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# OPIOID TREATMENT PROGRAMS (OTPs) MEDICARE BILLING AND PAYMENT FACT SHEET


**TARGET AUDIENCE**
OTP Providers

**Note:** We revised this product to add information on:

- Enrollment Form CMS-855A (pages 3, 19)
- Institutional claim form CMS-1450 (pages 3, 7, 14, 15, 19)
- New Type of Bill (TOB) codes (pages 7, 14)
- New Condition Code (pages 7, 14)
- Two new add-on codes for take-home supplies of naloxone (pages 8, 10, 11, 12)
- Health care professionals that can deliver medical services described by add-on codes (page 12)

## INTRODUCTION

This fact sheet educates Opioid Treatment Program (OTP) providers and institutions about Medicare billing and payment for Opioid Use Disorder (OUD) treatment services. This information helps OTP providers new to Medicare learn which claim form to file, learn how to code and submit claims for OTP services, and how to get electronic payment for OTP services.



CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

# CONTENTS

## BACKGROUND/PURPOSE

January 1, 2020, Medicare began paying Medicare-enrolled OTPs to deliver OUD treatment services to Medicare beneficiaries. OTPs enroll in the Medicare Program with a Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers (CMS-855B) or through the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). OTP providers submit claims electronically using the 837 Professional or the paper claim form CMS-1500.

Beginning January 1, 2021, Medicare Part B covers hospital outpatient Opioid Treatment Program services. Health care organizations may now apply on the Medicare Enrollment Application for Institutional Providers (CMS-855A) or through PECOS when they enroll in the Medicare Program. These providers submit claims electronically using the 837 Institutional or the paper claim form CMS-1450.

For more information on how to enroll as an OTP provider, review the Opioid Treatment Programs (OTPs) Medicare Enrollment Fact Sheet.

This fact sheet has information about:

- Covered opioid use disorder (OUD) treatment services
- Who can supply OTP services
- Enrolling in Medicare Electronic Data Interchange (EDI)
- Checking Medicare beneficiary eligibility
- Coding and submitting claims for OTP services
- Payment and remittance advice (RA)
- Issues with payment
- How to check claims status
- Helpful resources

OUD services are a Part B benefit provided by institutional and professional providers. For more information on this new **Part B** benefit for Medicare beneficiaries with OUD, visit the CMS Opioid Treatment Programs webpage, which includes Frequently Asked Questions.

OTPs are defined by Medicare law as those who:

- are enrolled in Medicare
- are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA)
- are accredited by a SAMHSA-approved entity
- meet additional conditions to ensure the health and safety of individuals being furnished services under these programs and the effective and efficient furnishing of such services
- have in effect a provider agreement with CMS

**Part B**:

- As an OTP, you can be a Part A or a Part B provider.

## COVERED OPIOID USE DISORDER (OUD) TREATMENT SERVICES

Covered opioid use disorder treatment services include:

- FDA-approved opioid agonist and antagonist treatment medications
- Dispensing and administering medications (if applicable)
- Substance use disorder counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

### Who Can Supply OTP Services?

- OTPs must Enroll in Medicare
- Get full certification from the Substance Abuse and Mental Health Services Administration (SAMHSA)
- Get accreditation from an accrediting body approved by SAMHSA
- Meet additional conditions as the Secretary may find necessary to ensure the health and safety of beneficiaries

Professionals who supply substance use counseling and individual and group therapy included in the bundled payment may include:

- Licensed clinical social workers
- Licensed professional counselors
- Licensed clinical alcohol and drug counselors
- Certified peer specialists permitted to furnish this type of therapy or counseling by State law and scope of practice
- Others permitted to furnish this type of therapy or counseling by State law and scope of practice

**Overview of OTP Billing/Payment Process**

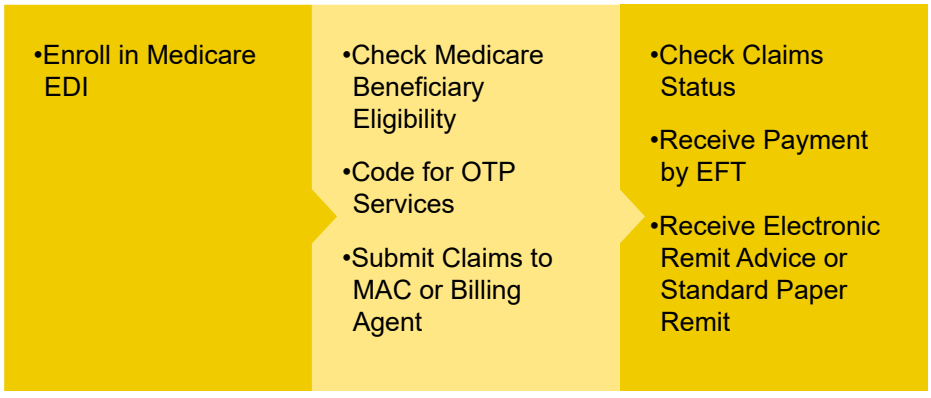


Figure 1: Overview of OTP Billing/Payment Process Diagram

Medicare does not cover therapy or counseling services for OUD treatment offered by professionals who are not authorized under State law to deliver such services.

## ENROLLING IN MEDICARE EDI

EDI transactions allow you to submit transactions and get payment faster at a lower cost than using paper or manual transactions.

After you enroll in Medicare, your Medicare Administrative Contractor (MAC) gives you information about enrolling in EDI. Each MAC has different instructions and methods for submitting EDI enrollment applications. Read your enrollment approval letter carefully and check your MAC's website(s) for instructions. Remember that you must complete the EDI enrollment process with each MAC to which you submit claims.

OTP providers must complete the EDI Registration Form and EDI Enrollment Form before submitting electronic media claims (EMC) or other EDI transactions to Medicare. While each MAC's EDI enrollment application submission process may vary, OTP providers must give identifying information about the provider(s) who submit(s) electronic data.

OTPs who intend to submit EMC or use EDI, either directly with Medicare or through a billing service or clearinghouse, must complete the forms. Each new EMC biller must sign and submit the forms to their MAC(s) as instructed. An OTP organization with multiple Medicare provider numbers can complete a single EDI Enrollment Form on behalf of the organizational components. For more information about the EDI forms, contact your MAC.

After you complete EDI enrollment, your EDI contractor helps you with connectivity, system access numbers and passwords, and testing your EDI format transmissions. MACs have EDI helplines to help you.

## CHECKING MEDICARE BENEFICIARY ELIGIBILITY FOR OTP SERVICES

When you schedule appointments for Medicare beneficiaries, remind them to bring all health insurance cards showing their health insurance coverage to their appointment. This helps you determine who to bill for services and give you the correct spelling of a Medicare beneficiary's first and last names and Medicare beneficiary identifier (MBI).

If the beneficiary has Medicare coverage but doesn't have a Medicare Health Insurance card, encourage the beneficiary to log into mymedicare.gov or call 1-800-MEDICARE (or 1-800-833-4455 if the beneficiary gets benefits under the Railroad Retirement Board) to get a replacement Medicare Health Insurance card.

You can check a beneficiary's Medicare eligibility in one of four ways:

1. Your vendor or clearinghouse can give you access to eligibility information for Medicare and other payers.
2. Your IT department can help you access eligibility information directly through the HIPAA Eligibility Transaction System (HETS).
3. Your MAC portals supply eligibility information.
4. You can also use the MACs' Interactive Voice Response (IVR) systems.

You must have the following information to run an eligibility search for a Medicare beneficiary:

- MBI
- Beneficiary's full first and last name
- Beneficiary's date of birth

Your eligibility search gives a basic set of eligibility information if the beneficiary is entitled to Part A and/or Part B, including:

- Medicare beneficiary demographics
- Part A and B entitlement, including any periods of inactivity
- Coverage status of requested and supported Service Type Codes (STCs)
- Medicare Secondary Payer (MSP), Medicare Advantage (MA), and Part D plan enrollment information (where applicable)
- Deductible remaining

For more detailed information on this process, review the CMS HETS 270/271 5010 Companion Guide, Section 7.2 General Transaction Notes.

If you already check eligibility electronically for another payer, work with your vendor to get access to Medicare information.

## How to Reach the HETS Help Desk

Contact the HETS Desktop (HDT) Help Desk Monday through Friday from 7 am to 7 pm, ET at:

- mcare@cms.hhs.gov or
- 1-866-324-7315

For more information, visit the HETS Help webpage.

## CODING AND BILLING FOR OTP SERVICES

CMS pays for the overall treatment of OUD delivered by an OTP. Any beneficiary with OUD is eligible for these services.

**CMS created 16 billable OTP-only Healthcare Common Procedure Coding System (HCPCS) G-codes (G2067 through G2080, and G2215 to G2216) for opioid treatment services on Medicare Part B claims.**

**Only OTPs can bill Medicare using the specific codes for OTP services. No other provider or supplier type except for an OTP can bill for OTP services (billed using HCPCS codes G2067 through G2080, and G2215 to G2216).**

**However, the CY2020 Physician Fee Schedule includes bundled payment codes (billed using HCPCS codes G2086 through G2088) and payment rates for an episode of OUD treatment offered by physicians and other practitioners in the office setting.**

For institutional providers billing on the Form CMS-1450 institutional claim form, the National Uniform Billing Committee (NUBC) established:

- A new Type of Bill (TOB) code for Freestanding Non-residential Opioid Treatment Programs (OTP): (087x)
- A new Condition Code for a provider-based OTP: (89)
- Hospital-based providers bill OTP services on TOB 013X and 085X effective January 1, 2021

Use Revenue Codes 090x-091x, 0949 on TOB 013x, 085x, or 087x, when billing for OTP services.

### Coding for Medication Assisted Treatment (MAT) and Add-On Codes

The threshold for billing the codes describing weekly episodes (HCPCS codes G2067-G2075) is the delivery of at least one service in the weekly bundle (from either the drug or non-drug component).

CMS established HCPCS G-codes describing treatment with:

- Methadone (G2067)
- Buprenorphine oral (G2068)
- Buprenorphine injectable (G2069)

Only OTPs can submit claims with codes G2067 through G2080 and G2215 to G2216.

The threshold to bill a full episode is that at least one service is furnished (from either the drug or non-drug component) to the beneficiary during the week that corresponds to the episode of care. If no drug was provided to the beneficiary during that episode, the OTP must bill the G-code describing a weekly bundle not including the drug (HCPCS code G2074) and the threshold to bill would be at least one service in the non-drug component. If a drug was provided with or without additional non-drug component services, the appropriate G-code describing the weekly bundle that includes the drug furnished may be billed.

- Buprenorphine implants (insertion, removal, and insertion/removal) (G2070, G2071, and G2072)
- Extended-release, injectable naltrexone (G2073)
- Non-drug bundle (G2074)
  - You administered no medication during an episode of care
  - **Example:** In the case of a beneficiary getting injectable buprenorphine, OTPs bill HCPCS code G2069 for the week during which you supplied the injection. For the following weeks, when you supply at least one non-drug service, bill HCPCS code G2074, which describes a bundle not including the drug. For the week you supply another injection, bill HCPCS code G2069.
- Medication not otherwise specified (G2075)
  - Use when you supply Medication Assisted Treatment (MAT) services with a new opioid agonist or antagonist treatment medication the FDA approved under Section 505 of the United States Federal Food, Drug, and Cosmetic Act (FD & C Act) for the treatment of OUD
  - HCPCS codes G2067 through G2073, and G2215 to G2216 cover all the FDA-approved drugs used for the treatment of OUD

All of the drugs that are FDA-approved for the treatment of OUD are currently covered by HCPCS codes G2067-G2073 and G2215 to G2216.

Additionally, CMS established add-on G-codes for:

- Intake activities (G2076)
- Periodic assessments (G2077)
- Take-home supplies of methadone (G2078) and take-home supplies of oral buprenorphine (G2079)
- Additional counseling furnished (G2080)
- Take-home supply of nasal naloxone (G2215)
- Take-home supply of injectable naloxone (G2216)

CMS uses the typical or average maintenance dose to determine drug costs for each of the bundles.

CMS assigned flat dollar payment amounts for the codes describing the OTP bundled services (HCPCS codes G2067 through G2080, and G2215 to G2216). See the CY 2021 Proposed Rule OTP Payment Rates on the Final Rule (CMS-1734-F) webpage in the Downloads section.

HCPCS code G2216 (take-home supply of injectable naloxone) is payable beginning January 1, 2021. When submitting a claim for HCPCS code G2216, OTPs must note the dosage that was dispensed to the beneficiary in the units field of the claim form (box 24G of the 1500 or Form Locator 46 of the UB-04), rounded to the nearest whole number (with a minimum dosage of 1mg).

**Note:** As an OTP provider, you must use only the codes describing bundled payments. Do not use other codes, such as those paid under the Physician Fee Schedule (PFS). Only Medicare-enrolled OTPs can bill for HCPCS codes G2067 through G2080, and G2215 to G2216.

## MAT codes, Descriptors, and National Medicare Payment Rates

**NOTE:** Use the In the Locality Key document to find the locality and corresponding MAC numbers assigned to your OTP based on the State/Fee Schedule Area/County location of your practice.

Use the Locality Adjusted Rates document to find your **locality** and corresponding **MAC** numbers then, use the **HCPCS code** to find the geographically-adjusted payment rate.

| G CODES | DESCRIPTORS FOR OTP BUNDLED SERVICES | DRUG COST | NON-DRUG COST | TOTAL COST |
|---|---|---|---|---|
| HCPCS code G2067 | Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program). | $37.38 | $174.62 | $212.00 |
| HCPCS code G2068 | Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program). | $81.08 | $174.62 | $255.70 |
| HCPCS code G2069 | Medication assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program). | $1,638.92 | $181.15 | $1,820.07 |
| HCPCS code G2070 | Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program). | $4,547.13 | $413.57 | $4,960.70 |

| G CODES | DESCRIPTORS FOR OTP BUNDLED SERVICES | DRUG COST | NON-DRUG COST | TOTAL COST |
|---|---|---|---|---|
| HCPCS code G2071 | Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program). | $0 | $433.30 | $433.30 |
| HCPCS code G2072 | Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program). | $4,547.13 | $635.75 | $5,182.88 |
| HCPCS code G2073 | Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program). | $1,228.91 | $181.15 | $1,410.06 |
| HCPCS code G2074 | Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program). | $0 | $163.97 | $163.97 |
| HCPCS code G2075 | Medication assisted treatment, medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program); partial episode. | - | - | - |

| G CODES | DESCRIPTORS FOR OTP BUNDLED SERVICES | DRUG COST | NON-DRUG COST | TOTAL COST |
|---|---|---|---|---|
| **INTENSITY ADD-ON CODES** | | | | |
| HCPCS code G2076 | Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment conducted by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician or other qualified personnel that includes preparation of a treatment plan that includes the beneficiary's short-term goals and the tasks the beneficiary must perform to complete the short-term goals; the beneficiary's requirements for education, vocational rehabilitation, and employment; and the medical, psycho- social, economic, legal, or other supportive services that a beneficiary needs, conducted by qualified personnel (provision of the services by a Medicare-enrolled Opioid Treatment Program); list separately in addition to code for primary procedure. | $0 | $181.97 | $181.97 |
| HCPCS code G2077 | Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment (provision of the services by a Medicare-enrolled Opioid Treatment Program); list separately in addition to code for primary procedure. | $0 | $111.82 | $111.82 |
| HCPCS code G2078 | Take-home supply of methadone; up to 7 additional day supply (provision of the services by a Medicare-enrolled Opioid Treatment Program); list separately in addition to code for primary procedure. | $37.38 | $0 | $37.38 |
| HCPCS code G2079 | Take-home supply of buprenorphine (oral); up to 7 additional day supply (provision of the services by a Medicare-enrolled Opioid Treatment Program); list separately in addition to code for primary procedure. | $81.08 | $0 | $81.08 |
| HCPCS code G2080 | Each additional 30 minutes of counseling in a week of medication assisted treatment, (provision of the services by a Medicare-enrolled Opioid Treatment Program); list separately in addition to code for primary procedure. | $0 | $31.37 | $31.37 |
| G2215 | Take-home supply of nasal naloxone (provision of the services by a Medicare-enrolled Opioid Treatment Program); list separately in addition to code for primary procedure. | $89.63 | $2.53 | $92.16 |

| G CODES | DESCRIPTORS FOR OTP BUNDLED SERVICES | DRUG COST | NON-DRUG COST | TOTAL COST |
|---|---|---|---|---|
| G2216 | Take-home supply of injectable naloxone (provision of the services by a Medicare-enrolled Opioid Treatment Program); list separately in addition to code for primary procedure. | Contractor-priced | $2.53 | Contractor-priced |

Table 1: MAT codes, Descriptors, and National Medicare Payment Rates

**Note:** The CY 2021 PFS Final Rule amends the definition of periodic assessment in Section 410.67(b)(7) to say that the definition is limited to a face-to-face encounter. A clinician must perform a face-to-face medical exam or biopsychosocial assessment to bill G2077. However, the Coronavirus Disease 2019 (COVID-19) Interim Final Rule (IFC) revised Section 410.67(b)(7) on an interim final basis to allow periodic assessments to be furnished during the Public Health Emergency (PHE) for COVID-19 using two-way interactive audio-video communication technology. In cases where beneficiaries do not have access to two-way audio-video communication technology, periodic assessments can be furnished using audio-only telephone calls providing all other applicable requirements are met.

The following health care professionals can supply medical services described by these add-on codes:

- Program physicians
- Primary care physicians
- Authorized health care professionals under the supervision of a program physician
- Qualified personnel such as:
  - nurse practitioners (NPs)
  - physician assistants (PAs)

Practitioners who are eligible to do so under State law and their scope of licensure may perform assessments, including psychosocial assessments. OTPs should document the rationale for billing the add-on code in the beneficiary's medical record. Services supplied must be medically reasonable and necessary.

## Frequency of Use and Other Billing Guidelines

The following rules apply when billing OTP G-Codes:

- **HCPCS codes G2067 through G2075** cover episodes of care lasting 7 days in a row. You cannot bill for the same beneficiary more than once per 7-day period.
- Some of the bundled payment codes describe a drug typically only administered once per month, such as the injectable drugs, or once in a 6-month period, in the case of the buprenorphine implants.
- Consistent with FDA labeling:
  - in general, do not use **HCPCS codes G2069 and G2073** more than once every 4 weeks
  - in general, do not use **HCPCS codes G2070 and G2072** more than once every 6 months

- You may give Medicare beneficiaries OUD services at more than one OTP within a 7-day period in certain, limited clinical situations, such as guest dosing or when a beneficiary transfers care between OTPs. Each of the involved OTPs may bill the appropriate HCPCS codes for the services given to the beneficiary, but both OTPs must maintain enough medical record documentation to reflect the clinical situation and services supplied.
- In instances in which a beneficiary switches from one drug to another, the OTP should only bill for one code describing a weekly bundled payment for that week. Determine which code to bill based on which drug you gave the beneficiary for most of the week.
- Bill the add-on code **HCPCS code G2076** describing intake activities () only for new beneficiaries (that is, beneficiaries starting treatment at the OTP).
- There are two add-on codes that describe take-home doses of medication that can be billed in addition to one of the bundled payment codes for a weekly episode of care:
  - **HCPCS code G2078** take-home supplies of methadone
    - up to 7 additional days of medication
    - can be billed along with the respective weekly bundled payment code in units of up to 3 (for a total of up to a one-month supply)
    - the add-on code for take-home doses of methadone can only be used with the methadone weekly episode of care code (HCPCS code G2067)
  - **HCPCS code G2079** take-home supplies of oral buprenorphine
    - up to 7 additional days of medication
    - can be billed along with the base bundle in units of up to 3 (for a total of up to a one-month supply)
    - can only be used with the oral buprenorphine weekly episode of care code (HCPCS code G2068)
    - allows a maximum take-home supply of one month of medication

SAMHSA allows a maximum take-home supply of one month of medication; therefore, we don't expect the add-on codes describing take-home doses of methadone and oral buprenorphine to be billed any more than 3 times in one month (in addition to the weekly bundled payment code).

The date of service for HCPCS codes G2078 and G2079 may reflect either the actual date you provided the medication to the beneficiary or may correspond with the first day in the weekly billing cycle for the week in which the beneficiary received the take-home supply of medication.

- **You can bill HCPCS code G2080** when you provide counseling or therapy services that substantially exceed the amount specified in the beneficiary's individualized treatment plan. OTPs are required to document the medical necessity for these services in the beneficiary's medical record.

## SUBMITTING CLAIMS TO YOUR MAC OR BILLING AGENT

As an OTP provider, you must submit all claims to your MAC or billing agency/agent.

- Institutional providers use the 837I transaction to transmit health care claims electronically, or the CMS-1450 (the paper version of the 837I)
- Professional providers use the 837P transaction to transmit health care claims electronically, or use the CMS-1500 (the paper version of the 837P)

If you are using the paper versions of the claim (CMS-1450 or CMS-1500), mail those to your MAC.

Review Chapter 39 of the Medicare Claims Processing Manual for more information on billing OTP claims.

**98 percent** of Medicare FFS providers/suppliers submit their claims electronically for a faster processing time. You must get an exception to file using paper claims.

### Include the following information on the Form CMS-1450 claim form:

A. Hospitals use bill type 013X and CAHs use bill type 085X in Field 4 Type of Bill

B. Freestanding OTP Facilities use bill type 087X

C. Hospitals and Free-Standing facilities report the number of times you performed the service or procedure, as defined by the HCPCS code, in Field 46 Serv. Units

D. Hospitals and CAHs report condition code 89 in Fields 18-28 to indicate a claim for OTP services

1. Files claims as soon as possible. Medicare claims must be filed to the appropriate MAC no later than 12 months, or 1 calendar year, after the date of service. Your claim will be denied if you file it 12 months or later after the date of service.
2. The new POS code 58 is for non-residential opioid treatment facilities.

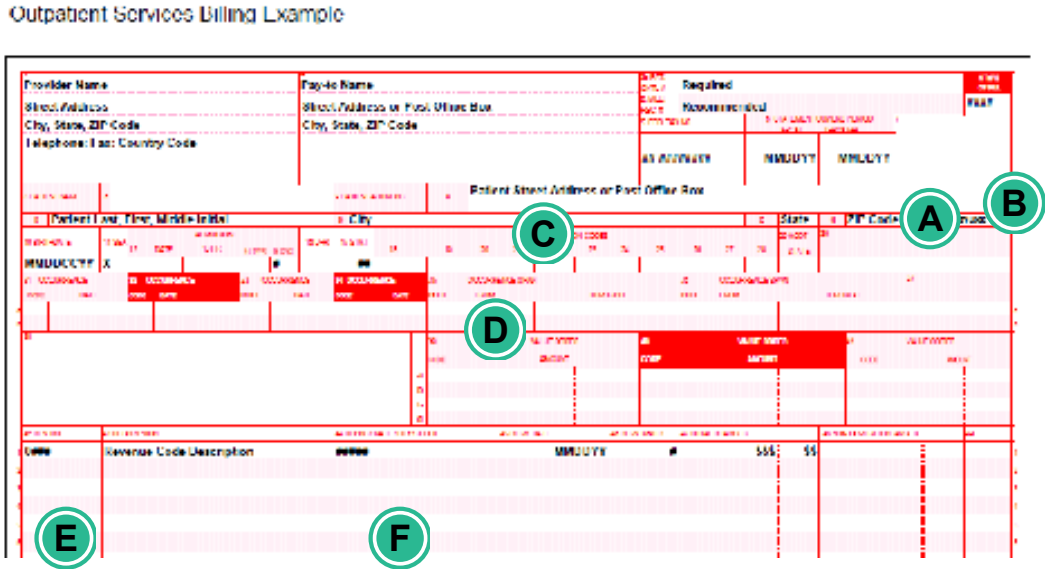


Figure 2: CMS-1450 Claim Form Sections A, B, C, D, E, F

E. Report a revenue code, HCPCS, units, and the charge for each individual covered service delivered in Field 42

F. Drugs reported with revenue code 0636 require HCPCS

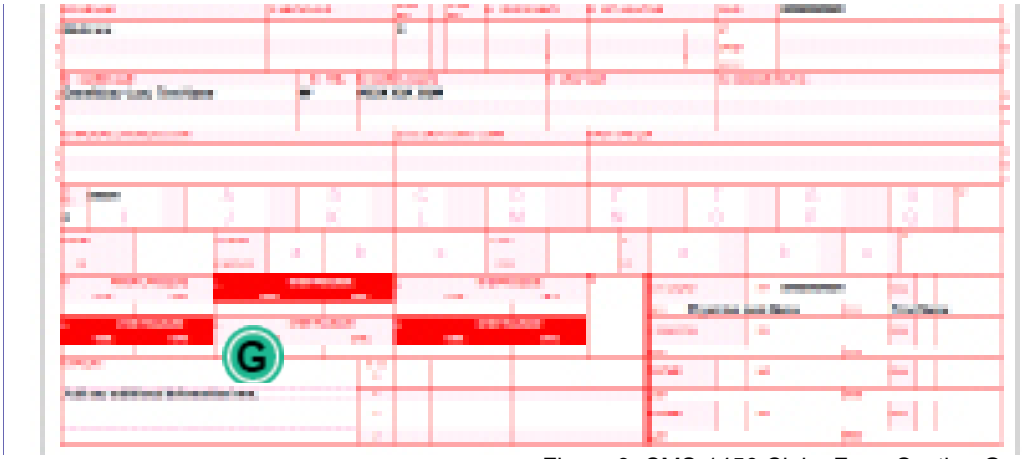


Figure 3: CMS-1450 Claim Form Section G

G. Outpatient providers don't have to report ICD-10 PCS codes in Fields 74-74e

For more detailed information on completing the CMS-1450 (UB-04), review the Medicare Claims Processing Manual (Pub.100-04), Chapter 25.

## Include the following information on Form CMS-1500:

A. HCPCS codes associated with the OTP service

B. The prescribing or medication-ordering physician's or other eligible professional's National Provider Identifier (NPI) in Field 17 (the ordering/ referring/other field) of the Form CMS–1500 (Health Insurance Claim Form; 0938–1197) or the electronic equivalent

C. Your organizational NPI as the Billing Provider in block 33 of the CMS-1500 or its electronic equivalent

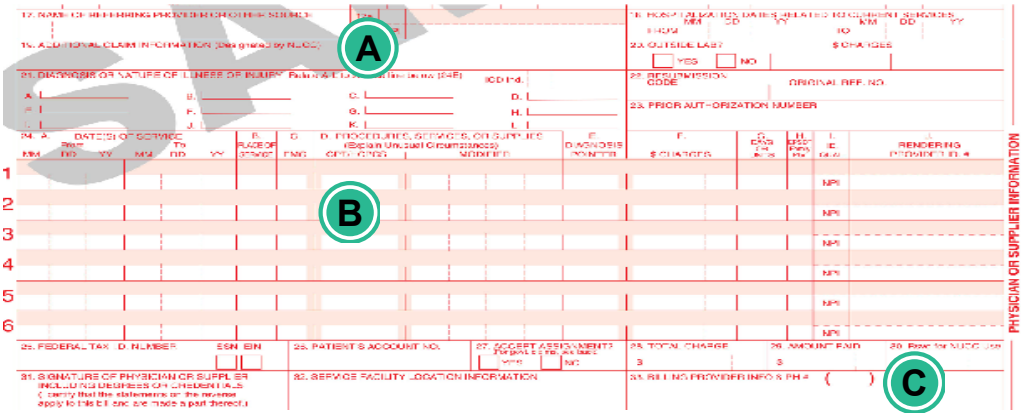


Figure 4: CMS-1500 Form Sections A, B, C

For an explanation of HCPCS codes, visit the HCPCS Coding Questions webpage.

D. Beneficiary first name, last name, and Medicare beneficiary identifier

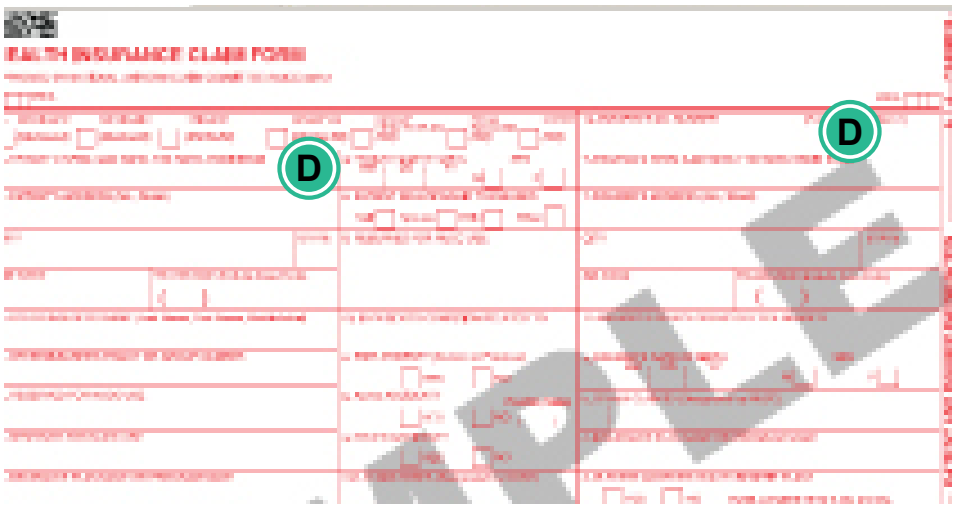


Figure 5: CMS-1500 Form Section D

E. Diagnosis or nature of illness or injury International Classification of Diseases, 10th Revision (ICD-10) diagnosis code

F. Place of Service (POS) code 58 in block 24B in the Physician or Supplier information section of the claim form to indicate a Non-residential Opioid Treatment Facility

G. Enter the provider of service's billing name, address, ZIP code, and telephone number in Item 33 and the billing NPI in 33B. If you're providing services in a location that is different from the information in Item 33, enter the name, address, and ZIP code of the facility where you furnished the services in Item 32.


Figure 6: CMS-1500 Form Sections E, F, G

Social Security Numbers (SSNs) are no longer used on Medicare cards. Every person with Medicare has been assigned a Medicare Beneficiary Identifier (MBI) and has been issued a new Medicare card. You MUST submit claims using MBIs.

Only use the new POS code 58 for nonresidential opioid treatment facilities on OTP claims.

For the codes that describe a weekly bundle (HCPCS codes G2067 through G2075), one week is defined as 7 days in a row. OTPs may choose to apply a standard billing cycle by setting a particular day of the week to begin all episodes of care. In this case, the date of service would be the first day of the OTP's billing cycle. If a beneficiary starts treatment at the OTP in the middle of the OTP's standard weekly billing cycle, the OTP may still bill the applicable code for that episode of care provided that it meets the threshold to bill for the code.

OTPs may also choose to adopt weekly billing cycles that vary across beneficiaries. Under this approach, the initial date of service will depend on the day of the week when the beneficiary was first admitted to the program or when Medicare billing began. With this approach, when a beneficiary is beginning treatment or re-starting treatment after a break in treatment, the date of service would be the first day the beneficiary was seen and the date of service for subsequent consecutive episodes of care would be the first day after the previous 7-day period ends.

For the codes describing add-on services (HCPCS codes G2076 through G2080, and G2215 to G2216), the date of service should reflect the date that service was furnished; however, if the OTP has chosen to apply a standard weekly billing cycle, the date of service for codes describing add-on services may be the same as the first day in the weekly billing cycle.

For general billing requirements, review the Medicare Claims Processing Manual, Chapter 1. For more detailed information on completing the Form CMS-1500, review the Medicare Claims Processing Manual, Chapter 26.

## PAYMENT AND REMITTANCE ADVICE

You get Medicare payments via Electronic Funds Transfer (EFT). You must complete an Electronic Funds Transfer (EFT) Authorization Agreement (Form CMS-588) as your MAC directs.

If there are no issues with the claim, payment arrives no sooner than 13 days after filing electronically (payment on the 14th day or after). For paper-based claims, payment arrives no sooner than 28 days after filing (payment on the 30th day or after).

After the MAC processes the claim, their system sends you or your billing agency/agent an Electronic Remit Advice (ERA) or a Standard Paper Remit (SPR) with final claim and payment information. An ERA or SPR usually:

- Includes itemized adjudication decisions about multiple claims
- Reports the reason and value of each adjustment to the billed amount on the claim

There is no copayment for beneficiaries for OUD treatment services; beneficiaries are responsible for the Part B deductible.

## ISSUES WITH PAYMENT

If there is an issue with the information included on a claim or with a beneficiary's eligibility, the MAC may either:

- **Deny the claim:** You or your billing agency/agent can file an appeal if you think the MAC denied the claim incorrectly. For more information on how to appeal a denied claim, check your MAC's website.
- **Reject the claim as unprocessable:** You or your billing agency/agent must submit a new claim.

Medicare offers free software, Medicare Remit Easy Print (MREP), to read the ERA. You can view, print, and export special reports to Excel and other applications.

## CHECK CLAIMS STATUS

### Interactive Voice Response (IVR) System

Each MAC has an IVR system that gives providers free access to Medicare claims information through a toll-free telephone number. You can enter data through the IVR telephone system and get information about your claims. Contact your MAC for information on the Provider Contact Center and IVR user guide.

### Customer Service Representative (CSR)

Visit your MAC website for information on the Provider Contact Center only if you are unable to access claims information through the IVR.

For more information review the Claim Status Request and Response webpage.

### MAC Portals

Providers can get claims status information for free via the MAC's Internet-based provider portal. Contact your MAC for portal features and access.

### Health Care Claim Status Request (276 Transaction)

Providers can send a Health Care Claim Status Request (276 transaction) electronically and get a Health Care Claim Status Response (277 transaction) back from Medicare. CMS recommends the electronic 276/277 process because you can automatically generate and submit 276 queries as needed, eliminating the need for manual entry of individual queries or calls to a contractor to get this information.

The 277 response allows you to automatically post the status information to beneficiary accounts, eliminating the need for manual data entry by provider staff members. If you do not know your software can automatically generate 276 queries or automatically post 277 responses, contact your software vendor or billing service. For more information, contact your MAC.

Most MAC portals allow you to check eligibility, see the remit, possibly submit a claim. See the listing of MAC Provider Portals.

## BILLING & PAYMENT FOR MEDICARE/MEDICAID DUAL ELIGIBLE BENEFICIARIES

Medicare calls beneficiaries eligible for both Medicare and Medicaid at the same time dually eligible.

Along with authorizing the Medicare OTP benefit, the SUPPORT Act also mandates that all states cover OTP services in their Medicaid Programs effective October 2020, subject to certain exception the Secretary may give. Currently, 42 states cover OTP services in their Medicaid Program.

On January 1, 2020, Medicare became the primary payer for OTP services for dually eligible beneficiaries who previously got OTPs through their Medicaid Program. During this transition, Medicaid must pay for services delivered to these beneficiaries by OTP providers enrolled in Medicaid, but not yet enrolled in Medicare. Medicaid pays for those services to the extent the state plan covers them. The state later recoups the Medicaid payments made to the OTP back to the effective date of the OTP's Medicare enrollment. Then, the OTP provider bills Medicare for those services.

For more information, see the Tip Sheet for Opioid Treatment Program Providers Serving Dually Eligible Individuals: State Coverage of the Medicare Part B Deductible.

### Need More Information?

Visit: Opioid Treatment Programs (OTP) webpage

Contact your Medicare Administrative Contractor (MAC)

### Key Takeaways

- January 1, 2020, Medicare began paying Medicare-enrolled OTPs to deliver OUD treatment services to Medicare beneficiaries.
- OTPs enroll in the Medicare Program with a Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers (CMS-855B) and submit claims using the CMS-1500.
- Health care organizations may now enroll in the Medicare Program using the Medicare Enrollment Application for Institutional Providers (CMS-855A) or through PECOS using the 837I. These providers submit claims using the CMS-1450.
- Covered opioid use disorder treatment services include FDA approved medications, counseling, toxicology testing and periodic assessments.
- OTPs must enroll in Medicare, get full certification from SAMHSA, get accreditation from a SAMHSA-approved accrediting body and meet additional conditions as the Secretary may find necessary to ensure the health and safety of beneficiaries.
- OTP providers must complete the EDI Registration Form and EDI Enrollment Form before submitting electronic media claims (EMC) or other EDI transactions to Medicare.
- CMS created **16** billable OTP-only Healthcare Common Procedure Coding System (HCPCS) G-codes (G2067 through G2080, and G2215 to G2216) for opioid treatment services on Medicare Part B claims.

- The CY2020 Physician Fee Schedule includes bundled payment codes (billed using HCPCS codes G2086-G2088) and payment rates for an episode of OUD treatment offered by physicians and other practitioners in the office setting.
- As an OTP provider, you must submit all claims to your MAC or billing agency/agent.
- You must complete an Electronic Funds Transfer (EFT) Authorization Agreement (Form CMS-588) to receive electronic payments.

## RESOURCES

- CMS 1500
- Electronic Billing & EDI Transactions
- Electronic Data Interchange (EDI) Support
- Electronic Health Care Claims Website
- Health Care Payment and Remittance Advice and Electronic Funds Transfer
- HIPAA Eligibility Transaction System (HETS)
- Institutional Paper Claim Form (CMS-1450)
- MAC Website List
- Medicare Basics: Parts A and B Claims Overview Video
- Medicare Billing: Form CMS-1450 and the 837 Institutional Booklet
- Medicare Billing: Form CMS-1450 and the 837 Institutional Web-Based Training (WBT) Course
- Medicare Billing: Form CMS-1500 and the 837 Professional Booklet
- Medicare Billing: Form CMS-1500 and the 837 Professional Web-Based Training (WBT) Course
- Medicare Claims Processing Manual, Chapter 1
- Medicare Claims Processing Manual, Chapter 1, Section 80.2.1.2 Payment Floor Standards
- Medicare Claims Processing Manual (Pub.100-04), Chapter 24
- Medicare Claims Processing Manual (Pub. 100-04), Chapter 25
- Medicare Claims Processing Manual, (Pub. 100-04) Chapter 26
- Medicare Claims Processing Manual, (Pub. 100-04) Chapter 39
- Medicare Parts A/B and DME EDI Helplines
- New Medicare Beneficiary Identifier (MBI) Get It, Use It
- Opioid Treatment Programs (OTP) webpage
- Professional Paper Claim Form (CMS-1500)
- Understanding Your Remittance Advice Reports