NEW YORK STATE
Department of Health
Medicaid

Treatment of Opioid Use Disorder Delivered Exclusively by Telehealth

Health Technology Assessment

July 2025

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Prepared by

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Conflict of Interest Disclosures: Conflict of Interest Disclosures: No authors have conflicts of interest to disclose. All authors have completed and submitted the Oregon Health & Science University form for Disclosure of Potential Conflicts of Interest, and none were reported.

Funding and Support: This research was funded by the New York State Department of Health through a contract with the Center for Evidence-based Policy at Oregon Health & Science University (contract number C038339).

Suggested Citation: McCausland R, Connor S, Leof A, Pavlech L, King VJ, Brown EJ. *Treatment of opioid use disorder delivered exclusively by telehealth.* Portland OR: Center for Evidence-based Policy, Oregon Health & Science University; 2025.

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List of Abbreviations

ASAM	American Society of Addiction Medicine
Center	Center for Evidence-based Policy
CI	confidence interval
CMS	Centers for Medicare & Medicaid Services
CoE	certainty of evidence
DEA	Drug Enforcement Agency
ED	emergency department
FDA	US Food and Drug Administration
GRADE	Grading of Recommendations, Assessment, Development, and Evaluation
HHS	Department of Health and Human Services
OUD	opioid use disorder
PHE	public health emergency
RCT	randomized controlled trial
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	substance use disorder

Executive Summary

Background

Opioid use disorder (OUD) is characterized by mild, moderate, or severe symptoms including cravings, withdrawal, unsuccessful efforts to reduce use, increased tolerance, and large amounts of time obtaining, using, and recovering from opioids; and continued use despite harm to interpersonal relationships, physical health, and their ability to fulfill responsibilities.[1] Deaths from drug overdose often involve multiple drugs, but the number of drug overdose deaths that involved opioids has been the largest category for the past 5 years in New York State.[2] After steady growth from 2015 through 2023, the number of opioid-related overdose deaths dropped 37% from 2023 to 2024, although opioids still accounted for 77% of overdose deaths in 2024.[2] Crude death rates involving drug overdose varied by race and ethnicity: in 2022, crude death rates were 55.5 per 100,000 for Black individuals and 50.6 per 100,000 for American Indian or Alaska Natives.[2]

Treatment for OUD often combines medications for OUD with psychosocial treatment to promote behavior change.[3-5] Medications for opioid use disorder work quickly to restore balance to the areas of the brain affected by addiction, reducing cravings and withdrawal symptoms and reducing the risk for overdose and overdose death, while enabling patients to address the psychosocial factors that contribute to their disease.[5] Three medications are currently approved by the US Food and Drug Administration (FDA) for treatment of OUD: methadone, buprenorphine, and extended-release naltrexone.[5] Access to medications for OUD has historically been highly regulated, especially for methadone and buprenorphine, and regulatory constraints have been identified as barriers to engagement with treatment.[6] Despite evidence that medications for OUD are effective, some patients may have difficulty accessing them.

Telehealth is not an intervention itself, but rather a mode of delivering services that can be offered through synchronous and asynchronous methods. The Health Resources and Services Administration defines telehealth in part as "the use of electronic information and telecommunications technologies to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance."[7] Telehealth services for the treatment of OUD may include telephone-based support, videoconferencing, texting, mobile applications, web-based treatment support, remote monitoring of medications for OUD, and remote monitoring of urine samples.[8,9] While hybrid models of OUD care are available, this report focuses on telehealth as the primary mode of delivery for OUD treatment.

Methods

Key Questions

KQ1. What is the clinical effectiveness of telehealth-only services for adults and adolescents with OUD?

KQ2. Does clinical effectiveness vary by patient characteristics (e.g., age, sex), disease characteristics (e.g., severity, comorbidities), or provider characteristics (e.g., opioid treatment program vs. other outpatient setting, staff for remote monitoring, staff for in-person care)?

   a. Does clinical effectiveness vary by program characteristics (i.e., delivery method, such as synchronous audio-visual communication, remote patient monitoring), frequency of contact with provider, devices used, or workforce composition of the staff (e.g., credentials)?

KQ3. What are the harms of telehealth-only services for adults and adolescents with OUD?

   a. Do harms vary by patient characteristics (e.g., age, sex), disease characteristics (e.g., severity, comorbidities), or provider characteristics (e.g., opioid treatment program vs. other outpatient setting, staff for remote monitoring, staff for in-person care)?

   b. Do harms vary by program characteristics (i.e., delivery method, such as synchronous audio-visual communication, remote patient monitoring), frequency of contact with provider, devices used, or workforce composition of the staff (e.g., credentials)?

KQ4. What are the costs or cost-effectiveness studies related to providing telehealth-only services for adults and adolescents with OUD, including relative costs compared with other treatment modalities?

KQ5. What are clinical practice guideline recommendations for telehealth-only services for adults and adolescents with OUD?

KQ6. What are relevant Medicaid program coverage policies and health plan policies for telehealth-only services for adults and adolescents with OUD?

Researchers from the Center for Evidence-based Policy (Center) searched Ovid MEDLINE and other clinical evidence sources for randomized controlled trials (RCTs), prospective comparative cohort studies, registry studies, cost and cost-effectiveness studies, and clinical practice guidelines. Inclusion and exclusion decisions were made by consensus of dual screeners, with additional dual screening of risk-of-bias assessment. Accuracy of data abstracted from included clinical studies was verified by a second researcher. We applied the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) approach to rate the certainty of evidence for each outcome from the data we abstracted. To identify relevant coverage policies, we searched 9 state Medicaid program websites, 8 health plan websites, and the Centers for Medicare & Medicaid Services (CMS) website for local and national coverage determinations of telehealth for OUD.

Summary of Clinical Evidence and Recommendations

Effectiveness

We identified 3 eligible studies, 1 randomized controlled trial (RCT),[10] and 2 prospective cohort studies[11,12] that investigated the effectiveness of treatment of OUD exclusively by telehealth. Two of the studies were assessed as having a moderate risk of bias,[10,11] and 1 of the studies was assessed as having a low risk of bias.[9] Table ES1 presents a summary of findings by key outcome of interest. Full details of the GRADE assessment are in Appendix F.

Table ES1. Summary of Findings (GRADE)

No of Participants (N) No. of Studies	Findings	Certainty of Evidence	Rationale for Certainty of Evidence Rating[a]
Retention in treatment			
N = 98 1 cohort study[12]	No significant difference • Guille et al. (2020) found no statistically significant between-group differences in rates of retention in treatment at 6 to 8 weeks postpartum, amongst women receiving perinatal treatment for OUD via telehealth or in person (80.4% vs. 92.7%; *P* = .12)	●○○○ Very low	Downgraded for indirectness with limited population (-1)
Abstinence from opioids			
N = 198 1 RCT,[10] 1 cohort study[12]	Unclear effect • Sigmon et al. (2023) report a statistically significant effect in favor of telehealth compared with control across 6 months, in both nonrural (85.3% vs. 24.0%; *P* < .001) and rural populations (88.0% vs. 21.3%; *P* < .001); however, only the telehealth group received medications for OUD • Guille et al. (2020) report no significant between group difference in rates of positive urine drug screen at delivery (13.2% vs. 20.6%; *P* = .34) and at 6- to 8-weeks postpartum (16.0% vs. 20.3%; *P* = .66) amongst women receiving perinatal treatment for OUD via telehealth or in person	●○○○ Very low	Downgraded for risk of bias (-1), inconsistency (-1), indirectness with limited population in one study (-1), and imprecision (-1)
Adherence to prescribed medications OUD			
N = 259 1 RCT,[10] 1 cohort study[11]	Effect in favor of telehealth • Sigmon et al. (2023) report high levels of adherence to prescribed medications for OUD across 24	●○○○ Very low	Downgraded for risk of bias (-1) and very serious limitations in imprecision

No of Participants (N) No. of Studies	Findings	Certainty of Evidence	Rationale for Certainty of Evidence Rating[a]
	weeks in both nonrural (98.9%) and rural (99.3%) populations receiving treatment via telehealth ○ There was no medication for OUD prescribed to the control group for comparison • Chan et al. (2024) report statistically significant effect in favor of telehealth treatment for adherence to prescribed medication for OUD at 24 weeks (adjusted risk of discontinuation 3.8% vs. 9.7%; *P* = .026)		due to lack of comparator in RCT (-2)
Neonatal outcomes			
N = 98 1 cohort study[12]	No significant difference • Guille et al. (2020) report no statistically significant between-group differences in rates of NAS in neonates born to women receiving treatment via telehealth or in person (45.4% vs. 63.2%; *P* = .24)	●○○○ Very low	Downgraded for indirectness with limited population (-1)
Patient satisfaction			
N = 100 1 RCT[10]	Unclear effect • Sigmon et al. (2023) report high levels of patient satisfaction with treatment via telehealth intervention ○ There was no patient satisfaction data collected from the control group	●○○○ Very low	Downgraded for risk of bias (-1) and very serious limitations in imprecision due to lack of comparator (-2)

Note. [a] *In grading certainty of evidence, cohort studies begin at low certainty due to the inherent risk of bias and confounding in an unrandomized study. For methods and interpretation of GRADE ratings, see Appendix C. Abbreviations. CoE: certainty of evidence; GRADE: Grading of Recommendations, Assessment, Development, and Evaluations approach; OUD: opioid use disorder; NAS: neonatal abstinence syndrome; No:. number; RCT: randomized controlled trial.*

Ongoing Trials

We identified 2 ongoing comparative trials on ClinicalTrials.gov investigating treatment for OUD delivered exclusively by telehealth. One trial, investigating sublingual buprenorphine through telemedicine versus in-person care as usual, is projected to start in June 2025 with an estimated completion date of September 2026. The other trial is investigating home versus office versus telehealth induction for medications for OUD and started in May 2021; it is no longer recruiting and has an estimated completion date of February 2026. Internet searches also identified a Patient-Centered Outcomes Research Institute (PCORI) research award, with a contract pending (as of July 11, 2025) for a study of in-person versus telehealth opioid use disorder treatment

after patients leave the ED. This study has not yet been registered with ClinicalTrials.gov but has a projected completion date of December 2030.

Harms

Although advocates of telehealth for OUD emphasize that telehealth may increase access to OUD treatment, there is a lack of empirical studies on the potential harms (e.g., fragmented care, inadequate follow-up care, worsening disparities) associated with treatment of OUD delivered exclusively by telehealth. Our searches did not identify any eligible studies that report harms outcomes for the treatment of OUD exclusively by telehealth.

Cost and Cost-Effectiveness

We identified 1 eligible economic modeling study that analyzed treatment of OUD exclusively by telehealth, rated as having a moderate risk of bias.[13] This economic evaluation reported that over a modeled 12-year horizon, telehealth alone resulted in a projected 126,866 quality-adjusted life years gained, and a projected $14,562,130,355 net monetary benefit compared with the status quo.[13] Telehealth alone was projected to be effective in increasing treatment duration but was associated with a projected initial increase in overdose deaths due to treatment capacity constraints.[13] However, when telehealth was combined with other interventions, such as psychotherapy or contingency management associated with increased treatment duration and capacity, there was a projected decrease in overdose deaths and the benefits were greater than the sum of the separate interventions.[13]

Clinical Practice Guideline Recommendations

We identified 2 publications with relevant clinical practice recommendations: a clinical practice guideline from the Veterans Administration (VA) and Department of Defense (DoD) and an evidence-based resource guide from the Substance Abuse and Mental Health Services Administration (SAMHSA).[14,15] We assessed methodological quality of the guidelines using established clinical practice guideline appraisal tools. The VA/DoD clinical practice guideline for the management of substance use disorder (SUD) from 2020 was of good methodological quality and had a section on telehealth for the treatment of SUD but concluded there was insufficient evidence to recommend for or against telemedicine-delivered treatment for SUD.[14] Conversely, a poor methodological quality guidance document published by SAMHSA made many recommendations affirming the effectiveness of telehealth for the treatment of SUD.[15] Importantly, although the SAMHSA publication offers practical guidance on telehealth for SUD, the evidence base used for affirming the effectiveness of telehealth is unclear.

Summary of Policy Findings

We did not identify any coverage policies that specifically addressed treatment of OUD exclusively by telehealth. None of the 8 health plans we routinely search for Evidence Based Evidence Review Advisory Committee (EBBRAC) reports had policies specific to this intervention. Internet searches did identify that 8 of the 9 health plans enrolled companies that deliver telehealth OUD treatment services as eligible providers. Of the 8 health plans we reviewed, 4 (Anthem Empire BCBS New York,[16] Fidelis Care,[17] Healthfirst,[18] and UnitedHealthcare[19,20]) have provider agreements with Ophelia to cover telehealth-only OUD treatment, although UnitedHealthcare does not appear to offer the coverage to its New York enrollees.[20] Aetna contracts with Workit Health for telehealth-only OUD treatment in 6 states,

but not New York.[21-26] Cigna enrolled Bicycle Health for telehealth-only addiction treatment in 26 states, not including New York.[27] Molina Healthcare works with Bright Heart Health to offer telehealth-only OUD treatment to all adult Molina enrollees in Washington State[28]; we were unable to identify whether Molina offers the service in other states, including New York.

For EBBRAC reports, we regularly search 9 state Medicaid programs for reference coverage policies: California, Florida, Massachusetts, New Jersey, North Carolina, Oregon, Pennsylvania, Texas, and Washington. None of these Medicaid programs had policies that directly addressed treatment of OUD exclusively by telehealth.

Conclusions

Evidence on the treatment of OUD exclusively by telehealth was limited to a small number of methodologically limited studies. These studies found treatment of OUD exclusively by telehealth was not significantly different for retention in treatment outcomes or rates of neonatal abstinence syndrome (in neonates born to women receiving treatment for OUD) compared with controls. Treatment exclusively by telehealth was associated with adherence to prescribed medications for OUD in studies, but only 1 trial reported comparative data for this outcome. There was an unclear effect of treatment exclusively by telehealth on abstinence from opioids and patient satisfaction. Importantly, none of the reviewed studies reported any outcomes with a treatment effect in favor of the control group, indicating treatment of OUD exclusively by telehealth may not be inferior to in-person treatment. However, our confidence in the evidence is very low for any of these findings. The limited number of trials, small sample sizes, lack of comparator for most outcomes, confounding factors, and limitations in generalizability should be considered when drawing conclusions about the certainty of evidence for treatment of OUD exclusively by telehealth. Overall, we have very low certainty in these results and expect that adequately designed and conducted controlled research would be likely to change our understanding about telehealth-only OUD treatment interventions.

Background

Description of the Condition

Opioid use disorder (OUD) is a brain disorder characterized by mild, moderate, or severe symptoms of cravings; withdrawal; unsuccessful efforts to reduce use; increased tolerance; large amounts of time invested in acquiring, using, and recovering from opioids; and continued use in spite of knowledge of negative effects on interpersonal relationships, physical risks, and inability to fulfill major role obligations.[1]

Deaths from drug overdose often involve multiple drugs, but the number of drug overdose deaths in New York State that involved opioids has been the largest category for the past 5 years,[2] and opioid-related overdose deaths contributed to 84.3% of all overdose deaths in 2022.[29] Synthetic opioids, such as fentanyl, were associated with 77.9% of all overdose deaths in 2022.[29] After steady growth from 2015 through 2023, the number of opioid-related overdose deaths in New York State dropped 37% from 2023 to 2024, although opioids still accounted for more than 77% of overdose deaths in 2024.[2] Crude death rates (2019–2023) per 100,000 population involving drug overdose in New York State varied by race and ethnicity: individuals identified as Black had a crude death rate of 59.2 and individuals identified as American Indian or Alaska Native had a crude death rate of 49.1, compared to 28.2 for White individuals.[2]

Treatment of Condition

Treatment that includes medications for OUD is the first-line approach for OUD.[30-32] Three medications for OUD are currently approved in the US by the Food and Drug Administration (FDA): methadone, buprenorphine, and extended-release naltrexone.[5] Methadone is a long-acting opioid receptor agonist. Buprenorphine is a partial agonist with very high affinity for opioid receptors. Both methadone and buprenorphine bind to and activate the brain's opioid receptors and reduce withdrawal symptoms, opioid cravings, and the euphoric effects of other opioids. While individuals treated with methadone or buprenorphine are physically dependent on these medications, their use is not associated with the same range of problematic behaviors seen with opioid misuse. Naltrexone, on the other hand, functions as an opioid antagonist and works by blocking the activation of opioid receptors.[33] Naltrexone negates the rewarding effects of opioid use, but it cannot be initiated until after a period of opioid abstinence to avoid precipitating potentially severe withdrawal.[33] Access to these medications has historically been highly regulated, especially for methadone and buprenorphine, and regulatory constraints have been identified as barriers to using medication for OUD treatment.[6]

Methadone for OUD is limited to federally certified opioid treatment programs, with most patients required to receive methadone in person daily.[5] During the COVID-19 pandemic public health emergency, waivers of some restrictions allowed for more flexible prescribing practices, such as take-home dosing in conjunction with telehealth counseling.[34,35] The efficacy of methadone in OUD treatment has been demonstrated in numerous clinical trials, although safety risks (prolonging the QT interval on electrocardiogram, in particular), strict regulations regarding use and administration due to the potential for misuse or diversion, and controversy related to using an opioid for treatment of OUD are barriers to use.[36] A systematic review that included 11 studies with 1,969 participants comparing methadone maintenance therapy with treatment that did not use opioid replacement therapy found methadone was significantly more effective in

retaining patients in treatment and reducing cravings.[37] A systematic review including 101 studies comparing methadone and buprenorphine found treatment retention was higher for methadone treatment at timepoints beyond 1 month.[38]

Buprenorphine can be prescribed in office-based settings by any individual appropriately licensed and registered within their state to prescribe medications up to schedule III, including physicians, physician assistants, and nurse practitioners.[5] Clinical trials demonstrated buprenorphine's comparability to lower doses of methadone.[36] Buprenorphine has a more favorable safety profile than methadone, with no evidence of QT prolongation, although concerns about misuse or abuse have been barriers to use.[36] Buprenorphine also has a ceiling effect (i.e., a point at which increasing the dosage does not increase the effect), making it less likely to cause fatal respiratory depression than other opioid agonists.[36] A systematic review that included 31 clinical trials with 5,430 participants found buprenorphine was comparable to methadone in suppressing illicit opioid use.[39] However, a systematic review that included 10 RCTs with 2,468 participants comparing buprenorphine with other medications for OUD reported that patients on buprenorphine experienced greater cravings than those on methadone.[40]

Extended-release naltrexone can be prescribed by any licensed clinician operating within their scope of practice, but given costs and logistical challenges related to medication induction, it is used less often than methadone or buprenorphine.[5] A large RCT that tracked 570 participants over 24 weeks showed that long-acting injectable naltrexone was comparable to buprenorphine in days abstinent, negative urine drug testing, and time-to-relapse at 6 months after patients were successfully detoxified from opioids.[41] Because the drug works by blocking opioid receptors, it does not have the same reinforcing effects as buprenorphine and methadone, and appears to work best with patients who are highly motivated and compliant, or those who wish to avoid opioid agonists.[36] The steps involved in initiating long-acting injectable naltrexone treatment are also a barrier to use.[36,41] For example, the drug cannot be started until patients have achieved abstinence, which requires a detoxification regimen before use. Buprenorphine and methadone, on the other hand, can be initiated as soon as patients are in mild to moderate withdrawal.[41]

Medications for OUD are typically combined with psychosocial treatment like individual or group counseling, cognitive behavioral therapy, motivational interviewing, and contingency management.[3-5] Psychosocial treatments are designed to help patients manage cravings and cope with the emotional and social challenges associated with OUD, with the goal of changing behavior and reducing likelihood of relapse.[30] Psychosocial treatments may improve clinical outcomes when combined with medications for OUD, but there is limited information on which psychosocial interventions are most effective in combination with different medications for OUD.[30,42] A 2016 systematic review by Dugosh and colleagues, which was part of the American Society of Addiction Medicine's (ASAM) guideline development process, included 27 publications and identified cognitive behavioral therapy and contingency management in conjunction with methadone treatment (14 studies) as the most frequently studied psychosocial approaches to OUD treatment.[42] Only 8 studies were identified that explored the effect of psychosocial interventions in conjunction with buprenorphine treatment, primarily in the context of cognitive behavioral therapy, and only 5 studies examined psychosocial interventions delivered in

conjunction with naltrexone, with 4 of 5 studies using a contingency management approach.[42] While results generally supported the benefit of combining psychosocial therapies with medications for OUD, small sample sizes, differences in comparison groups, and the use of control groups more intensive than those typically seen in clinical practice reduced certainty of evidence.[42] ASAM recommendations state that medication for OUD should not be delayed or denied because a psychosocial treatment is not available or declined by an individual.

Prevalence of Condition in New York State

According to the state's Opioid Data Dashboard, suspected opioid overdoses reported by emergency medical services agencies were 7.5 per 1,000 unique 911 dispatches in 2023, the most recent year available.[43] Opioid-related overdose deaths were 27.4 per 100,000 population in 2022, representing a significant increase from 25.1 in 2021.[43] In 2023, the age-adjusted rate of patients receiving at least 1 buprenorphine prescription was 464 per 100,000 population.[43] According to the New York State Opioid Annual Report (2024), the crude rate of unique individuals enrolled in substance use disorder (SUD) treatment programs for any opioid in New York State was 463.1 per 100,000 population in 2023.[44] During 2023, the highest crude rates of unique individuals enrolled for opioids were in mostly rural counties.[44] Because a significant amount of time often elapses from an individual's initial use of an opioid and their admission to treatment, the number of individuals enrolled in treatment for opioids is considered to be a trailing indicator of the prevalence of opioid misuse.[44]

Description of the Intervention

Telehealth is not an intervention itself, but rather a mode of delivering services that can be offered through synchronous and asynchronous methods. The Health Resources and Services Administration defines telehealth in part as "the use of electronic information and telecommunications technologies to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance."[7] Four distinct types of telehealth services are generally recognized[45-48]:

- Synchronous: live, two-way interaction between an individual and a provider using audio-visual or audio-only telecommunications technologies
- Asynchronous store-and-forward: transmission of health information through an electronic communications system outside of a real-time or live interaction (e.g., patient lab data sent from a provider's office to another provider to review later)
- Remote patient monitoring: transmission of health information collected from an individual in a location to a provider in a different location via electronic communication technologies (e.g., monitoring weight, blood pressure, or blood glucose with an in-home device)
- Mobile health: use of a digital device, such as a smartphone, tablet, or wearable device, and often involving use of a dedicated software application, to support patient health

Telehealth services for SUD may include benefits such as shorter wait times to initiate treatment, increased privacy compared with traveling to an in-person clinic, greater likelihood of accessing a provider who understands SUD, ability to continue care with a regular provider while participating in at-home or in-person treatment, and immediate access to support to cope with cravings through apps and text messaging.[49] Telehealth services increase access to care for individuals who live in remote or underserved communities, or those who cannot travel to in-

person appointments due to lack of reliable transportation or childcare.[50-52] Telehealth services for the treatment of OUD may include telephone-based support, videoconferencing, texting, mobile applications, web-based treatment support, remote monitoring of medications for OUD, and remote monitoring of urine samples.[8,9]

New York State Medicaid covers assessment, diagnosis, consultation, treatment, education, care management, and self-management services delivered by audio-visual or audio-only telehealth modalities.[53,54] Programs certified, funded, or otherwise approved by the New York State Office of Addiction Services and Supports (OASAS) must submit an application to OASAS for approval to provide services via telehealth.[54] Once approved, OASAS providers may offer audio-visual or audio-only telehealth services.[54] The *Telehealth Standards for OASAS Designated Providers* manual, updated in August 2023, indicates that a patient must be evaluated, either in person or via telehealth, by a Drug Enforcement Agency (DEA)-registered practitioner prior to issuance of a prescription for buprenorphine, which aligns with federal regulations (see contextual question 1).[54]

Contextual Questions

A number of contextual questions (CQs) were identified by the New York State Department of Health. These questions address issues related to federal guidance, place in the treatment care plan, experience of state Medicaid implementation, and health equity considerations.

CQ1. What is the federal guidance for implementing telehealth-only services for adults and adolescents with OUD? Does this guidance vary by type of medication prescribed for medications for OUD (e.g., in-person requirement for methadone initiation)?

All 50 state Medicaid programs have allowed select services to be delivered through telehealth modalities, including synchronous audio or video visits, remote patient monitoring, asynchronous store and forward, mobile health, and text-based communication.[55] Although state Medicaid programs individually determine which providers may deliver services through telehealth modalities without additional state plan amendments, Medicaid program determinations must follow all applicable federal and state laws (e.g., prescribing controlled substances, patient privacy regulations, and provider licensing requirements).[55]

The Controlled Substances Act establishes federal drug policy for regulating the manufacturing, importing, possession, use, and distribution of controlled substances.[56] Substances are placed into 1 of 5 schedules based on the substance's medical use, safety or dependence liability, and potential for abuse.[56] According to criteria established in the Controlled Substances Act, schedule I substances have no currently accepted medical use in treatment in the US and a high potential for abuse.[56] Schedule V substances have a currently accepted medical use in the US and low potential for abuse.[56] Methadone is a schedule II substance, and buprenorphine, or combinations of buprenorphine with other substances (e.g., buprenorphine and naloxone) are schedule III substances.[56] With few exceptions, when used for OUD treatment, methadone must be dispensed or administered through opioid treatment programs.[57] Opioid treatment programs are accredited with Substance Abuse and Mental Health Services Administration (SAMHSA) certification and DEA registration, and provide comprehensive treatment services for individuals with OUD, including administering and dispensing methadone, buprenorphine, and naltrexone. The Drug Addiction Treatment Act of 2000 allowed DEA-registered physicians who met certain

qualifications and obtained a waiver from the federal government to prescribe FDA-approved medications, like buprenorphine, for the treatment of OUD in settings other than opioid treatment programs.[58] The Consolidated Appropriations Act of 2023 removed the requirement for physicians to obtain a waiver to prescribe buprenorphine.[58] Buprenorphine can now be prescribed for treatment of OUD by any practitioner with a current DEA registration with schedule III authority who meets the training requirements (i.e., completion of 8 hours of training on opioid or other SUDs; board certification in addiction medicine or addiction psychiatry; or graduation within the past 5 years from a school that provided at least 8 hours of opioid or other SUD curriculum), with no limit on the number of patients they can treat.[58,59] Buprenorphine can be dispensed from a regular pharmacy.[5]

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 added provisions to the Controlled Substances Act to prevent illegal dispensation and distribution of controlled substances via the internet.[60,61] One of the key provisions of the Ryan Haight Act is that, except in limited circumstances, practitioners must conduct at least 1 in-person medical evaluation before issuing a prescription for or dispensing a controlled substance over the internet.[60,61] The Ryan Haight Act does not limit a practitioner's ability to prescribe controlled substances for a patient who has had an in-person medical evaluation.[60,61] Practitioners engaged in the practice of telemedicine are exempt from the in-person medical evaluation requirement. The practice of telemedicine is defined in 21 US Code 802(54) and includes 7 categories that Congress determined were appropriate to allow for the prescribing of controlled substances via telemedicine in the absence of an in-person medical evaluation[60-63]:

- Patient is physically located at a DEA-registered hospital or clinic, and the remote prescribing practitioner is DEA registered in the state in which the patient is located
- Patient is being treated by a prescribing practitioner and in the physical presence of a DEA-registered practitioner in the state in which the patient is located
- Prescribing practitioner is an employee or contractor of the Indian Health Service or a tribal organization
- Public health emergency declared by the Secretary of Health and Human Services
- Prescribing practitioner has obtained special registration with DEA
- Medical emergency that prevents the patient from being in the physical presence of an employee or contractor of the Veterans Health Administration and 1 of its hospitals or clinics, and immediate intervention by the practitioner using controlled substances is required to prevent injury or death
- Any other circumstances that DEA and Department of Health and Human Services (HHS) jointly determine to be consistent with effective controls against diversion and otherwise consistent with public health and safety

During the COVID-19 public health emergency (PHE), pandemic-related stressors and implementation of mitigation measures, such as stay-at-home orders, raised concerns about disruptions to medications for OUD and other treatment and recovery support services for individuals with OUD and subsequent increased risk of overdose.[64] Multiple federal actions were initiated after declaration of the nationwide COVID-19 emergency on March 13, 2020 to facilitate access to care for individuals with OUD.[33,65-70] These actions included exemptions to permit initial buprenorphine prescriptions without an in-person evaluation and flexibility to dispense 14- and 28-day take-home methadone doses.[33,65-69] Recently, final rules that make

permanent some of the flexibilities allowed during the COVID-19 PHE have been published (see Box 1).[5,58]

Box 1. Recent Federal Regulations for Prescribing or Dispensing Medications for Opioid Use Disorder via Telehealth

Medications for the Treatment of Opioid Use Disorder[5]

- Final rule modifies and updates regulations related to opioid treatment programs
- Makes permanent flexibilities allowed during the COVID-19 PHE, including:
  - Initiation of buprenorphine via audio-visual or audio-only telehealth modality when an opioid treatment program physician or other authorized health care professional determines that an adequate evaluation of the patient can be accomplished via telehealth
  - Screening for initiation of methadone via audio-visual telehealth modality when an opioid treatment program physician or other authorized health care professional determines that an adequate evaluation of the patient can be accomplished via telehealth (does not authorize prescription of methadone via telehealth)
  - Allows 7 days of take-home medication doses during the first 14 days of treatment, 14 days of take-home doses from 15 through 30 days of treatment, and 28 days of take-home doses from 31 days of treatment
- Effective date: April 2, 2024

Expansion of Buprenorphine Treatment via Telemedicine Encounter[58,71,72]

- Final rule expands the circumstances under which non-opioid treatment program practitioners are authorized to prescribe schedule III to V controlled substances for the treatment of OUD via telemedicine when the practitioner has not conducted an in-person medical evaluation
- Makes permanent flexibilities allowed during the COVID-19 PHE, with additional requirements:
  - Patients can receive up to a 6-month supply of buprenorphine through audio-visual or audio-only telehealth consultation
  - Practitioners need to check state prescription drug monitoring program before writing prescription
  - Pharmacists need to verify a patient's identity prior to dispensing medication
  - After the initial 6-month supply, patients can schedule an in-person visit or continue treatment through other forms of telemedicine authorized in the 7 categories of practice of telemedicine set forth in 21 USC 802(54)
- Effective date: December 31, 2025

Special Registrations for Telemedicine and Limited State Telemedicine Registrations[63]

- Proposed rule expands patient access to controlled medications via telemedicine pursuant to practice conducted by a practitioner who has obtained special registration, 1 of the categories of practice of telemedicine set forth in in 21 USC 802(54)[a]
- Introduces 3 types of special registrations for telemedicine:
  - Telemedicine Prescribing Registration: authorizes qualified clinician prescribers to prescribe schedule III to V controlled substances via telemedicine
  - Advanced Telemedicine Prescribing Registration: authorizes qualified, specialized clinician practitioners (e.g., psychiatrists) to prescribe schedule II to V controlled substances via telemedicine
  - Telemedicine Platform Registration: authorizes covered online telemedicine platforms, as platform practitioners, to dispense schedule II to V controlled substances through a practitioner possessing either a Telemedicine Prescribing Registration or Advanced Telemedicine Prescribing Registration
- Comment due date: March 18, 2025

Notes. [a] *The Ryan Haight Act only applies when the prescribing practitioner has never conducted an in-person medical evaluation of the patient before issuance of a prescription for a controlled substance. The proposed regulation would not apply to other forms of the practice of telemedicine authorized under the Ryan Haight Act. Abbreviations. OUD: opioid use disorder; PHE: public health emergency; USC: United States Code.*

CQ2. How do telehealth-only services fit into the overall health care management of adults and adolescents with OUD?

Professional guidance from the American Medical Association,[73] the American Psychological Association,[74] and SAMHSA[15] recommends inclusion of telehealth strategies into OUD treatment as a means of increasing accessibility, removing barriers to treatment, and addressing inequities in access to care. None, however, address the issue of providing OUD treatment—whether medications for OUD, psychosocial interventions, or both—solely through use of telehealth.[15,73,74] Little research or guidance is available on the place of telehealth-only services for OUD treatment.

Sousa and colleagues (2022) reported the results of a small survey of 20 individuals initiating OUD services with a multistate service provider (Bicycle Health) that followed a fully virtual care model.[75] The authors found patients appreciated the speed of getting started with telehealth and considered the process to be patient-centered.[75] Over three-fourths of patients said they felt telehealth for OUD treatment helped them overcome social barriers to OUD treatment, such as stigma.[75] Respondents found interacting via telehealth to be less intimidating than being seen in an in-person OUD treatment setting.[75] The study related primarily to the prescription management experience, with online peer support groups being optional and individual counseling only being available in some states.[75] However, some of those who used virtual groups for psychosocial care appreciated the greater anonymity, particularly the ability to interact with individuals from a wider geographic area where they were less likely to be known by fellow group members.[75] The authors noted more research is needed among different patient populations, such as determining the appropriateness of OUD treatment via telehealth for longer-term treatment and for people at different stages of recovery.[75]

In a cohort study using Medicaid data from November 2019 through December 2020 for 91,914 individuals from Kentucky and Ohio, Hammerslag and colleagues found those who initiated buprenorphine treatment via telemedicine had higher odds of retention, while there were no between-group difference in the odds of opioid-related nonfatal overdose.[76] The study referred only to buprenorphine dispensing, without any reference to any psychosocial elements in the treatment program.[76] Further, the study compared patients by the method used to initiate treatment and it is unknown whether those in the telehealth group had any in-person appointments, and vice versa, or whether all care was provided virtually.[76]

In a cross-sectional survey of 601 individuals receiving treatment for OUD through telemedicine, Hendy and colleagues (2025) compared the experiences of rural and nonrural patients.[77] Rural patients were more likely to report preferring telehealth due to a lack of providers in their local area (33% rural vs. 13% nonrural) and using telemedicine to get better access to health care services (94% vs. 76%).[77] The survey had some methodological issues, including leading wording of questions that presumed participants preferred telehealth over in-person care, but both rural and nonrural residents had high overall satisfaction with telehealth care, with no differences by rural residence.[77] However, the study did not specify which services participants were receiving via telehealth.[77] There were general references to use of telehealth for receiving buprenorphine for at-home initiation and use of telehealth for counseling or peer support groups, but it is unclear which services individual respondents were receiving or whether all services were provided through telehealth without the need for any in-person appointments.[77]

While telehealth is promoted as a means of increasing access to OUD treatment, the place of telehealth-only medications for OUD treatment in the treatment care path is not yet clear.[78] Many studies took place in the context of COVID-19, when programs transitioned all or most care to telehealth by necessity, with no opportunities to institute rules around which patients were most likely to benefit, or which would be better served by an in-person or hybrid treatment approach. Further, studies of telehealth treatment for OUD share little information on incorporation of psychosocial treatments to understand the place of comprehensive OUD treatment through telehealth that incorporates medications for OUD with psychosocial treatment in the care plan for adults or adolescents with OUD.

Telehealth for OUD in the Context of COVID-19

Although they did not meet inclusion criteria for this review, our searches identified many exploratory studies that documented findings related to how US health systems, opioid treatment programs, and office-based treatment providers modified service delivery during the COVID-19 PHE. A nationwide Veterans Health Administration cohort study, for example, evaluated differences in receipt of therapy, counseling, and medications for OUD among veterans with OUD during COVID-19 versus prepandemic onset.[79] This study reported a reduced likelihood of receiving medications for OUD, therapy, or counseling following the onset of COVID-19 but also reported that medications for OUD policy exemptions that went into effect during the pandemic may have prevented further treatment disruption and improved access to medications for OUD.[79] In another national study, researchers analyzed data among 175,778 Medicare beneficiaries to examine receipt of telehealth services for the treatment of OUD, prescription of medications for OUD, and overdose rates among individuals with OUD starting a new episode of care before the COVID-19 PHE compared with those during the PHE.[80] This study reported that compared with the prepandemic cohort, individuals in the COVID-19 PHE cohort were more likely to receive OUD-related telehealth services and medications for OUD.[80] Furthermore, the study reported that during the COVID-19 PHE, receipt of OUD-related telehealth services was associated with increased treatment retention and a lower risk of overdose compared with those not receiving OUD-related telehealth services.[80] While these (and other) studies offer many insights into the impact of expanding access to treatment for OUD through telehealth and the easing of medications for OUD restrictions, they were not included in this review due to their retrospective study designs. Any interpretation of the data from these retrospective studies is limited by the many confounders related to the COVID-19 PHE environment (e.g., extreme isolation, routine disruptions, employment status changes, etc.).

CQ3. What are the published findings from evaluations of state Medicaid programs' implementation of telehealth-only services for adults and adolescents with OUD?

We were unable to identify any published evaluations of state Medicaid programs' implementation of telehealth-only services for adults and adolescents with OUD. There are several articles that discuss the use of telehealth to deliver SUD treatment but none that focus on telehealth-only treatment. There are several journal articles documenting North Carolina Medicaid's experience with telehealth expansion during the COVID-19 PHE and some of these address telehealth OUD treatment.[81-83] One qualitative study that interviewed North Carolina Medicaid officials, Medicaid managed care organization staff, SUD treatment providers, and

beneficiaries found high satisfaction with telehealth delivery of SUD treatment but also noted that some beneficiaries preferred in-person services when they were an option.[82] A second study in North Carolina found that telehealth visits for OUD increased significantly early in the pandemic and then decreased slightly over time; by 2023, the percent of North Carolina Medicaid beneficiaries with a prescription for medications for OUD who had a telehealth visit during the month dropped from a high of 63% to approximately 43%.[83]

CQ4. What are the health equity considerations for providing telehealth-only services for adults and adolescents with OUD?

While telehealth may be a potential solution to improving care access, the integration of telehealth into OUD treatment raises concerns about the potential for increasing disparities in care access, particularly for members of racial and ethnic minority populations, and those residing in rural areas due to lower rates of broadband internet availability and technology adoption. For example, studies reported that Black individuals, especially those in lower income brackets, face challenges in accessing and using digital health resources, potentially limiting the effectiveness of telehealth interventions for OUD treatment among this demographic.[84,85] Rural populations, another demographic facing inequitable OUD treatment access, often have limited technological infrastructure and broadband access, posing substantial barriers to telehealth adoption and utilization.[86] Rural residents may experience difficulties in accessing telehealth services due to inadequate technological resources, which could further exacerbate disparities in OUD treatment for a population with a shortage of in-person treatment options.[86]

A systematic review by Vakkalanka and colleagues (2024) explored health equity related to telehealth use for SUD during the COVID-19 pandemic, finding that telehealth utilization was lower among rural, older, and African American populations and highlighting that the movement toward telehealth poses both risks and opportunities for disadvantaged populations with OUDs.[87] Walker and colleagues (2025) conducted a cross-sectional study that used a large, commercially available national claims experience database to explore the role of telehealth in addressing disparities in SUD treatment utilization.[88] Using a cohort of 16.2 million US adults, the authors found that while Medicaid-covered individuals accounted for 93% of all SUD treatment visits in the database, they accounted for only 75% of telehealth SUD treatment services.[88] Medicare Advantage and commercially insured individuals, on the other hand, accounted for a disproportionate share of SUD telehealth visits.[88] During the time period under review (2019 to 2023), both in-person and telehealth visits for SUD treatment rose, suggesting that an increase in telehealth visits does not necessarily free up treatment providers' time from in-person treatment.[88]

In addition to a multipronged policy approach involving broadband access and digital literacy initiatives to address the digital divide that disproportionately affects racial and ethnic minority communities and rural areas, reimbursement policies need to be thoughtfully designed to ensure telehealth reaches the individuals who need it most.[86,89] This may include fair reimbursement rates for audio-only telehealth visits, recognizing that some patients may have limited access to technologies and infrastructure required for audiovisual telehealth visits.[86,89] While New York State has statutorily mandated reimbursement rate parity for telehealth visits, the bundled prospective payment system utilized by most federally qualified health centers (FQHC) means that large gaps still persist in payments for in-person services compared to off-site services.[89] A

survey-based study of FQHCs in New York State indicated that staff and leadership perceived the state's Medicaid telehealth policy as exacerbating workforce shortages, particularly for mental health professionals, while straining FQHC resources and potentially exacerbating inequities in accessing care.[89]

CQ5. What are the benefits and barriers to implementation of telehealth-only services for adults and adolescents with OUD?

Benefits

Treatment provided by telehealth reduces geographical, logistical, and psychological barriers to accessing care for individuals with OUD. Implementation of telehealth services for patients with OUD may address gaps in care due to lack of qualified providers (e.g., physician, nurse practitioner, or physician assistant who can prescribe medications for OUD, or addiction medicine specialist) in certain geographic areas.[15,90,91] Abell-Hart and colleagues conducted a geospatial analysis of New York State, using data from 2004 through 2019 to identify regions with fewer buprenorphine prescribers.[90] The number of buprenorphine prescribers per county ranged from 0 in Hamilton County to 948 in New York County.[90] The authors suggested telehealth was a way to improve access to care in rural regions.[90]

Offering treatment for OUD via telehealth also alleviates the logistical and psychological barriers that prevent individuals from accessing in-person care. Logistical barriers include transportation challenges (e.g., availability of public transportation to and from the clinic, cost of transportation),[92-94] arranging care for children or other family members during an in-person appointment,[15,93,94] or requesting time off from work or school to attend an in-person appointment.[92-94] Psychological barriers to in-person care include stigma associated with having and getting help for OUD,[15,91,92,95,96] anxiety associated with visiting the area around a clinic,[92-94] and fluctuating motivation for treatment.[93,94] The flexible scheduling that telehealth allows, such as appointments outside of normal business hours, on-demand appointments, and virtual walk-in hours, may reduce the logistical and psychological barriers associated with in-person appointments, and thereby reduce no-shows and cancellations for clinics.[15,91,94,96]

Individuals with OUD may experience fluctuating motivation and ability to seek treatment; telehealth allows for timely initiation of care, especially medication-based treatment, when a patient is ready.[93] For individuals who anticipate or experienced stigma from family, friends, or providers when accessing care in a traditional health care system, telehealth is an opportunity to be treated in a more comfortable (e.g., home), less stigmatizing environment.[73,91,96] Telehealth may also allow patients to avoid triggering experiences, such as seeing people or places associated with past drug use at or around a clinic.[92-94] Finally, telehealth gives providers an opportunity to assess their patients' living environment, which they cannot do during an in-person appointment at a clinic.[15,96] Seeing a patient's home environment may prompt discussion of ways to alter that environment to reduce harm and enhance recovery.[15,96] A policy statement from ASAM, endorsed by the American College of Academic Addiction Medicine, the American College of Medical Toxicology, and the American Osteopathic Academy of Addiction Medicine, notes that "[e]fforts to measure and compare the quality of telehealth-delivered addiction care against care delivered in other settings should consider that without a telehealth option, many individuals would otherwise not receive any addiction care at all."[95(p1)]

Barriers

Barriers to implementation of telehealth services can be divided into 3 categories: technological, provider-patient relationship, and regulatory.[92-95,97] Aronowitz and colleagues described a layered digital divide in which patients may lack internet access, not own a device that can connect to the internet (e.g., desktop computer, laptop, tablet, or smartphone), or have low digital literacy.[93] The ASAM policy statement on optimizing telehealth access to addiction care observes that "[i]nfrastructure barriers often limit the digital inclusion of individuals who are marginalized and minoritized…[s]ocioeconomic factors, including age, limited English proficiency, and social isolation have a disparate impact across communities and affect people's ability to engage with addiction medicine via telehealth."[95(p3)] Patients may not have an internet subscription due to lack of internet service providers or infrastructure in their geographic location, or an inability to pay for internet access.[97] Some patients use public wireless networks or share a computing device, which may affect their willingness to share information during a telehealth appointment due to privacy concerns.[15,92] For patients who do have reliable access to the internet and a computing device, lack of comfort with technology may limit their ability to engage in telehealth services.[15,92-94,97] Less comfort with technology (i.e., low digital literacy) may be more common in certain populations, such as older or recently incarcerated individuals.[92] Clinics may also struggle to maintain the necessary hardware and software to enable staff to securely work from home.[15] Even if patients and providers have sufficient internet access and computing devices, common technical difficulties, such as poor image resolution or audio delay, may disrupt the flow of conversation.[15] Providers also have to consider the accessibility of the applications that they use for individuals who have visual or hearing impairments or require translation services.[15]

Low digital literacy, recurring technical interruptions, or patient and provider preference may make it difficult for some patients and providers to adapt to the delivery of care through telehealth modalities.[93] Providers express concerns about their ability to establish a trusting relationship with, and conduct an appropriate assessment of, their patients via telehealth.[91-94,97] Other providers indicated that the absence of objective data (e.g., physical exam findings, urine drug test results) forced them to communicate better with their patients and establish a trusting relationship that they could rely on to guide treatment.[94] Some patients felt more comfortable sharing information from their home.[94]

Urine drug testing has been a mainstay of OUD treatment, and inability to perform timely drug testing is cited as a barrier to allowing OUD treatment exclusively via telehealth.[96] Urine drug testing is performed for patients receiving treatment for OUD to assess response to medications for OUD (i.e., decreased use of other opioids), monitor adherence to prescribed medications for OUD (and detect possible diversion of medication), and detect the presence of other substances that could affect treatment.[96] While urine drug testing gives important clinical information, whether it improves patient outcomes during OUD treatment with buprenorphine remains unknown.[96]

In the telehealth for OUD toolkit from the SAMHSA-funded Providers Clinical Support System, the authors recommend that functional improvement and treatment engagement be used as measures of effective OUD treatment, with alternative methods (e.g., clinical interview, functional assessment, urine drug testing at an outside laboratory, supervised home testing, remote pill counts by video) used as an adjunct to monitor treatment.[96] Qualitative research

suggests there are varied perspectives on the utility of drug testing amongst providers and patients.[94] The ASAM public policy statement on optimizing telehealth access to addiction care states that "[r]equirements for ancillary services, such as toxicology testing, should not be barriers to accessing addiction care via telehealth and may be delivered via telehealth in some circumstances."[95(p5)]

Several regulatory and policy barriers limit the widespread implementation of telehealth services for OUD. One concern raised about expansion of buprenorphine prescribing via telehealth is the potential for drug diversion, which is when controlled substances are misused or unlawfully distributed.[58,98] The DEA acknowledges the inherent risk of diversion for any controlled substance.[58] When DEA and HHS published the notice of proposed rulemaking for expansion of buprenorphine via telemedicine encounter in March 2023, the agencies received 791 comments related to diversion of buprenorphine. Some commenters (135) observed there is no evidence that shows telehealth leads to higher diversion of buprenorphine than in-person care.[58] Other commenters pointed out that when buprenorphine is diverted, it is for therapeutic purposes and there would be less diversion if it were easier to obtain through a legitimate prescription.[58] A small number of commenters (12) expressed concern that the expansion of for-profit telehealth companies could lead to increased buprenorphine diversion.[58] In September 2023, the DEA and HHS held telemedicine listening sessions to receive input on the prescribing of controlled substances without an in-person evaluation. During these sessions, some presenters mentioned that buprenorphine may be sold to fund the purchase of other illicit substances, such as methamphetamine.[58]

A recent (2025) study found that among 500 newly enrolled patients at a large telehealth OUD provider (Bicycle Health), 232 (46.4%) were taking buprenorphine at the time of enrollment.[99] Ninety-two patients (18.4% of total, or 39.7% of those taking buprenorphine at enrollment) reported they obtained the buprenorphine via diversion.[99] The authors of this study suggested that increased access to legitimate buprenorphine prescriptions via telehealth may decrease buprenorphine diversion.[99] A 2023 scoping review on buprenorphine diversion in the US found motivations for using diverted buprenorphine fell into 5 categories: avoidance of withdrawal symptoms; treatment of OUD; to get high; management of drug use and effects; and inability to procure drug of choice.[100] Two of the included studies described the relationship between nonprescription buprenorphine use and nonfatal overdose.[100] In 1 study, more frequent buprenorphine use reduced the odds of nonfatal overdose.[100] In the other study, individuals who used nonprescription buprenorphine on a nearly daily basis had a lower prevalence of overdose compared with those who used it sporadically.[100]

Licensure may also pose a barrier to expansion of telehealth services.[15,95,101] Most states require physicians and other health care providers (e.g., nurses, psychologists) to be licensed in the state in which they practice.[101] For New York Medicaid members, providers located at a distant site within the US or US territories may provide telehealth services if the services are allowable, the provider is enrolled in New York State Medicaid, and the provider has a New York State license.[53] Proposed legislation (under review as of May 2025) to allow physicians licensed in another state or territory to practice time-limited follow-up care in New York State[102,103] and allow New York State to become a member of the Interstate Medical Licensure Compact[104,105] may ease licensure barriers for providers outside of New York State.

The final policy barrier to implementation and uptake of telehealth services is payment parity.[73,95,98] Before the COVID-19 PHE, telehealth services were often reimbursed at a lower rate than in-person services.[95] The ASAM policy statement on optimizing telehealth access to addiction care recommends that "[p]ayers should cover telehealth-delivered addiction care on the same basis and to the same extent they cover the provision of the same service through in-person care, including prescribing …"[95(p6)] This policy statement also recommends that reimbursement rates for telehealth-delivered addiction services be fair, equitable, and account for facility fees for individuals who need a safe, confidential location where they can access telehealth services.[95] CMS guidance indicates that states are not required to submit a State plan amendment to pay for services delivered by telehealth if those services are reimbursed in the same manner (i.e., rate and payment methodology) as when the service is delivered in person.[106-108] According to New York State law (Chapter 45 Article 29G §2999-DD), telehealth services are entitled to reimbursement on the same basis, at the same rate, and to the same extent as equivalent in-person services, with exceptions for some facility types.[53] This law is effective until April 1, 2026.[53] Bills (S354 and A6334) that allow the continuation of these provisions were introduced in the New York State Senate and Assembly in January and March 2025, respectively; as of June 24, 2025, the bill had passed in the Senate but was still under review in the Assembly.[109,110]

A notable exception to payment parity for services provided via telehealth exists for Article 28-licensed facilities in New York State.[111] Article 28-licensed FQHCs that have not opted into Ambulatory Patient Groups can only bill the in-person prospective payment system rate for telehealth services if either the practitioner or the patient is on site at the facility.[111] If both the practitioner and patient are offsite for the telehealth encounter, then the FQHC will be reimbursed at approximately one-third of the in-person rate.[111,112] This policy results in a financial loss for Article 28-licensed FQHCs, as well as a loss of qualified practitioners, who may go on to seek employment at institutions that offer higher salaries and remote work opportunities.[89] Article 31-licensed facilities (e.g., behavioral health clinics), regulated in New York State by the Office of Mental Health, and Article 32-licensed facilities (e.g., SUD outpatient clinics), regulated in New York State by the OASAS, receive nearly full payment of their bundled rates for telehealth services, regardless of the location of the practitioner and patient.[111] Bills (S3359 and A1691) that ensure Article 28-licensed facilities are fully reimbursed for providing telehealth services, regardless of the location of the practitioner and patient, were introduced to the New York State Senate and Assembly in January 2025.[112,113]

Methods

Key Questions

KQ1. What is the clinical effectiveness of telehealth-only services for adults and adolescents with OUD?

a. Does clinical effectiveness vary by patient characteristics (e.g., age, sex), disease characteristics (e.g., severity, comorbidities), or provider characteristics (e.g., opioid treatment program vs. other outpatient setting, staff for remote monitoring, staff for in-person care)?

b. Does clinical effectiveness vary by program characteristics (i.e., delivery method, such as synchronous audio-visual communication, remote patient monitoring), frequency of contact with provider, devices used, or workforce composition of the staff (e.g., credentials)?

KQ2. What are the harms of telehealth-only services for adults and adolescents with OUD?

a. Do harms vary by patient characteristics (e.g., age, sex), disease characteristics (e.g., severity, comorbidities), or provider characteristics (e.g., opioid treatment program vs. other outpatient setting, staff for remote monitoring, staff for in-person care)?

b. Do harms vary by program characteristics (i.e., delivery method, such as synchronous audio-visual communication, remote patient monitoring), frequency of contact with provider, devices used, or workforce composition of the staff (e.g., credentials)?

KQ3. What are the costs or cost-effectiveness studies related to providing telehealth-only services for adults and adolescents with OUD, including relative costs compared with other treatment modalities?

KQ4. What are clinical practice guideline recommendations for telehealth-only services for adults and adolescents with OUD?

KQ5. What are relevant Medicaid program coverage policies and health plan policies for telehealth-only services for adults and adolescents with OUD?

Study Eligibility Criteria

Table 1 summarizes key inclusion criteria.

Table 1. Key Study Inclusion Criteria

Study Component	Inclusion Criteria
Populations	• Adults and adolescents diagnosed with OUD
Interventions	• OUD treatment services, with or without medications for OUD, provided exclusively through telehealth-only modalities
Comparators	• Head-to-head comparisons of telehealth-only services • In-person services • Hybrid models of services • Standard care • No treatment

Study Component	Inclusion Criteria
Outcomes	Critical • Retention in treatment (e.g., sessions completed, uninterrupted treatment) • Abstinence from illicit use of opioids (e.g., number of days or weeks without use) • Serious adverse events Important • Adherence to prescribed medication for individuals prescribed medications for OUD • For individuals who were pregnant during the intervention, neonatal outcomes (e.g., neonatal intensive care admission, newborn length of stay) • Emergency department utilization • Cost and cost-effectiveness • Validated measures of patient quality of life • Patient satisfaction
Timing and follow-up	• Minimum follow-up of 90 days after service initiation
Setting	• Studies conducted in outpatient settings • Studies conducted in countries categorized as *very high* on the Human Development index
Study design	KQ1–KQ2 • RCTs • Prospective comparative cohort studies • Registry studies for harms only KQ3 • Comparative studies and economic evaluations • Cost-effectiveness analyses • Economic modeling studies KQ4 • Evidence-based clinical practice guidelines that have specific treatment recommendations
Sample size	• No limit
Publication type	• Peer-reviewed publication of primary study results • Published in the English language • Ancillary publications with additional comparative follow-up or prespecified subgroup analysis

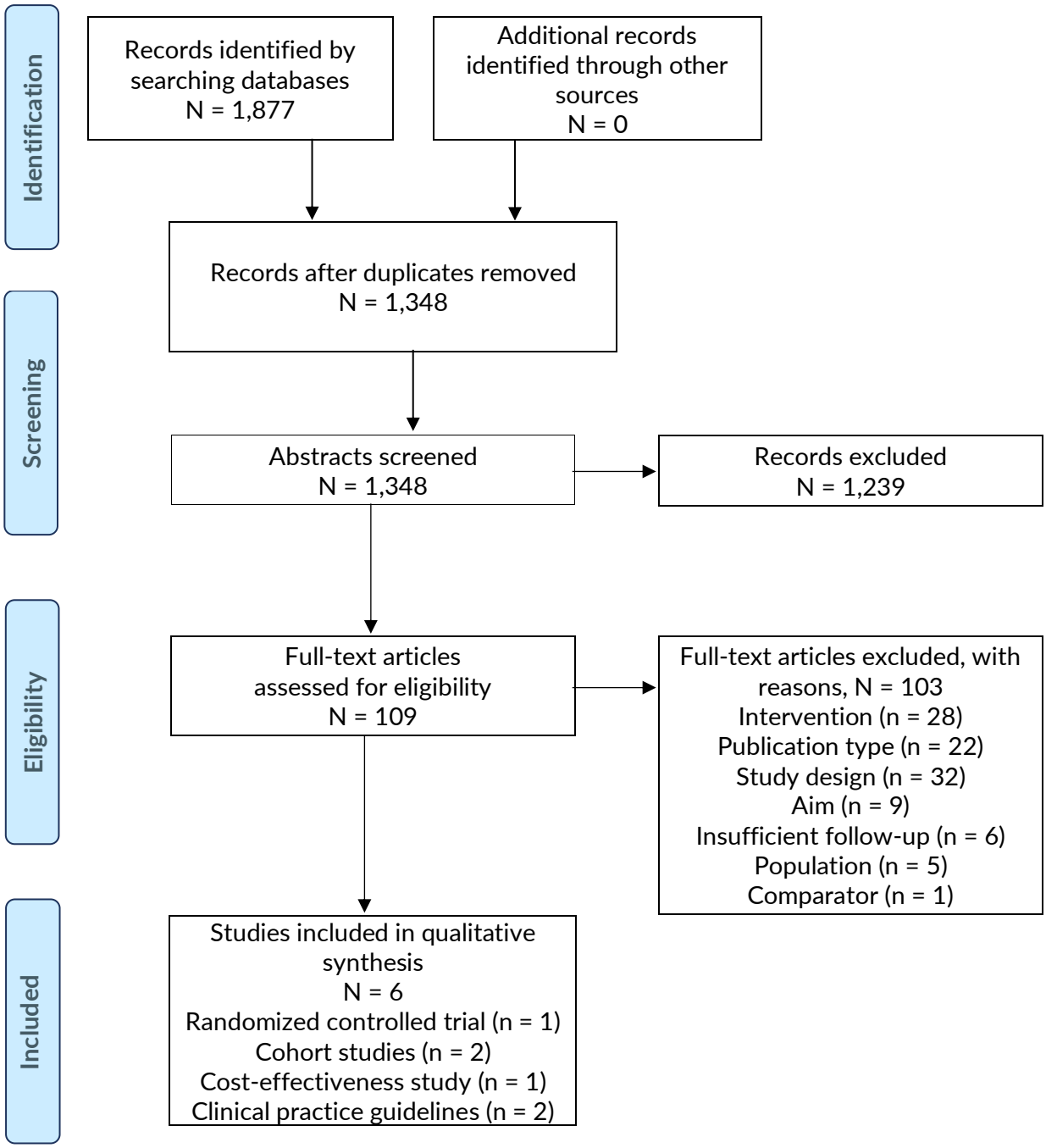
Abbreviations. KQ: key question; OUD: opioid use disorder; RCT: randomized controlled trial.

Evidence and Policy Searches

We searched Ovid MEDLINE, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, and other information sources for randomized controlled trials (RCTs), prospective comparative cohort studies, registry studies, cost and cost-effectiveness studies, and clinical practice guidelines. We identified 1,348 potentially relevant publications for the KQs of clinical evidence, harms, cost-effectiveness, and clinical practice guidelines (Figure 1). We also searched trial registries for relevant ongoing trials. Searches were conducted December 31, 2024 through January 2, 2025, and on March 5, 2025 (clinical trial registries). The Ovid MEDLINE search strategy was updated on March 17, 2025. A full list of searched sources and search strategies is in Appendix A. We did not conduct systematic searches to identify publications to answer contextual questions.

Researchers from the Center for Evidence-based Policy (Center) searched 9 state Medicaid program websites, health plan websites, and CMS for local and national coverage determinations of treatment of OUD exclusively by telehealth. Appendix A lists the search terms used to identify relevant policies as well as the sources searched.

Figure 1. PRISMA Diagram of Study Selection Process



Screening and Inclusion

Two Center researchers used the DistillerSR systematic review software platform to screen publications identified in the searches using the detailed inclusion and exclusion criteria listed in Appendix B. Disagreement about inclusion was resolved through discussion. Appendix D lists included studies, and Appendix G lists studies excluded during full text screening with the primary reason each study was excluded. Figure 1 shows the numbers of studies screened and included or excluded at each step.

Risk-of-Bias Assessment

Two Center researchers assessed each included study for risk of bias using standard forms. Appendix E provides detailed tables with criteria considered for assessing risk of bias or methodological quality. Disagreement between the researchers was resolved through discussion.

Data Abstraction

One Center researcher used a standard form to extract all data presented in tables, and a second researcher verified each data point against the original publication to ensure accuracy.

Synthesis

Without sufficiently similar data across multiple studies, we provided a qualitative synthesis and tables as necessary for all outcomes. We applied the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) approach to rate the certainty of evidence for each outcome from the data we abstracted from the trials that compared OUD treatment services, with or without medications for OUD, delivered exclusively through telehealth-only modalities with other telehealth-only services, in-person services, hybrid models of services, standard care, or no treatment. The GRADE system defines the overall quality of a body of evidence for an outcome in the following manner:

- **High:** Raters are very confident that the estimate of the effect of the intervention on the outcome lies close to the true effect. RCTs start at this level. Typical sets of studies are RCTs with few or no limitations, and the effect estimate is likely stable.
- **Moderate:** Raters are moderately confident in the estimate of the effect of the intervention on the outcome. The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is different. Typical sets of studies include RCTs with some limitations or well-performed nonrandomized studies with additional strengths that guard against potential bias and have large estimates of effects.
- **Low:** Raters have little confidence in the estimate of the effect of the intervention on the outcome. The true effect may be substantially different from the estimate of the effect. Nonrandomized studies start at this level. Typical sets of studies include RCTs with serious limitations or nonrandomized studies without special strengths.
- **Very low:** Raters have no confidence in the estimate of the effect of the intervention on the outcome. The true effect is likely to be substantially different from the estimate of the effect. Typical sets of studies include nonrandomized studies with serious limitations or inconsistent results across studies.
- **Not applicable:** Researchers did not identify any eligible studies.

Evidence Review

We identified 3 publications from 3 eligible studies with effectiveness outcomes,[10-12] 1 cost-effectiveness analysis,[13] and 2 clinical practice guidelines. We did not identify any eligible studies that reported harms outcomes. We identified 2 relevant ongoing trials. The clinical evidence review is organized by KQ and then by comparison group. Characteristics of the included studies are described in Table 2. Detailed information on risk-of-bias assessments for the included studies are available in Appendix E.

Table 2. Characteristics of Included Studies

Primary Publication Author, Year Study Design Trial Identifier (If Available) Length of Follow Up Purpose	Population Description N Total or Randomized Participants N Analyzed Participants % Female Age (Years)	Risk of Bias Outcomes of Interest Reported
Sigmon et al., 2023[10] 2 parallel RCTs NCT03420313 Follow-up: 24 weeks Purpose: To evaluate technology-assisted buprenorphine efficacy among individuals residing in both nonrural and rural communities	Adults with untreated OUD from nonrural (trial 1) or rural (trial 2) communities. Randomized N = 100 (50 nonrural, 50 rural) Analyzed N = 100 % Female = • Trial 1: 44.0 • Trial 2: 40.0 Mean age (SD) = • Trial 1: 40.6 (13.1) • Trial 2: 40.3 (10.8)	Moderate RoB • Abstinence from opioids (confirmed by urine sample at each study visit) • Adherence to prescribed medications for OUD (administered in-person by staff every 2 weeks, with remaining doses taken at home, with usage tracked through pill count) • Patient satisfaction (clinic-developed survey administered at week 24)
Chan et al., 2024[11] Prospective observational comparative cohort study NCT03224858 Follow-up: 24 weeks Purpose: To compare an intentionally designed telehealth-only buprenorphine treatment model to office-based treatment as usual on rates of buprenorphine discontinuation	Adults with OUD initiating buprenorphine treatment. Total N = 159 (103 telehealth, 56 in-person) Analyzed N = 159 % Female = 52 Mean age (SD) = 37.1 (10.2)	Moderate RoB • Adherence to prescribed medications for OUD (assessed at each follow-up appointment; 4-, 12-, and 24-weeks post study initiation) through a single yes/no question: “Do you still have a prescription for buprenorphine?”
Guille et al., 2020[12] Prospective observational comparative cohort study NCT04049032 Follow-up: during pregnancy through 8-weeks postpartum Purpose: To compare maternal and newborn outcomes among	Women receiving perinatal OUD treatment by telemedicine or in person. Total N = 98 (44 telehealth, 54 in-person) Analyzed N = 89 % Female = 100	Low RoB • Abstinence (verified by monthly urine drug screen)) • Retention in treatment (defined as continuous addiction treatment, including uninterrupted treatment with buprenorphine and at least

Primary Publication Author, Year Study Design Trial Identifier (If Available) Length of Follow Up Purpose	Population Description N Total or Randomized Participants N Analyzed Participants % Female Age (Years)	Risk of Bias Outcomes of Interest Reported
pregnant women with OUD receiving care via telemedicine compared with in person	Mean age (SD) = 30.2 (5.1)	monthly visits with the prescribing psychiatrist during pregnancy through 6- to 8-weeks postpartum) • Neonatal outcomes (neonatal abstinence syndrome documented in the electronic health record, length of newborn hospital stay and birth weight per electronic health record)
Claypool et al., 2023[13] Cost-effectiveness analysis 12-year time horizon Purpose: To conduct a cost effectiveness analysis and compare interventions associated with increased buprenorphine treatment initiation, duration, and capacity	The SOURCE model was used to estimate the potential public health effects and assess cost-effectiveness of 5 interventions (contingency management, psychotherapy, hub-and-spoke training and support model, ED-initiated buprenorphine, and telehealth for buprenorphine prescribing), and combinations of these interventions aimed at increasing OUD treatment with buprenorphine.	Moderate RoB • Cost-effectiveness

Abbreviations. ED: emergency department; NCT: national clinical trial; OUD: opioid use disorder; QoL: quality of life; RCT: randomized controlled trial; RoB: risk of bias; SD: standard deviation.

KQ1. Effectiveness

We identified 1 RCT[10] and 2 prospective cohort studies[11,12] evaluating the efficacy of treatment for OUD delivered exclusively by telehealth. Of the 3 studies, 1 evaluated a comprehensive app-based treatment for OUD,[11] 1 evaluated telehealth for management of medications for OUD,[10] and 1 evaluated telehealth treatment for OUD in pregnant women.[12] Two of the studies were assessed as having a moderate risk of bias,[10,11] and 1 of the studies was assessed as having a low risk of bias.[9] Table 3 presents a summary of the effectiveness outcomes from the 3 eligible studies, and outcomes are summarized in Table 4.

Table 3. Effectiveness Outcomes

Author, Year Population Study Arms Risk of Bias	Abstinence Outcomes	Retention and Adherence Outcomes	Other Outcomes
RCT			
Sigmon et al., 2023[10] Adults with untreated OUD from nonrural (trial 1) or rural (trial 2) communities Telehealth arm: Buprenorphine take-home doses dispensed by a computerized device during a predetermined 3-hour window Control arm: participants receiving community resource guides only (no medication) N = 100 Moderate RoB	Percent abstinent, across all monthly assessments (confirmed by urine sample) Trial 1 • Telehealth: 85.3% (95% CI, 70.7 to 93.3) • Control: 24.0% (95% CI, 13.6 to 38.8) • Difference: 61.3% (95% CI, 44.6 to 78.1; *P* < .001) Trial 2 • Telehealth: 88.0% (95% CI, 72.1 to 95.4) • Control: 21.3% (95% CI, 11.4 to 36.5) • Difference: 66.7% (95% CI, 49.9 to 83.4; *P* < .001)	Buprenorphine adherence, percent of doses taken (telehealth arm only, control did not receive medication) Trial 1: 98.9% (3614 of 3653) Trial 2: 99.3% (3812 of 3840)	Patient satisfaction (telehealth arm only), mean, rated 1-5 on a clinic-developed survey Trial 1: 4.9 (95% CI, 4.6 to 5.0) Trial 2: 4.9 (95% CI, 4.7 to 5.0)
Cohort studies			
Chan et al., 2024[11] Adults with OUD initiating buprenorphine treatment Telehealth arm: audio-visual mobile application for telehealth-only OUD treatment Control arm: treatment as usual at a university clinic and affiliated community health center N = 159	NA	Buprenorphine discontinuation (assessed through a single yes/no question: “Do you still have a prescription for buprenorphine?”) unadjusted at 24 weeks: • Telehealth: 4.1% • Control: 12.5% Adjusted risk of buprenorphine discontinuation at 24 weeks: • Telehealth: 3.8% • Control: 9.7%	NA

Author, Year Population Study Arms Risk of Bias	Abstinence Outcomes	Retention and Adherence Outcomes	Other Outcomes
Moderate RoB		• aRR 0.39 (95% CI, 0.17 to 0.89; *P* = .026)	
Guille et al., 2020[12] Consecutive women receiving perinatal OUD treatment, grouped by telemedicine or in-person delivery Telehealth arm: telehealth-only treatment for OUD Control arm: in-person treatment for OUD N = 98 Moderate RoB	Adjusted positive UDS at delivery: • Telehealth: 13.2% • Control: 20.6% • Difference −7.5% (95% CI, −22.7 to 7.8; *P* = .34) Adjusted positive UDS at 6 to 8 weeks postpartum: • Telehealth: 16.0% • Control: 20.3% • Difference −4.3% (95% CI, −22.6 to 18.4; *P* = .66)	Retention in treatment at 6 to 8 weeks postpartum: • Telehealth: 85.4% • Control: 91.7% • *P* =.50 Adjusted retention in treatment at 6 to 8 weeks postpartum: • Telehealth: 80.4% • Control: 92.7% • Difference −12.2% (95% CI, −32.3 to −4.4; *P* = .12) Retention in treatment defined as continuous addiction treatment, including uninterrupted treatment with buprenorphine and at least monthly visits with the prescribing psychiatrist during pregnancy through 6 to 8 weeks postpartum	Neonatal abstinence syndrome: • Telehealth: 43.6% • Control: 62.2% • *P* = .12 Adjusted neonatal abstinence syndrome: • Telehealth: 45.4% • Control: 63.2% • Difference −17.8 (95% CI, −41.0 to 8.9); *P* = .24)

Abbreviations. aRR: adjusted risk ratio; CI: confidence interval; NA: not applicable; OUD: opioid use disorder; RoB: risk of bias; UDS: urine drug screen.

Table 4. Summary of Findings (GRADE)

Participants (N) No. of Studies	Findings	Certainty of Evidence	Rationale for Certainty of Evidence Rating[a]
Retention in treatment			
N = 98 1 cohort study[12]	No significant difference • Guille et al. (2020) found no statistically significant between-group differences in rates of retention in treatment at 6 to 8 weeks postpartum, amongst women receiving perinatal treatment for OUD via telehealth or in-person (80.4% vs. 92.7%; *P* = .12)	●○○○ Very low	Downgraded for indirectness with limited population (-1). Cohort studies start at low CoE
Abstinence from opioids			
N = 198 1 RCT,[10] 1 cohort study[12]	Unclear effect • Sigmon et al. (2023) report a statistically significant effect in favor of telehealth compared with control across 6 months, in both nonrural (85.3% vs. 24.0%; *P* < .001) and rural populations (88.0% vs. 21.3%; *P* < .001); however, only the telehealth group received medication for OUD • Guille et al. (2020) report no significant between group difference in rates of positive urine drug screen at delivery (13.2% vs. 20.6%; *P* = .34) and at 6 to 8 weeks postpartum (16.0% vs. 20.3%; *P* = .66) amongst women receiving perinatal treatment for OUD via telehealth or in-person	●○○○ Very low	Downgraded for risk of bias (-1), inconsistency (-1), indirectness with limited population in 1 study (-1), and imprecision (-1) Cohort studies start at low CoE
Adherence to prescribed medication for OUD			
N = 259 1 RCT,[10] 1 cohort study[11]	Effect in favor of telehealth • Sigmon et al. (2023) report high levels of adherence to prescribed medication for OUD across 24 weeks in both nonrural (98.9%) and rural (99.3%) populations receiving treatment via telehealth ○ There was no medication for OUD prescribed to the control group for comparison • Chan et al. (2024) report statistically significant effect in favor of telehealth treatment for adherence to prescribed medication for OUD at 24 weeks (adjusted risk of discontinuation 3.8% vs. 9.7%; *P* = .026)	●○○○ Very low	Downgraded for risk of bias (-1) and very serious limitations in imprecision due to lack of comparator in RCT (-2) Cohort studies start at low CoE

Participants (N) No. of Studies	Findings	Certainty of Evidence	Rationale for Certainty of Evidence Rating[a]
Neonatal outcomes			
N = 98 1 cohort study[12]	No significant difference • Guille et al. (2020) report no statistically significant between-group differences in rates of NAS in neonates born to women receiving treatment via telehealth or in-person (45.4% vs. 63.2%; *P* = .24).	●○○○ Very low	Downgraded for indirectness with limited population (-1) Cohort studies start at low CoE
Patient satisfaction			
N = 100 1 RCT[10]	Unclear effect • Sigmon et al. (2023) report high levels of patient satisfaction with treatment via telehealth intervention ○ There was no patient satisfaction data collected from the control group	●○○○ Very low	Downgraded for risk of bias (-1) and very serious limitations in imprecision due to lack of comparator (-2)

Note. [a] For methods and interpretation of GRADE ratings, see Appendix C.
Abbreviations. CoE: certainty of evidence; GRADE: Grading of Recommendations, Assessment, Development, and Evaluations approach; OUD: opioid use disorder; NAS: neonatal abstinence syndrome; No.: number; RCT: randomized controlled trial.

Retention in Treatment

We identified 1 eligible study reporting retention in treatment outcomes associated with treatment of OUD exclusively by telehealth (Table 3 and Table G1).[12] Guille and colleagues (2020) found no statistically significant between-group differences in rates of retention in treatment at 6 to 8 weeks postpartum among women receiving perinatal treatment for OUD via telehealth or in-person (80.4% vs. 92.7%; difference −12.2% [95% CI, −32.3 to −4.4]; *P* = .12).[12]

Abstinence From Opioids

We identified 2 eligible studies reporting abstinence outcomes associated with treatment of OUD exclusively by telehealth (Table 3 and Table G1).[10,12] Overall, the direction of effect was unclear between the 2 studies. Sigmon and colleagues (2023) reported a statistically significant effect in favor of telehealth compared with control across 6 monthly assessments in both nonrural (85.3% vs. 24.0%; difference 61.3% [95% CI, 44.6 to 78.1]; *P* < .001) and rural populations (88.0% vs. 21.3%; difference 66.7% [95% CI, 49.9 to 83.4]; *P* < .001); however, only the telehealth group received medications for OUD (control participants only received community resource guides).[10] Although the authors reported that the treatment effect was attributable to the telehealth modality, it remains unclear if the significant difference in abstinence rates was due to the modality versus the administration of medications for OUD. Conversely, Guille and colleagues (2020) reported no significant between-group difference in rates of positive urine drug screen at delivery (13.2% vs. 20.6%; difference −7.5% [95% CI, −22.7 to 7.8]; *P* = .34) or at 6 to 8 weeks postpartum (16.0% vs. 20.3%; difference −4.3% [95% CI, −22.6 to 18.4]; *P* = .66) amongst women receiving perinatal treatment for OUD via telehealth or in-person.[12]

Adherence to Prescribed Medications for OUD

We identified 2 eligible studies reporting adherence to prescribed medications for OUD associated with treatment of OUD exclusively by telehealth (Table 3 and Table G1).[10,11] Both studies reported an effect in favor of telehealth. Chan and colleagues (2024) reported a statistically significant difference in risk of medications for OUD discontinuation in favor of telehealth treatment at 24 weeks (adjusted risk of discontinuation 3.8% vs. 9.7%; aRR 0.39 [95% CI, 0.17 to 0.89]; *P* = .026).[11] However, adherence was assessed using a single question related to having a buprenorphine prescription, not whether buprenorphine was being taken.[11] Sigmon and colleagues (2023) reported high levels of adherence to prescribed medications for OUD across 24 weeks in both nonrural (98.9%) and rural (99.3%) populations receiving treatment via telehealth; however, there were no medications for OUD prescribed to the control group for comparison.[10]

Neonatal Outcomes

We identified 1 eligible study reporting neonatal outcomes associated with treatment of OUD exclusively by telehealth (Table 3 and Table G1).[12] Guille and colleagues (2020) reported no statistically significant between-group differences in rates of neonatal abstinence syndrome among neonates born to women receiving perinatal treatment for OUD via telehealth or in-person (45.4% vs. 63.2%; difference −17.8% [95% CI, −41.0 to 8.9]; *P* = .24).[12]

Patient Satisfaction

We identified 1 eligible study reporting patient satisfaction outcomes associated with treatment of OUD exclusively by telehealth (Table 3 and Table G1).[10] Sigmon and colleagues (2023) reported high levels of patient satisfaction (mean 4.9, rated on a scale of 1 to 5) with treatment for OUD via telehealth in both nonrural and rural populations; however, no patient satisfaction data was collected from the control arm for comparison.[10]

Ongoing Trials

We identified 2 ongoing comparative trials on ClinicalTrials.gov investigating treatment for OUD delivered exclusively by telehealth. One trial, investigating sublingual buprenorphine through telemedicine versus in-person care as usual, is projected to start in June 2025 with an estimated completion date of September 2026. The other trial, investigating home versus office versus telehealth induction for medications for OUD, started in May 2021, is no longer recruiting and has an estimated completion date of February 2026. Internet searches also identified a Patient-Centered Outcomes Research award (with a contract pending) for a study of in-person versus telehealth OUD treatment after patients leave the emergency department (ED). This study has not been registered with ClinicalTrials.gov but has a projected completion date of December 2030. Other potentially relevant trials reviewed on ClinicalTrials.gov were either noncomparative or did not include OUD treatment delivered exclusively through telehealth. Registered trial characteristics are presented in Table 5.

Table 5. Characteristics of Relevant Ongoing Trials

Trial Identifier Intervention Location Estimated Completion Date Sponsor	Population Study Design Estimated Sample Size	Primary Outcomes
NCT05339256 Telehealth buprenorphine induction and maintenance US September 2026 New York State Psychiatric Institute	Adults with OUD voluntarily seeking buprenorphine treatment RCT N = 50	• Time in treatment
NCT04664062 3 methods of induction for medications for OUD (i.e., home, office, telehealth) US February 2026 University of Colorado, Denver	Individuals aged ≥ 16 years with opioid dependence seeking medications for OUD with buprenorphine RCT N = 303	• Number of days patient took buprenorphine (prescription refills and self-report) • Number of days patient took illicit opioids (patient self-report) • Number of patients that took buprenorphine on > 80% of days (initial prescription and refills, self-report, and urine test results) • Percentage of patients that took other opioids on < 10% of days (self-report and urine test results)

Abbreviations. OUD: opioid use disorder; RCT: randomized controlled trial; US: United States of America.

KQ2. Harms

Although advocates of telehealth for OUD emphasize that telehealth may increase access to OUD treatment,[95,114] empirical studies on the potential harms (e.g., fragmented care, inadequate follow-up care, worsening disparities) associated with treatment of OUD delivered exclusively by telehealth are lacking.[78] Our searches did not identify any eligible studies that report harms outcomes for the treatment of OUD exclusively by telehealth.

KQ3. Cost and Cost-Effectiveness

We identified 1 eligible economic modeling study that analyzed treatment of OUD exclusively by telehealth, rated as having a moderate risk of bias.[13] In this study, the SOURCE model was used over a 12-year horizon to estimate the potential public health effects and assess the cost-effectiveness of 5 interventions aimed at increasing buprenorphine OUD treatment initiation, duration, and capacity.[13] SOURCE is a system dynamics model that tracks opioid misuse and models treatment with medications for OUD, remission, relapse, and nonfatal opioid overdose.[13] Interventions included contingency management, psychotherapy, hub-and-spoke training and support model, ED-initiated buprenorphine, and telehealth for buprenorphine prescribing, individually and in combinations.[13]

This economic evaluation reported that telehealth alone resulted in a projected 126,866 quality-adjusted life years (QALYs) gained, and a projected $14,562,130,355 net monetary benefit compared with the status quo.[13] Telehealth alone was projected to be effective in increasing treatment duration but was associated with a projected initial increase in overdose deaths due to treatment capacity constraints.[13] However, when telehealth was combined with other interventions associated with increased treatment duration and capacity, there was a projected decrease in overdose deaths, and the benefits were greater than the sum of the separate interventions.[13] The authors further reported that a combination of strategies, including contingency management, hub-and-spoke-clinician training, ED buprenorphine initiation, and telehealth was the preferred approach at a generally accepted willingness-to-pay threshold of $100,000 per QALY and was likely to be cost-saving compared with the status quo.[13]

KQ4. Clinical Practice Guideline Recommendations

We identified 2 publications with relevant clinical practice recommendations: a VA/DoD clinical practice guideline and a SAMHSA evidence-based resource guide.[14,15] No other published guidelines or recommendations were identified that addressed treatment of OUD via telehealth.

VA/DoD Clinical Practice Guidelines

The VA/DoD published a clinical practice guideline for the Management of Substance Use Disorders in June 2020, and this document included a specific section on telehealth. [14] The VA/DoD clinical practice guideline is based on a systematic review of published clinical and epidemiological evidence with the stated purpose to "provide general guidance on best evidence-based practices."[14] We assessed the clinical practice guideline as having good methodological quality. The panel that drafted the clinical practice guideline included multidisciplinary experts (i.e., professionals in dietetics, emergency medicine, internal medicine, nursing, pain management, pharmacology, psychiatry, psychology, and social work).[14] Although the panel did not include patients, it considered feedback from a patient focus group while drafting the guideline.

Key guideline findings and recommendations related to the treatment of OUD via telehealth were limited to the following[14]:

- There is insufficient evidence to recommend for or against using technology-based interventions, in addition to usual care, for SUDs other than alcohol use disorder
- There is insufficient evidence to recommend for or against the use of telemedicine-delivered treatment for SUDs
- The use of structured telephone-based care may be useful as an adjunct to usual care for SUDs
- There is insufficient evidence to recommend for or against the use of computer-delivered behavioral treatments, either alone or in combination with usual care, for SUDs

SAMHSA Evidence-Based Resource Guide

SAMHSA published the Evidence-Based Resource Guide Series as a comprehensive set of modules with resources to improve health outcomes for people at risk for, experiencing, or recovering from serious mental illness (SMI) or SUD. In 2021, SAMHSA released a guide on Telehealth for the Treatment of SMI and SUD.[15] The guide is based on a review of published clinical and epidemiological evidence with the stated goal "to review the literature on the

effectiveness of telehealth modalities for the treatment of SMI and SUD, distill the research into recommendations for practice, and provide examples of how practitioners use these practices in their programs."[15] The panel that drafted the guide included federal, state, and nongovernmental experts, including scientists, researchers, service providers, community administrators, federal and state policy makers, and people with lived experience.[15] We assessed the guide as having poor methodological quality as a clinical practice guideline due to issues related to the rigor of the literature search, as well as a lack of transparent assessment of strength of evidence, clear and concise recommendations, consideration of harms, peer review, and conflict of interest disclosures. Despite these methodological limitations, the publication offers useful guidance with practical information to consider when implementing telehealth modalities for the treatment of SMI and SUD.

Key guideline findings and recommendations related to the treatment of OUD via telehealth included the following[15]:

- Telehealth is effective across the continuum of care for SMI and SUD
- Evidence-based treatments for SMI and SUD, traditionally provided face-to-face, are also effective when delivered using telehealth and have outcomes comparable to in-person service delivery
- Therapeutic services provided using telehealth modalities generate positive outcomes for the client, including engagement in treatment, retention in care, and client satisfaction, which in turn leads to improved long-term health outcomes
- Use of telehealth modalities increases individuals' and communities' access to trained providers and evidence-based practices that may otherwise be unavailable
- When geographic and other access barriers prevent individuals from accessing services, telehealth fills a treatment gap and improves health outcomes
- Some clients may prefer to receive services wholly or partially by telehealth, and any of the treatment practices present may be part of an overall treatment plan that includes a hybrid of telehealth and in-person services

KQ5. Coverage Policies

We did not identify any coverage policies that specifically addressed treatment of OUD exclusively by telehealth. Neither the 8 health plans nor the 9 state Medicaid agencies we routinely search for EBBRAC reports had policies specific to this intervention. Coverage information for the health plans and Medicaid agencies we searched are described below.

Health Plans

Through internet searches, we identified that all 8 health plans had enrolled companies that deliver telehealth OUD treatment services as eligible providers, although these do not all appear to offer the services to New York enrollees.

The 2 national commercial health plans we reviewed, Aetna and Cigna, both enroll telehealth-only OUD treatment providers to offer services to some of the plan enrollees. Aetna enrolled Workit Health to offer telehealth addiction treatment in 6 states,[21-26] though Workit Health provides services exclusively through telehealth and does not currently operate in New York.[115] Cigna enrolled Bicycle Health for telehealth addiction treatment in 26 states, not including New

York.[27,116-118] Bicycle Health provides services exclusively via telehealth and does not currently operate in the state of New York.[27,119]

Four of the New York health plans we reviewed, Anthem Empire BCBS New York,[16,120,121] Fidelis Care,[17] Healthfirst,[18] and UnitedHealthcare[19,20] have provider agreements with Ophelia to cover telehealth OUD treatment, although UnitedHealthcare does not appear to offer the coverage to its New York enrollees.[20] Both Healthfirst[18] and Fidelis Care[17] offer Ophelia services to both commercial and managed Medicaid enrollees. Ophelia provides services exclusively via telehealth.[122]

Molina Healthcare works with Bright Heart Health to offer telehealth OUD treatment to all adult Molina enrollees in Washington State.[28] We were unable to identify whether Molina offers the service in other states, including New York.

MetroPlus Health provides telehealth behavioral health services, including treatment for OUD, through NYC Health + Hospitals Virtual ExpressCare service.[123] A 2024 press release describing the Virtual ExpressCare services stated that in the first 2 years of the program, nearly 14,000 people had received telehealth behavioral health care and more than 60 people had been prescribed buprenorphine during that time.[123]

Medicaid

For EBBRAC reports, we regularly search 9 state Medicaid programs for reference coverage policies: California, Florida, Massachusetts, New Jersey, North Carolina, Oregon, Pennsylvania, Texas, and Washington. None of these Medicaid programs had policies that directly addressed treatment of OUD exclusively by telehealth. We reviewed SUD treatment policies and telehealth policies for these states for relevant information and searched the websites of a sample of telehealth OUD treatment providers for information about coverage. The 6 telehealth company websites we reviewed were: Affect Therapeutics,[124] Bicycle Health,[27] Bright Heart Health,[125] Eleanor Health,[126] Ophelia,[127] and Workit Health.[128] These companies were reviewed because they appeared in our internet searches; though there are likely more than 6 companies offering telehealth OUD treatment, our analysis is limited to these 6 companies. Findings from each state Medicaid program are summarized below. Relevant Medicaid policy language is in Appendix H.

California

In 2015, Medi-Cal, California's Medicaid program, received approval from CMS to implement the first Substance Use Disorder section 1115 SUD waiver.[129] CMS created the 1115 demonstration opportunity to assist states in addressing the opioid crisis.[130] Reforms have reorganized SUD treatment services in the state, increased access to treatment, and improved care coordination.[129]

Medi-Cal allows all enrolled SUD treatment providers to deliver all covered services via audio-only or audio-visual telehealth if the service provider believes telehealth is clinically appropriate and safe for the beneficiary.[131] Medi-Cal does require that service providers using telehealth either provide the option of receiving services in-person or facilitate the transfer of the care of the patient to a service provider offering in-person service to individuals who request in-person care.[131] The SUD treatment billing manual states that all outpatient SUD treatment services, including intensive outpatient treatment (ASAM level 2.1), partial hospitalization (ASAM level

2.5), and outpatient SUD treatment services, such as assessment, care coordination, individual and group counseling, family therapy, patient education, medication for OUD, recovery services, and crisis intervention services may be provided in person, by telehealth, or by telephone.[132]

Bright Heart Health, which is based in California, states on its website that it accepts Medi-Cal insurance for its telehealth OUD treatment services.[133] Bicycle Health, which was founded in California and now operates in 32 states,[134] lists California Medicaid on its list of accepted insurances with a note that new patient capacity is limited.[27]

Florida

We were unable to identify any Florida Medicaid coverage policies that discussed the use of telehealth in the treatment of OUD.

From our review of websites of companies that offer telehealth-only OUD treatment, 5 offer services to patients in Florida: Affect,[135] Bicycle Health,[27] Eleanor Health,[136] Ophelia,[20] and Workit Health.[115] Affect lists 6 Florida Medicaid managed care organizations (MCOs) on its insurance tracker as enrolled payers, but all 6 health plans currently have a notation that the company is not accepting new members from these plans at this time.[135] As with Medi-Cal, Bicycle Health includes Florida Medicaid on its list of covered insurances but notes that new patient capacity is limited and as of June 5, 2025, that it cannot currently accept Medicaid in Florida.[27] Eleanor Health's website states that it accepts most major insurance plans in Florida, including Aetna and UnitedHealthcare, but it does not mention Florida Medicaid.[136] Ophelia does not include Florida Medicaid in its insurance plan tracker.[20] Workit Health's website states that Florida Medicaid is not accepted at this time.[115]

Massachusetts

MassHealth, the Massachusetts Medicaid program, began to expand access to behavioral health services through telehealth in 2019, before the COVID-19 PHE.[137] Beginning January 1, 2019, outpatient SUD treatment providers were allowed to counsel individuals in treatment for OUD through audio-visual telehealth.[137] With the onset of the PHE, MassHealth expanded telehealth options to allow audio-only services and removed the requirement to have an in-person visit before prescribing medications for OUD.[138,139]

In 2022 and 2023, MassHealth established general rules for telehealth that allow all appropriate services (including SUD treatment services) to be provided by audio-visual or audio-only telehealth visits.[140,141] MassHealth policies require service providers to obtain consent from the individual to receive services via telehealth and requires that managed care plans continue to offer options for in-person services to meet network adequacy standards.[140,141]

According to their company websites, none of the companies we identified that provide telehealth-only OUD treatment offer services in Massachusetts.

New Jersey

As with Massachusetts, in 2019 New Jersey took steps to advance the use of telehealth as a strategy to address the opioid crisis.[142] The state adopted rules allowing the use of audio-visual telehealth when the service provider determines use of telehealth would be consistent with the

standard of care applicable for those services when provided in person.[143, 13:25-6B.3.a] Audio-only telehealth does not appear to be allowed in New Jersey.[143]

In 2024, New Jersey amended previous legislation requiring reimbursement parity for services delivered via telehealth and those services provided in person.[144,145] The new legislation states that parity provisions "do not apply to a health care service provided by a telemedicine or telehealth organization that does not provide the health care service on an in-person basis in New Jersey."[144,145] The legislation also prohibits health plans and New Jersey Medicaid from limiting coverage of services "only to services delivered by select third-party telemedicine or telehealth organizations"; in-person services must also be available for plan enrollees.[144,145]

Ophelia has a large presence in New Jersey.[146,147] According to company press releases, Ophelia began offering services in 2022 to commercial health plan enrollees and uninsured individuals.[147] In October 2024, Ophelia announced that it had enrolled as a provider with 3 New Jersey Medicaid MCOs (Horizon BCBS, UnitedHealthcare, and Wellpoint) and now offered service to 89% of Medicaid members in the state.[146,147]

Eleanor Health also offers services in New Jersey, both virtually and at 4 clinics located in Cherry Hill, Edison, Galloway, and Verona.[148] Eleanor Health lists managed care Medicaid as an accepted insurance plan but does not provide details on which plans are accepted.[148]

Workit Health also offers services in New Jersey, both through a clinic located in Marlton and virtually across the state.[149] Workit Health's insurance checker states that it is an enrolled provider in New Jersey state Medicaid, and 7 Medicaid MCOs (Amerigroup, Amerigroup/Wellpoint, Fidelis Care, Horizon NJ Health, MagnaCare, Oxford UnitedHealthcare, and UnitedHealthcare Community Plan of New Jersey).[115]

North Carolina

North Carolina Medicaid's general telehealth policy allows for audio-visual and audio-only telehealth delivery of services when use of the modality is appropriate for the services rendered and individuals have a choice of telehealth or in-person care.[150] The provider manual for office-based opioid treatment allows for use of telehealth for counseling and medical consultation; for physician exams, the office-based opioid treatment provider may use telehealth if the patient is at a medical facility where a nurse practitioner, physician assistant, or physician can conduct a physical exam on behalf of the clinician addressing the opioid use.[151] The provider manual for enhanced mental health and substance abuse services does not list the services that are allowed to be delivered via telehealth but does say that intensive outpatient SUD treatment (ASAM level 2.1) and comprehensive outpatient treatment (ASAM level 2.5 partial hospitalization) are not telehealth-eligible services.[152]

Of the surveyed companies offering telehealth OUD treatment, Affect lists North Carolina Medicaid and 7 North Carolina Medicaid MCOs as covered insurances but, as with Florida, the website states that the company is not accepting new members from these plans at this time.[135] As with California and Florida, Bicycle Health includes North Carolina Medicaid on its list of covered insurances but notes that new patient capacity is limited and, as of June 5, 2025, that it cannot currently accept Medicaid in North Carolina.[27] Eleanor Health has clinics in Durham and Hickory and offers virtual services across the state.[153] Accepted insurance plans for Eleanor

Health in North Carolina include select Medicare and Medicaid plans but no further details are provided.[153]

Oregon

Oregon Medicaid covers audio-visual and audio-only telehealth delivered services when the clinical value of the service is equivalent to in-person care. [154] No other relevant Medicaid policies were identified.

Affect lists Oregon Health Plan (Medicaid) and 8 Oregon Medicaid MCOs as enrolled insurers.[135] Unlike in Florida and North Carolina, there is no notation indicating that members of these health plans are not currently accepted.[135] Bicycle Health provides services to people in Oregon and the company website lists Oregon Health Plan (Medicaid) as an accepted insurance.[27] As with California, Florida, and North Carolina, the website notes that Medicaid coverage for new patient capacity is limited, but it does not state that Oregon Medicaid is not currently accepted.[27]

Pennsylvania

In 2016, the Pennsylvania Department of Human Services, which oversees both Medicaid and the state's Office of Mental Health and Substance Abuse, established a network of Centers of Excellence for Opioid Use Disorder (COEs).[155] The state selected 45 organizations to become COEs, including primary care practices, hospitals, FQHCs, SUD treatment providers, and single-county authorities.[155] The COEs identify individuals in communities that have OUD and provide integrated SUD treatment, physical health treatment, and address any co-occurring behavioral health conditions, such as anxiety or depression.[155] Community-based care management teams also assist in addressing social needs including housing, transportation and employment, and all individuals have access to peer support and recovery support services.[155]

Pennsylvania Medicaid allows the use of audio-visual and audio-only telehealth services when the service provider believes telehealth is clinically appropriate.[156,157] State policy requires that service providers who offer telehealth must offer in-person services when they are clinically appropriate or if requested by the Medicaid member.[157]

Bicycle Health provides services in Pennsylvania; as with California, Florida, and North Carolina, Bicycle Health includes Pennsylvania Medicaid on its list of insurances covered but notes that new patient capacity is limited and, as of June 5, 2025, that it cannot currently accept Medicaid in Pennsylvania.[27] Ophelia includes Pennsylvania Medicaid in its insurance tracker, implying it is an enrolled Medicaid provider in Pennsylvania.[20]

Texas

Texas Medicaid allows the use of audio-visual telehealth to provide SUD assessments, individual and group counseling, and medications for OUD-related services.[158] In person or audio-visual telehealth services are preferred, but the use of audio-only telehealth for individual or group counseling is allowed under certain circumstances.[158] For audio-only services, the billing clinician must have an existing relationship with the patient, defined as having received at least 1 in-person or audio-visual telehealth service within the past 6 months.[158]

Affect offers services in Texas and lists 5 Medicaid health plans on its website.[135] Of the 5 plans listed, 4 are not available for the OUD program and 1 has an annotation that new members from

the plan are not accepted at this time.[135] Workit Health offers services in Texas and accepts 12 commercial health plans, Medicare, and 9 Medicare Advantage plans.[115] The company's website states that it does not accept Texas Medicaid at this time.[115]

Bicycle Health provides services in Texas and its website states that it accepts Texas Medicaid but that new patient capacity for Medicaid is limited.[27]

Washington

Washington Medicaid allows telehealth for SUD treatment services when the services are within the service provider's scope of practice and are clinically appropriate to be delivered via telehealth.[159,160] Audio-only telehealth requires an established relationship (defined as an in-person or audio-visual interaction within the past 3 years between the patient and the treatment provider or with a provider employed by the same clinic or medical group).[160]

Affect lists Washington Medicaid and 4 Medicaid MCOs as covered insurances; there are no notations about limits on accepting members from any Washington Medicaid plans.[135] Bright Heart Health provides telemedicine OUD treatment in Washington and accepts Washington Medicaid.[161]

Bicycle Health also offers services in Washington, and accepts Washington Medicaid.[27] The website states new patient capacity for Medicaid is limited.[27]

Ophelia's insurance tracker includes Medicaid of Washington, implying that it is an enrolled provider in Washington Medicaid.[20]

Policy Discussion

Companies developed telehealth-only options for OUD treatment to address unmet treatment needs and as a business opportunity; Pitchbook described virtual SUD treatment as a market opportunity exceeding $10 billion.[162] Many commercial health plans and Medicaid MCOs have included these companies in provider networks. However, as described above, several companies that accept Medicaid either limit the number of Medicaid patients they serve or are not currently accepting Medicaid patients.

Some state Medicaid agencies also include these companies in provider networks, but states that moved early to reform SUD treatment systems or expand telehealth options for all providers may have worked to increase telehealth options without adding new treatment providers.

Discussion

Telehealth may improve access to OUD treatment by mitigating access barriers, broadening the patient base, and simplifying care delivery.[95,114] However, the need to improve access to OUD treatment must be balanced with the need to ensure that patient care remains clinically effective.[163] Telehealth advocates emphasize the importance of eliminating in-person requirements to provide convenient, patient-centered care and broaden access to essential treatments.[50,97] Critics fear unregulated prescription practices in the absence of proper oversight and regular in-person visits, and contend that stringent regulations are essential for patient well-being.[87,164] Health care professionals express worries about fragmented care caused by

telemedicine-only practitioners, leading to issues like drug interactions and inadequate follow-up care.[163]

Before the COVID-19 PHE, provision of medications for OUD typically required in-person care, and therapy or counseling tended to occur in person. Coverage for and the availability of telehealth services for OUD became more widespread during the COVID-19 PHE. Although the field of telehealth for OUD treatment is rapidly evolving, significant research gaps persist. Our searches only identified 3 small comparative studies investigating the effectiveness of treatment for OUD delivered exclusively by telehealth. We did not identify any eligible studies that reported harms outcomes. The limited number of trials, lack of comparative data for all outcomes, small sample sizes, and confounding factors should be considered when drawing conclusions about the certainty of evidence for treatment of OUD exclusively by telehealth. Overall, we have very low certainty in these results, and new research is likely to change our understanding.

We identified a single cost-effectiveness analysis for treatment of OUD exclusively by telehealth.[13] This economic modeling study projected that telehealth alone would result in gained QALYS and a net monetary benefit compared with the status quo.[13] Telehealth alone was also projected to be effective in increasing treatment duration, though it was associated with a projected initial increase in overdose deaths due to treatment capacity constraints.[13] Although beyond the scope of this review, we note that the study authors also reported a projected decrease in overdose deaths when telehealth was combined with other interventions that increased treatment duration and capacity. Notably, the combined effect was greater than the sum of the individual interventions.[13] Again, however, our ability to draw robust conclusions from this single study is limited.

A good methodological quality VA/DoD clinical practice guideline for the management of SUD (2020) included a section on telehealth for the treatment of SUD but concluded there was insufficient evidence to recommend for or against telemedicine-delivered treatment for SUD.[14] A poor methodological quality guidance document published by SAMHSA, conversely, made many recommendations affirming the effectiveness of telehealth for the treatment of SUD.[15] Although the SAMHSA publication provides practical guidance for the implementation of telehealth for SUD, the evidence base used for affirming the effectiveness of telehealth is unclear.

In summary, there is very low certainty of evidence on the effectiveness of treatment of OUD exclusively by telehealth, and no evidence on its safety. None of the 8 health plans or 9 state Medicaid programs we regularly search had policies specific to the treatment of OUD exclusively by telehealth.

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Appendix A. Search Methods

Clinical Evidence Sources and Search Strategies

We searched selected bibliographic databases and grey literature sources using key words such as *opioid use disorder*, *teleconsultation*, *telehealth*, *telemedicine*, *teletherapy*, and *virtual* to identify randomized controlled trials, nonrandomized comparative trials, cost-effectiveness studies, and clinical practice guidelines. We did not use date limits, but did limit search results to publications available in the English language. An information specialist constructed and executed all searches. A second information specialist peer reviewed the Ovid MEDLINE search strategy. Searches were conducted December 31, 2024 through January 2, 2025, and March 5, 2025 (clinical trial registries). The Ovid MEDLINE search strategy was updated on March 17, 2025.

Bibliographic Database Sources

- Cochrane Central Register of Controlled Trials (CENTRAL)
- Cochrane Database of Systematic Reviews (CDSR)
- Ovid MEDLINE
- Ovid PsycInfo

Evidence Synthesis Sources

- Agency for Healthcare Research and Quality (AHRQ)
- Canada's Drug Agency
- Epistemonikos
- Health Quality Ontario
- Institute for Clinical and Economic Review (ICER)
- Institute for Health Quality and Efficiency in Health Care
- International Health Technology Assessment (HTA) Database
- National Institute for Health and Care Excellence (NICE)
- Oregon Health Evidence Review Commission (HERC)
- Veterans Administration Evidence Synthesis Program (ESP)
- Washington Health Technology Assessment

Clinical Practice Guideline Sources

- American Medical Association (AMA)
- American Association of Addiction Psychiatry (AAAP)
- American Psychiatric Association (APA)
- American Psychological Association (APA)
- American Society of Addiction Medicine (ASAM)
- American Telemedicine Association
- Guidelines International Network (GIN) International Guidelines Library
- National Consortium of Telehealth Resource Centers
- National Institute on Drug Abuse (NIDA)
- Scottish Intercollegiate Guidelines Network (SIGN)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- US Preventive Services Task Force (USPSTF)
- Veterans Administration/Department of Defense Clinical Practice Guidelines

Clinical Trial Sources

- ClinicalTrials.gov
- ScanMedicine

Ovid MEDLINE Search Strategy

1946 to December 31, 2024
Dates searched (number of results): January 2, 2025 (1,129); March 17, 2025 (60)

1	exp opioid-related disorders/
2	opiate substitution treatment/
3	((alfentan#l* or buprenorfin* or buprenorphin* or codein* or demerol or diacetylmorfin* or diacetylmorphin* or diamorfin* or diamorphin* or fentan#l* or heroin* or hycodan or hydrocodon* or hydromorf#n* or hydromorph#n* or meperidin* or methadon* or morfin* or morphin* or narcotic* or operidin* or opiate* or opioid* or opium* or ox#codon* or ox#con* or ox#morfon* or ox#morphon* or penta#ocin* or pethidin* or sufentan#l* or tapentadol* or tramadol*) adj3 (abstain* or abstin* or abuse* or abusing or addict* or assisted therap* or assisted treat* or depend* or detox* or disorder* or habit* or misuse* or mis-use* or overdose* or over-dose* or overuse* or over-use* or problem* or replace* or substitut* or withdraw*)).ti,ab,kf.
4	medications for OUD.ti,ab,kf.
5	or/1-4
6	exp telecommunications/
7	mobile applications/
8	web browser/
9	(telebehavio?ral health* or tele-behavio?ral health* or tele behavio?ral health*).ti,ab,kf.
10	(telecare* or tele-care* or tele care*).ti,ab,kf.
11	(telecommunicat* or tele-communicat* or tele communicat*).ti,ab,kf.
12	(teleconferenc* or tele-conferenc* or tele conferenc*).ti,ab,kf.
13	(teleconsult* or tele-consult* or tele consult*).ti,ab,kf.
14	(telecounsel* or tele-counsel* or tele counsel*).ti,ab,kf.
15	(telehealth* or tele-health* or tele health*).ti,ab,kf.
16	(telehomecare* or tele-homecare* or tele homecare*).ti,ab,kf.
17	(telematic* or tele-matic* or tele matic*).ti,ab,kf.
18	(telemedic* or tele-medic* or tele medic*).ti,ab,kf.
19	(telemental health* or tele-mental health* or tele mental health*).ti,ab,kf.
20	(telemonitor* or tele-monitor* or tele monitor*).ti,ab,kf.
21	(telenurs* or tele-nurs* or tele nurs*).ti,ab,kf.
22	(tele-oud or tele oud).ti,ab,kf.
23	(telepharmac* or tele-pharmac* or tele pharmac*).ti,ab,kf.
24	(telepsychiatr* or tele-psychiatr* or tele psychiatr*).ti,ab,kf.
25	(telepsycholog* or tele-psycholog* or tele psycholog*).ti,ab,kf.
26	(telepsychotherap* or tele-psychotherap* or tele psychotherap*).ti,ab,kf.
27	(telerehab* or tele-rehab* or tele rehab*).ti,ab,kf.
28	(teletherap* or tele-therap* or tele therap*).ti,ab,kf.

29	(mhealth* or m-health* or m health*).ti,ab,kf.
30	(econsult* or e-consult* or e consult*).ti,ab,kf.
31	(ehealth* or e-health* or e health*).ti,ab,kf.
32	((audio or audiovisual* or audio-visual* or digital* or internet or online* or on-line* or phone? or telephon* or tele-phon* or remote* or video* or virtual* or web) adj3 (care or communicat* or conferenc* or consult* or counsel* or deliver* or health* or intervention* or medicine or monitor* or prescrib* or psychiatr* or psycholog* or psychotherap* or rehab* or therap* or treat* or visit?)).ti,ab,kf.
33	(electronic mail* or email* or e-mail* or e mail*).ti,kf.
34	(android or cellphone? or cell-phone? or iphone? or i-phone? or ipad? or i-pad? or mobile device? or mobile phone? or smartphone? or smart-phone?).ti,ab,kf.
35	(instant messag* or sms or text*).ti,kf.
36	(videoconferenc* or video-conferenc*).ti,ab,kf.
37	(webcast* or web-cast* or web cast* or webinar*).ti,ab,kf.
38	(facetim* or face-tim* or face tim* or google meet* or goto meeting or go-to meeting or go to? meeting or goto webinar or go-to webinar or go to? webinar or microsoft teams or skype or webex or web-ex or web ex or zoom).ti,ab,kf.
39	(digital app* or electronic app* or mobile app* or smartphone app* or smart-phone app* or smart phone app* or software app*).ti,ab,kf.
40	(smartwatch* or smart-watch* or smart watch*).ti,ab,kf.
41	((remote or wearable or wireless) adj2 (device? or sensing or sensor?)).ti,ab,kf.
42	or/6-41
43	and/5,42
44	(baboon? or bovine? or canine? or cat? or chimpanzee? or cow? or dog? or feline? or goat? or hens or macque? or mice or monkey? or (mouse adj2 model?) or murine? or ovine or pig? or porcine or (non-human adj2 primate?) or sheep or rabbit? or rat? or rattus or rhesus or rodent? or zebrafish).ti.
45	43 not 44
46	limit 45 to english language

Cochrane Database of Systematic Reviews (CDSR) and Cochrane Central Register of Controlled Trials (CENTRAL) via the Cochrane Library Search Strategy

CDSR: Issue 1 of 12, January 2025
CENTRAL: Issue 12 of 12, December 2024
Date searched (number of results): January 2, 2025 (CDSR 1; CENTRAL 467)

#1	[mh "opioid-related disorders"]
#2	[mh "opiate substitution treatment"]
#3	((alfentan?l*:ti,ab,kw OR buprenorfin*:ti,ab,kw OR buprenorphin*:ti,ab,kw OR codein*:ti,ab,kw OR demerol:ti,ab,kw OR diacetylmorfin*:ti,ab,kw OR diacetylmorphin*:ti,ab,kw OR diamorfin*:ti,ab,kw OR diamorphin*:ti,ab,kw OR fentan?l*:ti,ab,kw OR heroin*:ti,ab,kw OR hycodan:ti,ab,kw OR hydrocodon*:ti,ab,kw OR hydromorf?n*:ti,ab,kw OR hydromorph?n*:ti,ab,kw OR meperidin*:ti,ab,kw OR methadon*:ti,ab,kw OR morfin*:ti,ab,kw OR morphin*:ti,ab,kw OR narcotic*:ti,ab,kw OR operidin*:ti,ab,kw OR opiate*:ti,ab,kw OR opioid*:ti,ab,kw OR opium*:ti,ab,kw OR ox?codon*:ti,ab,kw OR ox?con*:ti,ab,kw OR

ox?morfon*:ti,ab,kw OR ox?morphon*:ti,ab,kw OR penta?ocin*:ti,ab,kw OR pethidin*:ti,ab,kw OR sufentan?l*:ti,ab,kw OR tapentadol*:ti,ab,kw OR tramadol*:ti,ab,kw) NEAR/3 (abstain*:ti,ab,kw OR abstin*:ti,ab,kw OR abuse*:ti,ab,kw OR abusing:ti,ab,kw OR addict*:ti,ab,kw OR (assisted NEXT therap*):ti,ab,kw OR (assisted NEXT treat*):ti,ab,kw OR depend*:ti,ab,kw OR detox*:ti,ab,kw OR disorder*:ti,ab,kw OR habit*:ti,ab,kw OR misuse*:ti,ab,kw OR mis-use*:ti,ab,kw OR overdose*:ti,ab,kw OR over-dose*:ti,ab,kw OR overuse*:ti,ab,kw OR over-use*:ti,ab,kw OR problem*:ti,ab,kw OR replace*:ti,ab,kw OR substitut*:ti,ab,kw OR withdraw*:ti,ab,kw))

#4 medications for OUD:ti,ab,kw

#5 [OR #1-#4]

#6 [mh telecommunications]

#7 [mh "mobile applications"]

#8 [mh "web browser"]

#9 ((telebehavio?ral NEXT health*):ti,ab,kw OR (tele-behavio?ral NEXT health*):ti,ab,kw OR (tele NEXT behavio?ral NEXT health*):ti,ab,kw)

#10 (telecare*:ti,ab,kw OR tele-care*:ti,ab,kw OR (tele NEXT care*):ti,ab,kw)

#11 (telecommunicat*:ti,ab,kw OR tele-communicat*:ti,ab,kw OR (tele NEXT communicat*):ti,ab,kw)

#12 (teleconferenc*:ti,ab,kw OR tele-conferenc*:ti,ab,kw OR (tele NEXT conferenc*):ti,ab,kw)

#13 (teleconsult*:ti,ab,kw OR tele-consult*:ti,ab,kw OR (tele NEXT consult*):ti,ab,kw)

#14 (telecounsel*:ti,ab,kw OR tele-counsel*:ti,ab,kw OR (tele NEXT counsel*):ti,ab,kw)

#15 (telehealth*:ti,ab,kw OR tele-health*:ti,ab,kw OR (tele NEXT health*):ti,ab,kw)

#16 (telehomecare*:ti,ab,kw OR tele-homecare*:ti,ab,kw OR (tele NEXT homecare*):ti,ab,kw)

#17 (telematic*:ti,ab,kw OR tele-matic*:ti,ab,kw OR (tele NEXT matic*):ti,ab,kw)

#18 (telemedic*:ti,ab,kw OR tele-medic*:ti,ab,kw OR (tele NEXT medic*):ti,ab,kw)

#19 ((telemental NEXT health*):ti,ab,kw OR (tele-mental NEXT health*):ti,ab,kw OR ("tele mental" NEXT health*):ti,ab,kw)

#20 (telemonitor*:ti,ab,kw OR tele-monitor*:ti,ab,kw OR (tele NEXT monitor*):ti,ab,kw)

#21 (telenurs*:ti,ab,kw OR tele-nurs*:ti,ab,kw OR (tele NEXT nurs*):ti,ab,kw)

#22 (tele-oud:ti,ab,kw OR "tele oud":ti,ab,kw)

#23 (telepharmac*:ti,ab,kw OR tele-pharmac*:ti,ab,kw OR (tele NEXT pharmac*):ti,ab,kw)

#24 (telepsychiatr*:ti,ab,kw OR tele-psychiatr*:ti,ab,kw OR (tele NEXT psychiatr*):ti,ab,kw)

#25 (telepsycholog*:ti,ab,kw OR tele-psycholog*:ti,ab,kw OR (tele NEXT psycholog*):ti,ab,kw)

#26 (telepsychotherap*:ti,ab,kw OR tele-psychotherap*:ti,ab,kw OR (tele NEXT psychotherap*):ti,ab,kw)

#27 (telerehab*:ti,ab,kw OR tele-rehab*:ti,ab,kw OR (tele NEXT rehab*):ti,ab,kw)

#28 (teletherap*:ti,ab,kw OR tele-therap*:ti,ab,kw OR (tele NEXT therap*):ti,ab,kw)

#29 (mhealth*:ti,ab,kw OR m-health*:ti,ab,kw OR (m NEXT health*):ti,ab,kw)

#30 (econsult*:ti,ab,kw OR e-consult*:ti,ab,kw OR (e NEXT consult*):ti,ab,kw)

#31 (ehealth*:ti,ab,kw OR e-health*:ti,ab,kw OR (e NEXT health*):ti,ab,kw)

#32 ((audio OR audiovisual* OR audio-visual* OR digital* OR internet OR online* OR on-line* OR phone OR telephon* OR tele-phon* OR remote* OR video* OR virtual* OR web) NEAR/3 (care OR communicat* OR conferenc* OR consult* OR counsel* OR deliver* OR health* OR

	intervention* OR medicine OR monitor* OR prescrib* OR psychiatr* OR psycholog* OR psychotherap* OR rehab* OR therap* OR treat* OR visit*)):ti,ab,kw
#33	((electronic NEXT mail*) OR email* OR e-mail* OR (e NEXT mail*)):ti,kw
#34	(android:ti,ab,kw OR cellphone?:ti,ab,kw OR cell-phone?:ti,ab,kw OR iphone?:ti,ab,kw OR i-phone?:ti,ab,kw OR ipad?:ti,ab,kw OR i-pad?:ti,ab,kw OR (mobile NEXT device?):ti,ab,kw OR (mobile NEXT phone?):ti,ab,kw OR smartphone?:ti,ab,kw OR smart-phone?:ti,ab,kw)
#35	((instant NEXT messag*) OR sms OR text*):ti,kw
#36	(videoconferenc*:ti,ab,kw OR video-conferenc*:ti,ab,kw)
#37	(webcast*:ti,ab,kw OR web-cast*:ti,ab,kw OR (web NEXT cast*):ti,ab,kw OR webinar*:ti,ab,kw)
#38	(facetim*:ti,ab,kw OR face-tim*:ti,ab,kw OR (face NEXT tim*):ti,ab,kw OR (google NEXT meet*):ti,ab,kw OR "goto meeting":ti,ab,kw OR "go-to meeting":ti,ab,kw OR (go NEXT to? NEXT meeting):ti,ab,kw OR "goto webinar":ti,ab,kw OR "go-to webinar":ti,ab,kw OR (go NEXT to? NEXT webinar):ti,ab,kw OR "microsoft teams":ti,ab,kw OR skype:ti,ab,kw OR webex:ti,ab,kw OR web-ex:ti,ab,kw OR "web ex":ti,ab,kw OR zoom:ti,ab,kw)
#39	((digital NEXT app*):ti,ab,kw OR (electronic NEXT app*):ti,ab,kw OR (mobile NEXT app*):ti,ab,kw OR (smartphone NEXT app*):ti,ab,kw OR (smart-phone NEXT app*):ti,ab,kw OR ("smart phone" NEXT app*):ti,ab,kw OR (software NEXT app*):ti,ab,kw)
#40	(smartwatch*:ti,ab,kw OR smart-watch*:ti,ab,kw OR (smart NEXT watch*):ti,ab,kw)
#41	((remote:ti,ab,kw OR wearable:ti,ab,kw OR wireless:ti,ab,kw) NEAR/2 (device?:ti,ab,kw OR sensing:ti,ab,kw OR sensor?:ti,ab,kw))
#42	[OR #6-#41]
#43	[AND #5, #42]

Ovid PsycInfo Search Strategy

1806 to December 2024 Week 4
Date searched (number of results): January 2, 2025 (455)

1	exp "opioid use disorder"/
2	exp "medication-assisted treatment"/
3	((alfentan#l* or buprenorfin* or buprenorphin* or codein* or demerol or diacetylmorfin* or diacetylmorphin* or diamorfin* or diamorphin* or fentan#l* or heroin* or hycodan or hydrocodon* or hydromorf#n* or hydromorph#n* or meperidin* or methadon* or morfin* or morphin* or narcotic* or operidin* or opiate* or opioid* or opium* or ox#codon* or ox#con* or ox#morfon* or ox#morphon* or penta#ocin* or pethidin* or sufentan#l* or tapentadol* or tramadol*) adj3 (abstain* or abstin* or abuse* or abusing or addict* or assisted therap* or assisted treat* or depend* or detox* or disorder* or habit* or misuse* or mis-use* or overdose* or over-dose* or overuse* or over-use* or problem* or replace* or substitut* or withdraw*)).ti,ab,id.
4	medications for OUD.ti,ab,id.
5	or/1-4
6	exp "telecommunications media"/
7	exp telemedicine/
8	exp "mobile applications"/
9	exp "mobile devices"/
10	(telebehavio?ral health* or tele-behavio?ral health* or tele behavio?ral health*).ti,ab,id.
11	(telecare* or tele-care* or tele care*).ti,ab,id.

12	(telecommunicat* or tele-communicat* or tele communicat*).ti,ab,id.
13	(teleconferenc* or tele-conferenc* or tele conferenc*).ti,ab,id.
14	(teleconsult* or tele-consult* or tele consult*).ti,ab,id.
15	(telecounsel* or tele-counsel* or tele counsel*).ti,ab,id.
16	(telehealth* or tele-health* or tele health*).ti,ab,id.
17	(telehomecare* or tele-homecare* or tele homecare*).ti,ab,id.
18	(telematic* or tele-matic* or tele matic*).ti,ab,id.
19	(telemedic* or tele-medic* or tele medic*).ti,ab,id.
20	(telemental health* or tele-mental health* or tele mental health*).ti,ab,id.
21	(telemonitor* or tele-monitor* or tele monitor*).ti,ab,id.
22	(telenurs* or tele-nurs* or tele nurs*).ti,ab,id.
23	(tele-oud or tele oud).ti,ab,id.
24	(telepharmac* or tele-pharmac* or tele pharmac*).ti,ab,id.
25	(telepsychiatr* or tele-psychiatr* or tele psychiatr*).ti,ab,id.
26	(telepsycholog* or tele-psycholog* or tele psycholog*).ti,ab,id.
27	(telepsychotherap* or tele-psychotherap* or tele psychotherap*).ti,ab,id.
28	(telerehab* or tele-rehab* or tele rehab*).ti,ab,id.
29	(teletherap* or tele-therap* or tele therap*).ti,ab,id.
30	(mhealth* or m-health* or m health*).ti,ab,id.
31	(econsult* or e-consult* or e consult*).ti,ab,id.
32	(ehealth* or e-health* or e health*).ti,ab,id.
33	((audio or audiovisual* or audio-visual* or digital* or internet or online* or on-line* or phone? or telephon* or tele-phon* or remote* or video* or virtual* or web) adj3 (care or communicat* or conferenc* or consult* or counsel* or deliver* or health* or intervention* or medicine or monitor* or prescrib* or psychiatr* or psycholog* or psychotherap* or rehab* or therap* or treat* or visit?)).ti,ab,id.
34	(electronic mail* or email* or e-mail* or e mail*).ti,id.
35	(android or cellphone? or cell-phone? or iphone? or i-phone? or ipad? or i-pad? or mobile device? or mobile phone? or smartphone? or smart-phone?).ti,ab,id.
36	(instant messag* or sms or text*).ti,id.
37	(videoconferenc* or video-conferenc*).ti,ab,id.
38	(webcast* or web-cast* or web cast* or webinar*).ti,ab,id.
39	(facetim* or face-tim* or face tim* or google meet* or goto meeting or go-to meeting or go to? meeting or goto webinar or go-to webinar or go to? webinar or microsoft teams or skype or webex or web-ex or web ex or zoom).ti,ab,id.
40	(digital app* or electronic app* or mobile app* or smartphone app* or smart-phone app* or smart phone app* or software app*).ti,ab,id.
41	(smartwatch* or smart-watch* or smart watch*).ti,ab,id.
42	((remote or wearable or wireless) adj2 (device? or sensing or sensor?)).ti,ab,id.
43	or/6-42
44	and/5,43

45	(baboon? or bovine? or canine? or cat? or chimpanzee? or cow? or dog? or feline? or goat? or hens or macque? or mice or monkey? or (mouse adj2 model?) or murine? or ovine or pig? or porcine or (non-human adj2 primate?) or sheep or rabbit? or rat? or rattus or rhesus or rodent? or zebrafish).ti.
46	44 not 45
47	limit 46 to english language
48	limit 47 to ("0100 journal" or "0110 peer-reviewed journal" or "0120 non-peer-reviewed journal" or "0130 peer-reviewed status unknown" or "0500 electronic collection")
44	and/5,43
45	(baboon? or bovine? or canine? or cat? or chimpanzee? or cow? or dog? or feline? or goat? or hens or macque? or mice or monkey? or (mouse adj2 model?) or murine? or ovine or pig? or porcine or (non-human adj2 primate?) or sheep or rabbit? or rat? or rattus or rhesus or rodent? or zebrafish).ti.
46	44 not 45
47	limit 46 to english language
48	limit 47 to ("0100 journal" or "0110 peer-reviewed journal" or "0120 non-peer-reviewed journal" or "0130 peer-reviewed status unknown" or "0500 electronic collection")

Policy Sources and Search Terms

We searched the websites of the state Medicaid programs and health plans listed below using terms such as *telehealth*, *telemedicine*, *opioid use disorder*, and *substance use disorder*. As no relevant coverage policies were identified on the health plan websites, we also conducted a DuckDuckGo internet search using the search term *does [health plan] cover telehealth for opioid use disorder?* We identified 5 companies that provide telehealth-only or telehealth primary opioid use disorder treatment. We searched those companies' websites for information about insurance coverage. See list of companies below. Searches were conducted between February 6, 2025 and March 10, 2025, and updated June 5, 2025.

State Medicaid Programs

- California Medicaid
- Florida Medicaid
- Massachusetts Medicaid
- New Jersey Medicaid
- New York Medicaid
- North Carolina Medicaid
- Oregon Medicaid and the HERC coverage guidance (including topics under consideration)
- Pennsylvania Medicaid
- Texas Medicaid
- Washington Medicaid and the Washington Health Technology Assessment Program coverage determinations (including topics under consideration)

Health Plans

- Aetna
- Anthem Blue Cross and Blue Shield
- Cigna
- Fidelis Care
- Healthfirst
- MetroPlusHealth
- Molina Healthcare
- UnitedHealthcare

Telehealth Opioid Use Disorder Companies

- Affect Therapeutics
- Bicycle Health
- Bright Heart Health
- Eleanor Health
- Ophelia
- Workit Health

Appendix B. Detailed Inclusion and Exclusion Criteria

Table B1. Detailed Inclusion and Exclusion Criteria

Study Component	Inclusion Criteria	Exclusion Criteria
Populations	• Adults and adolescents diagnosed with OUD	• Adults and adolescents without a diagnosis of OUD

Interventions	• OUD treatment services, with or without medications for OUD, provided exclusively through telehealth-only modalities:
	  ○ Synchronous audio-visual or audio-only communication
	  ○ Asynchronous store-and-forward
	  ○ Remote patient monitoring
	• Mobile health
		• Treatment services not provided exclusively via telehealth modalities

Comparators	• Head-to-head comparisons of telehealth-only services • In-person services • Hybrid models of services • Standard care • No treatment	• None listed
Outcomes	Critical • Retention in treatment (e.g., sessions completed, uninterrupted treatment) • Abstinence from illicit use of opioids (e.g., number of days or weeks without use) • Serious adverse events (e.g., fatal and nonfatal overdose) Important • Adherence to use of prescribed medication for individuals prescribed medications for OUD • For individuals who were pregnant during the intervention, neonatal outcomes (e.g., neonatal intensive care unit admission, newborn length of stay) • Emergency department utilization • Cost and cost-effectiveness • Validated measures of patient quality of life • Patient satisfaction	• None listed
Timing and follow up	• Minimum follow-up of 90 days after service initiation	• Less than 90 days of follow-up after service initiation
Setting	• Studies conducted in outpatient settings • Studies conducted in countries categorized as *very high* on the Human Development Index	• Sessions conducted in inpatient setting • Studies conducted in countries not categorized as *very high* on the Human Development Index

Study Component	Inclusion Criteria	Exclusion Criteria
Study design	KQ1–KQ2 • Randomized controlled trials • Prospective comparative cohort studies • Registry studies for harms only KQ3 • Comparative studies and economic evaluations • Cost-effectiveness analyses • Economic modeling studies KQ4 • Evidence-based clinical practice guidelines that provide specific treatment recommendations	• Studies without extractable data • Retrospective studies unless otherwise noted
Sample size	• No limit	• None listed
Publication type	• Peer-reviewed publication of primary study results • Published in the English language • Ancillary publications with additional comparative follow-up	• Abstracts, conference proceedings, posters, editorials, letters • Studies that have not been formally peer reviewed (i.e., preprint publications) • Studies published in languages other than English • Studies that cannot be found • Duplicate publications of the same study that do not report different outcomes or follow-up times, or single-site reports from published multicenter studies

Abbreviations. KQ: key question; OUD: opioid use disorder.

Appendix C. Additional Methods

Participant Characteristics and Association With Outcomes

When discussing risk and protective factors or variables in statistical models in Center research products, in almost all cases, we are referring to associations of participant characteristics with outcomes, and not causation of outcomes. This is important because participant characteristics, such as race and ethnicity, serve as proxy or surrogate measures for underlying etiological factors not measured or evaluated in analyses. Etiological factors that might cause differences in outcomes for subgroups of participants could include systemic racism or other forms of systemic discrimination, stress, poverty, housing instability, or epigenetics. For example, by describing any differences in outcomes by race and ethnic groups, we are noting observed associations; these associations are not caused by biological determinants of being Black, White, or Hispanic.

Risk of Bias

Table C1. Risk-of-Bias Assessment: Randomized Controlled Trials

Domain	Domain Elements[a]
Randomization	• An appropriate method of randomization is used to allocate participants or clusters to groups, such as a computer random number generator • Baseline characteristics between groups or clusters are similar
Allocation concealment	• An adequate concealment method is used to prevent investigators and participants from influencing enrollment or intervention allocation
Intervention	• Intervention and comparator intervention applied equally to groups • Co-interventions appropriate and applied equally to groups • Control selected is an appropriate intervention
Outcomes	• Outcomes are measured using valid and reliable measures • Investigators use single outcome measures and do not rely on composite outcomes, or outcome of interest can be calculated from composite outcome • The trial has an appropriate length of follow-up and groups are assessed at same time points • Outcome reporting of entire group or subgroups is not selective
Masking (blinding) of investigators and participants	• Investigators and participants are unaware (masked or blinded) of intervention status
Masking (blinding) of outcome assessors	• Outcome assessors are unaware (masked or blinded) of intervention status
Intention-to-treat analysis	• Participants are analyzed based on random assignment (intention-to-treat analysis)
Statistical analysis	• Participants lost to follow-up unlikely to significantly bias results (i.e., complete follow-up of ≥ 80% of participants overall and nondifferential, ≤ 10% difference between groups) • The most appropriate summary estimate (e.g., risk ratio, hazard ratio) is used • Paired or conditional analysis used for crossover RCT • Clustering appropriately accounted for in a cluster-randomized trial (e.g., use of an intraclass correlation coefficient)
Other biases (as appropriate)	• List others in table footnote and describe, such as: • Sample size adequacy • Interim analysis or early stopping • Recruitment bias, including run-in period used inappropriately • Use of unsuitable crossover intervention in a crossover RCT

Domain	Domain Elements[a]
Interest disclosure	• Disclosures of interest are provided for authors/funders/commissioners of study • Interests are unlikely to significantly affect study validity
Funding	• There is a description of source(s) of funding • Funding source is unlikely to have a significant impact on study validity

Note. [a] *The elements included in each domain are assessed and rated as yes, no, unclear, or not applicable based on performance and documentation of individual elements in each domain. The overall risk of bias for a study is assessed as high, moderate, or low based on an assessment of how well the overall study methods and processes were performed to limit bias and ensure validity.*
Abbreviation. RCT: randomized controlled trial.

Table C2. Risk of Bias Assessment: Nonrandomized Studies

Domain	Domain Elements[a]
Participant selection	For cohort studies: • The 2 groups being studied are selected from source populations comparable in all respects other than factor under investigation, or statistical adjustment is used appropriately to achieve this • The study indicates how many of people asked to take part did so in each of the groups being studied • The likelihood some eligible participants might have outcome at time of enrollment is assessed and considered in analysis • Fewer than 20% of individuals or clusters in each arm of study dropped out before study was completed For case-control studies: • Cases and controls are clearly specified and defined, with inclusion and exclusion criteria applied appropriately • Cases may be selected by meeting inclusion criteria, controls may be selected by meeting inclusion criteria and then being matched to cases • Sampling selection (ratio of cases to control) is justified • Cases and controls selected from same population and same timeframe; when not all cases and controls are selected from same population, these are randomly selected • Among cases, investigators confirm that exposure occurred before development of disease being studied and/or likelihood that some eligible participants might have outcome at time of enrollment is assessed and considered in analysis
Intervention	• The assessment of exposure to intervention is reliable • Exposure level or prognostic factors are assessed at multiple times across length of study, if appropriate • For case-control studies, assessors of (intervention) exposure status are unaware (masked or blinded) to case or control status of participants, and there is a method to limit effects of recall bias on assessment of exposure to intervention
Control	• Control condition represents an appropriate comparator
Outcome	• There is a precise definition of outcomes used • Outcomes are measured using valid and reliable measures, evidence from other sources is used to demonstrate method of outcome assessment is valid and reliable • Investigators use single outcome measures and do not rely on composite outcomes, or outcome of interest can be calculated from composite outcome • The study has an appropriate length of follow-up for outcome reported and groups are assessed at same time points • Outcome reporting of entire group or subgroups is not selective • When patient-reported outcomes are used, there is a method for validating measure

Domain	Domain Elements[a]
Masked outcome assessment	• The assessment of outcome(s) is made blind to exposure status. Where outcome assessment blinding was not possible, there is recognition that knowledge of exposure status could have influenced assessment of outcome. • For case-control study: assessors of exposure status are unaware (masked or blinded) of case or control status of participant
Confounding	• The main potential confounders are identified and considered in design and analysis of study
Statistical analysis	• Comparison is made between full participants and those who dropped out or were lost to follow-up, by exposure status • If groups were not followed for an equal length of time, analysis was adjusted for differences in length of follow-up • All major confounders are adjusted for using multiple variable logistic regression or other appropriate statistical methods • Confidence intervals (or information used to calculate them) are provided • For case-control studies that use matching, conditional analysis is conducted or matching factors are adjusted for in analysis
Other biases (as appropriate)	• List others in table footnote and describe, such as: • Sample size adequacy
Interest disclosure	• Disclosures of interest are provided for authors/funders/commissioners of study • Interests are unlikely to significantly affect study validity
Funding source	• There is a description of source(s) of funding • Funding source is unlikely to have a significant impact on study validity

Note. [a] *The elements included in each domain are assessed and rated as yes, no, unclear, or not applicable based on performance and documentation of individual elements in each domain. The overall risk of bias for a study is assessed as high, moderate, or low based on an assessment of how well the overall study methods and processes were performed to limit bias and ensure validity.*

Table C3. Risk-of-Bias Assessment: Economic Modeling Studies

Domain	Domain Elements[a]
Target population	• Target population and care setting described • Describe and justify basis for any target population stratification, identify any previously identifiable subgroups • If no subgroup analyses were performed, justify why these were not required
Perspective	• State and justify analytic perspective (e.g., societal, payer, etc.)
Time horizon	• Describe and justify time horizon(s) used in analysis
Discount rate	• State and justify discount rate used for costs and outcomes
Comparators	• Describe and justify selected comparators • Competing alternatives appropriate and clearly described
Modelling	• Model structure (e.g., scope, assumptions made) is described and justified • Model diagram provided, if appropriate • Model validation is described (may involve validation of different aspects such as structure, data, assumptions, and coding and different validation models such as comparison with other models) • Data sources listed and assumptions for use justified • Statistical analyses are described

Domain	Domain Elements[a]
Effectiveness	• Estimates of efficacy/effectiveness of interventions are described and justified • The factors likely to have an impact on effectiveness (e.g., adherence, diagnostic accuracy, values, and preferences) are described and an explanation of how these were factored into analysis is included • The quality of evidence for relationship between intervention and outcomes, and any necessary links, is described
Outcomes	• All relevant outcomes are identified, measured, and valued appropriately (including harms/adverse events) for each intervention, and justification for information/assumptions is given • Any quality-of-life measures used in modelling are described and use justified • Any other outcomes that were considered but rejected are described with rationale for rejection • Ethical and equity-related outcomes are considered and included when appropriate
Resource use/costs	• All resources used are identified, valued appropriately, and included in analyses • Methods for costing are reporting (e.g., patient level) • Resource quantities and unit costs are both reported • Methods for costing time (e.g., lost time, productivity losses) are appropriate and a justification is provided if time costs are not considered
Uncertainty	• Sources of uncertainty in analyses are identified and justification for probability distributions used in probabilistic analyses are given • For scenario analyses, values and assumptions tested are provided and justified
Results	• All results are presented in a disaggregated fashion, by component, in addition to an aggregated manner • All results are presented with undiscounted totals before discounting and aggregation • Natural units are presented along with alternative units (e.g., QALYs) • The components of incremental cost-effectiveness ratio are shown (e.g., mean costs of each intervention in numerator and mean outcomes of each intervention in denominator) • Results of scenario analyses, including variability in factors such as practice patterns and costs, are reported and described in relation to reference (base) case
Interest disclosure	• Disclosures of interest are provided for authors/funders/commissioners of study • Interests are unlikely to significantly affect study validity
Funding source	• There is a description of source(s) of funding • Funding source is unlikely to have a significant impact on study validity

Note. [a] *The elements included in each domain are assessed and rated as yes, no, unclear, or not applicable based on performance and documentation of individual elements in each domain. The overall risk of bias for a study is assessed as high, moderate, or low based on an assessment of how well the overall study methods and processes were performed to limit bias and ensure validity.*
Abbreviation. QALY: quality-adjusted life year.

Table C4. Methodological Quality Assessment: Clinical Practice Guidelines

Domain	Domain Elements[a]
Rigor of development: evidence	• Systematic literature search meets quality standards for a systematic review (i.e., comprehensive search strategy with, at a minimum, 2 or more electronic databases) • The criteria used to select evidence for inclusion is clear and appropriate • The strengths and limitations of individual evidence sources is assessed and overall quality of body of evidence assessed

Domain	Domain Elements[a]
Rigor of development: recommendations	• Methods for developing recommendations clearly described and appropriate • There is an explicit link between recommendations and supporting evidence • The balance of benefits and harms is considered in formulating recommendations • The guideline has been reviewed by external expert peer reviewers • The updating procedure for guideline is specified in guideline or related materials (e.g., specialty society website)
Editorial independence	• There is a description of source(s) of funding and views of funder(s) are unlikely to have influenced content or validity of guideline • Disclosures of interests for guideline panel members are provided and are unlikely to have a significant impact on overall validity of guideline (e.g., a process for members to recuse themselves from participating on recommendations for which a significant conflict is provided)
Scope and purpose	• Objectives specifically described • Health question(s) specifically described • Target population(s) for guideline recommendations is specified (e.g., patients in primary care) and target users for guideline (e.g., primary care clinicians)
Stakeholder involvement	• Relevant professional groups represented • Views and preferences of target population(s) sought (e.g., clinicians and patients)
Clarity and presentation	• Recommendations are specific and unambiguous • Different management options are clearly presented • Key recommendations are easily identifiable
Applicability	• Provides advice and/or tools on how recommendation(s) can be put into practice • Description of facilitators and barriers to its application • Potential resource implications considered • Criteria for implementation monitoring, audit, and/or performance measures based on guideline are presented

Note. [a] *The elements included in each domain are assessed and rated as* yes, no, unclear, *or* not applicable *based on performance and documentation of individual elements in each domain. The overall risk of bias for a study is assessed as* high, moderate, *or* low *based on an assessment of how well the overall study methods and processes were performed to limit bias and ensure validity.*

GRADE (Grading of Recommendations Assessment, Development and Evaluation)

Table C5. GRADE System for Rating the Certainty of Evidence for Outcomes

GRADE Rating	Plain Language Description	Detailed Category Description
●●●● High	New research is very unlikely to change our understanding of the relationship between this outcome and the health technology.	Center researchers are very confident that the estimate of the effect of the intervention on the outcome lies close to the true effect. Typical sets of studies are RCTs with few or no limitations, and the estimate of effect is likely stable.
●●●○ Moderate	New research may change our understanding of the relationship between this outcome and the health technology.	Center researchers are moderately confident in the estimate of the effect of the intervention on the outcome. The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is different. Typical sets of studies are RCTs with some limitations or well-performed nonrandomized studies with additional strengths that guard against potential bias and have large estimates of effects.

GRADE Rating	Plain Language Description	Detailed Category Description
●●○○ Low	New research is likely to change our understanding of the relationship between this outcome and the health technology.	Center researchers have little confidence in the estimate of the effect of the intervention on the outcome. The true effect may be substantially different from the estimate of the effect. Typical sets of studies are RCTs with serious limitations or nonrandomized studies without special strengths.
●○○○ Very low	New research is very likely to change our understanding of the relationship between this outcome and the health technology.	Center researchers have no confidence in the estimate of the effect of the intervention on the outcome. The true effect is likely to be substantially different from the estimate of effect. Typical sets of studies are nonrandomized studies with serious limitations or inconsistent results across studies.
Not applicable	There is no research to report.	Center researchers did not identify any eligible articles.

Source. Adapted from 2 publications about GRADE.[165,166]
Abbreviations. GRADE: Grading of Recommendations, Assessment, Development, and Evaluations; RCT: randomized controlled trial.

Appendix D. Included Studies

Table D1. Included Studies

Primary Publication From Included Trial	Publications Reporting Additional Results
Sigmon et al., 2023[10] NCT03420313	None
Chan et al., 2024[11] NCT03224858	None
Guille et al., 2020[12] NCT 04049032	None
Claypool et al., 2023[13]	None

Appendix E. Risk-of-Bias Assessment

Table E1. Risk of Bias in 1 RCT of Telehealth for OUD, Part 1

Study	Appropriate Randomization Method	Adequate Allocation Concealment Method	Blinding of Study Analysts	Appropriate Length of Follow Up	Single Outcome Measures Reported	Intention-to-Treat Analysis	Most Appropriate Summary Statistic Used	Similar Between-Group Baseline Characteristics
Sigmon et al., 2023[10]	Yes	Unclear	No	Yes	Yes	Yes	Yes	Yes

Table E1. Risk of Bias in 1 RCT of Telehealth for OUD, Part 2

Study	Loss to Follow Up Unlikely to Bias Results	Disclosures of Interest for All Authors	Description of Funding Source	Results Applicable to Purpose of Report	Overall Risk of Bias
Sigmon et al., 2023[10]	Unclear	Yes	Yes	Yes	• Moderate • Unclear allocation sequence and no blinding • Small sample sizes, no experimental isolation of the contribution of individual treatment components • No analysis or discussion of differential loss to follow up

Abbreviations. ITT: intention-to treat (in which all participants randomized in a trial are included in the analysis as part of the group to which they were originally randomized).

Table E2. Risk of Bias in 2 Cohort Studies of Telehealth for OUD, Part 1

Study	Comparable Cohort Groups	Valid, Reliable, and Consistent Measure of Exposure	Valid, Reliable, and Consistent Measure of Outcomes	Blinding of Assessors	Appropriate Length of Follow-Up	Equal Follow-Up	Inclusion of Confounding Variables in Analyses	Appropriate Effect Size Used
Chan et al., 2024[11]	No	Yes	Yes	No	Yes	Yes	Yes	Yes
Guille et al, 2020[12]	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	Yes

Table E2. Risk of Bias in 2 Cohort Studies of Telehealth for OUD, Part 2

Study	Loss to Follow Up Unlikely to Bias Results	Disclosures of Interest for All Authors	Description of Funding Source	Results Applicable to Purpose of Report	Overall Risk of Bias
Chan et al., 2024[11]	No	Yes	Yes	Yes	• Moderate • Potential recruitment bias (different recruitment procedures for the 2 groups), no blinding of assessors and differential loss to follow up
Guille et al., 2020[12]	No	Yes	Yes	Yes	• Low • Differential loss to follow up, but the percentage analyzed was similar between groups • Unclear blinding of assessors, but the outcome measures were objective

Appendix F. GRADE Assessment

Table F1. GRADE Profile
Effectiveness Outcomes Related to Treatment of OUD Exclusively by Telehealth

Outcome	Number of Participants and Studies	Study Design	Factors That May Decrease Certainty of Evidence				Summary of Results	CoE
			Risk of Bias	Inconsistency	Indirectness	Imprecision		
Retention in treatment	N = 98 1 study	1 cohort	No serious	No serious	Serious (-1) Limited to pregnant women	No serious	Downgraded for indirectness with limited population (-1) Cohort study starts at low CoE	●○○○ Very Low
Abstinence from opioids	N = 198 2 studies	1 RCT, 1 cohort	Serious (-1) RCT at moderate risk of bias	Serious (-1) 1 study found effect in favor of telehealth, 1 found no difference	Serious (-1) Cohort study limited to pregnant women	Serious (-1) RCT did not prescribe medications for OUD to control group. Unclear if effect is from medications for OUD or mode of delivery of intervention	Downgraded for risk of bias (-1), inconsistency (-1), indirectness with limited population in one study (-1), and imprecision (-1) Cohort study starts at low CoE	●○○○ Very Low
Adherence to prescribed medications for OUD	N = 259 2 studies	1 RCT, 1 cohort	Serious (-1) All studies at moderate risk of bias	No serious	No serious	Very serious (-2) RCT did not have medications for OUD prescribed to control group so no comparison was made	Downgraded for risk of bias (-1) and very serious limitations in imprecision due to lack of comparator in RCT	●○○○ Very Low
Neonatal outcomes	N = 98 1 study	Cohort	No serious	No serious.	Serious (-1) Limited to pregnant women	No serious	Downgraded for indirectness with	●○○○ Very Low

Outcome	Number of Participants and Studies	Study Design	Factors That May Decrease Certainty of Evidence				Summary of Results	CoE
			Risk of Bias	Inconsistency	Indirectness	Imprecision		
							limited population (-1) Cohort study starts at low CoE	
Patient satisfaction	N = 100 1 study	1 RCT	Serious (-1) Moderate risk of bias	No serious	No serious	Very serious (-2) No comparison data from control group	Downgraded for risk of bias (-1) and very serious limitations in imprecision due to lack of comparator (-2)	●○○○ Very Low

Abbreviations. CoE: certainty of evidence; RCT: randomized controlled trial.

Appendix G. Excluded Studies With Primary Reason for Exclusion

Table G1 lists the publications that were excluded during full text review and the primary reason for exclusion. There may be multiple reasons for exclusion for any given publication, and the table lists only the most influential reason for exclusion.

Table G1. Excluded Studies with Primary Reason for Exclusion

Reference Information	Primary Reason for Exclusion
Adepoju OE, Gilbert LR, Pham C, Singh M. Telemedicine-related opioid use disorder services in underserved populations: a qualitative evaluation of the waiver era. *Telemed J E Health.* 2025;31(2):242-248	Study design
Allen LD, Xu M. Telehealth and disparities in opioid use disorder treatment: Medicaid enrollees versus privately insured individuals. *Health Serv Res.* 2025;60(1):e14414. doi: 10.1111/1475-6773.14414	Study design
American Medical Association, Manatt Health. State toolkit to end the nation's drug overdose epidemic: leading-edge actions and strategies to remove barriers to evidence-based patient care. 2022. Accessed December 31, 2024.	Publication type
American Society of Addiction Medicine. The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused updated. 2020. Accessed December 31, 2024.	Intervention
APA Task Force on Telepsychology. APA guidelines for the practice of telepsychology. American Psychological Association. 2024. Accessed December 31, 2024.	Population
Argoff CE, Alford DP, Fudin J, et al. Rational urine drug monitoring in patients receiving opioids for chronic pain: consensus recommendations. *Pain Med.* 2018;19(1):97-117.	Study design
Aronowitz SV, Engel-Rebitzer E, Dolan A, et al. Telehealth for opioid use disorder treatment in low-barrier clinic settings: an exploration of clinician and staff perspectives. *Harm Reduct J.* 2021;18(1):119.	Aim
ASAM Covid-19 Task Force. Supporting access to telehealth for addiction services: regulatory overview and general practice considerations. American Society of Addiction Medicine. 2020. Accessed December 31, 2024.	Publication type
Bailey SR, Wyte-Lake T, Lucas JA, et al. Use of telehealth for opioid use disorder treatment in safety net primary care settings: a mixed-methods study. *Subst Use Misuse.* 2023;58(9):1143-1151.	Study design
Beech EH, Young S, Anderson JK, Belsher BE, Parr NJ. Evidence brief: safety and effectiveness of telehealth-delivered mental health care. Evidence Synthesis Program, Department of Veterans Affairs. 2022. Accessed December 31, 2024.	Study design
Bradford WS, England J, Bratches RWR, Eaton EF. Equal Access, Equal Outcomes: Telehealth utilization around the COVID-19 pandemic among people living with HIV and opioid use disorder in the deep south. *AIDS Behav.* 2024;15:15.	Study design
Brimmer M, Wahler A, Chambers M, et al. Buprenorphine prescription and treatment initiation through preemptive outreach and telehealth consultation with emergency medicine providers. *J Addict Dis.* 2024:1-7.	Follow up
Brooklyn JR, Stothart M, Stunell M, Berman VM, Rylant D, Hanson M. Characterizing the clinical use of a novel video-assisted dosing protocol with secure medication dispensers to reduce barriers to opioid treatment. *J Addict Med.* 2022;16(3):310-316.	Study design
Cahana A, Dansie EJ, Theodore BR, Wilson HD, Turk DC. Redesigning delivery of opioids to optimize pain management, improve outcomes, and contain costs. *Pain Med.* 2013;14(1):36-42.	Publication type

Reference Information	Primary Reason for Exclusion
Carreiro S, Ramanand P, Akram W, et al. Developing a Wearable Sensor-Based Digital Biomarker of Opioid Dependence. *Anesth Analg*. 2024;16:16.	Population
Castry M, Tin Y, Feder NM, et al. An economic analysis of the cost of mobile units for harm reduction, naloxone distribution, and medications for opioid use disorder. *J Subst Use Addict Treat*. 2024;167:209517.	Intervention
Chhabra, M, Chaiyachati, K, Compton, P. Behavioral incentives to improve mobility and decrease opioid use in veterans with chronic pain. *J Gen Intern Med*. 2020;35(Suppl 1):1-779.	Publication type
Cooperman, NA, Lu, SE, Hanley, AW, et al. Erratum: telehealth mindfulness-oriented recovery enhancement vs usual care in individuals with opioid use disorder and pain: a randomized clinical trial. *JAMA Psychiatry*. 2024. 81:428.	Publication type
Critchfield, AS. Pathways: comparative effectiveness study of peripartum opioid use disorder in rural Kentucky. *Journal of Women's Health*. 2018;27(11):1415-1433.	Publication type
Cunningham CO, Khalid L, Deng Y, et al. A comparison of office-based buprenorphine treatment outcomes in Bronx community clinics before versus during the COVID-19 pandemic. *J Subst Abuse Treat*. 2022;135:108641.	Study design
D'Arcey JN, Tackaberry-Giddens L, Junaid S, et al. Co-design of a digital health tool for use by individuals with opioid use disorder: App4Independence (A4i-O). *Subst Use Addctn J*. 2024:29767342241258915.	Aim
Davis CS, Samuels EA. Continuing increased access to buprenorphine in the United States via telemedicine after COVID-19. *Int J Drug Policy*. 2021;93:102905.	Publication type
DeFulio A, Rzeszutek MJ, Furgeson J, Ryan S, Rezania S. A smartphone-smartcard platform for contingency management in an inner-city substance use disorder outpatient program. *J Subst Abuse Treat*. 2021;120:108188.	Intervention
Dunn KE, Brooner RK, Stoller KB. Technology-assisted methadone take-home dosing for dispensing methadone to persons with opioid use disorder during the Covid-19 pandemic. *J Subst Abuse Treat*. 2021;121:108197.	Follow up
Eibl JK, Gauthier G, Pellegrini D, et al. The effectiveness of telemedicine-delivered opioid agonist therapy in a supervised clinical setting. *Drug Alcohol Depend*. 2017;176:133-138.	Study design
Farrell K. Wearable respiratory sensor for the detection of opioid-induced respiratory depression. *Canadian Journal of Health Technologies*. 2021;1(6).	Publication type
Flores JM, Kan E, Mooney LJ, et al. Medications for opioid use disorder among transition age youth compared with adults 26 or older in rural settings. *JAACAP Open*. 2024;2(4):231-238.	Aim
Frank D, Bennett AS, Cleland CM, et al. "I still can feel the sickness": withdrawal experiences of people on methadone maintenance treatment. *J Subst Use Addict Treat*. 2024:209616.	Aim
Frost MC, Zhang L, Kim HM, Lin LA. Use of and retention on video, telephone, and in-person buprenorphine treatment for opioid use disorder during the COVID-19 pandemic. *JAMA Netw Open*. 2022;5(10):e2236298.	Study design
Gannon K, Warnock CA. Medications for opioid use disorder and other evidence-based service offerings in faith-affiliated treatment centers: Implications for implementation partnerships. *J Subst Use Addict Treat*. 2024;169:209572.	Aim
Garland EL, Gullapalli BT, Prince KC, et al. Zoom-based mindfulness-oriented recovery enhancement plus just-in-time mindfulness practice triggered by wearable sensors for opioid craving and chronic pain. *Mindfulness (N Y)*. 2023:1-17	Population
Ge Y, Eisenberg MD, McGinty EE, Yu J, Tormohlen KN. Examining the use of telehealth to initiate buprenorphine for opioid use disorder treatment. *Health Aff Sch*. 2024;2(11):qxae137.	Study design

Reference Information	Primary Reason for Exclusion
Georgiadis RA, Sable P, Rosen D. Telemedication for opioid use disorder: a new approach for treatment. *Telemed Rep*. 2023;4(1):344-347.	Study design
Guarino H, Acosta M, Marsch LA, Xie H, Aponte-Melendez Y. A mixed-methods evaluation of the feasibility, acceptability, and preliminary efficacy of a mobile intervention for methadone maintenance clients. *Psychol Addict Behav*. 2016;30(1):1-11.	Study design
Guarino H, Fong C, Marsch LA, et al. Web-based cognitive behavior therapy for chronic pain patients with aberrant drug-related behavior: outcomes from a randomized controlled trial. *Pain Med*. 2018;19(12):2423-2437.	Intervention
Gullapalli BT, Carreiro S, Chapman BP, Garland EL, Rahman T. Pharmacokinetics-informed neural network for predicting opioid administration moments with wearable sensors. *Proc AAAI Conf Artif Intell*. 2024;38(21):22892-22898.	Population
Gunderson EW, Wang XQ, Fiellin DA, Bryan B, Levin FR. Unobserved versus observed office buprenorphine/naloxone induction: a pilot randomized clinical trial. *Addict Behav*. 2010;35(5):537-540.	Intervention
Gustafson DH, Landucci G, Vjorn OJ, et al. Effects of Bundling Medication for Opioid Use Disorder With an mHealth Intervention Targeting Addiction: A Randomized Clinical Trial. *Am J Psychiatry*. 2024;181(2):115-124.	Intervention
Hodges J, Waselewski M, Harrington W, et al. Six-month outcomes of the HOPE smartphone application designed to support treatment with medications for opioid use disorder and piloted during an early statewide COVID-19 lockdown. *Addict Sci Clin Pract*. 2022;17(1):16.	Study design
Hunter OO, Mariano ER, Harrison TK. Leveraging video telehealth for the transitional pain service in response to COVID-19. *Reg Anesth Pain Med*. 2021;46(5):460-461.	Publication type
Ikelheimer DM. Treatment of opioid dependence via home-based telepsychiatry. *Psychiatr Serv*. 2008;59(10):1218-1219.	Publication type
Jones CM, Shoff C, Blanco C, Losby JL, Ling SM, Compton WM. Association of receipt of opioid use disorder-related telehealth services and medications for opioid use disorder with fatal drug overdoses among medicare beneficiaries before and during the COVID-19 pandemic. *JAMA Psychiatry*. 2023;80(5):508-514.	Study design
Jones CM, Shoff C, Hodges K, et al. Receipt of telehealth services, receipt and retention of medications for opioid use disorder, and medically treated overdose among medicare beneficiaries before and during the COVID-19 pandemic. *JAMA Psychiatry*. 2022;79(10):981-992.	Study design
Kim SJ, Marsch LA. Can persons with a history of multiple addiction treatment episodes and chronic relapse benefit from technology-delivered behavior therapy? *Drug and Alcohol Dependence*. 2015;156:e111.	Publication type
King VL, Brooner RK, Peirce JM, Kolodner K, Kidorf MS. A randomized trial of Web-based videoconferencing for substance abuse counseling. *J Subst Abuse Treat*. 2014;46(1):36-42.	Intervention
Leo P, Gastala N, Fleurimont J, et al. A community partnership to improve access to buprenorphine in a homeless population. *Ann Fam Med*. 2021;19(1):85.	Publication type
Lin C, Zhu Y, Mooney LJ, et al. Referral of patients from rural primary care clinics to telemedicine vendors for opioid use disorder treatment: a mixed-methods study. *J Telemed Telecare*. 2024:1357633X231226261.	Aim
Lin L, Frank CJ. Telehealth for opioid use disorder toolkit: guidance to support high-quality care. Providers Clinical Support System, Substance Abuse and Mental Health Services Administration (SAMHSA). 2021. Accessed December 31, 2024.	Publication type

Reference Information	Primary Reason for Exclusion
Lin LA, Fortney JC, Bohnert ASB, Coughlin LN, Zhang L, Piette JD. Comparing telemedicine to in-person buprenorphine treatment in U.S. veterans with opioid use disorder. *J Subst Abuse Treat*. 2022;133:108492.	Study design
Lynch MJ, Vargas D, Winger ME, et al. A telemedicine bridge clinic improves access and reduces cost for opioid use disorder care. *Drug Alcohol Depend Rep*. 2024;11:100227.	Intervention
Mackey K, Veazie S, Anderson JK, Bourne D, Peterson K. Evidence brief: barriers and facilitators to use of medications for opioid use disorder. Evidence Synthesis Program, Department of Veterans Affairs. 2019. Accessed December 31, 2024.	Study design
Maricich YA, Gerwien R, Kuo A, Malone DC, Velez FF. Real-world use and clinical outcomes after 24 weeks of treatment with a prescription digital therapeutic for opioid use disorder. *Hosp Pract (1995)*. 2021;49(5):348-355.	Study design
Maricich YA, Nunes EV, Campbell ANC, Botbyl JD, Luderer HF. Safety and efficacy of a digital therapeutic for substance use disorder: secondary analysis of data from a NIDA clinical trials network study. *Subst Abus*. 2022;43(1):937-942.	Intervention
Maricich YA, Xiong X, Gerwien R, et al. Real-world evidence for a prescription digital therapeutic to treat opioid use disorder. *Curr Med Res Opin*. 2021;37(2):175-183	Study design
Marino EN, Karns-Wright T, Perez MC, Potter JS. Smartphone app-based contingency management and opioid use disorder treatment outcomes. *JAMA Netw Open*. 2024;7(12):e2448405.	Study design
Marsch LA, Guarino H, Acosta M, et al. Web-based behavioral treatment for substance use disorders as a partial replacement of standard methadone maintenance treatment. *J Subst Abuse Treat*. 2014;46(1):43-51.	Intervention
Maxwell JF, Feldman SS, Li L. Patient retention in a substance use disorder telemedicine clinic. *South Med J*. 2024;117(7):374-378.	Study design
McPherson SM, Smith CL, Hall L, et al. Mobile Medication Adherence Platform for Buprenorphine (MAP4BUP): A Phase I feasibility, usability and efficacy pilot randomized clinical trial. *Drug Alcohol Depend*. 2024;256:111099.	Follow up
Meads KL, Huettner S, Amata D, et al. Feasibility and acceptability of wearing a neuromodulation device at night in individuals in recovery from opioid use disorder. *Front Psychiatry*. 2024;15:1481795.	Comparator
Metrebian N, Carr E, Goldsmith K, et al. Mobile telephone delivered contingency management for encouraging adherence to supervised methadone consumption: feasibility study for an RCT of clinical and cost-effectiveness (TIES). *Pilot Feasibility Stud*. 2021;7(1):14.	Intervention
Moore BA, Buono FD, Lloyd DP, Printz DMB, Fiellin DA, Barry DT. A randomized clinical trial of the Recovery Line among methadone treatment patients with ongoing illicit drug use. *J Subst Abuse Treat*. 2019;97:68-74.	Intervention
National Institute for Health and Care Excellence. Drug misuse in over 16s: opioid detoxification. 2007. Accessed January 2, 2024.	Intervention
National Institute for Health and Care Excellence. Drug misuse in over 16s: psychosocial interventions. 2007. Accessed January 2, 2025.	Intervention
Nguyen B, Zhao C, Bailly E, Chi W. Telehealth initiation of buprenorphine for opioid use disorder: patient characteristics and outcomes. *J Gen Intern Med*. 2024;39(1):95-102.	Study design
Palazzo L, Dorsey CN, Mogk J, et al. Formative evaluation of the implementation of digital therapeutics for opioids and other substance use disorders in primary care (DIGITS trial). *Implement Res Pract*. 2024;5:26334895241301670.	Study design

Reference Information	Primary Reason for Exclusion
Peck K, Giannini J, Cole R, Badger G, Mosca L, Sigmon S. Prolonged exposure therapy for individuals with co-occurring posttraumatic stress disorder and opioid use disorder: a randomized clinical trial. *Drug and Alcohol Dependence.* 2024;260.	Publication type
Perry C, Liberto J, Milliken C, et al. The management of substance use disorders: synopsis of the 2021 U.S. Department of Veterans Affairs and U.S. Department of Defense clinical practice guideline. *Ann Intern Med.* 2022;175(5):720-731.	Publication type
Pessar SC, Boustead A, Ge Y, Smart R, Pacula RL. Assessment of state and federal health policies for opioid use disorder treatment during the COVID-19 pandemic and beyond. *JAMA Health Forum.* 2021;2(11):e213833.	Aim
Qian G, Humphreys K, Goldhaber-Fiebert JD, Brandeau ML. Estimated effectiveness and cost-effectiveness of opioid use disorder treatment under proposed U.S. regulatory relaxations: a model-based analysis. *Drug Alcohol Depend.* 2024;256:111112.	Intervention
Rajagopal S, Westra J, Raji MA, Wilkes D, Kuo YF. Access to medications for opioid use disorder during COVID-19: retrospective study of commercially insured patients from 2019-2022. *Am J Prev Med.* 2024;66(4):635-644.	Study design
Rollston R, Burke B, Weiner SG, et al. Evaluation of urine drug screen falsification of results among patients with opioid use disorder receiving treatment in a telehealth model of care. *J Subst Use Addict Treat.* 2023;154:209151.	Follow up
Rosen D. Addressing the crises in treating substance use disorders in later-life: tele-medication assisted treatment (TELE-MAT) for an older adult population. *Am J Geriatr Psychiatry.* 2022;30(10):1064-1066.	Publication type
Sahu N, Chen PH, Shimoni N. Telehealth to improve continuity for patients receiving buprenorphine treatment for opioid use disorder. *Ann Fam Med.* 2022;20(20 Suppl 1):01.	Study design
Samuels EA, Khatri UG, Snyder H, Wightman RS, Tofighi B, Krawczyk N. Buprenorphine telehealth treatment initiation and follow-up during COVID-19. *J Gen Intern Med.* 2022;37(5):1331-1333.	Study design
Scott CK, Dennis ML, Johnson KA, Grella CE. A randomized clinical trial of smartphone self-managed recovery support services. *J Subst Abuse Treat.* 2020;117:108089.	Intervention
Scottish Intercollegiate Guidelines Network. Use of long-acting injectable buprenorphine for opioid substitution therapy. Healthcare Improvement Scotland. 2022. Accessed January 2, 2024.	Intervention
Shi JM, Henry SP, Dwy SL, Orazietti SA, Carroll KM. Randomized pilot trial of Web-based cognitive-behavioral therapy adapted for use in office-based buprenorphine maintenance. *Subst Abus.* 2019;40(2):132-135.	Follow up
Stein BD, Saloner BK, Sheng F, Sorbero M, Dick AW, Gordon AJ. Associations between state policies facilitating telehealth and buprenorphine episode initiation and duration early in the COVID pandemic: state telehealth policies and buprenorphine. *J Gen Intern Med.* 2024;14:14.	Aim
Stidham Ba J, Jon-Emefieh Ba C, Carrano Ph DJ, Wenzel Ph DK, Fishman Md M. Characteristics of mHealth therapy app engagement by young adults with OUD. *J Addict Dis.* 2024:1-6.	Study design
Substance Abuse and Mental Health Services Administration (SAMHSA). Digital therapeutics for management and treatment in behavioral health. 2023. Accessed December 31, 2024.	Publication type
Substance Abuse and Mental Health Services Administration (SAMHSA). Practical tools for prescribing and promoting buprenorphine in primary care settings.	Publication type

Reference Information	Primary Reason for Exclusion
National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration. 2021. Accessed December 31, 2024.	
Substance Abuse and Mental Health Services Administration (SAMHSA). Treatment Improvement Protocol 63: medications for opioid use disorder. 2021. Accessed December 31, 2024.	Intervention
Talal, AH, Markatou, M, Liu, A, et al. Integrated Hepatitis C-Opioid Use Disorder Care Through Facilitated Telemedicine: A Randomized Trial. *JAMA*. 2024. 331:1369-1378.	Intervention
Tice, JA, Whittington, MD, Fluetsch, N, et al. Digital health technologies as an adjunct to medication assisted therapy for opioid use disorder. 2020.	Study design
Tofighi B, Badiei B, Badolato R, et al. Integrating text messaging in a low threshold telebuprenorphine program for New York City residents with opioid use disorder during COVID-19: a pilot randomized controlled trial. *J Addict Med*. 2023;17(5):e281-e286.	Follow up
Tormohlen KN, Eisenberg MD, Fingerhood MI, et al. Trends in opioid use disorder outpatient treatment and telehealth utilization before and during the COVID-19 pandemic. *Psychiatr Serv*. 2024;75(1):72-75.	Study design
Treloar D, Mayet S. Telemedicine in addictions feasibility RCT – staff and patient qualitative satisfaction. *BJ Psych Open*. 2021;7(S1):S297-S297.	Publication type
Tsui JI, Leroux BG, Radick AC, et al. Video directly observed therapy for patients receiving office-based buprenorphine - A pilot randomized controlled trial. *Drug Alcohol Depend*. 2021;227:108917.	Intervention
Velez FF, Colman S, Kauffman L, Anastassopoulos K, Murphy S, Maricich Y. Real-world changes in US health system hospital-based services following treatment with a prescription digital therapeutic for opioid use disorder. *Hosp Pract (1995)*. 2021;49(5):341-347.	Intervention
Velez FF, Colman S, Kauffman L, Ruetsch C, Anastassopoulos K. Real-world reduction in healthcare resource utilization following treatment of opioid use disorder with reSET-O, a novel prescription digital therapeutic. *Expert Rev Pharmacoecon Outcomes Res*. 2021;21(1):69-76.	Intervention
Velez FF, Huang D, Mody L, Malone DC. Five-year budget impact of a prescription digital therapeutic for patients with opioid use disorder. *Expert Rev Pharmacoecon Outcomes Res*. 2022;22(4):599-607.	Intervention
Velez FF, Luderer HF, Gerwien R, Parcher B, Mezzio D, Malone DC. Evaluation of the cost-utility of a prescription digital therapeutic for the treatment of opioid use disorder. *Postgrad Med*. 2021;133(4):421-427.	Intervention
Velez FF, Malone DC. Cost-effectiveness analysis of a prescription digital therapeutic for the treatment of opioid use disorder. *J Mark Access Health Policy*. 2021;9(1):1966187.	Intervention
Velez FF, Ruetsch C, Maricich Y. Evidence of long-term real-world reduction in healthcare resource utilization following treatment of opioid use disorder with reSET-O, a novel prescription digital therapeutic. *Expert Rev Pharmacoecon Outcomes Res*. 2021;21(4):519-520.	Intervention
Wagner AD, Gimbel S, Asbjornsdottir KH, et al. Cascade analysis: an adaptable implementation strategy across HIV and Non-HIV delivery platforms. *J Acquir Immune Defic Syndr*. 2019;82 Suppl 3(Suppl 3):S322-S331.	Aim
Wang W, Gellings Lowe N, Jalali A, Murphy SM. Economic modeling of reSET-O, a prescription digital therapeutic for patients with opioid use disorder. *J Med Econ*. 2021;24(1):61-68.	Intervention

Reference Information	Primary Reason for Exclusion
Weiner SG, Miller EN, Clear B. Use of diverted buprenorphine by individuals initiating telehealth opioid use disorder treatment. *Subst Use Misuse*. 2024:1-4.	Study design
Wenzel KR, Burgower R, Wildberger J, Fishman M, Vo H. 2019 Youth opioid recovery support intervention: home delivery of extended release naltrexone. *J Addict Med*. 2019;13(3):E1-E42	Publication type
Wesson DR. Stay tuned and find out. *J Addict Dis*. 2006;25(3):1-3.	Publication type
Williams AR, Aronowitz S, Gallagher R, Behar E, Gray Z, Bisaga A. A virtual-first telehealth treatment model for opioid use disorder. *J Gen Intern Med*. 2023;38(3):814-816.	Publication type
Wilson M, Finlay M, Orr M, et al. Engagement in online pain self-management improves pain in adults on medication-assisted behavioral treatment for opioid use disorders. *Addict Behav*. 2018;86:130-137.	Intervention
Winters A, Walter E. The impact of telehealth on buprenorphine prescribing at a large federally qualified health center during COVID-19. *J Addict Med*. 2024;19:19.	Study design
Wolitzky-Taylor, K, Mooney, LJ, Otto, MW, et al. Augmenting the efficacy of benzodiazepine taper with telehealth-delivered cognitive behavioral therapy for anxiety disorders in patients using prescription opioids: a pilot randomized controlled trial. *Contemporary Clinical Trials.* 2023. 133:107334.	Population

Appendix H. Description of Coverage Policies

Table H1. Relevant Medicaid Coverage Policies

State	Coverage Policy
California California Department of Health Care Services. Updated telehealth guidance for specialty mental health services and substance use disorder treatment services in Medi-Cal. 2023[131]	POLICY: Medi-Cal covered services delivered via telehealth (synchronous audio-only and synchronous video interactions) are reimbursable in Medi-Cal Specialty Mental Health Services (SMHS), the Drug Medi-Cal Organized Delivery System (DMC-ODS), and the Drug Medi-Cal (DMC) programs (including initial assessments, only as set forth in this BHIN). Patient choice must be preserved; therefore, patients have the right to request and receive in-person services. All covered SMHS, DMC, and DMC-ODS services delivered via telehealth shall be provided in compliance with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, Part 2 of Title 42 of the Code of Federal Regulations, the Medicaid State Plan, and any other applicable state and federal statutes and regulations. Specific guidance for providers regarding HIPAA and telehealth is available from the external resources listed on DHCS' Telehealth Resources page. More information on telehealth can be found on the DHCS Medi-Cal & Telehealth page and the DHCS Telehealth Resources page. **Provider Requirements** Providers that offer telehealth services to Medi-Cal beneficiaries must meet all applicable Medi-Cal licensure and program enrollment requirements. If the provider is not located in California, they must be licensed in California, enrolled as a Medi-Cal rendering provider, and affiliated with a Medi-Cal enrolled provider group in California or a border community, as outlined in DHCS' Telehealth Policy Paper and the Medi-Cal Provider Manual. As a general rule, DHCS requires that every provider offering covered services to a beneficiary via telehealth must also meet the requirements of Business and Professions Code Section 2290.5(a)(3), or otherwise be designated by DHCS as able to render Medi-Cal services via telehealth. All providers that are listed in the California Medicaid State Plan as qualified providers of SMHS, DMC, or DMC-ODS services are designated by DHCS as able to render covered services, within their scopes of practice, via telehealth. Effective no sooner than January 1, 2024, all providers furnishing applicable covered services via synchronous audio-only interaction must also offer those same services via synchronous video interaction to preserve beneficiary choice. Also, effective no sooner than January 1, 2024, to preserve a beneficiary's right to access covered services in person, a provider furnishing services through telehealth must do one of the following: 1. Offer those same services via in-person, face-to-face contact; or 2. Arrange for a referral to, and a facilitation of, in-person care that does not require a beneficiary to independently contact a different provider to arrange for that care.

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	Beneficiary Consent Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services, and must explain the following to beneficiaries: • The beneficiary has a right to access covered services in person. • Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the beneficiary's ability to access MediCal covered services in the future • Non-medical transportation benefits are available for in-person visits. • Any potential limitations or risks related to receiving covered services through telehealth as compared with an in-person visit, if applicable. Providers must also document the beneficiary's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. The beneficiary's consent must be documented in their medical record and made available to DHCS upon request. A provider may utilize a general consent agreement to meet this documentation requirement if that general consent agreement: 1) specifically mentions the use of telehealth delivery of covered services; 2) includes the information described above; 3) is completed prior to initial delivery of services; and 4) is included in the beneficiary record. DHCS has created model verbal and written consent language, which can be found on the DHCS website. **Requirements for Establishing New Patient Relationships** As a general rule, State law prohibits the use of asynchronous store and forward, synchronous audio-only interaction, or remote patient monitoring when providers establish new patient relationships with Medi-Cal beneficiaries. For the SMHS, DMC, and DMC-ODS delivery systems, DHCS defines the establishment of new patient relationships as follows: • For SMHS, the establishment of care for a new patient refers to the mental health assessment done by a licensed clinician. • For substance use treatment in DMC and DMC-ODS, the establishment of care for a new patient refers to the American Society of Addiction Medicine Criteria assessment. However, SMHS, DMC, and DMC-ODS providers may establish a relationship with new patients via synchronous audio-only interaction in the following instances:8 • When the visit is related to sensitive services as defined in subsection (n) of Section 56.06 of the Civil Code. 9 This includes all covered SMHS, DMC, and DMC-ODS services. • When the patient requests that the provider utilizes synchronous audio-only interactions or attests they do not have access to video. • When the visit is designated by DHCS to meet another exception developed in consultation with stakeholders. SMHS, DMC, and DMC-ODS providers shall comply with all applicable federal and state laws, regulations, bulletins/information notices, and guidance when establishing a new patient relationship via telehealth. **Program Specific Requirements** Services provided by telehealth may be provided and reimbursed by each of the following programs as described below.

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	Drug Medi-Cal Organized Delivery System: • The initial clinical assessment and establishment of a new patient relationship, including any determination of diagnosis, medical necessity, and/or level of care may be delivered through synchronous video interaction. • The initial clinical assessment and establishment of a new patient relationship, including any determination of diagnosis, medical necessity, and/or level of care shall only be delivered through synchronous audio-only interaction in the situations identified above in this BHIN. • Licensed providers and non-licensed staff may deliver services through telehealth, as long as the service is within their scope of practice. • Covered DMC-ODS services may be delivered through telehealth when those services meet the standard of care. The group size limit still applies for group counseling provided via telehealth. 10 • Certain services, such as residential services, require a clearly established site for services and in-person contact with a beneficiary in order to be claimed. However, California's State Plan does not require that all components of these services be provided in-person. (For example, services can be provided via telehealth for a patient quarantined in their room in a residential facility due to illness.) **Drug Medi-Cal:** • DMC services, as defined in W&I section 14124.24, provided by a licensed practitioner of the healing arts, or a registered or certified alcohol or other drug counselor or another individual authorized by DHCS to provide DMC services when those services meet the standard of care and the requirements of the service code being billed, may be delivered through telehealth. 11 The group size limit still applies for group counseling provided via telehealth. 12 • The initial clinical assessment and establishment of a new patient relationship, including any determination of diagnosis, medical necessity, and/or level of care may be delivered through synchronous video interaction. • The initial clinical assessment and establishment of a new patient relationship, including any determination of diagnosis, medical necessity, and/or level of care shall only be delivered through synchronous audio-only interaction in the situations identified above in this BHIN. • Certain services, such as perinatal residential services, require a clearly established site for services and in-person contact with a beneficiary in order to be claimed. However, California's State Plan does not require that all components of these services be provided in-person. (For example, services can be provided via telehealth for a patient quarantined in their room in a residential facility due to illness). **Claiming and Reimbursement for Services Delivered via Telehealth** Providers that meet the applicable provider requirements in this BHIN may deliver services via telehealth from anywhere in the community, including outside a clinic or other provider site, and beneficiaries may receive services via telehealth in their home or in other locations. Providers are required to complete service documentation in the patient record in the same manner as in-person visit. Beneficiary consent for telehealth services must be documented as described in this BHIN. The fact that a service was performed by telehealth must be clearly documented in the chart and must be reflected in the claim, using the appropriate billing code and modifier, as described below.

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	The use of telehealth modifiers on SMHS, DMC, and DMC-ODS claims is mandatory and necessary for accurate tracking of telehealth usage in behavioral health. Billing codes must be consistent with the level of care provided. The following codes shall be used in SMHS, DMC, and DMC-ODS: • Synchronous video interaction service: GT • Synchronous audio-only interaction service: SC • Asynchronous store and forward (e-consult in DMC-ODS only): GQ Effective July 1, 2023, additional modifiers will be required for Current Procedural Terminology (CPT) codes after DHCS implements a successor payment methodology and transitions from Healthcare Common Procedure Coding System (HCPCS) codes to a combination of HCPCS and CPT codes. See BHIN 22-046 for more information and the MEDCCC Library for the version of the billing manuals that will take effect in 2023. If a telehealth modifier is used for outpatient services on or after July 1, 2023, the place of service must be "02" or "10" unless the service is Mobile Crisis Services. **Telehealth Reimbursement:** Rendering services via telehealth does not change the payment methodologies or reimbursement rates to Medi-Cal behavioral health delivery systems. Medi-Cal behavioral health delivery systems must reimburse providers for a covered service, as it is described in the service description included with the claim, at the same rate regardless of the means of delivery (in-person, telehealth, or telephone). For example, if a provider receives $100 for an in-person visit, the provider should also be reimbursed $100 for an equivalent visit rendered via telehealth (either through synchronous audio-only interaction or synchronous video interaction), provided the means of service delivery is medically appropriate.
Florida	*We were unable to identify a Florida Medicaid policy covering telehealth for OUD treatment.*
Massachusetts MassHealth. MassHealth all provider bulletin 374: access to health services through telehealth options. 2023[141] MassHealth. MassHealth all provider bulletin 355: access to health services through telehealth options (amendment). 2022[140] MassHealth Provider Manual Series.	*From All Provider Bulletin 374 (2023)* **Overview** MassHealth's mission is to improve the health outcomes of our diverse members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life. In support of that mission, MassHealth has implemented a robust telehealth policy that promotes member choice and ensures that members retain access to medically necessary covered services. Since the introduction of its telehealth policy, MassHealth has seen robust use of telehealth for delivering medically necessary services. MassHealth's current telehealth policy is detailed in All Provider Bulletin 355 through September 30, 2023. This bulletin establishes MassHealth's agency-wide rules for reimbursement of services provided via telehealth, applicable to all MassHealth programs as of October 1, 2023. **Continuing Payment Parity** Under this policy, MassHealth will continue to allow MassHealth-enrolled providers to deliver a broad range of MassHealth-covered services via telehealth. MassHealth will reimburse for such services at parity with their in-person counterparts, including services provided through live-video, audio-only, or asynchronous visits that otherwise meet billing criteria, including use of required modifiers. All providers delivering services via telehealth must comply with the policy detailed in this

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Substance use disorder treatment manual. 2023[167]	bulletin. In addition, MassHealth may issue program-specific guidance (e.g., Continuous Skilled Nursing Agency Bulletin 10 and Home Health Agency Bulletin 84) with additional requirements and/or limitations that apply to the provision of services via telehealth by providers participating in those programs. **Option to Receive In-Person Services** This telehealth policy reflects feedback from our members, who have voiced a clear desire for flexibility in accessing covered services in the manner best tailored to their needs. As a result, member choice is an essential feature of this updated policy. Under this telehealth policy, providers must always obtain the member's consent to receive services via telehealth. This ensures that members will have the choice to decide between receiving services in-person or via telehealth. Under M.G.L. c. 118E, § 79(d), MassHealth members have a choice to decline to receive services via telehealth in order to receive such services in person. The availability of telehealth modalities does not mitigate the provider responsibility to accommodate member choice for in-person services (i.e., this language does not affect network adequacy standards for managed care plans). Important Note: Although MassHealth allows reimbursement for the delivery of certain services through telehealth for certain billing providers as described in this bulletin, MassHealth does not require providers to deliver services via telehealth. **Facility Claims for Services Provided via Telehealth** Consistent with All Provider Bulletin 355 and its predecessor bulletins, MassHealth will reimburse providers delivering any telehealth-eligible covered service via any telehealth modality at parity with its in-person counterpart as above. Likewise, an eligible distant-site provider delivering covered services via telehealth in accordance with this bulletin may bill MassHealth a facility claim if such a fee is allowed under the provider's governing regulations or contracts. **Applicability** This bulletin applies to members enrolled in MassHealth fee-for-service, the Primary Care Clinician (PCC) Plan, a Managed Care Organization (MCO), an Accountable Care Partnership Plan (ACPP), or a Primary Care Accountable Care Organization (PCACO). Information about coverage through MassHealth Managed Care Entities (MCEs) and the Program for All-inclusive Care for the Elderly (PACE) will be issued in a forthcoming MCE bulletin. A. Coverage of Services Provided via Telehealth As under All Provider Bulletin 355, Section B of this bulletin identifies specific categories of service that MassHealth has deemed inappropriate for delivery via any telehealth modality. Except for those services identified in Section B in this bulletin, and notwithstanding any regulation to the contrary, including the physical-presence requirement at 130 CMR 433.403(A)(2), a MassHealthenrolled provider may deliver medically necessary MassHealth-covered services on an outpatient basis to a MassHealth member via the telehealth modalities of audio-only, live video, and asynchronous visits, if: • the provider has determined that it is clinically appropriate to deliver such service via telehealth, including the telehealth modality and technology employed, including obtaining member consent; • such service is payable under that provider type; • the provider satisfies all requirements set forth in this bulletin, including in Appendix A, and any applicable program-specific bulletin;

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	• the provider delivers those services in accordance with all applicable laws and regulations (including M.G.L. c. 118E, § 79 and MassHealth program regulations); and • the provider is appropriately licensed or credentialed to deliver those services. MassHealth will continue to monitor telehealth's impacts on quality of care, cost of care, patient and provider experience, and health equity to inform the continued monitoring and iteration of its telehealth policy. Based on the results of this monitoring, and its analysis of relevant data and information, MassHealth may adjust its coverage policy, including by imposing limitations on the use of certain telehealth modalities for various covered services or provider types. B. Categories of Service Ineligible for Delivery via Telehealth As under All Provider Bulletin 355, MassHealth has deemed these following categories of service ineligible for delivery via any telehealth modality. • Ambulance Services • Ambulatory Surgery Services • Anesthesia Services • Certified Registered Nurse Anesthetist Services • Chiropractic Services • Hearing Aid Services • Inpatient Hospital Services1 • Laboratory Services • Nursing Facility Services • Orthotic Services • Personal Care Services • Prosthetic Services • Renal Dialysis Clinic Services • Surgery Services • Transportation Services • X-Ray/Radiology Services C. Billing and Reimbursement for Services Provided via Telehealth Providers must include the place of service (POS) code 02 when submitting a professional claim for telehealth provided in a setting other than in the patient's home. They must include POS code 10 when submitting a professional claim for telehealth provided in the patient's home. Additionally, for any such professional claim, providers must include: • modifier 95 to indicate counseling and therapy services rendered via audio-video telecommunications; • modifier 93 to indicate services rendered via audio-only telehealth; • modifier FQ to indicate counseling and therapy services provided using audio-only telecommunications; • modifier FR to indicate a supervising practitioner was present through a real-time two-way, audio and video communication technology; and/or • modifier GQ to indicate services rendered via asynchronous telehealth. Additionally, for any institutional claim, providers are allowed to use the following modifiers:

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	• modifier 95 to indicate counseling and therapy services rendered via audio-video telecommunications; • modifier 93 to indicate services rendered via audio-only telehealth; • modifier GT to indicate services rendered via interactive audio and video telecommunications systems; • modifier FQ to indicate counseling and therapy services provided using audio-only telecommunications; • modifier FR to indicate that a supervising practitioner was present through a real-time two-way, audio and video communication technology; and/or • modifier GQ to indicate services rendered via asynchronous telehealth. Modifier GT is required on the institutional claim, for the distant-site provider, when there is an accompanying professional claim containing POS 02 or 10. Professional and institutional claims with the aforementioned modifiers must also meet the following requirements: • modifier 93 is to be allowed only for codes listed in Appendix T of the CPT codebook; and • modifier 95 is to be allowed only with codes listed in Appendix P of the CPT codebook. Effective August 31, 2023, modifier V3, which was previously used to indicate services rendered via audio-only telehealth, will no longer be available. Providers must use modifier 93 in its place. **Appendix A** Requirements for Use of Telehealth to Deliver Covered Services Additional Requirements for Prescribing A provider may prescribe medications via telehealth as otherwise described in this bulletin and in accordance with the following requirements. 1. Providers must comply with all applicable state and federal statutes and regulations governing medication management and prescribing services when delivering these services via telehealth. 2. Providers who deliver prescribing services via telehealth must maintain policies for providing patients with timely and accurate prescriptions by use of mail, phone, e-prescribing, and/or fax. Providers must document prescriptions in the patient's medical record consistent with in-person care. Requirements for Telehealth Encounters When rendering services via telehealth, providers must comply with all applicable laws and regulations, including M.G.L. c. 118E, § 79. Providers must adhere to the following best practices when delivering services via telehealth. Providers are encouraged to have documented policies and procedures that incorporate these best practices. 1. Providers must properly identify the patient using, at a minimum, the patient's name, date of birth, and MassHealth ID. 2. Providers must disclose and validate the provider's identity and credentials, such as the provider's license, title, and, if applicable, specialty and board certifications.

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	3. For an initial appointment with a new patient, the provider must review the patient's relevant medical history and any available medical records with the patient before initiating the delivery of the service. 4. For existing provider-patient relationships, the provider must review the patient's medical history and any available medical records with the patient during the service. 5. Before each patient appointment, the provider must ensure that the provider is able to deliver the service to the same standard of care and in compliance with licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access) using telehealth, as is applicable to the delivery of the services in person. If the provider cannot meet this standard of care or other requirements, the provider must direct the patient to seek in-person care. 6. To the extent feasible, providers must ensure the same rights to confidentiality and security as provided in face-to-face services. 7. Providers must follow consent and patient information protocol consistent with those followed during in-person visits. 8. Providers must obtain the member's consent to receive services via telehealth and inform the member (a) of any relevant privacy considerations, and (b) that the member may revoke their consent to receive services via telehealth at any time. 9. Providers must inform patients of the location of the provider rendering services via telehealth (i.e., distant site) and obtain the location of the patient (i.e., originating site). 10. The provider must inform the patient of how the patient can see a clinician in-person in the event of an emergency or as otherwise needed. Documentation and Recordkeeping Providers delivering services via telehealth must meet all health records standards required by the applicable licensing body, as well as any applicable regulatory and program specifications required by MassHealth. This includes storage, access, and disposal of records. In addition to complying with all applicable MassHealth regulations pertaining to documentation of services, providers must include a notation in the medical record that indicates that the service was provided via telehealth. Providers must also include a notation in the medical record that lists the address in which the member received the service. MassHealth may audit provider records for compliance with all regulatory requirements, including recordkeeping and documentation requirements, and may apply appropriate sanctions to providers who fail to comply *From All Provider Bulletin 355 (2022): information is same as above but this bulletin includes a link to information about buprenorphine prescribing:* The U.S. Department of Health and Human Services published a statement, Telemedicine and Prescribing Buprenorphine for the Treatment of Opioid Use Disorder, providing relevant guidance to providers. *From MassHealth Substance Use Disorder Treatment Manual (2023); only retrieved information about telehealth.*

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	Definitions: Telehealth – the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to: (1) interactive audio-video technology; (2) remote patient monitoring devices; (3) audio-only telephone; and (4) online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient's physical health, oral health, mental health or substance use disorder condition. 418.412: Service Limitations (7) Telehealth. Services including the prescribing of controlled substances must be in accordance with state and federal regulations.
New Jersey New Jersey Administrative Code. N.J.A.C. 13:35-6B telemedicine. 2019[143]	§ 13:35-6B.1 Purpose and scope **(a)** The purpose of this subchapter is to implement the provisions of P.L. 2017, c. 117 (N.J.S.A. 45:1-16 et seq.), which authorizes healthcare providers to engage in telemedicine and telehealth. **(b)** This subchapter shall apply to all persons who are licensed by the Board as physicians or podiatrists. **(c)** Pursuant to N.J.S.A. 45:1-62 , a physician or podiatrist must hold a license issued by the Board if he or she: **1.** Is located in New Jersey and provides health care services to any patient located in or out of New Jersey by means of telemedicine or telehealth; or **2.** Is located outside of New Jersey and provides health care services to any patient located in New Jersey by means of telemedicine or telehealth. **(d)** Notwithstanding N.J.S.A. 45:1-62 and (c) above, a healthcare provider located in another state who consults with a licensee in New Jersey through the use of information and communications technologies, but does not direct patient care, will not be considered as providing health care services to a patient in New Jersey consistent with N.J.S.A. 45:9-1 et seq., and will not be required to obtain licensure in New Jersey in order to provide such consultation. § 13:35-6B.2 Definitions The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise. "Asynchronous store-and-forward" means the acquisition and transmission of images, diagnostics, data, and medical information either to, or from, an originating site or to, or from, the licensee at a distant site, which allows for the patient to be evaluated without being physically present. "Board" means the New Jersey Board of Medical Examiners. "Cross-coverage" means a licensee engages in a remote medical evaluation of a patient, without in-person contact, at the request of another licensee who has established a proper licensee-patient relationship with the patient. "Distant site" means a site at which a licensee is located while providing health care services by means of telemedicine or telehealth. "Licensee" means an individual licensed by the Board as a physician or podiatrist.

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	"On-call" means a licensee is available, where necessary, to physically attend to the urgent and follow-up needs of a patient for whom the licensee has temporarily assumed responsibility, as designated by the patient's primary care licensee or other health care provider of record. "Originating site" means a site at which a patient is located at the time that health care services are provided to the patient by means of telemedicine or telehealth. "Proper licensee-patient relationship" means an association between a licensee and patient wherein the licensee owes a duty to the patient to be available to render professional services consistent with his or her training and experience, which is established pursuant to the requirements of N.J.A.C. 13:35-6B.4 . "Telehealth" means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L. 2017, c. 117 (N.J.S.A. 45:1-61 et seq.). "Telemedicine" means the delivery of a health care service, including supportive mental health services, using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care licensee who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening licensee, and in accordance with the provisions of P.L. 2017, c. 117 (N.J.S.A. 45:1-61 et seq.). "Telemedicine" does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission. § 13:35-6B.3 Standard of care **(a)** Prior to providing services through telemedicine or telehealth, a licensee shall determine whether providing those services through telemedicine or telehealth would be consistent with the standard of care applicable for those services when provided in-person. **(b)** If a licensee determines, either before or during the provision of health care services, that services cannot be provided through telemedicine or telehealth in a manner that is consistent with in-person standards of care, the licensee shall not provide services through telemedicine or telehealth. **(c)** A licensee who determines that services cannot be provided through telemedicine or telehealth pursuant to (b) above shall advise the patient to obtain services in-person. **(d)** A licensee who provides a diagnosis, treatment, or consultation recommendation, including discussions regarding the risk and benefits of a patient's treatment options, through telemedicine or telehealth, shall be held to the same standard of care or practice standards as are applicable to in-person settings. § 13:35-6B.4 Licensee-patient relationship **(a)** Prior to providing services through telemedicine or telehealth, a licensee shall establish a licensee-patient relationship by: **1.** Identifying the patient with, at a minimum, the patient's name, date of birth, phone number, and address. A licensee may also use a patient's assigned identification number, Social Security number, photo, health insurance policy number, or other identifier associated directly with the patient; and **2.** Disclosing and validating the licensee's identity, license, title, and, if applicable, specialty and board certifications.

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	(b) Prior to initiating contact with a patient for the purpose of providing services to the patient using telemedicine or telehealth, a licensee shall: **1.** Review the patient's medical history and any available medical records; **2.** Determine as to each unique patient encounter, whether he or she will be able to provide the same standard of care using telemedicine or telehealth as would be provided if the services were provided in-person; and **3.** Provide the patient the opportunity to sign a consent form that authorizes the licensee to release medical records of the encounter to the patient's primary care provider or other healthcare provider identified by the patient. **(c)** Notwithstanding (a) and (b) above, health care services may be provided through telemedicine or telehealth without a proper licensee-patient relationship if the provision of health care services is: **1.** For informal consultations with another healthcare provider performed by a licensee outside the context of a contractual relationship, or on an irregular or infrequent basis, without the expectation or exchange of direct or indirect compensation; **2.** During episodic consultations by a medical specialist located in another jurisdiction who provides consultation services, upon request, to a licensee in this State; **3.** Related to medical assistance provided in response to an emergency or disaster, provided that there is no charge for the medical assistance; or **4.** Provided by a substitute licensee acting on behalf of, and at the designation of, an absent licensee in the same specialty on an on-call or cross-coverage basis. § 13:35-6B.5 Provision of health care services through telemedicine or telehealth **(a)** As long as a licensee has satisfied the requirements of N.J.A.C. 13:35-6B.4 , a licensee may provide health care services to a patient through the use of telemedicine and may engage in telehealth to support and facilitate the provision of health care services to patients. **(b)** Prior to providing services through telemedicine or telehealth, a licensee shall determine the patient's originating site and record this information in the patient's record. **(c)** A licensee providing healthcare services through telemedicine shall use interactive, real-time, two-way communication technologies, which shall include, except as provided in (e) below, a video component that allows a licensee to see a patient and the patient to see the licensee during the provision of health care services. **(d)** A licensee providing services through telemedicine or telehealth may use asynchronous store-and-forward technology to allow for the electronic transmission of: **1.** Images; **2.** Diagnostics; **3.** Data; and **4.** Medical information. **(e)** If, after accessing and reviewing the patient's medical records, a licensee determines that he or she is able to meet the standard of care for such services as if they were being provided in person without using the video component described in (c) above, the licensee may use interactive, real-time, two-way audio in combination with asynchronous store-and-forward technology, without a video component.

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	(f) Prior to providing services through telemedicine or telehealth, a licensee shall review any medical history or medical records provided by a patient as follows: **1.** For an initial encounter with a patient, medical history and medical records shall be reviewed prior to the provision of health care services through telemedicine or telehealth; and **2.** For any subsequent interactions with a patient, medical history and medical records shall be reviewed either prior to the provision of health care services through telemedicine or telehealth or contemporaneously with the encounter with the patient. **(g)** During and after the provision of health care services through telemedicine or telehealth, a licensee, or another designated licensee, shall provide his or her name, professional credentials, and contact information to the patient. Such contact information shall enable the patient to contact the licensee for at least 72 hours following the provision of services, or for a longer period, if warranted, by the patient's circumstances and accepted standards of care. **(h)** After the provision of health care services through telemedicine or telehealth, a licensee shall provide the patient, upon request, with his or her medical records reflecting the services provided. **(i)** A licensee shall provide, upon a patient's oral, written, or digital request, the patient's medical information to the patient's primary care provider or to other health care providers. **(j)** A licensee engaging in telemedicine or telehealth shall refer a patient for follow-up care when necessary. § 13:35-6B.6 Prescriptions **(a)** Notwithstanding the requirements for in-person interaction in N.J.A.C. 13:35-7 , a licensee providing services through telemedicine or telehealth may issue a prescription to a patient, if the issuance of such a prescription is consistent with the standard of care or practice standards applicable to the in-person setting. **(b)** A licensee shall not issue a prescription based solely on responses provided in an online questionnaire, unless the licensee has established a proper licensee-patient relationship pursuant to N.J.A.C. 13:35-6B.4 . **(c)** Notwithstanding (a) above, and except as provided in (d) below, a licensee shall not issue a prescription for a Schedule II controlled dangerous substance unless the licensee has had an initial in-person examination of the patient and a subsequent in-person visit with the patient at least every three months for the duration of the time the patient is prescribed the Schedule II controlled dangerous substance. **(d)** The prohibition of (c) above shall not apply when a licensee prescribes a stimulant for a patient under the age of 18 years, as long as the licensee is using interactive, real-time, two-way audio and video technologies and the licensee has obtained written consent for a waiver of in-person examination requirements from the patient's parent or guardian. § 13:35-6B.7 Records A licensee who provides services through telemedicine or telehealth shall maintain a record of the care provided to a patient. Such records shall comply with the requirements of N.J.A.C. 13:35-6.5 , and all other applicable State and Federal statutes, rules, and regulations for recordkeeping, confidentiality, and disclosure of a patient's medical record.
North Carolina North Carolina Medicaid. Telehealth,	*From Telehealth, Virtual Communications, and Remote Patient Monitoring Manual* Definitions **1.1.6 Established Patient**

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virtual communications and remote patient monitoring. 2025[150] North Carolina Medicaid. Office-based opioid treatment: use of buprenorphine and buprenorphine-naloxone. 2023[151] North Carolina Medicaid. Enhanced mental health and substance abuse services. 2025[152]	An Established Patient refers to a beneficiary who has received any professional services (including services via telehealth) from the provider or another provider of the same specialty who belongs to the same group practice within the past three years. Since telehealth services are considered professional services, a beneficiary and provider relationship may be established via telehealth. **1.1.7 New Patient** A New Patient refers to a beneficiary who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years. 3.0 When the Procedure, Product, or Service Is Covered **3.1 General Criteria Covered** Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and: a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs; b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider. **3.2 Specific Criteria Covered** 3.2.1 Specific criteria covered by Medicaid Medicaid shall cover services delivered via telehealth, virtual communications, and remote patient monitoring services when the all the following additional criteria are followed before rendering services via telehealth, virtual communications, or remote patient monitoring: a. Provider(s) shall ensure that services can be safely and effectively delivered using telehealth, virtual communications, or remote patient monitoring. b. Provider(s) shall consider a beneficiary's behavioral, physical and cognitive abilities to participate in services provided using telehealth, virtual communications, or remote patient monitoring. c. The beneficiary's safety must be carefully considered for the complexity of the services provided. d. In situations where a caregiver or facilitator is necessary to assist with the delivery of services via telehealth, virtual communications, or remote patient monitoring, their ability to assist and their safety must also be considered. e. Delivery of services using telehealth, virtual communications, or remote patient monitoring must conform to professional standards of care: ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements, such as Practice Act and Licensing Board rules; f. Provider(s) shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this must be documented. g. Beneficiaries are not required to seek services through telehealth, virtual communications, or remote patient monitoring, and shall be allowed access to in-person services, if the beneficiary requests; h. Provider(s) shall verify the beneficiary's identity using two points of identification before initiating service delivery via telehealth, virtual communications, or remote patient monitoring. i. Provider(s) shall ensure that beneficiary privacy and confidentiality is protected to the best of their ability. 3.3 Eligible Services and Providers Telehealth, Virtual Communications, and Remote Patient Monitoring Services Covered in Clinical Coverage Policy 1-H

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	A range of services may be delivered via telehealth, virtual communication, and remote patient monitoring to Medicaid beneficiaries. All telehealth, virtual communication, and remote monitoring services must be delivered in a manner that is consistent with the quality of care provided in-person. Each set of eligible services has its own set of eligible provider(s) as defined in Attachment A of this policy or Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies. Eligible services, eligible providers, and related detailed guidance for the following may be found in Attachment A below: **3.3.1 Telehealth, including:** a. office or other outpatient services and office and inpatient consultation codes; and b. hybrid telehealth visit with supporting home visit codes. **3.3.2 Virtual communication, including:** a. online digital evaluation and management codes; b. telephonic evaluation and management; c. telephonic evaluation and management and virtual communication codes; and d. interprofessional assessment and management codes. **3.3.3 Remote patient monitoring, including:** a. self-measured blood pressure monitoring; and b. remote physiologic monitoring. 3.4 Services Covered in Other Program-Specific Clinical Coverage Policies In addition to the eligible services and providers listed in Attachment A of this policy, the policies listed under "Related Clinical Coverage Policies" at the top of this document also include telehealth coverage information, such as telehealth-eligible services and providers. Please refer to those policies for program-specific telehealth guidance…… 6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall: a. meet Medicaid qualifications for participation; b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity. 6.1 Provider Qualifications and Occupational Licensing Entity Regulations None Apply. 6.2 Provider Certifications None Apply. *From Office-Based Opioid Treatment Manual; only retrieved telehealth references* **3.2.6 Telehealth** Telehealth services may be used for the medical or counseling portions of OBOT services providing they are in accordance with NC Medicaid clinical coverage policy 1H, Telehealth, Virtual Communications and Remote Patient Monitoring. If telehealth is utilized for the medical management portion of OBOT services, the beneficiary shall be located at a facility where a physical exam can be conducted by a nurse practitioner, physician assistant, or MD at the time of the telehealth visit

<table>
<tr><th>State</th><th>Coverage Policy</th></tr>
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From Enhanced Mental Health and Substance Abuse Services Manual; only retrieved telehealth references
3.1.1 Telehealth and Telephonic Services As outlined in Attachments A and D, select services within this clinical coverage policy may be provided via telehealth and telephonically. Services delivered via telehealth and telephonically must follow the requirements and guidance in clinical coverage Policy 1-H, Telehealth, Virtual Communications, and Remote Patient Monitoring, at https://medicaid.ncdhhs.gov/.

Attachment A: Claims-Related Information
Substance Abuse Intensive Outpatient Program (Medicaid)
<table>
<tr><td>HCPCS Code</td><td>Billing Unit</td><td>Telehealth Eligible</td></tr>
<tr><td>H0015</td><td>1 unit = 1 event per day (3 hours minimum)</td><td>No</td></tr>
</table>
Substance Abuse Comprehensive Outpatient Treatment (Medicaid only)
<table>
<tr><td>HCPCS Code</td><td>Billing Unit</td><td>Telehealth Eligible</td></tr>
<tr><td>H2035</td><td>1 unit = 1 hour</td><td>No</td></tr>
</table>
</td></tr>
<tr><td>Oregon

Oregon Health Authority. Ancillary guideline A5, telehealth, teleconsultations and online/telephonic services. 2025[154]</td><td>
ANCILLARY GUIDELINE A5, TELEHEALTH, TELECONSULTATIONS AND ONLINE/TELEPHONIC SERVICES
Telehealth services include a variety of health services provided by synchronous or asynchronous electronic communications, including secure electronic health portal, audio, or audio and video and clinician-to-clinician virtual consultations.
Criteria for coverage
The clinical value of the telehealth service delivered must reasonably approximate the clinical value of the equivalent services delivered in-person.
Coverage of telehealth services requires the same level of documentation, medical necessity, and coverage determinations as in-person visits.
Examples of covered telephone or online services include but are not limited to:
A. Extended counseling when person-to-person contact would involve an unwise delay or exposure to infectious disease.
B. Treatment of relapses that require significant investment of provider time and judgment.
C. Counseling and education for patients with complex chronic conditions.

Examples of non-covered telehealth services include but are not limited to:
A. Prescription renewal.
B. Scheduling a test.
C. Reporting normal test results.
D. Requesting a referral.
E. Services which are part of care plan oversight or anticoagulation management (CPT codes 99339-99340, 99374-99380 or 99363-99364).
</td></tr>
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	F. Services which relate to or take place within the postoperative period of a procedure provided by the physician are not separately covered. (Such a service is considered part of the procedure and is not be billed separately.) Codes eligible for telehealth delivery include 90785, 90791, 90792, 90832-90834, 90836, 90837-90840, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964-90970, 96116, 96156-96171, 96160, 96161, 97802-97804, 98000-98015,99201-99205, 99211-99215, 99231-99233, 99307-99310, 99354-99357, 99406-99407, 99495-99498, G0108-G0109, G0270, G0296, G0396, G0397, G0406-G0408, G0420, G0421, G0425-G0427, G0438-G0439, G0442-G0447, G0459, G0506, G0508, G0509, G0513, G0514, G2086-G2088. Codes eligible for teledentistry include CDT D0120-D0170, D0180, D0190, D0191, D1206, D1320, D1321, D1330, and D9991-D9997. Additional codes are covered when otherwise appropriate according to this guideline note and other applicable coverage criteria. The originating site code Q3014 is covered only when the patient is present in an appropriate health care setting and receiving services from a provider in another location. *Clinician to Patient Services billed using specified codes indicating telephone or online service delivery* Covered telephonic and online services include services related to evaluation, assessment and management as well as other technology-based services (CPT 98016, 98966-98968, 99441-99443, 99421-99423, 98970-98972, G2061-G2063, G2251-G2252). Covered telephone and online services billed using these codes do not include either of the following: A. Services related to a service performed and billed by the physician or qualified health professional within the previous seven days, regardless of whether it is the result of patient-initiated or physician-requested follow-up. B. Services which result in the patient being seen within 24 hours or the next available appointment. *Clinician-to-Clinician Consultations (telephonic, online or using electronic health record)* Covered interprofessional consultations delivered online, through electronic health records or by telephone (CPT 99446-99449, 99451-99452). *Store and Forward* Store and forward codes (HCPCS G2010, G2250) are only covered when billed concurrently with a code that includes medical decision making and communication with the patient (for example, HCPCS G2012).
Pennsylvania Pennsylvania Department of Human Services, Office of Mental Health and Substance Abuse Services Bulletin. Revised guidelines for the delivery of behavioral health	**SCOPE**: The bulletin applies to: (1) providers enrolled in the Medical Assistance (MA) Program who render behavioral health services in the fee-for-service (FFS) or managed care delivery system and (2) Primary Contractors and Behavioral Health Managed Care Organizations (BH-MCOs) in the HealthChoices (HC) Program. **PURPOSE:** The purpose of this bulletin is to update the guidelines for payment of behavioral health services delivered using telehealth technology previously issued in OMHSAS-21-09 Guidelines for the Delivery of Behavioral Health Services Through Telehealth. **BACKGROUND:** The Office of Mental Health and Substance Abuse Services (OMHSAS) first issued guidance on the use of telehealth through OMHSAS-11-09 OMHSAS Guidelines for the Approval of Telepsychiatry. OMHSAS issued updated guidance in OMHSAS-14-01 OMHSAS Guidelines for the Approval of Telepsych Services in HealthChoices, which clarified

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services through telehealth. 2022[157]	the availability of telehealth to deliver psychiatric and psychological services by MA enrolled psychiatrists and licensed psychologists in the Behavioral Health HC Program. Both bulletins were applicable only to MA enrolled psychiatrists and licensed psychologists when providing services in the HC Program. On February 20, 2020, OMHSAS issued OMHSAS-20-02 Guidelines for the Use of Telehealth Technology in the Delivery of Behavioral Health Services expanding the use of telehealth to the Fee-for-Service (FFS) delivery system and the practitioner types that may provide services through telehealth technology. On March 15, 2020, OMHSAS issued Memorandum Telehealth Guidelines Related to COVID19, which added temporary flexibilities for telehealth service delivery in response to the Governor's Proclamation of Disaster Emergency due to the novel coronavirus COVID-19, in order to ensure ongoing access to behavioral health services under social distancing guidelines, quarantines, and stay-at-home orders. This Memorandum was revised and reissued as Telehealth Guidelines Related to COVID-19 (Updated) on May 5, 2020. These flexibilities were critical in retaining individuals in treatment, increasing access to services, and expanding individual choice in the delivery of services. Based on stakeholder feedback and to allow for continued access to behavioral health services using telehealth, this bulletin provided for the continuation of certain telehealth flexibilities following the end of the state emergency disaster declaration. OMHSAS incorporated most of the flexibilities introduced during the COVID-19 pandemic into non-COVID-19 related policy with the issuance of OMHSAS-21-09, Guidelines for the Delivery of Behavioral Health Services Through Telehealth, issued August 26, 2021, and re-issued on September 30, 2021. OMHSAS-21-09 allowed for the utilization of audio-only services in limited circumstances, expanded the ability of licensed drug and alcohol providers to receive MA payment for telehealth delivered services, expanded the ability of licensed provider agencies to receive MA payment for telehealth services delivered by unlicensed mental health staff, and allowed the delivery of services through telehealth in community settings. This bulletin updates the guidance contained in OMHSAS-21-09 regarding documentation of consent and the use of electronic signatures and revises the billing instructions related to the place of service (POS) codes and modifiers to be used for telehealth. In addition, this bulletin addresses the ability of licensed practitioners who serve less than five individuals to request approval to deliver services using telehealth where they do not maintain a physical location in Pennsylvania within 60 minutes or 45 miles (whichever is greater) of the area served. PROCEDURE The following procedures apply to providers seeking to utilize telehealth for delivering behavioral health services within the Pennsylvania MA Program. **Licensed Practitioners** MA coverage and payment for services provided via telehealth is separate and apart from authorization to engage in telehealth from a professional licensing standpoint. Providers using telehealth must remain informed on federal and state statutes, regulations, and guidance regarding telehealth. Practitioners should exercise sound clinical judgement and should not provide services through telehealth when it is not clinically appropriate to do so. Services delivered using telehealth must comply with all service specific and payment requirements for the service. **Provider Agencies** Provider agencies using behavioral health staff who are unlicensed, including, but not limited to, unlicensed master's level therapists, mental health targeted case managers, mental health certified peer support specialists, certified recovery

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	specialists, and drug and alcohol counselors (as defined in 28 Pa. Code §704.7(b)), and licensed practitioners may provide services using telehealth. Provider agencies should establish and enforce policies for assessing when it is clinically appropriate to deliver services through telehealth. Services delivered using telehealth must comply with all service specific and payment requirements for the service. **Out-of-State Practitioners Providing Services to Individuals in Pennsylvania** Out-of-state licensed practitioners who provide treatment through telehealth to individuals in Pennsylvania through the MA program must meet the licensing requirements established by the Pennsylvania Department of State. In order to receive payment for services to beneficiaries in the FFS delivery system, practitioners must be enrolled in the MA Program. Practitioners seeking to provide services to beneficiaries in the managed care delivery system should contact the appropriate Managed Care Organization for its enrollment processes. Practitioners are also advised to consult with their professional liability insurance carrier regarding provision of services in other jurisdictions. **Access to Services Delivered In-Person** In the managed care delivery system, the HealthChoices Primary Contractor must ensure that provider agencies and licensed practitioners who deliver services through telehealth within their service area can arrange for services to be delivered in-person as clinically appropriate or requested by the individual served. HealthChoices Primary Contractors must ensure that each contracted provider agency and licensed practitioner meets one of the two following criteria: 1. The provider agency or licensed practitioner maintains a physical location in Pennsylvania within 60 minutes or 45 miles (whichever is greater) of the area served with appropriate licensure for all services provided through telehealth; or 2. The provider agency or licensed practitioner maintains a physical location in a state bordering Pennsylvania, located within 60 minutes or 45 miles (whichever is greater) of the area served in Pennsylvania, maintains licensure in the state where they are physically located for all services provided through telehealth and is enrolled with the Pennsylvania MA program The HealthChoices Primary Contractor may apply for an exception to allow licensed practitioners and/or provider agencies beyond the 60 minute/45 mile restriction to deliver services through telehealth in their service area when supporting additional access to services or in circumstances when the licensed practitioner and/or provider agency is needed to meet the cultural, racial/ethnic, sexual/affectional or linguistic needs of individual(s) served or in instances when the licensed practitioner serves less than 5 individuals. An exception request can be submitted to the OMHSAS Telehealth Resource Account using the form in Attachment B. **Originating Sites** The originating site is the setting at which an individual receives behavioral health services using telehealth delivery. When telehealth is being used to deliver services to an individual who is at a clinic, residential treatment setting, or facility setting, the originating site must have staff trained in telehealth equipment and protocols to provide operating support. In addition, the clinic or facility must have staff trained and available to provide clinical intervention in-person, if a need arises. Services delivered through telehealth may also be provided outside of a clinic, residential treatment setting or facility setting. With the consent of the individual served and when clinically appropriate, licensed practitioners and provider agencies may deliver services through telehealth to individuals in community settings, such as to an individual located in their home. The licensed practitioner or provider agency must have policies in place to address emergency situations, such as a risk of harm to self or others.

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	Determining Appropriateness for Telehealth Delivery of Services Licensed practitioners and provider agencies delivering services through telehealth must have policies that ensure that services are delivered using telehealth only when it is clinically appropriate to do so and that licensed practitioners are complying with standards of practice set by their licensing board for telehealth where applicable. Factors to consider include, but are not limited to: The preference of the individual served and/or the preference of parents or guardians Whether there is an established relationship with the service provider and the length of time the individual has been in treatment • Level of acuity needed for care • Risk of harm to self or others • Age of a minor child • Ability of the individual served to communicate, either independently or with accommodation such as an interpreter or electronic communication device • Any barriers to in-person service delivery for the individual • Access to technology of the individual served • Whether privacy for the individual served could be maintained if services are delivered using telehealth • Whether the service relies on social cueing and fluency The preference of the individual served and/or their parents or legal guardian(s), as applicable, should be given high priority when making determinations of the appropriateness of the telehealth delivery. However, no service should be provided through telehealth when, in the best clinical judgement of the licensed practitioner, it is not clinically appropriate. When the use of telehealth is not clinically appropriate, the licensed practitioner or provider agency must offer the services in-person. If the individual disagrees with the clinical determination, the licensed practitioner or provider agency may refer the individual to other in-network providers or the managed care organization. **High Intensity Services** Some behavioral health services may be appropriate to be provided primarily through telehealth, while other services will require ongoing in-person delivery for a significant portion of or all of the services. Providers and practitioners should carefully consider the clinical appropriateness of telehealth delivery for such services, including, but not limited to: Partial Hospitalization, Intensive Behavioral Health Services (IBHS), Family Based Mental Health, Assertive Community Treatment (ACT), or for beneficiaries in a residential facility or inpatient setting. **Title VI and Limited English Proficiency** All recipients of federal funding, including MA and federal grant funds, are subject to Title VI of the Civil Rights Act of 1964 and may not discriminate on the basis of race, color, or national origin and must offer language services to individuals with limited English proficiency. Providers who elect to deliver services through telehealth must have a policy that makes available interpretation services, including sign language interpretation, for individuals being served through telehealth.

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	Consent Licensed practitioners and provider agencies must obtain consent from the individual receiving services or their legal guardian, as applicable, prior to rendering a service via telehealth. Licensed practitioners and provider agencies must also allow individuals to elect to return to in- person service delivery at any time. Individuals may refuse to receive services through telehealth. As with services delivered in-person, licensed practitioners and provider agencies must obtain consent from the individual served or their legal guardian, as applicable, to make any recordings of the provision of services through telehealth appointments. Licensed practitioners and provider agencies are not permitted to mandate the use of recording for telehealth service delivery and must still provide the service if an individual or legal guardian, as applicable, does not consent to a recording. **Documentation** The medical record for the individual must indicate each time services are provided through telehealth in addition to the standard documentation requirements. Consent for services and service modality, such as in-person or telehealth, should be obtained and documented prior to rendering services. Additionally, if the individual served or their legal guardian, as applicable, consents to the recording of a telehealth service, documentation of consent must be included in the medical record. Signatures for consent to treatment, service verification, and acknowledgement of receipt of treatment or service plan(s) that are required by DHS regulations may be physical or electronic signatures, unless prohibited by other laws. Consistent with Act 69 of 1999 Electronic Transactions Act, an electronic signature is an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record. Providers using electronic signatures must have systems in place to ensure that there is an audit trail that validates the signer's identity. **Technology** Technology used for telehealth, whether fixed or mobile, should be capable of presenting sound and image in real-time and without delay. Telehealth equipment should clearly display the practitioners' and participants' faces to facilitate clinical interactions. The telehealth equipment must meet all state and federal requirements for the transmission or security of health information and comply with the Health Insurance Portability and Accountability Act (HIPAA). Audio-only refers to the delivery of behavioral health services at a distance using real-time, two-way interactive audio only transmission. Audio-only does not include text messaging, electronic mail messaging or facsimile (fax) transmissions. Providers may utilize audio-only when the individual served does not have access to video capability or for an urgent medical situation, provided that the use of audio-only is consistent with Pennsylvania regulations and federal requirements, including guidance by the Centers for Medicare & Medicaid Services with respect to Medicaid payment and the US Department of Health and Human Services Office of Civil Rights enforcement of HIPAA compliance. Audio-only and text messages may also continue to be utilized for non-service activities, such as scheduling appointments.

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	Provider Policies 1. Providers using telehealth must maintain written policies for the operation and use of telehealth equipment. Policies must include the provision of periodic staff training to ensure telehealth is provided in accordance with the guidance in this bulletin as well as the provider's established patient care standards. 2. Providers must maintain a written policy detailing a contingency plan for transmission failure or other technical difficulties that render the behavioral health service undeliverable. Contingency plans should describe how the plan will be communicated to individuals receiving services. 3. Prior to delivering services through telehealth, providers or practitioners should provide information to the individual receiving services that supports the delivery of quality services. At a minimum, information should address the importance of the individual being in a private location, preventing interruptions and distractions such as from children or other family members, visitors in the household and from other communication or bandwidth reducing devices. When services are being provided to a child, youth or young adult, consideration should also be given to how much caregiver involvement will be needed during the appointment. **Billing** Services delivered in the MA FFS delivery system through telehealth will be paid the same rate as if the services were delivered in-person. MA providers in the MA FFS delivery system that provide services via telehealth should bill for services with a Place of Service (POS) 02 for telehealth provided in a location other than the home of the individual being served and (POS) 10 for telehealth provided in the home of the individual being served, unless instructed otherwise for specific services. Please consult the MA Fee Schedule for procedure codes that have the POS 02 or 10. For services delivered through audio-only, informational modifier code FQ should be used. Providers in the MA HC program must follow the billing instructions of the BH-MCO. **Obsolete Bulletin** The issuance of this bulletin renders Bulletin OMHSAS-21-09, Guidelines for the Delivery of Behavioral Health Services Through Telehealth obsolete
Texas Texas Medicaid. Provider procedures manual volume 2 behavioral health and case management services handbook. 2025[158] Texas Medicaid. Provider procedures	From Texas Behavioral Health and Case Management Services Handbook; only retrieved information related to telehealth treatment of SUD 10.8 Telemedicine and Telehealth Services Providers of SUD services must defer to the needs of the person receiving the services, allowing the mode of service delivery to be accessible, person- and family-centered and primarily driven by the person's choice and not provider convenience. Providers must provide SUD services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, SUD services in full accordance with all applicable licensure and certification requirements.

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manual: telecommunications services handbook. 2025[168]	During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code. 10.8.1 Synchronous Audiovisual Technology The following SUD services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. SUD services provided by synchronous audiovisual technology must be billed using modifier 95. • Comprehensive assessment (procedure code H0001) • Individual and group counseling (procedure codes H0004 and H0005) • MAT services - Prescribing of certain MAT medications may be done via telemedicine presuming all other applicable state and federal laws and regulations are followed. Refer to: The Telecommunication Services Handbook (Vol. 2, Provider Handbooks) for more information about prescriptions generated from a telemedicine medical service. 10.8.2 Synchronous Telephone (Audio-only) Technology The following SUD services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of SUD services must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. SUD services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ. • Comprehensive assessment (procedure code H0001) - Only during certain public health emergencies or natural disasters; to the extent allowed by federal law (assessments for withdrawal management services are excluded); and the existing clinical relationship requirement is waived. • Individual and group counseling (procedure codes H0004 and H0005) An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) from the same provider within the six months prior to the initial service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual service by the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived. Note: "Same billing provider" refers to providers within the same entity or organization, as identified by the entity's or organization's NPI number or numbers, if the entity or organization has multiple locations (i.e., CDTF, opioid treatment program or clinic, or group practice).

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	Note: The required in-person or synchronous audiovisual-delivered SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology, presuming all other applicable state and federal laws and regulations are followed. The billing provider is required to conduct at least 1 in-person or synchronous audiovisual SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the person's medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following: • The person receiving services is located at a qualifying originating site in an eligible geographic area, e.g., a practitioner office in a rural Health Professional Shortage Area. • An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the person's condition(s). Note: The required in-person or synchronous audiovisual-delivered SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) may be delivered by another authorized professional, or paraprofessional, of the same billing provider as the professional, or paraprofessional, who delivers the service by synchronous telephone (audio-only) technology, presuming all other applicable state and federal laws and regulations are followed. Refer to: The Telecommunication Services Handbook (Vol. 2, Provider Handbooks) for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.
Washington Washington State Health Care Authority. Substance use disorder billing guide. 2025[159] Washington State Health Care Authority. Telemedicine policy billing guide. 2025[160]	*From Substance Use Disorder Billing Guide; only retrieved information related to telehealth* Telemedicine Telemedicine is covered under HCA's Substance Use Disorder program. Refer to HCA's Provider Billing Guides and Fee Schedules webpage, under Telehealth, for more information on the following: • Telemedicine policy, under Telemedicine policy and billing • Audio-only procedure code lists, under Behavioral health audio-only procedure codes For COVID PHE telemedicine policies, refer to HCA's Provider Billing Guides and Fee Schedules webpage, under Telehealth and scroll down to Clinical policy and billing for COVID-19. HCS reimburses the following codes:

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HCPCS Code	Short Description	Limitation Restricted to IDC DX and/or dosing
J0572	Buprenorphine/naloxone	Oral, less than or equal to 3mg buprenorphine
J0573	Buprenorphine/naloxone	Oral, greater than 3mg but less than or equal to 6 mg buprenorphine
J0574	Buprenorphine/naloxone	Oral, greater than 6 mg but less than or equal to 10 mg buprenorphine
J0575	Buprenorphine/naloxone	Oral, greater than 10 mg buprenorphine

From Telemedicine Policy Billing Guide

Definitions

Audio-only telemedicine – The delivery of health care services using audio-only technology, permitting real-time communication between the client at the originating site and the provider, for the purposes of diagnosis, consultation, or treatment.

Distant site – The site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine.

Established relationship – A relationship between a health care practitioner and an Apple Health (Medicaid) client in which both the following are true:

- The health care practitioner providing audio-only telemedicine has access to sufficient health care records to ensure safe, effective, and appropriate care services.
- The client meets either of the following:
  - Has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the health care practitioner providing audio-only telemedicine or with a health care practitioner employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under Chapter 48.44 or 48.46 RCW as the health care practitioner providing audio-only telemedicine.
  - Was referred to the health care practitioner providing audio-only telemedicine by another health care practitioner who has had, within the past three years, at least one in-person appointment, or at least one realtime interactive appointment using both audio and video technology, with the client and has provided relevant medical information to the health care practitioner providing audio-only telemedicine.

Face-to-face – The client could be receiving the care in person or via audiovisual technology

State	Coverage Policy
	Telemedicine – The delivery of health care services using interactive audio and video technology, permitting real-time communication between the client at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. Telemedicine includes audio-only telemedicine, but does not include any of the following services: • Email and facsimile transmissions • Installation or maintenance of any telecommunication devices or systems • Purchase, rental, or repair of telemedicine equipment • Incidental services or communications that are not billed separately, such as communicating laboratory results **Audio-only telemedicine** Established relationship Audio-only telemedicine requires an established relationship between the health care practitioner and the client. See Definitions. Documentation requirements In addition to the telemedicine requirements previously noted, providers must obtain consent before rendering the service per RCWs 74.09.325 and 71.24.335. Consent must be documented in the client record. Procedure codes Refer to HCA's Provider billing guides and fee schedules webpage, under Telehealth, for a complete list of audio-only telemedicine procedure codes, under Audio-only telemedicine. Billing HCA requires providers to bill audio-only services with the appropriate audioonly modifiers (93 or FQ). For services that are partially audio/visual and partially audio-only, a service is considered audio-only if 50% or more of the service was provided via audio-only telemedicine **Billing** The payment amount for the professional service provided through telemedicine by the provider at the distant site is equal to the current fee schedule amount for the service provided. Submit claims for telemedicine services using the appropriate CPT® or HCPCS code for the professional service. The service(s) rendered must be: • Consistent with the scope of professional licensure or certification. • Clinically appropriate to be provided via telemedicine for that client, on that date of service. Use place of service (POS) 02 or 10 to indicate that a billed service was furnished as a telemedicine service from a distant site.

Abbreviations. ACCP: Accountable Care Partnership Plan (Massachusetts); ACT: assertive community treatment; BHIN: behavioral health information notice; BH-MCO: behavioral health managed care organization; CDTF: chemical dependency treatment facility; CMR: Code of Massachusetts Regulations; CPT: current procedural terminology; DHCS: Department of Health Care Services (California); DHS: Department of Human Services (Pennsylvania); DMC: Drug Medi-Cal; DMC-ODS: Drug Medi-Cal Organized Delivery System; FFS: fee for service; HC: Health Choices (Pennsylvania); HCA: Health Care Authority (Washington); HHSC: Health and Human Services Commission (Texas); HIPAA: Health Insurance Portability and Accountability Act; IBHS: intensive behavioral health services; ID: identification; MA: medical assistance (Pennsylvania); MAT: medication assisted treatment; MCE: managed care entity; MCO: managed care organization; MGL: Massachusetts general laws; NJAC: New Jersey administrative code; NJSA: New Jersey statutes annotated; OMHSAS: Office of Mental Health and Substance Abuse Services (Pennsylvania); PACE: program of all-inclusive care for the elderly; PCC: primary care clinician; PL: public law; POS: place of service; RCW: Revised Code of Washington; SUD: substance use disorder; TAC: Texas Administrative Code; W&I: Welfare and Institutions Code (California)

Appendix I. Relevant Codes

Table I1. Applicable Codes for Telehealth OUD Treatment

Code	Description
ICD-10-CM codes	
F11.1	Opioid abuse
F11.2	Opioid dependence
F11.9	Opioid abuse unspecified
CPT codes	
99202-99205	Evaluation and management: new patient
99211-99215	Evaluation and management: established patient
HCPCS codes	
H0001	Comprehensive assessment
H0004	Individual counseling
H0005	Group counseling
J0572	Buprenorphine/naloxone oral, less than or equal to 3 mg buprenorphine
J0573	Buprenorphine/naloxone, oral, greater than 3 mg but less than or equal to 6 mg buprenorphine
J0574	Buprenorphine/naloxone oral, greater than 6 mg but less than or equal to 10 mg buprenorphine
J0575	Buprenorphine/naloxone oral, greater than 10 mg buprenorphine
Modifiers[a]	
GT	Synchronous video interaction service
GQ	Synchronous audio-only interaction service
SC	Synchronous audio-only interaction service
93	Synchronous telemedicine service rendered via telephone or other real time audio only telecommunications system
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system
FQ	For counseling and therapy provided using audio-only telecommunications
Place of service codes	
02	Telehealth provided in a location other than the home of the individual being served
10	Telehealth provided in the home of the individual being served

Notes. [a] States vary in the modifiers they require to identify services provided via telehealth.
Abbreviations. CPT: Current Procedural Terminology; HCPCS: Healthcare Common Procedure Coding System; ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification; mg: milligram; OUD: opioid use disorder.