Caring for Patients During the COVID-19 Pandemic

A guide for addiction treatment providers and programs working to address concerns related to the COVID-19 pandemic.

This Clinical Guidance ("Guidance") is provided for informational and educational purposes only. It is intended to offer physicians guidance regarding best practices in caring for and treating patients infected by COVID-19. Adherence to any recommendations included in this Guidance will not ensure successful treatment in every situation. Furthermore, the recommendations contained in this Guidance should not be interpreted as setting a standard of care, or be deemed inclusive of all proper methods of care nor exclusive of other methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding the propriety of any specific therapy must be made by the physician and the patient in light of all the circumstances presented by the individual patient, and the known variability and biological behavior of the medical condition. This Guidance and its conclusions and recommendations reflect the best available information at the time the Guidance was prepared. The results of future studies may require revisions to the recommendations in this Guidance to reflect new data. **ASAM does not warrant the accuracy or completeness of the Guidance and assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of this Guidance or for any errors or omissions.**

Supporting Access to Telehealth for Addiction Services: Regulatory Overview and General Practice Considerations

Purpose of the document

Provide guidance to addiction treatment providers and programs on the regulatory and general practice issues related to the use of telehealth during the COVID-19 pandemic.

This document contains links to other websites and content belonging to or originating from third parties. Such external links are provided for informational and educational purposes only and are not investigated, monitored, or checked for accuracy, adequacy, validity, reliability, availability or completeness by ASAM.

It is also important to note that, in general, telehealth policy at the state level is variable, and it is rapidly changing during the COVID-19 pandemic. ASAM strives to post state-level guidance as they become available (see "State Policy Changes" section below); however, it is recommended that clinicians seek guidance from their state department of health or addiction/mental health services agency to ensure you are compliant with changes and can bill appropriately. ASAM is also working on a process for rapid communication with state chapters and regions to help address concerns related to state regulations

and policies. If you have questions or concerns related to the guidance in this document, please email COVID@asam.org.

Topics

Benefits of Using Telehealth

Federal Policy Changes:

- HHS-Office of Civil Rights (HIPAA)
- Medicare
- SAMHSA/OTPs
- SAMSHA/DEA/OBOT
- SAMHSA/42CFR

State Policy Changes:

- Medicaid
- Licensing

Private Payors

General Considerations for Implementing Telehealth

General Resources

Reopening Considerations

While many places across the country are starting to relax physical distancing restrictions, the COVID-19 pandemic is not over. Communities and treatment programs across the country remain at risk for increasing population prevalence over time. Providers and programs should continue to implement policies and procedures to reduce the risk for coronavirus transmission, based on national scientific guidance and informed by the available data and guidance in their state and local areas. In addition, clinicians and clinical programs should prepare for potential spikes in transmission in their community and program. Programs and providers should consider:

- Maintaining or implementing an incident command structure to prepare for and address any issues that arise due to COVID-19
- Reviewing current infection control processes, including the extent to which staff and patients are adhering to them.
- Assessing what worked well in your initial response and where there may be room for improvement, updating related policies and procedures as needed.
- Assessing your program or practices' potential needs related to:
    - Personal protective equipment and other supplies needed to control and mitigate the spread of the coronavirus.
    - Staff training

    - Staff support
    - Technology to support telehealth
- Addressing the evolving phases of the epidemic and how to prepare for the next stages in your community.

Benefits of Using Telehealth

The National Consortium of Telehealth Resource Centers defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Telehealth can address COVID-19 and other epidemic situations by limiting exposure to infection for vulnerable populations and health care workers. Telehealth can also expand the reach of resources to communities that have limited access to needed services. Federal and state regulators have relaxed regulations, due to a declaration of a national emergency, governing the use of telehealth for general medical services as well as for addiction services including the use of audio and/or video technologies.

There are numerous benefits associated with using telehealth during the COVID-19 outbreak that apply across the continuum of addiction services including outpatient, residential and Opioid Treatment Services (OTP and OBOT).

These benefits include but are not limited to the following:

- Promotes the practice of social distancing to reduce spread – shifting visits and initial patient evaluation to a modality that does not require in-person and face-to-face interaction and thereby limit the physical contact between staff and patients.
- Allows monitoring of patients to identify potential and confirmed cases without person-to-person contact.
- Enables quarantined clinicians to continue to safely treat patients remotely.
- Reduces the risk of spread in high-volume/traffic areas such as waiting rooms by reducing the number of patients requiring face-to-face visits.
- Enables clinicians to continue patient engagement while reducing potential for exposure for those who are considered most vulnerable to COVID19.
- Reduces the likelihood of patients participating in activities/behaviors that could increase risk of exposure, such as use of public transportation to attend appointments.

Federal Policy Changes

1. Waiver of regulatory requirements related to HIPPA compliant telehealth platforms (HHS/Office of Civil Rights (HIPPA))

A change was made regarding the enforcement of the Health Insurance Portability and Accountability Act (HIPAA). HHS Office of Civil Rights (OCR) has issued a “Notification of Enforcement Discretion” for telehealth remote communications during the COVID-19 national

emergency, which is also a public health emergency. HHS 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 services during the COVID-19 nationwide public health emergency.

Covered health care providers that want to use audio or video communication technology to provide telehealth to patients during this nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype.

Penalties won't be imposed on covered health care providers who have not entered into HIPAA business associate agreements (BAAs) with video communication vendors that relates to the good faith provision of telehealth services during the COVID-19 nationwide public health emergency.

States may have their own laws and regulations regarding protected health information and what is required to protect and secure it. This federal action does not explicitly address state enforcement of those state laws and regulations. ASAM is working on a process for rapid communication with state chapters and regions to help address concerns related to state regulations and policies. If you have questions or concerns related to the guidance in this document, please email COVID@asam.org.

Resources:

- Notification of Enforcement Discretion for telehealth remote communications during the COVID-19 nationwide public health emergency
- FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency

2. Expansion of Medicare Coverage for Providing Services through Telehealth

Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances. This will allow clinicians to provide a wider range of services without beneficiaries having to travel to a healthcare facility. The Center for Connected Health Policy has created a table (click here) which summarizes these Medicare Fee for Service (FFS) changes.

Medicare Advantage (MA) plans are required to provide what is covered by Medicare FFS; however, they have some flexibility to expand their coverage of telehealth beyond what they currently do. What is covered will depend on what each plan decides to do. You will need to check with your MA plan to find out what, if any, changes they have made.

Licensing: The HHS Secretary has issued a 1135 Waiver for "requirements that physicians or other health care professionals hold licenses in the state in which they provide services if they have an equivalent license from another state." To learn more, see the notice. The Federation of State Medical Boards is tracking executive orders related to licensure (see Resources below).

Resources:

- CMS Fact Sheet:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

- Medicare Telehealth FAQ: https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf
- CMS General Provider Toolkit https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf
- AMA Quick Guide to Telemedicine in Practice https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice
- FSMB State Licensure Tracking Under COVID-19: http://www.fsmb.org/advocacy/covid-19/
- Center for Connected Health Policy: https://www.cchpca.org/sites/default/files/2020-03/CORONAVIRUS%20TELEHEALTH%20POLICY%20FACT%20SHEET%20MAR%2019%202020%205%20PM%20PT%20FINAL_0.pdf

3. Flexibility for Take Home Medication for OTPs (SAMHSA)

On March 19, SAMHSA issued updated OTP guidance indicating that states may request blanket exceptions for all stable patients in an OTP to receive 28 days of Take-Home doses of the patient's medication for opioid use disorder. That OTP guidance also notes that states may request up to 14 days of Take-Home medication for those patients who are less stable but who the OTP believes can safely handle this level of Take-Home medication. On March 19, SAMHSA issued a set of FAQs clarifying how telehealth can be used for patients being treated in OTPs. Specific questions that SAMHSA addressed in the FAQ are listed below. The detailed responses are provided in the FAQs under Resources at the end of this section.

- New patients being admitted to an OTP for OUD must receive a physical face – to – face evaluation if they are going to be treated with methadone.
- SAMHSA, however, has exempted OTPs from the requirement to perform a physical face-to-face evaluation for any new OTP patient who will be treated with buprenorphine (presumably when ordered and dispensed under OTP rules (see the caveat below regarding DEA guidance)), if a program physician, primary care physician, or an authorized healthcare professional under the supervision of a program physician, determines that an adequate evaluation of the patient can be accomplished using telehealth (including use of telephone, if needed). This exemption will last for the duration of the declared COVID-19 national emergency.
    - **It is important to note, however, that a similar statement has not been posted on the DEA website with respect to buprenorphine that is initially prescribed using the telephone under a DATA 2000 waiver, and ASAM is seeking clarification from the DEA about SAMHSA's FAQ in this regard.**
- Practitioners working in OTPs can continue treating existing patients with methadone and buprenorphine via telehealth (including use of telephone, if needed).

- An OTP can dispense medication (either methadone or buprenorphine products) based on telehealth evaluation (including telephone, if needed).

Resources:

- Opioid Treatment Program (OTP) Guidance: https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf
- FAQs: Provision of Methadone and Buprenorphine for the Treatment of OUD in the COVID-19 Emergency: https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf
- DEA Guidance: Exemption Allowing Alternate Delivery Methods for OTPs:

https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-015)%20SAMHSA%20Exemption%20NTP%20Deliveries%20(CoronaVirus).pdf

4. Flexibility for Prescribing Controlled Substances via Telehealth (SAMHSA/DEA)

According to recent DEA guidance while a prescription for a controlled substance issued by means of the Internet (including telemedicine) must generally be predicated on an in-person medical evaluation (21 U.S.C. 829(e)), the Controlled Substances Act contains certain exceptions to this requirement. One such exception occurs when the Secretary of Health and Human Services has declared a public health emergency under 42 U.S.C. 247d (section 319 of the Public Health Service Act), as set forth in 21 U.S.C. 802(54)(D). Secretary Azar declared such a public health emergency with regard to COVID-19 on January 31, 2020. For as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
- The telemedicine communication is conducted 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. Further, this same DEA guidance clarifies that if the prescribing practitioner has previously conducted an in-person medical evaluation of the patient, the practitioner may issue a prescription for a controlled substance after having communicated with the patient via telemedicine, or any other means, regardless of whether a public health emergency has been declared by the Secretary of Health and Human Services, so long as the prescription is issued for a legitimate medical

purpose and the practitioner is acting in the usual course of his/her professional practice. In addition, for the prescription to be valid, the practitioner must comply with any applicable State laws.

On March 19, SAMHSA stated in an FAQ document that a practitioner with a DATA 2000 waiver, and working outside the context of an OTP, can treat new and existing patients with buprenorphine via telehealth (including use of telephone). SAMHSA's response qualified its response stating that, "if a practitioner, has a DATA 2000 waiver, the practitioner may prescribe buprenorphine under the practitioner's DATA 2000 waiver while complying with all applicable standards of care. In such a case, the patient will count against the practitioner's patient limit and must treat the patient in accordance with any rules that apply to practicing with a waiver under 21 U.S.C. § 823(g)(2), and 42 C.F.R. Part 8, as applicable." **It is important to note, however, that a similar statement has <u>not</u> been posted on the DEA website and ASAM is seeking clarification from the DEA about SAMHSA's FAQ in this regard.**

<u>Resources</u>:

- Provision of Telemedicine While Providing MAT (May 2018) https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/telemedicine-dea-guidance.pdf
- DEA Information on Telemedicine: https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dea-information-telemedicine.pdf
- FAQs: Provision of Methadone and Buprenorphine for the Treatment of OUD in the COVID-19 Emergency: https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf

5. DEA Exception to Separate Registration Requirements Across State Lines

DEA issued guidance that will grant an exception to the requirements that normally require DEA-registered practitioners to obtain additional registrations with the DA in each state where the dispensing (including prescribing and administration) occur, for the duration of the public health emergency. The practitioner must be authorized to dispense controlled substances by both the state in which a practitioner is registered with DEA and the state in which the dispensing occurs. In other words, the prescriber must be registered with the DEA in at least one state and have permission under state lay to practice using controlled substance in the state where the dispensing will occur.

This exception also applies to the prescription of controlled substances via telemedicine. DEA-registered practitioners may prescribe controlled substances to patients via telemedicine in states in which they are not registered with DEA.

Resources:

- **DEA Policy: Exception to Separate Registration Requirements Across State Lines** https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-018)(DEA067)%20DEA%20state%20reciprocity%20(final)(Signed).pdf

6. Compliance with Addiction Treatment Confidentiality Regulations – 42 CFR Part 2 (SAMHSA)

SAMHSA has issued guidance related to use and disclosure of confidential information in cases of a medical emergency. SAMHSA advises that (see link to full guidance in resources at the end of this section):

- "patient identifying information may be disclosed by a part 2 program or other lawful holder to medical personnel, without patient consent, to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained."
- " Information disclosed to the medical personnel who are treating such a medical emergency may be re-disclosed by such personnel for treatment purposes as needed."

SAMHSA's guidance emphasizes that under this medical emergency exception, "providers make their own determinations whether a bona fide medical emergency exists for purposes of providing needed treatment to patients."

Resources:

COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance:

https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf

State Policy Changes

1. Medicaid

Changes to policies and regulations for Medicaid are largely being initiated at the state level. Increasingly, states are issuing new guidance and initiating changes that include but are not limited to the following:

- Allowing providers who do not have access to the technology required for video enabled virtual session to provide telephonic sessions in a member's home when there are concerns about COVID19;
- Waiving face-to-face requirements to allow for telephonic or telehealth services in programs such as health homes or care coordination programs;

- Temporarily waiving requirements that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have an equivalent licensing in another state;
- Permitting providers located out of state to provide care to another state's Medicaid enrollees impacted by the emergency; and
- Temporarily suspending certain provider enrollment and revalidation requirements to increase access to care.

These kinds of changes are largely on a state-by-state basis and are changing at a rapid rate. ASAM strives to post state-level guidance as they become available (see link below); however, it is recommended that clinicians seek guidance from their state department of health or addiction/mental health services agency to ensure you are compliant with changes and can bill appropriately. ASAM is working on a process for rapid communication with state chapters and regions to help address concerns related to state regulations and policies. If you have questions or concerns related to the guidance in this document, please email COVID@asam.org.

Resources:

- Medicaid Telehealth Guidance: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf
- ASAM list of State Guidance: https://www.asam.org/advocacy/practice-resources/coronavirus-resources
- Center for Connected Health Policy: https://www.cchpca.org/sites/default/files/2020-03/CORONAVIRUS%20TELEHEALTH%20POLICY%20FACT%20SHEET%20MAR%2019%202020%205%20PM%20PT%20FINAL_0.pdf
- Center for Connected Health Policy (CCHP) interactive map on state telehealth laws http://phi.org/resources/?resource=state-telehealth-laws-and-medicaid-program-policies (Fall 2019)

2. Licensing

Sometimes state level guidance also involves changes to state licensing. The Federation of State Medical Boards (FSMB) is tracking these state level changes. See link below under resources.

Resources:

- FSMB State Licensure Tracking Under COVID-19:

  http://www.fsmb.org/advocacy/covid-19/

Private Payors

Like state Medicaid programs, the policies of individual health plans are unique to each payor. Clinicians are encouraged to contact the payors they work with during this temporary public health crisis, to

permit addiction services to be provided via telemedicine and or via telephone using the established CPT codes commonly used during in-person care.

General Considerations for Implementing Telehealth

The following considerations were drawn from Best Practices for Telehealth During COVID-19 Public Health Emergency (National Council for Behavioral Health) and the AMA's Quick Guide to Telemedicine.

Vendor evaluation and selection: Check with your existing EHR vendor to see if there is telehealth functionality that can be turned on. Reach out to your state medical association/society for guidance on vendor evaluation, selection and contracting. (AMA)

Communicate visit changes to your patients: Let your patients know about your practice's telehealth policies during COVID19 outbreak. If you will only be providing telehealth visits, post information to your website, consider changing your organizations phone script to include this information at the beginning of your recording, call patients with upcoming appointments and offer telehealth visits. Consider targeted outreach to "high risk" patients. (National Council)

Practice using technology first: Whatever application you decide to use, practice with other staff before you use with a patient. You may be able to recommend preferred video conferencing applications to patients and send them test links to make sure a connection is available before starting your session. (National Council)

Create a backup plan: Establish protocols in case escalation of care is required or technology fails. Do you need to consult with another provider? What backup technology could you use? (National Council)

Consider appropriate screening tools: If you are still offering in-person appointments, incorporate approaches for screening for COVID19 symptoms prior to arrival and protocols for shifting appointments to virtual should someone be presenting symptoms. If someone is displaying symptoms but is in crisis or requires immediate support, consider protocols and partnerships that can alert EMS/crisis response teams of symptoms consistent in advance. (National Council)

Workflow: Determine when telehealth visits will be available on the schedule (i.e. throughout the day intermixed with in-person visits or for a set block of time specifically devoted to virtual visits). Set up space in your practice and/or home to accommodate telehealth visits. (AMA)

Documentation and record keeping: Ensure you are still properly documenting these visits – preferably in your existing EHR as you normally would with an in-person visit. This will keep the patient's medical record together, allow for consistent procedures for ordering testing, medications, etc. and support billing for telehealth visits. Ensure your staff are kept abreast of policy or billing changes as states and private payers adopt and expand access so that documentation is in compliance. (AMA)

Check in with patients: find out where the trouble areas are for them and make changes where necessary. Check in during the visit and afterwards. Did they struggle with this type of communication? (National Council)

Should you switch to a different application? Are there tests you could do beforehand to check patients' internet or phone connection if that is a trouble area? (National Council)

Check with your malpractice insurance carrier to ensure your policy covers providing care via telemedicine. (AMA)

General Resources

- AMA Quick Guide to Telemedicine in Practice
  https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice

- American Psychiatric Association: Telepsychiatry and COVID-19:

  https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19

- CMS General Provider Toolkit
  https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf

- National Consortium of Telehealth Resource Centers
  https://www.telehealthresourcecenter.org/

- National Council Resources for COVID-19:

  https://www.thenationalcouncil.org/covid19/