



OPIOID TREATMENT PROGRAMS (OTPs) MEDICARE BILLING AND PAYMENT FACT SHEET

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 10212

☐ PICA
☐ MEDICARE
☐ MEDICAID
☐ TRICARE
☐ CHAMPVA
☐ OTHER (ID#)

1. PATIENT'S NAME (Last Name, First Name, Middle Initial)
2. PATIENT'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

3. PATIENT'S BIRTH DATE
MM DD YY
a. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐
b. RESERVED FOR NUCC USE

4. INSURED'S ID NUMBER
5. INSURED'S NAME (Last Name, First Name, Middle Initial)
6. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

7. INSURED'S POLICY GROUP OR FECA NUMBER
8. INSURED'S DATE OF BIRTH
MM DD YY
9. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous)
YES ☐ NO ☐

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous)
YES ☐ NO ☐

11. INSURED'S POLICY GROUP OR FECA NUMBER
12. INSURED'S DATE OF BIRTH
MM DD YY

13. INSURED'S NAME (Last Name, First Name, Middle Initial)
14. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

15. INSURED'S POLICY GROUP OR FECA NUMBER
16. INSURED'S DATE OF BIRTH
MM DD YY

17. INSURED'S NAME (Last Name, First Name, Middle Initial)
18. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

19. INSURED'S POLICY GROUP OR FECA NUMBER
20. INSURED'S DATE OF BIRTH
MM DD YY

21. INSURED'S NAME (Last Name, First Name, Middle Initial)
22. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

23. INSURED'S POLICY GROUP OR FECA NUMBER
24. INSURED'S DATE OF BIRTH
MM DD YY

25. INSURED'S NAME (Last Name, First Name, Middle Initial)
26. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

27. INSURED'S POLICY GROUP OR FECA NUMBER
28. INSURED'S DATE OF BIRTH
MM DD YY

29. INSURED'S NAME (Last Name, First Name, Middle Initial)
30. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

31. INSURED'S POLICY GROUP OR FECA NUMBER
32. INSURED'S DATE OF BIRTH
MM DD YY

33. INSURED'S NAME (Last Name, First Name, Middle Initial)
34. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

35. INSURED'S POLICY GROUP OR FECA NUMBER
36. INSURED'S DATE OF BIRTH
MM DD YY

37. INSURED'S NAME (Last Name, First Name, Middle Initial)
38. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

39. INSURED'S POLICY GROUP OR FECA NUMBER
40. INSURED'S DATE OF BIRTH
MM DD YY

41. INSURED'S NAME (Last Name, First Name, Middle Initial)
42. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

43. INSURED'S POLICY GROUP OR FECA NUMBER
44. INSURED'S DATE OF BIRTH
MM DD YY

45. INSURED'S NAME (Last Name, First Name, Middle Initial)
46. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

47. INSURED'S POLICY GROUP OR FECA NUMBER
48. INSURED'S DATE OF BIRTH
MM DD YY

49. INSURED'S NAME (Last Name, First Name, Middle Initial)
50. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

51. INSURED'S POLICY GROUP OR FECA NUMBER
52. INSURED'S DATE OF BIRTH
MM DD YY

53. INSURED'S NAME (Last Name, First Name, Middle Initial)
54. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

55. INSURED'S POLICY GROUP OR FECA NUMBER
56. INSURED'S DATE OF BIRTH
MM DD YY

57. INSURED'S NAME (Last Name, First Name, Middle Initial)
58. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

59. INSURED'S POLICY GROUP OR FECA NUMBER
60. INSURED'S DATE OF BIRTH
MM DD YY

61. INSURED'S NAME (Last Name, First Name, Middle Initial)
62. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

63. INSURED'S POLICY GROUP OR FECA NUMBER
64. INSURED'S DATE OF BIRTH
MM DD YY

65. INSURED'S NAME (Last Name, First Name, Middle Initial)
66. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

67. INSURED'S POLICY GROUP OR FECA NUMBER
68. INSURED'S DATE OF BIRTH
MM DD YY

69. INSURED'S NAME (Last Name, First Name, Middle Initial)
70. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

71. INSURED'S POLICY GROUP OR FECA NUMBER
72. INSURED'S DATE OF BIRTH
MM DD YY

73. INSURED'S NAME (Last Name, First Name, Middle Initial)
74. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

75. INSURED'S POLICY GROUP OR FECA NUMBER
76. INSURED'S DATE OF BIRTH
MM DD YY

77. INSURED'S NAME (Last Name, First Name, Middle Initial)
78. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

79. INSURED'S POLICY GROUP OR FECA NUMBER
80. INSURED'S DATE OF BIRTH
MM DD YY

81. INSURED'S NAME (Last Name, First Name, Middle Initial)
82. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

83. INSURED'S POLICY GROUP OR FECA NUMBER
84. INSURED'S DATE OF BIRTH
MM DD YY

85. INSURED'S NAME (Last Name, First Name, Middle Initial)
86. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

87. INSURED'S POLICY GROUP OR FECA NUMBER
88. INSURED'S DATE OF BIRTH
MM DD YY

89. INSURED'S NAME (Last Name, First Name, Middle Initial)
90. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

91. INSURED'S POLICY GROUP OR FECA NUMBER
92. INSURED'S DATE OF BIRTH
MM DD YY

93. INSURED'S NAME (Last Name, First Name, Middle Initial)
94. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

95. INSURED'S POLICY GROUP OR FECA NUMBER
96. INSURED'S DATE OF BIRTH
MM DD YY

97. INSURED'S NAME (Last Name, First Name, Middle Initial)
98. INSURED'S ADDRESS (No., Street)
CITY
STATE
ZIP CODE

99. INSURED'S POLICY GROUP OR FECA NUMBER
100. INSURED'S DATE OF BIRTH
MM DD YY

TARGET AUDIENCE

OTP Providers

CONTENTS

BACKGROUND/PURPOSE	3
COVERED OPIOID USE DISORDER (OUD) TREATMENT SERVICES	3
Who Can Provide OTP Services?	4
ENROLLING IN MEDICARE EDI	5
CHECKING MEDICARE BENEFICIARY ELIGIBILITY FOR OTP SERVICES	5
How to Reach the HETS Help Desk	6
CODING AND BILLING FOR OTP SERVICES	7
Coding for Medication Assisted Treatment (MAT) and Add-On Codes	7
MAT codes, Descriptors, and National Medicare Payment Rates	8
Frequency of Use and Other Billing Guidelines	11
SUBMITTING CLAIMS TO YOUR MAC OR BILLING AGENT	12
Include the following information on each claim form:	12
Date of Service	14
PAYMENT AND REMITTANCE ADVICE	15
ISSUES WITH PAYMENT	15
CHECK CLAIMS STATUS	15
Interactive Voice Response (IVR) System	15
Customer Service Representative (CSR)	15
MAC Portals	15
Health Care Claim Status Request (276 Transaction)	16
BILLING & PAYMENT FOR MEDICARE/MEDICAID DUAL ELIGIBLE BENEFICIARIES	16
Need More Information?	17
RESOURCES	17

BACKGROUND/PURPOSE

Beginning January 1, 2020, Medicare will pay Medicare-enrolled Opioid Treatment Programs (OTPs) to deliver opioid use disorder (OUD) treatment services to Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) is now accepting and processing OTP enrollment applications. For more information on how to enroll as an OTP provider, review the [Opioid Treatment Programs \(OTPs\) Medicare Enrollment Fact Sheet](#).

This fact sheet has information about:

- covered opioid use disorder (OUD) Treatment Services
- who can provide OTP services
- enrolling in Medicare Electronic Data Interchange (EDI)
- checking Medicare beneficiary eligibility
- coding and submitting claims for OTP services
- payment and remittance advice (RA)
- issues with payment
- how to check claims status
- helpful resources

For more information on this new **Part B** benefit for Medicare beneficiaries with OUD, visit the CMS [Opioid Treatment Programs](#) webpage, including [Frequently Asked Questions](#).

COVERED OPIOID USE DISORDER (OUD) TREATMENT SERVICES

Covered opioid use disorder treatment services include:

- 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

OTPs are defined by Medicare law as those who:

- are enrolled in Medicare
- are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA)
- are accredited by a SAMHSA-approved entity
- meet additional conditions to ensure the health and safety of individuals being furnished services under these programs and the effective and efficient furnishing of such services
- have in effect a provider agreement with CMS

Part B:

- As an OTP, you are a Part B provider.

Who Can Provide OTP Services?

OTP providers must be:

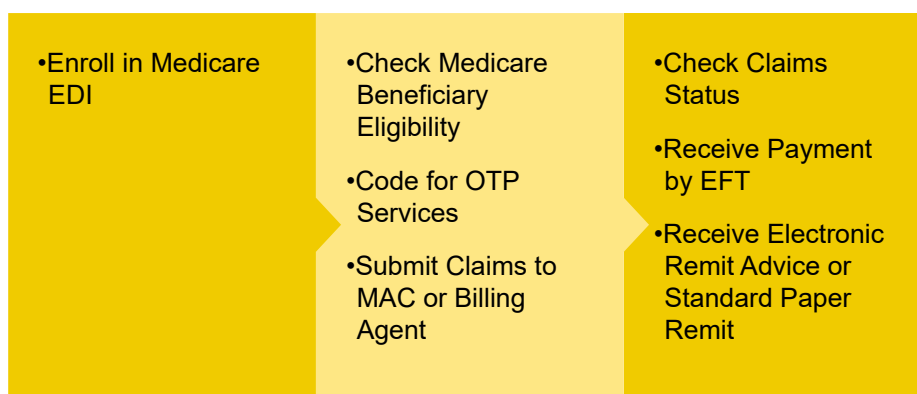
- enrolled in Medicare
- fully certified by SAMHSA
- accredited by an accrediting body approved by SAMHSA
- able to meet such additional conditions as the Secretary may find necessary to ensure the health and safety of individuals being provided services

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

- licensed clinical social workers
- licensed professional counselors
- licensed clinical alcohol and drug counselors
- certified peer specialists who are permitted to furnish this type of therapy or counseling by state law and scope of practice
- others who are permitted to furnish this type of therapy or counseling by state law and scope of practice

If the individuals furnishing therapy or counseling services are not authorized under state law to furnish such services, the therapy or counseling services provided by these professionals would not be covered as OUD treatment services.

Overview of OTP Billing/Payment Process



ENROLLING 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 Medicare Administrative Contractor (MAC) will give you information about enrolling in EDI. Each MAC has different instructions and methods for submitting EDI enrollment applications. Read your enrollment approval letter carefully and check your [MAC's website\(s\)](#) for instructions. Remember that you must complete the EDI enrollment process with each MAC to which you submit claims.

OTP providers must complete the [EDI Registration Form](#) and [EDI Enrollment Form](#) before you can submit electronic media claims (EMC) or other EDI transactions to Medicare. While each MAC's EDI enrollment application submission process may vary, OTP providers must give identifying information about the provider(s) who will submit electronic data.

OTPs who intend to submit EMC or use EDI, either directly with Medicare or through a billing service or clearinghouse, must complete the forms. Each new EMC biller must sign and submit the forms to their MAC(s) as instructed. 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, [contact your MAC](#).

After you complete EDI enrollment, your EDI contractor will help you with connectivity, system access numbers and passwords, and testing your EDI format transmissions. MACs have [EDI helplines](#) to help you.

Helpful Resources

- [Medicare Parts A/B and DME EDI Help Lines](#)
- [Medicare Claims Processing Manual \(Pub.100-04\), Chapter 24](#)
- [Electronic Billing & EDI Transactions webpage](#)

CHECKING MEDICARE BENEFICIARY ELIGIBILITY FOR OTP SERVICES

When you schedule appointments for Medicare beneficiaries, remind them to bring to their appointment all health insurance cards showing their health insurance coverage. This will help you determine who to bill for services, and give you the correct spelling of your Medicare patients' first and last names and Medicare beneficiary identifiers.

If your patient has Medicare coverage but does not have a Medicare Health Insurance card, encourage your patient to log into my.medicare.gov or call 1-800-MEDICARE (or 1-800-833-4455 if your patient gets benefits under the Railroad Retirement Board) to get a replacement Medicare Health Insurance card.

You can check your patient's Medicare eligibility in one of four ways:

1. Your vendor or clearinghouse can give you access to eligibility information for Medicare and other payers.
2. Your IT department can help you access eligibility information [directly from CMS through the HIPAA Eligibility Transaction System \(HETS\)](#).
3. Your [MAC portals](#) provide eligibility information.
4. You can also use the MACs Interactive Voice Response (IVR) systems.

You must have the following information to run an eligibility search: patient's Medicare beneficiary identifier (Medicare number), patient's full first and last name, and patient's date of birth.

You will get a basic set of eligibility information if your patient is entitled to Part A and/or Part B including:

- Medicare beneficiary demographics
- Part A and B entitlement including any periods of inactivity
- coverage status of requested and supported Service Type Codes (STCs)
- Medicare Secondary Payer (MSP), Medicare Advantage (MA), and Part D plan enrollment information (where applicable)
- deductible remaining

For more detailed information on this process, review the [CMS HETS 270/271 5010 Companion Guide, Section 7.2 General Transaction Notes](#).

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

How to Reach the HETS Help Desk

The HETS Desktop (HDT) Help Desk is open Monday through Friday from 7 am to 7 pm, Eastern Standard Time (EST). Contact the HDT Help Desk by:

- email at mcare@cms.hhs.gov or
- phone at 1-866-324-7315.

For more information, visit the [HETS Help Desk](#) webpage.

CODING AND BILLING FOR OTP SERVICES

Starting January 1, 2020, CMS pays for the overall treatment of OUD provided by an OTP. Any beneficiary with OUD is eligible for these services.

There are 14 billable OTP-only HCPCS G-codes (G2067 through G2080) for opioid treatment services on Medicare Part B claims. Only OTPs can bill Medicare using the specific codes for OTP services. No other provider or supplier type except for an OTP can bill for OTP services (billed using HCPCS codes G2067-G2080). However, the CY2020 Physician Fee Schedule includes bundled payment codes (billed using HCPCS codes G2086-G2088) and payment rates for an episode of opioid use disorder (OUD) treatment furnished by physicians and other practitioners in the office setting.

Coding for Medication Assisted Treatment (MAT) and Add-On Codes

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

CMS established HCPCS G-codes describing 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)
 - Bill for services furnished during an episode of care when a medication is not administered
 - **Example:** For example, in the case of a patient receiving injectable buprenorphine, we would expect that OTPs would bill HCPCS code G2069 for the week during which the injection was administered and you would bill HCPCS code G2074, which describes a bundle not including the drug, during any subsequent weeks when you furnish at least one non-drug service until you administer the injection again, at which time, you would bill HCPCS code G2069 again for that week.

Only OTPs can submit claims with codes G2067 through G2080.

The threshold to bill a full episode is that at least one service is furnished (from either the drug or non-drug component) to the patient during the week that corresponds to the episode of care. If no drug was provided to the patient during that episode, the OTP must bill the G-code describing a weekly bundle not including the drug (HCPCS code G2074) and the threshold to bill would be at least one service in the non-drug component. If a drug was provided with or without additional non-drug component services, the appropriate G-code describing the weekly bundle that includes the drug furnished may be billed.

All of the drugs that are FDA-approved for the treatment of OUD are currently covered by HCPCS codes G2067-G2073

- Medication not otherwise specified (G2075)
 - Use when you give Medication Assisted Treatment (MAT) services with a new opioid agonist or antagonist treatment medication approved by the FDA under Section 505 of the United States Federal Food, Drug, and Cosmetic (FFDCA) for the treatment of OUD

Additionally, CMS established 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)

CMS uses the typical or average maintenance dose to determine drug costs for each of the bundles.

CMS assigned [flat dollar payment amounts](#) for the codes describing the OTP bundled services (HCPCS codes G2067-G2080). See Table 18 of the [Final Rule \(CMS-1715-F and IFC\)](#).

Note: as an OTP provider, you must use only the codes describing bundled payments; do **not** use other codes, such as those paid under the [Physician Fee Schedule \(PFS\)](#). Only Medicare-enrolled OTPs can bill for HCPCS codes G2067-G2080.

MAT codes, Descriptors, and National Medicare Payment Rates

NOTE: Use the In the [Locality Key document](#) to find the locality and corresponding MAC numbers assigned to your OTP based on the State/Fee Schedule Area/County location of your practice.

Use the [Locality Adjusted Rates document](#) to find your locality and corresponding MAC numbers and then use the HCPCS code to find the geographically-adjusted payment rate.

G CODES	DESCRIPTORS FOR OTP BUNDLED SERVICES	DRUG COST	NON-DRUG COST	TOTAL COST
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).	\$35.28	\$172.21	\$207.49
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).	\$86.26	\$172.21	\$258.47

G CODES	DESCRIPTORS FOR OTP BUNDLED SERVICES	DRUG COST	NON-DRUG COST	TOTAL COST
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).	\$1,578.64	\$178.65	\$1,757.29
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).	\$4,918.98	\$407.86	\$5,326.84
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	\$427.32	\$427.32
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).	\$4,918.98	\$626.97	\$5,545.95
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).	\$1,164.02	\$178.65	\$1,342.67
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	\$161.71	\$161.71

G CODES	DESCRIPTORS FOR OTP BUNDLED SERVICES	DRUG COST	NON-DRUG COST	TOTAL COST
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.	-	-	-
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 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	\$179.46	\$179.46
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	\$110.28	\$110.28
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.	\$35.28	\$0	\$35.28
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.	\$86.26	\$0	\$86.26

G CODES	DESCRIPTORS FOR OTP BUNDLED SERVICES	DRUG COST	NON-DRUG COST	TOTAL COST
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	\$30.94	\$30.94

Frequency of Use and Other Billing Guidelines

The following rules apply to how often the OTP G-Codes can be billed:

- HCPCS codes G2067 - G2075 cover episodes of care of 7 contiguous days and cannot be billed for the same patient more than once per 7 contiguous day period.
- Some of the bundled payment codes describe a drug that is 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:
 - HCPCS codes G2069 and G2073 should generally not be used more than once every 4 weeks
 - HCPCS codes G2070 and G2072 should generally not be used more than once every 6 months
- Patients may be appropriately given OUD services at more than one OTP within a 7 day period in certain limited clinical situations, such as for 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 sufficient medical record documentation to reflect the clinical situation and services provided.
- In instances in which a patient is switching from one drug to another, the OTP should only bill for one code describing a weekly bundled payment for that week and should determine which code to bill based on which drug was furnished for the majority of the week.
- The add-on code describing intake activities (HCPCS code G2076) should only be billed for new patients (that is, patients starting treatment at the OTP)
- There are two add-on codes that describe take-home doses of medication, one for take-home supplies of methadone (HCPCS code G2078), which describes up to 7 additional days of medication, and can be billed along with the respective weekly bundled payment in units of up to 3 (for a total of up to a one month supply), and one for take-home supplies of oral buprenorphine (HCPCS code G2079), which also describes up to 7 additional days of medication and can be billed along with the base bundle in units of up to 3 (for a total of up to a 1 month supply). SAMHSA allows a maximum take-home supply of one month of medication; therefore, we do not expect the add-on codes describing take-home doses of methadone and oral buprenorphine to be billed any more than 3 times in one month (in addition to the weekly bundled payment). The add-on code for take-home doses of methadone can only be used with the methadone weekly episode of care code (HCPCS code G2067). Similarly, the add-on code for take-home doses of oral buprenorphine can only be used with the oral buprenorphine weekly episode of care code (HCPCS code G2068).
- HCPCS code G2080 may be billed when counseling or therapy services are furnished that substantially exceed the amount specified in the patient's individualized treatment plan. OTPs are required to document the medical necessity for these services in the patient's medical record.

SUBMITTING CLAIMS TO YOUR MAC OR BILLING AGENT

As an OTP provider, you must submit all claims to your MAC or billing agency/agent. You must use the 837P transaction to transmit health care claims electronically, or use the [CMS-1500](#) (the paper version of the 837P) and mail it to [your MAC](#).

Include the following information on each claim form:

- Healthcare Common Procedure Coding System (HCPCS) codes associated with the OTP service
- The OTP's NPI in the Rendering Provider Identifier section in block 24J of the CMS-1500 or its electronic equivalent. OTPs should list the prescribing or medication ordering physician's or other eligible professional's National Provider Identifier in Field 17 (the ordering/referring/other field) of the Form CMS-1500 (Health Insurance Claim Form; 0938-1197) or the electronic equivalent thereof
- Your organizational NPI as the Billing Provider in block 33 of the CMS-1500 or its electronic equivalent

The image shows a sample of the CMS-1500 Health Insurance Claim Form. A large 'S' watermark is overlaid on the form. Three green circles with letters A, B, and C highlight specific fields:

- Circle A:** Located in block 21, field 1, under 'A. ICD-10-CM Code', pointing to the first line of the diagnosis field.
- Circle B:** Located in block 24, field J, under 'J. RENDERING PROVIDER ID, #', pointing to the NPI field.
- Circle C:** Located in block 33, field 1, under '33. BILLING PROVIDER INFO & PH #', pointing to the NPI field.

98 percent of Medicare FFS providers/suppliers submit their claims electronically for a faster processing time. You must [get an exception](#) to file using paper claims.

For an explanation of HCPCS codes, visit the [HCPCS Coding Questions](#) webpage.

1. Files claims as soon as possible. Medicare claims must be filed to the appropriate MAC no later than 12 months, or 1 calendar year, after the date of service. Your claim will be denied if you file it 12 months or later after the date of service.

2. The new POS code 58 is for non-residential opioid treatment facilities.

D. Beneficiary first name, last name, and Medicare beneficiary identifier

TH INSURANCE CLAIM FORM
BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. INSURED'S I.D. NUMBER (For Program in Item 1)

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

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

4. INSURED'S CITY

5. INSURED'S STATE

6. INSURED'S ZIP CODE

7. INSURED'S TELEPHONE (Include Area Code)

8. INSURED'S POLICY OR FECA NUMBER

9. INSURED'S DATE OF BIRTH

10. INSURED'S SEX

11. INSURED'S POLICY OR FECA NUMBER

12. INSURED'S DATE OF BIRTH

13. INSURED'S SEX

14. INSURED'S POLICY OR FECA NUMBER

15. INSURED'S DATE OF BIRTH

16. INSURED'S SEX

17. INSURED'S POLICY OR FECA NUMBER

18. INSURED'S DATE OF BIRTH

19. INSURED'S SEX

20. INSURED'S POLICY OR FECA NUMBER

21. INSURED'S DATE OF BIRTH

22. INSURED'S SEX

23. INSURED'S POLICY OR FECA NUMBER

24. INSURED'S DATE OF BIRTH

25. INSURED'S SEX

26. INSURED'S POLICY OR FECA NUMBER

27. INSURED'S DATE OF BIRTH

28. INSURED'S SEX

29. INSURED'S POLICY OR FECA NUMBER

30. INSURED'S DATE OF BIRTH

31. INSURED'S SEX

32. INSURED'S POLICY OR FECA NUMBER

33. INSURED'S DATE OF BIRTH

34. INSURED'S SEX

35. INSURED'S POLICY OR FECA NUMBER

36. INSURED'S DATE OF BIRTH

37. INSURED'S SEX

38. INSURED'S POLICY OR FECA NUMBER

39. INSURED'S DATE OF BIRTH

40. INSURED'S SEX

41. INSURED'S POLICY OR FECA NUMBER

42. INSURED'S DATE OF BIRTH

43. INSURED'S SEX

44. INSURED'S POLICY OR FECA NUMBER

45. INSURED'S DATE OF BIRTH

46. INSURED'S SEX

47. INSURED'S POLICY OR FECA NUMBER

48. INSURED'S DATE OF BIRTH

49. INSURED'S SEX

50. INSURED'S POLICY OR FECA NUMBER

51. INSURED'S DATE OF BIRTH

52. INSURED'S SEX

53. INSURED'S POLICY OR FECA NUMBER

54. INSURED'S DATE OF BIRTH

55. INSURED'S SEX

56. INSURED'S POLICY OR FECA NUMBER

57. INSURED'S DATE OF BIRTH

58. INSURED'S SEX

59. INSURED'S POLICY OR FECA NUMBER

60. INSURED'S DATE OF BIRTH

61. INSURED'S SEX

62. INSURED'S POLICY OR FECA NUMBER

63. INSURED'S DATE OF BIRTH

64. INSURED'S SEX

65. INSURED'S POLICY OR FECA NUMBER

66. INSURED'S DATE OF BIRTH

67. INSURED'S SEX

68. INSURED'S POLICY OR FECA NUMBER

69. INSURED'S DATE OF BIRTH

70. INSURED'S SEX

71. INSURED'S POLICY OR FECA NUMBER

72. INSURED'S DATE OF BIRTH

73. INSURED'S SEX

74. INSURED'S POLICY OR FECA NUMBER

75. INSURED'S DATE OF BIRTH

76. INSURED'S SEX

77. INSURED'S POLICY OR FECA NUMBER

78. INSURED'S DATE OF BIRTH

79. INSURED'S SEX

80. INSURED'S POLICY OR FECA NUMBER

81. INSURED'S DATE OF BIRTH

82. INSURED'S SEX

83. INSURED'S POLICY OR FECA NUMBER

84. INSURED'S DATE OF BIRTH

85. INSURED'S SEX

86. INSURED'S POLICY OR FECA NUMBER

87. INSURED'S DATE OF BIRTH

88. INSURED'S SEX

89. INSURED'S POLICY OR FECA NUMBER

90. INSURED'S DATE OF BIRTH

91. INSURED'S SEX

92. INSURED'S POLICY OR FECA NUMBER

93. INSURED'S DATE OF BIRTH

94. INSURED'S SEX

95. INSURED'S POLICY OR FECA NUMBER

96. INSURED'S DATE OF BIRTH

97. INSURED'S SEX

98. INSURED'S POLICY OR FECA NUMBER

99. INSURED'S DATE OF BIRTH

100. INSURED'S SEX

Social Security Numbers (SSNs) are no longer used on Medicare cards. Every person with Medicare has been assigned a Medicare Beneficiary Identifier (MBI) and has been issued a new Medicare card. You MUST submit claims using MBIs.

E. Diagnosis or nature of illness or injury [International Classification of Diseases, 10th Revision \(ICD-10\) diagnosis code](#)

F. 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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to service line below (24E)) ICD-10

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS POINTER

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. Rcvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ()

PHYSICIAN OR SUPPLIER INFORMATION

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

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 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 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.

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](#).

Helpful Resources:

- [Medicare Basics: Parts A and B Claims Overview Video](#)
- [Medicare Claims Processing Manual, Chapter 1](#)
- [Medicare Claims Processing Manual, Chapter 26](#)
- [Electronic Health Care Claims webpage](#)
- [New Medicare Beneficiary Identifier \(MBI\) Get It, Use It](#)

PAYMENT AND REMITTANCE ADVICE

You will get payments via [Electronic Funds Transfer \(EFT\)](#). You must complete an [Electronic Funds Transfer \(EFT\) Authorization Agreement \(Form CMS-588\)](#) as directed by your MAC.

If there are no issues with the claim, you will get payment no sooner than 13 days after filing electronically (payment on the 14th day or after). For paper-based claims, you will get payment no sooner than 28 days after filing (payment on the 30th day or after).

After the MAC processes the claim, you or your billing agency/agent will get either an [Electronic Remit Advice \(ERA\)](#) or a Standard Paper Remit (SPR) with final claim and payment information. An ERA or SPR usually:

- includes itemized adjudication decisions about multiple claims
- reports the reason and value of each adjustment to the billed amount on the claim

ISSUES WITH PAYMENT

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

- **Deny the claim:** You or your billing agency/agent can file an appeal if you think the claim was denied incorrectly. Check your [MAC's](#) website for more information on how to appeal a denied claim.
- **Reject the claim as unable to be processed:** You or your billing agency/agent must submit a new claim.

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. [Contact your MAC](#) for information on the Provider Contact Center and IVR user guide.

Customer Service Representative (CSR)

Visit your [MAC](#) website for information on the Provider Contact Center only if you are unable to access claims information through the IVR.

MAC Portals

Providers can get claims status information for free via the MAC's Internet-based provider portal. [Contact your MAC](#) for portal features and access.

There is no copayment for beneficiaries for OUD treatment services; beneficiaries are responsible for the Part B deductible.

Medicare offers free software, [Medicare Remit Easy Print \(MREP\)](#), to read the ERA. You can view, print, and export special reports to Excel and other applications.]

For more information review the [Claim Status Request and Response](#) webpage.

Most MAC portals allow you to check eligibility, see the remit, possibly submit a claim. See the [listing of MAC Provider Portals](#).

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. CMS recommends the electronic 276/277 process because you can automatically generate and submit 276 queries as needed, eliminating the need for manual entry of individual queries or calls to a contractor to get this information.

The 277 response allows you to automatically post the status information to patient accounts, eliminating 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. Visit your [MAC](#) website for more information.

BILLING & PAYMENT FOR MEDICARE/MEDICAID DUAL ELIGIBLE BENEFICIARIES

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.

On January 1, 2020, Medicare became the primary payer for OTP services for dually eligible individuals who previously got OTPs 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.

For more information, see the [Tip Sheet for Opioid Treatment Program Providers Serving Dually Eligible Individuals: State Coverage of the Medicare Part B Deductible](#).

Helpful Resources

- [Medicare Claims Processing Manual \(IOM Pub. 100-04\), Chapter 1, Section 80.2.1.2 Payment Floor Standards](#)
- [Health Care Payment and Remittance Advice and Electronic Funds Transfer](#)
- [Remittance Advice Information: An Overview](#)
- [Professional Paper Claim Form \(CMS-1500\)](#)
- [Medicare Billing: Form CMS-1500 and the 837 Professional](#)
- [Medicare Billing: Form CMS-1500 and the 837 Professional Web-Based Training \(WBT\) course](#)
- [Electronic Data Interchange \(EDI\) Support webpage](#)

Need More Information?

Visit: [Opioid Treatment Programs \(OTP\) webpage](#)

[Contact your Medicare Administrative Contractor \(MAC\)](#)

RESOURCES

FOR MORE INFORMATION ABOUT...	RESOURCE
Administrative Simplification Compliance Act Waiver Application	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCAWaiver
CMS 1500	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854?DL-Page=1&DLEntries=10&DLFilter=1500&DL-Sort=0&DLSortDir=ascending
CMS Opioid Treatment Programs	https://www.cms.gov/Center/Provider-Type/Opioid-Treatment-Program-Center
Opioid Treatment Programs (OTPs) Medicare Enrollment Fact Sheet	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OTP-enrollment-factsheet-MLN6325432.PDF
EDI Enrollment Form	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10164B.pdf
EDI Registration Form	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10164A.pdf
Electronic Billing & EDI Transactions	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index
Electronic Data Interchange (EDI) Support	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/EDISupport
Electronic Funds Transfer (EFT)	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/EFT
Electronic Funds Transfer (EFT) Authorization Agreement (Form CMS-588)	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf
Electronic Health Care Claims Website	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/HealthCareClaims
Electronic Remit Advice (ERA)	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance
Final Rule (CMS-1715-F and IFC)	https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other
HCPCS Coding Questions	https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCS_Coding_Questions

FOR MORE INFORMATION ABOUT...	RESOURCE
Health Care Payment and Remittance Advice and Electronic Funds Transfer	https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Transactions/HealthCare-PaymentandRemittanceAdviceandElectronicFund-sTransfer
HIPAA Eligibility Transaction System (HETS)	https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index
HIPAA Eligibility Transaction System (HETS) Health Care Eligibility Benefit Inquiry and Response (270/271) 5010 Companion Guide	https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf
International Classification of Diseases, 10th Revision (ICD-10) diagnosis code	https://www.cms.gov/Medicare/Coding/ICD10/index
MAC Provider Portals	https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf
MAC Website List	https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List
Medicare Basics: Parts A and B Claims Overview Video	https://www.youtube.com/watch?v=Kv4k9MqMuag&list=PLaV7m2-zFKpihHxb4AiWNjbsIUUKCGIjK&index=9
Medicare Billing: Form CMS-1500 and the 837 Professional Medicare Billing: 837P and Form CMS-1500 booklet	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837P-CMS-1500.pdf
Medicare Billing: Form CMS-1500 and the 837 Professional Web-Based Training (WBT) course	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining
Medicare Claims Processing Manual, Chapter 1	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf
Medicare Claims Processing Manual (Pub.100-04), Chapter 24	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf
Medicare Claims Processing Manual, Chapter 26	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf
Medicare EDI Helplines	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Downloads/EDIHelplines.pdf
Medicare Remit Easy Print (MREP)	https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccessToDataApplication/MedicareRemitEasyPrint
New Medicare Beneficiary Identifier (MBI) Get It, Use It	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18006.pdf

FOR MORE INFORMATION ABOUT...	RESOURCE
Opioid Treatment Programs (OTP) webpage	https://www.cms.gov/Center/Provider-Type/Opioid-Treatment-Program-Center
Physician Fee Schedule	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index
Professional Paper Claim Form (CMS-1500)	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500
Remittance Advice Information: An Overview	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908325
Tip Sheet for Opioid Treatment Program Providers Serving Dually Eligible Individuals: State Coverage of the Medicare Part B Deductible	https://www.cms.gov/files/document/otp-crossover-tip-sheet

Medicare Learning Network® Content Disclaimer, Product Disclaimer, and Department of Health & Human Services Disclosure

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).