Reimbursement for Medications for Addiction Treatment Toolkit

PCSS Providers Clinical Support System

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Addiction is a treatable, chronic medical disease

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Introduction

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment and an individual's life experience. Medications are frequently used to treat addiction in conjunction with psychosocial interventions. In the U.S., most health care services, including medication treatment, are paid for via a third party, such as an insurance company or health plan. Roughly 300 million Americans are covered by some form of health insurance, with roughly one-third having coverage through public services such as Medicare, Medicaid, or CHAMPVA, and two-thirds having private coverage through an employer, direct purchase or TRICARE.[1] For simplicity's sake, these will collectively be referred to as "payers" throughout this toolkit.

This toolkit is intended to guide addiction medicine providers on how to bill third-party payers for treating patients with substance use disorder (SUD) with medications for addiction treatment (MAT). Due to the complexity and heterogeneity of the health insurance system in the United States, this toolkit will focus on billing and payment policies established by Medicare and Medicaid, the nation's largest payer of SUD treatment and recovery services.

This toolkit includes the following resources:

1. An overview info of MAT billing;
2. Information about state Medicaid payment policies;
3. Information about alternative payment models; and
4. Strategies to address reimbursement issues.

DISCLAIMER: The content below is for informational purposes only. Not all payers cover all the services listed below, and some payers may restrict reimbursement for certain billing codes to limited provider types. Please verify payer-specific requirements including coverage and correct coding prior to billing for services.

Overview of MAT Billing

MAT can be provided to patients in many settings, including outpatient physician offices or clinics, opioid treatment programs (OTPs), residential facilities, and hospitals. The correct billing and coding for MAT services depends on the treatment setting, services provided, and diagnosis. **See Appendix A for SUD-related diagnosis codes.**

CPT VS. HCPCS:

There are two standardized coding systems used to identify and bill for medical services and supplies in the United States: Current Procedural Terminology (CPT®),[a] which was developed and is maintained by the American Medical Association (AMA), and the Healthcare Common Procedure Coding System (HCPCS), which is maintained by the Centers for Medicare and Medicaid Services (CMS).

- CPT is a numeric coding system used primarily to identify medical services and procedures furnished by physicians and other health care professionals and billed to public or private payers. The CPT Codebook is updated annually, with changes implemented in January and July of each year.
- HCPCS is divided into two principal subsystems, referred to as level I and level II. HCPCS level I is the CPT coding system. HCPCS level II is an alpha-numeric standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

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Office or Other Outpatient Evaluation and Management (E/M) Codes

Office or other outpatient visits are billed using E/M codes (CPT codes 99202-99205 for new patients and 99211-99215 for established patients). Effective January 1, 2021, the Centers for Medicare and Medicaid Services (CMS) aligned their coding and documentation policies for office or other outpatient E/M services with revisions by the American Medical Association's (AMA) CPT Editorial Panel. Physicians and other qualified health professionals (QHP) can now code visits based solely on medical decision-making (MDM) or total time on the date of the encounter. History and exam components are no longer necessary to support coding levels, although they remain important components in establishing medical necessity, supporting medical decision making, and providing high-quality care.[2]

Health care professionals and payers rely on the results of toxicology tests to inform medical decision making for patients with addiction who are being treated with medication. It is critical to document toxicology test results and other elements that support medical decision making (MDM) in the patient's chart. For determining the level of MDM for E/M billing, the ordering and actual performance and/or interpretation of drug test results are not included when the professional interpretation of the test is billed separately by the health care professional reporting the E/M service. Tests that do not require separate interpretation (e.g., tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but they may be counted as ordered or reviewed for selecting an MDM level. [3]

For full code descriptions and instructions on selecting a level of an office or other outpatient E/M service, please see the AMA CPT Codebook. Additional resources from the AMA are available at the following links:

- AMA CPT Evaluation and Management
- Evaluation and Management (E/M) Office Visits—2021 (PDF)
- CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes (PDF) .

In addition to behavioral health services, office or other outpatient E/M services for patients with SUD may include physical medicine interventions such as assessment and management of narcotic bowel/constipation problems, insomnia, hepatitis C, or HIV. The number and complexity of these interventions would determine the level of MDM and thus the appropriate E/M code. In addition to E/M codes, outpatient visits for patients with SUD may involve psychotherapy, toxicology testing, and/or medication administration.

For **psychotherapy**, including motivational interviewing, cognitive-behavioral therapy, etc., the following codes may be used:

- **90832:** *Psychotherapy*, 30 minutes with patient (encounter separate from an E/M visit)
- **90833:** *Psychotherapy*, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure, e.g., 99214 + 90833)
- **90834:** *Psychotherapy*, 45 minutes with patient
- **90836:** *Psychotherapy*, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- **90837:** *Psychotherapy*, 60 minutes with patient
- **90838:** *Psychotherapy*, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

Note: When a psychotherapy add-on code is reported, the E/M code may not be selected based on time, i.e., it must be based on MDM.

Presumptive toxicology testing, also known as drug screening, is a qualitative test that establishes preliminary evidence regarding the absence or presence of drugs or metabolites in a sample. Results are expressed as negative or positive. Presumptive drug tests are normally reported by the treating provider using codes 80305, 80306, 80307. Each presumptive drug testing code represents all drug and drug class tests performed by the respective methodology (i.e., optical observation, instrument-assisted optical observation, or laboratory equipment alone) per date of service. **Definitive toxicology testing,** also known as confirmatory testing, is used when it is necessary to identify specific drugs, their metabolites, and/or drug quantities. Definitive toxicology testing is a quantitative and highly accurate manner of resolving the presence or absence of specific drugs. For definitive toxicology testing, some payers will require the use of CPT codes, while Medicare or a payer that follows Medicare's payment rules will require the use of HCPCS codes. Definitive tests are normally billed by the laboratory rather than the treating provider. In the setting of MAT services, definitive testing is only necessary when the results will change the treatment plan significantly; definitive testing is not used as a "screen." **See Appendix B for presumptive toxicology testing code descriptions.** For more information about toxicology testing, see the Appropriate Use of Drug Testing in Clinical Addiction Medicine.

For **medication administration**, the following codes may be used:

- **96372** (Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes chemotherapy and other highly complex drug or highly complex biologic agent administration); subcutaneous or intramuscular). This code may be appropriate for the physician / qualified healthcare professional to report administration of long-acting injectable buprenorphine or extended-release injectable naltrexone.
- **H0033** (Oral medication administration, direct observation). This code may be appropriate for the physician / qualified healthcare professional to report in-office sublingual buprenorphine initiation. H codes such as H0033 are primarily used by state Medicaid programs and may be used by commercial payers but are not reimbursable by Medicare.
- **G0516** (Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant)). This code may be appropriate for the physician / qualified healthcare professional to report administration of buprenorphine subdermal implants.

For clinician-administered **medications**, commercial insurers, Medicare and Medicaid use HCPCS J and Q codes for claims submission, such as:

- J2315 (Naltrexone, depot form, 1 mg)
- J0570 (Buprenorphine implant, 74.2 mg)
- J0571 (Buprenorphine, oral, 1 mg)
- J0572 (Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine)
- J0573 (Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine)
- J0574 (Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine)
- J0575 (Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine)
- J0592 (Injection, buprenorphine hydrochloride, 0.1 mg)
- Q9991 (Injection, buprenorphine extended-release, less than or equal to 100 mg)
- Q9992 (Injection, buprenorphine extended-release, greater than 100 mg)

Federal Medicaid law allows for the reimbursement of separate medical and behavioral health services on the same day, with federal matching funds available for states that choose to allow two billings. However, some states will not reimburse for both a primary care and a mental/behavioral health visit on the same day, and others may limit reimbursement based on the provider setting (e.g., in some cases, same-day billing is only allowed for Federally Qualified Health Centers (FQHCs) in a state, while other states exclude FQHCs from same-day billing and allow it for other providers).[4]

Examples

The scenarios below are provided for illustrative purposes only. Please verify payer-specific requirements including coverage and correct coding prior to billing for services.

1. Sandra is a 51-year-old female with alcohol use disorder severe, in early remission, nicotine use disorder, generalized anxiety disorder in remission, hypertension, and type 2 diabetes who is seen by her primary care physician for a routine follow-up visit, as well as to receive her monthly extended-release naltrexone injection. After she provides a urine sample, which is read by the practice's instrument reader, she mentions to the nurse that she feels ready now to address her nicotine use, which she reports as a pack and a half of cigarettes a day for the past 32 years. Her physician provides follow up care for her medical conditions, which included a 35-minute session of motivational interviewing geared specifically toward nicotine use disorder. She receives her extended-release naltrexone injection from the nurse, and at check out, she is given refills for the rest of her medications, including a new prescription for varenicline. Codes that may be appropriate to bill for this visit include:
   - 99214 – Established patient requiring moderate complexity medical decision-making (MDM)
   - 90833 – Between 30 minutes and 44 minutes of psychotherapy added on to an E/M code
   - 96372 – Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (for extended-release naltrexone injection)
   - J2315 – Naltrexone, depot form, 1 mg (if the medication is covered under the patient's medical benefit and has been purchased by the treating provider through a buy-and-bill arrangement)
   - 80306 – Presumptive urine drug testing
2. Joshua is a 28-year-old male who presents to his primary care physician for a new patient visit. He was referred directly from the emergency department for a same-day appointment, as he had just presented to the ED in mild opioid withdrawal. He reports a 4-year history of IV heroin use, and his exam indicates that he is now in moderate opioid withdrawal. He consents to in-office buprenorphine initiation, which results in significant improvement in his withdrawal symptoms. Codes that may be appropriate to bill for this visit include:
   - 99205 – New patient requiring at least 60 minutes of physician or other qualified health care professional time or high medical decision-making.
     - 99417 can be billed for each additional 15-minute increment beyond 60 minutes (if the primary code was selected based on time). The total time should be documented in the medical record when it is used as the basis for code selection.
     - G2212 should be used instead of 99417 when billing Medicare, for each additional 15 minutes beyond 60 minutes spent by the physician or qualified healthcare professional. (See more here.)
     - H0033 (Oral medication administration, direct observation) or H0016 (Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)) may be reimbursable by your State Medicaid program.
   - 80306 – Presumptive urine drug testing

Behavioral Health Screening

Given the high prevalence of co-morbid mental health conditions with substance use disorder, it may be necessary or advisable to screen patients for other chronic conditions and intervene as appropriate. The codes below may be appropriate to bill for these screening and intervention services.

- G0444 – Depression Screen; 15 minutes
- 96127 – Brief emotional/ behavioral assessment; can be billed for a variety of screening tools, including the PHQ-9 for depression, each 15 minutes face-to-face with the patient; initial assessment

- 96156 – Health behavior assessment or reassessment
  - includes health-focused clinical interviews, behavioral observations, and clinical decision making
- 96158 – Health behavior intervention; individual; initial 30 minutes; face-to-face
  - 96159 (Add on code) – Health behavior intervention; individual; each additional 15 minutes; face-to-face
- 96164 – Health and behavior intervention; group (two or more patients); initial 30 minutes; face-to-face
  - 96165 (Add on code) – Each additional 15 minutes; face-to-face
- 96167 – Health and behavior intervention; family (with patient present); initial 30 minutes; face-to-face
  - 96168 (Add on code) – Health and behavior intervention; family (with patient present); each additional 30 minutes; face-to-face
- 96170 – Health and behavior intervention; family (without patient present); initial 30 minutes; face-to-face
  - 96171 (Add on code) – each additional 15 minutes; face-to-face

Behavioral Screening & Intervention Services (MD/DO, NP/PA, LPC, LCSW, LSW)

- 99401 – Obesity preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual; approximately 15 minutes
  - 99402 – approximately 30 minutes
  - 99403 – approximately 45 minutes
  - 99404 – approximately 60 minutes
- 99406 – Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
  - 99407 – greater than 10 minutes
- 99408 – Alcohol and/or substance abuse (other than tobacco) screening and brief intervention services. Includes the time spent both administering the screening/assessment and the time spent reviewing the results, and counseling the patient; between 15-30 minutes
  - 99409 – greater than 30 minutes
- G0396 – Full Screening and Brief Intervention for substance misuse; 15 - 30 minutes [Medicare]
  - G0397 – 30 minutes or more
- H0049 – Full Screening and Brief Intervention for substance misuse; 15 - 30 minutes [Medicaid]
  - H0050 - 30 minutes or more

The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 removed the Medicare originating site geographic conditions and adds an individual's home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder. Medicare beneficiaries no longer need to be located in a county outside a Metropolitan Statistical Area or in a rural Health Professional Shortage Area in a rural census tract to receive SUD treatment via telehealth. **Click here** for more information about Medicare telehealth policies.

Telehealth Services

Telehealth (also known as telemedicine) services claims are billed using the appropriate CPT or HCPCS code and the modifier "95." CMS requires use of modifier 95 for telehealth services; other payers may require its use. For Medicare claims, the Place of Service (POS) code 02-Telehealth should be used to indicate that the billed service was furnished as a professional telehealth service from a distant site.

- Modifier 95: Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system. Append this modifier to an appropriate CPT code for a real-time interaction between a physician or other qualified healthcare professional and a patient who is located at a distant site from the reporting provider. The totality of the communication of information exchanged between the reporting provider and the patient during the synchronous telemedicine service must be of an amount and nature that would meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

For the list of services payable under the Medicare Physician Fee Schedule when furnished via telehealth, see here.

Medicare Bundled Payments for Office-Based SUD Treatment Services

The Medicare Physician Fee Schedule (PFS) includes coding and payment for a monthly bundle of office-based services for SUD treatment that includes:

- Overall management
- Care coordination
- Individual and group psychotherapy
- Substance use counseling
- Add-on code for additional counseling

CMS has established two HCPCS G-codes to describe the monthly bundles of services for office-based SUD treatment, and an add-on code to account for extraordinary circumstances requiring additional treatment resources and effort:

1. **G2086** describes the initial month of treatment, which includes intake activities and development of a treatment plan, as well as assessments to aid in development of the treatment plan in addition to care coordination, individual therapy, group therapy, and counseling. It requires at least 70 minutes in the first calendar month.
2. **G2087** describes subsequent months of treatment including care coordination, individual therapy, group therapy, and counseling. It requires at least 60 minutes in a subsequent calendar month.
3. The add-on code, **G2088**, can be billed in circumstances when effective treatment requires additional resources for a patient that substantially exceed the resources included in the base codes. The add-on code would address extraordinary circumstances that are not contemplated by the bundled code. It can be billed for each additional 30 minutes beyond the first 120 minutes and should be listed separately in addition to code for primary procedure.

These codes are not limited to any particular physician or non-physician practitioner (NPP) specialty, but CMS recommends that practitioners furnishing OUD treatment services should consult with addiction specialists, as clinically appropriate. These codes may be billed in addition to the E/M codes that are reported for E/M services.

At least one psychotherapy service must be furnished in order to bill for G2086 or G2087, as their payment rate incorporates the resource costs involved in furnishing psychotherapy. CMS recognizes that stable patients may not require monthly psychotherapy and encourages clinicians to use existing codes that describe care management services (CPT codes 99484, 99492, 99493, and 99494 – see page 8 for more detail) and E/M services rather than the codes for SUD service bundles for patients who do not require at least monthly psychotherapy.

Any of the individual therapy, group therapy and counseling services included in G2086-G2088 can be furnished via telehealth, as clinically appropriate, to increase access to care for beneficiaries.

Opioid Treatment Programs

Medicare and all state Medicaid programs now cover opioid use disorder (OUD) treatment services furnished by Opioid Treatment Programs (OTPs). State Medicaid programs typically pay for OTP services in daily or weekly bundles that include methadone dosing, toxicology testing, nursing services, and counseling using code H0020 (Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program). For more information, contact your State Medicaid Agency.

Medicare OTP Bundles

In January 2020, Medicare implemented a new Medicare Part B benefit for OUD treatment services furnished by OTPs, including:

1. Opioid agonist and antagonist treatment medications approved by the FDA for treatment of OUD;
2. Dispensing and administration of such medications;
3. Substance use counseling, including counseling furnished via two-way interactive audio-video communication technology;
4. Individual and group therapy, including those furnished via two-way interactive audio-video communication technology;
5. Toxicology testing, including both presumptive and definitive testing. The payment rates assume beneficiaries receive an average of two presumptive and one definitive test per month; and
6. Opioid antagonist medications, specifically naloxone, that are approved by Food and Drug Administration for emergency treatment of opioid overdose, and overdose education provided in conjunction with opioid antagonist medication.

CMS pays OTPs for weekly episodes of care through bundled payments that include a medication and non-medication component. The medication component varies based on the type (oral, injectable, or implantable) and cost of the

medication the patient takes. The non-medication component is based on the costs to provide non-medication services to patients. The non-medication component is scaled by the geographic adjustment factor (GAF) to account for geographic variations in costs and is updated annually.

Add-on codes can be billed to cover periodic changes in treatment intensity, such as intake activities, periodic assessments, take-home doses and additional counseling or therapy sessions.

CMS also created a new Place of Service (POS) code 58 (Non-residential Opioid Treatment Facility – a location that provides treatment for OUD on an ambulatory basis. Services include methadone and other forms of MAT). CMS expects that POS code 58 will be noted on claims submitted for the HCPCS G codes describing OTP services.

See Appendix C for a complete list and descriptions of the OTP codes. For more information on Medicare billing and payment for OTP services, including covered services and payment rates, please see this CMS Fact Sheet.

Residential Treatment Services

Medicare does not cover residential SUD treatment services, and does not authorize, as a provider-type, or reimburse freestanding SUD treatment facilities.[5]

Despite the historic prohibition on federal Medicaid financing of residential treatment services (known as the institutes for mental disease (IMD) exclusion), state Medicaid programs are incorporating SUD residential treatment providers in their networks through Section 1115 waiver programs, Medicaid managed care "in lieu of" authority, disproportionate share hospital (DSH) payments, and the SUPPORT Act state plan option.[6] Contact your State Medicaid Agency for state-specific information on residential treatment coverage and proper coding. Because Medicare does not cover these services, Medicaid would be the primary payer for dual Medicare-Medicaid eligible beneficiaries. Many states use the following HCPCS codes for residential treatment:

- H2034: Alcohol and/or drug abuse halfway house services, per diem
- H2036: Alcohol and/or other drug treatment program, per diem

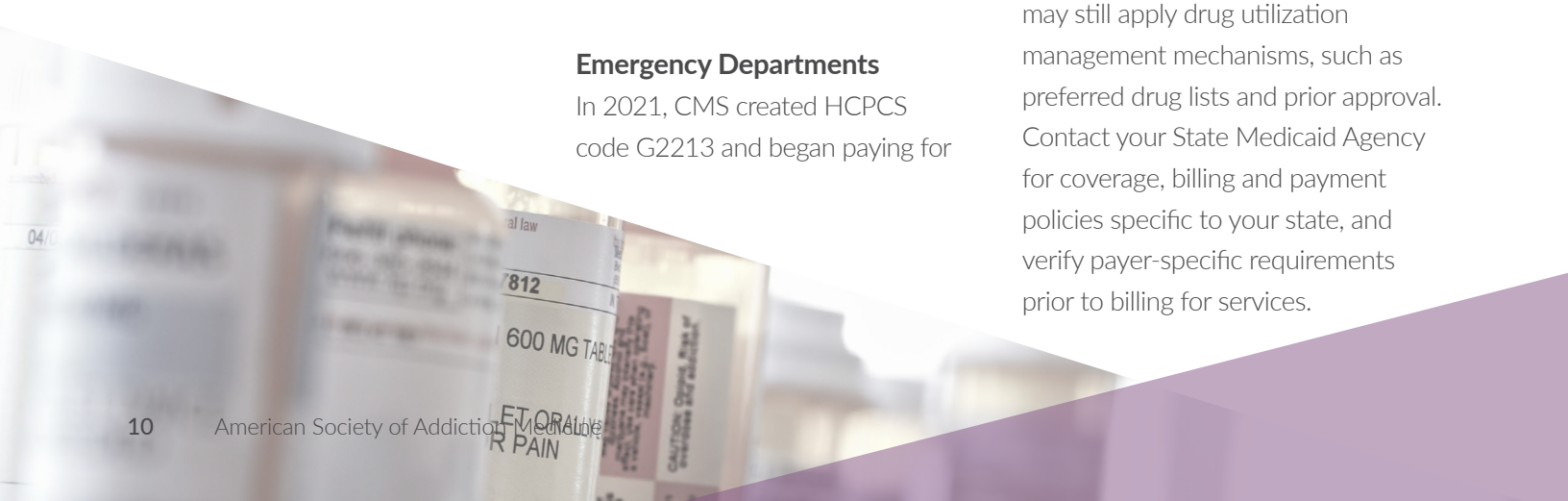
Emergency Departments

In 2021, CMS created HCPCS code G2213 and began paying for the initiation of medication for the treatment of opioid use disorder in the Emergency Department (ED) and referral for follow-up care. The add-on code G2213 is to be billed with E/M visit codes used in the ED setting.

G2213: Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services (List separately in addition to code for primary procedure).

State Medicaid Payment Policies

Nationally, Medicaid covers nearly 40% of all non-elderly adults with opioid use disorder (OUD). As of October 2020, and until 2025, **all state Medicaid programs are required to provide coverage of "Medication Assisted Treatment (MAT)" services and drugs** under a new mandatory benefit created by the SUPPORT Act of 2018. States must include as part of the new MAT mandatory benefit all forms of drugs and biologicals that the Food and Drug Administration (FDA) has approved or licensed for MAT to treat OUD. State Medicaid programs may still apply drug utilization management mechanisms, such as preferred drug lists and prior approval. Contact your State Medicaid Agency for coverage, billing and payment policies specific to your state, and verify payer-specific requirements prior to billing for services.



WASHINGTON STATE

As of 2018, Washington State Health Care Authority pays an enhanced rate for medication assisted treatment (MAT) for Medicaid eligible patients. It pays Medicare rates for specified E/M codes (99201-99205; 99211-99215; 99251-99255 (inpatient consults) to physicians, APRNs, and PAs who have a DATA 2000 waiver and:

a. Currently uses the waiver to prescribe MAT (i.e., buprenorphine) to patients with OUD; and

b. Bills for treating a client with a qualifying diagnosis of OUD; and

c. Provides opioid-related counseling during the visit (must be documented in clinical notes).

To learn more about how to bill for these services, click here.

VIRGINIA

On April 1, 2017, Virginia's Medicaid program launched an enhanced SUD treatment benefit – Addiction and Recovery Treatment Services (ARTS) – that significantly increases the payment rates for SUD treatment services. The ARTS benefits expanded Virginia Medicaid coverage of SUD treatment services to community-based addiction and recovery treatment services, inpatient detoxification and residential substance use disorder treatment. For detailed information on billing codes by setting and service, click here.

Alternative Payment Models

Payers are exploring and implementing various alternative payment models (APMs) to increase access to medication treatment services and to reward high-quality care, as well as to account for the more intensive staffing needs of addiction treatment services.

Collaborative Care Model

The Collaborative Care Model (CoCM) is an evidence-based model for integrating mental health care and SUD treatment into primary care.[9] Under CoCM, trained primary care providers and embedded behavioral care managers (BCM) provide medication and/or psychosocial treatments, supported by regular consultation with a psychiatrist or addiction medicine specialist. In 2018, CPT created a set of codes unique to CoCM and as of early 2021, 17 state Medicaid programs[b] and the majority of commercial insurers reimburse for the CoCM codes.[10]

CoCM services are billed by the treating medical provider. The treating provider can be any physician or non-physician practitioner whose scope of practice includes evaluation and management (E/M) services and who can independently report services to Medicare, including physicians of any specialty, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives. The codes generate monthly care management fees to reimburse the time and activities of the BCM and psychiatric/addiction medicine consultant, and the PCP's collaboration with this team.

For collaborative care management services, use:

- **99492:** *Initial psychiatric collaborative care management, first 70 minutes* in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional
- **99493:** *Subsequent psychiatric collaborative care management, first 60 minutes* in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional
- **99494:** *Initial or subsequent psychiatric collaborative care management, each additional 30 minutes* in a calendar month of behavioral health care manager activities
- **G0512:** Single monthly (inclusive of all time frames) rate for 60 minutes or more of collaborative care in Federally Qualified Health Clinic / Rural Health Clinic settings

[b]Arizona, Illinois, Iowa, Kentucky, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Utah, Vermont, and Washington.

For specialist consultation outside a formal collaborative care arrangement, treating medical providers and consulting specialist physicians may use the Interprofessional Telephone/Internet/Electronic Health Record Consultation Codes. These codes can be used when a physician or other qualified healthcare professional requests an opinion and/or treatment advice from a specialist using a secure platform (i.e., telephone, fax, or electronic health record) without the patient present.

- **99452** is to be used by the treating medical provider requesting the consult if 16-30 min of time is used preparing the referral and/or communicating with the consulting specialist physician. It cannot be reported more than once in a 14-day period per patient.
- **99446-99449** and **99451** may be used by the consulting specialist physician.

More information about these codes is available **here** and **here** (PDF).

General Behavioral Health Integration (BHI): Medicare and most state Medicaid programs provide separate reimbursement for behavioral health integration services that do not conform to the specific Collaborative Care Model. General BHI services only require 20 minutes of time per calendar month and can be delivered by a broader set of team members or the primary care provider alone. Similar to the CoCM codes, some specific tasks must be performed to bill the 99484 code.

- **99484:** Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month

For more information about CoCM and General BHI, including full code descriptors, see this CMS Fact Sheet and this document from the University of Washington.

Medicaid Innovation Accelerator Program

The Centers for Medicare and Medicaid Services (CMS) is also driving payment innovation in State Medicaid programs. In July 2014, the CMS launched the **Medicaid Innovation Accelerator Program (IAP)**, a collaboration between the Center for Medicaid and CHIP Services and the Center for Medicare and Medicaid Innovation (CMMI) focused on helping states improve care, reduce costs, and improve the health of their Medicaid beneficiaries. One IAP focus area is improving the care and outcomes for individuals with SUD. As part of this work, IAP developed service delivery models and corresponding rate design tools for the provision of MAT for OUD. Each service delivery model includes the following phases of treatment: clinical assessment and induction; stabilization; maintenance; and discontinuation and medical withdrawal (if discontinuation is the patient's choice). Contact your State Medicaid Agency for information about alternative payment models available in your state.

Model #1, adapted from the Baltimore Buprenorphine Initiative in Maryland, includes five different levels of bundled payments as a patient is treated with buprenorphine or extended-release naltrexone. Assessment, induction, and stabilization occur at a specialty substance use disorder treatment organization, with transfer to primary care for the maintenance phase of treatment.

Model #2, adapted from the Massachusetts Collaborative Care model and designed for patients receiving treatment at a primary care practice or clinic, includes bundled rates for both episodic and monthly components.

Model #3 is an office-based opioid treatment program (OBOT) model based on the "Spoke" component of Vermont's "Hub and Spoke" program. It includes four different levels of bundled payments as a client moves through a course of treatment.

Strategies to Address Reimbursement Issues

Given the complexity of the U.S. healthcare financing systems, providers may face several reimbursement challenges when treating patients with SUD. A few common challenges are described below, with suggested strategies to overcome them and/or links to additional helpful resources.

Utilization Management

Payers routinely use utilization management techniques, such as

prior authorization and preferred drug lists (PDL), to contain expenditures and encourage the proper use of medications, including for the treatment of alcohol and opioid disorders. Prior authorization – sometimes referred to as preauthorization, prospective review, or prior review – is a process by which a service or treatment, such as a medication, is subject to review and approval before it will be covered, and it can result in a delay in needed care for your patient. To learn how to navigate the various forms of utilization management that payers apply to medications for addiction treatment, see the Utilization Management for Medications for Addiction Treatment Toolkit.

Buy and Bill

Some states and payers require the use of "buy-and-bill" distribution for clinician-administered medications such as long-acting injectable buprenorphine and extended-release injectable naltrexone. This method requires providers to purchase and store these medications until administered to the patient, allowing immediate medication access for patients. However, this method places providers at financial risk if the medication is not used or the reimbursement is less than the providers' costs. Given these challenges, some states now allow providers to obtain these medications through specialty pharmacies.

Commercial payers may cover clinician-administered medications as a medical benefit, pharmacy benefit, or both. Specialty pharmacies will procure and ship a patient-specific prescription for a clinician-administered medication directly to the clinician's office in the patient's name. The specialty pharmacy will then bill the patient's health plan directly and collect any co-payment from the patient.

Credentialing

Third party payers are beginning to understand that integrated care is essential for patients with addiction. Unfortunately, addiction care remains siloed in many locations across the U.S. Some states limit the types of providers who may bill for behavioral health services or the types of procedures for which they may bill. They also may limit diagnosis codes for which primary care providers may receive reimbursement under Medicaid. Providers may work around billing limitations by recording patients' secondary, reimbursable physical health diagnosis rather than their primary non-reimbursable behavioral health diagnosis in claims and patient records, although this may lead to inaccurate treatment records and confusion among providers.

Providers or their staff can proactively minimize unintended consequences by reaching out to the provider services divisions at each of the payers where they are credentialed to clarify exactly what types of services are offered and any requirements/limitations on setting or provider type to deliver the service.

APPENDIX A: DSM-5 Diagnoses and ICD-10-CM Codes

DSM-5 Substance Use Diagnosis	Examples	Severity	ICD-10 Code (For billing purposes)
Opioid Use Disorder	Heroin, hydrocodone (Norco, Vicodin), oxycodone (Oxycontin, Percocet), morphine, hydromorphone (Dilaudid), codeine (cough syrup), meperidine (Demerol), fentanyl, etc.	MILD	F11.10
		MILD, In early or sustained remission	F11.11
		MODERATE	F11.20
		MODERATE, In early or sustained remission	F11.21
		SEVERE	F11.20
		SEVERE, In early or sustained remission	F11.21
Alcohol Use Disorder	Beer, liquor, etc.	MILD	F10.10
		MILD, In early or sustained remission	F10.11
		MODERATE	F10.20
		MODERATE, In early or sustained remission	F10.21
		SEVERE	F10.20
		SEVERE, In early or sustained remission	F10.21
Tobacco Use Disorder	Cigarettes, cigars, etc.	MODERATE	F17.200
		MODERATE, In early or sustained remission	F17.201
		SEVERE	F17.200
		SEVERE, In early or sustained remission	F17.201
Cannabis Use Disorder	Marijuana and marijuana-related products	MILD	F12.10
		MILD, In early or sustained remission	F12.11
		MODERATE	F12.20
		MODERATE, In early or sustained remission	F12.21
		SEVERE	F12.20
		SEVERE, In early or sustained remission	F12.21

Continued >

DSM-5 Substance Use Diagnosis	Examples	Severity	ICD-10 Code (For billing purposes)
Stimulant Use Disorder: Amphetamine-Type Substance	Methamphetamine (crystal meth, crank, speed, tweek, glass, etc.)	MILD	F15.10
		MILD, In early or sustained remission	F15.11
		MODERATE	F15.20
		MODERATE, In early or sustained remission	F15.21
		SEVERE	F15.20
		SEVERE, In early or sustained remission	F15.21
Stimulant Use Disorder: Cocaine	Cocaine (coke, rock, blow, snow, etc.)	MILD	F14.10
		MILD, In early or sustained remission	F14.11
		MODERATE	F14.20
		MODERATE, In early or sustained remission	F14.21
		SEVERE	F14.20
		SEVERE, In early or sustained remission	F14.21
Sedative, Hypnotic, or Anxiolytic Use Disorder	Benzodiazepines [alprazolam (Xanax), lorazepam (Ativan), diazepam (Valium), clonazepam (Klonopin), etc.], barbiturates [phenobarbital, pentobarbital, butalbital, secobarbital (Seconal), etc.], Z-drugs [zolpidem (Ambien), eszopiclone (Lunesta), and zaleplon (Sonata)]	MILD	F13.10
		MILD, In early or sustained remission	F13.11
		MODERATE	F13.20
		MODERATE, In early or sustained remission	F13.21
		SEVERE	F13.20
		SEVERE, In early or sustained remission	F13.21
Phencyclidine (PCP) Use Disorder **Or** **Other Hallucinogen Use Disorder**	PCP (phencyclidine) Or LSD (acid), ecstasy (MDMA), ketamine, magic mushrooms (psilocybin), peyote (mescaline), etc.	MILD	F16.10
		MILD, In early or sustained remission	F16.11
		MODERATE	F16.20
		MODERATE, In early or sustained remission	F16.21
		SEVERE	F16.20
		SEVERE, In early or sustained remission	F16.21

Continued >

DSM-5 Substance Use Diagnosis	Examples	Severity	ICD-10 Code (For billing purposes)
Stimulant Use Disorder-Other or Unspecified Stimulant	Methylphenidate (Ritalin, Concerta, among other brands), dextroamphetamine/ amphetamine (Adderall), lisdexamfetamine (Vyvanse), etc.	MILD	F15.10
		MILD, In early or sustained remission	F15.11
		MODERATE	F15.20
		MODERATE, In early or sustained remission	F15.21
		SEVERE	F15.20
		SEVERE, In early or sustained remission	F15.21
Inhalant Use Disorder	Glues, spray cans, etc.	MILD	F18.10
		MILD, In early or sustained remission	F18.11
		MODERATE	F18.20
		MODERATE, In early or sustained remission	F18.21
		SEVERE	F18.20
		SEVERE, In early or sustained remission	F18.21

Sources: American Psychiatric Association. DSM-5 Diagnoses and New ICD-10-CM Codes. Available at: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/ICD10-Changes-Listed-by-DSM5-October-2017.pdf Accessed April 6, 2021; and LA County Department of Public Health. DSM-5 Substance Use Diagnosis. Available at: http://publichealth.lacounty.gov/sapc/NetworkProviders/ClinicalForms/TS/DSM5Diagnoses.pdf Accessed April 6, 2021.

APPENDIX B: Presumptive Drug Testing Codes

Presumptive drug testing is reported using codes 80305, 80306, 80307:

- **80305** - Drug tests(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (e.g., utilizing immunoassay [dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service.
- **80306** - Drug tests(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by instrument-assisted direct optical observation (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service.
- **80307** - Drug tests(s), presumptive, any number of drug classes, any number of devices or procedures capable of being read by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.

APPENDIX C: Medicare OTP Billing Codes and Descriptions

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.*
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.*
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.* (Note: This code should be billed only during the week that the drug is administered. HCPCS code G2074, which describes a bundle not including the drug, would be billed during any subsequent weeks that at least one non-drug service is furnished until the injection is administered again, at which time HCPCS code G2069 would be billed again for that week.)
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.*
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.*
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*
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*
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*
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, partial episode*

*(provision of the services by a Medicare-enrolled Opioid Treatment Program).

Intensity Add-on and Take-Home Codes

The medical services described by these add-on codes could be furnished by a program physician, a primary care physician or an authorized healthcare professional under the supervision of a program physician or qualified healthcare professional such as nurse practitioners and physician assistants. The other assessments, including psychosocial assessments could be furnished by practitioners who are eligible to do so under their state law and scope of licensure.

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
HCPCS code G2077	**Periodic assessment;** assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment. (Periodic assessments may be furnished via two-way interactive audio-video communication technology, as clinically appropriate.)
HCPCS code G2078	**Take-home supply of methadone;** up to 7 additional day; list separately in addition to code for primary procedure*
HCPCS code G2079	**Take-home supply of buprenorphine (oral);** up to 7 additional day supply; list separately in addition to code for primary procedure.*
HCPCS code G2216	**Take-home supply of injectable naloxone;** list separately in addition to code for primary procedure.*
HCPCS code G2215	**Take-home supply of nasal naloxone;** list separately in addition to code for primary procedure*

*(provision of the services by a Medicare-enrolled Opioid Treatment Program).

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PCSS Providers Clinical Support System

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