PCSS Providers Clinical Support System

An Overview of Reimbursement for MAT: Utilizing the Toolkit and Telehealth Update

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NO RELEVANT DISCLOSURES

Target Audience

- The overarching goal of PCSS is to train healthcare professionals in evidence-based practices for the prevention and treatment of opioid use disorders, particularly in prescribing medications, as well for the prevention and treatment of substance use disorders.

Learning Objectives

- Demonstrate an understanding of codes available to bill for treatment of a SUD;
- Describe the federal changes to telehealth policies in outpatient and OTP treatment programs;
- Explain federal Medicaid policies around the treatment of SUD using telehealth;
- Describe alternative payment model arrangements indicated for treating SUD; and
- Identify strategies for addressing issues related to the payment of claims for the treatment of SUD.

AGENDA

01 – Billing for SUD Treatment

02 – State Medicaid Payment Policies

03 – Alternative Payment Models

04 - Strategies to Address Reimbursement Issues

05 – Telehealth Updates

06 – Q&A

Billing for SUD Treatment

The Big Picture

Treatment for a SUD can be provided to patients in many settings, including outpatient physician offices or clinics, opioid treatment programs (OTPs), residential facilities, and hospitals.

- **Addiction is a treatable, chronic medical**
- **Medications are frequently used to treat addiction in conjunction with psychosocial interventions**
- **In the U.S., most health care services, including medication treatment, are paid for via a third party, such as an insurance company or health plan.**
- **Payers such as a government payer, an insurance company or health plan**
  - **1/3 of those with health insurance have coverage through Medicare, Medicaid, or CHAMPVA**
  - **2/3 have private coverage through an employer, direct purchase or TRICARE**
- **Due to the complexity and heterogeneity of the health insurance system in the United States, this toolkit will focus on billing and payment policies established by Medicare and Medicaid, the nation's largest payer of SUD treatment and recovery services**

Billing for SUD Treatment

The Big Picture

Treatment for a SUD can be provided to patients in many settings, including outpatient physician offices or clinics, opioid treatment programs (OTPs), residential facilities, and hospitals.

The correct billing and coding for these services depends on the insurer, provider, treatment setting, services provided, and diagnosis.

Insurer
Each insurer has unique policy on what treatment services are covered. Medicare, TRICARE, and VA health insurance is guided by federal statute. Medicaid & private insurance is governed by federal & state statutes.

Provider
Physicians, psychologists, licensed mental health counselors, therapists, drug & alcohol counselors, pharmacists, and many other practitioners are involved in the delivery of care.

Practitioners are limited by the scope of their license, as well as insurer policy in terms of the services they may bill and receive payment for.

Treatment Settings
Some insurers, including Medicare limit coverage of services depending on the treatment setting (outpatient, residential, or hospital).

Medicare covers*:
- Early intervention (ASAM LV 0.5)
- Outpatient treatment (ASAM LV 1.0)
- Partial hospitalization but not intensive outpatient (ASAM LV 2)
- Medically managed inpatient services (ASAM LV 4) but 190 day lifetime limit

Each state's Medicaid plan is different in terms of the settings it covers. However, federal section 1115 & 1915 waiver authorities allow states flexibility for covering services not provided for under their state plans. Check with private carriers for info about coverage of treatment settings.

Services
Typical services provided for the treatment of a SUD may include, but are not limited to:
- Medication
- Individual/group therapy
- Behavioral health screenings
- SBIRT
- Care management
- Toxicology testing

Diagnosis
When submitting a claim for payment, most insurers will require an ICD-10 code. The correct ICD-10 code is derived from the official DSM-5 diagnosis. Check Appendix A of the toolkit for a list of common ICD-10 codes.

*Medicare does not cover residential SUD treatment services, and does not authorize, as a provider-type, or reimburse freestanding SUD treatment facilities.

Common Billing Codes

CPT/HCPCS Code	Service	CPT/HCPCS Code	Service
99201-99205	Evaluation& Management for new patients (code family)	96158 (for each add. 15 mins, use 96159)	Health behavior intervention; individual; first 30 mins
99211-99215	Evaluation & Management for established patients (code family)	96164 (for each add 30 mins, use 96165)	Health behavior intervention; group; first 30 mins
90832-90834 & 90836-90838	Psychotherapy (code family)	96167 (for each add 30 mins, use 96168)	Health behavior intervention; family; with patient present; first 30 mins
80305-80307	Presumptive toxicology testing (code family)	96170 (for each add 15 mins, use 96171)	Health behavior intervention; family; w/o patient present; first 30 mins
G0444*	Depression screening	99406 (use 99407 for visits longer than 10 mins)	Smoking and tobacco use cessation counseling visit; 3-10 mins
96127	Brief emotional/ behavioral assessment	99408 (use 99409 for visits longer than 30 mins)	Alcohol and/or substance abuse (other than tobacco) SBI; 15-30 mins
96156 & 96158	Health behavior assessment or reassessment	G0396 (use G0397 for visits longer than 30 mins)*	Full Screening and Brief Intervention for substance misuse; 15-30 minutes
G2086*	Management, care coordination, individual/group psychotherapy, substance use counseling; at least 70 mins in 1st month	G2067-G2079*	Medicare OTP bundled codes (see Appendix C)
G2087*	Management, care coordination, individual/group psychotherapy, substance use counseling; at least 60 mins in subsequent months	G0480-G0483*	Definitive drug testing
G2088*	>120 minutes of therapy and counseling		

* Denotes Medicare codes

DISCLAIMER: This content is for informational purposes only. Not all payers cover all the services described in this webinar, and some payers may restrict reimbursement for certain billing codes to limited provider types. Please verify payer-specific requirements including coverage and correct coding prior to billing for services.

Case Examples

Overview

- Sandra, a 51-year-old female has severe alcohol use disorder severe in early remission, nicotine use disorder, generalized anxiety disorder in remission, hypertension, and type 2 diabetes
- Seen by her primary care physician for a routine follow-up visit, as well as to receive her monthly extended-release naltrexone injection
- After she provides a urine sample, which is read by the practice's instrument reader, she mentions to the nurse that she feels ready now to address her nicotine use, which she reports as a pack and a half of cigarettes a day for the past 32 years
- Her physician provides follow up care for her medical conditions:
    - 35-minute session of motivational interviewing geared specifically toward nicotine use disorder
    - Extended-release (ER) naltrexone injection from the nurse
    - Refills for the rest of her medications, including a new prescription for varenicline

- Codes that may be appropriate:
    - 99214 – Established patient requiring moderate complexity medical decision-making (MDM)
    - 90833 – Between 30 minutes and 44 minutes of psychotherapy added on to an E/M code
    - 96372 – Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (for extended-release naltrexone injection)
    - J2315 – Naltrexone, depot form, 1 mg (if the medication is covered under the patient's medical benefit and has been purchased by the treating provider through a buy-and-bill arrangement)
    - 80306 – Presumptive urine drug testing

Contact your insurance carrier for coverage, billing and payment policies specific to your network, and verify payer-specific requirements prior to billing for services.

Case Examples

Overview

- Joshua is a 28-year-old male who presents to his primary care physician for a new patient visit
- He was referred directly from the emergency department for a same-day appointment, as he had just presented to the ED in mild opioid withdrawal
- He reports a 4-year history of IV heroin use, and his exam indicates that he is now in moderate opioid withdrawal
- He consents to in-office buprenorphine initiation, which results in significant improvement in his withdrawal symptoms

- Codes that may be appropriate:
  - 99205 – New patient requiring at least 60 minutes of physician or other qualified health care professional time or high medical decision-making
    - 99417 can be billed for each additional 15-minute increment beyond 60 minutes (if the primary code was selected based on time). The total time should be documented in the medical record when it is used as the basis for code selection
      - G2212 should be used instead of 99417 when billing Medicare, for each additional 15 minutes beyond 60 minutes spent by the physician or qualified healthcare professional. (See more here.)
      - H0033 (Oral medication administration, direct observation) or H0016 (Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)) may be reimbursable by your State Medicaid program
  - 80306 – Presumptive urine drug testing

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State Medicaid Payment Policies

Overview

- Medicaid is a health insurance program that is jointly funded by the federal and state governments
- The program is administered by state governments and must cover services for certain adults with low-incomes, children, pregnant women, elderly, and people with disabilities
- Nationally, Medicaid covers nearly 40% of all non-elderly adults with opioid use disorder (OUD)
- States may cover additional services but must cover the minimum set of federally-required services

Federal Payment Policies*

Prior to the COVID-19 pandemic, the SUPPORT Act of 2018 contained the following, important policy changes related to telehealth and addiction medications:

- Requires CMS to issue guidance to state Medicaid programs about the federal options for reimbursement of services delivered via telehealth; and
- Requires coverage of OUD treatment medications in Medicaid, subject to some allowable exceptions[5]
- States must include as part of the new MAT mandatory benefit all forms of drugs and biologicals that the Food and Drug Administration (FDA) has approved or licensed for MAT to treat OUD
- State Medicaid programs may still apply drug utilization management mechanisms, such as preferred drug lists and prior approval

Contact your State Medicaid Agency for coverage, billing and payment policies specific to your state, and verify payer-specific requirements prior to billing for services.

***Despite the historic prohibition on federal Medicaid financing of residential treatment services (known as the Institutes for Mental Disease (IMD) exclusion), state Medicaid programs are incorporating SUD residential treatment providers in their networks through Section 1115 waiver programs, Medicaid managed care "in lieu of" authority, disproportionate share hospital (DSH) payments, and the SUPPORT Act state plan option. Contact your State Medicaid Agency for state-specific information on residential treatment coverage and proper coding. Because Medicare does not cover these services, Medicaid would be the primary payer for dual Medicare-Medicaid eligible beneficiaries. Many states use the following HCPCS codes for residential treatment: H2034: Alcohol and/or drug abuse halfway house services, per diem • H2036: Alcohol and/or other drug treatment program, per diem**

[5] https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf

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Alternative Payment Models

Different Methods

Payers are exploring and implementing various alternative payment models (APMs) to increase access to medication treatment services and to reward high-quality care, as well as to account for the more intensive staffing needs of addiction treatment services.

Collaborative Care Model (CoCM)

The Basics
- An evidence-based model for integrating mental health care and SUD treatment into primary care.
- Trained primary care providers and embedded behavioral care managers (BCM) provide medication and/or psychosocial treatments, supported by regular consultation with a psychiatrist or addiction medicine specialist
- In 2018, the CPT Editorial Panel created a set of codes unique to CoCM
- Medicaid programs & majority of commercial insurers reimburse CoCM codes

Billing
- CoCM services are billed by the treating medical provider.
- The treating provider can be any physician or non-physician practitioner whose scope of practice includes evaluation and management (E/M) services and who can independently report services to Medicare (physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives)

Payment
- Codes generate monthly care management fees to reimburse the time and activities of the BCM and psychiatric/addiction medicine consultant, and the PCP's collaboration with this team.

Coding
- 99492: Initial psychiatric collaborative care management, first 70 minutes in the first calendar month
- 99493: Subsequent psychiatric collaborative care management, first 60 minutes
- 99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes
- G0512: Single monthly (inclusive of all time frames) rate for 60 minutes or more of collaborative care in Federally Qualified Health Clinic / Rural Health Clinic
- 99484: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time,

Alternative Payment Models

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CMS Innovation Accelerator Program (IAP)

The Basics

- Collaboration between the Center for Medicaid and CHIP Services and the Center for Medicare and Medicaid Innovation (CMMI)
- Focused on helping states improve care, reduce costs, and improve the health of their Medicaid beneficiaries
- 4 focus areas, including improving care and outcomes for individuals experiencing SUD
- IAP developed service delivery models and corresponding rate design tools for the provision of MAT for OUD

Each model includes:

- Following phases of treatment:
  - Clinical assessment and induction;
  - Stabilization;
  - Maintenance; and
  - Discontinuation and medical withdrawal (if discontinuation is the patient's choice).

Model #1

- Adapted from the Baltimore Buprenorphine Initiative in Maryland,
- Includes 5 different levels of bundled payments as a patient is treated with buprenorphine/ER naltrexone
- Assessment, induction, and stabilization occur at a specialty SUD treatment organization, with transfer to primary care for the maintenance phase of treatment.

Model #2

- Adapted from the Massachusetts Collaborative Care model
- Designed for patients receiving treatment at a primary care practice or clinic
- Includes bundled rates for both episodic and monthly components.

Model #3

- (OBOT) model based on the "Spoke" component of Vermont's "Hub and Spoke" program.
- Includes four different levels of bundled payments as a client moves through a course of treatment

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Utilization Management

What is it?

A set of techniques used by payers on behalf of purchasers of healthcare benefits to manage healthcare costs, ensure services align with payers' medical necessity criteria, and reduce or eliminate care that is wasteful, inefficient, or unnecessary.

Common techniques:

Formularies

- A list of approved drugs that a health plan, has agreed to cover, and defines the prescription drug benefit
- Usually grouped into tiers, which determine the patient's portion of the cost
- If a medication is not on the formulary, patient will either need to pay out of pocket for the entire cost of the medication/prescriber will need to submit an exception request

Quantity & Dose Limits

- Usually in accordance with FDA-approved dosages
- Particularly for medications that may be diverted, or for more expensive branded medications that have bioequivalent generic forms available.
- If provider prescribes more, RX denied/exception request needed

Medical Necessity Review

- Needed when a clinician prescribes a medication for which the payer protocol requires review
- Medical necessity review for medications for addiction treatment requires that the patient be diagnosed with an underlying disorder, such as opioid use disorder, for which the medication is appropriate
- Medical necessity is almost always one condition that must be met as part of a prior authorization or step therapy review
- If a prescribed medication=established medical necessity criteria & medication is covered, payer approves
- If not or isn't a covered benefit, legal obligation of the payer is to deny the request

Prior Authorization (aka "preauthorization, prospective review, or prior review")

Process by which a service or treatment subject to review and approval by the payer before it will be covered.

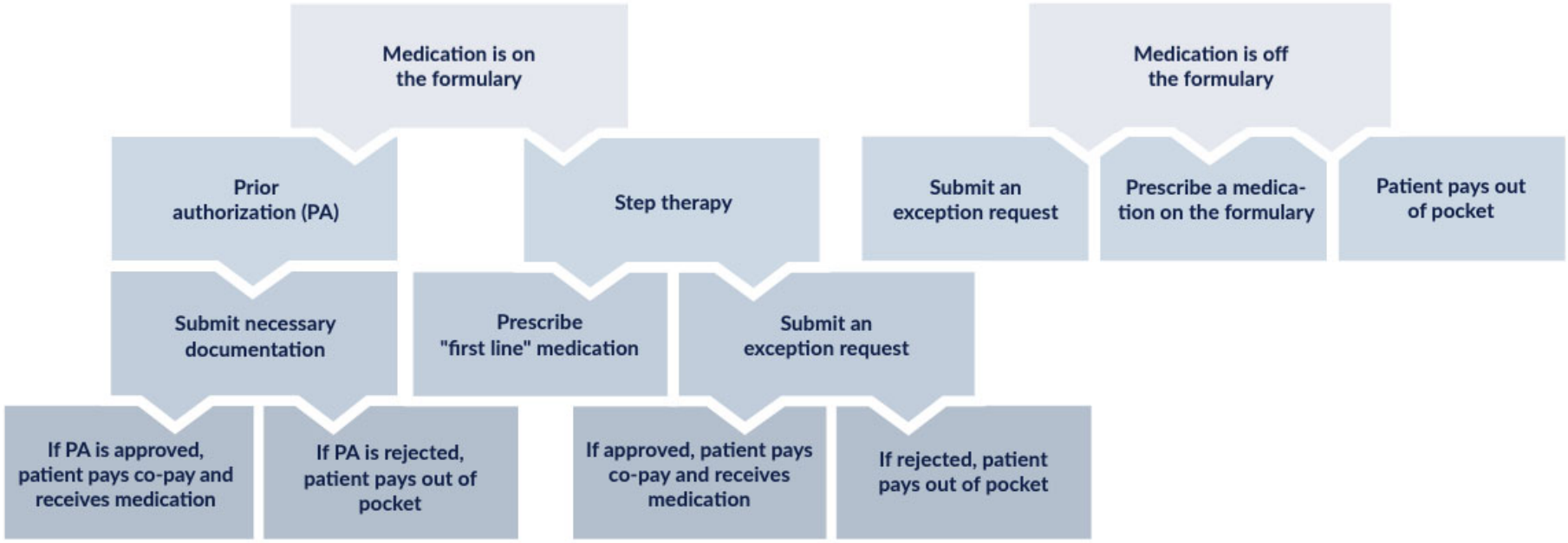
Step Therapy (aka "fail first")

Requires a patient to try one medication before a different, usually more expensive, medication will be covered.

Strategies to Address Utilization Management

Check the formulary

Most insurers will have a formulary that lists the medications that are covered benefits. Addressing a payer's utilization management technique will depend upon whether or not the medication was on the payer's formulary.



Other Reimbursement Issues

Other Issues

“Buy and bill” and credentialling are other issues commonly faced by addiction specialist physicians

Other techniques:

Buy and Bill

- Some states and payers require the use of “buy-and-bill” distribution for clinician-administered medications such as long-acting injectable buprenorphine and extended-release injectable naltrexone.
- Requires providers to purchase and store these medications until administered to the patient
- However, this method places providers at financial risk if the medication is not used or the reimbursement is less than the providers’ costs.
- Other avenues: specialty pharmacies
  - Procures and ships prescription for a clinician-administered medication directly to the clinician’s office in the patient’s name.
  - Specialty pharmacy will then bill the patient’s health plan directly and collect any co-payment from the patient.

Credentialling

- Some states limit the types of providers who may bill for behavioral health services or the types of procedures for which they may bill
- May limit diagnosis codes for which primary care providers may receive reimbursement
- Providers may work around billing limitations by recording patients’ secondary, reimbursable physical health diagnosis rather than their primary non-reimbursable behavioral health
- Reach out to the provider services divisions at each of the payers where they are credentialed to clarify exactly what types of services are offered and any requirements/limitations on setting or provider type to deliver the service.

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The advent of the COVID-19 pandemic has seen a surge in the use of telehealth[1] to treat patients with substance use disorder (SUD). Telehealth has proved to be a valuable resource for patients and clinicians who have been challenged by the nature of the COVID-19 pandemic. Additionally, regulatory flexibilities have allowed more patients struggling with SUD, including opioid use disorder (OUD), and their clinicians to use telehealth as a means for addiction medication initiation and receipt of related care. These slides are a synopsis of important statutes and regulations governing telehealth at the federal and state level, as well as a synopsis of select state actions to expand coverage and access to addiction treatment via telehealth.

[1] For purposes of this brief, the term “telehealth” includes “telemedicine” (i.e., the provision of remote clinical services).

Medicare

Federal Law

Telehealth policy is partly governed by federal statute and regulations. What constitutes "telehealth" and what is reimbursable is largely centered in the Medicare program under the Social Security Act.

Medicare

Medicare is a federal health insurance program for people 65 or older, some younger people with disabilities, and people with End-Stage Renal Disease. Part A covers hospital insurance, Part B covers physician services, and Part D covers prescription drugs. Patients may have original Medicare or Medicare Advantage. Medicare policy on technology to provide services can be broken into two buckets: **(1)** telehealth and **(2)** communications-based technology.[2]

In the case of telehealth, most established policy is on reimbursement and covers four main areas:

Location: Where patients and providers must be located in order to provide telehealth is dictated by statute and cannot be changed without Congressional action.

Service: Medicare provides a specific list of services it covers that is updated annually by the Medicare Physician Fee Schedule; these can be changed by CMS through rulemaking.

Provider: What providers can provide telehealth services is also dictated by statute and cannot be changed without Congressional action.

Modality: Telehealth services must be offered through a "telecommunications system." This "system" is not defined by statute; the definition is in CMS regulations. An interactive telecommunications system is defined by federal regulations as "at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner to include audio-only communication technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes."

Prior to the COVID-19 pandemic, the SUPPORT Act of 2018 instituted some Medicare policy changes to include:

- **Medicare coverage** of Opioid Treatment Programs (OTPs)
- **Removal of the geographic site** requirement and addition of a patient's home as an originating site for patients with SUD for the purposes of telehealth services for the treatment of SUD or co-occurring mental health conditions

[2]In 2018, CMS issued a final rule that created a new category of services to pay for services delivered using communications technology that is not considered telehealth. Section 1834 (m) of the Social Security defines a discrete set of services as "telehealth." Payment for communications-based technologies will be for services that are used to ascertain whether a patient needs an office visit, assess patient-submitted information, perform interprofessional consultations, or allow a patient to communicate with their physician through an online portal. These aforementioned services are not considered telehealth, are paid under the regular physician fee schedule, and do not have the limitations of telehealth services described in statute/regulations.

Ryan-Haight Act

Overview

- Under the Ryan Haight Act, controlled medications may not be provided by means of the internet (including telemedicine technologies) without a valid prescription[3]
- The Act generally requires an "in-person medical evaluation" in the physical presence of the prescribing clinician for the prescription to be considered valid
- The Act generally does not allow for circumstances in which a patient may have received a medical evaluation by another qualified practitioner but is not physically present in a DEA-registered hospital or clinic or with another DEA-registered practitioner

Exceptions

- The "practice of telemedicine" exceptions to this requirement provide for circumstances in which the patient is being treated by, and physically located in, a DEA-registered hospital or clinic, or in which the patient is being treated by and in the physical presence of another DEA-registered practitioner
- While there are seven "practice of telemedicine" exceptions (including the aforementioned two), to date, they have been of limited utility for expanding initiation of controlled medications for addiction treatment and co-occurring mental health conditions.

OVERSIGHT

Drug Enforcement Agency (DEA)

Prior to the COVID-19 pandemic

- The SUPPORT Act of 2018 directed the Attorney General, with the Secretary of Health and Human Services, to issue final regulations by October 2019 to implement the special registration "telemedicine exception" under the Ryan-Haight Act[4]

[3] 21 CFR 1306.09(a)

[4] As of the date of this policy brief, those regulations have not been promulgated.

Medicaid

Overview

- Medicaid is a health insurance program that is jointly funded by the federal and state governments
- The program is administered by state governments and must cover services for certain adults with low-incomes, children, pregnant women, elderly, and people with disabilities
- States may cover additional services but must cover the minimum set of federally-required services

Reimbursement for Telehealth Services

- In terms of Medicaid reimbursement of telehealth services, the federal government allows great flexibility in how states may formulate their Medicaid telehealth policies
- In general, Medicaid-covered telehealth services "must satisfy federal requirements of efficiency, economy and quality of care"
- States are not required to submit a state plan amendment (SPA) if its Medicaid program reimburses for telehealth services similarly to in-person services, but a state must submit a SPA if it decides to cover telehealth services under its Medicaid program differently
- CMS has issued a state Medicaid telehealth toolkit to assist states with setting Medicaid reimbursement policy for telehealth services in light of the COVID-19 pandemic
- CMS also issued specific federal Medicaid policy guidance on coverage of medical services to treat SUD

Prior to the COVID-19 pandemic, the SUPPORT Act of 2018 contained the following, important policy changes related to telehealth and addiction medications:

- **Requires CMS to issue guidance** to state Medicaid programs about the federal options for reimbursement of services delivered via telehealth; and
- **Requires coverage of OUD** treatment medications in Medicaid, subject to some allowable exceptions[5]

[5] https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf

Federal Actions

COVID-19 Federal Regulatory Flexibilities

The COVID-19 pandemic brought unprecedented challenges to delivering care for patients with SUD. The Secretary of Health and Human Services' (HHS) declaration of a public health emergency (PHE) due to COVID-19 and other actions allowed the Secretary to waive/alter certain federal health policies.

The following is a summary of federal actions taken since the beginning of the pandemic to promote greater flexibility and expand access to medical services, including addiction treatment:

HHS Office of Civil Rights issued temporary guidance that allows physicians to use commonly used applications such as FaceTime, Facebook Messenger, Google Hangouts, Zoom, and Skype – for telehealth services, even if the applications don't fully comply with HIPAA rules.

The Drug Enforcement Agency (DEA) has taken action to allow practitioners to initiate the prescribing of controlled medications via an audio-visual telehealth evaluation, even if the patient isn't at a DEA-registered hospital or clinic, and further allow initiation of buprenorphine for OUD to new patients based on a telephone evaluation. Further guidance from the DEA can be found here. Other DEA flexibilities related to the prescribing of controlled medications during the COVID-19 PHE can be found here.

CMS announced temporary waivers to make it easier for people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to receive medical care through telehealth services during the COVID-19 PHE. Some of these temporary changes allow providers to be reimbursed for telehealth services when:

- Conducting telehealth with patients located in their homes and outside of designated rural areas;
- Practicing remote care, even across state lines, through telehealth;
- Delivering care to both established and new patients through telehealth; and
- Billing for telehealth services (both video and audio-only) as if they were provided in person

The Substance Abuse and Mental Health Services Administration (SAMHSA) issued guidance on patient confidentiality during the time of COVID-19

SAMHSA issued guidance on the provision of methadone and buprenorphine for the treatment of OUD during the COVID-19 PHE

SAMHSA issued guidance extending flexibility for take-home doses at OTPs for one year after the conclusion of the PHE

CMS Final Rule

CMS 2022 Medicare Physician Fee Schedule Final Rule

On November 2, 2021, CMS issued a Final Rule which revises CY 2022 payment policies under the Medicare Physician Fee Schedule (PFS) and makes other policy changes, including the implementation of certain provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (the SUPPORT Act).

Highlights from that rule are as follows:

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can serve as distant sites and offer telehealth services to patients in their homes for the duration of the COVID-19 PHE

Allowed certain services to be conducted via audio-only technology, including:

- OBT: G2086-G2088
- OTP: G2067-G2075

Expanded the list of Medicare-covered telehealth services through calendar year 2023 to include:

- **Services to treat SUD in outpatient settings:**
  - **Office visit evaluation and management codes (99202-99215)**
  - **G2086:** Office-based treatment for substance use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month
  - **G2087:** Office-based treatment for substance use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
  - **G2088:** Office-based treatment for substance use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)
- **Counseling and therapy portions of the OTP bundle**:
  - See here for list of codes

CMS amended the current regulatory requirement for interactive telecommunications (multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner) to include audio-only communication technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes.

- **CMS clarified that SUD is included in the revised definition above such that practitioners can use audio-only communication technology to provide treatment for SUD.**

CMS will limit the use of an audio-only interactive telecommunications system to mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where the beneficiary is not capable of using, or does not consent to, the use of two-way, audio/video technology.

Recent legislative changes

Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020:

- Included a waiver removing restrictions on Medicare providers allowing them to offer telehealth services to beneficiaries regardless of whether the beneficiary is in a rural community[6]

Coronavirus Aid, Relief, and Economic Security (CARES) Act

Consolidated Appropriations Act, 2021 (CAA):

- $185 million to support rural critical access hospitals, rural tribal health and telehealth programs, and poison control centers
- Medicare patients can receive telehealth services for behavioral health care in their homes in any part of the country. This includes most behavioral health services such as counseling, psychotherapy, and psychiatric evaluations. The patient must have had at least one in-person visit with the provider in the six months before the telehealth visit in order to be eligible.[7] Please see this fact sheet from CCHP

[6] As of July 1, 2019, the SUPPORT Act eliminated the geographic limitations for telehealth services furnished to patients diagnosed with SUD or co-occurring mental health disorders when the telehealth service is used to treat the SUD or co-occurring mental health disorder. The SUPPORT Act also removed originating site restrictions. *Note: A Medicare provider may need to use an evaluation and management (E/M) code for the initial SUD diagnosis, subject to Medicare's otherwise applicable statutory restrictions.* Click here to learn more.

[7] CMS has clarified that the CAA's in-person requirements for Medicare reimbursement of mental health telehealth services do not apply to telehealth services for a patient diagnosed with SUD for treatment of that disorder or a co-occurring mental health disorder, as permitted under the SUPPORT Act of 2018.

Recent legislative changes

MEDICARE		
ISSUE	**CHANGE MADE BY BUDGET BILL**	**DIFFERENCE FROM CURRENT WAIVER**
Patient Location – Geographic	Extension of waiver on the geographic location of patient requirement to continue an additional 151 days after the Public Health Emergency (PHE) is declared over.	No difference from current COVID-19 temporary waiver.
Patient Location – Site	Extension of waiver on the site location of patient requirement to continue an additional 151 days after the PHE is declared over.	No difference from current COVID-19 temporary waiver.
Eligible Providers	Allow FQHCs, RHCs, PTs, OTs, Speech-Language Pathologists and Audiologists to continue to be reimbursed for services delivered via telehealth an additional 151 days after the PHE is declared over.	Under the current COVID-19 waivers, the category of providers is all eligible Medicare providers.
Audio-Only	Extension of waiver on the use of audio-only as a modality to continue an additional 151 days after the PHE is declared over.	No difference from current COVID-19 temporary waiver.
Recertification of eligibility for hospice care	Extension of waiver on the use of telehealth to continue to be used an additional 151 days after the PHE is declared over.	No difference from current COVID-19 temporary waiver.

OTHER TELEHEALTH POLICY ISSUE	
ISSUE	**CHANGE MADE BY BUDGET BILL**
In post-PHE environment, requirement of an in-person visit before a mental health visit via telehealth takes place when not meeting geographic and site requirements imposed on telehealth for Medicare program (Includes FQHCs, RHCs and audio-only requirement)	Delay requirement 151 days after the PHE is declared over.
Concern over fraud/waste and utilization	MedPAC will do a report for Congress on utilization and other issues in Medicare/OIG will do a report on fraud and waste. Due to Congress June 2023

Source: Center for Connected Health Policy. The 2022 Consolidated Appropriations Act extended certain flexibilities for a certain timeframe after the conclusion of the PHE.

State Policy

Overview

- Telehealth is also partly governed by state statutes and regulations
- Although federal statutes exist that govern the use of telehealth, practitioners must still abide by applicable state statutes and regulations
- The onslaught of the COVID-19 pandemic forced many states to consider changes to their telehealth laws and regulations.
- According to the Center for Connected Health Policy (CCHP), in 2021, 47 states passed 201 bills pertaining to telehealth. That is up from 104 bills in 36 states in 2020. Most of these bills focused on telehealth regulatory requirements, cross-state licensing, and private payer reimbursement.
- A complete rundown of state actions on telehealth can be found here and here.

Below are some examples of states that have enacted legislation in 2021 to expand coverage and access to treatment via telehealth:

Arizona: HB2454 requires pay parity for telehealth services that are also offered as in-person services. The law also requires health insurers to pay at parity with in-person rates for audio-only services used to treat SUD

Arkansas: HB 1176 allows Medicaid reimbursement for certain behavioral health services after the PHE ends

Colorado and **West Virginia** passed bills to require payment parity between in-person and telehealth services

Rhode Island: HB 6032 added audio-only to the definition of telehealth services

Kentucky passed HB 140 which required Medicaid payment parity between in-person and telehealth services, including audio-only services

Oklahoma: HB 2877 Authorizes sheriffs and peace officers to utilize telemedicine, when such capability is available and is in the possession of the local law enforcement agency, to have a person whom the officer reasonably believes is a person requiring treatment, assessed by a licensed mental health professional employed by or under contract with a facility operated by or contracted with the Department of Mental Health and Substance Abuse Services

Maryland: HB 1287 & SB 646: clarifies that an individual may practice clinical alcohol and drug counseling through telehealth

Nevada: SB 5 to require Medicaid payment parity in telehealth (excludes audio-only)

Virginia: HB 1987: Amends the state plan for medical assistance to provide for payment of medical assistance for remote patient monitoring services provided via telemedicine for certain high-risk patients, makes clear that nothing shall preclude health insurance carriers from providing coverage for services delivered through real-time audio-only telephone that are not telemedicine, and clarifies rules around prescribing of Schedule II through VI drugs via telemedicine

Washington: SB 1196: requires audio-only coverage and payment parity beginning in January 2023 when patients have an 'established relationship' with their provider

AGENDA

01 – Billing for SUD Treatment

02 – State Medicaid Payment Policies

03 – Alternative Payment Models

04 - Strategies to Address Reimbursement Issues

05 – Telehealth Updates

06 – Q&A

PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medications for opioid use disorder (MOUD)**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

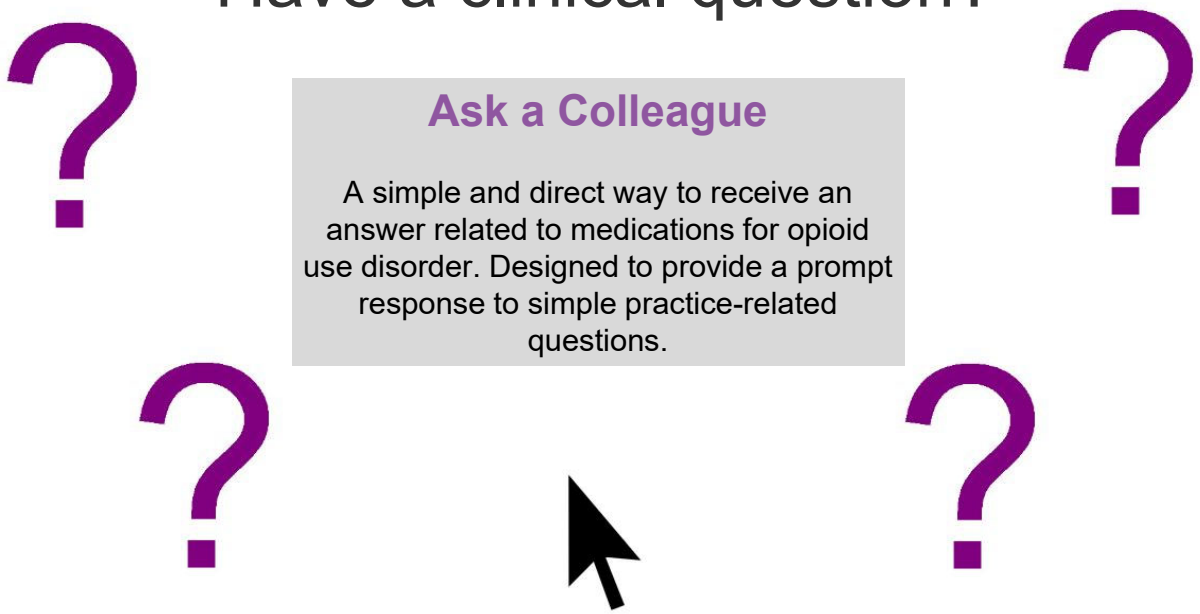
For more information visit:

https://pcssNOW.org/mentoring/

PCSS Providers Clinical Support System

PCSS Discussion Forum

Have a clinical question?



Ask a Colleague

A simple and direct way to receive an answer related to medications for opioid use disorder. Designed to provide a prompt response to simple practice-related questions.

http://pcss.invisionzone.com/register

PCSS Providers Clinical Support System

PCSS Providers Clinical Support System

PCSS is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

Addiction Technology Transfer Center	American Society of Addiction Medicine
American Academy of Family Physicians	American Society for Pain Management Nursing
American Academy of Pain Medicine	Association for Multidisciplinary Education and Research in Substance use and Addiction
American Academy of Pediatrics	Council on Social Work Education
American Pharmacists Association	International Nurses Society on Addictions
American College of Emergency Physicians	National Association of Social Workers
American Dental Association	National Council for Mental Wellbeing
American Medical Association	The National Judicial College
American Osteopathic Academy of Addiction Medicine	Physician Assistant Education Association
American Psychiatric Association	Society for Academic Emergency Medicine
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AGENDA

Questions?