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MEDICAID MEMO

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# Provider Flexibilities Related to COVID-19

This memo sets out the Agency's initial guidance on the flexibilities available to providers in light of the public health emergency presented by the COVID-19 virus. These flexibilities include expanded telehealth coverage, as well as the waiver of certain program requirements, including specified service authorizations and prescription drug limitations. DMAS is also waiving specific provider requirements, as set out below. These flexibilities are relevant to the delivery of covered services related to COVID-19 detection and treatment, as well as maximizing access to care and minimizing viral spread through community contact.

Providers of services to members enrolled in Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) must follow their respective contract requirements with the managed care plan or PACE provider. All DMAS contracted managed care plans will follow the DMAS COVID-19 delivery requirements. MCOs may, at their discretion, allow additional enhanced delivery flexibilities within their provider network.

Please note that the policy changes set out in this memo are in effect during the public crisis, as set out in the Governor's Emergency Declaration. This is a rapidly emerging situation and the Agency is moving quickly to address all aspects having an impact on both members and providers. Additional changes are forthcoming; DMAS is negotiating with its federal partners to authorize new flexibilities, which the Agency will announce as they are approved. Providers are encouraged to frequently access the Agency's website to check the central COVID-19 response page for both FAQ's 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

**Billing for COVID-19 Testing**

Testing is available through the Division of Consolidated Laboratory Services (State Laboratory) and from other private laboratories. For testing at DCLS, patients must meet certain clinical and epidemiologic criteria, and testing will be approved by the Virginia Department of Health. Further information on testing can be found on VDH's website. VDH approval is not required for testing at private laboratories.

VDH-enrolled clinical laboratories and health care facilities may bill DMAS for medically necessary, clinically appropriate COVID-19 lab tests using HCPCS Code U0001 (CDC testing laboratories to test patients for SARS-CoV-2, $35.91) and U0002 (non-CDC testing for SARSCoV, $51.31) with effective dates of service on or after February 4, 2020. DMAS' fee-for-service billing system has been updated to accept the new codes and service

authorization is not required. Laboratories will need to be Clinical Laboratory Improvement Amendments (CLIA) certified. DMAS is following the Center for Medicare and Medicaid Services (CMS) guidance for these two services. All Medicaid Managed Care Plans (MCOs) and Medicaid fee for service (FFS) cover COVID-19 testing.

**Billing for COVID-19 Related Services**

DMAS covers medically necessary services to treat or alleviate symptoms related to COVID-19. The CDC has provided Official Coding Guidelines for health care encounters and deaths related to COVID-19. All Medicaid Managed Care Plans (MCOs) and Medicaid fee for service (FFS) cover medically necessary services to treat or alleviate symptoms related to COVID-19.

**Coverage of Targeted Services Delivered Via Telehealth**

In order to maximize access to medically necessary services during the current public health emergency, DMAS is expanding coverage of telehealth as a method of service delivery. This is an initial policy memo; the agency is working as quickly as possible to leverage additional needed flexibilities in this area; for example, in the area of remote patient monitoring. Medicaid MCOs may offer additional flexibilities.

"Telehealth services" means the use of telecommunications and information technology to provide access to health assessments, diagnosis, intervention, consultation, supervision, and information across distance for both medical and behavioral health services. Telehealth services includes the use of such technologies as interactive and secure medical tablets, remote patient monitoring, and store-and-forward technologies. When delivering services via telehealth, providers are required to adhere to the same standards of clinical practice and record keeping that apply to other covered services.

During the COVID-19 national emergency and effective immediately, the Office of Civil Rights at the Department of Health and Human Services “will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency.” This applies to telehealth provided for any reason and does not have to be related to diagnosis and treatment of COVID-19. The full notice and related guidance on acceptable applications can be found here.

DMAS will reimburse for Medicaid-covered services delivered via telehealth where the following conditions are met:

- To the extent feasible under the circumstances, providers must assure the same rights to confidentiality and security as provided in face-to-face services. Providers must ensure the patient’s informed consent to the use of telehealth and advise

members of any relevant privacy considerations.

- DMAS is waiving the requirement that services delivered via telehealth (real-time, twoway communications) must utilize both audio and visual connection. DMAS is allowing the use of audio connections in addition to audio-visual connections.
- DMAS is waiving the requirement that provider staff must be with the patient at the originating site in order to bill DMAS for the originating site facility fee. These "telepresenters" shall not be required for payment of the originating site fee. Telehealth in the home is discussed more fully below, but no originating site fee shall be paid for telehealth in the home.
- Providers shall submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service delivered. In some cases, there are existing codes available for certain specifically telehealth-focused services. In others, such as behavioral health, please see the service specific section below for guidance. During the initial phase of the emergency, the Agency will permit providers who have not previously billed for telehealth delivery to bill for covered services delivered via telehealth (including audio and audiovisual) using their usual place of service code as the delivery location, but must document in the member's record the alternative location used and that the service was delivered via telehealth.
- Providers are asked to update their systems and procedures as soon as possible to enable the use of modifiers (GT or GQ) or telehealth POS (02) when billing for services delivered via telehealth. DMAS will require the use of these codes after the initial phase of the emergency is over. Additional information will be included in a future memo.
- Providers using telehealth POS (02) or modifiers for telehealth services covered under the prior policy shall continue to use the modifier GT (via interactive audio and video telecommunications system) or GQ (via synchronous telecommunications system), or POS code (02) when billing for services delivered via telehealth.
- Both services delivered via telehealth and billed using telehealth modifiers, and services delivered via telehealth and billed without modifiers will be reimbursed at the same rate as the analogous service provided face-to-face.
- Providers shall maintain appropriate documentation to support medical necessity for the service delivery model chosen, as well as to support medical necessity for the ongoing delivery of the service through that model of care.

*Home as Originating Site*

During the current emergency, DMAS will allow the home as the originating site. This is particularly important for members who are quarantined, those who are diagnosed with or demonstrating symptoms of COVID-19, or those who 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. No originating site fee shall be paid for telehealth in the home.

*Telehealth in the Delivery of Behavioral Health Services*

DMAS will allow for telehealth (including telephonic) delivery of all behavioral health services with several exceptions. Services that will be allowable via telehealth include:

- Care coordination, case management, and peer services
- Service needs assessments (including the Comprehensive Needs Assessment and the IACCT assessment in mental health and the Multidimensional Assessment in ARTS) and all treatment planning activities
- Outpatient psychiatric services
- Community mental health and rehabilitation services
- Addiction Recovery and Treatment Services

The per diem rates for therapeutic group homes, psychiatric residential treatment facilities, and inpatient psychiatric hospitalization will not be billable through telehealth; however, within these services, activities including assessments, therapies (individual, group, family), care coordination, team meetings, and treatment planning are allowable via telehealth.

As stated above in the general guidance and until otherwise notified, behavioral health providers delivering services via telehealth (including telephonic communications) shall simply bill and submit a claim as they normally would in their regular practice. The Place of Service (POS) that the provider usually bills should remain the same and no modifiers shall be necessary in order to minimize systems errors during this critical time. Providers shall maintain appropriate documentation to indicate the mode of delivery and to support medical necessity for the ongoing delivery of the service through that model of care. As noted above in the general guidance, providers should move to systems changes to allow Place of Service Codes (02) to reflect telehealth delivery as this will be required at a future date.

**Early Intervention Services**

Early Intervention (EI) providers are permitted to use telehealth or remote care delivery for all ongoing services to include developmental services, physical therapy, occupational therapy, and speech-language pathology to include monitoring of successful program and instructional implementation, coaching, treatment teaming and service plan development. Assessments for new cases can be done on a limited basis in person or using synchronous telehealth technologies at the discretion of the local service provider with the child and families consent.

**Requirements for Member Co-payments (Applicable across MCOs and FFS)**

This section applies to any out of pocket costs in Medicaid and FAMIS: All member co-pays have been suspended, effective March 13, 2020. No co-pays will be collected from any

Medicaid or FAMIS member in order to encourage all members to seek needed medical care and treatment.

**Pharmacy Benefit Changes in Response to COVID 19**

Effectively immediately, the 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 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.

**Waiving Service Authorization Requirements on Select Services**

Providers are required to submit for service authorization review any new request for services and requests for changes in services (such as an increase or decrease).

Please see Attachment B for a full list of services for which service authorization is being extended or waived.

Please note that DME providers may deliver up to a two (2)-month supply at a time (60 days) during the response to the COVID-19 pandemic. DME providers are instructed to bill in monthly increments with the anniversary date (30 days at a time). Providers will be required to keep records of patient/caregiver contact to determine the appropriate need for supplies during each 60-day period if it is determined a second 60-day supply period is needed. Providers are also required to maintain the normal delivery ticket documentation

and proof of delivery.

**Suspension of Out-of-Network Requirements (Applicable to Medallion and CCC Plus)** DMAS has asked MCOs to relax out-of-network authorization requirements as appropriate and to pay the Medicaid fee schedule, in order to expedite needed care for members.

**Face-to-Face Service Delivery Guidance for All DMAS-Covered Services:**

DMAS is issuing the following recommendations to assist agencies, health care organizations, and providers, and to assure that members continue to receive necessary interventions.

- All providers shall limit the amount of face-to-face contacts with members. If a provider, member, caregiver, and or anyone in home or facility is experiencing symptoms of a medical illness, all face-to-face contact shall be minimized or avoided.
- All face-to-face requirements including assessments, reassessments, and service delivery are waived for all members residing in the community, with the exception of instances when there is concern for the member's health safety and welfare. Face-to-face meetings shall be replaced with phone calls with members and/or documentation from providers.
- Existing face-to-face requirements continue to apply in cases where there is a compelling concern for the member's health, safety and welfare based on the professional judgement of licensed staff.

**Waiver Face-to-Face Requirements – CCC Plus Managed Care Program**

- *For CCC Plus members in nursing facilities* o All face-to-face requirements including initial health risk assessments, reassessments (both scheduled and triggering), interdisciplinary care team meetings, and care planning meetings are waived. Face-to-face meetings shall be replaced with phone calls with the member, family/authorized representatives, nursing facility staff and/or documentation, e.g., copy of most recent minimum data set or other available member records. Details on how the information was

  obtained in lieu of the face-to-face meeting must be documented within the member's record.

- *For CCC Plus members residing in the community* o With the exception of instances when there is concern for the member's health, safety, and welfare, all face-to-face requirements including health risk assessments, reassessments (both scheduled and triggering), interdisciplinary care team meetings, and care planning meetings are waived. Face-to-face meetings shall be replaced with phone calls with members

and/or documentation from providers. Face-to-face requirements may be waived for all CCC Plus members residing in the community if the member's health, safety, and welfare is maintained by authorized services and information can be received by using an alternate method in lieu of the face-to-face meeting. Details on how the information was obtained in lieu of the face-to-face meeting must be documented within the member's record. o Existing face-to-face requirements continue to apply in cases where there is a compelling concern for the member's health, safety, and welfare based on the professional judgement of licensed staff.

- *Quality Management Reviews (QMRs)* o All QMR reviews will be desk audit only. All needed materials will be requested from the provider to conduct the review. Providers will be allowed flexibility in instances where they have limited staff to submit records.
- *Annual Level of Care Evaluations (LOCERI)* o All face-to-face requirements to conduct the annual level of care evaluations (LOCERI) are waived. This waiving of face-to-face requirement is for both past due and currently due level of care evaluations. For CCC Plus Waiver members who have had a face-to-face assessment (initial or reassessment) between October 1, 2019 and March 12, 2020, the information from this assessment may be used to submit LOCERI data in lieu of the face-to-face meeting to complete and submit the annual level of care evaluation.
- *Documentation* o Providers shall document in their records the member's verbal consent, authorization, and confirmation of participation. The provider shall obtain written signatures within 45 days after the end of the emergency.

**Programs of All-Inclusive Care for the Elderly (PACE)**

All PACE providers must follow infection control requirements per 42 CFR 460.74, including implementing infection control plans for each PACE site and for each participant's residence. PACE providers should monitor the CDC website and CMS Emergency Preparedness and Response Operations for the latest guidance and resources.

PACE should follow CDC guidelines for preventing the spread of COVID-19 among participants and staff (https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html); however PACE sites are reminded that they are responsible for continuing to provide all required Medicare and Medicaid covered services including serving participants in their home as well as taking precautions to prevent the spread of COVID-19. Should there be instances where a PACE provider needs to implement strategies that do not fully comply with CMS PACE program requirements in order to provide services to participants, CMS will take those situations into consideration when conducting monitoring or oversight activities. All PACE sites must document the rationale for any change in procedures.

PACE sites may use remote technology (telehealth options) as appropriate for participant

assessments, care planning, monitoring, community and other activities that would normally be provided as a face to face service. CMS will provide PACE sites with notification when alternate processes should be discontinued.

**CCC Plus Waiver**

- *Face-to-face visits:*
  - For CCC Plus Waiver members, face-to-face Agency RN and Services Facilitation (SF) visit requirements are waived with the exception of instances when there is concern for the member's health, safety, and welfare. This includes agency-directed RN supervisory visits and SF routine and reassessment visits. Face-to-face meetings shall be replaced with phone calls or virtual communication (telehealth) with members and documentation by providers. **Visits to initiate services must be conducted face-to-face in order to ensure adequate service plan development**.
- *Documentation* o Required DMAS forms shall be used to document the interaction during these phone calls. Documentation of visits conducted through telehealth must meet the standards required for face-to-face visits**.**
  - Providers shall document in their records the member's verbal consent, authorization, and confirmation of participation. The provider shall obtain written signatures within 45 days after the end of the emergency.
  - Providers shall use existing procedure codes when billing for telehealth visits.
- *CCC Plus Waiver Service Authorization Extension* o To ensure continuity of care for members, service authorizations for certain CCC Plus waiver services will be extended. All personal care, respite, private duty nursing (PDN), and Personal Emergency Response Systems (PERS) service authorizations with end dates between March 12, 2020 and May 31, 2020 will be extended by two months. Providers may still submit service authorization requests during this time period. PDN providers shall continue to be responsible for obtaining MD orders for services**.**

**Developmental Disability Waivers** *Face-to-Face visits:*

- *Face-to-face visits by Support Coordinators* o Requirements for face-to-face visits by support coordinators will be suspended until the end of the emergency. In the interim, it is expected that Support Coordinators will conduct telephonic check-ins and request the same updates as would be gained during a face-to-face visits regarding, health, safety and satisfaction with services. o For all of these "visits", providers shall document a reference to COVID-19 so that future auditors will be reminded of these allowances made during this time frame.

- *QMR visits*
    - QMR on-site visits will be suspended until the end of the emergency. In the interim, QMR will conduct desk audits.
- *NCI survey visits* o NCI Survey visits have been suspended for the next 30 days and will be reevaluated at that time.
- *Telehealth support*: Telehealth is generally provided through electronic video chat that is HIPAA compliant; if video is not available, the SIS, VIDES, annual plan meetings, and case management visits may be completed telephonically during the emergency.
    - DMAS and DBHDS support the completion of annual plan meetings, case management visits, the VIDES and the SIS via telehealth or telephone until the end of the emergency.
- Telehealth/telephonic support for Therapeutic Consultation will be accepted for those activities within Therapeutic Consultation that do not require direct intervention by the behaviorist.

*Signatures:*

- Support Coordinators, including those private entities contracted with a CSB, can certify that signatures normally required for consent, authorization, and confirmation of participation, were verified verbally by the case manager with written consent gained within 45 days after the end of the emergency. o Documentation should include the name of the person who gave verbal consent, the date verbal consent was given, what was consented to, as well as alternatives to what was discussed.
- The services facilitator can certify that signatures normally required for agreement, consent, and authorization for consumer-directed services have been verified verbally by the service facilitator/case manager with written consent gained within 45 days after the end of the emergency. o Documentation should include the name of the person who gave verbal consent, the date verbal consent was given, what was consented to, as well as alternatives to what was discussed.

*Slots:*

- No slots will be rescinded or lost during the emergency. DMAS will begin reviewing Retain Slot Requests once the emergency has ceased and the normal reviews will be continued from the point in the individual's process prior to the emergency.

*Service Authorization:*

- Service Authorizations may be retroactively approved for up to 10 calendar days until the end of the emergency.
- Service authorization will prioritize authorizations for In-home Supports, Personal Assistance, Companion, Group Day, and Crisis services to meet the need during the state of emergency.

*Provider Operations*:

- A provider cannot provide a service for which they do not have a license or provider participation agreement.
- As long as staff are deemed competent according to the DSP competency standards and this is documented, training can be expedited.

**Group Homes and Community Engagement/Day Support**

*Service Authorizations*

- Service authorizations will be retroactively approved for up to 10 days until May 1, 2020.

  This will be re-evaluated at the end of April to determine if there is a continuing need.

- Service authorization will prioritize authorizations for in-home, personal care, companion, group day, and crisis services to meet the need during the state of emergency.

**Electronic Visit Verification (EVV)**

EVV requirements remain in effect for agency and consumer directed personal care, respite, and companion services. In order to ensure prompt and proper payment for services provided to members during the emergency declaration, DMAS will continue paying claims regardless of the status of EVV data on the provider's claims until June 30, 2020. This applies to services provided through fee for service, Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 managed care plans.

**Behavioral Health Services (Applicable across MCOs and FFS)**

DMAS will schedule a weekly call with provider associations, MCOs, DBHDS, and invited stakeholders during the emergency period to provide ongoing updates and receive feedback on system functioning.

Provider qualifications, licensure requirements, and the structure of the services shall remain intact. That is, QMHPs, Supervisees, and Residents must remain working under the direction of an LMHP and BCBA®/BCaBA® must provide supervision to unlicensed staff (i.e. technicians). Within the ARTS program, CSAC and CSAC-Supervisees must remain working under the direction of licensed providers authorized by the Board of Counseling. Provider Types allowed to bill for Medicaid services will remain the same regardless of the

delivery method (face to face vs. telehealth). Providers would continue to utilize the current service and billing National Provider Identifier (NPI) numbers as they are now regardless of the mode of delivery of care and should proceed with efforts to include Place of Service (02) Codes to indicate telehealth delivery as these will be required at a future date.

For any services *without* specific guidance below:

- Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care.
- Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
- Current service authorization requirements remain the same.

*Specific Service Considerations & Limitations*

- Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health SkillBuilding, Behavioral Therapy, Intensive Community Treatment and Psychosocial

  Rehabilitation.

  - Service delivery may be provided outside of the school setting, office setting, or clinic setting for the next 60 days.
  - Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care.
  - Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care. o For youth participating in both TDT and IIH, TDT should not be used in the home as this would be a duplication of services. o These services shall not be provided to a group of individuals at the same time and location (with the exception of family members/kinship in the same location) so as to promote containment of COVID-19 infection. o For new services, a prior authorization request is required to verify medical necessity and appropriateness of the service delivery model. o The prior 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.
  - If the provider is only providing services through telephonic communications, the provider shall bill a maximum of 1 unit per member per day, regardless of the amount of time of the phone call(s). o As the situation evolves regarding COVID-19, DMAS will re-evaluate the need for prior authorization of services.

- *Day Treatment/Partial Hospitalization Programs for Adults* o Face-to-face services shall not be required for reimbursement of the services, but documentation shall justify the rationale for the service through a different model of care. o Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care. o If providers are unable to provide the minimum amount of services required for the reimbursement of PHP/IOP, providers may bill behavioral therapy, assessment, and evaluation codes. o Providers will not be required to discharge members from the service if the provider is billing outpatient services rather than PHP or IOP codes.
- *Psychiatric Inpatient Hospitalizations* o The requirement for prior authorization remains in place. o Therapy, assessments, case management, team meetings, and treatment planning may occur via telehealth.

 *IACCT Assessment, Psychiatric Residential Treatment Facility, and Therapeutic Group Homes*

  - The requirement for prior authorization remains in place. o 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.
  - Therapy, assessments, case management, care coordination, team meetings, and treatment planning may occur via telehealth.

 *Psychiatric Inpatient and Residential Levels of Care* o For members in residential levels of care (including therapeutic group homes), 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.

**Addiction and Recovery Treatment Services (ARTS)**

- *ASAM 2.1 and 2.5 Intensive Outpatient and Partial Hospitalization Programs* o Managed Care Organizations will allow up to 14 days after the start of a new service or after the expiration of an existing authorization for a service authorization request to be submitted from the provider to the MCO.
  - Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care.
  - Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care. o If providers are unable to provide the minimum amount of services required for the reimbursement of PHP/IOP, providers may bill 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 PHP or IOP codes.

- *ASAM Levels 3.1 and Above* o Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care. o 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. o 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.

**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 COVID-19, 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.

*Recommendations for Reducing Transmission*

Please follow the guidance issued by the Department of Behavioral Health and Developmental

Services (DBHDS), the Centers for Disease Control (www.cdc.gov/COVID19) as well as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Virginia Department of Health.

*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 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 Network Relations staff.

*Counseling and Other Requirements*

During the Governor's State of Emergency, DMAS is allowing the counseling component of Medication Assisted Treatment (MAT) to be provided via telehealth or telephone communication. If an OBOT or OTP member is unable to participate in counseling services due to COVID-19, DMAS will not penalize the 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. 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.

*Home as Originating Site for Counseling Services*

DMAS will additionally allow 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 will not be available.

*Face-to-Face Contact Requirements*

Face-to-face contact requirements are waived for care coordinators, counselors, and peer recovery support specialists within 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.)

*Urine Drug Screens*

Providers should use clinical judgment when requiring urine drug screens to minimize clinic and member exposure to COVID-19. DMAS will not penalize OBOTs or OTP's for missed urine drug screens during the public health emergency.

*Billing for Telehealth Services*

Services provided via telehealth or telephonically shall be billed using the currently approved CPT and HCPCS codes allowed under the ARTS reimbursement structure. Documentation shall include the mode of service delivery.

**Providing Medication for Members with OUD**

*Guidance on Use of Telehealth for Members and Providers Affected by COVID-19 Ryan Haight Act of 2008*

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 Health and Human Services (HHS) Public Health Emergency, 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 public health emergency remains in effect, DEAregistered 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 using an audio-visual, real-time, two-way interactive communication system.
- 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

  (https://www.deadiversion.usdoj.gov/coronavirus.html).

*Home Delivery of Medications*

There is nothing under federal law that prohibits delivery of medications from occurring, although resources to offer this level of service may vary by program. OTPs shall contact the State Opioid Treatment Authority (SOTA) for information on how to attain approval for take-home dosing.

*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 Governor's State of Emergency, DMAS asks Preferred OBOTS to consider giving individuals who are deemed 'clinically stable' longer prescription lengths of buprenorphinecontaining 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."

*Billing Medicaid for Telehealth Services for Prescribing Medications*

Services provided via telehealth or telephone shall be billed using the currently approved CPT and HCPCS codes allowed under the ARTS reimbursement structure. Documentation shall include the mode of service delivery.

DMAS is waiving the requirement to use the specific telehealth billing codes in this time of emergency.

*Home as Originating Site*

Prior DMAS telehealth guidance related to the prescribing of controlled substances for the treatment of addiction delivered via telehealth required a qualified provider and a telepresenter located at the originating site, as well as a qualified prescribing provider located at the remote site. DMAS will allow a member's home to serve as the originating site for prescription of buprenorphine in accordance with the Ryan Haight Act which allows exceptions in the event of a Public Health Emergency. This may be particularly important for members 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 will not be available. (This does not apply for prescribing the initial dose of a controlled substance. Providers must follow the DEA requirements noted above for the initial visit.) For providers who are treating members in the home, contingency plans and emergency procedures shall be developed and documented.

*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.

If you have additional questions about the SUD-specific portions of this memo, you may also email SUD@dmas.virginia.gov in addition to the centralized access point for questions highlighted at the beginning of this memo.

**Eligibility and Enrollment**

Several changes are being made to Eligibility and Enrollment policies and procedures to ensure continued coverage during this emergency. The agency's priority is to ensure continued coverage and access to coverage during this time. DMAS encourages uninsured patients to apply online (www.commonhelp.virginia.gov) as the fastest way to apply for care during an emergency. However, if patients experience interruptions in coverage or need corrections to their coverage during this time, please contact the centralized contact option highlighted at the beginning of this memo.

**Fair Hearings and Appeals**

*Client Appeals*

DMAS is making the following changes:

- DMAS is seeking federal authority to accept client/member appeals filed during the COVID-19 emergency that miss the normal filing deadlines, and, if the authority is granted, those appeals will move forward as if the deadlines were met.
- For all appeals filed during the state of emergency, Medicaid members will automatically keep their health coverage and have access to Medicaid-covered medical services without any financial impact while the appeal is proceeding. Medicaid managed health plans will also approve continued coverage while their internal appeal process is underway.
- All DMAS State Fair Hearings will be conducted by telephone.
- DMAS will grant requests to reschedule hearings.
- Appeals may be submitted to DMAS via e-mail at Appeals@DMAS.Virginia.Gov

Additionally, State Fair Hearing decisions may not be issued within the normal timeframe, depending on the length of the emergency.

*Provider Appeals*

Pursuant to the Governor's Declaration of a State of Emergency issued on March 12, 2020 (Executive Order 51), the DMAS Director is authorized to waive state requirements and regulations. DMAS is exercising this authority for deadlines that govern provider appeals that are specified in the Code of Virginia and DMAS' provider appeal regulations. The following changes are being made:

- Providers affected by the COVID-19 emergency can request a hardship exemption to the normal deadline to file an appeal. The provider's request for an informal appeal or formal appeal must state an exemption is being requested and the reason for the exemption.
- Appeals may be submitted to DMAS via e-mail at Appeals@DMAS.Virginia.Gov  All deadlines after an appeal has been filed are extended for the period of the declaration of emergency. This applies to the following informal appeal deadlines: case summary, informal-fact-finding conference (IFFC), document submission after the IFFC, and the informal appeal decision. This also applies to the following formal appeal deadlines: documentary evidence, hearing date, post-hearing briefs, recommended decision, exceptions, and the Final Agency Decision. For example, if the declaration of emergency lasts 50 days, these deadlines are extended 50 days.
- All informal fact-finding conferences and formal hearings will be conducted by telephone during the period of emergency.

**Attachment A (Page 17): Table of Codes for Telehealth**

**Attachment B (Page 18): Service Authorizations Extensions or Waivers**

********** **Medicaid Expansion Eligibility Verification**

Medicaid coverage for the new expansion adult group began January 1, 2019. Providers may use the Virginia Medicaid Web Portal and the Medicall audio response systems, as shown in the table below, to verify Medicaid eligibility and managed care enrollment, including for the new adult group. In the Virginia

Medicaid Web Portal, individuals eligible in the Medicaid expansion covered group are shown as

"MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the "MED4" (Medallion 4.0) or "CCCP" (CCC Plus) managed care enrollment segment. Eligibility and managed care enrollment information is also available through the DMAS Medicall eligibility verification system. Additional Medicaid expansion resources for providers are available on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

| **PROVIDER CONTACT INFORMATION & RESOURCES** | |
|---|---|
| **Virginia Medicaid Web Portal**<br>**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-forservice members. | https://providerportal.kepro.com |
| **Managed Care Programs**<br>Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and the 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 feefor-service individuals. | |
| **Medallion 4.0 Managed Care Program** | http://www.dmas.virginia.gov/#/med4 |
| **CCC Plus Managed Care Program** | http://www.dmas.virginia.gov/#/cccplus |
| **PACE Program** | 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: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046 |
| **Provider HELPLINE**<br>Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available. | 1-804-786-6273<br>1-800-552-8627 |
| Aetna Better Health of Virginia | 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 | Uhccommunityplan.com/VA and myuhc.com/communityplan |
| | 1-844-752-9434, TTY 711 |
| Virginia Premier | 1-800-727-7536 (TTY: 711), |