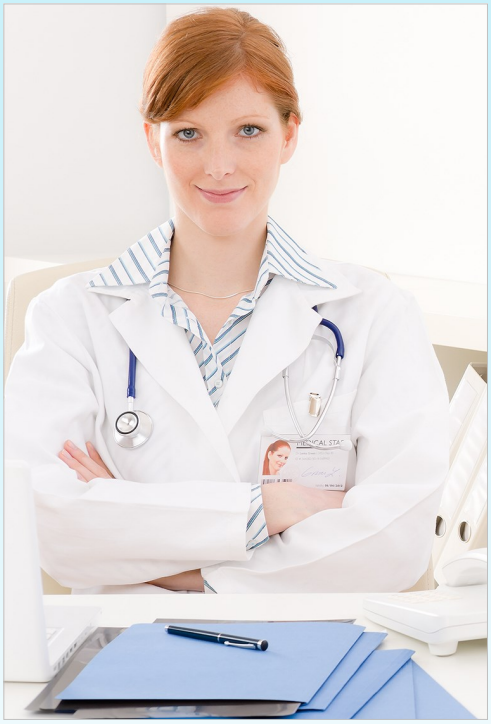
IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201744 JUNE 29, 2017

IHCP to enroll OTPs under a designated provider type and cover OTP-specific services



As announced in Indiana Health Coverage Programs (IHCP) Bulletin *BT201636*, in compliance with Indiana Code *12-23-18-0.5*, opioid treatment programs (OTPs) are required to enroll as Medicaid providers by July 1, 2017.

Currently, OTPs may choose to enroll as a billing group under the provider type and specialty that best identifies their practice. Providers can refer to the IHCP Provider Enrollment Type and Specialty Matrix for eligible provider options. Alternatively, individual practitioners and OTP entities may elect to enroll with the IHCP as ordering, prescribing, or referring (OPR) providers with a specialty of opioid treatment program. OPR providers can order, prescribe, and refer Indiana Medicaid members for Medicaid-covered services but cannot bill the IHCP directly for services rendered to members. When enrolling as OPR providers, the OTP entity and the individual practitioners must enroll separately.

Effective August 1, 2017, the IHCP will establish a provider type of *Addiction Services* and a specialty of *Opioid Treatment Program* that will be eligible to bill for services specific to opioid treatment. OTPs wanting to bill for the administration of methadone and other related services exclusive to OTPs must be enrolled under the *Addiction Services/Opioid Treatment Program* provider type and specialty. The option for an OTP to enroll as an OPR provider remains unchanged. All OTP providers enrolling with the IHCP will be required to have a Drug Enforcement Administration (DEA) license, as well as certification from the State's Division of Mental Health and Addiction (DMHA).

Coverage of OTP services

Effective August 1, 2017, OTP services will be covered for members enrolled in all IHCP programs, except for those with the following benefit plans:

- Individuals eligible for Family Planning Eligibility Program only
- Individuals eligible for Package E – Emergency services only
- Individuals eligible for Medicare Savings Programs only – Qualified Medicare Beneficiary (QMB)-only, Specified Low Income Medicare Beneficiary (SLMB)-only, or Qualified Individual (QI)

Coverage of OTP services will be restricted as follows:

- Individuals aged 18 and older seeking OTP services must meet the following medical necessity criteria:
  - Must be addicted to an opioid drug
  - Must have been addicted for at least one year before admission to the OTP
  - Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria
- Individuals under the age of 18 seeking OTP services must meet the following medical necessity criteria:
  - Must be addicted to an opioid drug
  - Must have two documented unsuccessful attempts at short-term withdrawal management or drug-free addiction treatment within a 12-month period preceding admission
  - Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the ASAM Patient Placement Criteria
- The following individuals are exempt from the one-year addiction requirement:
  - Members released from a penal institution – If the individual seeks OTP services within six months of release
  - Pregnant women
  - Previously treated individuals – If the individual seeks OTP services within two years after treatment discharge

Prior authorization (PA) is not required for OTP services. However, providers must maintain documentation demonstrating medical necessity, that the coverage criteria are met, as well as the individual's length of treatment, in the member's records.

Reimbursement and billing instructions for OTP services

For dates of service (DOS) on or after August 1, 2017, OTP providers will be reimbursed a daily bundled rate that includes payment for all required services within each phase of treatment. Additionally, certain codes will be reimbursable outside the bundled rate when medically necessary or required per the DMHA guidelines.

Reimbursement of bundled OTP services

Providers should bill Healthcare Common Procedure Coding System (HCPCS) code H0020 and modifier combinations shown in Table 1, as appropriate, for each day the member presents for treatment. It is not expected that the member will receive weekly or monthly services on each DOS, only that services be completed by the end of each week or month, as indicated. Providers are required to maintain documentation indicating the services provided to each member, each day.

Table 1 – Reimbursement for bundled OTP services

HCPCS code and modifier	Services
H0020 U1	*Phase 1 – Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program). First 90 days of treatment.* This code encompasses the following services/treatments: – Oral medication administration, direct observation, daily – Alcohol and/or other drug test specimen collection, monthly – Drug testing, monthly – Methadone, daily – Pharmacological management, daily – 30 minutes of case management, per week – Four (4) hours of counseling, per month, of which at least two (2) hours shall be in individual counseling Payment rate: $13.60/day
H0020 U2	*Phase 2 – Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program). Days 91 – 180 of treatment.* This code encompasses the following services/treatments: – Oral medication administration, direct observation, daily – Alcohol and/or other drug test specimen collection, monthly – Drug testing, monthly – Methadone, daily – Pharmacological management, daily – 30 minutes of case management, per week – Two (2) hours of counseling, per month, including one (1) hour of individual counseling. Payment rate: $10.57/day
H0020 U3	*Phase 3 – Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program). Days 181 – 365 of treatment.* This code encompasses the following services/treatments: – Oral medication administration, direct observation, daily – Alcohol and/or other drug test specimen collection, monthly – Drug testing, monthly – Methadone, daily – Pharmacological management, daily – 30 minutes of case management, per week – One (1) hour of counseling per month Payment rate: $9.32/day
H0020 U4	*Phase 4 – Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program). Days 366+ of treatment.* This code encompasses the following services/treatments: – Oral medication administration, direct observation, daily – Alcohol and/or other drug test specimen collection, monthly – Drug testing, monthly – Methadone, daily – Pharmacological management, daily – 30 minutes of case management, per week Payment rate: $7.54/day

Providers are expected to bill the appropriate phase for each member, based on the member's therapy timeline. In documented instances of a member having a positive drug screen, indicating a relapse in treatment, or of a member being absent from treatment for more than 30 consecutive days, providers may reset the therapy timeline back to the medically appropriate phase for that member.

Providers who allow take-home doses of methadone should bill the appropriate bundled rate code with the additional UA modifier for each DOS that a take-home dose is provided.

OTP services billable outside the bundled rate

The services in Table 2 may be billed outside the bundled rate, subject to the limitations stated. Any services billed outside the bundled rate are subject to post-payment review and must comply with all medical necessity requirements.

Table 2 – OTP services billable outside the bundled rate

Code	Description	Frequency limitations
90792	Psychiatric diagnostic evaluation with medical services	Limited to one (1) per rolling year without PA
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	Any combination of 99201 – 99204 and 99211 – 99214 are limited to one (1) per rolling 90 days
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	Any combination of 99201 – 99204 and 99211 – 99214 are limited to one (1) per rolling 90 days
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Any combination of 99201 – 99204 and 99211 – 99214 are limited to one (1) per rolling 90 days
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Any combination of 99201 – 99204 and 99211 – 99214 are limited to one (1) per rolling 90 days

Table 2 – OTP services billable outside the bundled rate (continued)

Code	Description	Frequency limitations
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	Any combination of 99201 – 99204 and 99211 – 99214 are limited to one (1) per rolling 90 days
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	Any combination of 99201 – 99204 and 99211 – 99214 are limited to one (1) per rolling 90 days
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	Any combination of 99201 – 99204 and 99211 – 99214 are limited to one (1) per rolling 90 days
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	Any combination of 99201 – 99204 and 99211 – 99214 are limited to one (1) per rolling 90 days
81025	Urine pregnancy test, by visual color comparison methods	As needed
86318	Immunoassay for infectious agent antibody, qualitative or semi quantitative, single step method (eg, reagent strip)	As needed
86701	Antibody; HIV-1	As needed
86702	Antibody; HIV-2	As needed
86703	Antibody; HIV-1 and HIV-2, single result	As needed
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); read by instrument assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service	As needed, if needed more frequently than once per month

Additionally, psychotherapy services (Current Procedural Terminology (CPT®[1]) code range 90832 – 90838) over and above those included in the bundled rate may be provided in the event of a relapse. These services must comply with the medical necessity requirements, as well as all restrictions regarding service providers, oversight, and limitations listed in the *Mental Health and Addiction Services* provider reference module. Any psychotherapy service billed in this manner is subject to post-payment review and must be billed with modifier SC – *Medically necessary service or supply.*

Additional evaluation and management (E&M) codes may be billed in excess of once per rolling 90 days, in the event of a relapse or other significant life event that makes the service medically necessary. Providers must use modifier SC to indicate that the service is medically necessary. Any E&M service billed in this manner is subject to post-payment review.

Other billing guidance

- The IHCP will recognize the following credentials, under the direction of a physician or health service provider in psychology (HSPP), for individuals rendering individual, group, or family counseling services in an OTP setting:
  - A licensed psychologist
  - A licensed clinical social worker (LCSW)
  - A licensed marriage and family therapist (LMFT)
  - A licensed mental health counselor (LMHC)
  - A licensed clinical addiction counselor (LCAC)
  - A physician assistant
  - A nurse practitioner
  - A clinical nurse specialist
  - An individual credentialed in addictions counseling by a nationally recognized credentialing body approved by the Division of Mental Health and Addiction (DMHA)
- Individuals who are presumptively eligible for the IHCP due to pregnancy are eligible only if services are billed with specific pregnancy-related diagnoses. Providers are encouraged to use diagnosis codes O99.320, O099.321, O99.322, or O99.323, as appropriate. The comprehensive list of Presumptive Eligibility for Pregnant Women (PEPW) diagnosis codes is available on the *Code Sets* page at indianamedicaid.com.
- For IHCP members who also have Medicare coverage, providers should bypass Medicare billing and bill the IHCP directly for OTP services. Other third-party insurers should be billed before billing the IHCP.
- Providers should contact the managed care entity (MCE) with which the member is enrolled for additional information on billing OTP services for members enrolled in a managed care program.
- Additional rules surrounding OTP services can be found in *440-IAC-10*.

QUESTIONS?

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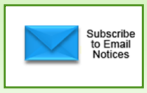

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