Office of Addiction Services and Supports

OASAS OTP Bundle Billing Guidance

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Medicaid Billing Guidance for NYS OTPs

Introduction

On **March 17, 2021**, CMS approved weekly Opioid Treatment Program (OTP) bundled fee billing in NYS Medicaid as an alternative to the OTP Ambulatory Patient Group (APG) methodology. The NYS OTP bundled fee methodology became permanent on **August 2, 2021**. This document is meant to give the most up to date information on bundle billing.

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

General Billing Guidelines

APG Methodology

Claims Submission: OTPs should continue to submit weekly claims. Providers can submit bundle claims if qualifying criteria are met, or they can opt for APG reimbursement for any given week. If they choose the bundle for a given week, they can also submit an APG claim if they also provide services that are outside of bundle. Please note that qualifying services for the bundle may not be billed under the bundle and on an APG claim during the same service week.

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

- Individual Counseling
- Group Counseling
- Medication Administration/Observation
- Medication Management

Toxicology Testing

Presumptive Toxicology testing (screening) is covered under the OTP Bundle. The lab should not bill Medicaid for the screen, but instead bill the OTP for the service.

As of April 2023, 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 Fentanyl confirmatory testing (80354).

The table below shows what should be billed under the bundle and what should be billed to APGs *for a week when the bundle option is being used*.

	MEDICARE			MEDICAID	
Service	**Medicare Bundle**	**Medicare Add-ons**	**Medicare Fee Schedules ***	**Medicaid Bundle**	**APGs**
Medication Administration/Observation	X			X	
Medication Management	X			X	
Individual/Group Counseling	X			X	
Toxicology testing	X			X	
Intake activities/assessments		X			X
Periodic assessments		X			X
Unrelated Medical Visits			X		X
Peers					X
Smoking Cessation			X		X
Psychiatric Evaluation		X			X

* If practitioner is enrolled in Medicare.

If ***only non-qualifying services are provided,*** then APGs must be used for that service.

If ***both*** qualifying and non-qualifying services occurred, then the provider can either:

- 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 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:

1. <u>Full bundle</u>: which includes medication administration and/or other and qualifying services.
2. <u>Take-home supply</u>: for weeks when take-home meds are provided but no clinical services that are part of the full bundle are provided.

Full Bundle Rate Codes:

7969 (COS 0160[1]) and 7973 (COS 0287): Methadone dispensing and/or qualifying clinical service.

- Qualifying clinical service

[1] COS 160 is for Free Standing Programs; COS 287 is for Hospital Based.

- Procedure code G2067

7971 (COS 0160) and 7975 (COS 0287): Buprenorphine dispensing and/or qualifying clinical service.

- Qualifying clinical service
- Procedure code G2068

Take-home Supply Rate Codes:

7970 (COS 0160) and 7974 (COS 0287): Methadone Take Home Supply.

- No qualifying clinical service.
- Methadone available from a previously supplied take home supply.
- Procedure code G2078 (Earlier guidance had mandated code H0020. Providers may still use H0020 at their discretion, but G2078 is recommended. Do not code more than one procedure code on the claim).

7972 (COS 0160) and 7976 (COS 0287): Buprenorphine Take Home Supply.

- No qualifying clinical service.
- Buprenorphine available from a previously supplied take home supply.
- Procedure code G2079 (Earlier guidance had mandated code H0033. Providers may still use H0033 at their discretion, but G2079 is recommended. Do not code more than one procedure code on the claim).

The take-home supply weekly bundles (rate codes 7970, 7974, 7972, and 7976) are billable only when no clinical contact occurs during the week and the patient was previously dispensed, by the OTP, their supply of take-home medication for that week. Medicare prefers to see the take-home G codes (e.g., G2078) on a claim with the full bundle (e.g., G2067), but for FFS Medicare the take-home G codes can be submitted on their own claim. Medicare Advantage plans rules may differ. For Medicaid billing, the take-home codes must be on their own claim since they are associated with a different set of rate codes than are used for the full bundles. The "from" date on the take-home claim should be the Monday of the week during which the take-home is intended to be consumed.

Billing Example:

1. For a New Patient

Week	Services	Reimbursement
One	• Assessment visit • Medical Exam • Three separate counseling session received during the week. • Three-Medication Administrations	Choose the higher of, either: • Bill the full bundle for all services included in the bundle and APGs for the services outside of the bundle (e.g., Medical Exam) **OR** • Bill APGs for all services on a single claim
Two	• Two medication administrations • Two separate counseling sessions (including a brief treatment)	Choose the higher of, either: • Bill the full bundle for all delivered services (since all are part of the bundle) **OR** • Bill APGs for all services on a single claim
Three	• Psychiatric Evaluation • One Smoking Cessation • Two medication administrations	• Bill the bundle for the medication administration **AND** • Bill APGs for the Psychiatric Evaluation and the Smoking Cessation
Four	• One medication administration • No counseling	• Bill the full bundle (the provider could bill APGs, but the bundle will pay more)

*Note: Weekly billing cycle is Monday to Sunday

2. An Existing Patient with one week of no medication

Week	Services	Reimbursement
One	• One medication administration • No counseling	• Bill the full bundle
Two	Patient refuses medication AND receives: • Counseling (to discuss with patient reinstatement of medication) • Peer Services	Choose the higher of, either: • Bill the full bundle for the counseling AND APGs for Peer Services **OR** • Bill APGs for counseling and Peer Services
Three	Patient Reinstates Medication: • One medication administration • One Medication Management	• Bill the full bundle
Four	• One medication administration • No counseling	• Bill the full Bundle

*Note: Weekly billing cycle is Monday to Sunday

3. An Existing Patient with two weeks of Take-home medication and no face-to-face or telephonic "qualifying service"

Week	Services	Reimbursement
One	• One medication administration with two weeks of take-home supply (for week one and week two). • No counseling	• Bill the full bundle
Two	• No Services Provided	• Bill Take-home Supply Bundle
Three	• Psychiatric Evaluation • One Smoking Cessation • One medication administration with two weeks of take-home supply (for week three and week four).	• Bill the bundle for the Medication Administrations **AND** • Bill APGs for the Psychiatric Evaluation and the Smoking Cessation
Four	• No Services Provided	• Bill Take-home Supply Bundle

*Note: Weekly billing cycle is Monday to Sunday

FQHC Billing:

FQHCs that have opted into the APG reimbursement methodology can bill as given in the above section on Claims Submission. For those FQHCs that have opted out of APGs they can continue to utilize their 1671 weekly rate code **OR** they can utilize weekly bundle billing, they **CANNOT** bill both 1671 and a bundle in the same week. 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). Bill guest dosing under APGs.

Billing for Dual Eligibles Medicare/Medicaid[2]

All new OTPs are expected to enroll in Medicare as quickly as possible. Medicare enrollment is not optional, and Medicare allows all OTP services to be billed to Medicare

[2] Medicare Advantage plans rules may differ

regardless of the practitioner's type and Medicare enrollment status as long as the provider agency is enrolled as a Medicare OTP biller.

Crossover Claiming

Submit the claim to Medicare utilizing the appropriate G code(s) for Medicare OTP billing. Do not list any APG procedure codes on the Medicare claim. The Medicare claim with the G code(s) can be crossed over to Medicaid under an OTP bundle rate code to obtain the patient responsibility (if any).

Any services not included in the Medicaid full bundle can be billed directly to Medicaid on a separate APG claim with a zero fill to the Medicare payment information.

Furthermore, if a dual eligible person receiving services is enrolled in a Medicare Advantage Plan, automatic crossover is not available, and the claim must be manually crossed over to Medicaid.

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 APGs 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 is carved out of the CCBHC's 1147 rate code rate calculation, the CCBHC should bill the recipient's Medication Administration 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

CMS Permanent Approval of Bundles

Ambulatory Patient Group Manual

Reimbursement Rates for OTP's