Legislative Commission on Primary Care Workforce Issues

May 28, 2020 2:00-4:00pm at the NH Hospital Association – Zoom Conference

Call in information:

Join Zoom Meeting
https://nh-dhhs.zoom.us/j/92541786036?pwd=WEJ6dnNmWUwzMnZQazZWYzZZaVp4dz09

Meeting ID: 925 4178 6036
Password: 003155
One tap mobile
+13017158592,,92541786036#,,1#,003155# US (Germantown)
+13126266799,,92541786036#,,1#,003155# US (Chicago)

Dial by your location
+1 301 715 8592 US (Germantown)
+1 312 626 6799 US (Chicago)
+1 646 558 8656 US (New York)
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 669 900 9128 US (San Jose)
Meeting ID: 925 4178 6036
Password: 003155
Dial *6 to mute or unmute if you connect by phone

Agenda

2:00 - 2:30 **Welcome and Introductions/Covid-19 Updates**

2:30 - 3:00 **Status of Rural Health/Primary Care in New Hampshire** – Alisa Druzba, Office of Rural Health & Primary Care

3:00 - 3:50 **MAT Integration in Primary Care Practices: COVID Challenges** – Peter Mason, MD, Medical Director, IDN 1 and James G. Potter, CAE, Executive Vice President, New Hampshire Medical Society

3:50-4:00 **Legislative Update/Next Meeting/Adjourn**

Next meeting: Thursday June 25, 2:00-4:00pm

State of New Hampshire
COMMISSION ON PRIMARY CARE WORKFORCE ISSUES

DATE: May 28, 2020

TIME: 2:00 – 4:00pm

LOCATION: Zoom Conferencing

Meeting Notes

TO: **Members of the Commission and Guests**

FROM: Danielle Weiss

MEETING DATE: May 28, 2020

Members of the Commission:
Rep. Polly Campion, NH House of Representatives
Laurie Harding – Chair
Alisa Druzba, Administrator, Rural Health and Primary Care Section – Vice-Chair
Stephanie Pagliuca, Director, Bi-State Primary Care Association
Mary Bidgood-Wilson, APRN, NH Nurse Practitioner Association
Don Kolisch, MD, Geisel Medical School
Jeanne Ryer, NH Citizens Health Initiative
Mike Ferrara, Dean, UNH College of Health and Human Services
Trinidad Tellez, M.D., Office of Health Equity
Bill Gunn, NH Mental Health Coalition
Tyler Brannen, Dept. of Insurance
Pamela Dinapoli, NH Nurses Association
Dianne Castrucci, NH Alcohol and Drug Abuse Counselors Association
Guests:
Danielle Weiss, Health Professions Data Center Manager, Rural Health and Primary Care
Leslie Melby, NH Medicaid
Paula Minnehan, NH Hospital Association
Anne Marie Mercuri, QI Nurse, Maternal and Child Health Section
Barbara Mahar, New London Hospital
Geoff Vercauteren, Director of Workforce Development, CMC
Catrina Watson, NH Medical Society
James Potter, NH Medical Society
Peter Mason, Geisel School of Medicine, IDN region 1
Kristine Stoddard, Bi-State Primary Care Association

Meeting Discussion:

2:00 - 2:10 **Welcome and Introductions/COVID-19 Updates** – Laurie Harding – Chair

Legislative

- Polly Campion is serving on the Medical Crisis Standard of Care, State Disaster Medical Advisory Committee and began subcommittee on mental health/SUD
- Passed Heros Act for COVID relief but stalled in Senate

Telehealth

- Campion reports that reimbursement rates for telehealth will likely stay and not return to pre-COVID rates
- Health centers across state are reporting to Bi-State that no-show rate virtually eliminated with telehealth, ECHO (Jeanne) reports no no-shows with telehealth medication-assisted treatment (MAT)
- Unclear how outpatient offices will work with telehealth and learners (med students)
- Maternal and Child Health, DHHS soliciting telehealth and satisfaction data from agencies to advocate for permanence
- Challenging for health care up north due to poor connections and computer availability – Shaheen's office recommending just audio portion (telephone) for reimbursement

Classes

- No in-person classes for 1st and 2nd year students at Geisel (med school); 3rd year students are off the wards and stewardships primarily because of lack of PPE for learners
- Nursing students at UNH will be affected by lack of clinical hours, faculty shortages, testing centers closed and just reopened so now backlogged and not accepting new applicants until Sept, can work under temporary licenses but practices can't take them in

Workforce

- Uncertainty around how workforce will be affected by
  - Leave under FMLA
  - Furlough
  - Lack of PPE and fear of infection
  - Imbalance of priority measures by provider type – some receiving stipends while others (nurses) aren't
- Health Professions Data Center workforce surveys still in circulation for participating provider types
  - Instructed to answer as they would before any COVID-related changes occurred to report typical practice outside of a state of emergency
- Federal funding available to provide enhanced payment so Medicaid providers are fairly reimbursed
- HRSA is tracking data on telehealth in funded FQHCs – https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data/nh

Hospitals

- Many opening doors to get up to 50% capacity
- People reaching out for solely alcohol counseling when it was usually in combination with another disorder

2:30 - 3:00 **Status of Rural Health/Primary Care in New Hampshire** – Alisa Druzba, Office of Rural Health & Primary Care

Refer to PowerPoint presentation, "Status of Rural Health & Primary Care in NH."

3:00 - 3:50 **MAT Integration in Primary Care Practices: COVID Challenges** – Peter Mason, MD, Medical Director, IDN 1 and James G. Potter, CAE, Executive Vice President, New Hampshire Medical Society

Refer to PowerPoint presentation, "Emergency Regulations: COVID-19 & SUD."

3:50-4:00 **Legislative Update/Next Meeting/Adjourn**

- Extending Commission - Bill 567
  - Got through Senate – at this time cannot hold public hearings in House
    - In absence of bill, Commission sunsets in November
- Following Governor's declaration in mid-March, all legislative activity came to halt

    - 3/12 were the last meetings held in the House and Senate
- Emergency Order #12 – government agencies to meet remotely
    - House worked to hold committee meetings that don't require public input
    - There's a number of executive sessions to vote on bills that have already had public meetings
- According to NH constitution, legislature cannot vote remotely; will meet in person to extend deadlines
- Minority caucus has voted against a deadline extension
    - If extension doesn't happen, nothing, including the Commission bill, will move forward

Next meeting: Thursday June 25, 2:00-4:00pm

Update on Rural Health/Primary Care in New Hampshire

May 28, 2020

NH DIVISION OF
Public Health Services
Department of Health and Human Services

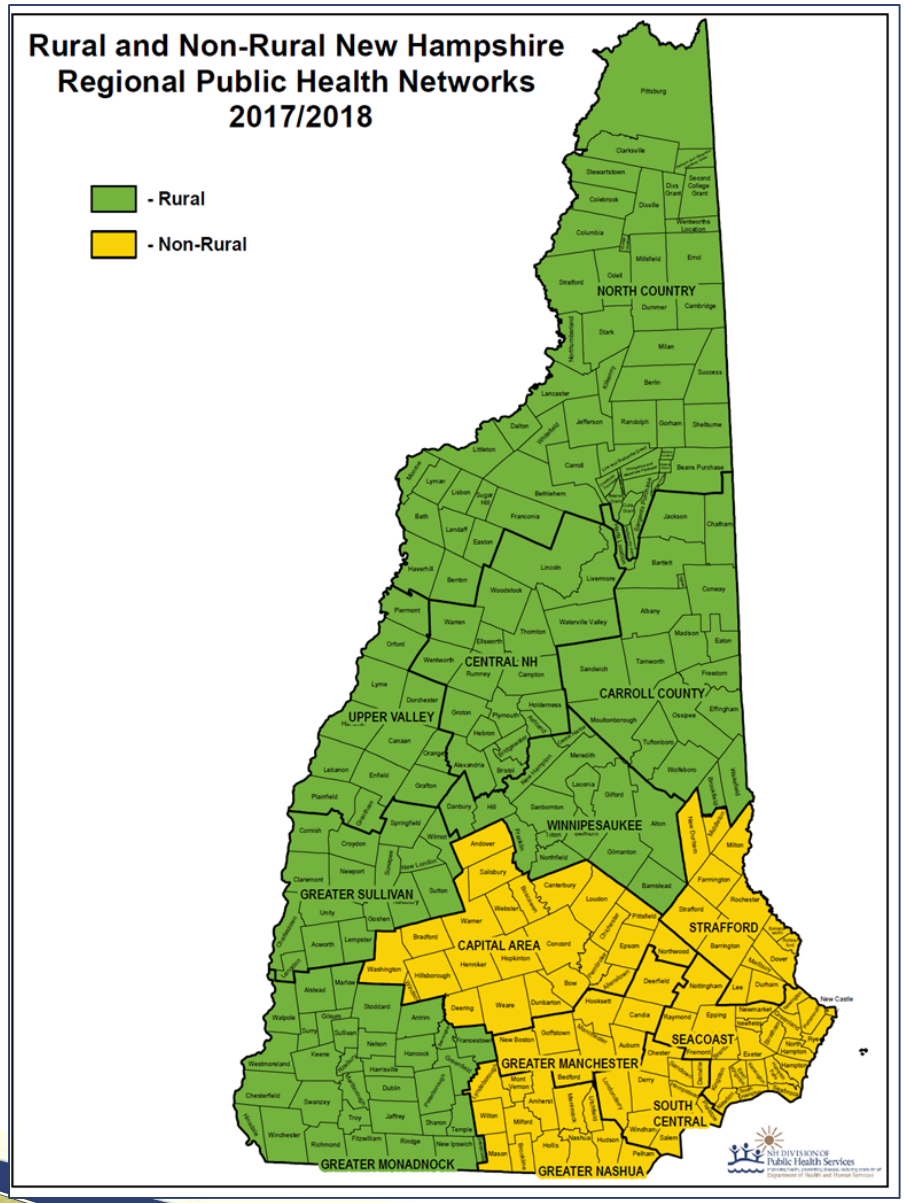
Today's Purpose

- What is rural?
- Brief overview of health outcomes in rural in NH
- RHPC areas of focus
- Two primary care projects

How we rank nationally

- In national rankings, New Hampshire often is in the top ten, in its healthcare delivery system as well as in population health and overall well-being.
- This is attributed to low unemployment, a more educated workforce, low poverty rate
- But this does not account for pockets of high uninsured rates in places such as the northern rural areas, particularly among young adults, and in the southern urban areas among Hispanics
- And the drug overdose rate has been steadily increasing and severely straining the health care system as a whole

DHHS Definition of Rural



Health in Rural NH

- Rural residents face geographic barriers to health care such as lack of transportation and increased travel time to health care providers and hospitals
- Significantly older, poorer, & less educated than non-rural residents
- Far more likely to be unemployed or out of the labor force, and rural workers are more likely to be self-employed or to work in industries where health insurance benefits are less available.
- Significantly less likely to be insured for health services, but more likely to be on Medicaid.
- Rural residents are also less likely to be insured for dental services.

Why is Rural Different?

Same Triple Aim goals as everywhere:

- Better care
- Better health
- Lower cost

But there are persistent rural priorities

- Access to services (includes how to finance)
- Community focus (IOM Report - Quality Through Collaboration: The Future of Rural Health)
- Innovative use of personnel and facilities

Funders & Responsibilities

- HRSA, Federal Office of Rural Health Policy
  - State Office of Rural Health – TA, funding, data, R&R
  - Medicare Rural Hospital Flexibility Program - CAHs
  - Small Rural Hospital Quality Improvement Program - >49 beds
- HRSA, Bureau of Health Workforce
  - Primary Care Office Grant – barriers to PC, shortage designations, NHSC/Nurse Corps, J1 waivers
- State General Funds
  - Health Professions Data Center
  - Complex data analysis for shortage designations
  - Recruitment Center contract
  - State Loan Repayment Program

Rural Health & Primary Care Section

Access

- Rural Health Clinic Technical Assistance Network
- Critical Access Hospitals (CAH) Technical Assistance
- Integrating local health care services including oral health and mental health care
- Statewide primary care needs assessment that identifies the key barriers to access health care for these communities
- Medicaid Waiver Delivery System Reform Incentive Program (DSRIP) – Workforce Taskforce

Quality Improvement

- Supporting effective clinical practices in Critical Access Hospitals by increasing staff capacity to engage in QI (IHI Expeditions, IHI Open School, certifications)
- Supporting reporting of Medicare Beneficiary QI Project (MBQIP) measures by federal timeline in Critical Access Hospitals
- Supporting Medicare Coding Bootcamp training for small rural hospitals

Sustainability

- Collecting and disseminating information to rural health stakeholders
- Federal and State Policy Information
- Coordinating rural health resources and activities statewide
- Participating in strengthening State, local and Federal partnerships
- Technical assistance for applying for federal funding
- Financial improvement support for Critical Access Hospitals
- Operational improvement support for Critical Access Hospitals

Workforce

- Health Professional Shortage Area Designations
- State Loan Repayment Program
- Technical assistance for National Health Service Corps (NHSC) & J1 Visa Waiver Programs
- Regular communication with the Area Health Education Centers
- Vice Chair - Legislative Commission on Primary Care Workforce Issues
- Contract with the NH Recruitment Center for recruitment & retention initiatives with rural safety net providers
- NH Health Professions Data Center – provider capacity survey and analysis

Quality Improvement Example

Hospital Compare Data	NH CAH Range	NH CAH Median	State	National
Overall Star Rating	3-4	3.5 Mean		
Heart Attack Care				
Median time (minutes) before outpatients with chest pain or possible heart attack got an ECG	2-17	8	9	7
Emergency Department Care				
Median time (minutes) patients spent in the emergency department before leaving from the visit	84-149	115	144	121
Median time (minutes) patients spent in the emergency department, before they were admitted to the hospital as an inpatient	182-409	285	300	280
Median time (minutes) patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room	34-116	66	120	102
Median time (minutes) patients spent in the emergency department before they were seen by a healthcare professional	14-60	20	25	20
Preventive Care (10/1/17-3/31/2018)				
Healthcare workers given influenza vaccination (percentage)	84-100	91	94	89
Survey of Patients' Experiences				
Patient Experience Stars (number of stars)	3-4	3.8 Mean		
Patients who reported, yes, they would definitely recommend the hospital (percentage)	49-81	76	73	72

Sustainability Example

- **Claims Denials Analytics Project (CDAP)**

- 11 Hospital Denied Claims Balance on a quarterly basis
  - End of first quarter, March 31 2019 Balance = $12.34 million
  - End of second quarter, June 30 2019 Balance = $9.39 million
- 11 Hospital Denied Claims as a percent of Revenue (average rate for all 11 hospitals)
  - End of first quarter, March 31,2019 = 9.58%
  - End of second quarter, June 30, 2019 = 8.50%
- Claims Denied due to untimely filing for the 10 direct participants (these are claims that are 100% lost due to the expiration of a timely filing date imposed by the payor)
  - January 31, 2019 = $2,384,419
  - March 30, 2019 = $376,873
  - June 31, 2019 = $328,014
- Overall, there has been an improvement in denial rates (11.27%) and the decline in the tally of untimely claims (lost revenue) by $2,056,405.

NESCO Primary Care Learning Community

- The New England States Consortium Systems Organization (NESCSO) is a non-profit organization governed by the New England State Health and Human Services agencies and the University of Massachusetts Medical School.
- NESCSO Multi-State Primary Care Investment Report project
- Core methodology - NESCSO Learning Community, Milbank report
  - Refine list of provider taxonomy codes and CPT/HCPCS codes
  - Learnings from other primary care studies (OR, WA, ME, CO, VT)
- Understanding data types and data availability
  - Administer survey to participating states
  - Work through data questions, data differences with the states
- Develop report specifications
- States produce summary reporting
- Onpoint analyzes and summarize results
- Quality review results and work with states to revise reporting, if needed
- Draft written report, including framework for ongoing and future analyses

Primary Care Collaborative (PCC) and The Green Center

- Founded in 2006, Primary Care Collaborative (PCC), formerly known as Patient-Centered Primary Care Collaborative, is a nonprofit multi-stakeholder membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. Representing a broad group of public and private organizations, PCC's mission is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support growth of high-performing primary care and achieve the "Quadruple Aim": better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care.
- The Larry A. Green Center for the Advancement of Primary Health Care for the Public Good is a thought collective founded by Rebecca Etz, PhD at Virginia Commonwealth University and Kurt Stange, MD PhD at Case Western Reserve University. The Green Center works to reclaim and reconstitute the intellectual foundations of primary care, to advance the science of medicine learned and practiced within layered and competing social frameworks of meaning, and to deliver on a now 50 year old promise: better health and improved health care through a synergistic focus on both humanism and healing. We are nimble, inquisitive, curious, and open. We make personal doctoring and innovation visible.

COVID-19 Weekly Primary Care Survey

- Patients are being seen in primary care when new symptoms arise, but known (e.g., chronic) and preventive health concerns continue to be delayed or postponed, leading to potential population health burden. • 81% of practices have limited wellness and chronic care visits; 70% report patients delaying these visits • Evaluation of new symptoms and acute injuries is happening as usual in nearly half of practices • 1/4 of clinician report NO routine adult vaccinations or cancer screenings taking place • Among chronic and preventive health concerns, clinicians are prioritizing follow up for: lung disease, hypertension, diabetes (30%); screening for PTSD, depression, anxiety (40%); and social health factors such as food, housing and work (35%). • Least assessed are cancer screenings (5%), adult vaccinations (10%), monitoring of cancer survivors (12%), childhood immunizations (14%), and screening for violence or neglect (25%).
- Primary care continues to require a financial lifeline, desiring “payment of any kind at this point” (53%) • Over 80% indicate payment based on volume, extensive documentation, and measure-driven incentive programs were not favorable to practice resilience during the pandemic • 50% of clinicians felt predictable payments in exchange for transparent reporting on a small essential set of meaningful measures was key to current and future primary care practice sustainability • Another 37% favored payment options that were majority prospective, capitated, and risk adjusted • 60% continue to see significant decrease in patient volume • 18% had digital health billing denied; 4% were denied SBA/PPP loans; 5% had state-based cuts to Medicaid

Survey Results Continued

- Harmful “new normal” for primary care continues; 55% fear we are unprepared for the next wave of the pandemic • 76% practices under severe or near severe stress • 51% continue to have no or severely limited access to testing; 59% continue to have no PPE • 84% have patients who struggle with digital health platforms; 20% experience significant obstacles to adoption
- The touted rapid shift to telehealth is also revealed in this week’s survey. For the past two months, survey data have shown that video visits were still slow to happen at many primary care practices, and (often unreimbursed) telephone visits were more common. But for the second week in a row, more clinicians (29%) reported using video for the majority of their visits as compared to telephone (25%).
- Yet challenges to telehealth remain. Eighty-four percent of surveyed clinicians report “patients who struggle with virtual health (internet or computer trouble)” as a stress on their practice. And 18% point to denied billing for virtual/telehealth as a stress. Only 57% of respondents say that half or more of the care they provide is reimbursable.
- https://www.pcpcc.org/
- Executive Summary with comments

https://www.pcpcc.org/sites/default/files/news_files/C19%20Series%2010%20National%20Executive%20Summary%20with%20comments.pdf

Contact

Division of Public Health Services

Rural Health & Primary Care Section

29 Hazen Drive

Concord, NH 03301

603-271-5934 or 1-800-852-3345 Ext 5934

alisa.druzba@dhhs.nh.gov

https://www.dhhs.nh.gov/dphs/bchs/rhpc/index.htm

Emergency Regulations:

COVID 19 & SUD

PETER MASON, MD

JAMES POTTER

Objectives

1. Review changes in care of patients with Substance Use Disorder with the advent of COVID-19
2. Recognize the Government Regulations that allow for changes
3. Evaluate risk and benefit to shifting to use of telehealth in the Addiction Medicine space
4. Lessons learned during COVID-19 that can influence the health of a vulnerable population

State of NH Telemedicine and SUD

Prohibition of prescription for a scheduled medication without an in-person face to face meeting based on Ryan Haight Act

HB1623/SB647: Seeking to increase access to MOUD/MAT using telemedicine without a face to face first visit IF patient is physically located in a specific site

- Doorways, Hospital/Clinic, Prison/Jail, CMHC
- Veteran's Affairs affiliated office

Monitoring via technology

Medicaid Coverage of services via telemedicine

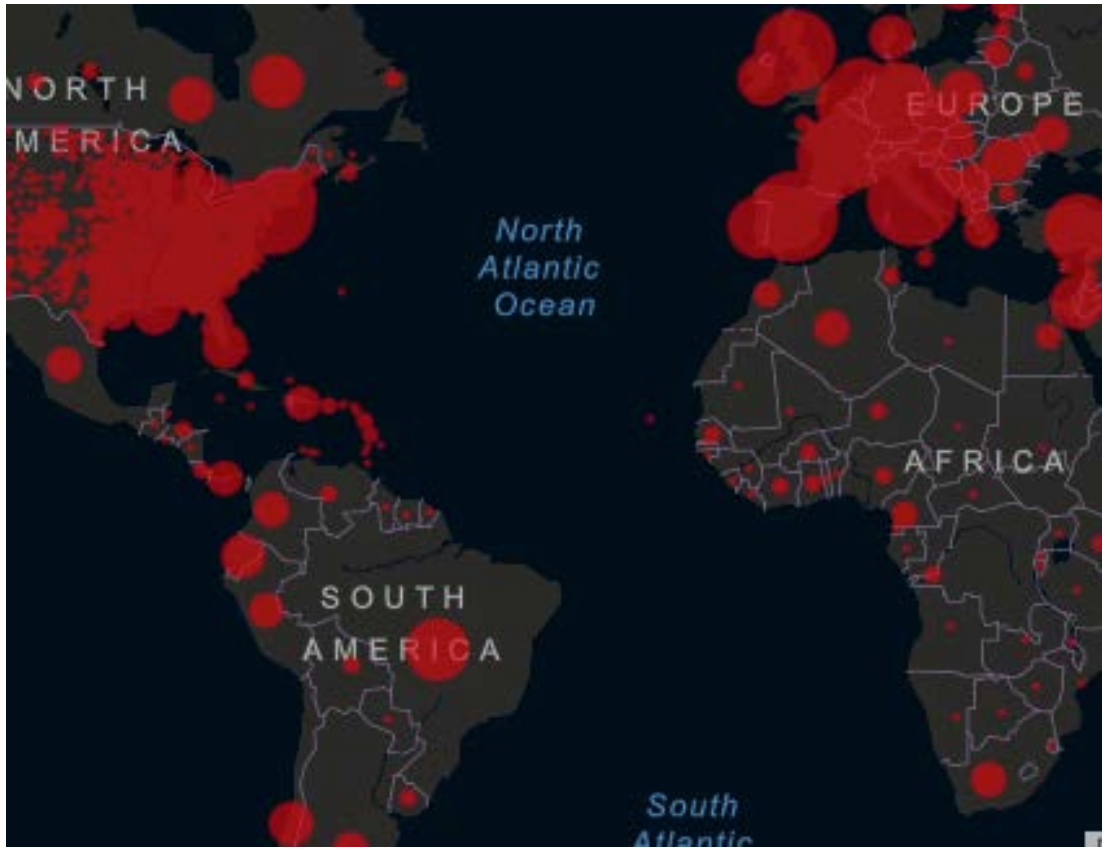
Temporary and Emergency Basis

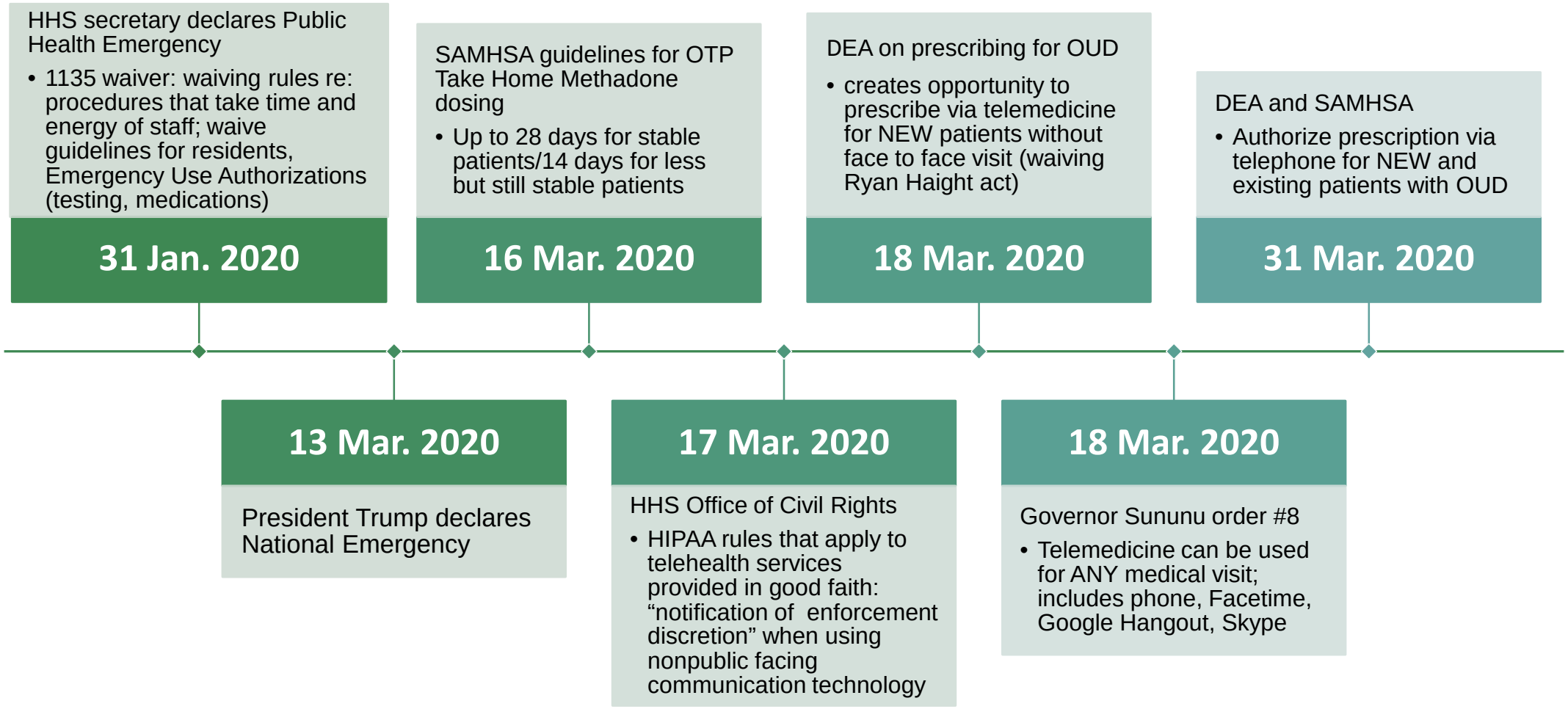
To keep people Healthy and contain COVID-19 community spread

<u>Stakeholders</u>

Federal Health and Human Services

- **Office of Civil Rights**
- **SAMHSA**
- **DEA**
- **Centers for Medicare and Medicaid Services**
- **Governor's Executive Orders & DHHS**
- **ASAM, NHMS & Other State Organizations**





Timeline of COVID 19 Regulations

SAMHSA
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

3/16/2020 (Updated 3/19/2020)

Opioid Treatment Program (OTP) Guidance

SAMHSA recognizes the evolving issues surrounding COVID-19 and the emerging needs OTPs continue to face.

SAMHSA affirms its commitment to supporting OTPs in any way possible during this time. As such, we are expanding our previous guidance to provide increased flexibility.

FOR ALL STATES

The state may request blanket exceptions for all stable patients in an OTP to receive 28 days of Take-Home doses of the patient's medication for opioid use disorder.

The state may request up to 14 days of Take-Home medication for those patients who are less stable but who the OTP believes can safely handle this level of Take-Home medication.

Office of Civil Rights: HIPAA

Discretion in enforcement of HIPAA rules during the national declaration of a state of emergency related to COVID-19 in order to allow or expanded use of telehealth.

SAMHSA: 42 CFR Part 2

Identifying information from a part 2 program can be disclosed to another provider without prior consent if deemed a medical emergency. Then redisclosure can be performed in setting of emergency. Must document incident and be a bona fide emergency.

Governor's Order #8: Telehealth

March 18,2020

Expands the coverage of telehealth: Commercial insurance, Medicaid including MCOs

MD/DO PA; APRN; CRNA; MDW; MLADC; Psychologists SW; MFT; CRSW; DMD; CMHCs; Dieticians

Originating Sites: NO Restrictions may include a private residence.

Reimbursement Parity: Modifier GT Place of service: POS 02: Telehealth

Document as if the service was delivered face-to-face

HIPPA Compliant, Audio Only, FaceTime, FB Messenger Video Chat, Google Hangouts, Skype

DO NOT USE: FB Live, Twitch, TikTok, similar public facing video apps

OPLC Telehealth Guidance (3/18/20):
Executive Order #8 overrides possible state law conflicts

DEA: Guidance and Responsibility

Telemedicine Rules

- Must be for a legitimate medical purpose
- By an appropriately licensed prescriber acting in the usual course of their professional practice
- Practitioner has sufficient information to conclude that the issuance of the medication is for a bona fide medical purpose
- Practitioner must comply with applicable State law

Ensure that supply of controlled substances is adequate

Reciprocity of DEA (no additional DEA required in other state) if license reciprocity (1/31/2020)

DEA/SAMHSA Buprenorphine Prescribing Guidance

Prescribing with initial-evaluation (new OUD patient):

- audio-visual, two-way, real-time, two-way interactive telehealth system, or
- audio-only telephone (provided adequate evaluation can be accomplished)
- in-person still required for methadone

Prescribing with ongoing evaluation (existing OUD patient):

- Either audio-visual telehealth system or audio-only telephone

As a Schedule III controlled substance, a qualified practitioner may submit a buprenorphine prescription electronically, via fax, photo image via email or by telephone during the emergency period.

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	

G2086	Off base opioid tx 70min
G2087	Off base opioid tx, 60 m
G2088	Off base opioid tx, add30

FACT SHEET: SUD Services

New Hampshire Standard Medicaid Substance Use Disorder Services

New Hampshire Department of Health and Human Services

Service Type	Code Information	Unit	Rate
Screening and Assessment			
Screening, by behavioral health practitioners	H0049	Each	$67.03
Assessment	H0001	Each	$164.83
Screening, Brief Intervention, Referral to Treatment (SBIRT)	99408	15 – 30 minutes	$38.49
SBIRT	99409	Over 30 minutes	$73.86
Withdrawal Management			
Ambulatory Withdrawal Management (ASAM Level 1-WM)	H0014	Per visit	$113.34
Medically Monitored Residential Withdrawal Management (ASAM Level 3.7-WM)	H0010:	Per day	$350.87
Medically Managed Inpatient Hospital Withdrawal Management (ASAM Level 4-WM)	DRG Codes 894 - 897	n/a	n/a
Medication Assisted Treatment			
Opioid Treatment Program, Methadone	H0020	Per visit	$10.54
Opioid Treatment Program, Buprenorphine	H0033	Per visit	$10.54
Medication Assisted Treatment (MAT), New patient office or other outpatient visit, typically 20 minutes	99201-HF	Per visit	$45.80
Medication Assisted Treatment (MAT), New patient office or other outpatient visit, typically 20 minutes	99202-HF	Per visit	$78.51
Medication Assisted Treatment (MAT), New patient office or other outpatient visit, typically 30 minutes	99203-HF	Per visit	$113.67
Medication Assisted Treatment (MAT), New patient office or other outpatient visit, typically 45 minutes	99204-HF	Per visit	$174.04
Medication Assisted Treatment (MAT), New patient office or other outpatient visit, typically 60 minutes	99205-HF	Per visit	$216.62

Available at: https://www.dhhs.nh.gov/ombp/sud/documents/sud-billable-services.pdf

Telemedicine Resources

NHMS COVID-19 Private Carrier Telehealth Coding Guide

New Hampshire MEDICAL SOCIETY
ADVOCATING FOR PHYSICIANS & PUBLIC HEALTH SINCE 1791

New Hampshire Private Carrier Telehealth Coding Guide

Anthem BC/BS			
Procedure	**Code**	**Modifier**	**Place of Service**
E/M Telehealth (new patient)	99201 (10 min) 99202 (20 min) 99203 (30 min) 99204 (45 min) 99205 (60 min)	95 - Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system GT - Via interactive audio and video telecommunications system	POS 02 - to indicate when telehealth services have been rendered for professional claims.
E/M Telehealth (established patient)	99212 (10 min) 99213 (15 min) 99214 (25 min) 99215 (40 min)	95 - Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system GT - Via interactive audio and video telecommunications system	POS 02 - to indicate when telehealth services have been rendered for professional claims.
E/M Telephone visit (new & established patient)	Use face-to-face E/M code (new or established patient)	95 - Synchronous telemedicine service rendered via a real-time interactive audio	POS 02 - to indicate when telehealth services have been rendered for

NHMS COVID-19 Telehealth Reimbursement Guide

NHMS Telehealth Vendor Options Guide

doxy.me | https://doxy.me/

- **Has free options**
- Functionality/Options:
  - No download required – works in most popular browsers
  - Live chat
  - HD audio visit
  - HD video visit
  - Virtual waiting room
  - Meeting history
- Other Notes:
  - HIPAA-compliant
  - Business associate agreement included
- Pricing: View differences in pricing options
  - Professional: $35/month
  - Clinic: $50/month/physician

Best Practices
Established SUD Patient: Telehealth

- Where is patient in treatment?
- Determine risk of patient coming to office - Implement virtual visit
- Forgo urine testing, consider oral fluid testing (OFT) options
- Check PDMP
- Extend prescriptions if appropriate
- Ensure medication safety & Consider refills
- Assign staff or self to check in with patients
- Discuss counseling opportunities, but do not require counseling “to get medication”
- Encourage mutual help - Many virtual platforms and opportunities
- **Co-prescribe naloxone**

*

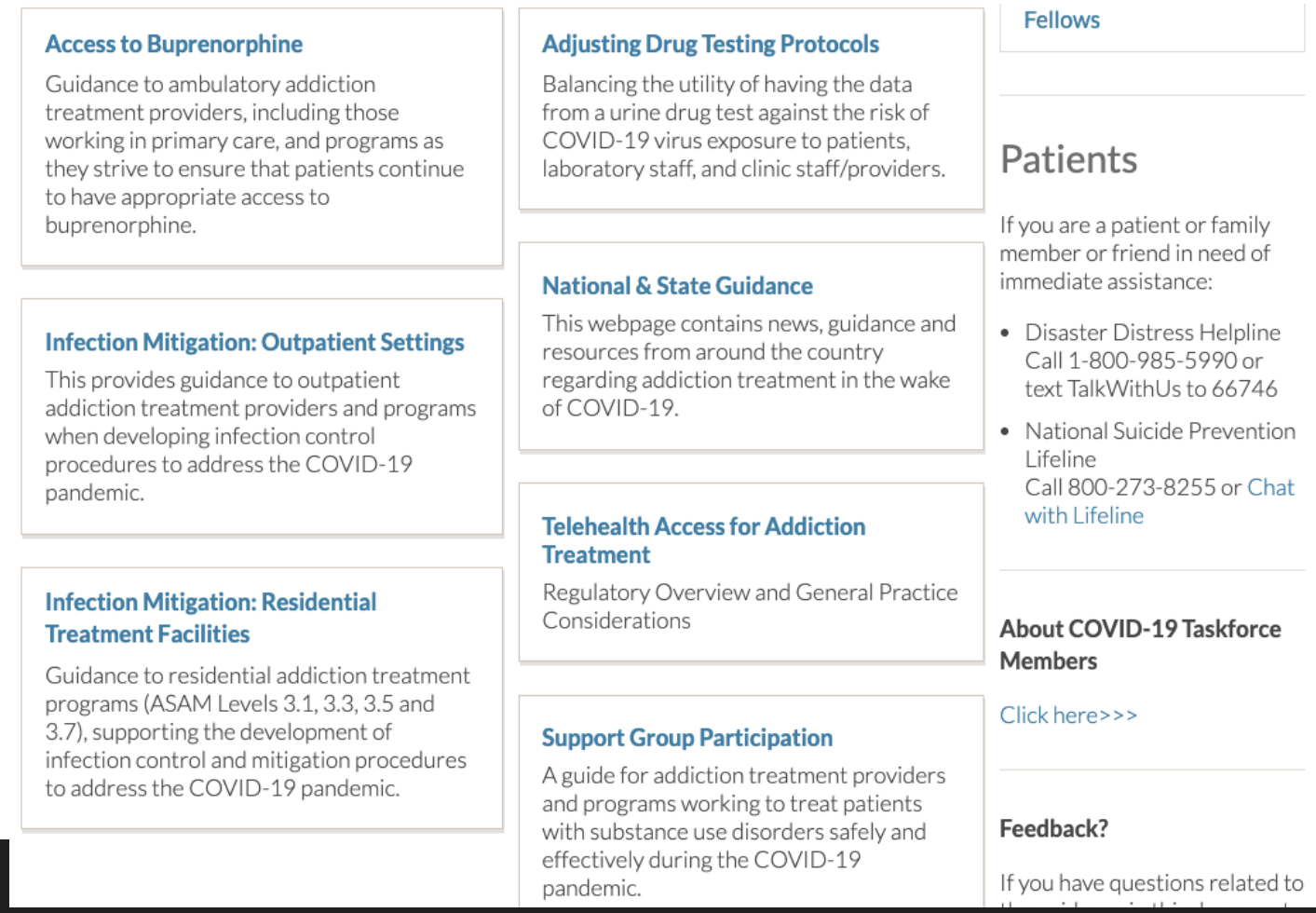
Best Practices
New SUD Patients: Telehealth

- DEA and SAMHSA allowing initiating patients without face to face visit

  Telemedicine or Telephone visit
- Review history, determine diagnosis and discuss treatment, follow up, confidentiality, expectations based on usual practice
- Consider sending Oral Fluid Testing (OFT) for patient to perform;
- Initiate home induction plan
- Involve staff as usual (case manager; counseling ~ virtual)
- Encourage mutual help
- Co-prescribe naloxone

ASAM Guidance

https://www.asam.org/Quality-Science/covid-19-coronavirus



Access to Buprenorphine

Guidance to ambulatory addiction treatment providers, including those working in primary care, and programs as they strive to ensure that patients continue to have appropriate access to buprenorphine.

Infection Mitigation: Outpatient Settings

This provides guidance to outpatient addiction treatment providers and programs when developing infection control procedures to address the COVID-19 pandemic.

Infection Mitigation: Residential Treatment Facilities

Guidance to residential addiction treatment programs (ASAM Levels 3.1, 3.3, 3.5 and 3.7), supporting the development of infection control and mitigation procedures to address the COVID-19 pandemic.

Adjusting Drug Testing Protocols

Balancing the utility of having the data from a urine drug test against the risk of COVID-19 virus exposure to patients, laboratory staff, and clinic staff/providers.

National & State Guidance

This webpage contains news, guidance and resources from around the country regarding addiction treatment in the wake of COVID-19.

Telehealth Access for Addiction Treatment

Regulatory Overview and General Practice Considerations

Support Group Participation

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

Fellows

Patients

If you are a patient or family member or friend in need of immediate assistance:

- Disaster Distress Helpline
  Call 1-800-985-5990 or text TalkWithUs to 66746
- National Suicide Prevention Lifeline
  Call 800-273-8255 or Chat with Lifeline

About COVID-19 Taskforce Members

Click here>>>

Feedback?

If you have questions related to

Lessons Learned

Policy Issues, Disputes & More Information

Please contact:

Jim Potter
Executive Vice President
New Hampshire
MEDICAL SOCIETY

7 North State Street
Concord, NH 03301
james.potter@nhms.org
(o) 603-224-1909
(m) 202-520-5809