

Early Intervention during the COVID-19 Public Health Emergency: Frequently Asked Questions

EI via Telehealth:

1. For initial assessments, do both providers need to participate via video or just one? How about the SC?

Response: At least one Early Intervention Professional needs to participate via video. The Service Coordinator and other provider could participate by phone.

2. Will professional boards (e.g., for OT, PT, SLP) allow phone-only use of telehealth?

Response: This question has been submitted to a contact at the Board of Health Professions. She sent that question to the Board of Medicine.

So far, we have received a response from the Board of Physical Therapy:

Phone-only (interactive audio) is permitted as telehealth for PTs if the interaction goes beyond simple communication and is more akin to an audio/video telehealth interaction. PTs should make sure they follow the Board's other guidance related to telehealth (e.g. verifying identity, standards of practice, records, etc.) if they are using phone-only for practice as interactive audio beyond simple communications.

Existing Virginia-specific telehealth guidance from PT, OT and SLP Boards has been posted to the COVID-19 webpage on the VEIPD website (see Question 3). Practitioners are encouraged to monitor information from their Board to determine whether any additional COVID-19 specific guidance is issued.

3. Where can I find more resources related to actually using telehealth?

Response: A dedicated COVID-19 page has been added to the VEIPD website and linked from their home page (https://veipd.org/main/covid19_ei_tele_updates.html). Resources posted there include helpful information for preparing providers to deliver EI through telehealth, preparing families to participate via telehealth, recommended platforms and technology considerations, and understanding telehealth practices allowed for specific disciplines. You can also find a link there to this telehealth webinar done by Virginia early intervention providers: [Telepractice in Early Intervention: ITCVA Webinar - April 2020](#).

4. Do I need a consent form for delivering EI services via telehealth?

Response: Virginia is not requiring the use of a notification or consent form(s) in order to deliver EI via telehealth. If you want forms or more information about what to consider when talking with a family about using telehealth, you are encouraged to review the following forms developed by Indiana:

- Virtual Early Intervention Technology Checklist
[https://www.in.gov/fssa/files/Virtual%20Visit%20Technology%20Checklist%2003.15.2020%20\(1\).pdf](https://www.in.gov/fssa/files/Virtual%20Visit%20Technology%20Checklist%2003.15.2020%20(1).pdf)
- Informed Consent for the Use of Virtual Early Intervention
[https://www.in.gov/fssa/files/Virtual%20Visits%20Consent%2003.15.2020%20\(1\).pdf](https://www.in.gov/fssa/files/Virtual%20Visits%20Consent%2003.15.2020%20(1).pdf)

The wording on these forms may be helpful even if you opt not to use an actual form.

If you do not use a form, document in a contact note your discussion with the family about the use of telehealth, including your explanation (if applicable) that using the allowed non-public facing third-party applications potentially introduce privacy risks, as does use of non-secure devices like cell phones or tablets. Document in the contact note that the family chose to proceed with the telehealth option.

5. Do we need to do an IFSP review in order to change from in-person visits to telehealth delivery of services? Do we need a new physician certification?

Response: No, neither an IFSP Review nor a new physician certification is necessary. The service delivery method remains “coaching, including hands-on as appropriate.” Document in a contact note the reason for temporarily delivering services via telehealth.

6. Can the first visit/evaluation by a PT (or OT or SLP) be conducted via telehealth or do state regulations governing their practice require the first visit to be in person?

Response: EI allows an initial visit via telehealth (audio-visual or audio only) and initial assessment via audio-visual technology during the state of emergency. Licensing boards are responsible for the scope of practice. We have sent a question to the Board of Medicine about loosening or clarification of their licensing regulations and have not received a response yet. Practitioners are encouraged to contact their professional board for clarification, as needed.

7. Child is out of state ... can we still provide telehealth? We have several children that have gone out of State temporarily for various reasons related to the COVID-19 public health emergency.

Response: Since they are temporarily out of state due to the public health emergency, they could still receive Virginia EI services through telehealth if the provider is allowed to do that based on their own professional regulations. Requirements are different for different disciplines.

8. If we did a session over the phone (coached and gave mom suggestions) but the child was with the aunt and not with mom (she was at work). Would that be a session?

Response: To constitute a billable service session (billable to Medicaid, private insurance or Part C), it needs to meet the same criteria as an in-person service session and include the parent/caregiver and the child.

9. What do we list on the contact note as the location of the service if it's delivered via telehealth?

Response: The contact note should document where the child and caregiver were (e.g., home) and the fact that the service was delivered by phone or videoconference.

10. The length of sessions listed on the IFSP sometimes ends up being too long with telehealth. What do we do? And do we have to make-up the time we miss?

Response: Telehealth sessions may be shorter than in-person sessions, based on child and family needs. Document in the contact note why the session was shorter than what was planned on the IFSP. It is not necessary to hold an IFSP Review and change the length listed on the IFSP since the change is due to a temporary emergency situation. Making up time missed is allowed but not automatically required. The need to make up time missed is determined by the IFSP team based on the child's developmental needs. For instance, if the child has not fallen behind expected progress during the period in which telehealth was used, then there is no need to make up missed time.

11. If the service length on the IFSP is 60 minutes, can we provide 45 minutes of service via telehealth, spend the other 15 minutes on documentation and bill for the full 60 minutes?

Response: No. Documentation is built into the EI rate, so only the time spent in service delivery with the child and family (45 minutes) can be billed.

12. How can we make videoconferencing more equitably accessible to all families? Low limits on data, no Wi-Fi and unreliable phone/internet service in rural areas can all be barriers.

Response: Public and private entities are actively working to address these issues. A number of large and small internet providers are offering free or reduced cost internet service and/or Wi-Fi hotspots during the COVID-19 pandemic. Search online for available providers in your areas using "free internet during COVID-19." At least two of the four providers of mobile service for Lifeline phones available to low-income families have raised their data limits, and efforts are underway at the state and national levels to further lift these limits. The Federal Communications Commission is also taking immediate action, granting temporary spectrum access to 33 wireless Internet service providers serving 330 counties in 29 states, including Virginia, to help them serve rural communities facing an increase in broadband needs during the COVID-19 pandemic (see <https://docs.fcc.gov/public/attachments/DOC-363358A1.docx> for more information). Finally, some school systems have issued Wi-Fi hotspots for students, and this may allow families with available devices to access videoconferencing options without impacting their data plans. Given all of these efforts and new options, don't write off telehealth because internet or Wi-Fi are not available right now.

13. Who is considered a "covered healthcare provider" as reference in the HHS HIPAA guidance?

Response: All early intervention practitioners who provide services reimbursable by Medicaid are covered healthcare providers.

14. Since we are not using our assessment tools (HELP, BDI, ELAP, etc) with fidelity when we're using video, can we forgo age scores until we're able to see the children in person? Some of my folks are very uncomfortable putting their name to quantitative data that they don't feel confident in. There are items on these tools we just can't complete by video, especially when we can't send the test kits to the families and they may not have appropriate toys in the home. Obviously we would still write a thorough assessment narrative with all the information we were able to gather. In the narrative

we're also able to specify which skills were observed versus reported, which is something we can't really do for the age scores.

Response: We appreciate that you and your assessment team members are using videoconferencing technology and being flexible about how you gather assessment information during the COVID-19 public health emergency. We recognize that this means you may not be implementing assessment tools in accordance with their written instructions/protocols and there may be some skills you're not able to test/observe. However, it sounds like your teams are gathering functional information by using toys and materials available in the child's natural environment and by using parent report, which allows you to hear how the child is (or is not) using functional skills across settings and situations.

The Age and Developmental Levels table in Section III of the IFSP must be based on information from all sources of assessment, including parent report, observation and informed clinical opinion, and may be given as an age range rather than a specific age level. For those reasons, we would expect the information gathered through an assessment conducted via videoconference would be sufficient to complete the table in addition to the assessment narrative. If it helps providers feel more comfortable, they are welcome to mark "Other" in the Assessment Sources box in Section III of the IFSP and specify something like this: Assessment was conducted via videoconference during the COVID-19 emergency and assessment narrative and age levels are based on the information available at the time, including partial completion of the assessment tool."

15. If the family does not have access to a virtual platform in order for providers to do the initial assessment via videoconferencing, what mitigating circumstance would we use if we exceed the 45-day timeline? What if the family could do videoconferencing but prefers to wait until in-person assessments resume?

Response: If the family is unable to access videoconferencing, then please select Disaster/Severe Weather as the mitigating circumstance. If they could do videoconferencing but prefer to wait for an in-person assessment, then select Family Scheduling Preference.

Other Alternative Service Delivery Options:

16. What do we do in those situations where telehealth is not an option (such as those discussed in Question 11) or the family would prefer an alternative other than videoconferencing?

Response: The goal is to continue supporting the family in helping their child develop and learn during daily activities, so you may need to get creative. Depending on the barriers to telehealth, you could explore the possibility of sending short videos or photos back and forth with the family to help you see challenges the family may want to work on, demonstrate strategies, and provide feedback to the family as they try the new strategy. This could be combined with text messages and/or phone conversation. All activities and time spent must be documented in the child's EI Record and "counts" toward the time planned on the IFSP. Neither an IFSP Review nor a new physician certification is necessary when services are provided using an alternate service delivery option. Time spent on the phone reviewing and discussing photos or videos with the family and planning for strategies to use can be billed as an EI service delivered via telehealth. For families who are reluctant to use videoconferencing, encourage them to try it once. Reassure them that they and their child are not expected to sit in front of the video camera or interact with you the whole time. Let them know that

they can carry you around with them (depending on the device they are using), that it's helpful to you to just observe them interacting with each other, that the session can be shorter than your in-person visit, etc. If the family is still not interested, then other ideas like those given earlier in this response may be used.

Reimbursement:

17. Has there been any change to physician certification requirements for the period of the COVID-19 public health emergency?

Response: No

18. Please clarify how Part C reimbursement works for a telehealth claim denied by private insurance and family has a monthly cap.

Response: Reimbursement/payment will work the same as if the service was provided in person. If private insurance denies the claim, then the family pays up to their cap and Part C funds are used to pay any balance up to the EI rate.

19. Families' financial situations may change significantly as a result of the COVID-19 public health emergency. How do we handle that?

Response: It is important to be cognizant of this possibility and remind families to let you know if there are changes. If there has been a significant change in the family's financial circumstances, complete a new Family Cost Share Agreement.

20. Based on information on Anthem's website (as of this date), their private insurance plans will not cover phone-only occupational, physical or speech therapies. Can the state office follow up with Anthem to see if they would change this policy?

Response: We reached out to a contact at Anthem and were told that this is a corporate decision and is unlikely to change. However, he agreed to forward the issue/request to someone who may be able to respond.

21. We have overall fiscal concerns ... how are we and our providers going to be able to stay afloat through this?

Response: We recognize that these are very stressful times on so many levels, as we worry about the health of ourselves and our loved ones; how to continue serving the infants, toddlers and families who need our support; and the economic impact this will cause for our families and businesses. We hope that the option to continue services via telehealth and at the same reimbursement rate as in-person services will help contract therapy providers remain in business. On the flip side, that policy has the potential to stress our federal and state Part C funding if those services are not covered by private insurance. Thankfully, we have reports from some local systems that at least some private insurance companies are reimbursing for telehealth at the same rate as in-person services. The federal COVID-19 economic stimulus bill passed by the U.S. Senate this week includes support for small businesses. We understand from national consultants that the disability community is advocating for the inclusion of significant additional funding for Part C in the next stimulus package,

and we will be monitoring this closely. We will continue to work with local systems to address fiscal challenges as we move through this public health emergency period, and we appreciate all that you are doing to maintain services.

22. A mother sent two videos of her son prior to his assessment, which were very helpful and are referenced in his IFSP. Would the 15 minutes of observation be included in the time for the assessment or is that more preparation for the assessment?

Response: This 15 minutes would be considered preparation rather than assessment time. It would be the same as reading the intake summary and eligibility determination form or looking at contact notes ahead of an assessment.

Procedural Safeguards:

23. Permission to remove records physically from an office - where should that permission come from? Is it ok if we have locally received permission or should that come from DMAS?

Response: This is a local decision and local permission is sufficient. If records are moved to a different location, you must ensure secure storage.

24. Can we add a caveat under the signature line on our consent forms that says, "Typing in your name means you have given consent to sign electronically or you may print and sign with ink and mail in the form."

Response: Yes, this is acceptable.

25. Once the public health emergency ends, do we need to go back and get written signatures for all forms for which we got verbal consent during the emergency period?

Response: For any temporary verbal consent obtained on or after February 1, 2021, written consent must be subsequently obtained as quickly as possible. Please see COVID-19 Policies and Procedures for more information.

26. We're working with a family where the father, who has the insurance, lost his job and his insurance. He filed for unemployment but hasn't been approved yet. Should we re-do the Family Cost Share Agreement now or wait until we see if he gets any unemployment benefits and how much?

Response: Complete a new Family Cost Share Agreement now, to reflect the family's new financial circumstances. If the father receives unemployment benefits, then complete another.

Transition:

27. Is there any new guidance on transition now that all public school systems are closed for the rest of the school year?

Response: DBHDS and the Virginia Department of Education have developed a new joint document to address common questions related to transition impacts from the current public health emergency. The document has been (or will soon be) posted to the COVID-19 webpage on the VEIPD website. This document was updated on May 20th with a new question "How are initial evaluations completed for preschool parent referrals or for children referred from Part C to Part B?" This question appears on page 3 of the revised document, which will be posted to the COVID-19 webpage on the VEIPD website.

28. Have you seen that U.S. Secretary of Education Betsy DeVos has released her recommended waiver authority under the Coronavirus Aid, Relief and Economic Security (CARES) Act (<https://www.ed.gov/news/press-releases/secretary-devos-reiterates-learning-must-continue-all-students-declines-see-congressional-waivers-fape-lre-requirements-idea>). The Special Ed Director for one of my local school districts sent it to me and requested that we hold off on making new referrals because of the change in timelines and provision of services. I take this letter to be a recommendation to Congress asking for a waiver to IDEA - so not a done deal. Is that how you read it? There is a recommendation in there that Part C continue to see kids after they turn three until they are evaluated and eligibility is determined for Part B (which would only happen when it is safe to do a face-to-face evaluation). There is a note that funding would be an issue, but no note on how they would provide said funding. What are your thoughts on this?

Response: These are the Secretary's recommendations for Congress to consider. There has been no change in transition requirements for Part C or Part B at this time. Unless or until Congress acts to implement these recommendations, Part C local systems should continue to send referrals to Part B in order to meet Part C transition requirements and timelines.

We recognize the funding concerns of potentially keeping children in Part C beyond age 3, as does the report. It's encouraging that the report specifically spells out the funding issue, including limits on how Part C and Part B funds can currently be used. If Congress decides to grant the recommended waivers related to transition, they could also act to address the funding issue. We also have heard that additional funding for Part C is a priority issue that disability advocacy groups plan to push for the next stimulus bill.

IFSPs:

29. Can we use an interim IFSP to get services started if we're not able to conduct an assessment for service planning right now (e.g., we are not allowed to go into homes and the family does not have access to videoconferencing)?

Response: If you have found the child eligible, you may develop an interim IFSP and begin services. An assessment for service planning must be conducted and a full IFSP developed as soon as the family can make the child available (e.g., home visits are allowed, videoconferencing becomes an option, etc.). At a minimum, the interim IFSP must include:

- *The name of the service coordinator who is responsible for implementation of the interim IFSP and coordination with other agencies and persons;*

- *The early intervention supports and services that are needed by the child and the child's family. Specify the frequency, length, intensity (individual or group), location, method, and potential payment source(s) for each service; and*
- *Signatures of both the service coordinator and the parent(s).*

There is no requirement to use pages or sections from the statewide IFSP form in developing an interim IFSP.

30. We have a child whose annual IFSP is due next week but mom wants to wait to do it face-to-face. Can we leave him open and still bill for service coordination or does she have to go ahead and let us do the annual via telehealth?

Response: Document the reason for the delay in developing the annual IFSP and continue to provide all services listed on the current IFSP.

31. For children who are entering our system now, during the COVID-19 state of emergency, should we write the IFSP outcomes and services (including frequency and length) based on the current situation or based on how we expect things to look once we're back to providing face-to-face services?

Response: Initial (and annual) IFSPs and the outcomes within those should reflect the child's needs and the family's resources, priorities, concerns and routines as they stand today. Services listed, including the type of service and the frequency and length of sessions, should then be based on what is needed to meet those outcomes. If you would typically meet a given child and family's need with one 60-minute (in person) visit every other week, you can write that on the IFSP and then document any deviation from that frequency and/or length of visit that occurs due to the state of emergency. Given the current circumstances and the fact that we don't know how long those circumstances will last, another option would be to write the frequency and length on the IFSP based on how you will meet that need via telehealth (maybe you'll do 30 minute visits weekly instead of 60 minutes every other week). As those circumstances change, you can hold an IFSP Review to alter the frequency and length as appropriate. The key is to ensure the services listed on the IFSP reflect what is needed to address the outcomes, even if you cannot provide that right now.

32. If we need to provide compensatory services to a child after they turn three, do we leave them open in ITOTS?

Response: Not all services missed during the COVID-19 public health emergency will need to be made-up. As indicated in the COVID-19 Policies and Procedures document issued by the Infant & Toddler Connection of Virginia on March 19, 2020, the make-up session policy detailed in Chapter 8 of the Practice Manual will be temporarily suspended for all providers until May 31, 2020 or until the Governor lifts the state of emergency in Virginia, whichever date is soonest. This means that make-up sessions are allowed but not automatically required if sessions are cancelled for system/provider reasons. If the local system is not able to provide services through any alternate means (even through an alternate method, alternate provider or at an alternate location) for an extended period of time, then once the system is able to resume services through some means, the IFSP team will determine whether make-up visits are necessary to address the child's developmental delay.

If the team determines that make-up visits are necessary and these will extend beyond the child's third birthday, you will still need to exit the child from ITOTS. There is no way in ITOTS to designate

children as receiving compensatory services. Local systems are asked to keep a list (name and date of birth) of any children receiving compensatory services after they turn three. We have sent an email to DMAS asking how we can handle Medicaid billing for these children beyond age three.

Family Survey:

33. Is there any update on when the family survey will go out?

Response: The family survey has been further delayed since our contractor, Old Dominion University, remains closed. At this time, there is no timetable for its dissemination. We plan to reassess the situation in one month.

Re-Opening:

34. Therapist A is assigned a specific caseload in a catchment area but does not feel comfortable going back now to face to face visits. As this is a "system" issue, do we give the therapist the opportunity to opt out and reassign within the company to Therapist B? If there is not another therapist within that specific company, the Local System will offer the family Provider choice to select another company. What happens if the family says "no" to Provider choice to change therapists/ companies? Is this a valid reason to wait and delay services with the therapist who does not want to go back out into the community right now?

Response: Hopefully, telehealth will continue to be an option. If not, then in this scenario, the family should be offered the option of changing to a new provider or waiting until their current provider is available for in-person visits. If a change in provider is needed and no provider is available from within the agency already selected by the family or if the family is requesting a change in provider agency, then the family must be offered a choice of provider agency.

35. Will the state Part C Office make recommendations for resuming services that are different from the decisions of the local lead agency (e.g., going immediately back into homes versus some other option for conducting face-to-face activities)?

Response: The state Part C Office has issued considerations for resuming in-person activities. These considerations recognize that the process of and progress toward reopening will look different across local systems. "Transitioning to In-Person Activities during COVID-19 Reopening: Considerations for Local Infant & Toddler Connection Systems" is available in the COVID-19 section of the VEIPD website.

36. What do we do with the families who don't want us back in the home now due to their own anxieties or medical issues with their children?

Response: Hopefully, telehealth will continue to be an option. If not, consider alternate locations that the family may prefer to home-based services. An outdoor location or clinic setting may be preferable. If neither telehealth nor an alternate location are viable options, then the family may opt to receive service coordination until the situation changes.

37. Private insurance agrees to fund telehealth longer than their initial 90 day period of time, can telehealth continue even if Medicaid does not extend telehealth past May 31st? If telehealth is not funded by Medicaid or Private insurance companies beyond their respective cap dates and the families want to continue with Telehealth due to their child's medical issues or family concerns relating to COVID-19, will the local system be responsible to pay for these services?

Response: The original May 31, 2020 end date for the Infant & Toddler Connection of Virginia COVID-19 Policies and Procedures that were issued on March 19, 2020 has been extended. These temporary policies will now be in effect until written notice from the Infant & Toddler Connection of Virginia changes these policies. The DMAS policies on telehealth are in effect during the Governor-declared state of emergency, which has no end date at this time. The Infant & Toddler Connection of Virginia state office is communicating with DMAS about the need to continue telehealth coverage for early intervention services during the re-opening transition (and beyond). Since both private insurance and Medicaid are covering telehealth right now, a decision about Part C paying for telehealth is premature at this time.

38. Who accepts the liability of us returning to homes? Is it the local systems, our respected companies; our own liability in the event we are exposed once back in the homes and get sick?

Response: Please consult with your local legal counsel on this issue.