Telehealth Policy & Addiction Medicine

ASAM American Society of Addiction Medicine

ASAM Brief → Feb 1, 2022

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. This policy brief is a synopsis of important statutes and regulations governing telehealth at the federal and state level, as well as a synopsis of ASAM and State Chapter advocacy actions to expand coverage and access to addiction treatment via telehealth.

Federal Policy

Federal Law →

Telehealth policy is partly governed by federal statute and regulations. What constitutes "telehealth" and what is reimbursable at the federal level 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."

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

[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.

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

- **Medicare coverage** of Opioid Treatment Programs (OTPs); and
- **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.

RYAN-HAIGHT ACT

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 "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. 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. 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. The Drug Enforcement Agency (DEA) oversees enforcement of the Ryan Haight Act.

> **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]

MEDICAID

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.

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]

---

[3] 21 CFR 1306.09(a)

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

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

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 do not fully comply with HIPAA rules.

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

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.

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 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 temporary 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
- $185 million to support rural critical access hospitals, rural tribal health and telehealth programs, and poison control centers. Consolidated Appropriations Act, 2021 (CAA):
  - 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.

State Policy

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.

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

Colorado and **West Virginia** passed bills to require payment parity between in-person and 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: Requires the Board of Medical Assistance Services to amend 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, including establishing a practitioner-patient relationship 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

ASAM Federal & State Chapter Advocacy

FEDERAL

- ASAM, AMA Recommend that States Request OTP Blanket Waiver
- ASAM Submits Letter Urging Regulators to Allow Providers to Deliver Audio-Only Telehealth Services to Medicare Beneficiaries
- Letter to Congress on CARES Act
- ASAM Applauds Introduction of the Tele-Mental Health Improvement Act of 2020
- ASAM Comments on the Proposed 2021 Medicare Physician Fee Schedule
- ASAM Sends Feedback to CMS About Proposed 2022 Fee Schedule Changes
- ASAM Submits Recommendations to Senators on Addiction Policy Proposals
- ASAM supports the TREATS Act: This legislation would make permanent a new, audio-video, telehealth evaluation exception to the Ryan-Haight Act's in-person exam requirement, which would allow clinicians to prescribe Schedule III and IV medications, including buprenorphine, to new patients through telehealth.

STATE

- RISAM Supports Legislation to Permanently Implement Telehealth Flexibilities in Rhode Island
- NWSAM Supports Expansion of Telehealth Services in North Dakota
- OKSAM Supports Legislation to Improve Access to Telehealth
- KYSAM Urges Retraction of Board of Medical Licensure Opinion Relating to Telemedicine and MAT

Billing and Coding for Telehealth Services

CMS provides a number of resources for guidance on properly coding and billing for telehealth services. Additional information can be found here.