

## Program Guide: Opioid Treatment Program

*Physicians and other qualified health professionals should use their own expertise in evaluating members for treatment options. The program guidelines included in this document are not intended to be required treatment protocols and may include comments developed by the MDwise's behavioral health team. Sources listed are for reference only and may look different in context of the program guideline. The program guide is not intended to replace policy regarding prior authorization, claims submission, or treatment protocol. MDwise has developed this program guideline based upon the current available information as of the most recent effective date. If there is a discrepancy between IHCP claims administration information, provider billing issues and MDwise policy, please notify MDwise immediately.*

### Program Guide Purpose

**Taking care of a member's behavioral health is an integral part of their health care.** Understanding the options for treatment is part of that care. MDwise offers coverage for a continuum of care related to behavioral health and addictions treatment. MDwise believes that integrated physical and behavioral health services are an integral part of health care. Our mission is to deliver consistent, high-quality care while focusing on compassion, excellence and leadership.

This program guide outlines the covered benefit for Opioid Treatment Program (OTP) services to be implemented in accordance with MDwise Medical Management and Behavioral Health policies and procedures and IHCP program requirements for Hoosier Healthwise and Healthy Indiana Plan members.

### Specific Program Guidelines

For the purpose of this program guide, Opioid Treatment Program (OTP) is defined as a daily bundled service that includes the daily administration of methadone, either at the OTP provider location or as an authorized take-home dose. The use of other agents (i.e. Suboxone, Subutex, Vivitrol, etc.) with or without the daily services is not considered OTP programming.

### Who is eligible for OTP?

OTP services will be covered for members enrolled in all IHCP programs, except for those in the benefit plans identified in BT201744 and BT201755.

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, however, should be billed before billing the IHCP.

Individuals who are presumptively eligible for the IHCP due to pregnancy are eligible for OTP services only if services are billed with specific pregnancy-related diagnoses. The comprehensive list of Presumptive Eligibility for Pregnant Women (PEPW) diagnosis codes is available on the Code Sets page at [indianamedicaid.com](http://indianamedicaid.com).

## Exclusions

- 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).

## Who can provide OTP?

OTPs may be enrolled under the provider type and specialty that best identify their practice. However, providers wanting to bill for the administration of methadone and other related services exclusive to Opioid Treatment Programs must be credentialed with MDwise and enrolled with IHCP under the Addiction Services/Opioid Treatment Program provider type and specialty (type 35/specialty 835).

The option for an OTP to enroll as other provider types, including as an Ordering, Prescribing and Referring (OPR) provider, remains unchanged. Providers already enrolled with IHCP as an OPR provider (type 50) that want to be able to bill IHCP for services provided to Medicaid members must disenroll as an OPR provider and re-enroll as an Addiction Services/Opioid Treatment Program provider (type 35/835).

All OTP providers enrolling with the IHCP under the Addiction Services/OTP provider type and specialty or as an OPR will be required to have a Drug Enforcement Administration (DEA) license, as well as certification from Indiana's Division of Mental Health and Addiction (DMHA). Additional rules surrounding OTP services can be found in Indiana Administrative Code 440 IAC 10.

**MDwise 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 addiction counseling by a nationally recognized credentialing body approved by the DMHA\*.
- \*Note:** *The Medication Assisted Treatment Specialist (MATS) credential is not currently recognized by DMHA and will not be allowed by the IHCP.*

Mid-level practitioners are to use the correct modifier with the appropriate procedure code when submitting a claim for reimbursement.

## Providers and Prior Authorization

Prior authorization is not required for MDwise providers for OTP services; however, providers must maintain documentation demonstrating medical necessity and that the coverage criteria were met, as well as indicating the individual's length of treatment. Providers are required to be registered with the IHCP as provider specialty type Opioid Treatment (specialty 835) and provider type Addiction Services (type 35).

Services provided by a non-contracted, out-of-network provider without obtaining required prior authorization will be denied for lack of authorization according to MDwise policy, IAC Rules, IHCP policies and bulletins. Services provided by a provider that is not a registered provider type/specialty type 35/835 will be denied according to MDwise policy and IHCP polices and bulletins (BT201744, BT201755, BR201738).

Benefit and medical necessity criteria are utilized in determining medical appropriateness of services and care setting, which includes criteria obtained from current nationally recognized commercial resources such as InterQual, American Society of Addiction Medicine (ASAM), state and federal regulations, OMPP/IHCP manuals, health policy, bulletins and banners, RFS, MDwise medical and benefit administration policies and/or approved internally developed guidelines and protocols.

The American Society of Addiction Medicine (ASAM) criteria is utilized for medical necessity determinations applied to individual cases. The member's age, comorbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable, are considered when applying criteria to the care requested, along with available services of the local delivery system.

When the clinical information collected in support of the request does not meet the applicable criteria, the request is reviewed by the MDwise Medical Director or Reviewer Designee, which is a psychiatrist or appropriate behavioral health professional. Any decision to not authorize the service as requested based on medical necessity is made by the Medical Director or Reviewer Designee. Medical necessity determinations and notifications are carried out according to MDwise policies.

## What is the criteria for OTP?

Coverage of OTP services is subject to the restrictions outlined, and individuals must meet the defined medical necessity criteria, and be documented sufficiently for post-payment review if requested.

- **Individuals aged 18 and older seeking OTP services must meet the following medical necessity criteria:**

- o Must be addicted to an opioid drug.
- o Must have been addicted for at least one year before admission to the OTP.
- o Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the ASAM Patient Placement Criteria.

- **Individuals under the age of 18 seeking OTP services must meet the following medical necessity criteria:**

- o Must be addicted to an opioid drug.
- o Must have two documented unsuccessful attempts at short-term withdrawal management or drug-free addiction treatment within a 12-month period preceding admission.
- o Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six (6) dimensions of the ASAM Patient Placement Criteria.

- **The following individuals are exempt from the one-year addiction requirement:**

- o Members released from a penal institution – If the individual seeks OTP services within six (6) months of release.
- o Pregnant women.
- o Previously treated individuals – If the individual seeks OTP services within two (2) years after treatment discharge.

## Billing and Reimbursement

OTP providers will be reimbursed a daily bundled rate that includes payment for required opioid treatment services. Providers should bill one unit of Healthcare Common Procedure Coding System (HCPCS) code H0020 – Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program), for each day a member presents for treatment. Providers that allow members take-home doses of methadone must bill code H0020 with modifier UA – Take home Methadone Dose (Medicaid Specific) (H0020 UA) for each date of service for which a take-home dose of methadone is dispensed. Methadone dispensed for unsupervised, take-home use should be dispensed in alignment with federal opioid treatment standards, per Code of Federal Regulations 42 CFR 8.12.

Service Provided	Procedure Code
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	H0020
Take-Home Methadone Dose (Medicaid Specific)	H0020 UA

Reimbursement for the above codes are limited to one unit per member per day. Providers are to use a professional claim form, CMS 1500, when billing services. OTP services are not eligible for Hospital Assessment Fee (HAF) adjustments. An OTP provider rendering services other than those included in the bundled rate must bill for those additional services using another appropriate IHCP-enrolled provider type and specialty.

For take-home doses, providers must bill each date of service using the UA modifier. The provider may bill the H0020 code (with or without the modifier) once per day. If the provider is seeing the member in the office twice in a week but then prescribing three days of take-home doses, they can bill and receive reimbursement for all five days.

It is not expected that the member will receive weekly or monthly services on each date of service (DOS), only that services be completed by the end of each week or month, as indicated.

**Reimbursement for code H0020 will be based on a daily bundled rate. The daily bundled rate includes reimbursement for the following services:**

- Oral medication administration, direct observation, daily.
- Methadone, daily.
- Drug testing, monthly.
- Specimen collection and handling, monthly.
- Pharmacologic management, daily.
- One hour of case management, per week.
- Four (4) hours of group or individual psychotherapy, per month.
- Hepatitis A, B and C testing, as needed.
- Pregnancy testing, as needed.
- One (1) office visit every 90 days.
- Tuberculosis testing, as needed.
- Syphilis testing, as needed.
- Complete Blood Count, as needed.

The daily bundled rate is only billable for individuals who are receiving daily methadone maintenance treatment. If a member is using an alternative medication for treatment, such as Suboxone or Vivitrol, the medication, along with any related services rendered, must be billed separately. Providers enrolled as Addiction Services/OTP providers cannot be reimbursed for alternate medication-assisted treatment. To be reimbursed for these services, an OTP must be enrolled and must bill under another IHCP provider type and specialty appropriate for delivering these services, as well as be enrolled with MDwise.

The below are services reimbursable outside the per diem rate. Any services billed outside the bundled rate are subject to post-payment review and must comply with all medical necessity requirements:

Code	Description	Frequency Limitations
90792	Psychiatric diagnostic evaluation, with medical services	Limited to one (1) per rolling year without prior authorization (PA). Additional units may be billed after obtaining PA.
90832 –90838  Must be billed with Modifier SC (Medically necessary service or supply)	Psychotherapy	Available to individuals in the event of a relapse. Any restrictions regarding service providers and medical necessity as outlined in this Policy.  Psychotherapy service provided outside of those included in the bundled package are subject to post-payment review and must be billed with modifier SC.

**REFERENCES:**

- A.1 Indiana Laws & Regulations: IC 12-15-6 Prior Authorization, IC 12-15-11-8 - Use of provider identification number; Indiana Administrative Code: 405 IAC 1-10.5-2 Reimbursement Methodology, 405 IAC 5-20 Rule 20: Mental Health Services; Code of Federal Regulations 42 CFR 8.12; Indiana Administrative Code 440 IAC 10
- A.2 RFS 10-40: Risk-Based Managed Care Services for Medicaid Beneficiaries (Hoosier Healthwise/HIP), HHW and HIP Scope of Work, Behavioral Health.
- A.3 IHCP Provider Manual: Chapter 2: Table 2-3, Hoosier Health Program Description & Covered Benefits; Chapter 6: Prior Authorization, Section 5: Outpatient Mental Health Prior Authorization Policy Requirements; Chapter 8: Billing Instructions, Section 2, UB-92 Billing Instructions - Inpatient Hospital Services & Outpatient Mental Health; Section 3, I500 and 837P Transaction Billing Instructions
- A.4 IHCP Medical Policy Fact Sheet: #H0105, Mental Health/Behavioral Health – Inpatient Services. Mental Health/Behavioral Health – Outpatient Services
- A.5 IHCP Provider Bulletin/Banner: BT201744, BT201755, BR201738