# Opioid Treatment Programs: Enrolling in Medicare Call

**Moderated by: Nicole Cooney**
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Nicole Cooney. Thank you. You may begin.

## Announcements & Introduction

Nicole Cooney: Good afternoon, everyone. I'm Nicole Cooney from the Provider Communications Group here at CMS, and I'll be your moderator today. I'd like to welcome you to today's Medicare Learning Network call on Opioid Treatment Programs: Enrolling in Medicare.

During today's session, CMS experts will briefly cover the Opioid Treatment Program or OTP benefit, as well as provide an overview of the Medicare enrollment process for OTPs. At the end of the presentation, we'll have – we'll open the lines for a question and answer session.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL: go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the question and answer session. If you have inquiries, contact press@cms.hhs.gov.

And with that, we'll get started. I have several speakers today. First up, to discuss the finalized policies, we have Dr. Pierre Yong and Lindsey Baldwin from our Center for Medicare.

Dr. Yong, would you like to start us off on slide 5?

## Presentation

Dr. Pierre Yong: Thanks, Nicole. My name is Dr. Pierre Yong, and I want to echo Nicole's welcome to everybody on this call. We are thrilled you're able to join us to learn more about this new Medicare Part B benefit for OTP.

On slide 6, Section 2005 of the SUPPORT, Substance-Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act or the SUPPORT Act established a new Medicare Part B benefit for OUD treatment services furnished by OTPs beginning January 1st, 2020. The statute allowed implementation, through one or more bundles based on the medication provided, the frequency of services, the scope of services, characteristics of the individuals furnished such services, or other factors as the Secretary determines appropriate.

Moving on to slide 7, we have some background that you are likely familiar. There are approximately 1,700 OTPs nationwide that are currently certified by SAMHSA or the Substance Abuse and Mental Health Services Administration.

OTPs provide medication-assisted treatment for people diagnosed with an OUD. OTPs must be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body. For SAMHSA certification, OTPs must comply with all pertinent state laws and regulations and all regulations enforced by the Drug Enforcement Administration.

The payer mix for OTPs currently include Medicaid, private payers, and TRICARE, as well as individual pay patients that, as I previously mentioned beginning January 1st, 2020, this will also include Medicare.

Medicare previously covered office-based opioid treatment with buprenorphine and naltrexone, but has not historically covered services furnished in OTPs, which are the only entities authorized to use methadone to treat OUD. Medicare coverage of OTPs is a new benefit that we anticipate will expand access to care.

Moving on to slide 8. We at CMS have defined an OTP according to current regulations at 42 CFR 8.2 as an entity that's enrolled in Medicare, is fully certified by SAMHSA, is accredited by an accrediting body approved by SAMHSA, and meets such additional conditions as the Secretary may find necessary to ensure the health and safety of individuals being furnished services under such program and the effective and efficient furnishing of such services.

Moving on to slide 9. OUD services provided by OTPs and covered by Medicare include the following: the FDA-approved opioid agonist and antagonist medications for the treatment of OUD, namely methadone, buprenorphine and naltrexone; the dispensing and administering of such medications, if applicable; substance use counseling; individual and group therapy; toxicology testing, including presumptive and definitive testing; intake activities; and periodic assessment.

CMS will allow OTPs to furnish the counseling and therapy services included in the bundle via two-way interactive audio/visual communication technology, as clinically appropriate, in order to increase access to care for beneficiaries.

Moving on to slide 10. We're going to begin the discussion of payment and coding. And at this point, I'm going to pass it off to Lindsey.

## Payment and Coding

Lindsey Baldwin: Great. Thanks, Pierre. So, on slide 10 under payment and coding, the codes describing OTP treatment services are not considered physicians' services and are paid outside of the physician fee schedule, and, therefore, are not assigned Relative Value Units or RVUs. These services are assigned flat-dollar payment amounts.

We adopted a coding structure for OUD treatment services that varies by the medication administered. We established nine G-codes, those are G2067 through G2075, and five add-on G-codes, G2076 through G2080 for weekly, that is a 7-day contiguous period, bundles describing treatment with methadone, oral buprenorphine, injectable buprenorphine, buprenorphine implants, extended-release injectable naltrexone, a medication not otherwise specified, and a non-drug bundle. There's a link on this slide, at slide 10, that you can click for more information on billing and payments.

Moving on to slide 11. Each bundled payment is composed of a drug component and a non-drug component. Under the drug component, the typical maintenance dose determines the drug costs for each of the bundles. CMS finalized a payment of an ASP plus zero percent when ASP data are available. For methadone, CMS will use TRICARE pricing when ASP is not reported. For oral buprenorphine, CMS will use NADAC pricing when ASP is not reported.

Under the non-drug components, the non-drug component includes payment for counseling, therapy, toxicology testing, and drug dispensing and administration, as applicable. We finalized an increased payment rate for the non-drug bundle rate using a building block methodology that uses the payment rates for similar services paid under Medicare in the non-facility setting. The threshold for billing the weekly episode is the delivery of at least one service in the weekly bundle, which can be from either the drug or the non-drug component.

There's also a link on this slide, that’s slide 11, for more information on those payment rates. We note that the rates for the non-drug component will be adjusted by geographic locality and will also be updated on an annual basis.

Moving on to slide 12. Under add-on adjustments, we will adjust the bundled payment rates through the use of an add-on code in order to account for instances in which intake activities or periodic assessments are performed, additional counseling or therapy is furnished for a particular patient that substantially exceeds the amount specified in the patient's individualized treatment plan, and take-home dosing for methadone or oral buprenorphine is provided to a patient.

OTPs can only bill Medicare using the specific codes for OTP services. OTPs cannot bill Medicare for non-OTP services. No other provider or supplier type except for an OTP can bill for OTP services. However, we do note that CMS also finalized bundled payment codes and payment rates under the PFS for an episode of OUD treatment furnished by physicians and other practitioners in the office setting.

Under partial episodes, the proposal to establish a partial episode was not finalized based on consideration of the public comments we received, but CMS may consider creating partial episodes in the future.

Moving on to slide 13 under beneficiary copayment. We set the copayment at zero for fee-for-service Medicare Part B as we believe this will minimize barriers to patient access for OUD treatment services. Setting the copayment at zero also ensures Medicare-enrolled OTP providers receive the full Medicare payment amount for Medicare beneficiaries if secondary payers are not available or do not pay the copayments, especially for those dually eligible for Medicare and Medicaid.

The Part B deductible will apply for OUD treatment services, as mandated for all Part B services. And with that, I'll pass it back to Nicole.

## Dually Eligible Beneficiaries

Nicole Cooney: Thank you. Next, to discuss the policies regarding dually eligible beneficiaries starting on slide 14, we have Sharon Donovan from our Medicare-Medicaid Coordination Office. Sharon?

Sharon Donovan: Thanks, Nicole. Moving on to slide 15. Dually eligible individuals are those who are eligible for both Medicare and Medicaid at the same time.

Along with creating the Medicare OTP benefits, 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 provide. At this time, there are 42 states that cover OTP services in their Medicaid program.

Starting on January 1 in 2020, Medicare will become the primary payer for OTP services for dually eligible individuals who currently get OTP through their Medicaid program. During this transition, Medicaid must pay for services delivered to these beneficiaries by OTP providers who are not yet enrolled in Medicare but are enrolled in Medicaid, to the extent the service is covered in that state plan. The state will later recoup the Medicaid payments made to the OTP back to the effective date of the OTP's Medicare enrollment, and then the OTP provider will bill Medicare for those services.

We encourage OTP providers to enroll in Medicare now so they can start billing for services for dually eligible individuals starting January 1, 2020. With that, I'll turn it back to Nicole.

## Medicare Advantage Beneficiaries

Nicole Cooney: Thank you. Up next to discuss Medicare Advantage on slide 16, we have Marty Abeln from our Center for Medicare. Marty?

Marty, you might be on mute.

Marty Abeln: Yes, thank you, Nicole. I was halfway through my presentation before I realized it. Yes, thank you very much.

And if you go to slide 17 for Medicare Advantage enrollees. In covering the OTP benefit, MA plans are required to only use OTP providers that meet the same requirements as those that apply in Original Medicare, that is they both have to be certified by SAMHSA and enrolled in Medicare. MA plans, as they do with other provider types, have the option of furnishing access to OTPs either through contractual relationships with the OTPs or they can do it on a non-contract basis.

MA plans must also furnish enrollees access to the OTP benefit that is good or better than what is available in Original Medicare. So, the basic rule is that where MA plans have a service area, they need to make sure that their enrollees residing in that service area have at least as good an access to an OTP provider as beneficiaries in Original Medicare would have.

And, finally, for MA plans that have new enrollees that are currently receiving the OTP benefit, we'll strongly encourage them to have a transition process if they have to switch to a new OTP provider for this population that are receiving medication-assisted therapy. It's really critical that there's no interruption in service. So, this is a real important point for – particularly for MA plans and across the board.

Okay, Nicole, I think that's it. Thank you.

## Enrolling in Medicare

Nicole Cooney: Thank you. Moving into the enrollment process on slide 18, we'll turn it over to Joe Schultz from our Center for Program Integrity.

Joe Schultz: Good afternoon, everybody. I will be reviewing the policies and procedures associated with OTPs who are interested in enrolling in Medicare.

On slide 19, we provided a link to our OTP enrollment fact sheet. This fact sheet provides information on what you need to do to be ready to submit your enrollment application. In addition, the fact sheet provides instructions on how to submit your application and what to expect afterwards.

On slide 20, we have listed the materials you should gather in preparation for enrolling. A copy of your SAMHSA letter acknowledging certification is used by CMS to verify your initial certification date. This letter may also be referred to as your renewal letter. As a reminder, only SAMHSA-certified OTPs can enroll in Medicare. OTPs in a provisional status are not eligible for enrollment, and applications will be denied.

In addition to the renewal letter, OTPs are required to submit a detailed organizational chart. This chart may be the same chart you provided SAMHSA during the certification process. This chart will be used by CMS and the MACs to ensure that OTPs appropriately list all individuals and organizations with ownership and/or managing control on the enrollment application.

Please be prepared to provide tax ID numbers and Social Security numbers and date of birth for these individuals and organizations. You will also want to prepare any information pertaining to adverse legal actions associated with the OTP and/or the individuals and organizations with ownership and/or managing control. These documents could include court records or records from state licensing boards, documenting the resolutions of those adverse legal actions as one example.

On to slide 21, here we discuss the NPI requirements. The OTP is required to have an NPI number. If your OTP already has an NPI number, you do not need to get another one.

You may obtain an NPI number by applying electronically or by paper. The electronic application process is easiest. And by applying electronically, you will also be set up with an Identity and Access account, which you will need to submit your Medicare enrollment applications online.

Slide 22, more about the MACs. The MACs are contractors that process Medicare claims and enrollment applications on a jurisdiction-by-jurisdiction basis. It's important to familiarize yourself with the MAC that is responsible for your jurisdiction. Your MAC will be the front lines for information pertaining to processing your enrollment application and in the future claims payments.

On slide 23, you have two options when it comes to submitting your enrollment application. You can either use the online electronic submission process or the paper-based application. The Provider Enrollment, Chain and Ownership System, known as PECOS, holds all Medicare provider enrollment information. If you submit your application electronically, you will be using the PECOS interface to submit your application. If you use the paper application, which you will mail to your MAC, your information will be entered into PECOS by your MAC.

Applications submitted electronically are processed up to 15 days faster on average. The application that you'll be using is the 855B.

On to slide 24. First and foremost, it is important to understand that you only need to submit one application per state, per tax ID number. As an example, if you have 10 separately certified OTPs in the state of Florida but they all fall under one tax ID number, you only need to submit one 855B enrollment application.

Moving to section 2. This is the section where you will enter the legal business name and tax ID, as well as the OTP certification numbers for each location. Section 3 is where you enter adverse legal actions associated with the OTP, the OTP's TIN and legal business name listed in section 2. This is not the section where you will list information pertaining to individuals or organizations with managing control.

In section 4, you will enter all of the locations – excuse me, all the locations within a state associated with the legal business name and tax ID you entered in section 2.

Sections 5 and 6 are for all organizations and individuals who have ownership and managing control, and their correlating adverse legal actions. It is required that the application identify an authorized official in the section, as well. An authorized official should be someone at the OTP who has the ability to legally bind the OTP to Medicare statutes and regulations.

The authorized official has the ability to assign a delegated official, and that designation should be done in this section, as well. Additionally, the program sponsor and medical director for each OTP location must be listed in section 6. Also, required in section 6 is at least one person identified as a managing employee.

The MAC will use your submitted organizational chart to ensure that you report the information in sections 5 and 6 accurately.

Section 8 will be for the legal business name and tax ID number associated with a billing agency if your OTP uses one. A billing agency is not required.

Section 13 is for the person or persons that the MAC should contact regarding the process on the enrollment application. If there is missing or incorrect information on the application, the MAC will reach out to the person listed in section 16 to fix what was missing.

In section 15 and 16, your authorized and or delegated official will sign the application. For more detailed explanation and a step-by-step resource, please use our OTP enrollment fact sheet.

All right, now on to slide 25. OTPs must set up an electronic funds transfer agreement. Payments will be made electronically to the bank account you list on this agreement. This account must be in the legal business name of the enrolling OTP and that legal business name must match the NPI registry. Along with your EFT agreement, you will also be asked to submit a voided check and – I'm sorry, a voided check or a bank letter to verify the account number and name associated with that application.

On to slide 26. OTPs are required to pay an application fee. Again, this is one fee per TIN, per state. The application fee in calendar year 2019 is $586. You'll be directed to pay the fee if you enroll online.

If you submit via paper, please use the web link on this slide to pay your application fee immediately after submitting your application. If you do not pay the fee, the MAC will ask you to do so. If you fail to do so, your application will ultimately be rejected.

An applicant does have the ability to file a hardship exemption or a waiver of the fee. For more information, please visit the OTP enrollment fact sheet.

On to slide 27. Slide 27 provides you more resources for assistance, including a link to the EUS help desk resource support, which is a resource who supports people with the Identity and Access System, with PECOS, and other system-related questions. However, this help desk will not be able to give specific policy information about Opioid Treatment Program policies.

On slide 28, more about the MAC processes. The MACs will review your application upon receipt and may send a request for additional information if there is information missing or incomplete. If your application is clean and does not require development, the application will take approximately 45 days to process. But if additional information is required, it may take longer.

On slide 29 is where we address additional screening measures, including fingerprinting and site visits. OTPs that were certified after October 23 of 2018 will be required to submit fingerprints for federal criminal background checks for all 5% or greater owners, including partners. Those OTP-certified prior to October 23 of 2018 will not. This check is designed to prevent owners who have felony backgrounds with convictions that may be deemed detrimental to the Medicare program from accessing the Medicare trust fund.

If your owners are required to submit fingerprints, you will receive instructions from your MAC after you submit your application. Do not do anything beforehand.

CMS will also continuously monitor all individuals after initial enrollment. And administrative action may be taken if an owner or managing employee or other individual has been found to be convicted of a felony offense.

On to site visits. All OTPs will receive an observational site visit. This site visit is conducted to ensure the OTP is operational. CMS has adjusted its operational site visit requirement based on comments from the American Association for Treatment of Opioid Dependency and the Medication Assisted Treatment Council, as well as others, to account for the discrete nature of OTPs.

OTPs do not have to prepare for these visits in any way. Again, the site visit is intended to ensure that brick and mortar exists. Also important to note is that the agency is and has been taking steps to ensure that the site visit and fingerprint requirement does not slow down your application and enrollment process.

On to slide 30. Once your enrollment application is approved, you will receive a letter from your MAC acknowledging your successful enrollment. The letter will include your PTAN, your Provider Transaction Access Number. This is like a pin number that you can use when speaking with your MAC about claim status. You'll also receive a copy of an executed provider agreement from your MAC.

As an enrolled provider, your billing effective date is limited to the latter of the date your MAC received the application or the date you began delivering services.

For most of you guys, you've been providing services for years. Therefore, your effective date will be limited by when your application is submitted. Therefore, it is vital that you submit your application as soon as possible. This is not all bad news. OTPs are eligible for a retrospective billing date up to 30 days prior to the receipt date of the application but no earlier than January 1 of 2020.

To be clear, any application that's submitted prior to January 1 of 2020 will allow you to be paid for services provided as of January 1 of 2020.

On the slide 31. There are still obligations you have once your OTP is enrolled. As a Medicare-enrolled provider, you're required to submit applications acknowledging certain changes. Changes in ownership and adverse legal action history are required to be reported within 30 days of when those changes occur. All other changes, including changes to the practice locations, managing employees, and others must be reported within 90 days of the change.

Also, OTPs will be required to revalidate once every 5 years. Revalidation includes submitting an application similar to that of your initial enrollment application in order to provide Medicare with updated information regarding the complete picture of your enrollment.

You will be notified by your MAC 6 months prior to your revalidation due date. There is additional information about revalidation on CMS's Provider Enrollment website, which you can go and your MAC websites.

On to slide 32. Last but not least, in order to start billing, OTP must set up Electronic Data Interchange or EDI. Please use the resources on this slide to sign up. You will also receive EDI sign-up information on the enrollment approval letter that you receive from your MAC.

Nicole?

## Question & Answer Session

Nicole Cooney: Thanks, Joe.

We're now ready to take your questions. In an effort to get to as many questions as possible,we'd like to ask each caller to limit themselves to one question. We will be mindful of the time spent on each question. This is in recognition of the number of folks we have on the line. We know there are a lot of questions and we want to reach as many of you as we possibly can. So, we asked for your cooperation in this.

And as a reminder, this event is being recorded and transcribed. Blair, we're ready for our first question.

Operator: To ask a question press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to ensure clarity. Once your line is open, state your name and organization.

Please note your line will remain open during the time you're asking your questions, so anything you say, or any background noise will be part of the conference. If you have more than one question, press star one to get back into the queue. And we will address additional questions as time permits. Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster.

First question comes from the line of Krista Ashbuck.

Krista Ashbuck: Hello?

Nicole Cooney: Yes. Did you have a question?

Krista Ashbuck: Yes, I do. So, the non-drug component does not include physician services. Can we bill separately on, I'm the medical director of Addiction and Psychotherapy Services in Austin, Texas. And we provide psychiatric and some medical services, as well. Can that be billed under the OTP or does the physician have to enroll separately to bill for those other kinds of services, and methadone and buprenorphine via definition are medication treatments that require physician, are medication monitoring visits with a physician also something that would be billed separately or does those fall under the non-drug component?

Lindsey Baldwin: Hi, thanks for your question. This is Lindsey Baldwin. So, I would draw your attention to the add-on code that we finalized in the final rule. So, we have an add-on code that describes intake activities at G-codes, G2076. There's also an add-on code for periodic assessments that are done. So, depending on what type of services are furnished by the physician that you're describing, that may very well fall into that periodic assessment code, that code G2077.

We also have an add-on code that describes each additional 30 minutes of counseling that is furnished, that's G2080. So, I think between those add-on codes that may cover a lot of what you're asking about.

Krista Ashbuck: Well, I mean, a psychiatric visit with a psychiatrist for medications is not covered by those necessarily for – like, for example, antidepressants or when patients have medical problems like antibiotics for abscesses and that sort of thing. Those don't appear to be covered under the, I think with G-codes.

Lindsey Baldwin: Oh, I see what you're saying. So, for services furnished that are not for treating the opioid use disorder, you mean?

Krista Ashbuck: Well, both. I mean – so, yes. Part of the question is for psychiatric and medical services that are not strictly part of the opioid use disorder. So, for concurrent medical and psychiatric problems, and the other is, you know, a counselor or a therapy visit with a psychiatrist is a very different level of service than a visit with the LCDC, for example. And those are very different classes of counseling, and a med check is a different level of service too, if you're talking about, like a med check visit with a physician for buprenorphine or methadone.

So, I'm just wondering more about the – So does – what I have to enroll as a physician separately for other services or are those covered under the OTP?

Lindsey Baldwin: I say to the extent that the services furnished are for the purpose of treating the OUD, and I understand there can certainly be comorbidities that would fall within the benefit, but to the extent that the treatment is for other diagnoses and is separate that would not be within this benefit.

Krista Ashbuck: Okay. So just if I understand you – so if I'm treating a patient for depression, or for an abscess, those do not fall under the OTP – under these codes, and I would have to as a physician be enrolled separately and bill separately for that?

Lindsey Baldwin: Yes, that's right.

Krista Ashbuck: Okay, thank you.

Operator: The next question will come from the line of Beth Koch.

Beth Koch: Hi, this is Beth Koch from Human Service Center in Peoria. I have a question about the NPI number. We have an existing OTP program, and the NPI number has two taxonomy codes. One are for outpatient substance use treatment services, the other are for methadone services. What's shown on the NPI website is a default to just the outpatient substance use services. Will this cause any difficulties as we submit an application to Medicare with our NPI number defaulting to methadone?

Joe Schultz: Yeah, thank you for your question, Beth. This is Joe. No, that's not going to make a difference here. The taxonomy associated with your NPI makes no difference in terms of Medicare enrollment.

Beth Koch: Thank you.

Joe Schultz: You're welcome.

Operator: The next question comes from the line of Gloria Cisneros.

Gloria Cisneros: Hi.

Nicole Cooney: Hello, did you have a question?

Gloria Cisneros: Yes. Hi, my name is Gloria. I'm calling via Counseling Service. And my question is for Joe. So, we're not currently enrolled with Medicare. So, to enroll for the OTP program we would have to obviously follow the whole process in enrolling as a Medicare provider where we bill on a UB form.

So, my understanding is that Medicare does not accept facility billing on a UB, we have to do it on a NUCC 1500. But my question is, do we – to be able to enroll for the OTP program we have to enroll with Medicare and follow all the steps with the applications, the 855B, et cetera, right?

Joe Schultz: Yeah. Gloria, thank you for your question. This pertains to not only you but everybody else on the phone. Yes, you do have to enroll as an OTP in order to bill for OTP services using the 1500 form. Even if you are currently enrolled, in order to bill for the OTP services we've discussed today you need to enroll as an OTP in Medicare.

Gloria Cisneros: Okay. Perfect. So, we have to enroll as a facility and as an OTP, so we have to do both?

Joe Schultz: No. You don't need to – you need to enroll as an OTP.

Gloria Cisneros: Perfect. Okay.

Joe Schultz: Yes.

Gloria Cisneros: Thank you.

Operator: Your next question will come from the line of Cecily Jackson.

Cecily Jackson: Hi, good afternoon. This is Cecily Jackson with AltaPointe Health Systems in Mobile, Alabama. I just wanted to follow up on the question that Ms. Cisneros had. We are currently enrolled – our facility is currently enrolled with Medicare, with Part B under the same NPI as several of our mental health facilities as well, and the same PTAN.

My question is, will we be required to have a separate NPI now for our Opioid Treatment Program? And then complete the enrollment to obtain a separate PTAN for this particular program?

Likewise, we – if this is the case, for our providers, are Medicare-eligible providers at this location will we also be required to complete an enrollment for them or a reassignment of benefits for them under this new PTAN?

Joe Schultz: Thank you for your question Cecily. So, first, let's talk about your NPI. You are not required to get a new or different NPI, that choice is entirely up to you. So, if you want to use the same NPI you're currently using in the other lines of business, that is okay. I often hear that it's easier sometimes though to enumerate your enrollments separately. But again, that decision is up to you and how you guys do your billing.

In terms of the PTAN, yes, in order to get you will – you are required to obtain a new PTAN and submit a new application to obtain that PTAN in order to enroll and bill for the OTP benefits we're discussing here today.

And third, and lastly, the – your OTP and the providers that work within your OTP are – your providers are not required to establish a reassignment of benefits. The OTP will bill Medicare directly, and you're not required to enroll your rendering providers to be reimbursed.

Cecily Jackson: Okay, thank you very much.

Joe Schultz: You're welcome.

Operator: The next question will come from the line of Liz Blair.

Liz Blair: Hi, this is Liz Blair. I'm with a New Vista in Lexington, Kentucky. We have an OTP that we've been billing outpatient services for. And I believe my question has been answered. I had the same question in regards to currently having the NPI and a PTAN and that we will need to get a new PTAN specific to the OTP program. I think I understand that now. So, thank you again for your answer.

Joe Schultz: You're welcome.

Operator: If you would like to ask a question, press star one on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

The next question will come from the line of Charlotte Neufeld.

Hi, this is Charlotte Neufeld from Mental Health Services in State of New York. And my question is we currently have a program, which is hospital-based, it's part of our hospital. And I think I'm understanding that we still do have to do an enrollment to get a different PTAN. But this also leads to the question currently our program, everything is billed out on a UB because it's hospital-based, are these services going to be billed out on a UB or strictly on a 1500?

Lindsey Baldwin: Hi, thanks for your question. This is Lindsey Baldwin. Yes, all the services billed for OTPs to Medicare will need to be billed on a 1500 claim form.

Joe Schultz: And it will require the separate enrollment.

Charlotte Neufeld: Okay. That was my question. Thank you.

Joe Schultz: Welcome.

Operator: Next question will come from the line of Lisa.

Amanda Ash: Hi. So, this is Amanda Ash calling from Lahey Behavioral Services in Massachusetts. Even though we are going to be billing under the OTP, do we – do our clinicians still need to follow the Medicare guideline for credential level?

Lindsey Baldwin: Hi, thanks for your question. This is Lindsey Baldwin. So, what we said in the final rule is that – first of all, can I just clarify? Are you asking about particularly the counseling and therapy services?

Amanda Ash: Yes, ma'am. Yes.

Lindsey Baldwin: Yes. Okay. That is a question we've gotten. So, we note in the final rule that the counseling and therapy services could be provided by licensed professional counselors, licensed clinical alcohol and drug counselors, and certified peer specialists that are permitted to furnish this type of therapy or counseling by state law and scope of practice.

Amanda Ash: Okay. All right, because currently, Medicare has – you have to be termly licensed to provide services. However, we have non-termly licensed clinicians who currently provide substance use services in our OTPs, so I just wanted to clarify that. Thank you

Lindsey Baldwin: Yes, to the extent that they're operating under state law and scope of practice. That's okay.

Amanda Ash: Thank you so much.

Operator: The next question will come from the line of Janice Kaufman.

Janice Kaufman: Hi, thanks so much for taking my question. Actually, one – that was one of the questions that I had. So just to clarify my understanding, is there a difference that you're determining between therapy and counseling? That wasn't clear from that question.

Lindsey Baldwin: Hi, sure. So, the Section 2005 of the SUPPORT Act did mandate that the bundled payments do include the substance use counseling, and you just said therapy. But just to clarify, one misunderstanding that we had been hearing is that not every single item that's included there needs to be furnished in order to build the bundle.

The threshold that we finalized was that at least just one service be furnished in the bundle in order to bill it and that could be from either the drug or the non-drug component.

Janice Kaufman: What isn't clear to me is the difference between – how you differentiate therapy from counseling.

Lindsey Baldwin: The way I think about it is that the substance use counseling is probably going to be more likely furnished by a certified addictions counselor, whereas the therapy is probably something more similar to the psychotherapy that's defined under Medicare and furnished by a professional with a licensure that is more like a bachelor's or master's level. But I do defer it back to the language that we included in the rule about the various professionals that can furnish the services.

And I would also note that SAMHSA requires an individualized treatment plan. And so, what's included in the treatment plan for any given patient is going to vary between patients and also over time. So that frequency might be higher in the beginning and decrease over time.

Janice Kaufman: Yes, I understand. Since this was a clarification of the one before, can I poke in one other question?

Lindsey Baldwin: Sure.

Janice Kaufman: So, I noticed in the bundled rate, there was no mention – there is mention of toxicology but there is no mention of blood work. Is that – do you have that included in the bundled rate since we are required both by federal law, and here in Massachusetts, by state to do admission and annual blood work?

Lindsey Baldwin: Sure, thanks for that question. So, to the extent that it is required, we would consider it to be included in the bundled payments that we set. I would also note that if that's something that is happening upfront when a patient is first admitted for treatments, you can look at the add-on code that we finalized for intake activity of G-2076.

Janice Kaufman: Okay, thank you. It is required for everyone.

Lindsey Baldwin: Okay.

Janice Kaufman: Thank you Lindsey.

Operator: If you would like to ask a question, press star one on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

The next question will come from the line of Valentina Kokiri.

Valentina Kokiri: Hi, my name is Valentina Kokiri. So, I'm from Central Florida Treatment Center in Lakewood, Florida. I'm calling because I didn't see mentioned on Part A or specifically the special needs plan that tends to come up when I run client's eligibility. So how would we – is that covered under the OTP change or is that something that is going to be billed differently?

Lindsey Baldwin: Hi, thanks for that question. This is Lindsey. I think just to make sure that we get you the most accurate answer possible, we'll have to follow back up with you on that one.

Nicole, can you give the email address they should?

Nicole Cooney: Yes. Yes. And we have an e-mail address it's for outstanding questions, it is on slide 34, it's OTP_Medicare@cms.hhs.gov. Thank you.

Valentina Kokiri: Thank you so much.

Operator: The next question will come from the line of Ronda Angel.

Ronda Angel: Yes. Hi, thanks so much for taking my question. I'm calling from Suffolk County Department of Health Services. And my question is regarding the drug counselors that provide services in our OTP. So they're atypical and they don't have an NPI, and I'm not really sure if it's a question that would pertain now, because I know you said that we're really going to be dealing under the clinic, not the therapist, where a mental health we have to send in an 855I for each clinician even though we simply need 855B for the mental health clinic.

Is it going to be the same, not the same for the methadone we were, just send in an 855B for the clinic? I won't be doing the 855. It's for my therapist, so it really won't matter if I have a drug counselor who doesn't have an NPI, and only has an eight-digit atypical because I know right with my mental health going and even some of my managed care billing for the OTP services, we're having a hard time with the atypical because it's claim forms want to – even you send electronic, you know, electronically or paper, they want that 10 digits in the NPI field. So, just wondering how that would play out with the drug counselors providing services.

Joe Schultz: Thank you for your question. The counselors are not required to have NPI numbers for your claims submission.

Ronda Angel: Okay. And just to clarify before, I want to make sure I understand it. You know, we're doing an 855B, we do not have to then send an 855I for all our clinicians providing services in the OTP? Is that correct?

Joe Schultz: Yes, that is correct. So, there is no enrollment requirement for any of the individuals providing counseling within the OTP setting. Therefore, there is no Medicare requirement that they have an NPI number on it.

Ronda Angel: Right. You don't have to have the ...

Nicole Cooney: Thank you.

Ronda Angel: Okay, thank you.

Operator: To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

The next question will come from the line of Krista Bernacchi.

Krista Bernacchi: Hi, thank you for taking my question. This is going to be for either Lindsey or Joe. I was hoping that you folks could provide just a little bit of clarification around the statement that was made earlier that we're required to submit one app per state per TIN.

We have an organization that has one tax ID number but has nine different locations all with their own NPI. So, would that all fall under one application as opposed to separate applications?

Joe Schultz: Thank you for your question. I hope this helps the group as well. The answer to the question is, yes, that would fall under one application. And on that application, you will, again, report the SAMHSA certification number for each of those locations if they're certified separately and you can also – you should also and you can submit the NPI numbers associated with each of those locations on the application as well.

Krista Bernacchi: Thank you.

Joe Schultz: You're welcome.

Operator: The next question will come from the line of Andre Pellegrini.

Andre Pellegrini: Hi, this is Andre. I'm with Turning Point Clinic in Baltimore City. Thank you, guys, for hosting this webinar. Really helpful.
So, a quick question. Would you guys take the SAMHSA certificate in lieu of the letter of certification? I just want to make sure they are not the same thing or if they are the same thing.

Joe Schultz: So, they are not the same thing. It should both belong with your enrollment application. We will use the SAMHSA certification letter to determine when you were fully accredited by a SAMHSA-approved accrediting body. If you have both of those documents, you'll see that the OTP certificate does not have the effective date essentially of your certification. Therefore, that's why we need the letter and we do need your certification, as well. So please submit both of those documents.

Andre Pellegrini: Okay, thank you very much.

Joe Schultz: You're welcome.

Operator: The next question will come from one of Terry Krantz.

Terry Krantz: Yes, hello. Thanks for taking my call. This is Terry Krantz from Connections Health Solutions in Phoenix, Arizona. I'm wondering if the psychiatric evaluation 90792 or the established patient follow-up visits 99212, if they're supposed to be billed separately with the NPI from the PA or the MP, or are they considered part of the G-code that's billed with the facility's number?

Lindsey Baldwin: Hi, thanks for that question. This is Lindsey Baldwin. So, as I mentioned before, I would point out the add-on codes that we finalized. There's one for periodic assessments, the G-2077, and then there's one for the additional counseling furnished in terms of 90792, that's the psychiatric diagnostic evaluation. You, instead of filling that code, the OTP should fill the intake activities add-on code described by G-2076.

Terry Krantz: And same thing with follow-up visits with the nurse practitioner or the physician assistant. Use the add-on codes? They no longer need to use their own NPI and fill the 99000 codes, correct?

Lindsey Baldwin: Correct. They can build an add-on code for periodic assessments of G-2077.

Terry Krantz: And again, using the NPI of the facility rather than their own, correct?

Lindsey Baldwin: Right. Just the OTP as an entity is going to be billing for all of these bundled payments.

Terry Krantz: Okay, thank you.

Lindsey Baldwin: Sure. Sure.

Operator: The next question will come from the line of Danielle Roylan.

Danielle Roylan: Hi, thanks. This is Danielle calling in from Chittenden Clinic in Burlington, Vermont. And my question is in regards to the application and the observational site visit that would be required. Is that similar to like a CARF site visit where you audit charts and review our systems and workflows?

Joe Schultz: Danielle, thank you for your question. No, it is nothing like that. It is purely an observational site visit with the intention of ensuring that your – the brick and mortar building exists and is operational.

You may not even know that the site visit representative has observed your facility. They primarily take pictures of the outside of the facility to make sure that it's there and it exists.

Danielle Roylan: Okay.

Joe Schultz: And just to reiterate, there is nothing that you would need to do in preparation for the site visit.

Nicole Cooney: Thank you for your question.

Operator: The next question will come from the line of Elizabeth Rodriguez.

Elizabeth Rodriguez: Good afternoon all. My name is Elizabeth Rodriguez. I'm calling from Camden, New Jersey. Our facility is Camden Treatment Associates.

My question is a two-part question. It's regarding the billing procedures with billing Medicare claims. Are we to install or download specific billing program? Or is there a website that allows us to bill, create and submit our Medicare claims? And let's see, no that's it. That's my two-part question.

Nicole Cooney: Hi, this is Nicole. We are working on some additional events and resources around billing that will be coming out next month. And so, to really get into those specific questions, if you want to bookmark our webpage, we have a specific billing and payments section of the webpage. That's where a lot of those resources will be.

We'll also be reaching out through the distribution list that we have that we use to publicize this call. So, if I can just ask you to look forward to those resources that will be coming soon in the next few weeks …

Elizabeth Rodriguez: Okay.

Nicole Cooney: … if that's helpful?

Elizabeth Rodriguez: No, that sounds good. So, we will be informed that there's any type of training for the billing process?

Nicole Cooney: Yes, we will – we sent out a notification about this call and our enrollment fact sheet. And so, we'll be using that same distribution process. We'll be posting it on our webpage, as well.

Elizabeth Rodriguez: Okay, that was very helpful. Thank you so much.

Nicole Cooney: Absolutely.

Operator: Your next question is from the line of Annette Giacometti.

Annette Giacometti: Good afternoon. My name is Annette Giacometti. And I'm calling from Virtual Health in Voorhees, New Jersey. Just a question with regard to the OTP being reimbursable on a hospital-based setting. Is that something based on what I heard in some of the previous answers that sounds like it can be a hospital-based program?

Nicole Cooney: Give us one second.

Annette Giacometti: Okay.

Joe Schultz: Hi, Annette. Can I just ask, are you a SAMHSA-certified OTP?

Annette Giacometti: Well, from what I understand there has been some discussions about opening up such a program within one of our facilities. But my question was really related to whether we're even going to be reimbursed if we did that be via a hospital-based program.

Joe Schultz: So, regardless if you're hospital-based or not, as long as you're certified by SAMHSA, you can and should enroll using the CMS-855B form to be a Medicare enrolled OTP.

Annette Giacometti: Okay.

Joe Schultz: The hospital-based has nothing to do.

Annette Giacometti: Okay, so it is reimbursable then even from a hospital-based facility?

Joe Schultz: Yes.

Annette Giacometti: It's not a standalone. It's hospital based. Okay. Thank you.

Joe Schultz: Yes.

Operator: The next question is from the line of Vicki Nichols.

Vicki Nichols: Hi. Yes, thank you for the opportunity to ask a question. I see in the slide deck that the copayment was set at zero to not only ensure access for the member but to ensure that the OTP providers receive the full payment amount. Does that zero cost-sharing also apply to the Medicare Advantage benefit design?

Nicole Cooney: Marty, can you address that question?

Marty Abeln: Yes. Medicare Advantage plans submitted bids and they – there are cost-sharing what works for those bids. So, they won't necessarily all be zero.

Vicki Nichols: Okay, thank you.

Operator: Your next question comes from the line of Cambis Moratti.

Cambis Moratti: Hi. This is Cambis Moratti. I'm calling from Pixel Health Services in Baltimore, Maryland. We do have two clinics in Baltimore that each one of them has a separate EIN number which I'm assuming that we have to send – submit two separate applications.

My question is do we have – are we able to submit these two separate applications under the same PECOS ID or do we have to create a new login and password in order to submit these two separate applications?

Joe Schultz: Thank you very much for your question. It can be a little bit of a technical one, so I'll do my best to answer now and then I'll point you to our technical resources on using Identity Access System and PECOS. But here's what you need to know.

So, you need to set up an Identity and Access System first, which is for you, yourself, to start the enrollment process. Once you've established an Identity and Access System, you can then take the next step to gaining access to PECOS in order to submit applications on each of those entities they have. So, you will have one Identity and Access account, but you'll have two separate enrollments. You'll have two separate PECOS accounts for the two separate facilities.

Cambis Moratti: Would it be easier to just create two separate PECOS ID and passwords and just keep them separately? So, this way we don't have to go through that process?

Joe Schultz: No. So, there's only one way you can do it and it's the way I described. You'll create your Identity and Access enrollment – I'm sorry, Identity and Access profile, which will then lead you to setting up your organizations and PECOS, which will be separate.

Cambis Moratti: Okay.

(Inaudible)

Joe Schultz: Please feel free to submit a question to the mailbox and we'll give you some technical resources that will walk you step by step through how to do that.

Cambis Moratti: Thank you. Thank you very much.

Joe Schultz: Yes, no problem.

Operator: To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

The next question comes from Maleah Guthrie.

Nicole Cooney: Hi, did you have a question for us?

Maleah Guthrie: Hi, yes. I'm Maleah Guthrie with HealthCore Clinic in Wichita, Kansas. I was just wondering if this applies – we are an FQHC facility and I was just wondering if that applies within our clinic as an FQHC?

Joe Schultz: Go ahead, Lindsey.

Lindsey Baldwin: Everything has the same answer that Joe provided previously about hospital-based outpatient department, just so long as you are SAMHSA certified and …

Maleah Guthrie: Okay.

Lindsey Baldwin:  … yes, you can enroll.

Joe Schultz: But just – if you're going to be an FQHC but you're also going to be an OTP after you enroll as an OTP. It's not that you're an FQHC doing this. I mean you might be, but you're going to have two separate enrollment records.

Maleah Guthrie: Okay, awesome. Thank you.

Operator: Your next question is from the line of Marianne Kern.

Nicole Cooney: Hi. Did you have a question?

Marianne Kern: I do. So, this is Marianne Kern from Baltimore, Maryland. I guess I'm getting down a little bit into the weeds when I'm talking about the bundled rate for patients who have to take homes. I just want to get some clarification on a patient who comes once a month to see us, once every 4 weeks for that weekly bundle. Does the patient get – in Maryland now we bill every week even though we don't physically see the patient every week. How do we bill those services?

Lindsey Baldwin: Hi, Marianne. This is Lindsey. Thanks for that question. So, we did finalize add-on payments for take-home supplies. There's a code that describes a take-home supply of methadone up to 7 additional days, that's G-2078, and then there's one describing take-home supplies of oral buprenorphine, G-2079. So, you would build those in units according to how large of a quantity of a take-home supply was given to that patient with a maximum of up to three in addition to the base bundle.

Marianne Kern: I see. So, they don't – if they're not a weekly fee that you end up paying – billing without seeing the patient. You would bill all those services at one time for the whole month?

Lindsey Baldwin: Yes. So, for example, let's say the patient comes in just one time and they get a 4-week supply of methadone. You would bill that base monthly bundle describing methadone G-2067. And then you would build three units of G-2078 to add-on describing a week supply of methadone.

Marianne Kern: That's what I was assuming. I just wanted to be clear. Thank you.

Lindsey Baldwin: Great.

Nicole Cooney: And just as a reminder, on our billing and payment page is the link to the payment rates, the chart that has the add-ons as well, just for reference.

Operator: The next question comes from the line of Israem Tibby

Israem Tibby: Yes, hi. This is Israem Tibby from Tibby Health in New Jersey. I wanted to know, regards to the counseling, like what are the requirements? And also, to become an OTP, first you have to apply with SAMHSA and then my question about the counseling.

Joe Schultz: So, to your second part of the question about whether you need to apply to SAMHSA first, the answer to that is, yes. You need to both be accredited by a SAMHSA-approved accrediting organization and certified by SAMHSA in order to be eligible for Medicare enrollment.

Lindsey Baldwin: Sure. And so, on the piece of your question about counseling, we did not specify any minimum amount of counseling that would be furnished in a week or any other period of time. It would really vary depending on what the clinicians at the OTP put in that patient's individualized treatment plan.

Israem Tibby: All right. Thank you.

Lindsey Baldwin: Sure.

Operator: The next question will come from the line of David Burnfield.

David Burnfield: Hello. And thank you for taking my question. My question is, should we be getting Medicaid denials for dually enrolled individuals currently and I'm calling from North Carolina.

Sharon Donovan: Currently, right now in November 2019, no. When we get to 2020 and Medicare becomes primary, once you're a Medicare-enrolled provider, then you would see the denials for a dually eligible individual.

David Burnfield: Can I do a follow up?

Nicole Cooney: Go ahead.

David Burnfield: If we are getting those denials based on current claims for 2019, what steps should we take?

Sharon Donovan: I think from the Medicaid contacting the provider relations components of that state Medicaid agency or their claims processing contractor would be the next step to understand why it's being denied.

David Burnfield: They're stating that we should get a denial from Medicaid – from Medicare first in order for them to kick in with Medicaid. So, they're citing this new benefit as a way to deny it. It's saying and we have got to get denied through Medicare first in order for them to pay on that claim in 2019.

Sharon Donovan: So, it sounds like there's an error of some sort, obviously. I think we've – if you look at our – the pages that we've pointed you to that talk very clearly about Medicare starting in January of 2020 then that would be (inaudible).

David Burnfield: Perfect. Thank you.

Operator: The next question will come from the line Star Ridlove.

Star Ridlove: Hi. My name is Star from Central Forest Treatment Center. And my question is, we completed the Medicare application via PECOS, and we tried to submit the payment for the application, but we keep getting a rejection code. We've spoken with First Coast, we contacted end-user customer service, and we still haven't been able to make the payment. So, I'm wondering if this is going to create a rejection of our application.

Joe Schultz: Is this – is the CGI EUS Help Desk team on?

Robert Bush: Yes. Hi, Joe. This is Robert. That error that she was mentioning actually was looked at and has been resolved. So, if you haven't had a chance to go back in and try that today, you should be able to do that.

Star Ridlove: All right, thank you very much.

Robert Bush: Absolutely.

Operator: Your next question will come from the line of Susan Forther.

Susan Forther: Hi. We were wondering what is a week defined as and what if somebody starts like in midweek?

Lindsey Baldwin: Hi, thanks for that question. This is Lindsey. We defined a week as 7-contiguous-day period. And so, we didn't specify that that would need to begin and end on any particular days. It can start whenever the patient first came.

Susan Forther: Okay, thank you.

Susan Forther: Thanks.

Operator: The next question is from the line of Brian Venamon.

Brian Venamon: Hi. This is Brian Venamon with UC Health from Cincinnati, Ohio. I have a question about billing for the weekly oral buprenorphine bundle including the substance abuse counseling, how many instances of counseling and or therapy does that include before we would then start using the add-on codes?

Lindsey Baldwin: Hi, thanks for your question. This is Lindsey. So, for oral buprenorphine but also for all of the bundles, we did not specify any minimum amount of counseling that would need to be furnished. It would vary depending on what is specified in that patient's individualized treatment plan. The add-on code G-2080 for each additional 30 minutes in counseling that exceeds that amount specified in the treatment plan.

Brian Venamon: Okay …

Nicole Cooney: Thank you for your …

Brian Venamon: So, it's all dependent on the individual patient's treatment plan?

Lindsey Baldwin: Yes, that's right.

Operator: The next …

Nicole Cooney: Thank you.

Operator: … question will come from the line of Jodi Urbanski.

Jodi Urbanski: Hi, this is Jodi Urbanski. I'm calling from SEF Center in Toledo, Ohio. I'm having some confusion with the one tax ID number. So, we've been billing Medicare for years. And we're currently set up underneath our tax ID. And then we have our NPI and we plan to enroll the OTP under the same NPI.

When I'm looking at PECOS, do I just click on create new application, or how do I handle that? And then the other question is we are actually a nonprofit organization. Does the fee apply to all OTPs or does it matter?

Joe Schultz: Hi, Jodi. Thank you for your question. So, the answer to the first part is you are correct. You will go in and you'll start a new application. If you are having challenges with that in any way, please use the technical resources listed in the slide and they should be able to help.

The second part pertaining to whether or not the fee is applicable to nonprofit organization, the fee is applicable to all OTPs including nonprofit organizations. However, if you have a reason to believe that, not a reason to believe, but if you're having a hardship, financial hardship, and you wish to file, to apply for an exception to the application fee, you can do that and it will be evaluated. We will look at your case and evaluate whether you meet the qualifications for a hardship.

For more information on that, please use the OTP enrollment fact sheet. And for everybody, there are also resources on the CMS Provider Enrollment webpage that would speak to additional enrollment related topics, including the hardship exemption and other things that you might find useful.

Jodie Urbanski: Okay, thank you.

Joe Schultz: You're welcome.

Operator: The next question is from the line of Mark Gonzalo.

Mark Gonzalo: Hello, good afternoon. Mark Gonzalo from here in Oceanside, California. I just want to see what – how this will affect, will we be able to bill courtesy doses? So, we get a lot of courtesy doses patients from other counties, sometimes other states that come into courtesy doses while visiting our city, would that be for like …

Nicole Cooney: Just one second.

Mark Gonzalo: Okay.

Nicole Cooney: Yes. Give us one second. Pierre, can you take that question for us?

Dr. Pierre Yong: Sure. This is Pierre. And so, yes, we understand that there are some clinical circumstances where courtesy dosing is a range between two different OTPs for a single patient. In those cases, we would encourage the OTPs to make sure there is complete documentation of that arrangement to back up the need for billing the courtesy dosing, and in that case, the two different OTPs providing the guest's dosing would be able to provide or would be able to bill Medicare for that guest dosing.

Mark Gonzalo: And then the G-code – just to follow, G-code would be 2067 or 2068 depending on the medication?

Dr. Pierre Yong: Depending on the medication, correct.

Mark Gonzalo: Okay, thank you.

Operator: The next question is from the line of Steve Davis.

Steve Davis: Yes, this Private Clinic North in Rossville, Georgia. We're on a border of Tennessee and Alabama. And it looks like our MAC would be in Georgia. Does that affect anything as far as enrollment goes or as well as reimbursement?

Joe Schultz: I'm sorry, you said Tennessee and Georgia and where is it geographically located? In terms of which state is that in, is it literally right on the border? What's your postal? What's your mailing address?

Steve Davis: Our mailing address is Georgia. But we have Tennessee residents as well as Alabama residents that come.

Joe Schultz: Okay. So, you'll use the geographic location associated with Georgia as your Medicare Administrative Contractor, which is Cahaba, or I'm sorry, not Cahaba, it's Palmetto.

Operator: The next question is from the Leticia Harrison.

Leticia Harrison: Hello, hi. I'm calling from High Point Treatment Center in Brockton, Massachusetts, the Opioid Treatment Program. I was calling because I wanted to know if we would need to obtain prior auth for the services that you'll be – that you'll pay for. I can't hear. Hello?

Joe Schultz: I'm sorry, yes, the answer is no.

Leticia Harrison: No? So, we wouldn't need to obtain a prior auth. Okay.

Marty Abeln: So, this is Marty Abeln. If you're talking about a Medicare Advantage plan, you know, you might have some people who are enrolled in MA plans, and you would want to work with the MA plan. Since you're not going to be billing Original Medicare, you'd be billing the MA plan for the OTP services.

So, I think one of the things you'd want to be careful to do is identify anybody that you're treating that's enrolled in a Medicare Advantage plan. And as soon as possible contact the MA plan to make sure that these services are going to be covered.

Leticia Harrison: Okay.

Dr. Pierre Yong: And to build on that if you're billing, if your beneficiary is enrolled in Medicare fee-for-service, this is would not be MA side, there's no prior authorization.

Leticia Harrison: So, for the fee-for-service, there's no preauthorization. But the Medicare Advantage plan, we need to contact them just to make sure they cover the services.

Marty Abeln: That's right, because the MA plan, it's possible an MA plan could have a contract with an OTP provider already. But what we suggest though, or highly recommend, everybody in this call is you identify enrollees or individuals in your plan that are in MA plans and reach out to the MA plan, because they can also pay for services on a non-contract basis. The last thing we want to have happen is an interruption in somebody getting MAT, medication-assisted therapy.

Leticia Harrison: That is true because we have long-time patients that that may affect.

Marty Abeln: Yes. And we're going to advise MA, you know, this is something we will work closely with the MA plans and if – we'll work closely with the OTPs too if there's a problem with a beneficiary getting access to MAT.

Leticia Harrison: Okay.

Nicole Cooney: Thank you so much. In the interest of time, I need to move on to the next question.

Operator: The next question is from the line of Annalisa Rovelli.

Annalisa Rovelli: Hi. This is Annalisa Rovelli from San Francisco, California. My question was similar to the Medicare Advantage plan enrollees. So, I think partially you answered the question earlier, that we need to submit the claims to the private health plans. Is that correct?

Marty Abeln: Yes, I mean, yes, if you have an MA enrollee, you would submit the claim to the MA plan, not to the MAC.

Annalisa Rovelli: Okay. And I know you answered earlier that we may need prior authorization.

Marty Abeln: Yes.

Annalisa Rovelli: Okay.

Marty Abeln: That's possible.

Annalisa Rovelli: All right, thank you.

Operator: The next question will come from the line of Brittany Bell.

Brittany Bell: I think the person right in front of me just asked the same question because we have Kaiser patients. So currently we have a contract with Kaiser for medication-assisted treatment. So, I was just wondering if we would continue with Kaiser for those patients or if we would bill Medicare as the primary.

Marty Abeln: If they're what? If they're enrolled in a Kaiser MA plan then you would bill Kaiser.

Brittany Bell: Okay. Perfect. Thank you so much.

Operator: The next question is from the line of Mary Weaver.

Mary Weaver: Yes. I'm looking at the payment rates and I know that they're adjusted geographically. If we do the weekly bundle if someone is coming in for the medication and they miss several days during the week,do we still bill for the weekly bundle?

Lindsey Baldwin: Great. Thank you for that question. This is Lindsey. Yes, as long as at least one service is furnished, you can bill for the weekly bundle. And I also just want to clarify one point that the rates that you see in the final rule in table 15 and also on the OTP website, those are the national rates that are not adjusted for localities.

Mary Weaver: Right. Right.

Lindsey Baldwin: Yes, we will be actually posting an additional file we plan to that shows what the rates are in each locality.

Mary Weaver: Okay, thank you so much. And I'm calling from Vance Recovery in Henderson, North Carolina.

Lindsey Baldwin: Great, thank you so much.

Operator: The next question is from the line of Debbie Austin.

Debbie Austin: Hello. We have a couple of questions. And the first one is, when is the grace period over for providers to bill Medicaid as primary until they get their Medicare enrollment done? We're wondering if is that going to be a 3-months or is it a 6-months grace period before Medicaid actually goes ahead and recoup those payments from our providers?

Sharon Donovan: Hi. This is Sharon Donovan. Thanks for your question. There's not a specific timeframe or grace period in which you have to get enrolled so that Medicaid can cover an OTP, just for the whatever duration of time the OTP provider is not enrolled in Medicare, Medicaid can pay. But as soon as the provider's enrolled, that's when the recoupment happens.

Debbie Austin: So, there isn't a reasonable test. Whereas, you know, we've got, you know, a month or a month and a half now, 3 months into the next year, it's just whenever they get enrolled?

Sharon Donovan: That's correct.

Debbie Austin: And would, is Medicare going to go back to the first day of January 2020 in those cases?

Sharon Donovan: I think as Joe mentioned earlier, Medicare will go back to 30 days prior to when the application was received. So, if you didn't apply until June 1st, it would only be retroactive on Medicare up to 30 days prior to June 1st.

Debbie Austin: So, would a state be well within its purview to, if a provider didn't apply until June, to start denying claims for those particular services, if the provider was not planning on submitting enrollment paper to Medicaid before June?

Sharon Donovan: Yes. I mean the downside in that situation the state would continue to pay. Obviously, the OTP could not be billing Medicare for folks who are not dually eligible for the rest of the Medicare population who needs the benefit, hence, some of the urgency on our part encouraging you to enroll as soon as you can.

Debbie Austin: Okay. And is the fee an application fee for provider or is it a fee per site?

Joe Schultz: It is one fee per application.

Debbie Austin: Okay.

Nicole Cooney: Thank you very much for your question.

Operator: The next question will come from the line of Joe Sabeth.

Joe Sabeth: Hi. Thank you for taking my call. So, it seems like this may be addressed on the billing guidance which is forthcoming. But currently, when we submit claims for individual providers who don't have an NPI or can't enroll – who are not Medicare-eligible individual providers, the claims reject on the front end, in NGS Medicaid in New York.

So, will the guidance indicate what to report in the rendering provider field on the claim if at all? That's question number one. And question number two is that, since this is a weekly individual code, should the data service on the claim be PTAN data service for the week or should it just be one individual day on that day? And then my final question is, if there are additional lines, CPT codes reported besides to the G-codes, because the dual eligible in New York State Medicaid they pay against other people codes. Do we have to apply GY modifiers, you know, pay against those lines?

Lindsey Baldwin: Thanks so much for those questions, just to make sure we give you the most accurate answer. Let us take that one back. And we will get back with you if you don't mind emailing those questions to us at OTP_Medicare@cms.hhs.gov.

Operator: The next question is from the line of Teresa Karen.

Teresa Karen: Yes, thank you for taking my call. This question pertains to when clients have Medicare and Medicaid and their deductible applies with the Medicare claims. How is that going to be reimbursed by Medicaid?

Sharon Donovan: Hi. This is Sharon Donovan again. When OTP providers enrolled in Medicare, in Original Medicare, and bills, and the person happens to still be in their Part B deductible phase, Medicare will automatically cross that claim over to Medicaid in all states, except South Carolina.

And then, let's see, state will process that claim for the deductible amounts and notify the provider of the results of that processing for the coverage of the deductible. We did note in the final regulation that Medicaid and Medicare sometimes use different codes for these services. And so, there's a possibility in that state notification to the provider that those indicated denial because of the wrong code.

In that case, as we noted again in the final regulation, the provider would just need to recode and bill Medicaid again to get the final adjudication for the deductible.

Teresa Karen: Thank you for that answer. I have another question. Will you be issuing a companion guide so that we can make sure that when we submit our 837 or set up the 837P file that it goes correctly?

Nicole Cooney: We will, like I said earlier, this is Nicole. We will have some additional billing resources that we expect to be posting in the next few weeks to our billing and payment page.

Sharon Donovan: This is Sharon, just to make sure I understand your question, is this about a companion guide with respect to that Medicare crossing the claim over to Medicaid for the deductible processing?

Teresa Karen: No. It's actually the companion guide because OTPs are going to be billing under the group NPI number versus the individual counselor. So, I want to make sure that everything is set up correctly. We bill mental health services now, and we bill them out using the rendering provider number, NPI number, to identify that licensure level.

Nicole Cooney: Okay, thank you. We do anticipate addressing that situation in the materials that will be coming out in the next few weeks. Thank you very much for your question.

Blair, I have time for one more question.

Operator: The final question will come from the line of Lisa Raleigh.

Lisa Raleigh: Hello. We're an FQHC. And I just want to confirm, do we need to enroll all of our providers as an OTP individually, as well as the facility as an FQHC?

Joe Schultz: So long as that your FQHC is certified by SAMHSA, certified as an OTP. All you have to do is enroll your organization. So, your FQHC – enroll your FQHC in Medicare additionally as an OTP. None of the individuals associated with the OTP need to be separately enrolled. They do not need to be separately enrolled.

Lisa Raleigh: Okay. And then my follow-up question is all the codes that you had there, I believe it's on page 10. Those are add-on codes. Do they get billed to Part B or are they covered under our G-codes for mental health for PPS?

Lindsey Baldwin: These are all covered under Part B Medicare.

Lisa Raleigh: Okay, so we'll split that to Part B. Okay. Okay, that's what I needed to know. I appreciate your help. And by the way, I'm from Hyndman Area Health Center in Hyndman, Pennsylvania.

## Additional Information

Nicole Cooney: Okay. Thank you. Unfortunately, that's all the time that we have today for questions. Slide 34, in today's presentation lists the number of resources for obtaining more information, including our website and the new enrollment fact sheet. We hope that you'll take a few moments to evaluate your experience on today's call. See slide 35 for more information.

An audio recording and transcripts for today's session will be available in about two weeks at go.cms.gov/npc My name is Nicole Cooney. And I'd like to thank all of our presenters and also thank you for participating in today's Medicare Learning Network call on Opioid Treatment Programs: Enrolling in Medicare. Have a great day everyone.

Operator: Thank you for participating in today's conference call, you may now disconnect. Presenters, please hold.