



Telepractice FAQs

March 20, 2020

Prior to reading the following “Frequently Asked Questions” (FAQs), OASAS suggests that interested individuals first explore the current guidance documents thus far posted relative to the COVID-19 response and Telepractice in relation thereto and continue to check the OASAS website for updates:

- COVID-19 guidance generally:
 - <https://oasas.ny.gov/keywords/coronavirus>
- Links related to Telepractice:
 - <https://oasas.ny.gov/telepractice-waiver-guidance>
 - <https://oasas.ny.gov/telepractice-attestation>
 - <https://oasas.ny.gov/telepractice-waiver-update>
 - <https://oasas.ny.gov/telepractice-waiver-update-31820>

In response to the COVID-19 crisis, all OASAS certified or otherwise authorized providers should submit a self-attestation for permission to utilize Telepractice during this emergency.

Frequently Asked Questions (FAQs):

1. What are the requirements for Staff providing Telepractice Services?
 - Practitioners must be employed by or contracted with an OASAS certified or otherwise authorized program;
 - For Medical/Medication-related services, prescribing professionals must be Data 2000 waived in order to prescribe buprenorphine; and
 - For other services (counseling, assessments), Clinical Staff must work within their respective [Scope of Practice](#).
2. Is the telephone an acceptable means of Telepractice?

Yes. During the duration of the declared disaster emergency, telephonic delivery is an acceptable means of service delivery for Telepractice by OASAS programs.
3. Please clarify who can provide these services who could not previously.

OASAS is allowing for the provision of any service by any staff member otherwise authorized to be delivered in the certified/otherwise authorized setting to now be performed via Telepractice, for the duration of this emergency. This includes CASAC-T’s, Peers and provisional QHPs.
4. Can Peers deliver reimbursable services via Telepractice?

Yes. During the declared emergency, Peers can deliver any services otherwise authorized and reimbursable via Telepractice or telephonic means. Such services shall be reimbursable by Medicaid and Commercial payors.
5. I am assuming CASAC-T staff are allowed to do Telepractice/telephonic sessions?

Yes.

6. What settings/locations are acceptable?

Telepractice is not limited to certified or authorized OASAS locations. The client and/or practitioner can be at any site that meets with privacy and confidentiality standards, including a home. The space utilized for a Telepractice session should assure the privacy and protection of patient confidentiality.

7. Is a provider/staff member's home an approved distant site for Telepractice Reimbursement?

Yes, per Question 6.

8. If you are already approved by OASAS for Telehealth, do we need another for just telephonic or is it covered in our original approval?

All guidance now being issued applies equally to providers already approved for Telepractice, as well – no new authorizations are necessary.

9. Did you want one self-attestation per program or per person? Do we have to name every service on the attestation? (i.e. family support services, BH adult empowerment, etc..) or can it just be under our BH approved umbrella?

No. OASAS is requesting one attestation per agency, to cover all of their programs. Each program PRU should be listed on the attestation. Approval is granted to an entire agency, listed by PRU – it does not need to be granted by specific service or specific practitioners delivering the services.

10. Please confirm it is acceptable for a hospital certified by OMH and/or OASAS to submit 1 attestation for all providers.

No. Separate attestations will be needed, one to each agency.

11. How long should we expect to receive approval for the self-attestation?

For OASAS providers, once the self-attestation is submitted, a provider is approved to begin use of Telepractice for service delivery during the emergency period. The auto-response generated from the submission should be saved to document this authorization.

12. What does "The space occupied by the patients and the practitioner both meet minimum privacy standards consistent with patient-practitioner interaction and confidentiality at a singled OASAS certified location mean"? If we are calling clients who are off-site there is no way to ensure this statement.

Providers should ask the patients where they are located and if the location is private. Verbal acknowledgment is sufficient and should be documented.

13. What are the technology requirements for Telepractice Services?

Providers should be utilizing HIPAA and 42 CFR compliant technologies, or other video conferencing solutions the client has agreed to. Although, it is noted that the Department of Health and Human Services' (HHS) Office of Civil Rights (OCR) has stated that it will not enforce HIPAA with telehealth during this emergency. Under this Notice, covered health care providers may use popular applications that allow for video chats 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. Also, HHS provided the list below of vendors that represent that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA Business Associates Agreement (BAA):

- Skype for Business
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me

- Google G Suite Hangouts Meet

However, while acknowledging this relaxing of enforcement, OASAS providers approved for Telepractice should make every effort to utilize HIPAA and 42 compliant technologies.

14. Do I need consent for Telepractice and telephonic services and must it be written?

Informed consent continues to be required. While written consent is preferable, oral consent is permissible when it is the only available option or circumstances require immediate service delivery which do not allow time for written consent. The verbal consent will suffice, provided the program note such in the patient record and follow-up with a written consent at the earliest possible convenience.

15. Does each note need to indicate verbal consent or can it be documented once in the client record?

Consent only needs to be documented once, while each encounter conducted via Telepractice must be documented in the patient record.

16. On treatment plans, can we get verbal sign-off from providers/patients or do we need to have them come in to sign them? Any other documents that need patient signatures, can those be with verbal consent?

Flexibility will be granted in treatment plan deadlines for OASAS programs. However, until such time as physical signatures can be obtained, providers should document all necessary consents and other signature requirements obtained verbally.

17. What protocol should employees use to ensure that off-site use of EMRs are secure from staff homes/computers?

Due to the uniqueness of each EMR, this question needs to be answered by the provider's IT vendor.

18. Can sessions be recorded?

Yes, but only with patient consent. Providers who intend to record are encouraged to include this language in any written consent forms or, if unable to obtain written consent, obtain oral consent and document it.

19. For OASAS Certified programs, will we still be required to have the MAT/Buprenorphine Induction visit done face-to-face before any MAT/Buprenorphine service is done via Telepractice?

No. CMS has temporarily waived the Ryan-Haight Act provisions, which will allow the first visit for MAT/Buprenorphine induction services to commence via Telepractice. It's important to note, however, that only a traditional Telepractice (i.e., video) session will count for such visit – a telephone contact will not suffice.

20. Organizations are looking for guidance related to the provision of group services specifically given how difficult it is to manage these safely while complying with the social distancing guidelines and group gathering guidance.

Group sessions can be conducted through Telepractice via many available platforms. Telephonic group sessions are also permitted where a provider is able to verify the call-in was not distributed to anyone not invited (this can be done by asking), has obtained consent from participants and has a plan for how such sessions can be conducted to ensure meaningful participation by patients.

21. Should the number of patients in a group be changed to practice social distancing for those that do not want to come in person and also to decrease the anxiety levels amongst patients and staff.

Providers should follow the OASAS guidance for OMH and OASAS programs at:

<https://oasas.ny.gov/covid-19-guidance-march-7-2020>. Providers should utilize their best judgement, while exploring Telepractice as an alternative.

22. There are multiple different Modifiers given for use with Telepractice, GT, 95, 02, HE. Which one(s) should we use and under what circumstances, i.e. is it dependent on the service, the staff providing, context?

OASAS outpatient providers should use the most recent Medicaid update available from the DOH website for details on modifiers. Generally, modifier "95" is for codes listed in Appendix P of the AMA's CPT

Professional Edition 2018 Codebook. “GT” modifier should be used where the modifier “95” cannot be used. Place of Service Code (POS) 2 should be used on all claims for services delivered via Telepractice.

23. Are OTP’s allowed to perform “telemedicine?” What Modifier should we use? What will be the effective date of service?

Yes, all OASAS certified or otherwise authorized providers can use Telepractice and should be doing so consistent with any OASAS guidance issued specifically to OTPs. The modifiers are the same for all OP levels of care: 95/GT and POS 2. The effective date of service is the date of which the self-attestation was submitted (or starting with your approval date, if already approved).

24. What’s the best way to work with insurers around reimbursement for Telepractice?

Advise Plans of your designation to provide the contracted services via Telepractice, and your plan of action for doing so. Plans that require verification can be provided the OASAS “auto-response” e-mail generated upon receipt of your attestation

25. Are you recommending that we close physical facilities sites to patients and go virtual? Do you have any guidance for clients who receive injectable medication if the MD/NPP is unavailable to give the injection?

No, the closure of physical sites is not being recommended at this time. Particularly for injectable medications and any other services requiring an in-person encounter, with proper precautions, providers should continue delivery of the service as would ordinarily. Providers who do not have medical staff capable of delivering necessary services should make every effort to secure temporary staff or refer patients to other providers where still is available.

26. If our agency serves primarily a Medicare population, and we do plan to serve them via phone or video conference for the duration of the novel coronavirus crisis, is there an advantage to completing the attestation?

Programs should attempt to maximize revenues. Where patients are also Medicaid eligible, there may be an opportunity to bill for services Medicare will not reimburse (e.g. Peers/counseling by a CASAC). All certified providers should submit an attestation, in the event it may be needed in the coming days/weeks.

27. Do programs charge clients their copayments when using Telepractice?

No. There is no co-payment per the Department of Financial Services (DFS) circular letter. https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_06

28. Are copays only waived if there would be NO copay face-to-face? Or are they waived no matter what? They are waived only for Telepractice-related services.

29. Should we be collecting full session rates for tele services if we have clients without insurance who pay on a sliding scale?

Yes, if the enrollee is capable of paying.

30. Does waiving the co-pay also mean private insurance will waive deductibles?

Yes. Per the DFS, no insured is required to pay co-payments, co-insurance or annual deductibles for in-network services delivered via Telepractice when such service would have been covered under the policy if it had been delivered in person. See: https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_06

31. Has OASAS checked with MCOs that their systems can handle these billing changes and if they are not how will providers get paid?

In light of the emergency circumstances currently facing us all, NYS would expect MCOs to be likewise amending their existing processes to best facilitate the delivery and payment for necessary services. However, Telepractice services have always been permitted and the modifiers should already be in MCO systems.

32. Can you let us know what the status will be for Medicare recipients to receive tele-medical services?
CMS has removed the rural and site limitations, allowing telehealth to now be provided regardless of where the enrollee is located geographically and the type of site. This includes allowing the home to be an eligible originating site.