

New York State Guidance for Accessing Buprenorphine through Telemedicine

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Those with questions relating to this document and/or the provision of buprenorphine can direct questions to buprenorphine@health.ny.gov. New York State encourages providers to start prescribing buprenorphine and, if already prescribing, to increase the number of patients under care. It is critical to initiate and retain patients with OUD in routine care.

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Purpose of this document:

The purpose of this document is to provide guidance from the New York State Department of Health (DOH) to inform both waived and non-waived medical providers on how to use telemedicine for buprenorphine provision, *where the patient presents at a setting that does not have waived providers*. This document has been reviewed by the Office of Addiction Services and Supports (OASAS) and New York State Office of Mental Health (OMH) to ensure consistency with current regulations in certified OASAS or licensed OMH programs. The guidance outlines the importance of collaborating with community-based providers for ongoing support throughout an individual's continuum of care. Telemedicine services for the provision of buprenorphine aim to ensure that individuals with opioid use disorder (OUD) presenting in different clinical and non-clinical settings have timely access to this medication.

The unprecedented disruption to our healthcare system caused by the Coronavirus Disease 2019 (COVID-19) pandemic has brought the need for enhancing telemedicine options across all systems into even sharper focus. In addition, telemedicine may be a practical and life-saving option for provision of buprenorphine, particularly in rural areas and/or areas of the state that have shortages of Drug Addiction Treatment Act of 2000 (DATA)- waived practitioners authorized to provide buprenorphine.

For the purposes of this document, “**originating provider**” refers to the healthcare practitioner who is in the same physical location as the patient at the time buprenorphine is initiated and does not have the capacity to prescribe buprenorphine for their patient. If the originating provider is a hospital, correctional health facility or emergency department, the originating provider will need to plan for continuity of care post discharge. “**Distant provider**” refers to the healthcare provider who is providing treatment and prescribing through telemedicine. “**Receiving provider**” refers to the local or community ambulatory healthcare provider who provides ongoing care to the patient when the originating provider was an acute or temporary setting.

Federal Regulation Adjustments Due to COVID 19

As a result of the COVID-19 pandemic, the US Drug Enforcement Administration (DEA) exercised its authority to provide flexibility in the prescribing and dispensing of controlled substances to ensure necessary patient therapies remain accessible. As part of this effort, DEA partnered with the US Substance Abuse and Mental Health Services Administration (SAMHSA) to ensure authorized practitioners may admit and treat new patients with OUD during the [public health emergency](#). The DEA developed a [decision tree](#) which summarizes the policies for quick reference and reflects the notable changes that relate to telemedicine, such as:

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- Practitioners may prescribe controlled substances to patients using telemedicine without first conducting an in-person evaluation during this public health emergency under 21 U.S.C. 802(54)(D).
- Prescribe buprenorphine to new and existing patients with OUD via telephone by otherwise authorized practitioners without requiring such practitioners to first conduct an examination of the patient in person or via telemedicine.

Telemedicine Regulations to Prescribe Buprenorphine

The “practice of telemedicine” is defined in the **federal law at 21 U.S.C. 802(54) and allows for the prescribing of buprenorphine via telemedicine.** Both the United States Department of Health and Human Services (HHS) and the DEA released public statements in 2018 on the use of telemedicine for providing buprenorphine to certain patients under certain conditions. For more information, go to [Telemedicine and Prescribing Buprenorphine for the Treatment of Opioid Use Disorder](#) or [Use of Telemedicine While Providing Medication Assisted Treatment \(MAT\)](#).

There are no federal regulations that limit use of telemedicine to any clinical specialties or areas of practice. Federal regulations that permit buprenorphine by telemedicine for Medication Assisted (formerly for Addiction) Treatment¹ (MAT) also apply to OMH-licensed Article 31 and OASAS-certified Article 32 programs, as well private offices. The originating and distant providers can be in the same or different fields of medicine.

In order for the in-person medical evaluation requirement to be met while provided via telemedicine, the following criteria must be met:

- A.) Prior to initiating buprenorphine, a provider (originating or distant) must conduct a medical evaluation of the patient. **Due to the temporary change in federal regulations due to the COVID public health emergency, medical evaluations may be conducted via telehealth and telephonic screening during the emergency.**
- B.) The practitioner doing the prescribing via telemedicine (distant provider) must be licensed to practice in the state where the patient is physically located.
- C.) The distant provider must be DEA-registered in the patient’s state and their own state.
- D.) The distant provider must have a valid DATA- waiver.
- E.) The distant provider must not have exceeded the patient limit.

The distant provider is exempt from being physically present with the patient for the medical evaluation when initiating buprenorphine via telemedicine if the physical medical evaluation is conducted by the originating provider or another healthcare provider at the originating site. Once initiated, buprenorphine can be continued solely by the distant or receiving provider, given that they meet the stated requirements.

In addition, [New York State Public Health Law \(NYS PHL\) 2805 - U](#) requires that the distant provider be credentialed and privileged by the facility when treating patients in an Article 28 facility. The originating hospital may enter into an agreement with a distant site hospital to

¹ Also know as Medication for Opioid Use Disorder (MOUD)

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grant privileges, relying on the privileging process of the distant site hospital for the purposes of providing services via telemedicine.

When offering MAT treatment for OUD, OMH-licensed Article 31 clinics should comply with both the Federal law at 21 U.S.C. 802(54) mentioned above and current NYS regulations that approve the use of telepsychiatry in certain OMH-licensed programs, [Title 14 NYCRR Part 596 – Telepsychiatry Services](#).

When offering MAT for OUD via telehealth, OASAS-certified Article 32 programs must be designated to deliver services via telehealth in accordance with 14 NYCRR Part 830. Programs shall also comply with all applicable state and federal laws and regulations as well as guidance issued by OASAS.

Considerations for Originating Provider

The originating healthcare provider is responsible for linking the patient to the distant provider and, if necessary, local community providers for ongoing buprenorphine care. This aligns with NYS regulations advising “warm” hand-offs and other protocols for discharge planning for patients with substance use or mental health conditions (10 NYCRR 405.9). In originating settings such as an urgent care, office or hospital/emergency department, the originating provider is able to administer a first dose of buprenorphine if indicated (waiver not required).

DOH recommends that originating providers establish relationships with multiple waived telemedicine providers in advance, confirm their eligibility to prescribe, communicate appointment availability and make their contact information available to practitioners who may encounter patients with OUD in order to have access to remove providers. Facilities can use treatment locators to identify possible telemedicine partners.

The originating provider is responsible for the treatment of all presenting conditions, follow-up care, and referrals, except for buprenorphine prescribed by the distant provider. The originating provider remains responsible for either facilitating the patient’s access to the distant provider or transitioning their care to a receiving provider who has the capacity to provide continued access to buprenorphine treatment. In order for the originating provider to offer buprenorphine through telemedicine, it is required that the originating and distant providers utilize the prescription monitoring program and have the capacity to prescribe electronically.

a) Establish Network of Community (Receiving) Providers

If the originating provider cannot provide longitudinal treatment, it should create a network of community receiving partners to increase access to community care post discharge from originating provider. It may be beneficial to identify a point person at the receiving provider who facilitates the referral process. Facilities can also utilize treatment locators to identify possible community partners to receive referrals (see additional resources under *Provider Directories*).

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b) Coordinate Continuity of Care through Telemedicine

Once originating providers who are unable to provide ongoing buprenorphine treatment have developed their treatment network, they should aim to connect individuals with the earliest available appointment using telemedicine services or other referral mechanisms. All providers must utilize HIPAA compliant videoconferencing to coordinate care for the referred individual. Receiving providers may also use telemedicine to access a DATA-waived provider to continue buprenorphine treatment. **Naloxone should always be given to the individual on discharge and the individual should be trained on how to use it.** Friends and family should also have access to naloxone and be [trained](#) on its administration as well.

If an appointment cannot be confirmed for next day, providers should consider:

- Providing individuals with a bridging prescription or supply individuals with enough medication to bridge until the appointment. (Please note that the practitioner should determine the appropriate dosage given the number of days until the appointment following the discharge from the originating provider.)
- Instructing the individual to return to either be administered additional buprenorphine, receive an additional prescription, or be provided a supply to bridge until the appointment, and/or make other alternative arrangements (i.e. connection to peer support, refer to Opioid Overdose Prevention Programs, a prescription for naloxone for insured individuals, etc.)

c) Originating Provider Discharge Planning

If the Originating Provider is unable to provide ongoing care, it must confirm the individual is able and willing to follow up at a designated receiving provider and ensure an appointment is made prior to discharge. Staff should ensure the individual is provided brief education on buprenorphine. The coordinating staff should take into consideration the geographical location of the individual's residence, along with accessibility to transportation upon discharge. Staff should use a standard release of information to share discharge documentation with the appropriate continuing care, receiving provider, if possible. Discharge paperwork should include community follow-up instructions, community resources, in-home induction fact sheet (if applicable), clinic information, etc.

To assist in the transitioning process, hospitals and EDs may connect individuals with available family supports as well as Recovery Coaches (RCs), Recovery Support Navigators (RSNs), other Peer Navigators even if the individual is not connected to services.

d) Refusal of Services

If an individual refuses buprenorphine and/or connection to continuing treatment, the originating provider should continue the general discharge plan that includes existing care coordination of the originating provider's ED, hospital or clinic and provide the individual with information on the availability and importance of MAT, including local and statewide treatment providers, harm-reduction resources including overdose prevention/naloxone resources, and other relevant information as deemed appropriate.

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The clinical team should document the refusal of buprenorphine provision as well as additional treatment recommendations within the individual's clinical/medical record. If informed, any serious events such as an opioid overdose and other opioid-related complications should also be documented.

Considerations for the Distant Provider

Buprenorphine Prescriptions

Patient health and condition, provider discretion, clinical judgement, and availability and access to community care should be the key factors in determining the initial dosage and formulation. The length of the initial buprenorphine prescription should allow the patient sufficient time to be seen by the receiving provider or clinic, if a referral for longitudinal care is necessary.

The distant provider issues an electronic prescription that is sent to the patient's preferred pharmacy. If there is any concern about a patient being able to immediately access a pharmacy and it is clinically appropriate, originating providers can administer an initial dose of buprenorphine after the telemedicine session before the patient leaves the facility. This is permitted according to 21 CFR §1306.07 (b), which allows any practitioner registered with the DEA to administer, but not prescribe, a dose of buprenorphine to mitigate opioid withdrawal for up to three days. Naloxone should always be given to the individual on discharge and the individual should be trained on how to use it. Friends and family should also have access to naloxone and be trained on its administration as well.

Buprenorphine Waiver DATA-2000 patient limits

For purposes of the DATA-2000 patient limit, the patient counts as an active patient of the distant provider until the patient is being seen by a DATA-waived local practitioner. Patients being served by originating providers do not count towards the originating providers' DATA-2000 patient limit. It is the responsibility of the telemedicine DATA-waived practitioner to track their patient load, to stay within their approved limit and to inform the originating provider if they are not able to accept new patients at that time.

Considerations for Receiving Provider

When the originating provider is unable to provide ongoing care, it is responsible for making appropriate referrals for follow-up care unrelated to buprenorphine or OUD, and to facilitate a warm hand-off to the receiving provider to continue buprenorphine. Medical management, including monitoring of medication side effects and the behavioral counseling that is typically a part of medical management, should be provided by the DATA-waived receiving provider. If the receiving provider does not possess a DATA waiver, it is that provider's responsibility to facilitate access to a DATA-waived provider either locally or via telemedicine. Receiving providers are not required to have an in-person DEA-licensed provider physically present with the patient during distant sessions with the distant provider. Engaging with community-based organizations can benefit the patient and assist with linking to services (i.e., Health

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Hubs, Centers of Treatment Innovation (COTIs), Peer Support Agencies, Syringe Services Programs, etc.).

Best outcomes are achieved when the originating and receiving providers have established protocols that prioritize individuals for next day follow-up appointments. Originating providers should coordinate with the providers with whom they have developed a continuity of care relationship. Through this network partnership, best outcomes are achieved when a common set of clinical and other information is included with the patient's discharge paperwork, along with patient consent, to assist in the streamlining of treatment admission. These items may include:

- clinical treatment history
- medication information
- prior buprenorphine utilization
- prescription information
- contact information for the individual should they not attend the next scheduled appointment, and
- information for family or caregivers, if applicable

Naloxone should always be given to the individual on discharge and the individual should be trained on how to use it. Friends and family should also have access to naloxone and be trained on its administration as well.

Mental Health Treatment

Mental health services should be available as the patient and the community provider deem appropriate, consistent with SAMHSA's guidance and federal rules for DATA waiver prescribing. SAMHSA's guidance regarding counseling indicates that prescribers should "offer referrals for adjunctive counseling and recovery support services as needed." Prescribers should ensure continued access to buprenorphine, even in the absence of counseling. Oftentimes, patients who are not initially receptive to counseling may request it once they are stabilized. Counseling and supportive services can be discussed as part of the plan of care with the receiving provider and is not the responsibility of the originating or distant provider. Providers should not withhold buprenorphine treatment to a patient who is unable or unwilling to participate in counseling.

Example of Process for Initiating Buprenorphine via Telemedicine

1. Originating Provider identifies patient suitable for buprenorphine.
2. Originating Provider discusses buprenorphine with patient and, if patient is agreeable, requests a telemedicine consult.
3. Originating Provider provides a first dose of buprenorphine in the originating setting such as an urgent care, office or hospital/emergency department if indicated (waiver not required).
4. Distant Provider with a DATA waiver is alerted to a request for a consultation.
5. During operational hours, Distant Provider responds within 30 minutes (best practice) and performs telemedicine consultation with patient and originating provider. During

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non-operational hours, the Originating Provider may elect to provide a referral to a community provider through a referral mechanism with or without a single dose of buprenorphine if the patient is in a hospital/ED. The Originating Provider may alternatively elect to wait until operational hours resume as Distant Provider may not be available immediately.

6. Distant Provider checks IStop/Prescription Monitoring Program.
7. Distant Provider electronically prescribes buprenorphine if indicated.

Billing, Coding and Insurance Coverage

If the patient has Medicaid, then the distant provider must also be enrolled in the Medicaid program in order to bill. **Medicaid permits both the originating and receiving practitioners to bill for the visit and be reimbursed.** For services provided in OMH-licensed Article 31 and OASAS-certified Article 32 settings, only the originating site (i.e. where the patient is located) can bill for the visit. Determine the appropriate coding and medical necessity documentation requirements to ensure coverage for these services within the specific setting. There are specific CPT codes, place of service and telehealth modifiers that the originating practitioner and the distant practitioner should use. Refer to [March 2020 Medicaid Update](#) for NYS Medicaid's policy on telehealth and relevant codes. For OASAS Certified Article 32 program guidance, please review the Telepractice Standards and Guidance available via the [OASAS agency home page](#).

Medicaid will pay for a buprenorphine prescription prescribed by a distant provider who has met the regulation requirements, which includes: must be licensed to practice in the state the patient is physically located (in this case, New York), be DEA-registered in the patient's state and their own state, have a valid DATA-2000 waiver and be enrolled in Medicaid. If the medication is on the formulary for Medicaid Fee for Service or Managed Care, prior authorization is not required. Medicaid Managed Care formularies are available [here](#).

In addition, NYS Insurance Law §§ 3216(i)(31-a), 3221(l)(7-b) and 4303(l-2) requires insurance carriers to provide at least 5 days' coverage for emergencies, without prior authorization. This includes medications associated with the management of opioid withdrawal and/or stabilization as well as medication used for opioid overdose reversals. This section of insurance law also allows at least 5 days' coverage of buprenorphine for management of OUD when the prescription issued by an authorized healthcare provider is for a product not on the plan formulary, or is not for the preferred product and prior authorization has not been provided.

Telehealth Resource Centers

The United States has 14 Telehealth Resource Centers, all funded by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth. These resource centers serve as a local hub of information and research about telehealth, usually with a focus on increasing healthcare access for underserved communities.

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For a listing of all centers or to find your regional center, please see the [National Telehealth Resource Center](#).

National Telehealth Policy Resource Center

Phone: 877.707.7172

Direct: 916.285.1860

Provider Directories

Source of information for persons seeking treatment facilities for substance use disorder and behavioral health disorders treatment.

- [SAMHSA Treatment Locator](#)
- [NYSDOH AIDS Institute Provider Directory](#) **Providers can request to be placed on the directory through this link**
- [OASAS \(Office of Addiction Services and Supports\) Treatment Locator](#)
- [OMH \(Office of Mental Health\) Program Directory](#)
- [Telehealth OASAS MAT Providers](#)

Examples of community partners to include in network:

- [Opioid Treatment Programs \(OTPs\) / Office Based Opioid Treatment \(OBOTs\)](#)
- [Drug User Health Hubs](#)
- [Centers for Treatment Innovations \(COTIs\)](#)
- [Federally Qualified Health Center \(FQHC\)](#)
- [Certified Community Behavioral Health Clinics \(CCBHCs\)](#)
- Mental Health Clinics with capacity to provide buprenorphine treatment
- [Syringe Service Programs](#)
- Additional community-based service providers

Frequently Asked Questions

[Use of Telehealth and Telephonic Services During the COVID-19 State of Emergency FAQs](#)

[OASAS Telehealth Practices FAQs](#)

[SAMHSA FAQs: Provision of Methadone and Buprenorphine for the Treatment of Opioid Use Disorder in the COVID-19 Emergency](#)