mln Booklet
KNOWLEDGE • RESOURCES • TRAINING

Opioid Treatment Programs (OTPs) Medicare Billing & Payment

What's Changed?

- Use new HCPCS code G1028 - Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 mL nasal spray (pages 6-7)
- Use HCPCS code G2215 - Take-home supply of nasal naloxone; 2-pack of 4mg per 0.1 mL nasal spray (page 6)
- After the conclusion of the PHE, add Modifier 95 (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) to your claim for counseling and therapy you provide via audio-video telecommunications using HCPCS code G2080 (pages 11 and 13)
- After the conclusion of the PHE, add Modifier FQ to your claim for counseling and therapy you provide via audio-only telecommunications using HCPCS code G02080 (pages 11 and 13)

You'll find substantive content updates in dark red font.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

Table of Contents

This booklet informs you about Medicare billing and payment for Opioid Use Disorder (OUD) treatment services. It has information about:

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

In this booklet, **you** refers to OTP providers and institutions.

Medicare pays Medicare-enrolled OTPs to deliver OUD treatment services to Medicare patients. As of January 1, 2021, Medicare Part B covers hospital outpatient OTP services. For more information on how to enroll as an OTP provider, review the Opioid Treatment Programs (OTPs) Medicare Enrollment Booklet.

If you provide OUD services as a Part B benefit, as an OTP you can be a Medicare Part A or a Part B provider. For more information, visit the CMS Opioid Treatment Programs webpage and the FAQs.

Covered OUD Treatment Services

Medicare covers these OUD treatment services for any patient with OUD:

- 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

Supply Covered OUD Treatment Services

You must:

- Enroll in Medicare
- Get full certification from the Substance Abuse and Mental Health Services Administration (SAMHSA)
- Get accreditation from an accrediting body that SAMHSA approves
- Meet additional conditions necessary for the health and safety of patients
- Have a provider agreement with CMS

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

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

OTP Billing and Payment Steps

1. Enroll in Medicare EDI.
2. Check Medicare patient eligibility.
3. Code for OTP services.
4. Bill for OTP services.
5. Submit claims to your MAC or billing agencies, clearinghouses, or software vendors.
6. Check claims status.
7. Payment & Remittance Advice.

Medicare only covers therapy or counseling services for OUD treatment offered if you are authorized under state law to deliver such services.

Enroll 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 MAC tells you how to enroll in EDI. Each MAC has different instructions and methods for submitting EDI enrollment applications. Read your enrollment approval letter carefully and find your MAC's website for instructions.

You must:

- Complete the EDI enrollment process with each MAC you submit claims to
- Complete the EDI Registration Form and EDI Enrollment Form before submitting electronic media claims (EMC) or other EDI transactions to Medicare
- Give identifying information about the providers who submit electronic data

If you plan to submit EMC or use EDI, either directly with Medicare or through a billing agency, clearinghouse, or software vendor, you must complete the forms. You must sign and submit the forms to your MAC as instructed for each new EMC biller. Find your MAC's website.

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, find your MAC's website.

After you complete EDI enrollment, your billing agency, clearinghouse, or software vendor helps you with:

- Connectivity
- System access numbers and passwords
- Testing your EDI format transmissions

MACs have EDI helplines to help you.

Check Medicare Patient Eligibility

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

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

Review the Checking Medicare Eligibility Fact Sheet for ways to check your patient's Medicare eligibility.

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

Code for OTP Services

CMS pays for the overall treatment of OUD delivered by an OTP. **There are 17 billable OTP-only HCPCS G-codes (G2067 to G2080, G2215, G2216, and G1028) for opioid treatment services on Part B claims.**

HCPCS codes G2067 to G2073, G2215, G2216, and G1028 cover all FDA-approved drugs for the treatment of OUD.

Code for Medication Assisted Treatment (MAT) & Add-On Codes

The threshold for billing the codes describing weekly episodes (HCPCS codes G2067 to G2075) is the delivery of at least 1 service in the weekly bundle (from either the drug or non-drug component).

These HCPCS G-codes describe treatment with:

- Methadone (G2067)
- Buprenorphine oral (G2068)
- Buprenorphine injectable (G2069)
- Buprenorphine implants (insertion, removal, and insertion/removal) (G2070, G2071, and G2072)
- Extended-release, injectable naltrexone (G2073)
- Non-drug bundle (G2074)
  - You didn't administer medication during an episode of care.
  - **Example:** In the case of a patient getting injectable buprenorphine, OTPs bill HCPCS code G2069 for the week you supply the injection. For the following weeks, when you supply at least 1 non-drug service, bill HCPCS code G2074, which describes a non-drug bundle. For the week you supply another injection, bill HCPCS code G2069.
- Medication not otherwise specified (G2075)
  - Use when you supply MAT services with a new opioid agonist or antagonist treatment medication the FDA approved under Section 505 of the U.S. Federal Food, Drug, and Cosmetic Act (FD & C Act) for the treatment of OUD
  - HCPCS codes G2067 to G2073, G2215, G2216, and G1028 cover all the FDA-approved drugs used for the treatment of OUD

CMS 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, 2-pack of 4mg per 0.1 mL nasal spray (G2215)
- Take-home supply of injectable naloxone (G2216)
- Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 mL nasal spray (G1028)

We use the typical or average maintenance dose to decide drug costs for each of the bundles.

We use flat dollar payment amounts for the codes describing the OTP bundled services (HCPCS codes G2067 to G2080, G2215, G2216, and G1028). Review the CY 2022 OTP Payment Rates on the Final Rule (CMS-1751-F) webpage in the Downloads section.

When submitting a claim for HCPCS code G2216 (take-home supply of injectable naloxone), you must note the dosage dispensed to the patient 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).

Beginning January 1, 2022, Medicare covers HCPCS code G1028 (take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 mL nasal).

Payment for the add-on code HCPCS code G1028 is limited to once every 30 days unless an additional take-home supply of the medication is medically reasonable and necessary.

Note: As an OTP provider, you must use only the codes describing bundled payments. Don't use other codes, such as those paid under the Physician Fee Schedule (PFS). Only Medicare-enrolled OTPs can bill for HCPCS codes G2067 to G2080, G2215, G2216, and G1028.

All FDA-approved drugs for the treatment of OUD are currently covered by HCPCS codes G2067-G2073, G2215, G2216, and G1028.

MAT Codes, Descriptors, & National Medicare Payment Rates

To find the geographically adjusted payment rate, follow these steps:

1. Use the Locality Key to find your locality number and MAC numbers assigned to your OTP based on the state/fee schedule area/county location of your practice.
2. Look up your locality number and MAC numbers on the Locality Adjusted Rates to find the HCPCS code and corresponding geographically adjusted payment rate.

Table 1: MAT Codes, Descriptors, & National Medicare Payment Rates

G Codes	Descriptors for OTP Bundled Services	Drug Fee	Non-Drug Fee	Total Fee
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	$178.29	$215.67
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)	$78.79	$178.29	$257.08

G Codes	Descriptors for OTP Bundled Services	Drug Fee	Non-Drug Fee	Total Fee
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)	$1,695.09	$184.96	$1,880.05
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)	$4,950.00	$422.26	$5,372.26
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	$422.40	$422.40
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)	$4,950.00	$649.10	$5,599.10
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)	$1,264.26	$184.96	$1,449.22
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	$167.42	$167.42

G Codes	Descriptors for OTP Bundled Services	Drug Fee	Non-Drug Fee	Total Fee
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	-	$0	-
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 patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psycho-social, economic, legal, or other supportive services that a patient 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	$185.79	$185.79
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	$114.17	$114.17
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

G Codes	Descriptors for OTP Bundled Services	Drug Fee	Non-Drug Fee	Total Fee
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.	$78.79	$0	$78.79
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	$32.03	$32.03
G2215	Take-home supply of nasal naloxone; 2-pack of 4mg per 0.1 mL nasal spray (provision of the services by a Medicare-enrolled Opioid Treatment Program); list separately in addition to code for primary procedure.	$89.47	$2.58	$92.05
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	$2.58	Contractor-priced
G1028	Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 mL nasal spray (provision of the services by a Medicare-enrolled Opioid Treatment Program); list separately in addition to code for primary procedure.	$125.00	$2.58	$127.58

Note: *In accordance with the annual update methodology finalized in the CY 2020 PFS final rule (84 FR 62667), the drug component has been updated for CY 2022 using the most recent data files available at the time of drafting this rule (with the exception of methadone, which has been maintained at the CY 2021 rate per CMS-1715-F-IFC) and the non-drug component has been updated based on the Medicare Economic Index (MEI), which reflects an increase of 2.1% for CY 2022.

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 during the Public Health Emergency (PHE) for COVID-19 using 2-way interactive audio-video communication technology. If patients don't have access to 2-way audio-video communication technology, you can provide periodic assessments using audio-only telephone calls, if you meet all requirements.

After the conclusion of the PHE, CMS expects OTPs to add Modifier 95 (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) to your claim for counseling and therapy you provide via audio-video telecommunications using HCPCS code G2080.

Additionally, after the conclusion of the PHE, CMS expects OTPs to add Modifier FQ (the service was provided using audio-only communication technology) to your claim for counseling and therapy you provide via audio-only telecommunications using HCPCS code G2080.

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

- Program physicians
- Primary care physicians
- Authorized health care professionals under a physician's supervision
- Qualified personnel such as:
  - Nurse practitioners (NPs)
  - Physician assistants (PAs)

You may perform assessments, including psychosocial assessments, if you are eligible to do so under state law and the scope of your licensure. Document the rationale for billing the add-on code in the patient's medical record. Services must be medically reasonable and necessary.

Bill OTP Services

Only OTPs can bill Medicare using the specific codes for OTP services. No other provider or supplier type can bill for OTP services (billed using HCPCS codes G2067 to G2080, G2215, G2216, and G1028).

However, the CY 2022 Physician Fee Schedule includes bundled payment codes (billed using HCPCS codes G2086 to G2088) and payment rates for an episode of OUD treatment you provide in the office setting.

Institutional providers billing on the Form CMS-1450 institutional claim form, may use:

- Type of Bill (TOB) code (087x) for freestanding non-residential OTP
- Condition Code (89) for provider-based OTP
- TOB 013X and 085X for hospital-based providers OTP services

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

Only OTPs can submit claims with codes G2067 to G2080, G2215, G2216, and G1028.

The threshold to bill a full episode is that you must provide at least 1 service (from either the drug or non-drug component) to the patient during the week that corresponds to the episode of care.

If you don't provide a drug to the patient during that episode, you must bill the G-code describing a weekly bundle without including the drug (HCPCS code G2074) and the threshold to bill would be at least 1 service in the non-drug component.

If you provide a drug with or without additional non-drug component services, you may bill the appropriate G-code describing the weekly bundle including the drug provided.

Frequency of Use Guidelines

The following rules apply when billing OTP G-Codes:

- **HCPCS codes G2067 to G2075** cover episodes of care lasting 7 days in a row. You can't bill for the same patient 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, don't use **HCPCS codes G2069 and G2073** more than once every 4 weeks.
  - In general, don't use **HCPCS codes G2070 and G2072** more than once every 6 months.
- You may give Medicare patients OUD services at more than 1 OTP within a 7-day period in certain, limited clinical situations, such as guest dosing or when a patient transfers care between OTPs. Each of the involved OTPs may bill the appropriate HCPCS codes for the services given to the patient, but both OTPs must maintain enough medical record documentation to reflect the clinical situation and services provided.
- If a patient switches from 1 drug to another, the OTP should only bill for 1 code describing a weekly bundled payment for that week. Use the code for the drug you gave the patient for most of the week.
- Bill the add-on code **HCPCS code G2076** describing intake activities only for new patients starting treatment at the OTP.
- There are 2 add-on codes that describe take-home doses of medication that can be billed in addition to 1 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 1-month supply)
    - The add-on code for take-home doses of methadone can only be used with the methadone weekly
  - **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 1-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 1 month of medication

SAMHSA allows a maximum take-home supply of 1 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 1 month (in addition to the weekly bundled payment code).

The date of service (DOS) for **HCPCS codes G2078 and G2079** may reflect either the actual date you provide the medication to the patient or the first day in the weekly billing cycle for the week the patient gets the take-home supply of medication. **You can bill HCPCS code G2080** when you provide counseling or therapy services that largely exceed the amount listed in the patient's individualized treatment plan. After the conclusion of the PHE, if you provide counseling or therapy services via audio-video telecommunications, CMS expects you to use Modifier 95 on your claims. If you provide audio-only counseling or therapy services, CMS expects you to use Modifier FQ. Document the medical necessity for these services in the patient's medical record.

Submit Claims to Your MAC, Billing Agency, Clearinghouse, or Software Vendor

As an OTP provider, you must submit all claims:

- 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 Form CMS-1500 (the paper version of the 837P)

If you're using the paper versions of the claim (CMS-1450 or CMS-1500), mail those to your MAC. Find your MAC's website.

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

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

Billing Tips

- File claims as soon as possible and no later than 1 calendar year after the date of service. Your claim will be denied if you file it 12 months or later after the DOS.
- Place of Service (POS) code 58 is for non-residential opioid treatment facilities.

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

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

B. Freestanding OTP facilities use bill type 087X

C. Hospitals and freestanding 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

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

Outpatient Services Billing Example

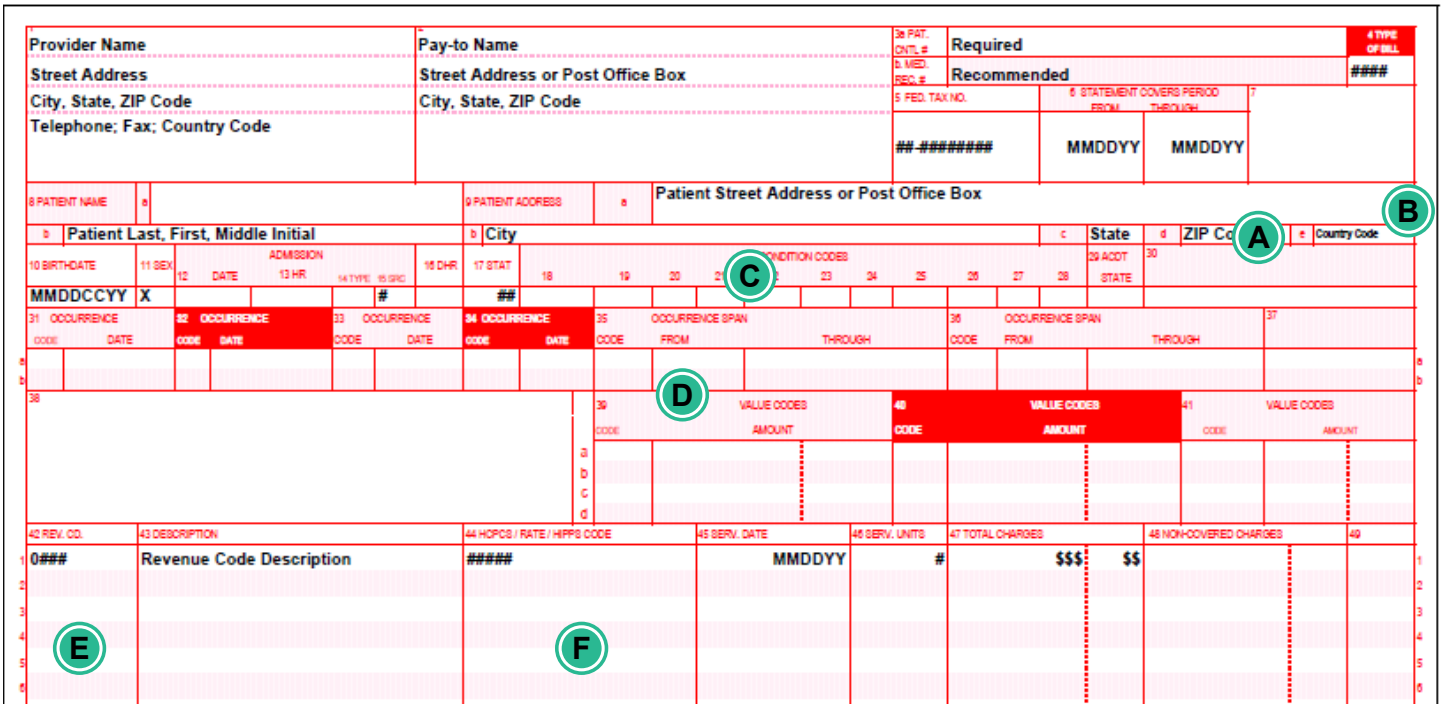


Figure 1: CMS-1450 Claim Form Sections A, B, C, D, E, F

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

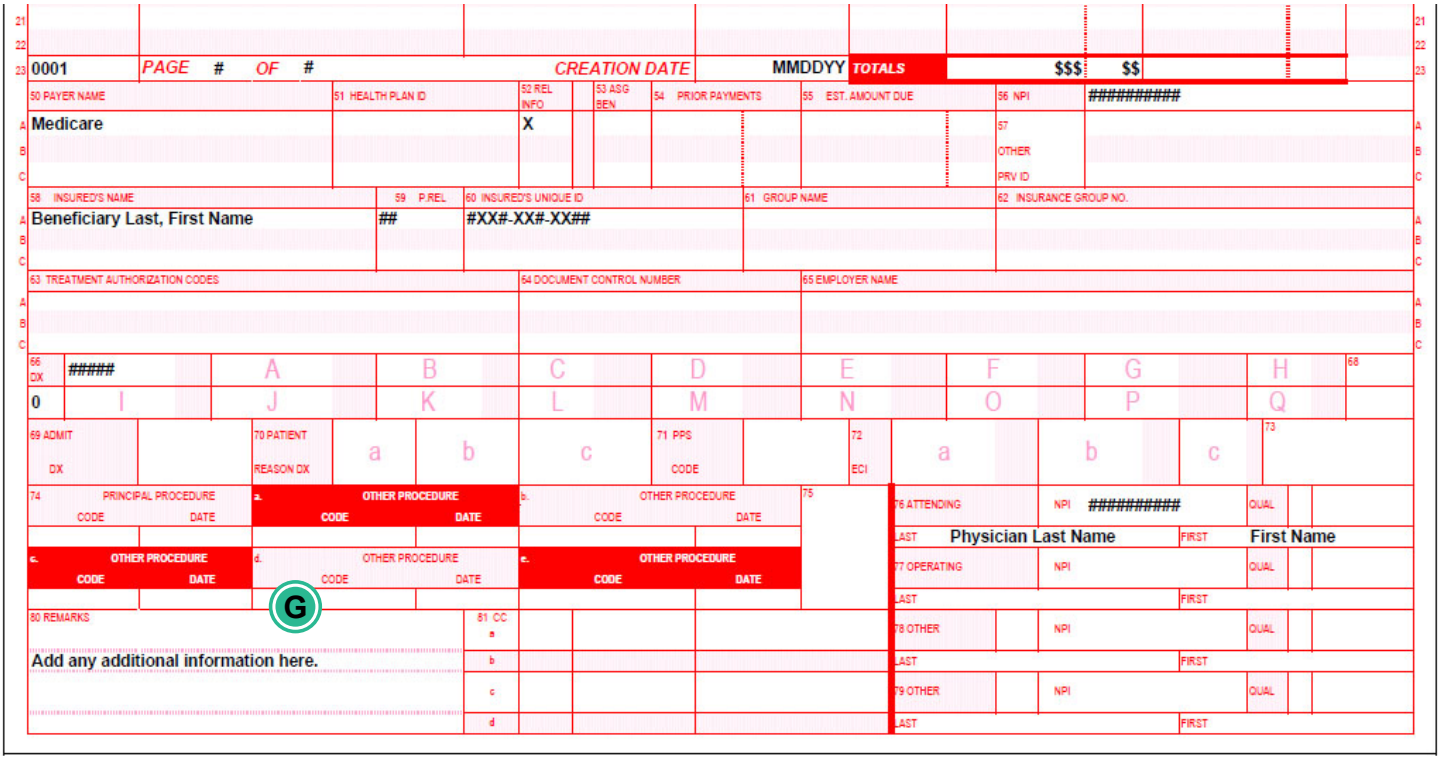


Figure 2: CMS-1450 Claim Form Sections G

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

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

Include the following information on Form CMS-1500:

A. HCPCS codes associated with the OTP service.

B. NPI of the individual prescribing or ordering medication 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.

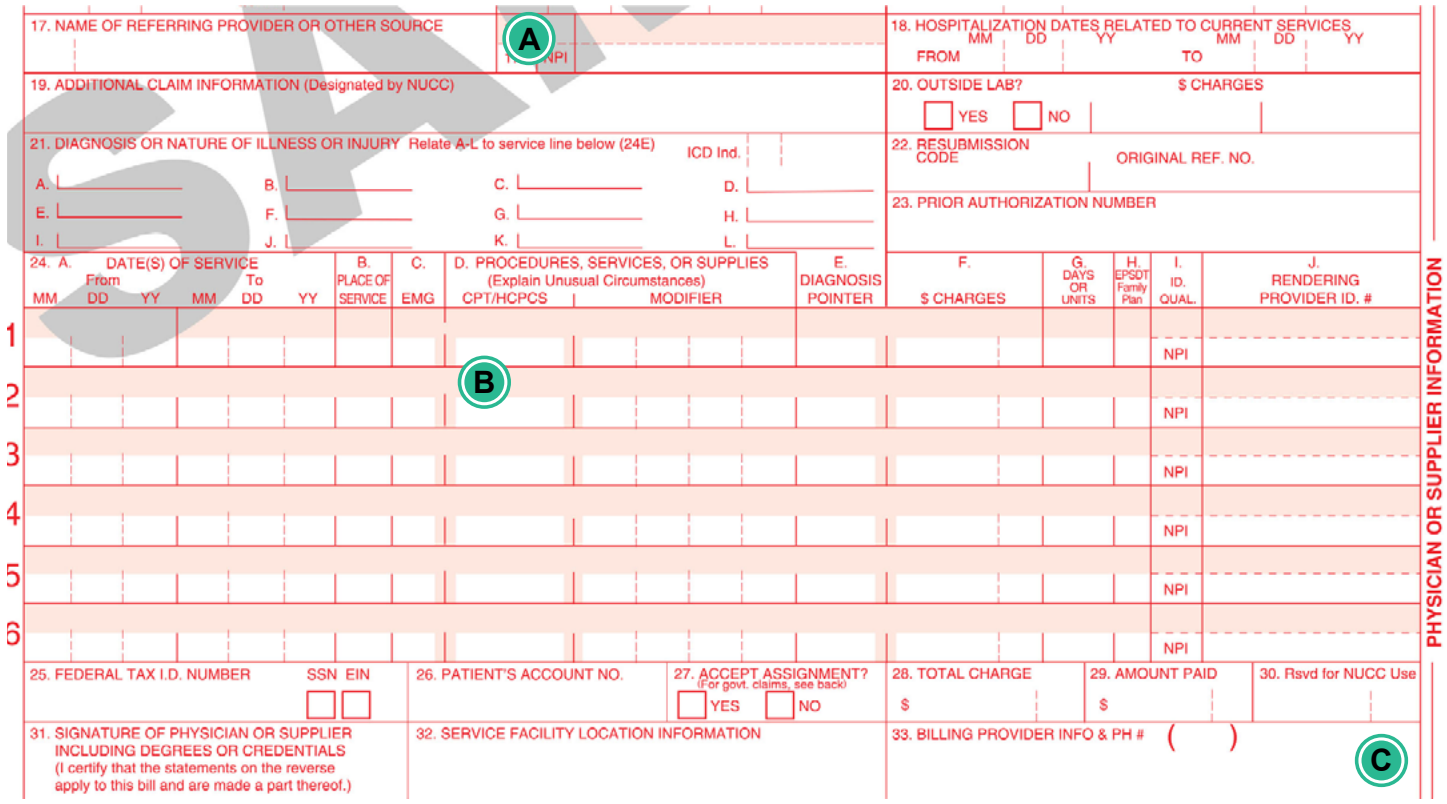
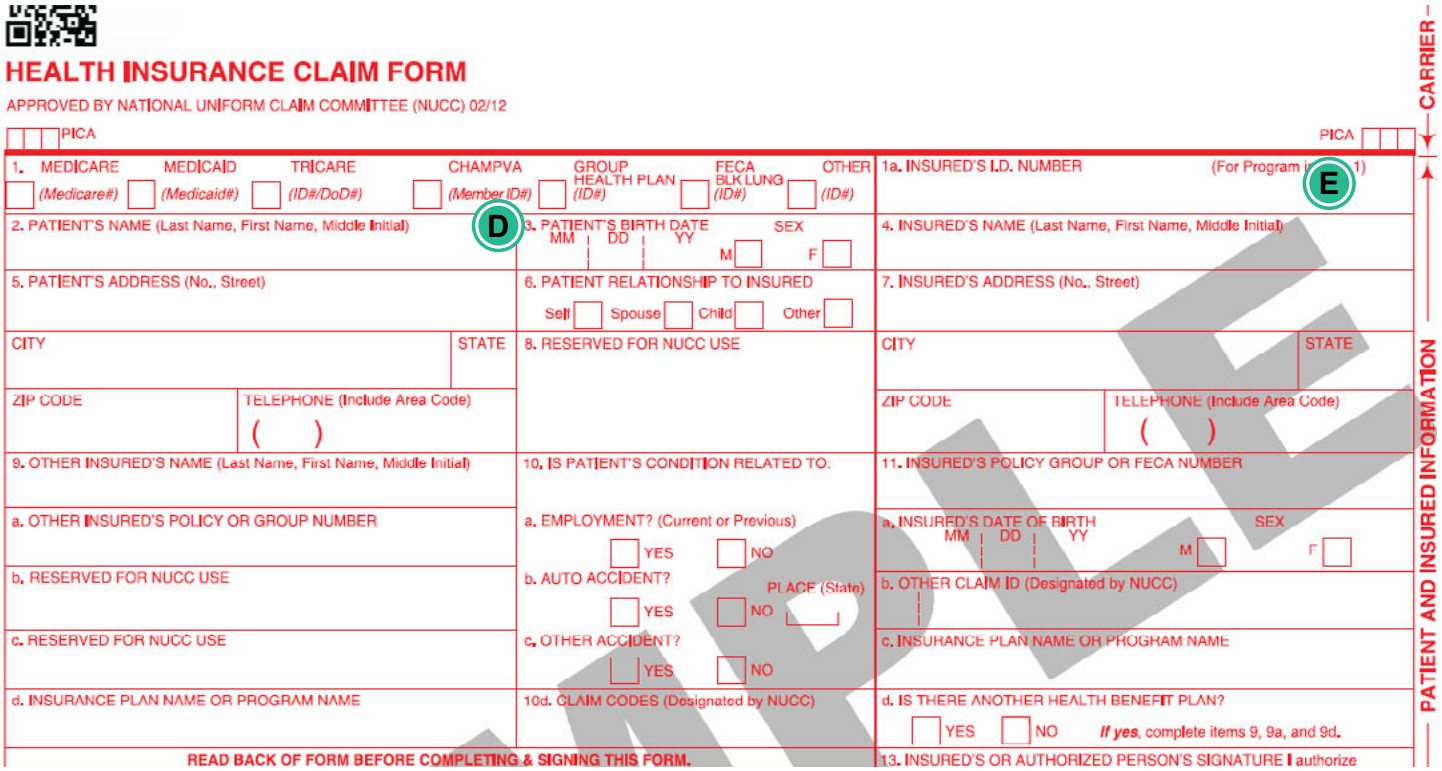


Figure 3: CMS-1500 Form Sections A, B, C

D. Patient first name, and last name.

E. Patient's MBI.


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program E)

D

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize

CARRIER

PATIENT AND INSURED INFORMATION

SAMPLE

Figure 4: CMS-1500 Form Sections D, E

F. Diagnosis or nature of illness or injury using ICD-10-CM diagnosis codes.

G. 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.

H. 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's different from the information in Item 33, enter the name, address, and ZIP code of the facility where you provided the services in Item 32.

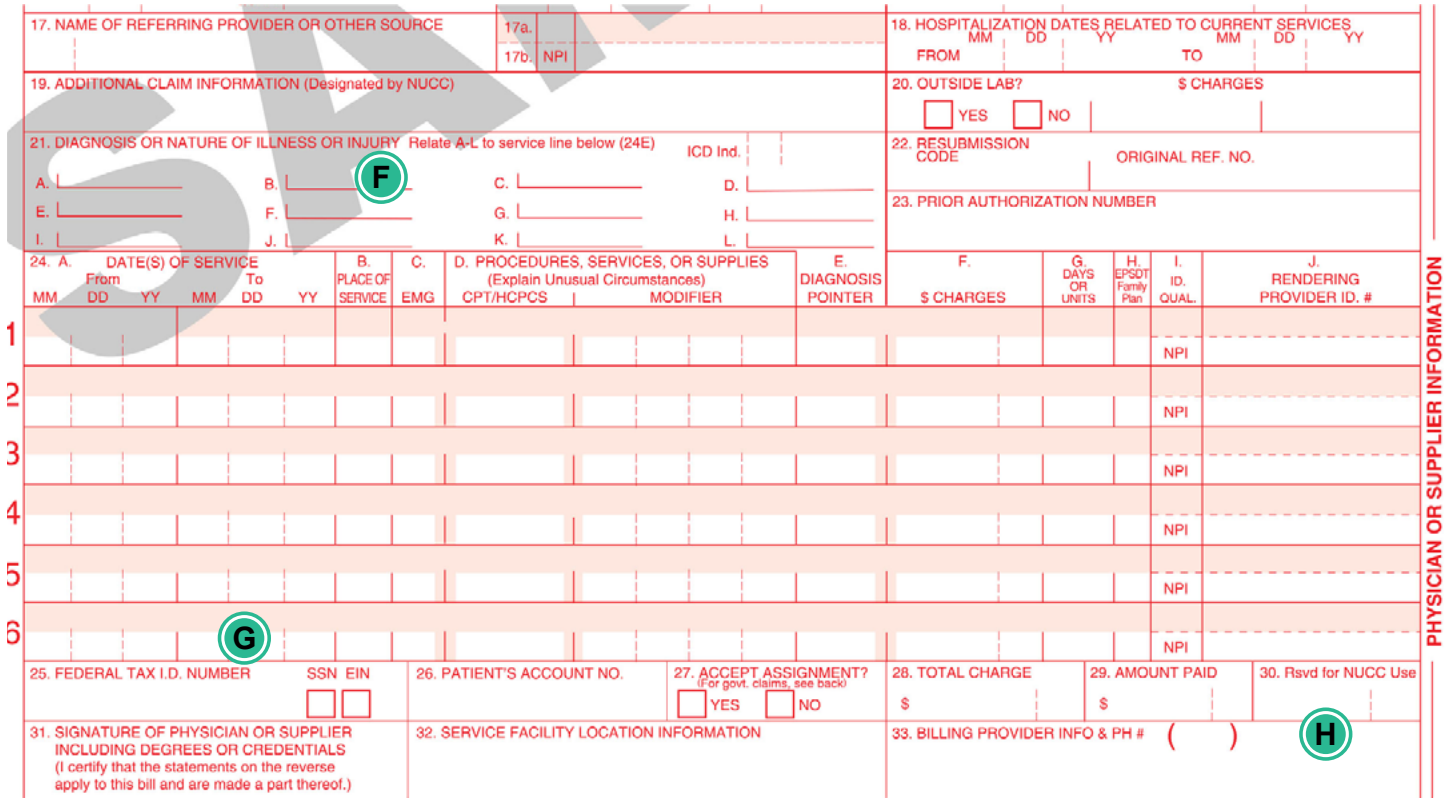


Figure 5: CMS-1500 Form Sections F, G, H

For the codes that describe a weekly bundle (HCPCS codes G2067 to G2075), 1 week is defined as 7 days in a row. You can apply a standard billing cycle by choosing a particular day of the week to begin all episodes of care. In this case, the DOS is the first day of your standard weekly billing cycle. If a patient starts treatment in the middle of your standard weekly billing cycle, you may bill the applicable code for that episode of care if it meets the threshold to bill for the code.

You can also adopt weekly billing cycles that vary depending on the patient. Under this approach, the initial DOS will depend on the day of the week when the patient is first admitted to the program or when Medicare begins billing. With this approach, when a patient is beginning treatment or re-starting treatment after a break in treatment, the DOS will be the first day the patient is seen and the DOS for later following episodes of care will be the first day after the previous 7-day period ends.

For the codes describing add-on services (**HCPCS codes G2076 to G2080, and G2215 to G1028**), the DOS should show the date that service is provided. However, if you choose to apply a standard weekly billing cycle, the DOS for codes describing add-on services can 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.

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

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. Find your MAC's website for information on the Provider Contact Center and IVR user guide.

Customer Service Representative (CSR)

Find your MAC's website for information on the Provider Contact Center if you're unable to access claims information through the IVR.

MAC Portals

Providers can get free claims status information via the MAC's web-based provider portal. Find your MAC's website 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. We recommend the electronic 276/277 process because you can automatically generate and submit 276 queries ending the need for manual entry of individual queries or calls to a contractor for this information.

The 277 response allows you to automatically post the status information to patient accounts, ending the need for manual data entry by provider staff members. If you don't know your software can automatically generate 276 queries or automatically post 277 responses, contact your software vendor or billing service. For more information, find your MAC's website.

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

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

Payment & Remittance Advice

After the MAC processes the claim, they'll send you or your billing agency a remittance advice with final claim and payment information. It usually:

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

There's no copayment for OUD treatment services. Patients are responsible for the Part B deductible.

You get Medicare payments via Electronic Funds Transfer (EFT). You must complete an Electronic Funds Transfer (EFT) Authorization Agreement (Form CMS-588) to set up EFT.

If there aren't issues with the claim, you can expect payment as follows:

- Electronic filing - no sooner than 13 days after filingPaper filing - no sooner than 28 days after filing (payment on the 30th day or after)

Issues with Payment

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

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

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

Medicare/Medicaid Dual Eligible Patients

Medicare calls patients 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 beginning October 2020, with exceptions from the Secretary. Currently, 42 states cover OTP services in their Medicaid Program.

Medicare is the primary payer for OTP services for dual eligible patients who get services through their Medicaid Program. Medicaid must pay for OTP services you deliver to your patients enrolled in Medicaid, but not yet enrolled in Medicare. Medicaid only pays for the services that the state plan covers. The state will recoup Medicaid payments made to you back to the effective date of your Medicare enrollment. Then, you bill Medicare for those services.

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

Resources

- Electronic Billing & EDI Transactions
- Electronic Data Interchange (EDI) Support
- Electronic Health Care Claims Website
- Health Care Payment and Remittance Advice and Electronic Funds Transfer
- 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, Section 80.2.1.2 Payment Floor Standards