Provider Update

March 30 Coronavirus (COVID-19) Update – Service Authorizations

Virginia Premier continues to be committed to the safety of you, our providers, patients and communities that we serve together. We want to support your heroic efforts to address the COVID-19 outbreak.

Since COVID-19 developments are occurring quickly, we're providing this update on Service Authorizations for Medicaid

Virginia Premier is waiving service authorization requirements on selected services in accordance with DMAS Requirements:

- Providers are required to submit for service authorization review any new request for services and requests for changes in services, such as an increase or decrease.
- Click here to see a full list of services for which service authorization is being extended or waived. Providers should check the DMAS list of waived authorization requirements. Any service on that code does not require an authorization through May 24, 2020. If you do not find your corresponding code on the list, you should visit the Prior Authorization List (PAL) per normal Utilization Management Process.
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    - DME Providers may deliver up to a two month supply (60-days) at a time during the response to the coronavirus (COVID-19) pandemic.*
    - DME Providers are instructed to bill in monthly increments with the anniversary date (30 days at a time).
    - Providers will be required to keep records of patient/caregiver contact to determine the appropriate need for supplies during each 60-day period, if it is determined a second 60-day supply period is needed.
    - Providers are also required to maintain the normal delivery ticket documentation and proof of delivery.

- To ensure that all authorizations have a minimum of a 60-day time span to allow for two months worth of delivery to the member at once. This does not apply to Behavioral Health services.
- Virginia Premier has already pulled all of the authorizations that would need a minimum of 60 days and extended the time span as applicable. providers should receive letters via mail with the new service dates
- If you do not receive a letter about a particular service, you should call the Utilization Management Department, who will extend the service authorization to ensure an

available 60 days
- If you have a question about a service authorization following the normal process, contact the Utilization Management team.

Face-to-Face Service Delivery Guidance for All DMAS-Covered Services:
In accordance with DMAS guidelines, Virginia Premier waiving the requirement for face-to-face requirements in most instances.

- All providers should limit the amount of face-to-face contacts with members. If a provider, member, caregiver, and or anyone in home or facility is experiencing symptoms of a medical illness, all face-to-face contact should be minimized or avoided.
- All face-to-face requirements including assessments, reassessments, and service delivery are waived for all members residing in the community; with the exception of instances when there is concern for the member's health safety and welfare. Face-to-face meetings should be replaced with phone calls with members and/or documentation from providers.
- Existing face-to-face requirements continue to apply in cases where there is a compelling concern for the member's health, safety and welfare based on the professional judgement of licensed staff.

Waiver Face-to-Face Requirements – CCC Plus Managed Care Program
For CCC Plus members in nursing facilities

- All face-to-face requirements including initial health risk assessments, reassessments (both scheduled and triggering), interdisciplinary care team meetings, and care planning meetings are waived.
- Face-to-face meetings should be replaced with phone calls with the member, family/authorized representatives, nursing facility staff and/or documentation, e.g., copy of most recent minimum data set or other available member records. Details on how the information was obtained in lieu of the face-to-face meeting must be documented within the member's record.
- **For CCC Plus members residing in the community**
- With the exception of instances when there is concern for the member's health, safety, and welfare, all face-to-face requirements including health risk assessments, reassessments (both scheduled and triggering), interdisciplinary care team meetings, and care planning meetings are waived.
- Face-to-face meetings should be replaced with phone calls with members and/or documentation from providers.
- Face-to-face requirements may be waived for all CCC Plus members residing in the community if the member's health, safety, and welfare is maintained by authorized services and information can be received by using an alternate method in lieu of the face-to-face meeting. Details on how

the information was obtained in lieu of the face-to-face meeting must be documented within the member's record.
- Existing face-to-face requirements continue to apply in cases where there is a compelling concern for the member's health, safety, and welfare based on the professional judgement of licensed staff.

Quality Management Reviews (QMRs)
- All QMR reviews will be desk audit only. All needed materials will be requested from the provider to conduct the review. Providers will be allowed flexibility in instances where they have limited staff to submit records.

Annual Level of Care Evaluations (LOCERI)
- All face-to-face requirements to conduct the annual level of care evaluations (LOCERI) are waived. This waiving of face-to-face requirement is for both past due and currently due level of care evaluations.
- For CCC Plus Waiver members who have had a face-to-face assessment, initial or reassessment, between October 1, 2019 and March 12, 2020, the information from this assessment may be used to submit LOCERI data in lieu of the face-to-face meeting to complete and submit the annual level of care evaluation.

Documentation
- Providers should document in their records the member's verbal consent, authorization, and confirmation of participation.
- The provider must obtain written signatures within 45-days after the end of the emergency.

Programs of All-Inclusive Care for the Elderly (PACE)

All PACE providers must follow infection control requirements per 42 CFR 460.74, including implementing infection control plans for each PACE site and for each participant's residence.
- PACE providers should monitor the CDC website and CMS Emergency Preparedness and Response Operations for the latest guidance and resources.
- PACE should follow CDC guidelines for preventing the spread of COVID-19 among participants and staff (https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html); however PACE sites are reminded that they are responsible for continuing to provide all required Medicare and Medicaid covered services including serving participants in their home as well as taking precautions to prevent the spread of COVID-19.
- Should there be instances where a PACE provider needs to implement strategies that do not fully comply with CMS PACE program requirements in order to provide services to participants, CMS will take those situations into consideration when conducting monitoring or oversight activities. All PACE sites must document the rationale for any change in procedures.
- PACE sites may use remote technology (telehealth options) as appropriate for participant assessments, care planning, monitoring, community and other activities that would normally be provided as a face to face service. CMS will provide PACE sites with notification when alternate

processes should be discontinued.

CCC Plus Waiver

Face-to-face visits:

- For CCC Plus Waiver members, face-to-face Agency RN and Services Facilitation (SF) visit requirements are waived with the exception of instances when there is concern for the member's health, safety, and welfare. This includes agency-directed RN supervisory visits and SF routine and reassessment visits.
- Face-to-face meetings should be replaced with phone calls or virtual communication – telehealth--with members and documentation by providers. **Visits to initiate services must be conducted face-to-face in order to ensure adequate service plan development**.

Documentation

- Required DMAS forms shall be used to document the interaction during these phone calls. Documentation of visits conducted through telehealth must meet the standards required for face-to-face visits**.**
- Providers must document in their records the member's verbal consent, authorization, and confirmation of participation. The provider shall obtain written signatures within 45 days after the end of the emergency.
- Providers should use existing procedure codes when billing for telehealth visits.

- **CCC Plus Waiver Service Authorization Extension**
  To ensure continuity of care for members, service authorizations for certain CCC Plus waiver services will be extended:
  - All personal care, respite, private duty nursing (PDN), and Personal Emergency Response Systems (PERS) service authorizations with end dates between March 12, 2020 and May 31, 2020 will be extended by two months.
- Providers may still submit service authorization requests during this time period. PDN providers should continue to be responsible for obtaining MD orders for services**.**

Developmental Disability Waivers

Face-to-face visits by Support Coordinators

- Requirements for face-to-face visits by support coordinators will be suspended until the end of the emergency. In the interim, it is expected that Support Coordinators will conduct telephonic check-ins and request the same updates as would be gained during a face-to-face visit regarding health, safety and satisfaction with services.
- For all of these "visits", providers shall document a reference to COVID-19 so that future auditors will be reminded of these allowances made during this time frame.
- **QMR visits**
  o QMR on-site visits will be suspended until the end of the emergency. In the interim, QMR

will conduct desk audits.

NCI survey visits

- NCI Survey visits have been suspended for the next 30 days and will be re-evaluated at that time.

Telehealth support: Telehealth is generally provided through electronic video chat that is HIPAA compliant; if video is not available, the SIS, VIDES, annual plan meetings, and case management visits may be completed telephonically during the emergency.

- DMAS and DBHDS support the completion of annual plan meetings, case management visits, the VIDES and the SIS via telehealth or telephone until the end of the emergency.
- Telehealth/telephonic support for **Therapeutic Consultation** will be accepted for those activities within Therapeutic Consultation that do not require direct intervention by the behaviorist.

Signatures:

- Support Coordinators, including those private entities contracted with a CSB, can certify that signatures normally required for consent, authorization, and confirmation of participation, were verified verbally by the case manager with written consent gained within 45 days after the end of the emergency.
- Documentation should include the name of the person who gave verbal consent, the date verbal consent was given, what was consented to, as well as alternatives to what was discussed.
- The services facilitator can certify that signatures normally required for agreement, consent, and authorization for consumer-directed services have been verified verbally by the service facilitator/case manager with written consent gained within 45 days after the end of the emergency.
- Documentation should include the name of the person who gave verbal consent, the date verbal consent was given, what was consented to, as well as alternatives to what was discussed.

Slots:

- No slots will be rescinded or lost during the emergency. DMAS will begin reviewing Retain Slot requests once the emergency has ceased and the normal reviews will be continued from the point in the individual's process prior to the emergency.

Service Authorization*:*

- Service Authorizations may be retroactively approved for up to 10 calendar days until the end of the emergency Service authorization will prioritize authorizations for In-home Supports, Personal Assistance, Companion, Group Day, and Crisis services to meet the need during the state of emergency.

Provider Update

Provider Operations*:*

- A provider cannot provide a service for which they do not have a license or provider participation agreement.
- As long as staff are deemed competent according to the DSP competency standards, and this is documented, training can be expedited.

Group Homes and Community Engagement/Day Support

Service Authorizations

- Service authorizations will be retroactively approved for up to 10 days until May 1, 2020. This will be re-evaluated at the end of April to determine if there is a continuing need.
- Service authorization will prioritize authorizations for in-home, personal care, companion, group day, and crisis services to meet the need during the state of emergency.

Electronic Visit Verification (EVV)

- EVV requirements remain in effect for agency and consumer directed personal care, respite, and companion services.
- In order to ensure prompt and proper payment for services provided to members during the emergency declaration, DMAS will continue paying claims regardless of the status of EVV data on the provider's claims until June 30, 2020. This applies to services provided through fee for service, Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 managed care plans.

Behavioral Health Services (Applicable across MCOs)

- DMAS will schedule a weekly call with provider associations, MCOs, DBHDS, and invited stakeholders during the emergency period to provide ongoing updates and receive feedback on system functioning.
- Provider qualifications, licensure requirements, and the structure of the services should 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, CSAC and CSAC-Supervisees must remain working under the direction of licensed providers authorized by the Board of Counseling.
- Provider Types allowed to bill for Medicaid services will remain the same regardless of the delivery method (face to face vs. telehealth). Providers would continue to use the current service and billing National Provider Identifier (NPI) numbers as they are now regardless of the mode of delivery of care and should proceed with efforts to include Place of Service (02) Codes to indicate telehealth delivery as these will be required at a future date.

For any services *without* specific guidance below:

- Face-to-face services should not be required, but documentation shall justify the rationale for the service through a different model of care.
- Providers should maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
- Current service authorization requirements remain the same.

Specific Service Considerations & Limitations

- Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health Skill-Building, Behavioral Therapy, Intensive Community Treatment and Psychosocial Rehabilitation.
- Service delivery may be provided outside of the school setting, office setting, or clinic setting for the next 60 days.
- Face-to-face services will not be required, but documentation should justify the rationale for the service through a different model of care.
- Providers should 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 should 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 should bill a maximum of one unit per member per day, regardless of the amount of time of the phone call(s).
- As the situation evolves regarding COVID-19, DMAS will re-evaluate the need for prior authorization of services.

Day Treatment/Partial Hospitalization Programs for Adults

- Face-to-face services will not be required for reimbursement of the services, but documentation shall justify the rationale for the service through a different model of care.
- Providers should maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.

Provider Update

- 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.

Psychiatric Inpatient Hospitalizations

- The requirement for prior authorization remains in place.
- Therapy, assessments, case management, team meetings, and treatment planning may occur via telehealth.

IACCT Assessment, Psychiatric Residential Treatment Facility, and Therapeutic Group Homes

- 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.

Psychiatric Inpatient and Residential Levels of Care

- For members in 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.

Addiction and Recovery Treatment Services (ARTS)

ASAM 2.1 and 2.5 Intensive Outpatient and Partial Hospitalization Programs

- Managed Care Organizations 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 will not be required, but documentation shall justify the rationale for the service through a different model of care.
- Providers should 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.

ASAM Levels 3.1 and Above

Provider Update

- Face-to-face services will not be required, but documentation shall justify the rationale for the service through a different model of care.
- Providers should 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 should 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.

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.

Recommendations for Reducing Transmission:

Please follow the guidance issued by the Department of Behavioral Health and Developmental Services (DBHDS), the Centers for Disease Control (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 back-up prescribers and behavioral health clinicians. DMAS recommends making 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 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 an OBOT or OTP member is unable to participate in counseling services due to COVID-19, DMAS will not penalize the OBOT or OTP provider for the missed services.

Provider Update

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. 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.

Face-to-Face Contact Requirements
Face-to-face contact requirements are waived for care coordinators, counselors, and peer recovery support specialists within 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 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 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.

Provider Update

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 (https://www.deadiversion.usdoj.gov/coronavirus.html).

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 should 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 "tele presenter" 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.

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 for questions highlighted at the beginning of this memo.

Eligibility and Certification Date Extensions for Virginia Premier's Medallion 4.0

Certification periods for SNAP, TANF and Childcare expiring in March, April and May 2020 will be extended for six months until September, October and November 2020.

For March renewals, cases already in renewal mode will not have the certification date extended. Workers must complete these. For cases in ongoing and change mode, the certification date will be

extended. For cases where renewals have already been processed, no action will be taken. Renewal packets for April and May will not be mailed to customers.

Eligibility and Enrollment

DMAS encourages uninsured patients to apply online (www.commonhelp.virginia.gov) as the fastest way to apply for care during an emergency.

Virginia Premier is monitoring the coronavirus (COVID-19) pandemic situation and will keep you apprised as additional information becomes available. Should you have any questions, please contact our Provider Relations team at (804) 968-1529 from 8 am to 6 pm, Monday through Friday.