Billing Guidance for Medicare Enrolled individuals receiving services in NYS Opioid Treatment Programs (OTP)

IMPORTANT ALERT! Beginning January 1, 2021 OTP providers should not bill Medicaid for OTP services provided to an individual eligible for both Medicare and Medicaid (a "dual") until a claim has been processed by Medicare. This directive applies to all dates of service, including those prior to January 1, 2021. Once the Medicare claim has been adjudicated, the provider may bill Medicaid at their option. It is recommended that Medicaid only be billed when there is an actual liability on the part of Medicaid relative to deductibles or the Medicaid "higher of" payment (see detailed section below). Providers that disregard this notice risk recoveries of inappropriately claimed Medicaid revenue upon audit under Medicaid's coordination of benefits rules. Additionally, by March 30, 2021 all OTPs must have submitted claims to Medicare for all services provided to duals beginning April 1, 2020 or after. To facilitate this retroactive claiming, providers have 2 options. They can:

1) Void the Medicaid claims, submit Medicare claims and then rebill to Medicaid only those claims with Medicaid liability (use delay reason code 7 – explained below); or

2) Submit the claim and receive reimbursement from Medicare and then adjust (or void) the Medicaid claims as appropriate.

To the extent possible, providers should process any January 1 to March 30, 2020 claims for Medicare eligible individuals.

Introduction

Beginning January 1, 2020, Medicare began paying a weekly bundle (plus add-ons) for services delivered in Opioid Treatment Programs (OTPs). Many of these Medicare enrollees are also enrolled in Medicaid, making them what is commonly referred to as "dual eligible or duals". Providers serving dual eligible patients are entitled to receive the full Medicare payment and any additional sums due from Medicaid that exceed the Medicare payments ("higher of" – see below).

All OTPs certified by OASAS that serve Medicare eligible individuals must also be enrolled in Medicare as an OTP to facilitate billing for Medicare eligible individuals and dual eligible individuals. Providers that are already enrolled in Medicare as a different provider/practitioner type must separately enroll as an OTP**.**

NOTE: OASAS expects all Medicaid OTPs that serve Medicare eligible individuals to be enrolled as a Medicare OTP by January 1, 2021. After that date, providers are required to bill Medicare and have that claim adjudicated prior to submitting a Medicaid claim for dual eligibles. Additionally, providers are expected to retroactively bill Medicare, to whatever extent possible, for all Medicare billable OTP services back to the effective date of the provider's OTP enrollment in Medicare. After the Medicare claim is paid, the provider may need to adjust Medicaid claims already submitted for those same services (see retroactive billing section below). That adjustment, if needed, must show all the Medicare payment information so Medicaid can calculate and recover the Medicaid overpayment (if any).

Complete details for billing Medicare can be found at the following link:

https://www.cms.gov/files/document/otp-billing-and-payment-fact-sheet.pdf

The Medicare Billing Codes

The following codes are used to bill Medicare for services provided in a Medicare-enrolled Opioid Treatment Program:

G CODES DESCRIPTORS FOR OTP BUNDLED SERVICES

G2067 - Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed.

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.

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.

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.

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.

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.

G2073 - Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed.

G2074 - Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed.

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; partial episode.

INTENSITY ADD-ON CODES

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 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; list separately in
addition to code for primary procedure.

G2077 - Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment; list separately in addition to code for
primary procedure.

G2078 - Take-home supply of methadone; up to 7 additional day supply; list separately in addition to code for primary procedure.

G2079 - Take-home supply of buprenorphine (oral); up to 7 additional day supply; list separately in addition to code for primary procedure.

G2080 - Each additional 30 minutes of counseling in a week of medication assisted treatment; list separately in addition to code for primary procedure.

G2215 – Naloxone - nasal

G2216 – Naloxone - auto-injection

NOTE: None of these Medicare "G codes" pay under Medicaid OTP claiming. Provider must bill Medicaid using the same set of APG procedure codes they have been using (see below).

The following is the <u>Medicare</u> billing guidance from CMS with respect to date of service:

"Date of Service - For the codes that describe a weekly bundle (HCPCS codes G2067-G2075), one week is defined as 7 contiguous days. OTPs may choose to apply a standard billing cycle by setting a particular day of the week to begin all episodes of care. In this case, the date of service would be the first day of the OTP's billing cycle. If a beneficiary starts treatment at the OTP on a day that is in the middle of the OTP's standard weekly billing cycle, the OTP may still bill the applicable code for that episode of care [meaning 7 day cycle or week] provided that the threshold to bill for the code has been met. Alternatively, OTPs may choose to adopt weekly billing cycles that vary across patients. Under this approach, the initial date of service will depend upon the day of the week when the patient was first admitted to the program or when Medicare billing began. Therefore, under this approach of adopting weekly billing cycles that vary across patients, when a patient is beginning treatment or re-starting treatment after a break in treatment, the date of service would reflect the first day the patient was seen and the date of service for subsequent consecutive episodes of care [meaning 7 day cycle or week] would be the first day after the previous 7-day period ends. For the codes describing add-on services (HCPCS codes G2076-G2080), the date of service should reflect the date that service was furnished; however, if the OTP has chosen to apply a standard weekly billing cycle, the date of service for codes describing add-on services may be the same as the first day in the weekly billing cycle."

**NOTE: Information in brackets has been added by OASAS. OASAS recommends that providers chose the standard billing cycle option, with that standard cycle running from Monday to Sunday. This cycle comports with the normal Medicaid billing cycle of Monday to Sunday, which is currently optional (though by far the most common way to bill Medicaid) and could become mandatory again in the not to distant future).*

Billing Medicare

The Medicare claim may be submitted to Medicare on the professional claim form (837p) or the institutional claim form (837i). Which claim form is used depends on which enrollment form the provider uses to enroll in Medicare, the CMS-855B for use of the 837p or the CMS-855A for use of the 837i. If the 837i is used to bill Medicare, and the Medicaid rate code is included on the Medicare claim, the claim can automatically crossover to Medicaid. **When billing in that manner, in addition to putting the Medicare G codes on the claim, the biller should also put the applicable Medicaid rate code and Medicaid (APG) procedure codes on the claim. Medicare will ignore any procedure code that does not begin with G on an OTP claim, but the inclusion of the non-G codes should facilitate the appropriate Medicaid payment amount upon crossover.** If the biller submits to Medicare on the 837p they will need to manually crossover the claim on the 837i (see guidance below). If the biller submits to Medicare on the 837i but omits the Medicaid procedure codes, they will need to adjust the claim created by the auto crossover to include the Medicaid procedure codes so the correct Medicaid "higher of" payment can be calculated. If the Medicaid procedure codes are included on the Medicare 837i claim, Medicare will issue CARC codes representing the denial. At this point it looks like Medicaid won't cover those procedure codes unless the line level Medicare denial CARC codes are moved to the header of the claim (thus requiring a manual crossover). OASAS is working with eMedNY to attempt to resolve this issue.

IMPORTANT NOTE: CMS has officially informed OASAS (see fact sheet link above) that a provider may switch from using the 837p to the 837i by reenrolling with CMS using the CMS-855A and that reenrollment will be retroactive to the original enrollment date under the CMS-855B if so desired.

The Medicare claim includes the G code(s) representing the appropriate bundle and add-ons (as applicable), plus whatever intensity add-on codes (noted above) that may apply. The OTP may bill Medicare using the same day of the week for all patients, using the first day of the seven contiguous days as the date of service (regardless of the actual dates of service within the billing cycle). Or the OTP can vary the start dates for each cycle by patient. Again, OASAS recommends that providers bill Medicare on a Monday – Sunday standard cycle (and, in turn, do the same for Medicaid). The G code for the bundle will always have a date of service that coincides with the start date of the seven-day billing cycle (week). Add-on codes may use the actual date of service or the date of service that coincides with the start date of the seven-day billing cycle. To quote the Medicare billing guidance, "The date of service for HCPCS codes G2078 and G2079 may reflect either the actual date you provided the medication to the beneficiary or may correspond with the first day in the weekly billing cycle for the week in which the beneficiary received the take-home supply of medication."

NOTE: Normally, the Medicare and Medicaid claims must be for 7 contiguous days with the same start date on each claim. However, for the week that includes January 1,

2020, the Medicare claim may cover fewer than 7 days and have a different start date from that of the Medicaid claim – but it must have the same end date as the Medicaid claim that includes January 1, 2020. For example, the Medicaid claim covers the 7 days from December 30, 2019 to January 5, 2020. The Medicare claim should cover January 1, 2020 to January 5, 2020 (only 5 days). The Medicare claim must be submitted first. Then the Medicaid claim would be submitted with the December 30 start date and the Medicare paid amount as described below. ***This exception applies only to the claims that include the date January 1, 2020 – or for claims starting where the actual date of the provider's Medicare enrollment is after January 1, 2020 and also not the first day of their standard weekly billing cycle.***

Billing Medicaid for Duals: Automatic or Manual Crossover

There are two options for Medicaid billing when a dual eligible individual is involved; automatic crossover from Medicare or manual crossover. Typically for all claims except those involving retroactive billing, the provider will bill Medicare on the 837i and include the Medicaid rate code and procedure codes on the claim. This will allow an automatic crossover wherein the claim will be processed by Medicare and then automatically crossed over to process any additional payment by Medicaid. No separate additional claim to Medicaid is necessary. This is the simplest, most convenient and most accurate way to bill for a dual eligible. However, automatic crossover billing applies only for persons in straight Medicare (Part B). If the person is enrolled in a Medicare Advantage Plan, the claim must be manually crossed over to Medicaid (or to Medicaid Advantage Plus, if the person is in a MAP plan – see table below).

NOTE: There have been problems reported with automatic crossover relative to CARC codes placed on the claim by Medicare. We are working with eMedNY to resolve these issues and will issue additional guidance when the problems are resolved. If you are experiencing problems with automatic crossover, manual crossover may be the only option. However, given that the volume of duals eligible for a higher of payment by Medicaid is minimal it is expected that any need for manual cross-over claiming will be limited and unlikely to be a substantial burden.

For manual crossover, once the claim submitted to Medicare (or Medicare Advantage) has been adjudicated, and the Medicare Paid Amount is known, the provider can bill Medicaid. The provider must bill Medicaid using the 837i claim form and include the appropriate Medicaid OTP rate code, as well as the procedure codes that describe the services delivered (both those G codes used for the Medicare billing and those procedure codes used for Medicaid APG billing, coding Medicaid procedures daily at the line level). Additionally, the claim must include all Medicare payment information associated with that claim. This is provided by including all Claim Adjustment Reason Codes (CARC codes) from the Medicare claim on the Medicaid claim. These codes include information on the Medicare Calculated Amount, the Medicare Paid Amount,

and the Medicare Coinsurance (Deductible) attributable to the Medicare claim. NOTE: Again, we are finding problems with automatic crossover relative to CARC codes placed on the claim by Medicare. We are working with eMedNY to resolve these issues and will issue additional guidance when the problems are resolved.

The following rules apply to claims submitted in a manual crossover:

1. The Medicaid claim must have the same start date as the Medicare claim and cover the same seven contiguous days.
2. The Medicaid claim must include the G code(s) from the Medicare claim with the same date(s) of service. These codes do not pay in APGs, but they still must be coded on the Medicaid claim. The Medicaid claim must also include all applicable Medicaid APG rate and procedure codes.
3. The Medicaid claim must include the Medicare Paid Amount (the total paid for all G codes on the Medicare claim) in the **header** of the Medicaid claim. Do not put this information on the claim lines of the Medicaid claim. The Medicare Calculated Amount and Medicare Deductible information must also be included on the Medicaid claim. All CARC code information from the Medicare claim must be included on the Medicaid claim.

Non-APG billers (i.e., some FQHCs) should use their usual Medicaid rate code. They must include the G code(s) on their Medicaid claim and put the Medicare Paid Amount in the header of the claim.

Retroactive Claiming to Medicare

Most OTP providers were not approved as an OTP provider to bill the new bundled rates to Medicare early in 2020 and they continued to bill Medicaid for dual eligibles. This has resulted in a large Medicaid overpayment to providers and gross underpayment by Medicare. To correct these issues and ensure Medicaid is the payor of last resort, providers must retroactively bill Medicare. In so doing, they can either:

1. Void the Medicaid claim, bill Medicare, have the Medicare claim adjudicate, and then rebill to Medicaid only those claims with Medicaid liability (use delay reason code 7 – explained below). The from and through dates on the Medicare and Medicaid claims must coincide. **It is extremely important that the from date on both claims coincide.** If the from dates on the claims are not the same, the biller could be liable for fraudulent billing. The provider only has one year from the date of service to bill Medicare. The Medicaid claim under this scenario will not encounter a timely filing issue, if submitted within 30 days after the Medicare claim adjudicates.

2. Get paid by Medicare and then adjust (or void) the Medicaid claims as appropriate. Adjust if there is Medicaid liability, void if there is none. Again, the

from and through dates on the Medicare claim must coincide with those of the already submitted Medicaid claim. The adjustment to the Medicaid claim under this scenario should not encounter a timely filing issue so long as it is done within a reasonable amount of time.

Crossover Possibilities

Medicare Coverage	Medicaid Coverage	Type of Crossover
Straight Medicare Part B	Medicaid FFS, or Mainstream Medicaid Managed Care, HARP or MLTC (Medicaid Partial Capitation Plan)	Automatic to FFS Medicaid (because OTP is a not in the MLTC benefit package and dual eligible are not enrolled in Medicaid Managed Care. Billable to FFS Medicaid).
Medicare Advantage	Medicaid FFS, or Mainstream Medicaid Managed Care, HARP or MLTC (Medicaid Partial Capitation Plan)	Manual to FFS Medicaid.

NOTE: During the COVID emergency, automatic disenrollments from Medicaid, or from any form of Medicaid Managed Care, did not occur. Providers should bill Medicaid based on the enrollment information shown in ePACES and not based on any other criteria.

Penalties

Medicaid is the payor is of last resort. OTP providers MUST enroll in Medicare as soon as they are eligible. Medicare enrolled OTPs must bill Medicare as primary and Medicaid as secondary for dual eligible enrollees.

Failure to bill Medicare for OTP services provided to a dual eligible may constitute Medicaid fraud. Failure to provide the Medicare Paid Amount on the APG claim may constitute Medicaid fraud. Providers should be aware there are various degrees of penalties for failure to bill in accordance with these guidelines, including possible criminal penalties.

Higher of Payment Logic

As with many mental hygiene outpatient services provided to dual eligibles in outpatient settings, Medicaid will pay the difference between the Medicaid calculated amount and the Medicare paid amount if the Medicaid calculated amount is higher. If the reverse is true, Medicaid will pay zero. Submission of claim to Medicaid is optional and should generally be done only when Medicaid is believed to have some liability.

Timely Billing

Medicaid regulations require that claims for payment of medical care, services, or supplies to eligible beneficiaries be initially submitted within 90 days of the date of service to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider. All such claims submitted after 90 days must be submitted within 30 days from the time submission came within the control of the provider and contain the appropriate delay reason code. Per regulation, claims must be submitted to Medicare and/or other Third-Party Insurance before being submitted to Medicaid. If the Medicaid claim comes in more than 90 days after the date of service, but within 30 days from the time the submission came within control of the provider, delay reason code 7 (Third-Party Processing Delay) applies. This delay reason applies when processing by Medicare or another payer (a third-party insurer) caused the delay. Again, claims must be submitted within 30 days from the date submission came within the control of the provider. Delayed claims that comply with the use of reason code 7 may be submitted electronically. If, for some reason, a paper claim is submitted, the EOB must be included with the claim. Providers that have delays for other reasons should contact OASAS to determine if another delay reason code applies.

Important Information Regarding the Level of Medicaid Payment Relative to Medicare

In the earlier drafts of this guidance and conversations with providers, OASAS indicated that it expected crossover to Medicaid (whether automatic or manual) for duals would be mandatory. After further examination, OASAS has determined that crossover is optional. Generally, Medicaid should only be billed when there is liability on the part of Medicaid, either for a deductible and/or for the “higher of”. If providers want to forgo Medicaid participation all together, they may do so. That is illustrated by the table below:

AVERAGE OTP PAYMENT - Medicare Weekly Bundle versus Weekly APG Claim

Medicare Region	Medicare Payment for Methadone Bundle (2021)	Medicaid Average Weekly APG Payment	Difference	% Diff
Manhattan	$ 240.67	$ 205.80	$ 34.87	16.9%
Queens	$ 247.27	$ 205.80	$ 41.47	20.2%
Rest of NYC, Long Island, Rockland, Westchester	$ 246.23	$ 205.80	$ 40.43	19.6%
Hudson Valley	$ 227.54	$ 205.80	$ 21.74	10.6%
Rest of State	$ 205.71	$ 143.49	$ 62.22	43.4%

As seen from the table, Medicare methadone bundles pay between 10 and 43 percent more than the **average** APG weekly claim. Since there are various issues with crossover which could lead to higher billing expenses, providers may choose to submit a claim to Medicaid for a dual when deductibles and/or higher of are owed – or possibly, for some providers, to forgo Medicaid billing all together if the savings on billing expenditures are expected to outweigh any potential Medicaid revenues.