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MEDICAID MEMO

TO: All Providers Participating in the Virginia Medicaid and FAMIS Programs

FROM: Karen Kimsey, Director
Department of Medical Assistance Services (DMAS)

DATE: 3/27/2020

SUBJECT: Clarifications and Changes: Behavioral Health and ARTS Provider Flexibilities Related to COVID-19

This memo is part of a series of memos that sets out the Agency's guidance on the flexibilities available to providers in light of the public health emergency presented by the COVID-19 virus. This memo includes clarifications and changes from the text of the March 19, 2020, "Provider Flexibilities Related to COVID-19" memo, for Behavioral Health and Addiction and Recovery Treatment Services (ARTS) services. These changes affect both fee-for-service and Managed Care Organization (MCO) models of care. These flexibilities are relevant to the delivery of covered services related to COVID-19 detection and treatment, as well as maximizing access to care and minimizing viral spread through community contact.

Please note that the policy changes set out in this memo are in effect during the public crisis, as set out in the Governor's Emergency Declaration. This is a rapidly emerging situation and additional changes are forthcoming. Providers are encouraged to frequently access the Agency's website to check the central COVID-19 response page for both Frequently Asked Questions (FAQs) and guidance regarding new flexibilities as they are implemented. For additional questions about this memo or other COVID-19 related issues, the agency has created a centralized point of access for submission at http://dmas.virginia.gov/contactforms/#/general. Questions may also be submitted to COVID-19@dmas.virginia.gov.

Clarifications and Changes Related to Behavioral Health and ARTS

Behavioral Health and ARTS providers are advised of the following new flexibilities and requirements, indicated by the underlined text below, and effective today. Underlined text represents new clarifications and the non-underlined text is included for readability and context; this guidance is in addition to the first memo dated March 19, 2020, "Provider Flexibilities Related to COVID-19."

Behavioral Health Services (Applicable Across MCOs and Fee-for-Service)

DMAS will continue to hold a weekly call with provider associations, MCOs, the Department of Behavioral Health and Developmental Services (DBHDS), and invited stakeholders during the emergency period to provide ongoing updates and receive feedback on system functioning.

Trauma Informed Care
Providers are encouraged to continue to provide interventions and formulate responses to COVID-19 guided by trauma informed care (TIC) principles: trustworthiness, equity, choice, collaboration, empowerment, and safety. Providers are encouraged to consider these principles as they navigate the implementation of flexibilities outlined in this guidance.

Telehealth Services
DMAS will allow for telehealth (including telephonic) delivery of all behavioral health services with several exceptions. Services that will be allowable via telehealth include:

- Care coordination, case management, and peer services
- All service needs assessments (including the Comprehensive Needs Assessment and the Independent Assessment Certification, and. Coordination Team (IACCT) assessment in mental health and the Multidimensional Assessment in ARTS) and all treatment planning activities
- Outpatient psychiatric services
- Community Mental Health and Rehabilitation Services (CMHRS)
- ARTS

DMAS is allowing a member's home to serve as the originating site for members. This is particularly important for those who are quarantined, are diagnosed with and/or demonstrating symptoms of COVID-19, and/or are at high risk of serious illness from COVID-19. Clinicians shall use clinical judgment when determining the appropriate use of home as the originating site. The originating site fee will not be available for reimbursement. The telepresenter requirements do not apply when member is at home as the origination site.

The per diem rates for therapeutic group homes, psychiatric residential treatment facilities, and inpatient psychiatric hospitalization will not be billable through telehealth; however, within these services, activities including assessments, therapies (individual, group, and family), care coordination, team meetings, and treatment planning are allowable via telehealth.

As stated in the March 19, 2020 memo, "Provider Flexibilities Related to COVID-19" for general telehealth guidance and until otherwise notified, behavioral health providers delivering services via telehealth (including telephonic communications) shall simply bill and submit a claim as they normally would in their regular practice. The Place of Service (POS) that the provider usually bills should remain the same and no modifiers shall be necessary in order to minimize systems errors during this critical time. Providers shall maintain appropriate documentation to indicate the mode of delivery (e.g. telephonic or telehealth platform used) and to support medical necessity for the ongoing delivery of the service through that model of care. As noted in the March 19, 2020 memo for general telehealth guidance, behavioral health providers should move to systems changes to allow Place of Service Codes (02) to reflect telehealth delivery as this will be required at a future date.

Services delivered via telehealth (either audio or audio-visual) must have accompanying documentation in the member's record that states the alternative location used and that the

service was delivered via telehealth to support access to care during the state of emergency. DMAS recognizes that providers may have limited or no access to their offices, and members' physical records or other team members and that this may create barriers to obtaining necessary signatures on documentation. Thus, providers shall update documentation and treatment plans (including individual service plans (ISPs), interdisciplinary plans of care (IPOCs)) with at least notation that verbal consent was obtained and providers shall make reasonable attempts to obtain appropriate physical signatures within 45 days after the end of the State of Emergency.

In regards to obtaining clinician signatures on relevant documentation, each provider shall make reasonable attempts to obtain signatures from the clinicians or document receiving the clinician's verbal consent or sign-off, with the name of the clinician and the date of receipt. If the clinician is unable to sign-off on documentation, the clinician shall maintain documentation of verbal consent or sign-off in their files.

If providers are delivering treatment in a different form (i.e. telephonic or telehealth only), this shall be documented in the member's medical record and in any new or subsequent service request authorization submission(s).

Provider Qualifications and Licensure Requirements

Provider qualifications, licensure requirements, and the structure of the services shall remain intact. That is, QMHPs, Supervisees, and Residents must remain working under the direction of an LMHP and BCBA®/BCaBA® must provide supervision to unlicensed staff (i.e. technicians). Within the ARTS program, Certified Substance Abuse Counselors (CSAC) and CSAC-Supervisees must remain working under the direction of licensed providers authorized by the Board of Counseling. Providers licensed in the state of Virginia, but located outside the state of Virginia, are allowed to provide telehealth services to individuals in Virginia. Provider Types allowed to bill for Medicaid services will remain the same regardless of the delivery method (face-to-face vs. telehealth). Please note that Virginia Medicaid allows for physicians (those licensed to practice medicine) who are actively licensed in states bordering Virginia but are not licensed in Virginia to continue to see their Virginia resident patients via telemedicine/telehealth or telephonic communications so members can continue to receive their prescriptions. The Board of Medicine requires that physicians must have an established relationship with the patient to meet this allowance.

Service Authorizations

A fourteen (14) day grace period for the submission of Behavioral Health Authorizations in CMHRS, Assessments, Psychotherapies, Inpatient Treatment Services, and ARTS Levels of Care:

- MCOs and the Magellan of Virginia will allow up to 14 days after the start of a new behavioral health service or after the expiration of an existing authorization for a service authorization request to be submitted from the provider to the MCO or the Magellan of Virginia. This grace period does not waive medical necessity requirements for the services or other requirements currently set forth in policies for submissions of service authorization requests.

Specific Service Considerations & Limitations

- For any services *without* specific guidance below:
  - Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care (telephonic/telehealth delivery).
  - Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
- *Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health Skill- Building, Behavior Therapy (including applied behavior analysis (ABA)), Intensive Community Treatment and Psychosocial Rehabilitation.*
  - Service delivery may be provided outside of the school setting, office setting, or clinic setting for the next 120 days.
  - Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care. Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
  - For youth participating in both TDT and IIH, TDT should not be used in the home as this would be a duplication of services.
  - These services shall not be provided to a group of individuals at the same time and location (with the exception of family members/kinship in the same location) so as to promote containment of COVID-19 infection.
  - For new services, a prior authorization request is required to verify medical necessity and appropriateness of the service delivery model.
  - The prior authorization request for new services will be used to track which members are continuing to receive these services, assess the appropriateness of the services being delivered via different modes of treatment, and to determine if this is an appropriate service to meet the member's needs.
  - If the provider is only providing services through telephonic communications, the provider shall bill a maximum of 1 unit per member per day, regardless of the amount of time of the phone call(s).
  - Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue.
  - For Behavior Therapy services, a physician letter, referral, or determination is not required for submission of a prior authorization. The MCO shall review the request and make a determination without the physician referral. The physician referral, letter or determination shall be completed within at least 60 days of the start of the service.
  - As the situation evolves regarding COVID-19, DMAS will re-evaluate the need for adaptation of these services.

- *Day Treatment/Partial Hospitalization Programs for Adults*
  - Face-to-face services shall not be required for reimbursement of the services,

but documentation shall justify the rationale for the service through a different model of care.
  - Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
  - If providers are unable to provide the minimum amount of services required for the reimbursement of PHP/IOP, providers may bill behavioral therapy, assessment, and evaluation codes.
  - Providers will not be required to discharge members from the service if the provider is billing outpatient services rather than PHP or IOP codes.
  - Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue.

- *Crisis Stabilization/Crisis Intervention Services*
  - The appropriateness of a crisis response using tele-health (including telephonic) shall be evaluated by the clinician and a determination shall be made by the clinician responding to the crisis.
  - Any therapeutic interventions to include, but not limited to, therapy, assessments, care coordination, team meetings, and treatment planning can occur via telehealth.
  - Face-to-face services shall not be required for reimbursement of the services, but documentation shall justify the rationale for the service through a different model of care.

- *IACCT Assessment, Psychiatric Residential Treatment Facility (PRTF), and Therapeutic Group Homes (TGH)*
  - The requirement for prior authorization remains in place.
  - IACCT Assessments may occur via telehealth or telephone communication.
  - IACCT Assessments may be completed by out-of- network providers, but these individuals must be an independent evaluator separate from the residential facility.
  - Therapy, assessments, case management, care coordination, team meetings, and treatment planning may occur via telehealth.
  - For members in residential levels of care (including TGH) and/or higher medical necessity can be waived for continuation of care if the individual is unable to transition to lower levels of care due to COVID-19 and quarantines.
  - If an individual currently in a PRTF or TGH requires acute or inpatient medical treatment (non-psychiatric) for more than 7 days, the authorization will NOT be ended and the individual does not have to be discharged from the PRTF or TGH. For any subsequent admission to a PRTF or TGH, the previous admission shall be extended.
  - The provider shall not bill for the time where the individual is admitted into acute care.
- *Psychiatric Inpatient, Facility Based Crisis Stabilization, and Residential Levels of*

Care

- The requirement for prior authorization remains in place.
- Therapy, assessments, case management, team meetings, and treatment planning may occur via telehealth.
- For members in psychiatric inpatient, facility based crisis stabilization, and residential levels of care (including therapeutic group homes), medical necessity for continuation of care may be waived if the individual is unable to transition to lower levels of care due to COVID-19 and quarantines.
- Providers should refer to guidance from the Centers for Disease Control (CDC) regarding best practices for facilities.
- If members are needing to be quarantined because they are ill, the provider should coordinate their efforts with their department of health. More information can also be found on the Virginia Department of Health (VDH) webpage.
- If individuals are needing to be quarantined and hospitals are attempting to step them down to a psychiatric unit or facility, we would encourage providers and clinicians to evaluate the appropriateness of this transfer or step down.
- Service authorization requirements and medical necessity criteria will have to be met for admission into this level of care.

If you have additional questions about the behavioral health specific portions of this memo, you may also email EnhancedBH@dmas.virginia.gov in addition to the centralized access point that was noted at the beginning of this memo.

Addiction and Recovery Treatment Services (ARTS)

- *ASAM 2.1 and 2.5 Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP)*
  - MCOs and Magellan of Virginia will allow up to 14 days after the start of a new service or after the expiration of an existing authorization for a service authorization request to be submitted from the provider to the MCO.
  - Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care.
  - Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
  - If providers are unable to provide the minimum amount of services required for the reimbursement of PHP/IOP, providers may bill psychotherapy, assessment, and evaluation codes.
  - Providers will not be required to discharge members from the service if the provider is billing outpatient services rather than PHP or IOP codes.
  - If providers are unable to provide the minimum amount of services required for the reimbursement of PHP/IOP, providers may bill psychotherapy, assessment, and evaluation codes.
    - During the State of Emergency, if CSACs or CSAC-Supervisees are performing substance use disorder (SUD) counseling within their

scope of practice, DMAS will waive the requirement for only licensed practitioners to bill the psychotherapy codes. CSACs and CSAC-Supervisees will be allowed to bill using the most appropriate psychotherapy code based on the amount of time spent performing the service, bill under their licensed supervisor NPI and document the reason for billing the psychotherapy code by the CSAC or CSAC-Supervisee is due to not meeting the minimum time for billing the per diem.

- Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue.

- *ASAM Levels 3.1 and Above*
  - The requirement for prior authorization remains in place.
  - Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care.
  - Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
  - Therapy, assessments, case management, care coordination, team meetings, and treatment planning can occur via telehealth or telephonic consults.
  - Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
  - For members in ASAM Level 3.1 and above, medical necessity for continuation of care may be waived if the individual is unable to transition to lower levels of care due to COVID-19 and quarantines.
  - Providers should refer to guidance from the CDC regarding best practices for facilities.
  - If members need to be quarantined because they are ill, the provider should coordinate their efforts with their department of health. More information can also be found on the VDH webpage.
  - If individuals need to be quarantined and hospitals are attempting to step them down to a lower ASAM Level of Care, we would encourage providers and clinicians to evaluate the appropriateness of this transfer or step down.
  - Service authorization requirements and medical necessity criteria will have to be met for admission into this level of care.

Opioid Treatment Programs (OTP) and Preferred Office-Based Opioid Treatment (OBOT) Services

Individuals with Opioid Use Disorder (OUD) may have high-risk co-morbidities such as chronic obstructive pulmonary disease (COPD), cirrhosis, or HIV that may increase the risk of severe disease related to COVID-19. In light of the potential risk of exposure to COVID-19, as well as barriers to accessing treatment due to illness, quarantine, and risk of serious illness, we ask providers and staff to exercise clinical judgment and to prioritize the continuation of members' medication for treatment of OUD.

In line with the updated National Practice Guidelines issued by the American Society of Addiction Medicine (ASAM), DMAS is instructing providers of medication assisted treatment (MAT) to not delay initiation or continuation of medication due to a member's inability to see medical or behavioral health clinicians face-to-face. DMAS expects that Preferred OBOTs and OTPs remain open and accept new patients interested in MAT initiation during this time. If a Preferred OBOT or OTP is at member capacity for MAT services, the Preferred OBOT or OTP should have procedures in place to connect individuals with care. DMAS is especially mindful of the mental and emotional duress that may be experienced by Medicaid members as well as potential disruptions in illicit drug supply that may encourage individuals to seek treatment and the importance of initiating MAT during this time. DMAS echoes SAMHSA in the strong recommendation of "the use of telehealth and/or telephonic services to provide evaluation and treatment of patients. These resources can be used for initial evaluations including evaluations for consideration of the use of buprenorphine products to treat opioid use disorder".
(https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf)

- OTPs and Preferred OBOT Providers are considered essential medical services. Thus, providers shall be making efforts to ensure current members have access to life saving medications in accordance to DMAS memo dated March 19, 2020. Providers shall also be making necessary arrangements to serve new members who are in need of initiation of medication assisted treatment.

- DMAS also recognizes that members may not be able to pick up their medications from OTPs during this State of Emergency. Thus, DMAS will allow OTP providers to deliver the medications to the member's location and be reimbursed for this service.
    - For delivery of up to a two week supply of medications: Bill 5 units of H0020 at $8.00/unit (equates to $40.00 or 70 miles round trip applying the federal personal mileage rate of 57.5 cents per mile).
    - For delivery of three weeks or greater supply of medications: Bill 10 units of H0020 at $8.00/unit (equates to $80.00 or 140 miles round trip).

Recommendations for Reducing Transmission
Please follow the guidance issued by DBHDS, CDC (www.cdc.gov/COVID19) as well as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Virginia Department of Health.

Back-Up Staff
Preferred OBOTs, OTPs, in-network buprenorphine waivered practitioners, and behavioral health clinicians shall be prepared in the case of staff illness, including making arrangements for backup prescribers and behavioral health clinicians. DMAS recommends making these arrangements in advance and ensuring in-network back-up providers are available for each Medicaid MCO or Magellan of Virginia for fee-for-service member. If an in-network

provider is not available for a member, providers shall contact MCO or Magellan of Virginia Network Relations staff.

Counseling and Other Requirements
During the Governor's State of Emergency, DMAS is allowing the counseling component of Medication Assisted Treatment (MAT) to be provided via telehealth or telephone communication. If a Preferred OBOT or OTP member is unable to participate in counseling services due to COVID-19, DMAS will not penalize the Preferred OBOT or OTP provider for the missed services.

The provider must have emergency procedures in place to address the needs of any member in a psychiatric crisis. The provider should also ensure that the member continues to have access to medications to treat OUD, as well as care coordination activities as appropriate. Preferred OBOT and OTP providers may continue to bill for care coordination that is provided telephonically and in the absence of counseling services, if necessary and appropriate.

Home as Originating Site for Counseling Services
DMAS will additionally allow a member's home to serve as the originating site for members. This is particularly important for those who are quarantined, are diagnosed with and/or demonstrating symptoms of COVID-19, and/or are at high risk of serious illness from COVID-19. Clinicians shall use clinical judgment when determining the appropriate use of home as the originating site. The originating site fee will not be available for reimbursement. The telepresenter requirements do not apply when member is at home as the origination site.

Face-to-Face Contact Requirements
Face-to-face contact requirements are waived for care coordinators, counselors, and peer recovery support specialists within Preferred OBOT or OTP. Staff members may use telehealth, including telephonic communication, and should use the same billing codes. Any type of contact with the member shall be documented, including the method of contact (face-to-face, telehealth, telephonic.)

Urine Drug Screens
Providers should use clinical judgment when requiring urine drug screens to minimize clinic and member exposure to COVID-19. DMAS will not penalize Preferred OBOTs or OTP's for missed urine drug screens during the public health emergency.

Billing for Telehealth Services
Services provided via telehealth or telephonically shall be billed using the currently approved CPT and HCPCS codes allowed under the ARTS reimbursement structure. Documentation shall include the mode of service delivery.

Providing Medication for Members with OUD

Guidance on Use of Telehealth for Members and Providers Affected by COVID-19 Ryan Haight Act of 2008

Under the Ryan Haight Act of 2008, general requirements are that the prescribing practitioner shall have conducted at least one in-person medical evaluation of the patient before prescribing a controlled substance (including buprenorphine and buprenorphine/naloxone) for treatment of addiction. However, during the federal Health and Human Services (HHS) Public Health Emergency, the Drug Enforcement Agency (DEA) has lifted the requirements under the Ryan Haight Act of 2008 for prescribing practitioner to have conducted at least one in-person medical evaluation of the patient before prescribing a controlled substance scheduled II – V, including buprenorphine and buprenorphine/naloxone for treatment of addiction.

For as long as the federal HHS 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 (www.deadiversion.usdoj.gov/coronavirus.html).

The initial visit for Buprenorphine prescribing via home as originating site is allowed as long at the DEA requirements are met above. The telepresenter requirements do not apply when member is at home as the origination site.

Buprenorphine (Schedule III) Products and Refills

As noted in the March 19, 2020 memo, effectively immediately, Fee-for-Service and Medicaid managed care health plans will:

1) Suspend all drug co-payments for Medicaid, FAMIS and FAMIS Moms members,

2) Cover a maximum of a 90 day supply for all drugs **excluding** Schedule II drugs. In Virginia, Schedule II drugs include most opioids, amphetamines, methylphenidate, etc. A complete list of Schedule II drugs can be found at:

https://law.lis.virginia.gov/vacode/title54.1/chapter34/section54.1-3448/.

3) Suspend refill "too soon" edits for all drugs prescribed for 34 days or less. Drugs dispensed for 90 days will be subject to a 75% refill "too-soon" edit. Patients will only

be able to get a subsequent 90 day supply of drugs after 75% of the prescription has been used (approximately day 68).

4) Federal and state law prohibit the early refilling of Schedule II drugs except in the case of an emergency. Pharmacists should refer to Virginia Board of Pharmacy's guidance for emergency fill procedures.

Pharmacists and prescribers must continue to comply with all applicable state and federal laws and regulations related to the prescribing and dispensing of controlled substances. Pharmacists are encouraged to review the Virginia Board of Pharmacy's **Emergency Provisions for Pharmacists During the COVID-19 Declared Emergency** for additional guidance.

Home Delivery of Medications
There is nothing under federal law that prohibits delivery of medications from occurring, although resources to offer this level of service may vary by program. OTPs shall contact the State Opioid Treatment Authority (SOTA) for information on how to attain approval for take-home dosing.

Naloxone
Providers are advised to write prescriptions for naloxone for members in case of interruptions in community-based distribution.

Preferred OBOT Prescription Management
During the Governor's State of Emergency, DMAS asks Preferred OBOTS to consider giving individuals who are deemed 'clinically stable' longer prescription lengths of buprenorphine-containing products, as permitted by the Virginia Board of Pharmacy. 'Clinically stable' should be determined by the prescribing provider's clinical judgment and care team. DMAS encourages providers to consider a minimum two-week supply of buprenorphine-containing products, and telehealth or telephonic follow up when clinically appropriate to lessen an individual's risk of coming into contact with persons who may be carrying the virus.

Providers should review proper prescription storage for the safety and well-being of members.

Sublocade and Vivitrol
If a member is receiving subcutaneous buprenorphine (Sublocade) and cannot attend a clinic, providers can transition the member to sublingual buprenorphine (Suboxone) without additional in-person examinations. Similarly, members receiving intramuscular naltrexone (Vivitrol) may be transitioned to oral naltrexone without an additional examination.

Billing Medicaid for Telehealth Services for Prescribing Medications
Services provided via telehealth or telephone shall be billed using the currently approved CPT and HCPCS codes allowed under the ARTS reimbursement structure. Documentation shall include the mode of service delivery.

DMAS is waiving the requirement to use the specific telehealth billing codes in this time of emergency.

Home as Originating Site
Prior DMAS telehealth guidance related to the prescribing of controlled substances for the treatment of addiction delivered via telehealth required a qualified provider and a telepresenter located at the originating site, as well as a qualified prescribing provider located at the remote site. DMAS will allow a member's home to serve as the originating site for prescription of buprenorphine in accordance with the Ryan Haight Act which allows exceptions in the event of a Public Health Emergency. This may be particularly important for members who are quarantined, are diagnosed with and/or demonstrating symptoms of COVID-19, and/or are at high risk of serious illness from COVID-19. Clinicians shall use clinical judgment when determining the appropriate use of home as the originating site. The originating site fee will not be available. (This does not apply for prescribing the initial dose of a controlled substance. Providers must follow the DEA requirements noted above for the initial visit.) For providers who are treating members in the home, contingency plans and emergency procedures shall be developed and documented.

In-Network Buprenorphine Waivered Practitioners
Information contained in this section for MAT applies to in-network buprenorphine waivered practitioners. Please note that if providers are not approved as Preferred OBOT providers, care coordination is not a reimbursable service.

Out-of-State Licensed Buprenorphine Waivered Physicians

- Virginia allows for licensed physicians in bordering states and who are not licensed in Virginia to continue to see their Virginia resident patients via telemedicine/telehealth or telephonic communications so members can continue to receive their buprenorphine scripts. The Board of Medicine requires that physicians must have an established relationship with the patient to meet this allowance.

Emergency Room and Other Urgent Care Settings

- DMAS supports providers following the American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder - 2020 Focused Update. These updated recommendations aim to support initiation of buprenorphine treatment in the emergency department and other urgent care settings.
- Please note that all assessments do not need to be completed before initiating pharmacotherapy for OUD. In addition, the guidelines provide greater flexibility on dosing during the initiation of buprenorphine treatment and for initiation of buprenorphine at home, which is significant in the midst of the COVID-19 crisis.

If you have additional questions about the SUD-specific portions of this memo, you may also email SUD@dmas.virginia.gov in addition to the centralized access point that was noted at the beginning of this memo.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627
Aetna Better Health of Virginia	aetnabetterhealth.com/virginia 1-800-279-1878
Anthem HealthKeepers Plus	www.anthem.com/vamedicaid

	1-800-901-0020
Magellan Complete Care of Virginia	www.MCCofVA.com 1-800-424-4518 (TTY 711) or 1-800-643-2273
Optima Family Care	1-800-881-2166
United Healthcare	Uhccommunityplan.com/VA and myuhc.com/communityplan 1-844-752-9434, TTY 711
Virginia Premier	1-800-727-7536 (TTY: 711),