

ASAM COVID-19 TASK FORCE RECOMMENDATIONS

CARING FOR PATIENTS DURING THE COVID-19 PANDEMIC

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



SUPPORTING ACCESS TO TELEHEALTH FOR ADDICTION SERVICES: REGULATORY OVERVIEW AND GENERAL PRACTICE CONSIDERATIONS

A guide for addiction treatment clinicians and programs working to treat patients with substance use disorders safely and effectively during the COVID-19 pandemic¹.

For additional recommendations for the Ongoing Management of the Continuum of Addiction Care during COVID-19, [please click here](#).

CONTENT DISCLAIMER

This Clinical Guidance (“Guidance”) is provided for informational and educational purposes only. It is intended to provide practical clinical guidance to addiction medicine physicians and others caring for individuals with substance use disorders during the COVID-19 pandemic as it unfolds. 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.

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SUPPORTING ACCESS TO TELEHEALTH FOR ADDICTION SERVICES: REGULATORY OVERVIEW AND GENERAL PRACTICE CONSIDERATIONS

Purpose of the document

The purpose of this document is to provide guidance to addiction treatment clinicians and programs on the regulatory and general practice issues related to the use of telehealth during the COVID-19 national emergency, which is also a public health emergency.

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,

¹This resource was developed by a Task Force appointed by ASAM’s Executive Council. To enable more rapid development and dissemination it was not developed through ASAM’s normal process for clinical guidance development that is overseen by the ASAM Quality Improvement Council.

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In general, telehealth policy at the state level is variable and has rapidly changed during the COVID-19 pandemic. ASAM strives to post state-level guidance as they become available (see "[State Policy Changes](#)" section); however, we recommend that clinicians seek guidance from their state authorities to ensure compliance with changes and appropriate billing. ASAM can also be a resource during this time. ASAM is working with its 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.

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1. 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. Federal and state regulators have relaxed regulations, governing the use of telehealth for general medical services as well as for addiction services including the use of phone only or audio/visual technologies, due to a declaration of a national emergency.

Using telehealth during the COVID-19 pandemic offers numerous benefits that apply across the continuum of addiction services including outpatient, office based opioid treatment (OBOT), residential settings, and opioid treatment programs (OTP).

These benefits include but are not limited to the following:

- Promotes the practice of physical distancing to reduce viral spread – shifting visits and initial patient evaluation to a modality that does not require in-person and face-to-face interaction and thereby limiting the physical contact between staff and patients.
- Addresses COVID-19 and other epidemic situations by limiting exposure to infection for vulnerable populations and health care workers.
- Expands the reach of resources to communities that have limited access to needed services.
- 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 COVID-19.
- Reduces the likelihood of patients participating in activities/behaviors outside of the clinic that could increase risk of exposure, such as use of public transportation to attend appointments.

2. Federal Policy Changes

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

A change was made regarding the enforcement of the Health Insurance Portability and Accountability Act (HIPAA). HHS Office of Civil Rights (OCR) 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 clinicians in connection with the good faith provision of telehealth services during the COVID-19 public health emergency. This includes penalties imposed on covered health care clinicians who have not entered into HIPAA business associate agreements (BAAs) with video communication vendors.

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

States may have their own laws and regulations regarding protected health information (PHI) and what is required to protect and secure it. This federal action does not explicitly address state enforcement of their laws and regulations. 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
<https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>
- FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency

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 change 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 which summarizes these Medicare Fee for Service (FFS) changes².

Medicare Advantage (MA) plans are required to provide the same coverage as Medicare FFS; however, they have some flexibility to expand payment for telehealth beyond their current coverage. Coverage levels depend on the specific plan. 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 [Waiver or Modification of Requirements Under Section 1135 of the Social Security Act](#).

Resources:

- CMS Fact Sheet:
<https://www.cms.gov/newsroom/fact-sheets/medicare-telehealth-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-telehealth-toolkit.pdf>
- AMA Quick Guide to Telehealth in Practice
<https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telehealth-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

Flexibility for Take Home Medication for OTPs (SAMHSA)

SAMHSA issued [OTP guidance](#) and a [telehealth FAQ](#) to assist OTPs in responding to the COVID-19 public health emergency. As a result, 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. 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. 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 in the Resources section.

Highlights from the OTP Guidance and SAMHSA FAQ:

²<https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies>

- New patients starting methadone treatment for an OUD must receive an in-person medical evaluation.
- SAMHSA and the DEA standardized guidance to allow buprenorphine to be prescribed in any applicable setting or started in an OTP without a face-to-face evaluation using phone only or audio/visual telehealth. The guidance specifies that telehealth or phone only evaluation is allowed 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. This exemption will last for the duration of the declared COVID-19 national emergency.
- Practitioners working in OTPs can continue treating existing patients with methadone and buprenorphine via phone only or audio/visual telehealth.
- An OTP can dispense medication to established patients (either methadone or buprenorphine products) based on phone only or audio/visual telehealth evaluation.

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

- DEA information on Telemedicine

https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dea-information-telemedicine.pdf

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

According to DEA guidance³ while a prescription for a controlled substance issued by means of the Internet (including telehealth) 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 telehealth 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 method of prescribing currently available and in the manner set forth in the DEA regulations.

³https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dea-information-telehealth.pdf

- Schedule II-IV drugs can be prescribed electronically
- Schedule II drugs can be called into a pharmacy as an emergency prescription
- Schedule III-V prescriptions can be called into a pharmacy with refills for up to 6 months.

SAMHSA and the DEA have clarified that a practitioner with a DATA 2000 waiver, working outside the context of an OTP, can treat new and existing patients with buprenorphine via telehealth (including use of telephone). SAMHSA 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.”

Resources:

- Provision of Telehealth While Providing MAT (May 2018)
https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/telehealth-dea-guidance.pdf
- DEA Information on Telehealth: https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dea-information-telehealth.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 Exception to Separate Registration Requirements Across State Lines

During the COVID-19 public health emergency, the DEA will exempt prescribers from having to obtain additional licenses for each state in which they are prescribing. 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 law to practice using controlled substances in the state where the dispensing will occur.

This exception also applies to the prescription of controlled substances via telehealth. DEA-registered practitioners may prescribe controlled substances to patients via telehealth 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](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-018)(DEA067)%20DEA%20state%20reciprocity%20(final)(Signed).pdf)

Compliance with Addiction Treatment Confidentiality Regulations – 42 CFR Part 2 (SAM-HSA)

SAMHSA has issued guidance related to use and disclosure of confidential information in cases of a medical emergency. SAMHSA advises that:

- “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, “clinicians make their own determinations whether a bona fide medical emergency exists for purposes of providing needed treatment to patients.”

As of August 14, 2020, revisions to 42 CFR Part 2 that further align it with HIPAA go into effect, as more fully described [here](#).

Resources

- Health Privacy Rule 42 CFR Part 2

<https://www.samhsa.gov/newsroom/press-announcements/202007131115>

- 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>

3. State Policy Changes

Medicaid

Changes to policies and regulations for Medicaid are largely being initiated at the state level. States are continuing guidance and changes that include but are not limited to the following:

- Allowing clinicians 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 COVID-19.
- 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 license in another state.
- Permitting clinicians located out of state to provide care to another state’s Medicaid enrollees impacted by the emergency.
- 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; however, it is recommended that clinicians seek guidance from their state department of health or addiction/mental health services agency to ensure compliance with changes and to bill appropriately. ASAM is communicating 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)

Licensing

In some states, 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/>

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

5. 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 Telehealth](#).

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. 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. Also ensure that you are able to continue providing care to those patients who may not have access to telehealth services. (National Council)

Practice using technology first: Whatever application you decide to use, practice with other staff before you use it 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 COVID-19 symptoms prior to arrival and upon arrival and protocols for shifting appointments to virtual should someone be presenting with 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. (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. Also, have plans for how to continue providing care to patients who are not able to access telehealth services for whatever reason.

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, see resources below)

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, see resources below)

Switching to a different application: Consider testing the patient’s internet and/ or phone connection before the telehealth visit. (National Council, see resources below)

Malpractice insurance: Check with your malpractice insurance carrier to ensure your policy covers providing care via telehealth. (AMA, see resources below)

5. General Resources

- AMA Quick Guide to Telehealth in Practice
<https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telehealth-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-telehealth-toolkit.pdf>
- National Consortium of Telehealth Resource Centers
<https://www.telehealthresourcecenter.org/>
- National Council Resources for COVID-19:
<https://www.thenationalcouncil.org/covid19/>

