of senior citizens and individuals who are disabled.

Community Support Specialist – Training Guidance

In addition to the above:
- General understanding of Key Service Functions of CSS

The key service functions below have been updated and are currently reflected in CCBHO and CSTAR State Plan Amendments. This is a reduction from the original 25 key service functions. The CPR and CSTAR Medicaid manuals are in the process of being updated to reflect this.

Key Service Functions of CSS:

1. Developing recovery goals; identifying needs, strengths, skills, resources and supports and teaching how to use them to support recovery; and identifying barriers to recovery and assisting in the development and implementation of plans to overcome them.
2. When the natural acquisition of skills is negatively impacted by the participant’s SUD and/or co-occurring mental illness, or emotional disorder, helping participants restore skills and resources to address symptoms that interfere with the following:
   i. Seeking or successfully maintaining a job, including but not limited to, communication, personal hygiene and dress, time management, capacity to follow directions, planning transportation, managing symptoms/cravings, learning appropriate work habits, and identifying behaviors that interfere with work performance.
   ii. Maintaining success in school including, but not limited to, communication with teachers, personal hygiene and dress, age appropriate
time management, capacity to follow directions and carry out school assignments, appropriate study habits, and identifying and addressing behaviors that interfere with school performance.

iii. Obtaining and maintaining housing in the least restrictive setting including, but not limited to, issues related to nutrition; meal preparation; and personal responsibility.

3. Supporting and assisting participants in crises to access needed treatment services to resolve a crisis.

4. Discharge planning with participants receiving CSTAR services who are hospitalized for medical or behavioral health reasons.

5. In conjunction with the participant, family, significant others and referral sources, identifying risk factors related to relapse in mental illness and/or SUDs, developing strategies to prevent relapse, and advising and otherwise assisting the participant in implementing those strategies.

6. Promoting the development of positive support systems by providing information to family members, as appropriate, regarding the participant’s mental illness, emotional disorders and/or SUDs, and ways they can be of support to their family members recovery. Such activities must be directed toward the primary well-being and benefit of the participant.

Peer Support Specialist - Training and Billing Options

In addition to the above:

1. Individual self-identifies as being in personal recovery from a mental illness or substance use disorder
2. General understanding of the Core Competencies for Peer Workers (found online at https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf)
3. Completion of Relias and other trainings
4. Shadowing and mentoring from other CPS staff members
5. Agency specific orientation and training
6. Boundaries and ethics training
7. A clear job description
8. Supervision on a weekly basis. The Direct Supervisor must have attended the Peer Specialist Supervisors training and be a QMHP or QAP
9. Individual must plan to attend CPS training once COVID-19 pandemic has been determined to no longer be a crisis situation

Family Support Provider - Training and Billing Options

These services are designed to provide a support system for parents of children and youth up to age 17 with serious emotional disorders.

The eligible provider must be a family member (other than the identified caretaker/legal guardian of the child receiving the services) of a child or youth who had or currently has
a behavioral or emotional disorder, has a high school diploma or equivalent and supervised by a qualified mental health professional.

**Billing Options**

**Billing Option 1:** Family Support Provider (FSP) and the Family Support Provider Supervisor must have completed the face-to-face FSP training approved by or provided by the department.

**Billing Option 2:** FSP can bill for services without face to face training if:

A. The Direct Supervisor has attended the DMH face-to-face training and
B. The FSP has completed the FSP101 webinar. Login to Relias E-Learning --->
   Course title: MOCMHC-family support
C. FSP must attend the face-to-face FSP training approved by or provided by the department within six to eight months to continue to bill

For technical assistance needs, regarding this service please contact Jill Richardson at jill.richardson@dmh.mo.gov.
Appendix B – Template for Gap Payment Invoices

See accompanying Excel template