Medicaid Billing Guidance for NYS OTPs

Introduction

On March 16, 2020, during the COVID-19 Emergency, the use of bundle billing regarding Opioid Treatment programs (OTPs) became effective. The purpose of bundle billing at the time was to lessen the need for face-to-face time with the provider, and to allow for reimbursement for dispensing of longer duration take home medication.

On March 17, 2021, CMS approved weekly Opioid Treatment Program (OTP) bundled fees as a permanent alternative to the OTP Ambulatory Patient Group (APG) methodology. The new permanent OTP bundled fee amounts became effective as of August 2, 2021. An adjustment to the COVID OTP Bundle rate was made to accommodate Medicare bundles and regional factors.

Since the initial COVID implementation of bundle billing many changes have taken place regarding claiming and billing rules. This document is meant to give the most up to date information on bundle billing. Along with providing the updates at the end of this document there are FAQ’s to answer the most frequently asked provider questions.

Questions regarding this guidance and/or bundle billing should be emailed to PICM@oasas.ny.gov.

General Billing Guidelines

APG Methodology

Claims Submission: OTP’s should continue to submit weekly claims. Providers can submit bundle claims if qualifying criteria are met and/or APG reimbursement for those services that fall outside of bundle billing rules. Please note that qualifying services should not be billed in a bundle and an APG claim during the same service week.

One of the following qualifying services must be provided to use bundle billing:

- Assessment
- Psychiatric Evaluation
- Individual Counseling
- Group Counseling
- Medication Administration/Observation
- Medication Management
- Addiction Medication Induction
**Toxicology testing**, though not a specific clinical service, is covered under the OTP Bundle when provided as within one of the above qualifying services. The lab should not bill Medicaid, but instead bill the provider for the service.

**Fentanyl** presumptive testing is the exception to this rule. As of April 2023, Fentanyl confirmatory testing was added to the Medicaid lab fee schedule. As such, Fentanyl confirmatory testing has been carved out of the OTP APG Rate, and the OTP Bundles. Labs can bill Medicaid directly for the Fentanyl confirmatory testing.

If the *only* service provided is a non-qualifying service then APG’s should be used for that service.

If *both* qualifying and non-qualifying services occurred, then the provider can:
- bill the full bundle for the qualifying service(s) and APGs for the non-qualifying service(s), **OR**
- submit a single APG claim to Medicaid for all of the services if they so choose and the patient is not a dual Medicaid/Medicare.

**Bundle Rate Codes:**

There are two categories for bundle billing:
- Dispensing and qualifying service – when dispensing and qualifying service occur in same week.
- Take-home supply – for weeks when take home meds are provided but no clinical service.

**Billing Example:**

During week¹ one of a four-week period, the provider (a freestanding OTP) sees the patient on Wednesday of the first week and dispenses a 28-day supply of methadone. During week two there is no further contact. During week three, the provider does counseling using telemedicine. During week four there is no face-to-face contact, but there is telephonic med admin contact

Week 1 – Bill 7969, using G2067, and a Monday date of service. Do not bill APGs.

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¹ Monday is the first day of the billing week
Week 2 – Bill 7970, using G2068 (or H0020), and a Monday date of service. Do not bill APGs.
Week 3 – Bill 7969, using G2067, and a Monday date of service. Do not bill APGs.
Week 4 – Bill 7969, using G2067, and a Monday date of service. Do not bill APGs.

**Bundle Rate Codes:**

7969 (COS 0160) and 7973 (COS 0287): Methadone dispensing and/or qualifying clinical service.
- Qualifying clinical service, **AND/OR**
- Medication Administration Service or Methadone from a previously supplied take home.

7971 (COS 0160) and 7975 (COS 0287): Buprenorphine dispensing and/or qualifying clinical service.
- Qualifying clinical service, **AND/OR**
- Medication Administration Service or Buprenorphine from a previously supplied take home.

7970 (COS 0160) and 7974 (COS 0287): Methadone Take Home Supply.
- No qualifying clinical service.
- Methadone available from a previously supplied take home.

7972 (COS 0160) and 7976 (COS 0287): Buprenorphine Take Home Supply.
- No qualifying clinical service.
- Buprenorphine available from a previously supplied take home.

**Procedure Codes on line level with the bundle rate codes:**

**For Medicaid:**
- **Full Bundle** Methadone: G2067
- **Take Home** Methadone: G2078

- **Full Bundle** Buprenorphine: G2068
- **Take Home** Buprenorphine: G2079

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2 COS 160 is for Free Standing Programs; COS 287 is for Hospital Based.
For Medicare clients billing on the Full bundle (rate codes xxx) following procedure codes should be used:

- G2067 with G2076 add on code
- G2067 with G2077 add on code for Psychiatric Evaluation(s)

**Take Home Methadone:** Include G – codes for Take Homes at the line level of the Full Bundle Claim.

**FQHC Billing:**

FQHC’s who have opted into the APG reimbursement methodology can bill as given in the above section on Claims Submission. For those FQHC’s who have opted out of APG’s they can continue to utilize their 1671 weekly rate code **OR** they can utilize the weekly Full bundle billing, they **CANNOT** bill both for the same service week. Further if the provider bills the weekly bundle for qualified clinical services, they **CANNOT** additionally/separately bill for services that do not qualify for the Full bundle.

**For dual eligibles,** the FQHC must bill the Medicare bundles to the extent possible. Then they should cross that claim over to Medicaid on a Medicaid bundle rate code. If they are an APG biller, they may bill Medicaid directly, under APGs, for any services provided during the week that are not covered by the Medicaid bundles or add-ons (see Non-Medicare Services Provided to Duals).

**Guest Dosing**

The OTP bundles are not to be used for guest dosing (meaning the serving of a patient who is enrolled at another provider’s OTP) and must utilize the APGs.
Billing for Dual Eligibles Medicare/Medicaid

Seeking reimbursement for those with Medicare/Medicaid can provide a challenge for providers due to the different claiming rules, reimbursement amounts, and for those providers who have not yet been enrolled as a Medicare provider.

- Reimbursement amount: Medicare reimbursement amounts are set at the Federal level whereas Medicaid is set by the state, therefore the reimbursement rates may be different.
- If a provider is not yet enrolled in Medicare, they will not be able to seek Medicare bundle billing and will have to process utilizing the APG Methodology and submitting to Medicaid only. Providers can still bill the Medicaid bundle, but the Medicaid bundle is paid at lower reimbursement than the Medicare bundle.

Crossover Claiming

General Claiming Steps:

1. Submit the claim to Medicare utilizing the bundle G codes as given in the previous section. Do not list the APG procedure codes on the Medicare claim form.
2. Once you receive the remittance from Medicare
   a. submit the claim to Medicaid including the Medicare remittance information.
   b. utilize the rate codes and the Medicaid procedure (G codes) as given in the previous section, as well as the associated APG Procedure Code(s).
   c. If the Medicaid rate is higher than the Medicare rate, Medicaid will reimburse the difference.

The Provider can bill Medicaid directly for “non-qualifying” services, such as smoking cessation, peers, and medical services unrelated to intake activities or assessments. The provider, using the APG procedure codes and rate code, can zero-fill the Medicare Payment information as they have been doing.

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3 Medicare Advantage plans rules may differ
Billing for Duals in a Skilled Nursing Facility

Generally speaking, the nursing home Medicare rate is considered to be “payment in full” for any day during which the patient resides in the nursing home. As such, an OTP cannot bill Medicare for services provided to a nursing home resident. The OTP must obtain whatever payment they can directly from the nursing home.

Exceptions:

Medicaid Nursing Home benefit exhausted:

- If a dual-eligible has exhausted their nursing home benefit and Medicaid is paying for the nursing home, Medicare should pay the OTP claim with the remainder being crossed over to Medicaid.
- If it is determined that Medicare will not pay, you can bill Medicaid with a zero fill of the Medicare information once you receive the denial.
- **Do not** bill Medicaid without first attempting to get payment from Medicare.

**Medicaid Advantage Plans:**

For those in long term care who are enrolled in a Medicaid Advantage Plan (MAP) The MAP Plan is required to pay for OTP services regardless of the service type.

Billing for Persons Enrolled in Both OTP and Outpatient Clinic/Rehab

For individuals admitted to an OTP who receive additional services at an Outpatient Clinic (OPC) or Outpatient Rehab (OPR) Bundle Billing is available. However, if a person is billed against the Medicaid OTP full bundle for a given week, that bundled payment constitutes payment in full for all OTP/OPC/OPR qualifying services. Therefore, no Medicaid billing is allowed for that person for Clinic/Rehab services covered by the full bundles.

The billing of the OTP full bundle by one provider agency does not preclude a different provider agency from billing for that person under APGs for that same week in the Clinic/Rehab. The OTP could bill for the bundle while the Clinic/Rehab can claim non-qualifying services via APG’s for the same week of service.

**CCBHCs and the Medicaid Bundles**

CCBHC’s can utilize bundle billing. However, if a CCBHC bills the full bundle for a given week, they cannot submit any claims under their CCBHC rate code for qualifying bundle services for that service week. They may submit a CCBHC claim for non-qualifying services that are not covered by the Medicaid full bundle.
If Medication Administration/Observation is carved out of the CCBHC’s 1147 rate code rate calculation, the CCBHC should bill the recipient’s Medication Administration/Observation service utilizing APGs. Providers would then bill their CCBHC rate for counseling and other medical services.

For dual eligibles, the CCBHC must bill the Medicare bundles to the extent possible. Then they should cross that claim over to Medicaid on a Medicaid bundle rate code. They may bill their CCBHC rate for any services provided during the week that are not covered by the Medicaid bundles or add-ons (see Non-Medicare Services Provided to Duals).

Questions can be directed to PICM@oasas.ny.gov

Resources:

- Dual Billing Guidance for Opioid Treatment Programs
- Guidance on OTP Bundled Codes & Fees (August 2021)
- CMS Permanent Approval of Bundles
- COVID-19 Billing Guidance for OTPs (March 2021)
- Ambulatory Patient Group Manual
- Reimbursement Rates for OTP’s