Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov
MEDICAID MEMO

**Last Updated: 07/15/2022**

# Updates on COVID-19 Continuation and Timelines for Behavioral Health and Addiction and Recovery Treatment Services

Background on Federal and State Authorities

The purpose of this memo is to notify providers on certain flexibilities, which are in effect only during the federal public health emergency (PHE).

On July 23, 2020, the Secretary of HHS renewed the federal PHE due to the continued consequences of the Coronavirus Disease (COVID-19), effective July 25, 2020:

www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-23June2020.aspx.

This 90-day extension will expire on October 22, 2020 unless renewed. At the state level, Virginia Executive Orders (EO) 51 and 58 provide corresponding policy flexibilities associated with the state PHE declaration, which currently do not have an expiration date.

Most flexibilities that DMAS has implemented depend on both state and federal authorities. DMAS is required to unwind the flexibilities obtained when either the federal or the state PHE declarations expire. Any flexibilities listed in these Medicaid Memos are still in effect during this current PHE unless explicitly stated otherwise. At such time that these and other flexibilities and allowances cease, providers will be notified through a DMAS Medicaid Memo noting the effective dates of those actions. DMAS will issue a memo at least thirty (30) days in advance of these changes to allow providers to adequately prepare their process and systems. DMAS continues to monitor Virginia General Assembly legislative actions and impact on Medicaid policies and will notify providers of any changes as result of this legislative session.

Telehealth Place of Service and Modifier Billing Practice

Providers delivering services via telehealth, including telephonic (audio only) communications, shall bill and submit a claim as they normally would in their regular practice. The Place of Service (POS) that the provider usually bills for telehealth shall remain the same as well. DMAS is not requiring use of telehealth modifiers in order to minimize systems errors during this critical time. Providers using telehealth POS (02) or modifiers GT (interactive audio and video telecommunications system) or GQ (synchronous telecommunications system) based on guidance provided prior to COVID, shall continue to use these when billing for services delivered via telehealth. DMAS will issue a memo on specific billing policies for telehealth delivery at a future date.

Behavioral Health and Addiction and Recovery Treatment Services (ARTS) Flexibilities

This memo summarizes the Agency's guidance on the flexibilities available to Behavioral Health and

ARTS providers in light of the federal and state PHEs presented by the COVID-19 virus. These flexibilities and clarifications were originally detailed in the following Behavioral Health and ARTS memos: 1) March 19, 2020, "*Provider Flexibilities Related to COVID-19*"; 2) March 27, 2020, "*Clarifications and Changes: Behavioral Health and ARTS Provider Flexibilities Related to COVID-19*"; 3) June 11, 2020, "*Behavior Therapy Provider Flexibility Update*"; and 4) July 1, 2020, "*Group-Based Service Delivery in Behavioral Health and ARTS Update*".

DMAS has merged the flexibilities in the above memos related to Behavioral Health and ARTS and included this language in the "Behavioral Health and ARTS Policy Continuation and Timelines" section below. Underlined text in this memo below represents new clarifications.

**BEHAVIORAL HEALTH AND ARTS POLICY CONTINUATION AND TIMELINES**

**-EFFECTIVE MARCH 19, 2020**

POLICY FLEXIBILITIES APPLICABLE TO BEHAVIORAL HEALTH AND ARTS

*Trauma Informed Care*

Providers are encouraged to continue to provide interventions and formulate responses to

COVID-19 guided by trauma informed care (TIC) principles: trustworthiness, equity, choice, collaboration, empowerment, and safety. Providers are encouraged to consider these principles as they navigate the implementation of flexibilities outlined in this guidance.

*Recommendations for Reducing Transmission*

Please follow the guidance issued by the Department of Behavioral Health and Developmental Services (DBHDS), the Centers for Disease Control (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Virginia Department of Health (VDH).

*Telehealth Services*

DMAS is not requiring face-to-face delivery of Behavioral Health and ARTS services during the COVID-19 PHE. DMAS is allowing for telehealth (including telephonic) delivery of all Behavioral Health and ARTS services with several exceptions; these are differentiated below.

Allowable services via telehealth and telephonic delivery:

- Care coordination and case management;
- Peer Recovery Support Services;
- All service needs assessments (including the Comprehensive Needs Assessment (CNA), the Independent Assessment Certification, and Coordination Team (IACCT) assessment and the American Society of Addiction Medicine (ASAM) Multidimensional Assessment) and all treatment planning activities;
- Outpatient psychiatric services (this includes both medication management and psychotherapy services);
- Community Mental Health and Rehabilitation Services (CMHRS); and
- ARTS Levels of Care including the following:

- substance use intensive outpatient and partial hospitalization programs (ASAM Levels 2.1 and 2.5);
- opioid treatment services (Opioid Treatment Programs (OTPs) and Preferred Office-Based Opioid Treatment (OBOT));
- substance use outpatient services (ASAM Level 1.0);
- early intervention services (ASAM Level 0.5);
- substance use care coordination and case management; and
- withdrawal management services.

*Telehealth and Inpatient/Residential Settings*

The applicable per diem or diagnostic related groups (DRG) rates for therapeutic group homes, psychiatric residential treatment facilities, ASAM Level 3.1 through 4.0 and inpatient psychiatric hospitalizations will not be billable through telehealth. The professional activities within these services including assessments, therapies (individual, group, and family), care coordination, team meetings, and treatment planning are allowable via telehealth.

*Home as Originating Site*

DMAS is allowing a member's home to serve as the originating site for members. This is particularly important for those who are quarantined, are diagnosed with and/or demonstrating symptoms of COVID-19, and/or are at high risk of serious illness from COVID-19. Clinicians shall use clinical judgment when determining the appropriate use of home as the originating site. The originating site fee is not available for reimbursement when the patient's home is the originating site.

*Documentation for Behavioral Health and ARTS Providers*

Services delivered via telehealth (including telephonic communications) must have accompanying documentation in the member's record that states the alternative location used and that the service was delivered via telehealth to support access to care during the PHE. The mode of delivery shall also be included in any new or subsequent service authorization requests. DMAS recognizes that providers may have limited or no access to their offices, and members' physical records or other team members and that this may create barriers to obtaining necessary signatures on documentation. Thus, providers shall update documentation and treatment plans (including individual service plans (ISPs), interdisciplinary plans of care (IPOCs)) with at least notation that verbal consent was obtained and providers shall make reasonable attempts to obtain appropriate physical signatures within 45 days after the end of the PHE. Provider and member electronic, including telephonically recorded, signatures are acceptable during the PHE. Providers need to ensure that the person "signing" is the intended individual, an authorized or someone acting responsibly for the individual. Providers do not need to attempt to obtain physical signatures after the end of the PHE from individuals who have been discharged from the provider's services.

In regards to obtaining clinician signatures on relevant documentation, each provider shall make reasonable attempts to obtain signatures from the clinicians or document receiving the clinician's verbal consent or sign-off, with the name of the clinician and the date of receipt. If the clinician is unable to sign-off on documentation, the clinician shall maintain documentation of verbal consent or sign-off in their files.

*Allowance of Face-to-Face Delivery of Group Services*

As of July 1, 2020, DMAS resumed reimbursement for face-to-face delivery of group-based services. DMAS advises that providers carefully weigh the vulnerabilities and benefits of resuming face-to-face group services. Group-based providers are reminded that they retain, until further notice, the ability to offer services individually or through individual or group telehealth or telephonic contact. Providers are encouraged to prioritize the health and safety of members and their staff and to consider member preferences, engagement and optimal access to care. Providers who elect to provide face-to-face services should integrate guidance provided through the CDC, VDH, and any relevant licensing bodies.

For initial and continued stay reviews, a service authorization request shall be completed for those services that require a service authorization to verify medical necessity and appropriateness of the service delivery model.

*Provider Qualifications and Licensure Requirements*

Provider qualifications, licensure requirements, and the structure of the services shall remain intact. Thus Qualified Mental Health Professionals (QMHPs), Licensed Mental Health Professional (LMHP) Supervisees (LMHP-S), LMHP Residents (LMHP-R) and LMHP Residents in Psychology (LMHP-RP) must remain working under the direction of an LMHP. Licensed Behavior Analysts (LBA) and Licensed Assistant Behavior Analysts (LABA) must provide supervision to unlicensed staff (i.e. technicians) and LABAs must remain working under the direction of a LBA.

Within the ARTS benefit, Certified Substance Abuse Counselors (CSAC) and CSAC-Supervisees must remain working under the direction of licensed providers authorized by the Board of Counseling. Providers licensed in the state of Virginia, but located outside the state of Virginia, are allowed to provide telehealth services to individuals in Virginia. Provider Types allowed to bill for Medicaid services will remain the same regardless of the delivery method (face-to-face vs. telehealth). The Department of Health Professions allowed for temporary licensure by endorsement of behavioral health clinicians whose licenses are issued by another state. Such temporary licenses expired on September 8, 2020. Practitioners who obtained these temporary licenses will not meet DMAS requirements for reimbursement effective September 9, 2020 unless they obtain a full Virginia license.

Virginia Medicaid allows for physicians (those licensed to practice medicine) who are actively licensed in states bordering Virginia but are not licensed in Virginia to continue to see their Virginia resident patients via telemedicine/telehealth or telephonic communications. The Board of Medicine requires that physicians must have an established relationship with the patient to meet this allowance.

*Service Authorizations for Behavioral Health and ARTS*

A 14-day grace period will be granted for the submission of Behavioral Health Authorizations within CMHRS, Assessments, Psychotherapies, Inpatient Treatment Services, and ARTS Levels of Care:

- Medicaid managed care organizations (MCOs) and Magellan of Virginia will allow up to 14 days after the start of a new behavioral health or ARTS service or after the expiration of an existing authorization for a service authorization request to be submitted from the provider to

the MCO or Magellan of Virginia.
- This grace period does not waive medical necessity requirements for the services or other requirements currently set forth in policies for submissions of service authorization requests.
- This grace period does not guarantee payment.

*Policy Flexibilities Applicable to Behavioral Health Services*

- Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health Skill-Building (MHSS), Intensive Community Treatment (ICT) and Psychosocial Rehabilitation (PSR).
    - Service delivery may be provided outside of the school setting, office setting, or clinic setting for the duration of the PHE.
    - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual.
    - For youth participating in both TDT and IIH, TDT should not be used in person in the home as this would be a duplication of services. TDT may be provided through telehealth to youth receiving IIH (in person or via telehealth) as long as services are coordinated to avoid duplication and ensure efficacy of the treatment provided.
    - TDT providers licensed for school-based and non-school based care may provide services outside of the school, including during the summer, with their current license due to current needs to maintain social distancing. Providers are reminded that they must report to DBHDS Office of Licensing any changes to their programs that have occurred as a result of COVID-19.
    - The service authorization request for new services will be used to track which members are continuing to receive these services, assess the appropriateness of the services being delivered via different modes of treatment, and to determine if this is an appropriate service to meet the member's needs.
    - During the PHE, TDT, IIH, MHSS, ICT and PSR providers may bill for one unit on days when a billable service is provided, even if time spent in billable activities does not reach the time requirements to bill a service unit. This allowance only applies to the first service unit and does not apply to additional time spent in billable activities after the time requirements for the first service unit is reached. Providers shall bill for a maximum of one unit per day if any of the following apply:
        - The provider is only providing services through telephonic communications. If only providing services through telephonic communications, the provider shall bill a maximum of one unit per member per day, regardless of the amount of time of the phone call(s).
        - The provider is delivering services through telephonic communications, telehealth or face-to-face and does not reach a full unit of time spent in billable activities.
        - The provider is delivering services through any combination of telephonic communications, telehealth and in-person services and does not reach a full unit of

time spent in billable activities.
    - Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue.
- Behavioral Therapy
    - Services are geared to be provided in settings that are natural or typical for the child or adolescent and may vary during the PHE. Behavioral Therapy may only be provided in the school setting (includes in–person or virtual learning) when the purpose is for observation and collaboration related to behavior and skill acquisition (not direct therapy) and services have been authorized by the school, parent and provider and included in the ISP.
    - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA or LABA.
    - One service unit equals 15 minutes for this level of care. Effective June 11, 2020, Behavioral Therapy providers do not have a one unit max limit per day for audio-only communications.
    - For Behavior Therapy services, a physician letter, referral, or determination is not required for submission of a service authorization. The MCO and Magellan of Virginia shall review the request and make a determination without the physician referral. The physician referral, letter or determination shall be completed within at least 60 days of the start of the service.
- Day Treatment/Partial Hospitalization Programs (PHP) for Adults
    - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA or LABA.
    - If providers are unable to provide the minimum amount of services required for the reimbursement of Day Treatment/PHP, providers may bill traditional outpatient psychotherapy, assessment, and evaluation codes.
    - Providers will not be required to discharge members from the service if the provider is billing outpatient services rather than Day Treatment/PHP code.
    - Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue.
- Behavioral Therapy
- Day Treatment/Partial Hospitalization Programs (PHP) for Adults
- Crisis Stabilization/Crisis Intervention Services

  - The appropriateness of a crisis response using telehealth (including telephonic) shall be evaluated by the clinician and a determination shall be made by the clinician responding to the crisis.
  - Any therapeutic interventions to include, but not limited to, therapy, assessments, care coordination, team meetings, and treatment planning can occur via telehealth.
  - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP, if one is required, shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19 as well as any newly identified problem and documented according to the requirements in the CMHRS Provider manual.
- Independent Assessment Certification and Coordination Team (IACCT) Assessments
- IACCT Assessments may occur via telehealth or telephone communication.
- IACCT Assessments may be completed by out-of- network providers, but these individuals must be an independent evaluator separate from the residential facility. IACCT Assessments completed by an out-of-network provider must be coordinated with Magellan of Virginia.
- Psychiatric Inpatient, Facility Based Crisis Stabilization, Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH) Levels of Care
  - The requirement for service authorization remains in place.
  - Therapy, assessments, case management, team meetings, and treatment planning may occur via telehealth. The plan of care should be updated to include any change in service delivery as well as any change in goals, objectives, and strategies, including impacts on the individual due to COVID-19.
  - For members in psychiatric inpatient, facility based crisis stabilization, PRTF and TGH, medical necessity for continuation of care may be waived if the individual is unable to transition to lower levels of care due to COVID-19 and quarantines. Please see the April 23, 2020 Magellan of Virginia provider notice for additional details on information needed to justify a delay in discharge due to COVID-19. The provider notice is available at the following link:

https://www.magellanofvirginia.com/media/5555/04-23-20-discharges-related-to-covid-19.pdf

- If an individual currently in a PRTF or TGH requires acute or inpatient medical treatment (non-psychiatric) for more than seven days for PRTF and ten days for TGH, the authorization will NOT be ended and the individual does not have to be discharged from the PRTF or TGH. For any subsequent admission to a PRTF or TGH, the previous admission shall be extended. The provider shall not bill for the time where the individual is admitted into acute care.
- Providers should refer to guidance from the CDC regarding best practices for facilities.
- If members are in need of quarantine because they are ill, the provider should coordinate their efforts with their department of health. More information can also be found on the VDH webpage.
- If individuals are in need of quarantine and hospitals are attempting to step them down to a psychiatric unit or facility, we would encourage providers and clinicians to evaluate the appropriateness of this transfer or step down.
- Service authorization requirements and medical necessity criteria will have to be met for admission into this level of care.

*Policy Flexibilities Applicable to Addiction and Recovery Treatment Services (ARTS)*

- ASAM 2.1 and 2.5 Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP)
    - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
    - Providers will not be required to discharge members from the service if the provider is billing outpatient services rather than PHP or IOP codes.
    - If providers are unable to provide the minimum amount of services required for the reimbursement of PHP/IOP as detailed in the July 22, 2020 memo titled "Changes to the Service Delivery Hour Requirements for Addiction and Recovery Treatment Services (ARTS) Intensive Outpatient Services (IOPs) Effective August 1, 2020 and Clarification for Partial Hospitalization Services (PHS) Requirements", providers may bill the most appropriate psychotherapy, assessment, and evaluation codes.
        - During the PHE, if CSACs or CSAC-Supervisees are performing substance use disorder (SUD) counseling within their scope of practice, DMAS will waive the requirement for only licensed practitioners to bill the psychotherapy codes. CSACs and CSAC-Supervisees will be allowed to bill using the most appropriate psychotherapy code based on the amount of time spent performing the service, bill under their licensed supervisor NPI and document the reason for billing the psychotherapy code by the CSAC or CSAC-Supervisee is due to not meeting the minimum time for billing the per diem.
    - The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the Credential Addiction Treatment Professional, LMHP-R, LMHP-RP or LMHP-S.

Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue.

- ASAM Levels 3.1 and Above
    - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
    - Therapy, assessments, case management, care coordination, team meetings, and treatment planning can occur via telehealth or telephonic consults.
    - Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care. Please see additional details on information needed to justify a delay in discharge due to COVID-19:
        - For members in ASAM Level 3.1 and above, medical necessity for continuation of care may be waived if the individual is unable to transition to lower levels of care due to COVID-19 and quarantines. Please see the April 23, 2020 Magellan of

Virginia provider notice for additional details on information needed to justify a delay in discharge due to COVID-19. The provider notice is available at the following link:

- https://www.magellanofvirginia.com/media/5555/04-23-20-discharges-related-to-covid-19.pdf
  - Providers should refer to guidance from the CDC regarding best practices for facilities.
  - If members need to be quarantined because they are ill, the provider should coordinate their efforts with their department of health. More information can also be found on the VDH webpage.
  - If individuals need to be quarantined and hospitals are attempting to step them down to a lower ASAM Level of Care, we would encourage providers and clinicians to evaluate the appropriateness of this transfer or step down.
  - Service authorization requirements and medical necessity criteria as noted in this memo will have to be met for admission into this level of care.
  - The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID 19 as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the Credential Addiction Treatment Professional, LMHP-R, LMHP-RP or LMHP-S.

*Opioid Treatment Programs (OTP) and Preferred Office-Based Opioid Treatment (OBOT) Services*

Individuals with Opioid Use Disorder (OUD) may have high-risk co-morbidities such as chronic obstructive pulmonary disease (COPD), cirrhosis, or HIV that may increase the risk of severe disease related to COVID-19. In light of the potential risk of exposure to COVID19, as well as barriers to accessing treatment due to illness, quarantine, and risk of serious illness, we ask providers and staff to exercise clinical judgment and to prioritize the continuation of members' medication for treatment of OUD (MOUD).

In line with the updated National Practice Guidelines issued by the American Society of Addiction Medicine (ASAM), DMAS is instructing providers of medication assisted treatment (MAT) to not delay initiation or continuation of medication due to a member's inability to see medical or behavioral health clinicians face-to-face. DMAS expects that Preferred OBOTs and OTPs remain open and accept new patients interested in MAT initiation during this time. If a Preferred OBOT or OTP is at member capacity for MAT services, the Preferred OBOT or OTP should have procedures in place to connect individuals with care.

DMAS is especially mindful of the mental and emotional duress that may be experienced by Medicaid members as well as potential disruptions in illicit drug supply that may encourage individuals to seek treatment and the importance of initiating MAT during this time. DMAS echoes SAMHSA in the strong recommendation of "the use of telehealth and/or telephonic services to provide evaluation and treatment of patients. These resources can be used for initial evaluations including evaluations for consideration of the use of buprenorphine products to treat opioid use disorder".

(https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mentalsubstance-use-disorders-covid19.pdf)

- OTPs and Preferred OBOT Providers are considered essential medical services. Thus, providers shall be making efforts to ensure current members have access to life saving medications. Providers shall also be making necessary arrangements to serve new members who are in need of initiation of medication assisted treatment. The initiation of MOUD can be done through telehealth during the PHE.
- DMAS also recognizes that members may not be able to pick up their medications from OTPs during this PHE. Thus, DMAS will allow OTP providers to deliver the medications to the member's location and be reimbursed for this service.
    - For delivery of up to a two week supply of medications: Bill 5 units of H0020 at $8.00/unit (equates to $40.00 or 70 miles round trip applying the federal personal mileage rate of 57.5 cents per mile).
    - For delivery of three weeks or greater supply of medications: Bill 10 units of H0020 at $8.00/unit (equates to $80.00 or 140 miles round trip).
- DMAS is allowing flexibility of the rule defined in the ARTS program manual, which limits the reimbursement of medication administration encounters within OTPs to only those encounters when the member is presenting in-person, daily, to get their medication dose.
    - The OTPs have received approval from the State Opioid Response Authority to administer medication as take-home dosages, up to a 28-day supply, to minimize exposure of COVID-19 to staff and patients.
    - Thus, DMAS is allowing for the reimbursement of the medication encounter for the total number of days' supplied of the take-home medication. This flexibility is critical to minimize face-to-face contact during the emergency.
- Effective the date of this memo, DMAS is allowing Preferred OBOTs and OTPs the flexibility during the PHE to review and update the IPOC at least every 90 calendar days instead of every 30 days to alleviate some burden on providers. Providers shall modify the IPOC as the needs and progress of the member changes. An IPOC that is not updated either every 90 calendar days or as the member's needs and progress change shall be considered outdated.

*Back-Up Staff*

Preferred OBOTs, OTPs, in-network buprenorphine waivered practitioners, and behavioral health clinicians shall be prepared in the case of staff illness, including making arrangements for backup prescribers and behavioral health clinicians. DMAS recommends making these arrangements in advance and ensuring in-network back-up providers are available for each Medicaid MCO or Magellan of Virginia for fee-for-service member. If an in-network provider is not available for a member, providers shall contact MCO or Magellan of Virginia Network Relations staff.

*Counseling and Other Requirements*

During the PHE, DMAS is allowing the counseling component of Medication Assisted Treatment (MAT) to be provided via telehealth or telephone communication. If a Preferred OBOT or OTP member is unable to participate in counseling services due to COVID-19, DMAS will not penalize the Preferred OBOT or OTP provider for the missed services.

The provider must have emergency procedures in place to address the needs of any member in a psychiatric crisis. The provider should also ensure that the member continues to have access to

medications to treat OUD, as well as care coordination activities as appropriate. Preferred OBOT and OTP providers may continue to bill for care coordination that is provided telephonically and in the absence of counseling services, if necessary and appropriate.

*Face-to-Face Contact Requirements*

Face-to-face contact requirements are waived for care coordinators, counselors, and peer recovery support specialists within Preferred OBOT or OTP. Staff members may use telehealth, including telephonic communication, and should use the same billing codes. Any type of contact with the member shall be documented, including the method of contact (face-to-face, telehealth, telephonic.) This includes obtaining verbal signatures from members in conducting the reviews for IPOCS and ISPs.

*Urine Drug Tests*

Providers should use clinical judgment when requiring urine drug tests to minimize clinic and member exposure to COVID-19. DMAS will not penalize Preferred OBOTs or OTP's for missed urine drug tests during the PHE. DMAS encourages providers to familiarize themselves with the recent bulletin "Guidance for the use of Urine Drug Testing in Substance Use Disorder (SUD) Treatment" posted September 4, 2020.

*Providing MOUD via Telehealth*

Under the Ryan Haight Act of 2008, general requirements are that the prescribing practitioner shall have conducted at least one in-person medical evaluation of the patient before prescribing a controlled substance (including buprenorphine and buprenorphine/naloxone) for treatment of addiction. However, during the federal PHE, the Drug Enforcement Agency (DEA) has lifted the requirements under the Ryan Haight Act of 2008 for prescribing practitioner to have conducted at least one in-person medical evaluation of the patient before prescribing a controlled substance scheduled II – V, including buprenorphine and buprenorphine/naloxone for treatment of addiction. For as long as the federal HHS designation of a PHE remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice.
- The telemedicine communication is conducted by questioning the patient over the telephone or via telemedicine using a real-time, two-way, audio-visual communications device.
- The practitioner is acting in accordance with applicable Federal and State law. Provided the practitioner satisfies the above requirements, the practitioner may issue the prescription using any of the methods of prescribing currently available and in the manner set forth in the DEA regulations. Thus, the practitioner may issue a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy (See the DEA Decision Tree).
- The initial visit for Buprenorphine prescribing via home as originating site is allowed as long at the DEA requirements are met above. The telepresenter requirements do not apply when member is at home as the origination site.

*Buprenorphine (Schedule III) Products and Refills*

As noted in the March 19, 2020 memo, Fee-for-Service and Medicaid managed care health plans will:

1. Suspend all drug co-payments for Medicaid, FAMIS and FAMIS Moms members.
2. Cover a maximum of a 90 day supply for all drugs excluding Schedule II drugs. In Virginia, Schedule II drugs include most opioids, amphetamines, methylphenidate, etc. A complete list of Schedule II drugs can be found at:
    1. https://law.lis.virginia.gov/vacode/title54.1/chapter34/section54.1-3448/.
3. Suspend refill "too soon" edits for all drugs prescribed for 34 days or less. Drugs dispensed for 90 days will be subject to a 75% refill "too-soon" edit. Patients will only be able to get a subsequent 90 day supply of drugs after 75% of the prescription has been used (approximately day 68).
4. Federal and state law prohibit the early refilling of Schedule II drugs except in the case of an emergency. Pharmacists should refer to Virginia Board of Pharmacy's guidance for emergency fill procedures.

Pharmacists and prescribers must continue to comply with all applicable state and federal laws and regulations related to the prescribing and dispensing of controlled substances. Pharmacists are encouraged to review the Virginia Board of Pharmacy's "Emergency Provisions for Pharmacists during the COVID-19 Declared Emergency" for additional guidance available www.dhp.virginia.gov/Pharmacy.

*Naloxone*

Providers are advised to write prescriptions for naloxone for members in case of interruptions in community-based distribution.

*Preferred OBOT Prescription Management*

During the PHE, DMAS asks Preferred OBOTS to consider giving individuals who are deemed 'clinically stable' longer prescription lengths of buprenorphine containing products, as permitted by the Virginia Board of Pharmacy. 'Clinically stable' should be determined by the prescribing provider's clinical judgment and care team. DMAS encourages providers to consider a minimum two-week supply of buprenorphine-containing products, and telehealth or telephonic follow up when clinically appropriate to lessen an individual's risk of coming into contact with persons who may be carrying the virus. Providers should review proper prescription storage for the safety and well-being of members.

*Sublocade and Vivitrol*

If a member is receiving subcutaneous buprenorphine (Sublocade) and cannot attend a clinic, providers can transition the member to sublingual buprenorphine (Suboxone) without additional in-person examinations. Similarly, members receiving intramuscular naltrexone (Vivitrol) may be transitioned to oral naltrexone without an additional examination.

*In-Network Buprenorphine Waivered Practitioners*

Information contained in this section for MAT applies to in-network buprenorphine waivered practitioners. Please note that if providers are not approved as Preferred OBOT providers, care coordination is not a reimbursable service.

Providers are encouraged to frequently access the Agency's website to check the central COVID-19 response page for both Frequently Asked Questions (FAQs) and guidance regarding new flexibilities as they are implemented. For additional questions about this memo or other COVID-19 related issues, the agency has created a centralized point of access for submission at http://dmas.virginia.gov/contactforms/#/general. Questions may also be submitted to COVID-19@dmas.virginia.gov.

If you have additional questions about the behavioral health specific portions of these memos, you may email EnhancedBH@dmas.virginia.gov or SUD@dmas.virginia.gov in addition to the centralized access point that was noted in the paragraph above.

**********

| **PROVIDER CONTACT INFORMATION & RESOURCES** | |
|---|---|
| **Virginia Medicaid Web Portal Automated Response System (ARS)**<br>Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice. | www.virginiamedicaid.dmas.virginia.gov |
| **Medicall (Audio Response System)**<br>Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice. | 1-800-884-9730 or 1-800-772-9996 |
| **KEPRO**<br>Service authorization information for fee-for-service members. | https://dmas.kepro.com/ |
| **Managed Care Programs**<br>Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals. | |
| **Medallion 4.0** | http://www.dmas.virginia.gov/#/med4 |
| **CCC Plus** | http://www.dmas.virginia.gov/#/cccplus |
| **PACE** | http://www.dmas.virginia.gov/#/longtermprograms |
| **Magellan Behavioral Health**<br>Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members. | www.MagellanHealth.com/Provider<br>For credentialing and behavioral health service information, visit:<br>www.magellanofvirginia.com, email:<br>VAProviderQuestions@MagellanHealth.com,or<br>Call: 1-800-424-4046 |

| | |
|---|---|
| **Provider HELPLINE**<br>Monday–Friday 8:00 a.m.-5:00 p.m.<br>For provider use only, have Medicaid Provider ID Number available. | 1-804-786-6273<br>1-800-552-8627 |
| Aetna Better Health of Virginia | www.aetnabetterhealth.com/Virginia<br>1-800-279-1878 |
| Anthem HealthKeepers Plus | www.anthem.com/vamedicaid<br>1-800-901-0020 |
| Magellan Complete Care of Virginia | www.MCCofVA.com<br>1-800-424-4518 (TTY 711) or 1-800-643-2273 |
| Optima Family Care | 1-800-881-2166 |
| United Healthcare | www.Uhccommunityplan.com/VA<br>and www.myuhc.com/communityplan<br>1-844-752-9434, TTY 711 |
| Virginia Premier | 1-800-727-7536 (TTY: 711), |