Navigating Payment and Reimbursement Pathways for Substance Use Disorder Treatment and Addiction Medicine Services

Webinar # 1
American Society of Addiction Medicine
February 14, 2017

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President
Schatz Reimbursement Strategies LLC

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Advancing ASAM’s Educational and Professional Goals

- This webinar does not endorse or advocate for the use of any product, service, procedure, or health care provider. Nor does it endorse any policies or any health plan/payer or managed care organization. The goals of the webinar are to help ASAM members better understand the complexities of reimbursement for addiction medicine services and improve patient access, consistent with ASAM’s educational and professional mission.
Disclaimer

ACCME Accreditation Statement

The American Society of Addiction Medicine (ASAM) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

AMA Credit Designation Statement:

The American Society of Addiction Medicine designates this live activity for a maximum of 1 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Gordon Schatz JD, President of Schatz Reimbursement Strategies LLC, represents medical innovators, health care professionals, and manufacturers of medical devices, drugs, and diagnostics on coding, coverage and payment. He has worked with ASAM on coding issues. Over the past 25 years, he has improved billing and reimbursement policies for innovative health care services/products by CMS/Medicare, other government and private payers, at the national and local levels.

CPT codes, descriptions and other CPT coding data are copyright 2017 by the American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the American Medical Association.
Goals and Content of this Webinar

1. Describe how you can fit into different reimbursement models
2. Identify the major health insurance payers
3. Explain the basic language of reimbursement
   a. Coding
   b. Coverage - Prior authorization, levels of care, coverage determination guidelines
   c. Payment
4. Present fundamentals of claims submission and how to work with payers for appropriate payment
5. Suggest best practices on reimbursement and practical tips on advocating for your patient
6. Analyze case studies
7. Give you an opportunity to ask questions
Caution

- Health payers have several hot buttons. Payers are reluctant to work with physicians or providers whose goals are to:
  
  “Maximize reimbursement”. Or, “Increase profits.”

- Keep your focus on patient needs, quality care, and patient access.

- Know the insurer’s rules. Follow the rules.
Your Goals

- Provide your patients with high quality care
- Build a satisfying professional practice
- Send your kids to college
- Pay the mortgage
- Take an occasional vacation
Getting on Track with the Big Reimbursement Picture

- Identify patient-specific needs, individualize care, use the appropriate intensity service in the appropriate setting.

- Expect that appropriate reimbursement will be based on the appropriate intensity of and time with the patient interaction.
<table>
<thead>
<tr>
<th></th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Pay – Cash/check/credit card</td>
<td>Efficient, No claims processing, Predictable cash flow. Flexible. Fast</td>
<td>Limits revenue to patient’s financial status. Checks bounce. Credit card fraud. Unpredictable. Leaves money on the table as health insurers expand coverage for addiction medicine. Lack of payer oversight can open practices to diversion/abuse, and increase total health care costs.</td>
</tr>
<tr>
<td>Reimbursement from 3rd party payers</td>
<td>Can increase total revenue. May enable expansion of practice. Forward looking as insurers improve reimbursement policies. Get ahead of the curve. Help shape the curve to strengthen long term finances.</td>
<td>Requires understanding and ability to manage the complexity of reimbursement. Need to make up-front investment. Slower cash flow. Frustrating. Exposure to audits by insurers.</td>
</tr>
</tbody>
</table>
1. Patient pays cash to physician
2. Physician bills patient’s insurer and is reimbursed:
   a. Fee for Service
   b. Bundled/Capitated/Alternative payment model
Under recent SAMHSA regulations, practitioners are eligible for the 275 patient limit if they provide medication-assisted treatment (MAT) in a qualified practice setting, which includes:

- Medical emergency coverage
- Case management
- Health information technology systems – electronic health records
- Registration with state prescription drug monitoring program
- Accepting third-party payment for costs in providing health services, including written billing, credit, and collection policies and procedures, or Federal health benefits. [Cannot have a cash only business.]

81 Federal Register 44721-44722 (July 8, 2016), 42 CFR section 8.615
Case Study #1 – Navigating Payer Pathways – Key Players

Patient = 19 year old – potential opioid use disorder. His mother. His father, employed at Ecomp. With benefits manager- Ellen

Payer – PIC and claims processing staff: Mary, Meg, Minnie, Mabel, Meredith
PIC Medical Director
PIC Designated Lab - MegaLab

Dr. King and his billing staff:
Barbara

Physician

Payer
Case Study # 1 – Navigating Payer Pathways

- Nineteen year old male (with mother at intake) presents with potential opioid use disorder.
- Dr. King’s biller - Barbara calls Parent’s Insurance Company (PIC) – Mary (#1) - to confirm coverage and is put on hold for 20 minutes. Then told that the services are not covered under the father’s plan.
- Mother calls husband, outraged, and he calls his company EComp’s benefits manager – Ellen - who confirms they do have coverage. Father calls PIC and Meg (#2) acknowledges there is coverage.
- Barbara calls back to say the patient has coverage. Put on hold for 20 minutes. Minnie (#3) first says the son is not covered for these services, but will check, 20 minutes later Minnie confirms coverage is available for son. But Dr. King is not a PIC participating provider.
- Barbara says that Dr. King is the only ASAM certified/Board certified addiction doctor in the city. Minnie says Barbara will have to get in touch with Mabel (#4) to get him enrolled.
Barbara gets Dr. King enrolled, submits claim, it is denied. She calls Mary who says she has to talk to Meredith (#5). Barbara calls Meredith, (put on hold for 20 minutes) and Meredith says she will look into it and get back to her.

Meredith calls back saying she needs a letter of medical necessity from the doctor, and they won’t cover the lab tests which have to go to MegaLab. But Barbara can bill for a specimen draw.

Barbara thanks Meredith profusely for the clarification and signals that she would like Meredith to send her PICs “format/content/guidelines” for letters of medical necessity and PICs coverage policies for addiction medicine services. Barbara also says that Dr. King expects to complete the course of therapy and can she plan to send to Meredith the claim for all the final services as a package so they can be processed together, and facilitate prompt payment.

Meredith says she certainly can, but Meredith is not sure if she can release the policies, which are confidential, and she can’t make any changes in the time frames required by her plan to process and pay claims.

Barbara asks if Meredith has processed any claims for addiction medicine services, and Meredith says no. Barbara suggests that at some point, Dr. King would like to reach out to chat with the appropriate medical director at the plan and who would that be.
Major Commercial Payers

HIGHMARK

Anthem

Aetna

UnitedHealth Group

Kaiser Permanente

Cigna

HCSC

Blue Cross Blue Shield

HUMANA

ASAM American Society of Addiction Medicine
Federal and State Health/Insurance Agencies

UNITED STATES DEPARTMENT OF LABOR

ILLINOIS DEPARTMENT OF INSURANCE

50 State Medicaid Programs

Center for Medicare and Medicaid Services

CMS
A 50-state look at Medicaid expansion: 2016

One of the most important provisions of Affordable Care Act is the expansion of health coverage to low-income families through the Medicaid program. Here are basic facts on where states stand on Medicaid expansion.

**FEDERAL GOVERNMENT AND MEDICAID EXPANSION**

2014-2016: The federal government will cover 100 percent of the costs of Medicaid expansion in 2014, 2015, and 2016.

2020-beyond: In 2020 and beyond, the government will cover 90 percent of the costs of Medicaid expansion.
States Expanding Medicaid to Date: 32

States Not Currently Expanding Medicaid: 19

*Number of states, including the District of Columbia, that are expanding Medicaid

American Society of Addiction Medicine (ASAM)
MHPAEA

Group and individual health programs cannot impose more restrictive limits on mental health or substance use disorder benefits than limitations on medical/surgical benefits.
## Commercial Health Payers

<table>
<thead>
<tr>
<th>Payer</th>
<th>Number of Members</th>
<th>Headquarters</th>
<th>Locations</th>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Healthcare</td>
<td>70,000,000</td>
<td>Minneapolis, MN</td>
<td>Nationwide</td>
<td></td>
</tr>
<tr>
<td>Anthem</td>
<td>34,000,000</td>
<td>Indianapolis, IN</td>
<td>California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin.</td>
<td>Consolidation of Blue Cross Blue Shield plans, especially WellPoint</td>
</tr>
<tr>
<td>Aetna</td>
<td>18,000,000</td>
<td>Louisville, KY</td>
<td>Nationwide</td>
<td></td>
</tr>
<tr>
<td>Cigna</td>
<td>11,400,000</td>
<td>Philadelphia, PA</td>
<td>Nationwide</td>
<td></td>
</tr>
<tr>
<td>Kaiser</td>
<td>11,000,000</td>
<td>Oakland, CA</td>
<td>Nationwide</td>
<td></td>
</tr>
<tr>
<td>Humana</td>
<td>10,200,000</td>
<td>Louisville, KY</td>
<td>Nationwide</td>
<td></td>
</tr>
</tbody>
</table>
## Government Payers

<table>
<thead>
<tr>
<th>National</th>
<th>Patient Population</th>
<th>How Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>65 years of age and older, disabled, end-stage renal disease</td>
<td>Medicare Administrative Contractors (MACs)</td>
</tr>
<tr>
<td></td>
<td>55,500,000</td>
<td>Part A – Institutional care (Hospitals, skilled nursing facilities), Part B – Physician Services, lab and diagnostic tests</td>
</tr>
<tr>
<td>Department of Defense/Tricare/(CHAMPUS)</td>
<td>Active duty, reserve, retired members of the armed forces and family members</td>
<td>Military hospitals and clinics. HealthNet, Humana, United Healthcare</td>
</tr>
<tr>
<td>Department of Veterans Affairs</td>
<td>21,000,000</td>
<td>Nationwide – VA facilities</td>
</tr>
<tr>
<td>Federal Employees Health Benefits Program</td>
<td>8,200,000</td>
<td>Nationwide</td>
</tr>
<tr>
<td>State</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>73,100,000</td>
<td>50 State Medicaid Programs</td>
</tr>
</tbody>
</table>
Basic Language of Reimbursement
1. **Coding.** Physician submits claim form with codes describing patient, procedure, products

2. **Coverage.** Payer makes coverage determination that service can be paid to this physician

3. **Payment.** Payer makes determination on how much to pay this physician
ICD-10** Diagnoses Codes

F10 Alcohol related disorders
  F10.1 Alcohol abuse
    F10.12 Alcohol use with intoxication
    F10.121 Alcohol use with intoxication delirium
  F11 Opioid related disorders
    F11.93 Opioid use, unspecified with withdrawal
  F12 Cannabis related disorders
  F13 Sedative, hypnotic or anxiolytic related disorders
  F14 Cocaine related disorders

** Replaces the ICD-9 diagnoses codes – e.g. 304.00 Drug dependence, opioid type dependence
ICD-10 Diagnosis Coding – Practical Tip

- Get the complete 2017 ICD-10 book
- Report on the patient’s medical record all appropriate diagnoses
- Ensure that the claim form to the payer includes all the ICD-10 codes and those most specific and accurate
- If the claim is denied, check with the payer if their ICD-10 codes are up to date for 2017. Ask what diagnoses codes are recognized for the particular service.
## CPT Procedure Codes – Evaluation and Management Key Components

<table>
<thead>
<tr>
<th>Patient</th>
<th>Level of Service</th>
<th>Location</th>
<th>Complexity/Type of Decision Making</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>-- New</td>
<td>-- Problem-focused</td>
<td>-- Office/Outpatient</td>
<td>-- Low</td>
<td>10, 15, 25, 45, 60 minutes</td>
</tr>
<tr>
<td>-- Established</td>
<td>-- Expanded Problem-focused</td>
<td>-- Hospital Inpatient</td>
<td>-- Moderate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Detailed</td>
<td>-- Nursing Facility</td>
<td>-- High</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Comprehensive</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CPT E&M Procedure Codes* - Example

99214  Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 or 3 components:
  o Detailed history
  o Detailed examination
  o 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

E&M codes extend from CPT 99201 to CPT 99499  *Copyright AMA 2017
CPT Psychiatry and Clinical Lab Codes

- Psychiatry codes
  90832 Psychotherapy, 30 minutes with patient
  90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for the primary procedure)

- Clinical lab tests *
  - 80300 Drug Screen, any number of drug classes from Drug Class A, direct optical observation, instrument assisted, dipstick, cups, cards, cartridges
  - 80303 Drug Screen, presumptive, single drug class from Drug Class B, immunoassay
  - 80361 Definitive Drug Class - opiates Urinalysis, by dipstick or tablet reagent

*Confirm that payer coverage/reimbursement guidelines recognize these codes and allow doctor to bill (or independent lab) to bill the insurer. Check for frequency limits
Medicaid HCPCS H Codes - Selection

- **H0001** Alcohol and/or drug assessment
- **H0002** Behavioral health screening to determine eligibility for admission to treatment program
- **H0003** Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs
- **H0004** Behavioral health counseling and therapy, per 15 minutes
- **H0005** Alcohol and/or drug services; group counseling by a clinician
- **H0006** Alcohol and/or drug services; case management
- **H0007** Alcohol and/or drug services; crisis intervention (outpatient)
Medicaid HCPCS H Codes - Selection

- H0008 Alcohol and/or drug services; sub-acute detoxification (hospital inpatient)
- H0009 Alcohol and/or drug services; acute detoxification (hospital inpatient)
- H0010 Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)
- H0011 Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)
- H0012 Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)
- H0013 Alcohol and/or drug services; acute detoxification (residential addiction program outpatient)
- H0014 Alcohol and/or drug services; ambulatory detoxification
- H0015 Alcohol and/or drug services; intensive outpatient treatment (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling, crisis intervention, and activity therapies or education
Other H Codes describe

- Behavioral health
- Drug administration
- Prevention services
HCPCS G codes – For Medicare

- G0396  Alcohol and/or substance (other than tobacco) abuse, structured assessment (e.g. audit, DAST), and brief intervention 15-30 minutes
- G0397  Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g. audit, DAST), and intervention, greater than 30 minutes
HCPCS Product Codes

- J0570 Buprenorphine, implant, 74.2 mg
- J0571 Buprenorphine, oral
- 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 3.1 to 6 mg
- J0574 Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine
- J0757 Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine
- J2310 Injection, naloxone hydrochloride, per 1 mg
- J2315 Injection, naltrexone, depot form, 1 mg
Crucial Coding Resources
Coverage Basics

Is the patient eligible under the particular health plan – Member/subscriber/enrollee/beneficiary

Is the procedure/product a covered benefit:
- Medical
- Behavioral services
- Lab/Pharmacy/Ancillary

Is the Physician within the Payer’s network? Does the physician have the credentials for the particular services? Inpatient/outpatient/specialty facility.
Get the Numbers

Patient

Subscriber enrollment number, patient/dependent

Service/Product

CPT Procedure codes, ICD10 Diagnoses codes, HCPCS Product and Procedure codes (G, H, J,)

Provider/Physician

Provider number from insurer, DEA authorized prescriber, SAMHSA authorization

ASAM American Society of Addiction Medicine
Patient Coverage Issues
/Prior Authorization
Claims Submission- Practical Tips

Is the patient eligible under the particular health plan – Member/subscriber/enrollee/beneficiary

1. Get and copy the patient’s insurance card – both sides
2. Call the patient’s insurer
3. Confirm eligibility
4. Ask if prior authorization is needed
5. Get the name, telephone number, and email address of the contact individual
6. Ask when is the best time to call for any follow up with that individual
7. Fill out and submit the form with all relevant information

Coverage
Service/Product Coverage Principles*

- Is there a defined benefit category for the service?
  - Diagnostic, evaluation, assessment (SBIRT)
  - Medication Assisted Treatment
  - Physician/professional qualifications (psychiatrist), ABAM/ASAM certified, PA, NP
- Is the service reasonable and necessary for the diagnosis or treatment of illness or injury (Medicare)?
- Is the service medically necessary for the particular patient?
- Does the service improve net health outcomes compared to alternatives?
- Appropriate frequency of services
- Fail first on initial stage, treatment of late resort, treatment of last resort

* These are typically medico-legal standards, from the payer’s policies. Not what the doctor thinks is right. The doctor has to document the patient’s needs, treatment and outcomes in the medical record, if the payer challenges – reasonable and necessary, improved health outcomes.
Drug Medi-Cal (DMC) Treatment Program

This page provides links to information for counties, direct providers and those interested in becoming providers about the requirements for participating in the DMC Treatment Program, the California Code of Regulations (CCR), Title 22, Sections 51341.1, 51490.1, 51516.1 and the standards applicable to substance abuse treatment reimbursable through DMC.

Overview

In California, the federal Medicaid Program is administered by the state as the California Medical Assistance Program (Medi-Cal). This program provides health care services to welfare recipients and other qualified low-income persons (primarily families with children and the aged, blind, or disabled). The federal Centers for Medicare and Medicaid Services (CMS) oversees the program to ensure compliance with federal law.

At the state level, the Department of Health Care Services (DHCS) administers the Medi-Cal Program. Other state agencies, including the Department of Social Services (DSS), the Department of Developmental Services (DDS), and the California Department of Aging (CDA) receive Medi-Cal funding from DHCS for eligible services that they provide to Medi-Cal beneficiaries through an Interagency Agreement. At the local level, county welfare departments determine the eligibility of applicants for Medi-Cal and are reimbursed by DHCS for the cost of those activities.

In addition to administering DMC funding, DHCS does the following:
- Certifies DMC treatment providers
- Funds reimbursements for substance abuse treatment through county alcohol and drug programs and directly to some treatment providers.
- Monitors treatment providers in order to ensure that they are following CCR Title 9 and Title 22, which govern DMC treatment.

http://www.dhcs.ca.gov/services/adp/Pages/default.aspx
XIII. Outpatient (Office Based) Medication Assisted Treatment (MAT) of Opioid Use Disorder

Medically Necessary:

Severity of Illness Criteria
Outpatient (office-based) medication assisted treatment (MAT) of opioid use disorder is considered **medically necessary** when the member has all of the following:

1. There is a reasonable expectation of compliance; **AND**
2. There is evidence that the member has restorative potential. This will be demonstrated in part, although not limited to, member's expression of an interest or desire to work towards the goals of treatment and recovery, including abstinence from all illicit substance use and all opioid use; **AND**
3. Member's social system and significant others are supportive of recovery, or member demonstrates the social and cognitive skills to develop a sober support system; **AND**
4. There is documentation of the absence of current, active untreated use of alcohol, sedative-hypnotics or other central nervous system depressants; **AND**
5. If the member is pregnant, the program physician should verify the pregnancy and the obstetrician or other provider managing the pregnancy has been consulted and care concurs with the treatment plan before MAT is initiated; **AND**
6. The member is not acutely psychotic, imminently suicidal, or imminently homicidal; **AND**
7. The member gives permission for free exchange of clinical information among all health care providers, including pharmacists.

Continued Stay Criteria
Outpatient (office-based) medication assisted treatment (MAT) of opioid dependence is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has one of the following:

1. Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **OR**
2. If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:
Outpatient (office-based) medication assisted treatment (MAT) of opioid dependence is considered **not medically necessary** when the above criteria are not met.

Coding edits for medical necessity review are not implemented for this guideline. Where a more specific policy or guideline exists, that document will take precedence and may include specific coding edits and/or instructions. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.
FACT SHEET
Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services

http://www.integration.samhsa.gov/clinical-practice/sbirt

What Is SBIRT?
SBIRT is an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach is in contrast with the primary focus of specialized treatment of individuals with more severe substance use, or those who have met the criteria for diagnosis of a Substance Use Disorder.

When Will Medicare Pay for SBIRT Services?
Medicare pays for medically reasonable and necessary SBIRT services when they are delivered in the following settings: physicians’ offices and outpatient hospitals. In these settings, providers assess for and identify individuals with, or at-risk for, substance use-related problems and furnish limited interventions/treatment.

What Types of Health Care Providers May Provide SBIRT Services Under Medicare?
In order to bill Medicare, providers of mental health services must be qualified to perform the specific mental health services rendered. In order for these services to be covered, mental health professionals must be working within their State Scope of Practice Act, and licensed (or certified) to perform mental health services by the state in which the services are performed. Refer to Change Request (CR) 2520 (Transmittal AB-03-037, March 28, 2003) at http://www.cms.gov/Transmittals/downloads/AB03037.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Physician
A qualified physician must be legally authorized to practice medicine by the state in which he or she performs his or her services, and perform his or her services within the scope of his or her license as defined by state law.

Physician Assistant (PA)
A PA must have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs and the Committee on Allied Health Education and Accreditation), or have passed the national
## Medicare payment levels for selected CPT codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Descriptor</th>
<th>Medicare Payment (National)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>New Patient, minor, 10 minutes</td>
<td>$44.50</td>
</tr>
<tr>
<td>99205</td>
<td>New Patient, moderate to high severity, 60 minutes</td>
<td>$209.23</td>
</tr>
<tr>
<td>99211</td>
<td>Established patient, minimal, 5 minutes</td>
<td>$20.46</td>
</tr>
<tr>
<td>99214</td>
<td>Established patient, detailed, moderate to high severity, 25 minutes</td>
<td>$108.74</td>
</tr>
<tr>
<td>99215</td>
<td>Established patient, comprehensive, moderate to high severity, 40 minutes</td>
<td>$146.43</td>
</tr>
<tr>
<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for the primary procedure)</td>
<td>Local payment determination ($25.42 – rural health clinic charge)</td>
</tr>
</tbody>
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# Medicare Payment for Psychiatric Collaborative Care Management

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0502</td>
<td>Initial psychiatric collaborative care management, first 70 minutes</td>
<td>$142.84</td>
</tr>
<tr>
<td>G0503</td>
<td>Subsequent psychiatric collaborative care management, first 60 minutes</td>
<td>$126.33</td>
</tr>
<tr>
<td>G0504</td>
<td>Initial or subsequent psychiatric collaborative care management, each additional 30 minutes</td>
<td>$66.04</td>
</tr>
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## Reimbursement for SBIRT

<table>
<thead>
<tr>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
<th>Fee Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commercial Insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CPT 99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
<td>$33.41</td>
</tr>
<tr>
<td></td>
<td>CPT 99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
<td>$65.51</td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
<td>G0396</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
<td>$29.42</td>
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<tr>
<td></td>
<td>G0397</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
<td>$57.69</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>H0049</td>
<td>Alcohol and/or drug screening</td>
<td>$24.00</td>
</tr>
<tr>
<td></td>
<td>H0050</td>
<td>Alcohol and/or drug screening, brief intervention, per 15 minutes</td>
<td>$48.00</td>
</tr>
</tbody>
</table>

Source: SAMHSA
TO: Executive Directors of Medicaid Participating ODADAS-Certified Treatment Programs
Executive Directors of Medicaid Participating ODMH-Certified Community Mental Health Agencies

FROM: Nilu Ekanayake, Medicaid Program Specialist, ODADAS
Theresa Rohrbaugh, Medicaid Program Administrator, ODMH

DATE: September 22, 2010 via the ODADAS and ODMH Medicaid e-mail distribution lists

RE: Medicaid Fee Schedule Implementation

ODMH Numbered Advisory: 9-FY11-5

The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Mental Health (ODMH) are transitioning their respective community Medicaid programs from the cost-based/reconciled payment method to fee schedule payment methods effective for services provided on or after October 4, 2010.

For your convenience, the following tables are the fee schedules for Medicaid covered alcohol and other drug treatment and mental health services.

<table>
<thead>
<tr>
<th>Alcohol and other Drug Treatment Service</th>
<th>Fee Schedule</th>
<th>HCPCS/CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Detoxification</td>
<td>$ 193.87</td>
<td>H0014</td>
</tr>
<tr>
<td>Assessment</td>
<td>$ 96.24</td>
<td>H0001</td>
</tr>
<tr>
<td>Case Management</td>
<td>$ 78.17</td>
<td>H0006</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>$ 129.59</td>
<td>H0007</td>
</tr>
<tr>
<td>Group Counseling</td>
<td>$ 9.52</td>
<td>H0005</td>
</tr>
<tr>
<td>Individual Counseling</td>
<td>$ 21.82</td>
<td>H0004</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>$ 136.90</td>
<td>H0015</td>
</tr>
<tr>
<td>Laboratory Urinalysis</td>
<td>$ 60.00</td>
<td>H0003</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health Service</th>
<th>Fee Schedule</th>
<th>HCPCS/CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Hospitalization</td>
<td>$ 116.81</td>
<td>S0201</td>
</tr>
<tr>
<td>Pharmacological Management</td>
<td>$ 210.87</td>
<td>90862</td>
</tr>
<tr>
<td>CPST-Individual</td>
<td>$ 21.33</td>
<td>H0036</td>
</tr>
<tr>
<td>CPST-Group</td>
<td>$ 9.81</td>
<td>H0036</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>$ 154.35</td>
<td>S9484</td>
</tr>
<tr>
<td>Mental Health Assessment</td>
<td>$ 129.99</td>
<td>H0031</td>
</tr>
<tr>
<td>Psychiatric Diagnoses</td>
<td>$ 210.87</td>
<td>90801</td>
</tr>
<tr>
<td>BH Counseling-Group</td>
<td>$ 9.87</td>
<td>H0004</td>
</tr>
<tr>
<td>BH Counseling-Intensive</td>
<td>$ 60.00</td>
<td>H0003</td>
</tr>
</tbody>
</table>

The tables above provide the fee schedules for services provided under the Medicaid program for alcohol and other drug treatment and mental health services.
Case Study # 2 - Payment

- Medicaid patient presents with opioid abuse/use disorder
- Course of assessment, diagnosis, initial treatment, follow-up management, including urine drug testing (in-office) over 30 days
- Medicaid payment for physician services and lab tests ≈ $700 - $800
- Private insurer payment which includes insurer payment + patient co-pay ≈ $630 - $850
- Patient cash payment ≈ $550 - $900
**Example of Medicaid Payment for 30 Day Drug Treatment**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Descriptor</th>
<th>Payment*</th>
<th>Number</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204</td>
<td>E&amp;M Office Visit for New Patient, Comprehensive history/exam, moderate complexity, 45 minutes</td>
<td>174.10</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99205</td>
<td>E&amp;M Office Visit for New Patient, Comprehensive history/exam, high complexity, 60 minutes</td>
<td>$216.65</td>
<td>1</td>
<td>$216.65</td>
</tr>
<tr>
<td>99214</td>
<td>E&amp;M Office Visit for Established Patient, Detailed History/Exam, moderate Complexity, 25 minutes</td>
<td>$113.09</td>
<td>2-3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td>E&amp;M Office Visit for Established Patient, Comprehensive History/Exam, High Complexity, 40 minutes</td>
<td>$151.24</td>
<td>2-3</td>
<td>$453.72</td>
</tr>
<tr>
<td>99354</td>
<td>Prolonged E&amp;M or psychotherapy (ambulatory detox)</td>
<td>$80.32</td>
<td>1</td>
<td>$80.32</td>
</tr>
<tr>
<td>G0477</td>
<td>Drug Test(s), Presumptive, (dipstick optical read)</td>
<td>$13.52</td>
<td>4</td>
<td>$54.08</td>
</tr>
</tbody>
</table>

**30 Day projected total Medicaid revenue**  

* Maryland Medicaid, North Carolina Medicaid. Payment rates can vary by state and over time
Fundamentals of Claims Submission

A. Check and get prior authorization
B. Ensure medical record is complete
C. Fill out the claim completely and accurately

• Increasingly, claims are electronically; payers review, process and make coverage/payment determination electronically.
• Put the “right” numbers/codes – CPT/ICD 10 into the right boxes
• Can you integrate your Electronic Medical Records with your billing system?
Reimbursement Best Practices and Practical Tips

1. Pick your reimbursement model (cash, participating provider/network, claims submission, etc.)
2. Hire/designate staff to manage billing/reimbursement – (outsource billing)
3. Get in-house billing staff the resources they need – current coding books
4. Have staff do their homework on the patient’s policies
6. Complete patient medical records with clinical details
7. Review sample of claims before submitted – Report all codes
9. Draft letters of medical necessity
10. If your staff need help, call the health plan.
11. Try to establish a single point of contact
12. Be an advocate for reimbursement for substance use disorder treatment. Be an advocate for your patient. Integrate reimbursement into the financial/economic growth of your practice.
Getting Started. The real reimbursement world is complex

A combination of models:
- Cash
- Fee for Service
- Capitated Rates

Be alert – payers who cover your patient may not allow you to charge/accept cash if you are a participating provider. You must “accept assignment”.

Patient

Physician

Payer
Multiple Reimbursement/Revenue Streams in a Growing Practice

- **Cash**
  - 100% patient pay

- **Fee for Service**
  - Insurance payment fee schedule amount, plus patient co-pay;

- **Capitated/Negotiated**
  - Bundled payment for total plan of care.
  - Fixed payment per patient per month.
  - Risk sharing alternative payment models
What Comes Next – Webinar # 2

- Advanced reimbursement – Digging into the details of key payer substance abuse/addiction treatment coverage policies
- Appealing denied claims – Be patient, persistent, professional
- Compliance protections – what to do before and if the Medicaid fraud control unit knocks on the door.
- Ten Step Program to Navigating Payment Pathways
Questions

Discussion
Health insurers are expanding coverage for addiction medicine.
Addiction specialists/addictionologists have an opportunity to expand their practice by engaging directly with 3rd party payers.
Reimbursement requires advance planning, on-going attention, and commitment to make the numbers work.
Register for Navigating Payment Pathways Part 2

- Tuesday, March 7, 2017
- 1pm ET
- Register: https://attendee.gotowebinar.com/register/3031026283987851011
Thanks to many ASAM staff and members for their input on this webinar.

An e-mailed CME certificate will be sent out in the following weeks.
References and Website Resources

- http://dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&noSaveAs=1&Rendition=Primary&allowInterrupt=1&dDocName=dhs16_162941
- https://www.medicaid.gov/medicaid/by-state/by-state.html
- https://www.samhsa.gov/treatment/substance-use-disorders
Acronyms

- ACA – Affordable Care Act (Obama Care) – Patient Protection and Affordable Care Act
- ACO - Accountable Care Organization
- APCs – Ambulatory Payment Classifications
- APM – Alternative Payment Model
- ASAM – American Society of Addiction Medicine
- BCBSA – Blue Cross Blue Shield Association
- CMS – Centers for Medicare and Medicaid Services
- COT – Chronic Opioid Treatment program
- CPT – Current Procedure Terminology
- DAST – Drug Abuse Screening Test
- DEA – Drug Enforcement Agency
- DHHS - Department of Health and Human Services
- DOJ – Department of Justice
- EOB/EOMB – Explanation of Medical Benefits
- HCPCS – Healthcare Common Procedure Coding System
- HMO – Health Maintenance Organization
- ICD-10 CM– International Classification of Diseases, 10th edition, Clinical Modification
- ICD-10-PCS International Classification of Diseases, 10th edition, Procedure Coding System
- MAT – Medication-Assisted Treatment
- MCO – Managed Care Organization
- MFCU – Medicaid Fraud Control Unit
- MHPAEA – Mental Health Parity and Addiction Equity Act
- MS-DRGs – Medicare Severity Diagnosis Related Groups
- OIG – Office of Inspector General
- OTP – Opioid treatment program
- PDMP – Prescription drug monitoring program
- PPO – Preferred provider organization
- RBRVS – Resource based relative value scale
- SAMHSA – Substance Abuse Mental Health Services Administration
- SBIRT – Screening, Brief Intervention, Referral to Treatment
- UDT – Urine Drug Testing
## History

### Chief Complaint (CC)
- Location; Severity; Timing; Quality; Duration; Context; Modifying Factors; Associated signs and symptoms

### History of present illness (HPI)
- Past medical; Family; Social

### Review of systems (ROS)
- Constitutional; Eyes; Ears, Nose, Mouth, and Throat; Cardiovascular; Respiratory; Genitourinary; Musculoskeletal; Gastrointestinal; Skin/Breast; Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; Allergic/Immunologic

<table>
<thead>
<tr>
<th>History Type</th>
<th>CC</th>
<th>HPI</th>
<th>PFSH</th>
<th>ROS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief (1-3 elements or 1-2 chronic conditions)</td>
<td>Yes</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Extended (4 elements or 3 chronic conditions)</td>
<td>Yes</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pertinent (1 element)</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Complete (2 elements (est) or 3 elements (new/init))</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

## Examination

### System/body area
- Constitutional
  - 3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight
  - General appearance
- Musculoskeletal
  - Muscle strength and tone
  - Gait and station
- Psychiatric
  - Speech
  - Thought process
  - Associations
  - Abnormal/psychotic thoughts
  - Judgment and insight
  - Orientation

### Examination Elements
- 1-5 bullets: Problem focused (PF)
- At least 6 bullets: Extended problem focused (EPF)
- At least 9 bullets: Detailed (DET)
- All bullets in Constitutional and Psychiatric (shaded) boxes and 1 bullet in Musculoskeletal (unshaded) box: Comprehensive (COMP)

## Medical Decision Making Element

### Determined by
- Number of diagnoses or management options
- Amount and/or complexity of data to be reviewed
- Risk of significant complications, morbidity, and/or mortality

### Problem Points

<table>
<thead>
<tr>
<th>Category of Problems/Major New symptoms</th>
<th>Points per problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limiting or minor (stable, improved, or worsening): (max=2)</td>
<td>1</td>
</tr>
<tr>
<td>Established problem (to examining physician); stable or improved</td>
<td>1</td>
</tr>
</tbody>
</table>
Medical Coverage Policy  Treatment of Opioid Dependence Effective Date: 07/05/2011 Policy Last Updated: 6/3/2008

Note: This policy addresses the use of buprenorphine as a maintenance treatment of opioid addiction and not the use of rapid withdrawal regimens.

Description: The Food and Drug Administration (FDA) has approved two forms of buprenorphine, Subutex or Buprenex (buprenorphine hydrochloride) and Suboxone (buprenorphine hydrochloride and naloxone hydrochloride in a 4:1 ratio), for the treatment of opioid dependence. These drugs treat opiate addiction by preventing symptoms of withdrawal from heroin or other opiates and thereby reducing addiction behaviors. Federal law (DATA, the Drug Addiction Treatment Act) allows physicians to administer and/or prescribe buprenorphine for addiction treatment, including a maintenance phase whereby the drug may be utilized indefinitely. The law was intended to create greater access to opioid addiction treatment programs by facilitating the creation of a cohort of physician office treatment programs and an allowance for prescriptions for self-administration of the agents, when clinically appropriate. In contrast, methadone maintenance requires facility-based treatment and direct administration of the drug. The use of these agents in medication-assisted treatment of opioid addiction is regulated by federal and state statute.

Buprenorphine with naloxone (Suboxone) is used as an alternative to methadone for the maintenance treatment of opiate addiction. The drug is less rigidly controlled than methadone because it has a lower potential for abuse and is less dangerous in an overdose. The intention of adding naloxone to the formulation is to deter misuse. Buprenorphine is pharmacologically related to morphine and is a partial opioid agonist: It has the same effect on mu-opioid receptors in the brain as does heroin or other opiate drugs, but it has a ceiling affect whereby higher doses do not result in higher effects. Buprenorphine, when used correctly, reduces or eliminates withdrawal symptoms associated with opioid dependence but does produce the euphoria and sedation caused by heroin or other opiates. However, warnings exist that both formulations have the potential for abuse and produces dependence of the opioid type. Also, buprenorphine has been associated with significant respiratory depression, and several deaths have occurred when addicts intravenously misused the drug, usually concomitantly with benzodiazepines (sedative/hypnotics) or other depressants such as alcohol and other opioids.
Treatment is conducted in phases as described below.

- **Induction:**

  Patients must be assessed for opioid dependence and appropriateness for buprenorphine therapy. Once judged appropriate, patients may start treatment with buprenorphine alone or buprenorphine with naloxone. As naloxone is an antagonist, withdrawal may be precipitated when it is used. Therefore, patients on higher doses of long-acting narcotics will typically be treated with buprenorphine alone or converted to short-acting drugs or first undergo reduction in doses. They may also experience significant withdrawal regardless of buprenorphine administration and require symptomatic therapies. Patients are instructed to discontinue their opioids and are scheduled to be seen in the office at a time when they would begin to experience withdrawal symptoms. The presence of these symptoms is assessed and if present, the buprenorphine is administered usually at a dose of 4 mg (2-8 mg). The patient is observed for relief of withdrawal signs and symptoms or adverse effects. Symptoms are typically relieved in 20-40 minutes. If controlled, the patient is usually observed longer and at approximately 2-4 hours given a second 4 mg dose. Rarely, some patients with high likelihood of breakthrough withdrawal are sent home with a third nighttime dose.

  The patients are then seen daily to assess whether withdrawal is controlled. Doses are adjusted as needed until a stable dose is found. A dose of not greater than 16 mg is maintained for several days before dosage escalation to allow steady state equilibration. Usually the target daily dose is determined or the maximum daily dose is reached by three days and administration can be changed to once daily.

- **Stabilization:** The goal of the stabilization phase is to attempt to reach a daily maintenance dose within 12 weeks. Patients started on buprenorphine without naloxone are converted to the combined product. Doses greater than 32 mg are not generally needed. Patients are regularly assessed for adherence, use of illicit drugs, intoxication or withdrawal and satisfaction. A “Treatment Improvement Protocol” guidelines (TIP 40) recommend that initial and ongoing drug screening should be used to detect or confirm the use of recent use of drugs which could complicate patient management. Urine screening is the most commonly used testing method.
Maintenance Therapy: Once stable, patients enter maintenance therapy, which may last indefinitely. It may be associated with gradual dose reductions (medical withdrawal) and eventual elimination of treatment, or there may be an indefinite continuance to avoid relapse of addiction.

Dosage and Administration of Suboxone: Suboxone treatment is intended for use in adults and adolescents more than 16 years of age and is administered sublingually as a single daily dose. The recommended target dose is in the range of 12 to 16 mg/day. The pill is placed underneath the tongue until it has fully dissolved and typically will be absorbed within 10-20 minutes. As patients progress on therapy, the physician may write a prescription for a take-home supply of the medication.
Physician Qualifications: The Drug Addiction Treatment Act (DATA) requires that before physicians begin prescribing buprenorphine they must notify the Secretary of Health and Human Services-specifically the Division of Pharmacologic Therapies (DPT) within the Center for Substance Abuse Treatment (CSAT)-of their intent to treat patients with this product. CSAT will in turn notify the Drug Enforcement Administration (DEA) if, and when, the provider is qualified as required by DATA. Only those physicians who have approval from the DEA are able to start in-office treatment and provide prescriptions for ongoing medication. The CSAT maintains an active database to help individuals locate qualified doctors. Buprenorphine treatment must be combined with concurrent behavioral therapies and with the provision of needed social services by the primary treating physician. Therefore, qualified physicians must be able to provide or refer patients for these services. Only physicians may be qualified in accordance with DATA. Other professionals with prescriptive privileges by state law are not eligible to be qualified.

NOTE TO THE PRESCRIBER: The prescriber is responsible to adhere to the SAMHSA regulations for addiction treatment under the provisions of the Drug Addiction Treatment Act of 2000 (DATA 2000). The prescriber is responsible for complying with all associated state and federal opioid treatment and maintenance protocols as they relate to physician qualifications, privacy and confidentiality of the patient, dispensing and prescribing of buprenorphine products, record keeping and coordinating treatment with addiction and psychiatric treatment programs.
Medical Criteria:

- Office-based treatment of opioid dependence requires the following:
  - Diagnosis of opioid dependence 304.00, 304.01, 304.02
  - Member has been informed on safe and effective alternatives to treatment and has chosen this method of treatment and understands the potential risks and benefits, and is willing and able to follow the treatment plan.
  - Not dependent on high doses of benzodiazepines or other central nervous system depressants including alcohol.
  - No co-occurring mental health conditions that may undermine the ability to participate in treatment.
  - History of relapse does not indicate the need for a higher level of care.
  - History of poor response to well-conducted episodes of buprenorphine treatment.

Policy:

- Treatment of opioid dependence using buprenorphine is covered when the criteria above it met.
Drug Testing and Other Compliance Monitoring: Periodic testing for use of other opiates or illicit substances or alcohol misuse is expected in the management. Usually urine screening is performed during initial phases of treatment and randomly eight times a year. In order to be sure patients are not diverting medication, they may be required to report at random intervals to the office with their pill supply to be sure it is consistent with the prescribed use (i.e., no pills are missing.) Physicians must maintain careful records of prescribed doses. (Dispensed doses require exact narcotic administration records). Blue Cross & Blue Shield of Rhode Island (BCBSRI) may report to the prescribing physician regarding the prescription payment history and assess whether the patient receiving buprenorphine is receiving other opiates. The use of opiates to control acute pain may be appropriate, but such use is very complex when used in conjunction with Suboxone due to antagonist affects, tolerance, and risk of over-dosage. Therefore, patients concomitantly receiving opiates and buprenorphine would be unusual when the agents are used in a clinically appropriate manner. BCBSRI may also monitor physicians to be sure that they are qualified by CSAT and prescribing in conformance with the regulations.
Medicare

- Medicare is a national government health payment program for individuals who are 65 years of age and older, have end stage renal disease, or are disabled.
- Medicare has Part A and Part B contractors (Private insurance companies) who process claims from hospitals and doctors for services to Medicare patients.
- The Part A and Part B contractors cover specified states (See map).
- Note that some contractors have distinct health payment programs: for Medicare, and for private insurance. Different rules. Different payment levels.