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OPIOID TREATMENT SERVICES SUPPLEMENT

On April 1, 2017, Virginia's Medicaid program launched an enhanced substance use disorder treatment benefit called **Addiction and Recovery Treatment Services (ARTS)**. The ARTS benefit expands access to a comprehensive continuum of evidence-based addiction treatment services for all enrolled members in Medicaid, Medicaid Expansion, FAMIS and FAMIS MOMS throughout the state, including community-based addiction and recovery treatment services, coverage of inpatient withdrawal management and residential substance use disorder treatment.

The ARTS benefit increases access to medication assisted treatment (MAT), the evidence-based combination of Medication for Opioid Use Disorder (MOUD), psychotherapy, counseling, and psychosocial supports that results in the highest chances of recovery by recognizing Opioid Treatment Programs (OTPs) and Preferred Office-Based Opioid Treatment (OBOT) Providers. DMAS encourages practices that co-locate licensed behavioral health professionals with the buprenorphine-waivered practitioner to reduce barriers for members with opioid use disorder (OUD) in accessing these services.

OPIOID TREATMENT SERVICES

The purpose of this supplement is to provide specific information on Opioid Treatment Services (OTS), which include the following

- OTPs,
- Preferred OBOT,
- MAT services provided by an in-network buprenorphine waivered practitioners independent from Preferred OBOTs and OTP settings.

PROVIDER ENROLLMENT

To become an in-network provider of OTS with DMAS, its contractor and Managed Care Organizations (MCO), providers must be credentialed and enrolled according to all applicable contractor standards. Providers are subject to applicable Department of Health Professions and Department of Behavioral Health and Developmental Services (DBHDS) licensing requirements. DMAS provider enrollment is located:
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/WebRegistration.

Additionally, any licensed practitioner joining a contracted group practice or a contracted organization adding a newly licensed location must also become credentialed with the DMAS fee-for-service contractor prior to rendering services. Per §38.2-3407.10:1, the MCOs are required to establish reasonable protocols and procedures for reimbursing new provider applicants, within 30 days of being credentialed by the MCO, for health care services or mental health services provided to covered persons during the period in which the applicant's completed credentialing application is pending. To initiate the application process for contracting and the credentialing process,

providers should contact the specific DMAS fee-for-service contractor or MCO. Please note: All participating Medicaid providers are required to complete a new contract agreement as a result of any name change or change of ownership.

In addition to following all general provider requirements outlined in the Addiction and Recovery Treatment Services (ARTS) manual Chapter II, OTS providers must also meet the applicable requirements listed below in addition to practicing within the scope of their license/certification/registration with the Department of Health Professions (i.e. Board of Medicine, Nursing, Counseling, Social Work, Psychology, etc.). Providers must have the knowledge, skills and abilities (KSAs) for substance use disorders (SUD) and treatment with applicable experience. Providers may obtain certification for SUD treatment to support having the KSAs.

All providers of the OTS services listed within this supplement must submit the appropriate ARTS Attestation Packet to the DMAS fee-for-service contractor and MCOs to initiate the credentialing process. The ARTS Attestation Forms and Staff Roster and other application forms mentioned below are posted online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/credentialing/.

Application Process

- **OTP –** OTPs must submit the ARTS Attestation Form for Opioid Treatment Programs, ARTS Staff Roster and copy of relevant DBHDS license directly to the DMAS fee-for-service contractor and MCOs to begin the credentialing process.

- **Preferred OBOTs–** Preferred OBOTs application process requires several steps including:

  - All licensed practitioners within the program must be credentialed as an in-network provider with DMAS fee-for-service contractor or at least one of the MCOs.
    - Providers must submit the "ARTS Preferred Office-Based Opioid Treatment Program Attestation Form", the "ARTS Preferred OBOT Organizational Staff Roster", and the "ARTS Preferred OBOT Credentialing Checklist" directly to DMAS. The Application Packet is located online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/credentialing/ and must be submitted via email to SUD@dmas.virginia.gov.
  - DMAS will review the Application Packet and determine if it meets the criteria and model of care for the Preferred OBOT status.

Once recognition by DMAS as a Preferred OBOT has been established, DMAS will send the provider a "Preferred OBOT Recognition Letter". The provider must then submit a copy of this

letter and a copy of the "ARTS OBOT Organizational Staff Roster" to the DMAS fee-for-service contractor and MCOs and finalize the credentialing process as a Preferred OBOT in order to begin to receive the enhanced reimbursement. Please note the DMAS fee-for-service contractor and the MCOs may require additional documentation to complete the credentialing process.

Continued participation as a Preferred OBOT is contingent on providers maintaining their credentialing or contract status with the DMAS fee-for-service contractor or MCOs, as well as meeting the standards of care and best practices specified in the ARTS Regulations and ARTS Provider Manual.

Out-Of-Network Providers

DMAS strongly encourages the MCOs to transfer members from out-of-network providers who are requiring members to pay out-of-pocket, to in-network Preferred OBOTs, OTPs, and other in-network buprenorphine-waivered practitioners who are within 30 miles in an urban area and 60 miles in a rural area (which meets DMAS network adequacy standards for MCOs) of the member. The MCO will cover all the members' addiction treatment services (e.g., physician visits, laboratory tests, counseling, medication, care coordination, etc.) instead of members needing to pay out-of-pocket to out-of-network providers. Medicaid covers transportation coverage for members to and from their appointments to Medicaid covered services.

This increased access to Preferred OBOT Providers and OTPs will ensure that members receive evidence-based MAT including MOUD, counseling and psychosocial supports, as well as the "high touch" care coordination that will result in the best outcomes.

Providers are considered Medicaid providers if they are enrolled with DMAS, credentialed with at least one Medicaid MCO or credentialed with DMAS's fee-for-service contractor. Providers who are enrolled with DMAS, credentialed with a Medicaid MCO or the DMAS fee-for-service contractor are considered Medicaid providers in any setting they practice that involves services to individuals enrolled in the Medicaid, Medicaid Expansion, FAMIS or FAMIS MOMS, and for which the provider may receive reimbursement through Medicaid, either directly or indirectly.

The acceptance of payment or anything of value beyond any deductible, coinsurance or copayment required by the member's benefit, by a Medicaid provider outside of the Medicaid reimbursement system for covered SUD treatment services is prohibited and DMAS will take action against any provider who violates this rule. The Agency investigates complaints concerning providers who solicit and receive cash or excess payments from members enrolled in Virginia Medicaid for covered services including office visits, counseling sessions, and MOUD. A Virginia Medicaid provider's solicitation or acceptance of money, or anything of monetary value, in exchange for Medicaid covered SUD treatment services is not permitted. Accepting payment for Medicaid covered-services from an enrolled member is considered "balance billing," which is federally

prohibited in accordance with 42 CFR § 447.15, and 12 VAC 30-10-580, as well as the Medicaid Provider Agreements.

In-Network Buprenorphine Waivered Practitioners Practicing Independently of an OTP and Preferred OBOT

Buprenorphine waivered practitioners must be credentialed by DMAS, its fee-for-service contractor and MCOs. Please note laboratory services that are not covered by the DMAS fee-for-service contractor must be billed to DMAS, practitioners need to be enrolled with DMAS for reimbursement. DMAS will also complete the federal screening requirements as noted in Chapter II of the ARTS Manual.

The ARTS specific procedure codes, reimbursement structure and service authorization requirements for MAT services delivered independently of a Preferred OBOT or OTP setting are posted online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/ and included as an Appendix to this Supplement.

If not currently enrolled with DMAS, providers must complete a provider enrollment request with DMAS via the online enrollment application on the DMAS Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at:
www.virginiamedicaid.dmas.virginia.gov.

If you have any questions regarding the online or paper enrollment process, please contact the Provider Enrollment Services at toll free 1-888-829-5373 or local 1-804-270-5105.

All participating Medicaid providers are required to complete a new contract agreement as a result of any name change or change of ownership.

OTS PROVIDER OVERVIEW

Opioid Treatment Programs (OTPs)

OTPs are programs certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) that engage in supervised assessment and treatment, using methadone, buprenorphine, L-alpha acetyl methadol, or naltrexone, of members who are addicted to opioids (12VAC30-130-5020). OTS includes the use of MOUD in addition to the psychotherapy services to treat a member with an OUD.

Preferred Office-Based Opioid Treatment (OBOT) Providers

OBOT Providers, also known as "Preferred OBOTs", deliver addiction treatment services to members with opioid use disorders provided by buprenorphine-waivered practitioners working in collaboration and co-located with Credentialed Addiction Treatment Practitioners providing psychosocial treatment in public and private practice settings (12VAC30-130-5020).

In-Network Buprenorphine Waivered Practitioners

DMAS supports buprenorphine waivered practitioners practicing independently from an OTP or Preferred OBOT site to be in-network with the member's MCO or DMAS's fee-for-service contractor to leverage the available supports for members.

MEDICAL NECESSITY CRITERIA

In order to receive reimbursement for OTS, the member must be enrolled in Virginia Medicaid and must meet the following medical necessity criteria below:

- The member must have a primary diagnosis of OUD as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders.
- The member must be assessed by a Credentialed Addiction Treatment Professional acting within the scope of their practice, who will determine if the severity and intensity of treatment requirements as defined by the most current version of the American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions (Third Edition, 2013) is met for this level of care.

Please note that Preferred OBOTs and OTPs are required to develop the following within these time frames:

- Individual Service Plan (ISP) within 24 hours from intake;
- Interdisciplinary Plan of Care (IPOC) within 30 calendar days from initiation of treatment; and
- Update the IPOC, at a minimum, every 90 calendar days.

Providers may use, but are not required to use the DMAS ISP form for Preferred OBOTs and the IPOC form for Preferred OBOTs and OTPs. The DMAS ISP and IPOC forms are further defined later in this Supplement and posted online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/policy-and-provider-manual/ .

COVERED SERVICES & STAFF REQUIREMENTS

General Evidence-Based Practices for Treatment of OUD

DMAS emphasizes the importance of providing care that is responsive to individual patient preferences, needs and values, and supports Medicaid providers to effectively address the needs of members with OUD. DMAS' goals are to minimize treatment barriers for members who have an OUD while ensuring these members obtain access to high quality MAT and other proven therapies.

Below is a summary of the current evidence and coverage through the ARTS benefit that applies to both OTP and Preferred OBOT settings. Nothing in this summary is intended to eliminate the need to follow the Virginia Board of Medicine regulations (18 VAC 85-21-10 et seq.) concerning the prescribing of MOUD for addiction treatment.

- DMAS supports **same day access and initiation of MOUD** for individuals with OUD.
- **Maintenance pharmacotherapy should be prescribed based on the individual's treatment needs,** without arbitrary tapering or time limits.
- **No prior authorization is required for the preferred buprenorphine/naloxone product, Suboxone films**. Evidence exists that **some individuals may benefit from buprenorphine doses greater than 16 milligrams per day** through higher rates of treatment retention and abstinence from illicit substances. Therefore, DMAS provides coverage for doses up to 24 milligrams per day of Suboxone films in alignment with the Virginia Board of Medicine maximum dosage per day. Providers shall continue to follow the Virginia Board of Medicine guidelines regarding dosing during the induction phase as well as maximum prescribing dosages. Please note that the Virginia Board of Medicine requires documentation in the member's record to support prescribed doses of greater than 16 milligrams per day.
- DMAS acknowledges that diversion and misuse of buprenorphine/naloxone may still occur but is relatively rare in comparison to diversion and misuse of prescription opioid pain medications. The most commonly cited reason is to manage the negative side effects of opioid withdrawal.

- DMAS requires the **co-prescribing of the overdose reversal agent naloxone with MOUD** since individuals with OUD are at elevated risk for overdose. When possible, family members and significant others should also be trained in the use of naloxone. Medicaid **covers naloxone at no cost to the member.**

- DMAS supports the **integration of medical services with addiction services including clinically indicated infectious disease testing** such as HIV, Hepatitis A/B/C, syphilis, and tuberculosis testing for members with OUD at initiation of and as indicated during treatment. DMAS also covers Hepatitis C treatment and HIV treatment and prevention including pre-exposure prophylaxis (PrEP). **Hepatitis C treatment is covered** for all Medicaid members with any fibrosis score. Primary care providers can prescribe preferred drugs such as Mavyret (glecaprevir/pibrentasvir) without a referral to a specialist. Members should not be denied treatment for Hepatitis C for the sole reason of Substance Use Disorder. Please see the DMAS Preferred Drug List for more information: https://www.dmas.virginia.gov/for-providers/prescription-drug-formularies.

- DMAS supports **integration of reproductive health services including contraception with addiction treatment**. Medicaid covers all family planning medications and devices including long acting reversible contraception (LARC) without a prior authorization.

- DMAS **allows and encourages same-day billing of medical and behavioral health services** to support integrated medical services and addiction services. **Providers should contact the Medicaid MCOs to determine the appropriate modifier to place on claims (such as "GB" or "25")** which defines the services as separate and distinct from each other to support billing**.**

- DMAS **supports home induction on buprenorphine products** in accordance with the ASAM National Practice Guideline.

- Relapse to opioid use is a common occurrence among individuals with OUD. DMAS **encourages providers to use urine drug testing as a therapeutic tool and not to discharge patients based on relapse and/or positive drug test results**. Upon discovering relapse, providers should re-assess a patient's condition, their adherence, their dose of pharmacotherapy and behavioral treatment, and consider intensification of care. Additional guidance for urine drug testing is covered later in this manual.

- The introduction of **MOUD prior to and immediately after release from institutional settings,** such as hospitals, inpatient rehabilitation facilities, correctional facilities and jails, can reduce the elevated risk of fatal overdose related to loss of tolerance

Opioid Treatment Programs (OTP)

OTP providers must be licensed by DBHDS as a provider of Medication Assisted Opioid Treatment/Opioid Treatment Services and contracted by the MCOs and the DMAS fee-for-service Contractor as an ARTS OTP Provider.

The ARTS specific procedure codes and reimbursement structure for OTP services are posted online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/ .

In addition, OTP providers must meet the following criteria:

1. Staff requirements for OTP programs must meet the licensing requirements of 12VAC35-105-925 et al. The interdisciplinary team must include Credentialed Addiction Treatment Professionals acting within the scope of their practice and trained in the treatment of opioid use disorder including an addiction credentialed physician or physician extenders and as defined in 12VAC30-130-5020.

   OTPs may also utilize Certified Substance Abuse Counselors (CSACs) (defined § 54.1-3507.2) and CSAC-Supervisees (defined in §54.1-3507.1 C) within the scope of their practice to provide substance use disorder counseling, psychoeducational services which is further defined in the Board's Guidance Document: 115-11. The CSACs and CSAC-Supervisees may not practice autonomously and must be supervised according to Board of Counseling requirements. Note: A "diagnostic" assessment completed by the appropriately licensed professional and a "multidimensional" assessment, conducted according to the ASAM Criteria, are both required for Medicaid reimbursement for services. CSACs and CSAC-Supervisees are not allowed to do a diagnostic assessment but are allowed to do the multidimensional assessment to make recommendations for a level of care that must then be signed off on or approved by a licensed professional who is supervising the CSAC or CSAC-Supervisee.

   OTPs may also utilize CSAC-A's (as defined in §54.1-3507.2) as well as Certified Peer Recovery Specialists within their scope of practice (12VAC30-130-5160 et al).

2. Staff must be knowledgeable in the assessment, interpretation, and treatment of the biopsychosocial dimensions of alcohol or other substance use disorders.

   A physician or physician extender, as defined in 12VAC30-130-5020, must be available during medication dispensing and clinical operating hours, in-person or by telephone.

OTPs that are dispensing buprenorphine or naloxone products under the authority of the OTP are not required to be a Preferred OBOT provider.

Service Delivery

Providers must meet the DBHDS regulations for OTPs as defined in 12VAC35-105-925 et al. OTPs must also meet the Medicaid service components and risk management requirements outlined below and as defined in 12VAC30-130-5050.

- Link the member to psychological, medical, and psychiatric consultation as necessary to meet the member's needs.
- Ensure access to emergency medical and psychiatric care through connections with more intensive levels of care.
- Ensure access to evaluation and ongoing primary care.
- Conduct or arrange for appropriate laboratory and toxicology tests including urine drug screenings.
- Ensure appropriately licensed and credentialed physicians are available to evaluate and monitor (i) use of methadone, buprenorphine products, or naltrexone products and (ii) pharmacists and nurses to dispense and administer these medications and who follow the Virginia Board of Medicine guidance for treatment of individuals with buprenorphine for addiction.
- Ensure medication for other physical and mental health conditions are provided as needed either on-site or through collaboration with other providers.
- Provide individualized, patient-centered assessment and treatment.
- Assess, order, administer, reassess, and regulate medication and dose levels appropriate to the member; supervise withdrawal management from opioid analgesics, including methadone, buprenorphine products or naltrexone products; and oversee and facilitate access to appropriate treatment for opioid use disorder.
- Provide cognitive, behavioral, and other substance use disorder-focused therapies, by a Credentialed Addiction Treatment Professional, reflecting a variety of treatment approaches, provided to the member on an individual, group, or family basis. CSACs and CSAC-Supervisees are recognized to provide substance use disorder counseling in these settings as allowed within scopes of practice as defined in § 54.1-3507.1 of the Code of Virginia.
- Provide optional substance use care coordination that includes integrating behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring individual progress and tracking individual outcomes; supporting conversations between buprenorphine-waivered practitioners and behavioral health

professionals to develop and monitor individualized treatment plans; linking individuals with community resources to facilitate referrals and respond to social service needs; and tracking and supporting individuals when they obtain medical, behavioral health, or social services outside the practice.

- Provide onsite screening or the ability to refer for screening for infectious diseases such as human immunodeficiency virus, hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors and the ability to provide or refer for treatment of infectious diseases as necessary.
- Onsite medication administration treatment during the induction phase, which must be provided by a physician, nurse practitioner, physician assistant, registered nurse or licensed nurse practitioner. Medication administration during the maintenance phase may be provided either by a registered nurse or licensed practical nurse.
- Prescription of naloxone for each member receiving methadone, buprenorphine products, or naltrexone products.
- Ability to provide pregnancy testing for individuals of childbearing age.
- For individuals of childbearing age, the ability to provide family planning services or to refer the individual for family planning services.

OTP risk management must include the following activities which must be clearly and adequately documented in each member's record:

- Conduct random urine drug screening for all members, conducted at least eight times during a twelve-month period as defined in 12VAC35-105-980. Definitive screenings must only be utilized when clinically indicated. Outcomes of the urine drug screening must be used to support positive patient outcomes and recovery instead of punitive approaches, and must be discussed in a nonjudgmental and supportive manner.
- Check the Virginia Prescription Monitoring Program prior to initiation of buprenorphine products or naltrexone products and at least quarterly for all members.
- Provide opioid overdose prevention education, including the prescribing of naloxone.
- Clinically indicated infectious disease testing such as HIV, Hepatitis A/B/C, syphilis, and tuberculosis testing at treatment initiation and then annually or more frequently depending on the clinical scenario and the patient’s risk. Those who test positive must be treated either on-site or through referral.
- Individuals without immunity to the hepatitis B virus must be offered vaccination either on-site or through referral. Individuals without HIV infection must be offered pre-exposure prophylaxis (PrEP) to prevent HIV infection either on-site or through referral.

- Individuals of child-bearing age must be offered onsite or through referral pregnancy testing and contraceptive services.

Service Units and Limitations

- See ARTS Reimbursement Structure for billing codes and units for OTP services is available online: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/ .
- OTPs may bill the H0014 MAT induction code for three separate inductions per 365 calendar days per member that must be at least 90 calendar days apart. H0014 includes the physician/physician extender services only. This does not cover the medications as part of the induction. The first day of each induction is billed using H0014. Additional physician visits within a 365 calendar day period must be billed using the appropriate evaluation and management code. Thus providers would submit H0014 for day one of induction, and the appropriate evaluation and management code on day two and after. Providers can bill for additional inductions beyond 3 separate inductions per 365 calendar days using the appropriate evaluation and management codes. If a member fails three inductions within a 365 calendar day period in an OTP setting, the provider should consider referring the member to a higher level of care for assessment for treatment.
- Group counseling by Credentialed Addiction Treatment Professionals, CSACs and CSAC-Supervisees shall have a maximum limit of 12 individuals in the group or less depending on the clinical model. Such counseling must focus on the needs of the members served. Group size and composition should be based on the needs of the group members and determined using standards of care.
- The buprenorphine waivered practitioner who is providing physician/physician extender induction services (H0014) and psychotherapy or opioid counseling (H0004 or H0005) within their scope of practice and meet the criteria as a Credentialed Addiction Treatment Professional as defined in Chapter IV of the ARTS Provider Manual, is permitted to **bill** for the MOUD induction (H0014) and psychotherapy or opioid counseling (H0004 or H0005). Services must be separate and distinguishable and well documented within the member's records.
- A different Credentialed Addiction Treatment Professional can provide opioid counseling and bill for H0004 or H0005 on the same date of service that the buprenorphine waivered practitioner is providing the MOUD induction (H0014). The buprenorphine waivered practitioner who is providing follow up/maintenance physician services (E&M office visit codes) and psychotherapy or opioid counseling (H0004 or H0005) within their scope of practice and meet the criteria as a Credentialed Addiction Treatment Profession as defined in Chapter IV of the ARTS Provider Manual, **may provide these services on the same day as long as there is documentation supporting services are separate and distinguishable.**

- Take home doses have a maximum 28-day limit dispensing at a time and must be approved by the SOTA. OTPs may bill H0020 for the medication encounter for the total number of days' supplied of the take-home medication as allowed by the SOTA.

Preferred Office-Based Opioid Treatment (OBOT) Services

Preferred OBOT services must be provided by a buprenorphine-waivered practitioner and a co-located Credentialed Addiction Treatment Professional and may be provided in a variety of practice settings including primary care clinics, outpatient health system clinics, psychiatry clinics, Federally-Qualified Health Centers (FQHCs), Community Service Boards (CSBs), local health department clinics, and physicians'/physician extenders' offices. DMAS expects Preferred OBOT services to be primarily delivered in-person/on site and utilize telehealth as an option to increase access to services as needed. DMAS does not support Preferred OBOTs services to be delivered solely or primarily through telehealth. The practitioners must be credentialed by DMAS, the DMAS fee-for-service contractor or MCOs to perform Preferred OBOT services. Preferred OBOT providers do not require a separate DBHDS license.

The ARTS specific procedure codes and reimbursement structure for Preferred OBOT services are posted online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/ .

In addition, Preferred OBOT service providers must meet the following criteria.

1. The buprenorphine-waivered practitioner licensed under Virginia law must have completed one of the continuing medical education courses approved by the Center for Substance Abuse Treatment and obtained the waiver to prescribe or dispense buprenorphine for opioid use disorder required under the Drug Addiction Treatment Act of 2000 (DATA 2000). The practitioner must have a Drug Enforcement Agency (DEA)-X number issued by the Drug Enforcement Agency that is included on all buprenorphine prescriptions for treatment of opioid use disorder.

    a. As of April 28, 2021, the U.S. Department of Health and Human Services' *Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder (OUD)*, under 21 U.S.C. 823(f)(2)(B)(i)-(ii), provides eligible physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives, (hereinafter collectively referred to as "practitioners") an exemption from certain statutory requirements that allows them to treat up to thirty (30) patients for OUD using buprenorphine without having to meet any training-related certifications and without certifying their capacity to provide counseling and ancillary services. Practitioners seeking to leverage these flexibilities must still meet the following conditions:

i. Practitioners must be state licensed and obtain (and maintain) a valid DEA registration under 21 U.S.C. 823(f).

ii. Practitioners must submit a Notice of Intent (NOI) in accordance with current procedures in order to receive a waiver, specifying a patient limit of 30 (allowing them to circumvent training, counseling or other ancillary services requirements otherwise applied under 21 U.S.C. 823(g)(2)(B)(i)-(ii)).

Practitioners utilizing this exemption are limited to treating no more than 30 patients at any one time. Time spent practicing under this exemption will not qualify the practitioner for a higher patient limit under 21 U.S.C. 823(g)(2)(b)(iii).

iii. Licensed Physician's Assistants or Nurse Practitioners must have completed the 24 hours of training required by SAMSHA and obtained a waiver to prescribe buprenorphine for opioid use disorder from the DEA. Physician Assistants and Nurse Practitioners, who have obtained a SAMHSA waiver, must only prescribe buprenorphine for opioid addiction pursuant to a practice agreement with a waivered doctor of medicine or doctor of osteopathic medicine as in accordance to the Board of Medicine regulations (12VAC85-21-130).

b. Nurse Practitioners may practice without a practice agreement with a patient care team physician if attestation states that he/she completed the minimum requirements of full-time clinical experience per the Board of Nursing if the proper Board approval is obtained in accordance with the laws and requirements of the Board of Nursing (defined in §54.1-2957). There is no requirement that a collaborating physician be physically located in the same practice site as the nurse practitioner.

2. Credentialed Addiction Treatment Professionals must be co-located at the same practice site as the buprenorphine waivered practitioner. The Credentialed Addiction Treatment Professional, under the scope of their practice, provides psychotherapy and counseling within the Preferred OBOT model to support the evidence-based practice for treatment of OUD. The Credentialed Addiction Treatment Professional must work with the buprenorphine-waivered practitioner prescribing buprenorphine or naltrexone to patients with OUD. The Credentialed Addiction Treatment Professionals may utilize telehealth as an option to increase access to services as needed.

Preferred OBOT providers may also utilize CSACs and CSAC-Supervisees in their practice to provide substance use disorder counseling and psychoeducational services within their scope of practice which is further defined in the Board's Guidance Document: 115-11. The CSACs and CSAC-Supervisees may not practice

autonomously and must be supervised according to Board of Counseling requirements. Note: A "diagnostic" assessment completed by the appropriately licensed professional and a "multidimensional" assessment, conducted according to ASAM Criteria, are both required for Medicaid reimbursement for services. CSACs are not allowed to do a diagnostic assessment but are allowed to do the multidimensional assessment to make recommendations for a level of care that must then be signed off on or approved by a licensed professional who is supervising the CSAC. CSACs nor CSAC-Supervisees may practice autonomously and must be supervised according to Board of Counseling requirements.

The Credentialed Addiction Treatment Professional must develop a shared care plan with the buprenorphine-waivered practitioner and the patient and take extra steps to ensure that care coordination and interdisciplinary care planning are occurring.

The Credentialed Addiction Treatment Professional must engage in interdisciplinary care planning with the buprenorphine-waivered practitioner including working together to develop and monitor individualized and personalized treatment plans that are focused on the best outcomes for the patient.

3. Pharmacists can serve as a member of the interdisciplinary team. Pharmacists can advise buprenorphine-waivered practitioners on the selection of buprenorphine vs naltrexone as treatment options, assist with buprenorphine induction and dose adjustments, contribute to the development of the interdisciplinary treatment plan, and assist with monitoring, communicating with, and educating patients.

4. Credentialed Addiction Treatment Professionals must be employed by, have a contractual relationship or an established agreement with the buprenorphine-waivered practitioner or the organization employing the practitioner.

5. Ability to utilize Peer Recovery Support Services through employment or contractual relationship.

Preferred OBOTs **must not** dispense or prescribe Methadone for treatment of OUD, as this is only allowed by a DBHDS licensed OTP. OBOTs may dispense buprenorphine products on-site **only** during the induction phase and then must prescribe buprenorphine products after the induction phase.

Service Delivery

Preferred OBOT service components and risk management requirements must include the following activities. Providers must document the provision of the following activities, as rendered, in the member's medical record.

Preferred OBOT Service Components

- Develop the initial ISP within 24 hours of initiation of services and complete the comprehensive ISP within 7 calendar days from intake.
- Develop and maintain the DMAS Individualized Plan of Care (IPOC) within 30 calendar days from the ISP assessment date and update it a minimum every 90 calendar days. Providers may use the DMAS IPOC form but not required.
- Ensure rapid initiation of MOUD within 24 to 48 hours from referral.
- Capability for pharmacotherapy induction, stabilization and maintenance including delivering maintenance pharmacotherapy without arbitrary tapering or time limits and only discontinuing pharmacotherapy if it is worsening a member's condition or after sufficient time in recovery.
- Ensure appropriate dosing of buprenorphine/naloxone for up to 24 mg. per day per the Board of Medicine regulations. There is strong evidence that some individuals may benefit from increased buprenorphine dose >16 mg in terms of treatment retention and abstinence from illicit substance.
- Provide home inductions for buprenorphine products when clinically indicated.
- Ensure access to emergency medical and psychiatric care.
- Establish affiliations with more intensive levels of care such as intensive outpatient programs and partial hospitalization programs that unstable members can be referred to when clinically indicated.
- Provide individualized, patient-centered multidimensional assessment and treatment.
- Assess, order, administer, reassess, and regulate medication and dose levels appropriate to the member; supervise withdrawal management from opioid analgesics; and oversee and facilitate access to appropriate treatment for opioid use disorder and alcohol use disorder.
- Ensure medication for other physical and mental illnesses are provided as needed either on-site or through collaboration with other providers.
- Ensure buprenorphine products are only dispensed on-site during the induction phase. After induction, buprenorphine products should be prescribed to the member. Preferred OBOTs may also prescribe buprenorphine products during the induction phase.
- Ensure that buprenorphine monoproduct is only prescribed in accordance with Virginia Board of Medicine rules related to the prescribing of buprenorphine for addiction.
- Provide cognitive, behavioral, and other substance use disorder-focused counseling and psychotherapies, reflecting a variety of treatment approaches, shall be provided to the individual on an individual, group, or family basis and shall be provided by Credentialed

Addiction Treatment Professionals working in collaboration with the buprenorphine-waivered practitioner who is prescribing buprenorphine products or naltrexone products to individuals with a primary opioid use disorder. The Credentialed Addiction Treatment Professional **must be co-located at the same practice site** and provide counseling in collaboration with the buprenorphine-waivered practitioner in prescribing buprenorphine or naltrexone to members with OUD.

- DMAS requires individualized substance use disorder counseling and/or psychotherapy to be provided along with pharmacotherapy. However, DMAS recognizes not all members are ready to engage in counseling or psychotherapy. Providers shall document continuous efforts to engage members in treatment utilizing motivational interviewing techniques, relapse prevention strategies, etc. and are not required to discharge members from pharmacotherapy during this period.

- Preferred OBOTs may utilize CSACs and CSAC-Supervisees to provide substance use disorder counseling and psychoeducational services within their scope of practice as defined in § 54.1-3507.1 of the Code of Virginia and further defined in the Board's Guidance Document: 115-11.

- The foundation of the Preferred OBOT model is to provide the medical and behavioral health services within the same location, have in-person interactions with the member and provide the high-touch care coordination to support the member in their recovery. DMAS recognizes that there may be situations that telehealth is necessary to engage the member in treatment and recovery. Thus Preferred OBOT services may be provided via telehealth based on the individualized needs of the member and must have supporting documentation of why the in-person interactions are not meeting the member's specific needs. The primary means of services delivery shall be in-person for the Preferred OBOT model with the exception of telehealth for specific member circumstances (such as transportation issues, childcare, employment, co-morbidities, distance, etc.) that impede their access to treatment. Providers delivering services using telemedicine shall bill according to the requirements in the DMAS Telehealth Services Supplemental Manual.

- Provider substance use care coordination, including interdisciplinary care planning between the buprenorphine-waivered practitioner and the treatment team to develop and monitor individualized and personalized treatment plans focused on the best outcomes for the individual. This care coordination includes monitoring individual progress, tracking individual outcomes, linking the individual with community resources to facilitate referrals and respond to social service needs, and tracking and supporting the individual's medical, behavioral health, or social services received outside the practice.

- Provide onsite screening or referral for screening for clinically indicated infectious disease testing for diseases such as HIV; hepatitis A, B, and C; syphilis; and tuberculosis at treatment initiation and then at least annually or more often based on risk factors and the ability to provide or refer for treatment of infectious diseases as necessary.

- Provide onsite medication administration treatment during the induction phase, which shall be provided by a physician, nurse practitioner, physician assistant, registered nurse or licensed practical nurse.

- Provide pregnancy testing for individuals of childbearing age.

- Provide family planning services or to refer the individual for family planning services if they are of childbearing age.

- At least weekly visits by the buprenorphine-waivered practitioner or Credentialed Addiction Treatment Professional during the first three months when initiating treatment. Member must be seen at least weekly for at least 3 months with documented clinical stability before spacing out to a minimum of monthly visits with buprenorphine-waivered practitioner or Credentialed Addiction Treatment Professional. The IPOC must be updated to reflect these changes.

Preferred OBOT must include the following risk management activities which must be documented in each member's record:

- Due to a higher risk of fatal overdose when opioids are prescribed with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber must only co-prescribe these substances when there are extenuating circumstances and must document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed (pursuant to Board of Medicine regulations).
- Random drug screening, using either urine or blood serums, for all individuals, conducted at a minimum of eight times per year. Drug screenings include presumptive and definitive screenings and shall be accurately interpreted. Definitive screenings shall only be utilized when clinically indicated. Outcomes of the drug screening shall be used to support positive patient outcomes and recovery. See "Urine Drug Testing Guidance" section below.
- A check of the Virginia Prescription Monitoring Program prior to initiation of buprenorphine products or naltrexone products and at least quarterly for all individuals thereafter.

- Periodic monitoring of unused medication and opened medication wrapper counts when clinically indicated.
- Opioid overdose prevention education, including the purpose of and the administration of naloxone and the impact of polysubstance use. Education shall include discussion of the role of medication assisted treatment and the opportunity to reduce harm associated with polysubstance use. The goal is to help individuals remain in treatment to reduce the risk for harm.
- Clinically indicated infectious disease testing for diseases such as HIV; hepatitis A, B, and C; syphilis; and tuberculosis at treatment initiation and then annually or more frequently, depending on the clinical scenario and the patient's risk. Those individuals who test positive shall be treated either onsite or through referral.

Urine Drug Testing Guidance

According to the Centers for Medicare & Medicaid Services (CMS), current coding for testing for drugs of SUD relies on a structure of "screening" known as "presumptive" testing or "definitive" testing (Gas Chromatography/Mass Spectrometry Combined (GC/MS)) that identifies the specific drug and quantity in the patient. Urine Drug Testing (UDT) is used to monitor patients treated for SUD. Their use should be supportive and non-punitive: providers are encouraged to consider both positive and negative UDT results in shaping and informing current and future treatment to best support their patients. Drug test frequency is based on the practitioner's best clinical judgment and use of unannounced or random screening schedule rather than a mandated or fixed schedule. The primary purposes of UDTs in a SUD treatment environment include:

- To determine if the patient is taking the buprenorphine as prescribed (Note: this can only be determined through GC/MS testing and should include a test for the presence of buprenorphine and norbuprenorphine, a metabolite of buprenorphine, the presence of which would indicate that the client has taken their medication and metabolized it);
- To assess if the patient is taking medications which have a higher risk of overdose when taken with buprenorphine, such as benzodiazepines; and
- If the patient is not taking their medication but still getting their prescription filled, this may indicate diversion. Likewise, a patient's continued use of benzodiazepines or other substances could suggest a need for a higher level of care.

Results of point of care tests should be considered presumptive. Definitive screening (GC/MS) should be performed prior to changes in clinical care. GC/MS testing provides exact levels of specific substances found in samples, and it is up to the treatment provider, in coordination with the lab, to determine if a sample is 'positive or negative'. This is done by selecting a cut-off level for each substance.

The Virginia practice guidelines require drug tests or serum medication levels for addiction treatment with buprenorphine at least every three months for the first year of treatment and at least every six months thereafter. A sample schedule for urine screening is initially weekly for four to six weeks but no more than three per week, then biweekly to every three weeks for four to six weeks and then monthly as the patient becomes stable on buprenorphine. On a case-by-case basis, an individualized clinical review might be indicated to determine whether exceeding these limits is justified. High-acuity and high frequency testing should be based on medical necessity and medical records should support services rendered.

The American Society of Addiction Medicine has a Consensus Statement on the best practices for UDT entitled Appropriate Use of Drug Testing in Clinical Addiction Medicine: https://www.asam.org/docs/default-source/quality-science/appropriate_use_of_drug_testing_in_clinical-1-(7).pdf?sfvrsn=2.

Providers should consult with their respective MCOs for Medicaid members if they have additional questions about specific member situations. Services should be based on individual patient needs and may vary.

Mobile OBOT

Preferred OBOT Providers of an opportunity to provide OBOT services through a new mode of delivery called "Mobile Preferred OBOTs."

The Mobile Preferred OBOT model shall allow Preferred OBOT providers to provide the same services in a Mobile Unit as in a traditional Preferred OBOT setting. As indicated by the Centers for Medicare and Medicaid Services (CMS), and accepted by the Medicaid MCOs and the DMAS fee-for-service contractor, a "Mobile Unit" is designated as place of service (POS) 15 and is defined as a facility or unit that moves from place to place equipped to provide preventive, screening, diagnostic, and/or treatment services: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

Providers using the Mobile OBOT settings shall have the ability to deliver time sensitive screenings, treatment and recovery services to Medicaid members with an OUD. The goal is to expand access to evidence-based treatment for members with OUD, targeting higher-risk, vulnerable populations transitioning from an institutional or hospital setting such as emergency departments, residential, hospital settings as well as prisons, local and regional jails.

Settings for Mobile Preferred OBOTs

The following settings shall be permitted for Mobile Preferred OBOTs:

1. A Preferred OBOT shall be allowed to receive approval by DMAS to operate exclusively as a Mobile Unit. To apply to become a Mobile Preferred OBOT, providers must complete

the ARTS Preferred OBOT attestation form, organizational staff roster, and credentialing checklist found at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/credentialing/ . All required provider types as well as the Preferred OBOT model of care must meet the traditional Preferred OBOT model, outlined in the this manual, and shall be present in the Mobile Unit for DMAS to consider approval for this setting. Mobile OBOTs shall have a physical address attached to the Mobile Unit for billing purposes. When billing for services provided in a Mobile OBOT, the place of service (POS) shall be listed as "015" for a Mobile Unit. Upon recognition by DMAS as a Mobile OBOT, providers must submit the "Preferred OBOT Recognition Letter" from DMAS to the MCOs and Magellan of Virginia to initiate the credentialing process. ARTS Network Relations Contacts at the MCOs and Magellan of Virginia can be found at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/credentialing/ .

Credentialing with the MCOs and the DMAS fee-for-service contractor must occur prior being eligible for reimbursement for services furnished to members in managed care. The MCOs shall follow the Virginia Code §38.2-3407.10:1 that requires MCOs to establish reasonable protocols and procedures for reimbursing new provider applicants of physicians or mental health professionals in its network for services provided to covered persons during the period in which the applicant's completed credentialing application is pending (see DMAS Provider memo "Provider Reimbursement for Licensed Mental Health Professionals – December 13, 2019": www.virginiamedicaid.dmas.virginia.gov).

2. A Mobile Unit shall also be permitted to operate as an extension of an established Preferred OBOT's primary location. This shall allow providers at a Preferred OBOT to also provide services in the community using the POS "015" for a Mobile Unit. Providers working in the Mobile OBOT setting shall provide services in-person as well as be permitted to utilize technology to provide telemedicine sessions with providers located at the Preferred OBOT's primary location. Providers delivering services using telemedicine shall follow the requirements set forth in the DMAS Telehealth Services Supplemental Manual. Current Preferred OBOT Providers shall notify the MCOs and the DMAS fee-for-services contractor prior to providing services in a Mobile Unit.

Service Units and Limitations

- See ARTS Reimbursement Structure for billing codes and units for Preferred OBOT services available online: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/.
- Preferred OBOT's physician and physician extender who are buprenorphine waivered may bill the H0014 MAT induction code for three separate inductions per 365 calendar days per member that must be at least 90 calendar days apart. H0014 includes the physician/physician extender services only. This does not cover the medications as part of

the induction. The first day of each separate induction is billed using H0014. Additional physician/physician extender follow up and maintenance visits within a 365 calendar day period must be billed using the appropriate evaluation and management code. Thus providers would submit H0014 for day one of induction, and the appropriate evaluation and management code on day two and after. Providers can bill for additional inductions beyond 3 separate inductions per 365 calendar days using the appropriate evaluation and management codes. If a member fails three buprenorphine or buprenorphine/naloxone inductions within a 365 calendar day period in a Preferred OBOT setting, the provider should consider referring the member to an OTP or higher level of care for assessment for treatment.

- Group counseling by Credentialed Addiction Treatment Professionals, CSACs and CSAC-Supervisees shall have a maximum limit of 12 individuals in the group or less depending on the clinical model. Such counseling must focus on the needs of the members served. Group size and composition should be based on the needs of the group members and determined using standards of care.
- The buprenorphine waivered practitioner **may bill** for MAT induction (H0014) and psychotherapy or opioid counseling (H0004 or H0005) if **provided by the same practitioner on the same date of service**. Service must be separate and distinct, meaning services may not be provided at the same time and billed as two different services The buprenorphine waivered practitioner who is providing MOUD induction services (H0014) and psychotherapy or opioid counseling (H0004 and H0005) must provider both within their scope of practice and meet the criteria as a Credentialed Addiction Treatment Profession as defined in Chapter IV of the ARTS Provider Manual. The buprenorphine waivered practitioner who is providing follow up/maintenance physician services (E&M office visit codes) and psychotherapy or opioid counseling (H0004 or H0005) within their scope of practice and meet the criteria as a Credentialed Addiction Treatment Profession as defined in Chapter IV of the ARTS Provider Manual, **may provide these services on the same days as long as there is supporting documentation.**
- Credentialed buprenorphine waivered practitioners at Preferred OBOTs do not require service authorizations for the preferred products: buprenorphine SL, Suboxone® film, Sublocade™ SQ nor Vivitrol®. Service authorization is required for non-preferred products. DMAS is also removing service authorization requirement for Sublocade™ SQ effective July 1, 2021. The only prerequisite will be the Risk Evaluation and Mitigation Strategy (REMS) criteria from the specialty pharmacy.

Provider Qualifications for Substance Use Care Coordinator:

1. At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and have one of the following qualifications (i) substance use related direct experience providing services to individuals with a diagnosis substance abuse use disorder

or (ii) clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or

2. Licensure by the Commonwealth as a registered nurse with (i) substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or (ii) clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or
3. Board of Counseling CSAC, CSAC-Supervisee or CSAC Assistant under supervision as defined in 18VAC115-30-10 et seq.

All Substance Use Care Coordinators must be under the general supervision of a buprenorphine waivered practitioner or Credentialed Addiction Treatment Professional in the OTP or Preferred OBOT setting. Substance Use Care Coordinators must be employed by or have a contractual relationship with either the buprenorphine waivered practitioner or Licensed Credentialed Treatment Professional or the organization employing the buprenorphine waivered practitioner or Credentialed Addiction Treatment Professional.

Service Delivery

Substance Use Care Coordination includes activities to ensure that necessary services, including mental health services, are integrated into primary care and specialty medical settings through interdisciplinary care planning and monitoring member progress, tracking member outcomes and reporting back to the buprenorphine-waivered practitioner and the Credentialed Addiction Treatment Professionals. Substance Use Care Coordination supports interdisciplinary care planning meetings between buprenorphine-waivered practitioners and Credentialed Addiction Treatment Professionals to develop and monitor the IPOC. Care coordination includes connecting members with community resources to facilitate referrals, as well as linking members with peer supports and tracking and supporting members when they obtain medical, behavioral health, or other community based services outside the practice.

The Preferred OBOT or OTP must have a designated staff member who performs the following Substance Use Care Coordination functions:

- Meet face-to-face and utilize telephonic/collateral contacts with the member and significant others to facilitate recovery.
- Act as the primary point of contact for the member and the interdisciplinary team in the Preferred OBOT or OTP setting.
- Ensure that members have access (e.g., a telephone number, e-mail address) to their Substance Use Care Coordinator.
- Engage members in Substance Use Care Coordination activities as identified in the ISP for OTP settings and the ISP/IPOC in Preferred OBOT settings.

- Ensure that members have viable access to emergency services.
- Communicate with the member about their ongoing or newly identified needs on at least a monthly basis (or a frequency as requested by the member), to include a phone call or face-to-face meeting, depending on the member's needs and preferences.
- Notify members who their assigned care coordination contact is and if there needs to be a change, what is the plan for coverage.
- When possible, ensure continuity of care when care coordinator changes are made whether initiated by the member or by the Preferred OBOT or OTP.

The staff member with the primary responsibility for Substance Use Care Coordination must execute the following responsibilities **at a minimum to support the monthly billing** of Substance Use Care Coordination (G9012):

- Participate in interdisciplinary treatment team meetings for care planning at least once every 30 days for each member that assess the member's needs, planning of services, reviewing and making updates to members goals and objectives as needed to ensure the ISP and the IPOCs are developed and updated as necessary in collaboration with the member;
- Enhancing community integration through increased opportunities for community access and involvement and enhancing community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;
- For individuals involved in the pre or post carceral system, care coordinators must establish and maintain coordination with community corrections for members on probation, parole, or participating in a diversion program with appropriate consents;
- Linking the member to those community supports that are most likely to promote the personal rehabilitative, recovery, and life goals of the member;
- Monitoring the provision of services, including outcomes, assessing appropriate changes or additions to services, and facilitating referrals for the member;
- Assisting the member directly to locate, develop, or obtain needed services, resources, and appropriate public benefits through empowerment and the use of self-sufficiency skills;
- Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments;
- Ensuring that appropriate mechanisms are in place to receive member input, complaints and grievances, and secure communication among relevant parties;

- Soliciting and helping to support the member's wishes (e.g., health care decisions, prioritization of needs and implementation of strategies, etc.);
- Knowing and monitoring the member's health status, any medical conditions, medications and potential side effects, and assisting the member in accessing primary care and other medical services, as needed; and
- Providing education as needed to support informed decisions and assisting with planning for transitions in the member's life.

Service Units and Limits

- Only OTPs and Preferred OBOTs can bill for Substance Use Care Coordination.
- The initial and final months of treatment, Substance Use Care Coordination may be billed prior to the initial IPOC being completed, as long as the required activities noted above are provided and documented in the member's medical record for the billing month. The first IPOC must be finalized in the member's medical record within 30 calendar days from the ISP assessment date.
- Medicaid will not reimburse for Substance Use Care Coordination (G9012) if a member is in an ARTS Intensive Outpatient (ASAM Level 2.1), Partial Hospitalization (ASAM Level 2.5) or Inpatient/Acute Care (ASAM Level 4.0) setting.
- OTPs and Preferred OBOTs may bill for Substance Use Care Coordination if a member is also receiving Group Home (ASAM Level 3.1) services. Members should be seen at frequency as required earlier in this Supplement.
- Substance Use Care Coordination services are not reimbursable for members while members are residing in institutions, including Residential (ASAM Level 3.3, 3.5, 3.7), except that Substance Use Case Coordination may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.
- Substance Use Care Coordination services are not reimbursable for members also receiving Substance Use Case Management.
- Care coordination activities must be documented to support the billing of the Substance Use Care Coordination to transition member from residential setting to community and re-engagement to the Preferred OBOT or OTP. Documentation of monthly care coordination can be in the form of a monthly progress note.
- Substance Use Care Coordination does not include maintaining service waiting lists, scheduling transportation rides or periodically contacting or tracking members to determine potential service needs that do not meet the requirements for the monthly billing.
- Contact with the ARTS Care Coordinator or other health plan care coordination or case management staff do not count towards the monthly Care Coordination service activities.
- The IPOC must be updated at minimum every 90 calendar days or as the member's needs change throughout the course of treatment.

MAT in ASAM LEVELS 2.1 through 3.7

Providers within the Preferred OBOT setting may continue to prescribe to members who may require during the course of treatment a higher level of care. Providers should coordinate these services with the new provider to ensure there is no duplication to services. Members who continue to be seen by the Preferred OBOT provider do not require discharging; however changes within treatment setting should be well documented within the IPOC and progress notes.

MAT can be billed separately from the per-diem ARTS payments in community-based settings providing ASAM Levels 1.0 through 3.7 (excluding inpatient services where it is included in the per diem ARTS payment).

See the MAT chart in the appendix of this supplement for instructions on how to bill for physician visits, psychotherapy, medication, laboratory tests, and urine drug screens for MAT inductions and ongoing assessments and monitoring.

Buprenorphine Waivered Practitioners Practicing Independently of an OTP and Preferred OBOT Setting

Buprenorphine Waivered Practitioners must follow the Board of Medicine regulations for provisions for prescribing of buprenorphine for addiction treatment (12VAC85-21-130 to 170) including incorporating relapse prevention strategies into counseling or assure that they are addressed by a mental health service provider, as defined in §54.1-2400.1 of the Code of Virginia, who has the education and experience to provide substance use disorder counseling.

- Buprenorphine Waivered Practitioners do not have a service authorization requirement for preferred product for treatment of OUD -Suboxone® film. Claims for the mono-buprenorphine product shall process without prior authorization for members who are pregnant. Sublocade™ SQ, is only be covered by in-network prescribers. Service authorization is required for non-preferred products.

Documentation in the member's medical record must include the following:

- A documented diagnosis of OUD;
- Documentation of ongoing psychological counseling;
- Medical justification for doses greater than 16 mg per day;
- Compliance with the Virginia Prescription Monitoring Program;
- Documentation of person-centered plan of care that is specific to the individual's unique treatment needs, developed with the individual, in consultation with the individual's family, as appropriate.

- Documentation of member's pregnancy if monoproduct is prescribed;
- Documentation of urine drug screens;
- Documentation of co-prescribing naloxone; and
- Documentation to support Non-Preferred agents (if applicable).

The DMAS service authorization form for fee-for-service members are located online at: https://www.virginiamedicaidpharmacyservices.com. MCOs have their own service authorization forms posted on their provider websites but will accept the DMAS service authorization forms for the non-preferred agents. The provider records must contain all information as required under the Board of Medicine regulations for provisions for prescribing of buprenorphine for addiction treatment (18VAC85-21-130 through 170) available online: https://law.lis.virginia.gov/admincode/title18/agency85/chapter21/.

DOCUMENTATION REQUIREMENTS

Providers must be required to maintain documentation detailing all relevant information about the Medicaid members who are in the provider's care. Such documentation must fully disclose the extent of services provided in order to support provider's claims for reimbursement for services rendered. This documentation must be written and dated at the time the services are rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

Individual Service Plans (ISP)

Preferred OBOTs and the Initial ISP

Preferred OBOTs must develop the initial ISP within 24 hours of admission by a Credentialed Addiction Treatment Professional to address the immediate service needs, health, and safety needs of the member at the initial point of contact. Following the Substance Abuse and Mental Health Services Administration (SAMHSA) Buprenorphine Quick Start Guide the assessment for prescribing MOUD should include: a patient history including medical, psychiatric and substance use as well as evaluation of family and psychosocial supports; checking the Prescription Drug Monitoring Program; physical examination that focuses on physical findings related to addiction and it's complications; laboratory tests but not delay treatment awaiting laboratory results. A Credentialed Addiction Treatment Professional must sign off on the ISP if developed by a CSAC or CSAC-Supervisee. Preferred OBOTS must complete the ASAM multidimensional assessment within seven calendar days from treatment initiation to determine the most appropriate level of care and to support the comprehensive ISP.

The ISP is person-centered, recovery oriented, includes all planned interventions, aligns with the member's identified needs and recovery goals, care coordination needs, is regularly updated as the member's needs and progress change, and shows progress throughout the course of treatment.

The written ISPs must contain, but is not limited to:

- The member's treatment or training needs;
- The member's measurable goals;
- The member's measurable objectives and recovery strategies to meet the identified needs;
- Services to be provided with the recommended frequency to accomplish the measurable goals and objectives;
- The estimated timetable for achieving the goals and objectives; and
- An individualized discharge plan that describes transition to other appropriate services.

For persons with co-occurring psychiatric and substance use conditions, providers are expected to integrate the treatment needs in the member's ISP.

The adult member must sign his or her own ISP and if unwilling or unable to sign the ISP, then the service provider must document the reasons why the member was not able or willing to sign the ISP. The child's or adolescent's ISP must be signed by the parent/legal guardian except in cases where a minor who is deemed an adult for purposes of consenting to medical or health services needed for treatment of substance use disorder services meets requirements per §54.1-2969.

Interdisciplinary Plan of Care (IPOC)/Comprehensive ISP

Preferred OBOTs/OTPs

The IPOC meets the requirements of the comprehensive ISP and must be developed and documented within 30 calendar days from the initial assessment date by a Credentialed Addiction Treatment Professional to address needs specific to the member's unique treatment as identified in the assessment and the ASAM Multidimensional Assessment as applicable to the ASAM Level of Care. The IPOC/Comprehensive ISP must be more detailed in addressing member's needs and goals throughout treatment. The Initial ISP must be used to help expound on member's overall treatment goals. A Credentialed Addiction Treatment Professional must sign off on the IPOC/Comprehensive ISP if developed by a CSAC or CSAC-Supervisee.

The IPOC/Comprehensive ISP must be reviewed every 90 calendar days and documented within the member's medical record no later than seven calendar days from the date of the review and signed off within 24 hours as evidenced by the dated signatures of the Credentialed Addiction Treatment Professional as noted above, and the member and/or guardian, when a minor child is the recipient (unless meeting §54.1-2969).

The formatting of the ISPs may be at the discretion of the provider but must include all required components as stated above. Providers may also use the DMAS IPOC form.

The IPOC/Comprehensive ISP is a comprehensive treatment plan specific to the member's unique treatment needs. The IPOC/Comprehensive ISP is person-centered, recovery oriented, includes all planned interventions, aligns with the member's identified needs, including care coordination needs and recovery goals, is regularly updated as the member's needs and progress change, and shows progress and or regression throughout the course of treatment. The documentation contains, but is not limited to:

- The member's treatment or training needs,
- The member's measurable goals,
- Measurable objectives and recovery strategies to meet the identified needs and goals,
- Services to be provided with the recommended frequency to accomplish the measurable goals and objectives,
- The estimated timetable for achieving the goals and objectives;
- An individualized discharge plan that describes transition to other appropriate services; and
- Be based on the ASAM Multidimensional Assessment.

For persons with co-occurring psychiatric and substance use conditions, providers are expected to integrate the treatment needs in the member's IPOC/Comprehensive ISP.

If providers utilize templates other than the standard IPOC template, they should ensure that all required elements are included in order to remain in compliance with documentation requirements.

The IPOC/Comprehensive ISP must be developed and documented within 30 calendar days from the initial ISP by a Credentialed Addiction Treatment Professional to address needs specific to the member's unique treatment. A Credentialed Addiction Treatment Professional must sign off on the IPOC/Comprehensive ISP if developed by a CSAC or CSAC-Supervisee. The adult member must sign his or her own IPOC/Comprehensive ISP and if unwilling or unable to sign the IPOC/Comprehensive ISP, then the service provider must document the reasons why the member was not able or willing to sign the IPOC/Comprehensive ISP. The child's or adolescent's IPOC/Comprehensive ISP must be signed by the parent/legal guardian except in cases where a minor has been deemed an adult for purposes of consenting to medical or health services needed for treatment of substance use disorder services meets requirements per §54.1-2969.

The IPOC is considered meeting the Comprehensive ISP requirements if it is reviewed and updated a minimum of every 90 calendar days from the date of the last update. Documentation of the interdisciplinary treatment team meetings must be added to the member's medical record no later than seven days from the calendar date of the review. This will be evidenced by the dated signatures of the Credentialed Addiction Treatment Professional as noted above, and the member and/or guardian, when a minor child is the recipient (unless meeting §54.1-2969). The

IPOC/Comprehensive ISP must be modified at a minimum of every 90 calendar days or as the needs and progress of the member changes. If the review identifies any changes in the member's progress and treatment needs, the goals, objectives, and strategies of the IPOC/Comprehensive ISP must be updated to reflect any changes in the member's progress and treatment needs as well as any newly-identified problems.

The IPOC is an essential documentation and planning tool to use during the interdisciplinary treatment team meetings. While the IPOC must be reviewed monthly during interdisciplinary treatment meetings, the minimum requirement to update the IPOC is at least every 90 calendar days or whenever there is a significant change in the member's treatment goals and objectives.

In Preferred OBOT settings where no single staff member functions as the designated care coordinator and care coordination activities are conducted by multiple members of the care team, the interdisciplinary treatment team meeting may be the only recurring opportunity for team members to come together to share information, and develop a care plan that truly incorporates and addresses the member's ongoing needs.

OTPs

OTPs must create and update an ISP that meets all criteria contained in the Department of Behavioral Health and Developmental Services Regulations for Licensing Providers (12VAC35-105-660 through 675).

Progress Notes

Progress notes must disclose the extent of services provided and corroborate the units billed. Claims not supported by corroborating progress notes may be subject to recovery of expenditures. Progress notes must be individualized and specific to the particular member's circumstances, treatment, and progress. Progress notes must be signed and dated according to dates services are provided by the professional staff who have prepared the notes.

Progress notes must convey the member's status, staff interventions, and as appropriate, the individual's progress or lack of progress toward goals and objectives as stated within the treatment plan. The progress notes must include, at a minimum:

- The name of the service rendered;
- The date and time of the service rendered;
- The setting in which the service was rendered,
- The signature and credentials of the person who rendered the service;
- Summary of progression or regression towards goals;
- Observations and orientations of the member's behaviors;
- Any notable changes in the members emotional, mental or behavioral status or affect, and;
- Any recommendations for additional services and or community supports.

The content of each progress note must corroborate the billings for each rendered service. Progress notes must be documented for each service that is billed. Daily progress notes do not require co-signature, but must be reviewed by the supervising staff. Progress notes must be completed within 24 hours following the delivery of services and promptly placed within the member's charts.

Discharge Planning

Discharge planning should take place throughout the member's treatment, should commence on admission to service, and continue throughout treatment. Discharge planning must be well documented within the member's behavioral health records. When a member is discharged from services, the provider must document the following in the member's records:

- Document the goals stated within the IPOC/Comprehensive ISP that describes members transition within treatment, and;
- Provide a summary of the services provided as well as referrals or follow-up recommendations.

Substance Use Care Coordination

Substance Use Care Coordination is an optional service available within Preferred OBOT and OTP settings. Preferred OBOTs or OTPs may bill for substance use care coordination if they meet all provider and documentation requirements. Provider may choose to utilize a different format than the IPOC; however, all required elements of the IPOC must be present. Separate documentation must be completed to support and document activities that meet billing requirements. The following information much be documented:

Development and monitoring of the individualized IPOC. The IPOC must be reviewed and updated as needed every 90 calendar days. These documents should reflect progress and or regression made toward specific, time limited and personalized goals and reflect the contributions and efforts made on behalf of the member by the interdisciplinary treatment team (including buprenorphine-waivered practitioners, Credentialed Addiction Treatment Professionals, allied health care professionals, and other relevant personnel involved in providing and coordinating the member's care). Providers must document activities to address all elements identified in the IPOC that is posted on the DMAS website at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/policy-and-provider-manual/ .

- Interdisciplinary care planning should consist of at least monthly meetings of the interdisciplinary treatment team (including all relevant medical and behavioral health care professionals involved in providing and coordinating the member's care). Updates to the IPOC is only necessary if changes to the member's treatment is determined.

The purpose of the interdisciplinary treatment team meeting includes:

- Review of the member's complete medical record (including urine drug screens and laboratory tests);
- Discussion of the current status of member's progress toward meeting their goals and objectives as specified in their plan of care;
- Particular attention should be paid to any barriers toward the member's progress in meeting their identified treatment goals as well as the actions which will be undertaken by the treatment team to address those barriers;
- Identification of any new problems and/or goals and modification of the IPOC action plan accordingly.
- A reassessment of the member's status utilizing the ASAM Criteria's Multidimensional Assessment process and determining if a change in the ASAM Level of Care is required.
- A progress note must be used to document the interdisciplinary meeting and outcomes and to document members treat and outcomes following scheduled member visits.

- Substance Use Care Coordination must include the appropriate use of and facilitation of referral to a variety of community based support modalities, including consideration of referral to 12-step and other self-help programs, peer recovery services, social service agencies, and other community based resources appropriate to the member's recovery. Referrals to community programs and services must be documented in progress notes and tracked. All efforts to help the member address any barriers to access of appropriate community based referrals such as transportation issues, must be documented as well.

- Substance Use Care Coordination also must include supporting the member's medical, behavioral health, and other health care needs through facilitation of necessary referrals to help meet the overall biopsychosocial needs to the member. This should include addressing needs beyond the member's medical status and include issues such as unstable housing, food insecurity, child care, transportation and other social determinants of health. Subsequent referrals must be documented and tracked along with efforts to assist and educate the member in addressing any barriers to completing the recommended referrals must be documented.

- All contacts with the member regarding the overall care plan should be documented, as well as efforts to educate the member regarding treatment planning, the importance of treatment plan adherence and timely reporting of all updates and concerns should be documented. Safety plans must be documented as well as alternative plans for coverage of critical services in the event of provider unplanned unavailability.

- Face-to-face Substance Use Care Coordination is encouraged and should be documented. If for some reason the member is unable to meet face-to-face and other forms of communication are conducted, such as telehealth or telephonic mode of delivery, this too must be documented. If the member continues to be unavailable for face-to-face Substance Use Care Coordination, the member should then be re-evaluated to see if the service is appropriate for the member currently within their treatment process.

Risk Management for Preferred OBOT and OTPs

Preferred OBOT and OTPs must include the following activities, which must be documented in each member's record:

- Random urine drug screens per the "Urine Drug Testing Guidance" section in this Supplement.
- Virginia Prescription Monitoring Program checked at least quarterly for all members.
- Opioid overdose prevention education including the prescribing of naloxone for all members.
- At least weekly visits by the buprenorphine-waivered practitioner or Credentialed Addiction Treatment Professional during the first three months when initiating treatment. Member must be seen at least weekly for at least three months with documented clinical stability before spacing out to a minimum of monthly visits with buprenorphine-waivered practitioner or Credentialed Addiction Treatment Professional. The IPOC must be updated to reflect these changes.
- Periodic monitoring of unused medication and opened medication wrapper counts when clinically indicated.

BILLING, PROCEDURE CODES AND REIMBURSEMENT

The licensed behavioral health provider providing the psychotherapy component for opioid treatment must be co-located at the same practice site as the buprenorphine waivered practitioner and providing psychotherapy at the same location where the buprenorphine waivered practitioner is prescribing buprenorphine or naltrexone to patients with opioid use disorder. This also applies for CSACs providing substance use disorder counseling or psychoeducational activities. Note the telehealth flexibilities indicated earlier in this Supplement. The licensed behavioral health provider in an OBOT or OTP setting, if billing independently from the buprenorphine waivered practitioner, must submit claims coinciding with the buprenorphine waivered practitioner to support member is receiving the required psychotherapy and substance use counseling services along with the practitioner services.

The ARTS specific procedure codes and reimbursement structure are documented online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/ .

PATIENT UTILIZATION AND SAFETY MANAGEMENT PROGRAM (PUMS)

All contracted Medicaid managed care plans including Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) are required to have a Patient Utilization & Safety Management Program (PUMS). Note: The FFS Contractor does not have the PUMS requirements. The PUMS program is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations.

The PUMS Program is a utilization control and case management program designed to promote patient safety and support proper medical management of essential health care. Upon the member's placement in the PUMS, the Contractor must refer members to appropriate services based upon the member's unique situation.

Placement into a PUMS Program

Members who are prescribed Buprenorphine containing products may be placed into a PUMS program for a period of twelve (12) months based on an independent review of medical needs by DMAS, or the MCOs. Once a member meets the PUMS placement requirements, the MCO may limit a member to a single primary care provider, pharmacy, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO must limit a member to providers that are credentialed within their network.

EXHIBITS

Appendix

Medication Assisted Treatment Provided Simultaneously and Approved to be Reimbursed Separately from other ASAM Levels of Care								
MAT Services	**Procedure Code**	**ASAM Level 2.1 and 2.5**	**ASAM Level 3.1 Group Home**	**ASAM Level 3.3 RTS**	**ASAM Level 3.5 RTS**	**ASAM Level 3.5 Inpt Psych Unit**	**ASAM Level 3.7 RTS**	**ASAM Level 3.7 Inpt Psych Unit**
Practitioner Induction **Day 1**	OBOT/OTP -H0014 Non OBOT/OTP = E&M Codes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Practitioner Visits **after Day 1** (OBOT/OTP and non-OBOT/OTP)	E&M Codes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Psychotherapy* for MAT	CPT Psychotherapy Codes	No, included in IOP/PHP rate	Yes	Yes	Yes	Yes	Yes	Yes
Medications	Prescription filled at Pharmacy or Dispensed on site = HCPCS Codes S0109/J0571/J0572 /J0573/J0574/J0575/J2315	Yes	Yes	Yes	Yes	No	Yes	No
Urine drug screens	80305 - 80307	Yes	Yes	Yes	Yes	No	Yes	No
Labs	CPT Codes	Yes	Yes	Yes	Yes	No	Yes	No
Care Coordination	G9012	No, included in IOP/PHP rate	Yes	No	No	No	No	No

*MAT psychotherapy must be provided through the provider of ASAM Level of Care 2.1 – 4.0 and requires a Credentialed Addiction Treatment Professional practicing within the scope of their license. This does not replace the minimum requirements for psychotherapy as required in RTS. Professionally qualified practitioners affiliated with RTS providers may bill additional psychotherapy as an ancillary service.

Appendix

Medication Assisted Treatment (MAT) – Outpatient Settings *Not OTP/OBOT Settings*		
Billing Code	**Service Name**	**Authorization Required**
99202-99205	Evaluation and management services new patient	No
99211-99215	Evaluation and management services established patient	No
82075	Alcohol Breathalyzer	No
80305-80307	Presumptive drug class screening, any drug class	No
G0480-G0483	Definitive drug classes	No
86592 86593 86780	RPR Test	No
86704 86803 86701 86702 86703	Hepatitis B and C / HIV Tests	No
81025	Pregnancy Test	No
86580	TB Test	No
93000 93005 93010	EKG	No
90832 – alone or GT (w/o E&M)	Psychotherapy, 30 minutes with patient and/or family member	No
90833 – alone or GT (w/ E&M)	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service	No

Appendix

Medication Assisted Treatment (MAT) – Outpatient Settings – non OTP/OBOT Settings continued		
Billing Code	**Service Name**	**Authorization Required**
90834 – alone or GT (w/o E&M)	Psychotherapy, 45 minutes with patient and/or family member	No
90836 – alone or GT (w/ E&M)	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service	No
90837 – alone or GT (w/o E&M)	Psychotherapy, 60 minutes with patient and/or family member	No
90838 – alone or GT (w/ E&M)	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service	No
90846 alone or GT	Family psychotherapy (without patient present)	No
90847 – alone, GT or HF if SA	Family psychotherapy (with patient present)	No
90853 – alone, GT or HF if SA	Group psychotherapy (other than multi-family)	No
90863 – alone, GT or HF if SA	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	No
Q3014 – GT	Telehealth originating site facility fee	No