

## Addiction and Recovery Treatment Services (ARTS) Updated 11/2/2020

This document answers frequently asked questions (FAQs) specifically related to the Agency guidance on the flexibilities available to providers to address the current state of emergency presented by the COVID-19 virus. These FAQs are an update to the guidance posted in April 2020 and reflects current COVID-19 flexibilities. Guidance contained in these FAQs are summarized in the “Federal and State Authorities for COVID-19 Public Health Emergencies and Update for Behavioral Health and Addiction and Recovery Treatment Services Policy Continuation and Timelines” memo dated 9/30/2020 available on the DMAS website under COVID-19 Policy Updates available at <http://dmas.virginia.gov/#/emergencywaiver>.

These FAQs focus on flexibilities for the Addiction and Recovery Treatment Services (ARTS) benefit. For Behavioral Health FAQs related to the Agency's response to COVID-19 please visit: <http://www.dmas.virginia.gov/#/emergencywaiver>

### General Questions

#### *How long will the flexibilities last?*

Most flexibilities that DMAS has implemented depend on both state and federal authorities. At the federal level, the Public Health Emergency (PHE) is being extended in 90 day increments. The current Federal PHE is set to expire on January 20, 2021 unless it is renewed. Information on the Federal PHE is located at: <https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx>

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.

DMAS is required to unwind the flexibilities obtained when either the federal or the state PHE declarations expire. 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 30 days in advance of these changes to allow providers adequate time to prepare their process and systems.

#### *Which services do the flexibilities cover?*

DMAS is not requiring face-to-face delivery of ARTS services during the COVID-19 PHE. DMAS is allowing for telehealth (including telephonic) delivery of ARTS services as detailed below.

ARTS Services and Levels of Care allowable via telehealth and telephonic delivery:

- American Society of Addiction Medicine (ASAM) Multidimensional Assessment for level of care determination;
- 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;
- Peer Recovery Support Services; and
- Withdrawal management services.

The applicable per diem for ASAM Level 3.1 through 4.0 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.

*Are individual, family and group sessions in all American Society of Addiction Medicine (ASAM) Levels of Care approved for the telehealth/telephonic flexibilities?*

Yes

*Can we continue to use home as the 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.

*Should we start using the telehealth modifiers?*

Providers delivering services via telehealth, including telephonic (audio only) communications, shall bill and submit a claim as they normally would in their regular practice. Claims for services available through telehealth prior to the PHE can be submitted with the proper telehealth modifiers. See the DMAS memo, "Updates to Telemedicine Coverage" dated May 13, 2014 for more information. DMAS memos are available at <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/>

DMAS will issue a memo on specific billing policies for telehealth delivery at a future date.

*Are we required to provide services through telehealth? What about groups?*

Unless noted elsewhere, services may be provided through telehealth, face-to-face or a combination of both depending on the individual's needs and as outlined in the Individual Service Plan (ISP). Service Specific face-to-face requirements outlined in DMAS provider manuals may be delivered through telehealth unless otherwise noted.

Effective 7/1/2020, 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 tele-health 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 Centers for Disease Control and Prevention, the Virginia Department of Health, and any relevant licensing bodies. For initial and continued stay reviews, a service authorization request shall be completed for those services that require a prior authorization to verify medical necessity and appropriateness of the service delivery model.

### *Have documentation requirements changed?*

All documentation requirements remain the same with the exception of signatures (see next question). The method of service delivery must be documented in the individual's record and included in the treatment plan appropriate for the service (including interdisciplinary plans of care (IPOCs)). The method of service delivery must also be included in any new or subsequent service authorization requests.

Effective 9/30/2020, 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.

### *What are the allowances for obtaining signatures during the PHE?*

Where signatures are required, providers may note that verbal consent was obtained. Providers should make reasonable attempts to obtain appropriate physical signatures within 45 days after the end of the PHE. Providers do not need to attempt to obtain physical signatures for individuals who have been discharged prior to the end of the PHE.

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.

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.

### *Are there any allowances for provider qualifications?*

Provider qualifications, licensure requirements, and the structure of the services remain the same. Agency/facility employees must be appropriately supervised as described in the ARTS Manual and Department of Health Professions (DHP) and DBHDS guidelines.

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).

Earlier in the PHE, DHP 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.

### *Are there any allowances for service authorizations?*

A 14-day grace period will be granted for the submission of ARTS services:

- Medicaid managed care organizations (MCOs) and Magellan of Virginia will allow up to 14 days after the start of a new 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.

*We have moved to telehealth and saw the guidance for some programs that a unit can be billed regardless of the length of time?*

The reference to billing one unit applies to a Community Mental Health and Rehabilitation Service (CMHRS) that is a telephonic/audio visit only as defined in the Memo.

*Can the American Society of Addiction Medicine (ASAM) COVID-19 guidance be shared?*

<https://www.asam.org/Quality-Science/covid-19-coronavirus>

*What about privacy requirements under 42 C.F.R. Part 2?*

On 3/19/2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) released guidance that recognized that due to COVID-19 and the current state of emergency, it may not be currently feasible to obtain written patient consent. SAMHSA indicated that, “The prohibitions on use and disclosure of patient identifying information under 42 C.F.R. Part 2 would not apply in these situations to the extent that, as determined by the provider(s), a medical emergency exists.” SAMHSA is leaving it up to providers to determine what constitutes a medical emergency. When obtaining written consent is not feasible, obtain verbal consent and document this in the chart.

<https://www.samhsa.gov/medication-assisted-treatment>

### **Outpatient Psychiatric Services (ASAM Level 1.0)**

*What are the limits for the number of outpatient sessions a week?*

There are no limits to outpatient therapy services that can be given in a week but they must be clinically appropriate.

*When billing for outpatient therapy, should the individual code be billed when service is provided in a virtual group setting?*

The group therapy code should be billed when providing group therapy services in a virtual group session.

*If running a virtual group, is it still required to limit group size to no more than ten?*

DMAS has not changed the group size limit. However, prior to the state of emergency, policy has supported special situations where there may be a few more attendees with appropriate supporting documentation; the goal is not to turn members away from treatment. DMAS recommends scheduling multiple group sessions to meet the needs for larger patient populations.

*How should I bill for individuals who have Medicare primary?*

Providers must first bill Medicare as they normally would. If the member has both Medicare and Medicaid, providers shall continue to follow Medicare and CMS rules for behavioral health services that are covered by Medicare and if a provider type is not recognized by Medicare, Medicaid becomes primary and the provider may follow Medicaid guidelines for behavioral health services.

CMS has also expanded the outpatient psychiatric CPT codes that are allowed to be billed for Medicare recipients through telehealth during the Public Health Emergency. More information on Medicare billing during the Public Health Emergency is available at: <https://www.cms.gov/files/document/covid-dear-clinician-letter.pdf>

CMS announced on 4/30/2020 that Medicare will cover audio only behavioral health counseling services retroactive to 3/1/2020. Additional information including a link to covered codes is located at <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.

In addition, Medicare covers Telephone Service codes for assessment and management services:

- Codes \*99441, \*99442 and \*99443 are used by M.D.s, D.O.s, nurse practitioners and physician assistants who deliver evaluation and management services.

These Medicare telephone codes currently do not have a Virginia Medicaid rate, but they can be reimbursed by Medicare when submitted by the appropriate Medicare provider type and any crossover claims for deductibles and copays can be covered by Medicaid.

### **Intensive Outpatient Program (IOP) and Partial Hospitalization**

*ASAM Level 2.1 / Intensive Outpatient Program (IOP) is supposed to be a minimum of 3 hours per day. Is that still the expectation through telehealth?*

Intensive outpatient services (ASAM Level 2.1) as defined in 12VAC30-130-5090 are structured programs of skilled treatment services for adults, children and adolescents delivering a minimum of 3 service hours per service day. Per Chapter IV of the ARTS Provider Manual, skilled treatment services include but are not limited to: Individual, family and/or group psychotherapy; medication management and psychoeducational activities; Occupational and recreational therapies, motivational interviewing, enhancement, and engagement strategies to inspire a member's motivation to change behaviors; Withdrawal management services; Addiction medication management.

The minimum hour requirement will remain with the option of utilizing telehealth to deliver the services.

If providers are unable to provide the minimum amount of skilled treatment services required for the reimbursement of IOP, providers may bill the most appropriate psychotherapy, assessment, and evaluation codes. Providers should bill the most appropriate CPT code for individual therapy based on the time (minimum of 30 minutes per CPT); family psychotherapy with or without patient requires 50 minutes and the group psychotherapy does not have a time minimum.

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 Level 2.1/Partial Hospitalization Program (PHP) is supposed to be a minimum of 5 hours per day. Is that still the expectation through telehealth?*

Substance use partial hospitalization services (ASAM Level 2.5) as defined in 12VAC30-130-5100, are structured program of skilled treatment services for adults, children and adolescents delivering. There is a 20-hour minimum for service hours per week, including at least five service hours per service day of skilled

treatment services. Per Chapter IV of the ARTS Provider Manual, skilled treatment services include but are not limited to: member and group psychotherapy; medication management; education groups; occupational, recreational therapy, and/or other therapies.

The minimum hour requirement will remain with the option of utilizing telehealth to deliver the services. If providers are unable to provide the minimum amount of services required for the reimbursement of PHP, providers may bill the most appropriate 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.

***Can IOP/PHP individual, family and/or group psychotherapy sessions be split across different sessions through the same day?***

Yes, these sessions can be split up across different sessions throughout the day.

***How should we bill for counseling provided by a CSAC or CSAC-Supervisee if we do not reach the minimum time required to bill the per diem?***

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 during the PHE.

***Do we need to discharge individuals if we are unable to provide services for 30 days?***

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.

**SUD Residential and Inpatient Services**

***Which service components can be provided via telehealth?***

Therapy, assessments, case management, team meetings, and treatment planning may occur via telehealth or telephonic consults. 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.

***What happens if a member cannot be discharged from a residential or inpatient setting due to COVID-19 or quarantine?***

DMAS recognizes there may be situations where a member is unable to discharge from the following levels of care related to COVID-19: ARTS(SUD) Residential or Inpatient Levels 3.1-4.0. Providers who are requesting service authorization for members who are unable to discharge due to barriers related to COVID-19, are asked to answer the following questions when requesting an authorization. Please submit an

additional page with the information when submitting the request online or be prepared to answer the questions during phone reviews.

- What are the barriers to discharge related to COVID-19?
- Please describe attempts to overcome these barriers since the last Service Request Authorization was submitted.
- What are the restrictions and/or limitations for step-down to the identified discharge disposition?
- What aftercare services are available in their community during this pandemic?
- What agencies has this individual been referred to?
- How will the treatment plan and goals be adjusted to sustain current progress and prevent regression?

Answering all these questions when requesting authorization will expedite the review process. The answers to these questions are required each time you are requesting continued stay for a member who has not discharged due to barriers related to COVID-19.

#### *Is there additional guidance available for ARTS (SUD) Residential and Inpatient providers?*

- 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 Virginia Department of Health (VDH) webpage, <https://www.vdh.virginia.gov/>.
- If individuals are in need of quarantine 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 will have to be met for admission into this level of care.
- Providers shall notify Magellan of Virginia and the MCO of any members or staff being tested positive for COVID-19 within one business day.

### **Medication and Prescribing Requirements**

#### *We are losing buprenorphine waiver slots as we lose prescribers to illness. Has DMAS talked to SAMHSA regarding loosening the buprenorphine patient limits?*

Current legislation allows for emergency increases. Practitioners with a current buprenorphine waiver to prescribe up to 100 patients (who are not otherwise eligible to treat up to 275 patients) under 42 CFR §8.610 may request a temporary increase to treat up to 275 patients in order to address emergency situations as defined in 42 CFR §8.2. The practitioner must provide information and documentation defined in this [CFR section](#)

The cap on patient limits is determined by the United States Secretary of Health and Human Services.

#### *What flexibilities does DMAS allow for take-home doses of methadone?*

DMAS reimburses Opioid Treatment Programs (OTPs) to dispense up to a 28 day supply of take-home methadone doses.

As noted in the March 27, 2020 memo, DMAS also recognizes that members may not be able to pick up their medications from OTPs during this state of emergency. Thus, DMAS will reimburse OTP providers for

the delivery of methadone doses, provided they follow the DEA guidance dated March 16, 2020 [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-015\)%20SAMHSA%20Exemption%20NTP%20Deliveries%20\(CoronaVirus\).pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-015)%20SAMHSA%20Exemption%20NTP%20Deliveries%20(CoronaVirus).pdf).

- 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.

***What if the patient needs to transition from an injectable form of medication to another formula?***

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.

***Is DMAS flexing the requirement for at least weekly visits by the buprenorphine-waivered practitioner or Credentialed Addiction Treatment Professional during the first three months when initiating treatment?***

Yes. 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. 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. Per the March 27, 2020 memo, 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."

***In light of COVID-19, are you providing transportation to non-emergency appointments, such as picking up medications at Opioid Treatment Programs?***

Yes, however transportation vendors may also be impacted by the state of emergency. If you need additional assistance, your managed care organization or LogistiCare can assist in communicating your needs to arrange for transportation. <https://www.dmas.virginia.gov/#/transportation>

***Can I use telehealth or telephonic assessments to initiate my patient on Medication for Opioid Use Disorder?***

Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA), under the nationwide public health emergency, is allowing practitioners to prescribe buprenorphine to new and existing patients with opioid use disorder via telehealth and audio-only/telephone by otherwise authorized practitioners without requiring such practitioners to first conduct an examination of the patient in person or via telehealth or audio/visual means. This exemption does not apply to new OTP patients treated with methadone. [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-022\)\(DEA068\)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20\(Final\)%20+Esign.pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-022)(DEA068)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20(Final)%20+Esign.pdf)  
***Does the 90-day supply of medications apply to Buprenorphine/Naloxone tablets?***

Yes, fee-for-service and the managed care organizations are allowing 90-day supply as well as extended current prior authorizations for 90 days for all medications.

***Does Medicaid require co-prescribing of Naloxone?***

Providers are advised to write prescriptions for naloxone and provide training on its use for members in case of interruptions in community-based distribution. There are no copays or prior authorizations.

Naloxone HCL (injectable) and the brand-name Narcan nasal spray are both on Medicaid's Preferred Drug List, meaning all MCOs will reimburse for these formulations. Many pharmacies are mailing medications as well as offering curbside pick-up. Thus Preferred OBOTs and OTPs play a significant role in access of naloxone to members.

***Are pharmacies stocking enough buprenorphine to meet the capacity of 90 day scripts?***

Drug inventories in pharmacies are determined by previous trends and utilization. Some pharmacies may not have sufficient buprenorphine inventory to fill prescriptions written for 90 days. If providers experience their local pharmacies having a shortage of buprenorphine, prescribers should evaluate writing a 30-day supply with up to 2 refills to minimize the impact on pharmacies' inventories. Many pharmacies are now offering curb-side pickup or delivery during the state of emergency.

***What happens if a member can't participate in required counseling services during this time?***

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.