



Frequently Asked Questions (FAQs) for NYS Opioid Treatment Programs (OTPs) Operating During the COVID-19 Emergency

For additional questions please email PICM@OASAS.NY.GOV and LEGAL@OASAS.NY.GOV

General billing:

Q1: Do the new COVID rate codes apply to both Medicaid Managed Care Plans and Medicaid Fee-For-Service?

A: Yes. For patients with Medicaid Fee-For-Service, the rate codes are active, and billing can begin immediately.

For Medicaid Managed Care Plans, the Plans were advised of the new rate codes on April 8, 2020 and asked to have them active within two weeks. Programs may want to reach out to their Plan partners to alert them that programs will begin billing the new rates as of a specified effective date, and retroactive to March 16, 2020. Regardless of any contract language, plans are required to pay these rates retroactive to March 16, 2020.

Q2: Do the COVID rate codes apply to FQHC OTPs that have opted out of billing APGs?

A: Yes. The COVID rate codes will also apply to FQHC OTPs that are billing APGs. These programs have received additional guidance. Questions may be sent to Trisha.Schell-Guy@oasas.ny.gov.

Q3: What is the effective date of the COVID rate codes? Are programs and plans required to go back and resubmit claims?

A: The effective date of the COVID rate codes is March 16, 2020. Plans will be required to reimburse for services delivered in accordance with this guidance as of that date. Programs are NOT required to go back and resubmit APG claims under the new rate codes, however in some cases it may be advantageous to the provider to do so. Each program will need to determine whether it is in their interest to resubmit claims.

Q4: If a program uses the new COVID rate codes, must they be applicable to every patient in the program?

A: No. The COVID rate codes were developed to facilitate the reduction in face-to-face visits during the COVID-19 pandemic while ensuring adequate reimbursement to support programs. The program must determine the best approach to billing for services for each patient, using either the APG rate codes or the COVID rate codes based on the services delivered to each patient, each week. A patient may be billed under the new rate codes during one week and then under APGs the next week (or vice versa) if the provider so wishes.

Q5: If the COVID rate codes are used for one patient, must the COVID rate codes always be used or can APGs also be billed for the same patient?

A: In different weeks, yes, however the COVID rate codes and APG rate codes may NOT be billed for the same patient in the same week.

COVID rates and APGs may be billed for the same patient over the course of several weeks. For example, over the course of one month, a program could bill APGs for a patient in week 1, bill COVID rate codes in weeks 2 and 3, and bill APGs again in week 4. Programs will need to determine which rate codes they will use to support the delivery of services. Be mindful that these new COVID rates have been developed to support guidance from OASAS and SAMHSA to reduce face-to-face visits as much as possible during the COVID-19 pandemic. Programs must weigh this public health crisis against patient safety and what is clinically required for each patient to determine how often the patient must visit the OTP.

Q6: Will providers be notified when DOH has the provider files updated?

A: The new rates codes are already effective and billable, with a start date of March 16, 2020.

Q7: Since all programs are struggling with revenue, and this is only a temporary change, why wouldn't the payors make these changes as opposed to programs incurring these programming costs?

A: The managed care plans will have to adapt. Minimal changes are required for the providers and billing vendors. Providers will need to use a different rate code and will need to code only a single procedure code for each claim. Apart from APGs, physician, and hospital inpatient (DRG) billing, this is standard billing practice in NYS Medicaid so billing vendors should already be familiar with this billing methodology.

Q8: When the COVID pandemic is over, will these rate codes continue to be effective?

A: No. These rate codes are effective only during the COVID pandemic.

Telepractice:

For additional Telehealth FAQ please visit the following website:

<https://oasas.ny.gov/system/files/documents/2020/04/telepractice-faqs.pdf>

Q9: Do we need to use POS 02 to indicate telehealth?

A: No. OASAS programs are advised to bill using the appropriate 95 or GT modifier consistent with the OASAS Telepractice guidance.

Q10: Can programs mix APG billing and COVID billing if we are also using Telepractice to deliver services to a patient?

A: Programs may bill using either the COVID rates or the APG rates (but not both for the same patient in the same week). OTPs have the ability to bill APG rates for services delivered via Telepractice provided they meet all other requirements for service delivery (length of visit, etc.). Programs must determine which rate codes are appropriate for each patient each week based on the services delivered.

Q11: Are the GT or 95-modifier optional at this time or is it something programs need on our claims?

A: Programs should update their systems to use the appropriate modifier when delivering services via Telepractice. See the OASAS Telepractice guidance for use of the appropriate modifier.

Q12: What is the minimum time for the Telepractice visits?

A: All applicable service delivery rules are applicable to services delivered via Telepractice based on the service. For example, peer support services may be delivered via Telepractice and are billed in 15-minute increments. Please see the APG Billing Manual and submit claims consistent with the requirements for each service.

Q13: Does telehealth need to be provided by a Counselor who is at the actual clinic or can these be performed from a Counselor's home?

A: Telehealth counseling services can be done remotely by a counselor who is either physically located at the OTP or at the counselor's home/off-site.

Q14: We have been using only phone tele practice. Are there any safe face-to-face sites we can use?

A: Providers should be utilizing HIPAA and 42 CFR compliant technologies, or other video conferencing solutions the client has agreed to, whenever able to do so.

However, it is noted that the Department of Health and Human Services' (HHS) Office of Civil Rights (OCR) has stated that it will not enforce HIPAA with telehealth during this emergency. Under this Notice, covered health care providers may use popular applications that allow for video chats to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency.

Also, HHS provided the list below of vendors that represent that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA Business Associates Agreement (BAA):

- Skype for Business
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me
- Google G Suite Hangouts Meet

However, while acknowledging this relaxing of enforcement, OASAS providers approved for Telepractice should make every effort to utilize HIPAA and 42 CFR compliant technologies.

Q15: Not all clinical services can be done through Telepractice. Large numbers of the population don't have cell phones with unlimited minutes. Or they have no cell phone at all. Or their living situation does not warrant any confidentiality / ability to participate in telehealth services. Any recommendations?

A: Some recommendations include:

1. Calling patients, if they have a cell phone, for a brief check in and touch base to see how they are doing,
2. In community services can be done for patients who are home bound, where both counseling and/or peer support services can be rendered (ensure maintenance of social distancing and wear facemasks to protect staff.)
3. In community services can be done with patients who are not home bound and receiving take home medication and unable to have services rendered in their home, by meeting in the community (ensure maintenance of social distancing and wear facemasks to protect staff.)



Using the COVID Rate Codes:

Q16: Can the COVID rate code be used for a patient if there are multiple dosing days in one week?

A: No. The COVID rate codes were developed to facilitate the reduction in face-to-face encounters. The expectation is that as much as practicable and clinically permitted, patients will be seen once every 28-days. The rates support at least the provision of a 7-day supply, if it is not appropriate to provide a 28-day supply. If a patient must be seen more than one time in a week, APG rates shall be billed for that patient.

Q17: If a program bills using APGs, may they bill for dispensation onsite and take homes?

A: The COVID rate codes were developed to facilitate the reduction in face-to-face encounters, where there is no more than one visit per week. If a patient requires multiple services during a one-week time period, the program shall bill using the APG rate codes.

Q18: If a patient has a 7-day pick-up and a telephonic connection in the same week, can the program bill for both services?

A: Programs may bill using either the COVID rates or the APG rates for each patient each week. Programs must determine the appropriate rate codes to use for each patient each week. Using the COVID rate codes, that scenario pays \$207.49.

Q19: For a patient receiving 14 days of take-home medication, the program could bill the 1st week with the new billing method for \$207.49 and the second week with the H0020 for \$35.28. The 3rd/4th weeks could repeat weeks 1 and 2?

A: Yes.

Billing for Buprenorphine in OTP Settings:

Q20: Are programs that were advised to use HCPCS code H0020 with a modifier U1 rather than the H0033 current coding for buprenorphine?

A: No. That was a mistake that will be corrected immediately. Programs should use HCPCS H0033. The guidance will be updated to reflect this correction.

Third Party Pick-up and Home Delivery:

Q21: There are no codes for reimbursement on third party pick up or home delivery. May these codes be used for those services?

A: Yes, these codes can be used for third party pick up or home delivery. There is an expectation that if the patient is not seen at the pick-up or delivery there will be a reach out during the delivery week to confirm the patient is complying with medication administration. A counselling or other service would also meet this “reach out” requirement.

Guest Dosing:

Q22: Is there guidance regarding guest dosing?

A: All OTPs must continue to provide guest dosing, to ensure that patients, no matter where they are in the state of NY, can access medication.

Q23: How long can a client who is guest dosing remain in our OTP during these times? I have North Carolina client who can't get to her home state. We are assessing her case weekly.

A: The client can remain in guest dosing as long as they are in New York. North Carolina and New York have similar guidance regarding guest dosing. As long as the client is in the state and needs guest dosing, they should be getting the treatment.

Q24: What about limiting travel of OTP patients - containing to NYC? Guest dosing? Transfers?

A: At this point, there are no required travel limitations of OTPs patients, all OTPs must make available guest dosing and transfers must continue during this crisis unless approved otherwise by the SOTA office.

Q25: Is there any barrier for a guest dosing OTP becoming a permanent transfer? For instance, they came for a visit but can't go back home and are staying?

A: There is no barrier.

Clinical:

Q26: Should administrative tapers be put on hold?

A: Yes, as per earlier OASAS guidance for OTPs, all administrative tapers should be put on hold at this time.

Q27: Is the expectation to not take any toxicology at all during all these weeks? What instances would they be deemed necessary?

A: Toxicology testing is at the discretion of the physician. Discussing and honoring patient self-report of substance use should be considered when evaluating a patient's use of substances. The concept is the program should not bring someone in for an in person visit unless there is a critical medical need. Also, if a person is already coming into the program for other critical services, you could collect the toxicology at that time.

Q28: If we have treatment plans due during the time that a patient has been given take homes, and they are not updated, will we get cited?

A: No, you will not get cited. You should include treatment planning, including any collaboration with the patient, in the progress note as part of general client record-keeping. Please note that additional guidance and/or waivers regarding treatment recovery planning is forthcoming.

Q29: For initial treatment plan patient signatures, what should we do?

A: Per 14 NYCRR Part 822, treatment recovery plans are not required to be signed by the patient.

Q30: In terms of treatment plan/recovery plan reviews: what is the guidance surrounding how to document that we've reviewed this with the team/client without all physically signing?

A: Additional guidance and/or waivers regarding treatment planning is forthcoming. Physical signatures on a treatment plan and treatment plan reviews are not required during the COVID disaster emergency.

Q31: What are ways to limit risk of COVID-19 for new intakes?

A: One possibility is to currently prioritize buprenorphine admissions and limit methadone admissions until the crisis is over. Someone started on buprenorphine who is not doing well could also be transitioned to methadone, which is pharmacologically much easier than the other way. Telehealth indication can be done safely and is supported by federal regulation with buprenorphine, while admission using methadone requires in-person attendance for at least the intake and for dose adjustments. When a methadone admission occurs, just as with patients that are coming to the clinic in general, ensure that the OTP is enforcing social distancing at the clinic. OTP staff should maintain the use of universal precautions and the program should adopt scheduled dosing to help with reducing transmission risk in the clinic setting.

Q32: Are nurse practitioners now allowed to function in the same capacity as a physician with regards to admission?

A: Currently, only OTPs that have received mid-level practitioner waiver approval from SAMHSA are permitted to have either designated Nurse Practitioner(s) or a Physician Assistant(s) do admission in place of a physician. We are encouraging all OTPs that do not have this approval to complete and submit a mid-level practitioner waiver to Sharon Davis at Sharon.davis@oasas.ny.gov for review. OASAS will notify OTP providers if this requirement changes.

Q33: Can the counselors do their portion of intakes for new admission on telehealth and then have patient go to clinic to see the medical provider only?

A: Yes. And when the medical provider sees the patient, they should maintain social distancing as much as possible, do only procedures that require direct or close contact that are medically necessary, use appropriate PPE, and document in the chart which procedures were deferred and why.

Q34: Will there be any change in the requirement to do initial evaluations face-to-face, especially since we are able to do buprenorphine initials via telehealth?

A: While for a patient admitted to an OTP and treated with buprenorphine, the entire evaluation can be done via telehealth, SAMHSA has clearly indicated that there will not be a federal waiver to do an entire methadone initial evaluation via telehealth.

Q35: Recent guidance states we should stop getting patient signatures for their doses. We have not heard any input from the DEA on this. Are we safe to forego patient signatures for doses at this time?

A: As there is already inconsistency across OTPs in NYS around this practice and it is not defined in DEA regulations nor in Medicaid requirements, OASAS is recommending that OTPs stop requiring patients to sign that they have received their medication when medicated and picking up their take home medication doses.

Q36: Could you define better the guidance to 14-day take home medication for people who are not stable in treatment?

A: The guidance actually specifically references up to 14-day take home medication doses for people who are LESS stable, rather than NOT stable. The decision to give take homes to less stable patients' needs to balance the risks associated with potential diversion and overdose, with those of possible transmission of the virus or becoming sick. This decision rests with the physician with the assistance of the treatment team in determining an individual's take home schedule.