CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13147	**Date: March 28, 2025**
	Change Request 13948

Transmittal 13088 issued February 21, 2025, is being rescinded and replaced by Transmittal 13147, dated March 28, 2025, to update the Medicare Claims Processing Manual (Pub. 100-04) Chapter 39. This correction does not make any revisions to Pub. 100-02. All other information remains the same.

SUBJECT: Updates to Medicare Benefit Policy Manual and Medicare Claims Processing Manual for Opioid Treatment Programs (OTPs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise the Medicare Benefit Policy Manual, Chapter 17, and the Medicare Claims Processing Manual, Chapter 39, to reflect changes made in the Calendar Year (CY) 2025 Physician Fee Schedule Final Rule.

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 25, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	39/TOC
R	39/20/Statutory authority for OTPs billing Medicare
R	39/30/30.3/Non-drug episode of care
R	39/30/30.5/Site of service (telecommunications)
R	39/30/30.6/Coding
R	39/30/30.6.1/Adjustments to Bundled Payment Rate
R	39/30/30.8/Locality Adjustments
R	39/30/30.9/Annual Updates
R	39/40/Practitioner Claims submission – A/B MAC (B)
R	39/40/40.2/Date of Service
D	39/50/50.2/OUD Diagnosis Code
N	39/60/OUD Diagnosis Code

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13147	Date: March 28, 2025	Change Request: 13948

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II. GENERAL INFORMATION

A. Background: Section 2005 of the SUPPORT for Patients and Communities Act established a new Medicare Part B benefit for OTPs. CMS finalized policies related to implementing this new benefit in the Calendar Year (CY) 2020 Physician Fee Schedule final rule. CMS finalized additional OTP policies in the CY 2025 Physician Fee Schedule final rule.

B. Policy: This CR updates the Medicare Claims Processing Manual by revising Chapter 39, OTPs.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13948 - 04.1	Medicare contractors shall be aware of changes to the Medicare Claims Processing Manual, Chapter 39, contained in this CR.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Pre-Implementation Contact(s): Rebecca Ray, 667-414-0879 or rebecca.ray@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 39 – Opioid Treatment Programs (OTPs)

Table of Contents
(Rev. 13147; Issued: 03-28-25)

Transmittals for Chapter 39

20 - Statutory authority for OTPs billing Medicare

(Rev. 13147; Issued: 03-28-25; Effective: 01-01-25; Implementation: 03-25-25)

Section 2005 of the SUPPORT Act amended section 1861 of the Act by adding a new subsection (jjj)(2) to define an OTP as an entity meeting the definition of OTP in 42 CFR 8.2 or any successor regulation (that is, a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 U.S.C. 823(g)(1)), that meets the additional requirements set forth in subparagraphs (A) through (D) of section 1861(jjj)(2) of the Act. Specifically that the OTP: is enrolled under section 1866(j) of the Act; has in effect a certification by the Substance Abuse and Mental Health Services Administration (SAMHSA) for such a program; is accredited by an accrediting body approved by SAMHSA; and meets such additional conditions as the Secretary may find necessary to ensure the health and safety of individuals being furnished services under such program and the effective and efficient furnishing of such services.

We defined "opioid treatment program" at § 410.67(b) as an entity that is an OTP as defined in § 8.2 (or any successor regulation) that meets the applicable requirements for an OTP. For an OTP to participate and receive payment under the Medicare program, the OTP must be enrolled under section 1866(j) of the Act, have in effect a certification by SAMHSA for such a program, and be accredited by an accrediting body approved by SAMHSA. *Additionally, payments made to OTPs under the Medicare OTP benefit must be for the treatment of an opioid use disorder (OUD).*

30.3 - Non-drug episode of care

(Rev. 13147; Issued: 03-28-25; Effective: 01-01-25; Implementation: 03-25-25)

HCPCS code G2074 describes a non-drug episode of care. This provides a mechanism for OTPs to bill for non-drug services, including substance use counseling, individual and group therapy, and toxicology testing, that are rendered during weeks when a medication is not administered, for example, in cases where a patient is being treated with injectable buprenorphine or naltrexone on a monthly basis.

30.5 - Site of service (telecommunications)

(Rev. 13147; Issued: 03-28-25; Effective: 01-01-25; Implementation: 03-25-25)

During the Public Health Emergency (PHE) for the COVID-19 pandemic, *CMS allowed various flexibilities for OUD treatment services furnished by OTPs via communication technology, including allowing* the therapy and counseling portions of the weekly bundles of services furnished by OTPs, additional counseling or therapy payable under the add-on code for additional counseling or therapy, the OTP intake add-on code for the initiation of treatment with buprenorphine, *and periodic assessments to* be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology if beneficiaries *did* not have access to two-way audio/video communications technology, provided all other applicable requirements *were* met. This include*d* instances when the beneficiary *wa*s not capable of, or does not consent to, the use video technology for the service. *All these aforementioned flexibilities have been made permanent either during the COVID-19 PHE or following the PHE which ended May 11, 2023.*

In total, CMS allows the following flexibilities for use of communication technology for OUD treatment services furnished by OTPs, as clinically appropriate and in compliance with all applicable requirements:

- *Two-way interactive audio-video communication technology*
  - *Substance use counseling and individual and group therapy services included in the bundled payment*
  - *The add-on code for additional counseling and therapy*
  - *Periodic assessments*

    - *Initiation of treatment with buprenorphine if authorized by DEA and SAMHSA at the time the service is furnished*
    - *Initiation of treatment with methadone if authorized by DEA and SAMHSA at the time the service is furnished*
- *Audio-only communication technology, if beneficiaries do not have access to two-way audio-video communications technology, including instances when the beneficiary is not capable of, or does not consent to, the use of video technology for the service:*
    - *Substance use counseling and individual and group therapy services included in the bundled payment*
    - *The add-on code for additional counseling and therapy*
    - *Periodic assessments*
    - *Initiation of treatment with buprenorphine if authorized by DEA and SAMHSA at the time the service is furnished*

Beginning January 1, 2025, OTPs may bill the OTP intake add-on code (HCPCS code G2076) when used for the initiation of treatment with methadone when furnished via two-way audio-video communications technology. This is permitted if an OTP practitioner determines that an adequate evaluation of the patient can be accomplished through audio-video communication technology, to the extent that the use of audio-video telecommunications technology to initiate treatment with methadone is authorized by DEA and SAMHSA at the time the service is furnished, and all other applicable requirements are met. OTPs may bill the OTP intake add-on code (HCPCS code G2076) for the use of audio-only initiation of treatment with methadone if pursuant to the exception specified in § 8.12(f)(2)(v)(A), which allows for the use of audio-only devices when the patient is in the presence of a licensed practitioner who is registered to prescribe (including dispense) controlled medications, and when audio-visual technologies are not available or their use is not feasible for a patient. The licensed practitioner would need to be present in the same room as the patient and be available to conduct the visual component of the examination.

OTPs providing intensive outpatient services to Medicare beneficiaries with an OUD shall not receive payment under Medicare part B if these services are furnished via audio-video or audio-only communications technology.

CMS expects OTPs to add Modifier 93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system) to the claim for counseling and therapy provided via audio-only telecommunications using HCPCS code G2080, as well as for intake activities and periodic assessments furnished using audio-only communication technology. Additionally, CMS expects OTPs to add Modifier 95 (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) to the claim for counseling and therapy provided via audio-video telecommunications using HCPCS code G2080, as well as for intake activities and periodic assessments furnished using audio and video communication technology.

As OTP services are not PFS services, no originating site facility fee (HCPCS code Q3014) applies to OUD treatment services, and OTPs are not authorized to bill for the originating site facility fee. Additionally, the payment for the substance use counseling and individual and group therapy are included in the bundled payment rates made to OTPs; therefore, the practitioner furnishing the service remotely should not bill separately for the service.

30.6 – Coding

(Rev. 13147; Issued: 03-28-25; Effective: 01-01-25; Implementation: 03-25-25)

The codes describing bundled payments made to OTPs are HCPCS codes *G2067-G2069, G2073-G2075, and G0533*. There are add-on codes described by HCPCS codes G2076-G2080, HCPCS codes G2215,

G2216, G1028, *G0137, G0532, and G0534-G0536*. Only an entity enrolled with Medicare as an OTP can bill these codes. Additionally, OTPs are limited to billing only these codes describing bundled payments, and may not bill for other codes, such as those paid under the PFS.

The coding structure for OUD treatment services varies by the medication administered. There are G codes for weekly bundles describing treatment with methadone, oral buprenorphine, *and* injectable buprenorphine, *monthly bundles describing treatment with* extended-release injectable naltrexone *and injectable buprenorphine*, a non-drug bundle, and one for a medication not otherwise specified (see full list of codes below).

The code describing the bundled payment for an episode of care with a medication not otherwise specified (HCPCS code G2075) should be used when the OTP furnishes MAT with a new opioid agonist or antagonist treatment medication approved by the FDA under section 505 of the FFDCA for the treatment of OUD. OTPs may use this code until CMS has the opportunity to propose and finalize a new G code to describe the bundled payment for treatment using that drug and price it accordingly in the next rulemaking cycle.

HCPCS code G2075 should not be used when the drug being administered is not a new opioid agonist or antagonist treatment medication approved by the FDA under section 505 of the FFDCA for the treatment of OUD, and therefore, for which Medicare would not have the authority to make payment since section 1861(jjj)(1)(A) of the Act requires that the medication must be an opioid agonist or antagonist treatment medication approved by the FDA under section 505 of the FFDCA for the treatment of OUD.

HCPCS code G2074, which describes a non-drug bundle, can be billed for services furnished during an episode of care when a medication is not administered, but other services in the bundle are furnished. For example, when a patient receives a buprenorphine injection on a monthly basis, the OTP will only require payment for the medication during the first week of the month when the injection is given, and therefore, would bill the code describing the bundle that includes injectable buprenorphine during the first week of the month and would bill the code describing the non-drug bundle for the remaining weeks in that month for services such as substance use counseling, individual and group therapy, and toxicology testing.

Some of the bundled payment codes describe a drug that is typically only administered once per month, such as the injectable drugs. *Consistent with FDA labelling, CMS does not generally expect the codes describing bundled payments including the monthly injectable drugs (HCPCS codes G2069 and G2073) to be furnished more than once every 4 weeks.* In those cases, the code describing the bundled payment that includes the cost of the drug would be billed during the week that the drug is administered, and if at least one service is furnished in a subsequent week, the non-drug bundle would be billed. For example, in the case of a patient receiving injectable buprenorphine, CMS would expect that HCPCS code G2069 would be billed for the week during which the injection was administered and that 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.

CMS understands there are limited clinical scenarios when a beneficiary may be appropriately furnished OUD treatment services at more than one OTP within a 7 contiguous day period, such as for guest dosing or when a beneficiary transfers care between OTPs. In these limited circumstances, each of the involved OTPs may bill the appropriate HCPCS codes that reflect the services furnished to the beneficiary. CMS expects that both OTPs involved would provide sufficient documentation in the patient's medical record to reflect the clinical situation and services provided. Additionally, in instances in which a patient is switching from one drug to another, the OTP should only bill for one code describing a weekly bundled payment for that week and should determine which code to bill based on which drug was furnished for the majority of the week.

Modifier 59

CMS notes that as HCPCS codes G2067 – G2069, and G2073-G2075, cover episodes of care of 7 contiguous days, CMS will not permit an OTP to bill any of these codes for the same beneficiary more than once per 7 contiguous day period. However, there may be certain circumstances when the OTP has a valid reason for billing the bundled payments (G2067 – G2069 and G2073-G2075) more than once in a 7-day period, such as when a patient is first beginning treatment and the OTP needs to synch that patient up with the OTP's standard weekly billing cycle, or during holiday weeks when the OTP may be closed for a portion of the week. In these circumstances when the OTP has a valid reason for billing these bundles more than once per 7 contiguous day period, OTPs should append modifier 59 to the claim and document the valid reason (including providing sufficient documentation) for billing more than one bundled payment for an episode of care.

30.6.1 - Adjustments to Bundled Payment Rate

(Rev. 13147; Issued: 03-28-25; Effective: 01-01-25; Implementation: 03-25-25)

There are add-on codes for intake activities, periodic assessments, take-home supplies of methadone, take home supplies of oral buprenorphine, additional counseling or therapy services furnished, take-home supplies of naloxone, *intensive outpatient program services, take-home supplies of nalmefene, coordinated care and/or referral services, patient navigational services, and peer recovery support services.*

CMS notes that the add-on code describing intake activities (HCPCS code G2076) should only be billed for new patients (that is, patients starting treatment at the OTP).

There are two add-on codes that describe take-home doses of medication, one for take-home supplies of methadone (HCPCS code G2078), which describes up to 7 additional days of medication, and can be billed along with the respective weekly bundled payment in units of up to 3 (for a total of up to a one month supply), and one for take-home supplies of oral buprenorphine (HCPCS code G2079), which also describes up to 7 additional days of medication and can be billed along with the base bundle in units of up to 3 (for a total of up to a 1 month supply). SAMHSA allows a maximum take-home supply of one month of medication; therefore, CMS does not expect the add-on codes describing take-home doses of methadone and oral buprenorphine to be billed any more than 3 times in one month (in addition to the weekly bundled payment). The add-on code for take-home doses of methadone can only be used with the methadone weekly episode of care code (HCPCS code G2067). Similarly, the add-on code for take-home doses of oral buprenorphine can only be used with the oral buprenorphine weekly episode of care code (HCPCS code G2068).

HCPCS code G2080 may be billed when counseling or therapy services are furnished that substantially exceed the amount specified in the patient's individualized treatment plan. OTPs are required to document the medical necessity for these services in the patient's medical record.

OTPs billing for intensive outpatient services (G0137) must be furnishing these services as part of a distinct and organized intensive ambulatory treatment program for the treatment of Opioid Use Disorder, and as part of a program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting. By billing G0137, OTPs are attesting that these intensive outpatient services are reasonable and necessary for the diagnosis or active treatment of the individual's condition; are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization; and are furnished in accordance with a physician or non-physician practitioner (as defined in section 1842(b)(18)(C) of the Act) certification and plan of care, as permitted by State law and scope of practice requirements. A physician or non-physician practitioner must certify that the individual has a need for a minimum of nine hours of services per week and requires a higher level of care intensity compared to other non-intensive outpatient OTP services. FDA-approved opioid agonist or antagonist medications for the treatment of OUD, opioid antagonist medications for the emergency treatment of known or suspected opioid overdose, or toxicology testing, do not count as payable OTP intensive outpatient services but if rendered, should be billed using existing bundles and/or add-on codes as long as all other applicable requirements are met.

OTPs may furnish social determinants of health (SDOH) risk assessments provided as part of intake activities (HCPCS code G2076) and periodic assessments (HCPCS code G2076), as long as these assessments are medically reasonable and necessary for the diagnosis or treatment of an OUD. OTPs should have a reason to believe unmet health related social needs (HRSNs) or the need for harm reduction intervention or recovery support services identified during such an assessment could interfere with the OTP's ability to diagnose or treat the patient's OUD. CMS does not require that OTPs utilize a specific assessment tool when furnishing SDOH risk assessments, but CMS expects that these tools are validated and evidence-based and will allow the OTP to identify more specific individual-level HRSNs as part of the care plan, including considerations to potential harm reduction interventions and recovery support service needs. CMS requires that when billing for SDOH risk assessments as part of intake activities (HCPCS code G2076) and periodic assessments (HCPCS code G2076), that OTPs continue to abide by SAMHSA certification requirements at § 8.12(f)(4). CMS notes that since intake activities may only be billed for new patients (that is, patients starting treatment at the OTP), additional SDOH risk assessments provided following intake at an OTP should be billed as part of periodic assessments (HCPCS code G2076), as long as all other requirements are met.

OTPs may additionally bill G0534 for coordinated care and/or referral services, when an OTP coordinates care or provides referral or linkage services to adequate and accessible community resources or community-based organizations that address a patient's identified unmet HRSN, or the need and interest for harm reduction interventions and recovery support services, which may limit the ability of an OTP to diagnose or treat a patient's OUD. These community-based organizations may include, but are not limited to, harm reduction organizations, peer support organizations, housing agencies, job training programs, recovery centers, food assistance or distribution programs, residential programs, and educational services.

When a patient with an OUD requires additional navigational services to navigate multiple settings of care and to accomplish (Medications for opioid use disorder) MOUD treatment and recovery goals, they may qualify for patient navigational services (G0535) and/or peer recovery support services (G0536). OTPs can bill for patient navigational services or peer recovery support services when an OTP provides these services either directly or by referral. While OTPs may choose to refer patients with an OUD to peer recovery support services and patient navigation services outside the OTP, HCPCS codes G0535 and G0536 are only payable to OTPs. Patient navigational services help the patient with an OUD navigate multiple settings of care, including by identifying care providers or recovery supportive services, communicating with other health care or social service providers and securing appointments for patients, building patient self-advocacy and communication skills, and facilitating patient-driven goal-setting and action plans for MOUD treatment and recovery. OTPs can bill for peer recovery support services (G0536) that are performed by individuals either with knowledge of an OUD, or with lived experience of an OUD, and who provide support, coaching, mentorship, or inspiration to patients with an OUD to meet various MOUD treatment and recovery goals. These peer recovery support services may assist Medicare beneficiaries with an OUD to stay engaged in treatment at an OTP; connect patients with other peer support networks or recovery services in the community; conduct interviews of the patient to understand their background, needs, and goals, and then propose or strategize means for accomplishing such treatment and recovery goals. We expect OTPs document in the patient's care plan how these aforementioned services (HCPCS codes G0534-G0536) relate to the diagnosis or treatment of an OUD prior to billing Medicare for these services.

The codes and long descriptors for the OTP bundled services and add-on services are:

- HCPCS code G2067: Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program).

- HCPCS code G2068: Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and

toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program).

- HCPCS code G2069: Medication assisted treatment, buprenorphine (injectable) *administered on a monthly basis*; bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program).

- HCPCS code G2073: Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program).

- HCPCS code G2074: Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program).

- *HCPCS code G0533: Medication assisted treatment, buprenorphine (injectable) administered on a weekly basis; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program*).

- HCPCS code G2075: Medication assisted treatment, medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program).

- HCPCS code G0137: Intensive outpatient services; minimum of nine services over a 7- contiguous day period, which can include individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law); occupational therapy requiring the skills of a qualified occupational therapist; services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; drugs and biologicals furnished for therapeutic purposes, excluding opioid agonist and antagonist medications that are FDA-approved for use in treatment of OUD or opioid antagonist medications for the emergency treatment of known or suspected opioid overdose; individualized activity therapies that are not primarily recreational or diversionary; family counseling (the primary purpose of which is treatment of the individual's condition); patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment); diagnostic services (not including toxicology testing); (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure, if applicable

- HCPCS code G2076: Intake activities, including initial medical examination that *is conducted by an appropriately licensed practitioner and preparation of a care plan, which may be informed by administration of a standardized, evidence-based Social Determinants of Health Risk Assessment to identify unmet health-related social needs, and that includes the patient's goals and mutually agreed-upon actions for the patient to meet those goals, including harm reduction interventions; the patient's needs and goals in the areas of education, vocational training, and employment; and the medical and psychiatric, psychosocial, economic, legal, housing, and other recovery support services that a patient needs and wishes to pursue, conducted by an appropriately licensed/credentialed personnel* (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to *each primary* code.

- HCPCS code G2077: Periodic assessment; assessing periodically by *an OTP practitioner and includes a review of MOUD dosing, treatment response, other substance use disorder treatment needs, responses and patient-identified goals, and other relevant physical and psychiatric treatment*

needs and goals; assessment may be informed by administration of a standardized, evidence-based Social Determinants of Health Risk Assessment to identify unmet health-related social needs, or the need and interest for harm reduction interventions and recovery support services (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to *each primary* code.

- HCPCS code G2078: Take-home supply of methadone; up to 7 additional day supply (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.

- HCPCS code G2079: Take-home supply of buprenorphine (oral); up to 7 additional day supply (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.

- HCPCS code G2080: Each additional 30 minutes of counseling or group or individual therapy in a week of medication assisted treatment, (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.

- HCPCS code G2215: Take-home supply of nasal naloxone; 2-pack of 4mg per 0.1 mL nasal spray (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.

- HCPCS code G2216: Take-home supply of injectable naloxone (provision of the services by a Medicare- enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.

- HCPCS code G1028: Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 mL nasal spray (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.

- *HCPCS code G0532: Take-home supply of nasal nalmefene hydrochloride; one carton of two, 2.7 mg per 0.1 mL nasal sprays (provision of the services by a Medicare-enrolled Opioid Treatment Program);(List separately in addition to each primary code).*

- *HCPCS code G0534: Coordinated care and/or referral services, such as to adequate and accessible community resources to address unmet health-related social needs, including harm reduction interventions and recovery support services a patient needs and wishes to pursue, which significantly limit the ability to diagnose or treat an opioid use disorder; each additional 30 minutes of services (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to each primary code).*

- *HCPCS code G0535: Patient navigational services, provided directly or by referral; including helping the patient to navigate health systems and identify care providers and supportive services, to build patient self-advocacy and communication skills with care providers, and to promote patient-driven action plans and goals; each additional 30 minutes of services (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to each primary code).*

- *HCPCS code G0536: Peer recovery support services, provided directly or by referral; including leveraging knowledge of the condition or lived experience to provide support, mentorship, or inspiration to meet OUD treatment and recovery goals; conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes; developing and proposing strategies to help meet person-centered treatment goals; assisting the patient in locating or navigating recovery support services; each additional 30 minutes of services (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to each primary code).*

Note: Effective January 1, 2025, HCPCS codes G2070 through G2072 will be deleted because the buprenorphine implant (Probuphine ®) reflected within these bundled payments was discontinued on October 19, 2020. There are currently no other generic equivalent available for buprenorphine implants.

30.8 - Locality Adjustments

(Rev. 13147; Issued: 03-28-25; Effective: 01-01-25; Implementation: 03-25-25)

The payment amounts for the non-drug component of the bundled payment for an episode of care, and the adjustments for counseling or therapy, intake activities, periodic assessments, take-home supplies of naloxone, *take-home supplies of nalmefene, intensive outpatient program services, coordinated care and/or referral services, patient navigational services, and peer recovery support services* (HCPCS codes G2067-G20*69*, *G2073-G2077,* G2080, G2215, G2216, G1028, G0137*, and G0532- G0536*) will be geographically adjusted using the Geographic Adjustment Factor (GAF). Additionally, for purposes of the GAF, OUD treatment services that are furnished via an OTP mobile unit will be treated as if they were furnished at the physical location of the OTP registered with the Drug Enforcement Administration (DEA) and certified by SAMHSA.

30.9 - Annual Updates

(Rev. 13147; Issued: 03-28-25; Effective: 01-01-25; Implementation: 03-25-25)

The payment amounts for the non-drug component of the bundled payment for an episode of care, and the adjustments for counseling or therapy, intake activities, periodic assessments*, take-home supplies of naloxone, take-home supplies of nalmefene, intensive outpatient program services, coordinated care and/or referral services, patient navigational services, and peer recovery support services* (HCPCS codes G2067-*G2069, G2073-G2077,* G2080*, G2215, G2216, G1028, G0137, and G0532-G0536*) will be updated annually using the Medicare Economic Index.

40 - Practitioner Claims submission – A/B MAC (B)

(Rev. 13147; Issued: 03-28-25; Effective: 01-01-25; Implementation: 03-25-25)

Beginning January 1, 2020, claims for OTP services are submitted using the 837P transaction to transmit health care claims electronically, or using the CMS-1500 (the paper version of the 837P). Beginning January 1, 2021, OTPs may apply on the Medicare Enrollment Application for Institutional Providers (CMS-855A) or through the Internet-based Provider Enrollment, Chain and Ownership System (PECOS)(837I) when they enroll in the Medicare Program. These providers will submit claims using the CMS-1450.

HCPCS codes *G2067-G2069, G2073-G2077, G0137, and G0533* cover episodes of care of 7 continuous days and cannot be billed for the same patient more than once per 7 continuous day period.

HCPCS codes G2076-G2080*, G0137, and G0534-G0536* are add-on codes that are billed in addition to one of the base bundle codes described by HCPCS codes G2067-*G2069, G2073-G2077, and G0533.*

Consistent with FDA labeling, HCPCS codes G2069 and G2073 should not be used more than once every 4 weeks.

HCPCS codes G2078 and G2079 may be billed in multiple units, up to 3 in one month (in addition to the base bundle code).

HCPCS codes G2215, G2216*, and G0532* are limited to being billed once every 30 days, however, exceptions to this limit are allowed in the case where the beneficiary overdoses and uses the initial supply of naloxone *or nalmefene* dispensed by the OTP to the extent that it is medically reasonable and necessary to furnish additional naloxone *or nalmefene*. If an additional supply of naloxone *or*

nalmefene is needed within 30 days of the original supply being provided, OTPs must document in the medical record the reason for the exception. HCPCS code G2216 (injectable naloxone) is contractor-priced for CY 2021.

Patients may be appropriately given OUD services at more than one OTP within a 7 day period in certain limited clinical situations, such as for guest dosing or when a patient transfers care between OTPs. Each of the involved OTPs may bill the appropriate HCPCS codes for the services provided to the patient, but both OTPs must maintain sufficient medical record documentation to reflect the clinical situation and services provided.

In instances in which a patient is switching from one drug to another, the OTP should only bill for one code describing a weekly bundled payment for that week and should determine which code to bill based on which drug was furnished for the majority of the week.

40.2 - Date of Service

(Rev. 13147; Issued: 03-28-25; Effective: 01-01-25; Implementation: 03-25-25)

For the codes that describe a weekly bundle (HCPCS codes*G2067-G2069, G2073-G2077, and G0533*) *as well as HCPCS code G0137*, one week is defined as 7 contiguous days. OTPs may choose to apply a standard billing cycle by setting a particular day of the week to begin all episodes of care. In this case, the date of service would be the first day of the OTP's billing cycle. If a beneficiary starts treatment at the OTP on a day that is in the middle of the OTP's standard weekly billing cycle, the OTP may still bill the applicable code for that episode of care provided that the threshold to bill for the code has been met.

Alternatively, OTPs may choose to adopt weekly billing cycles that vary across patients. Under this approach, the initial date of service will depend upon the day of the week when the patient was first admitted to the program or when Medicare billing began. Therefore, under this approach of adopting weekly billing cycles that vary across patients, when a patient is beginning treatment or re-starting treatment after a break in treatment, the date of service would reflect the first day the patient was seen and the date of service for subsequent consecutive episodes of care would be the first day after the previous 7-day period ends.

For the codes describing add-on services (HCPCS codes G2076-G2080*,* G0137*, and G0534-G0536*), the date of service should reflect the date that service was furnished; however, if the OTP has chosen to apply a standard weekly billing cycle, the date of service for codes describing add-on services may be the same as the first day in the weekly billing cycle.

60. OUD Diagnosis Code

(Rev. 13147; Issued: 03-28-25; Effective: 01-01-25; Implementation: 03-25-25)

Consistent with statutory provisions under sections 1861(s)(2)(HH), 1861(jjj)(1), and 1834 of the Act, Medicare payment made under Part B to OTPs furnishing OUD treatment services must be for the treatment of an OUD. Professional claims submitted on form CMS-1500 (or the electronic equivalent form 837P) and institutional claims submitted on form CMS-1450 must include an OUD diagnosis. These diagnosis codes must apply to HCPCS G-codes representing both the bundled payments for an episode of care and add-on codes to the bundled payments. Applicable diagnosis codes for an OUD that must be submitted on claims include ICD-10-CM codes in the F11 range for "disorders related or resulting from abuse or misuse of opioids" : https://www.icd10data.com/ICD10CM/Codes/F01-F99/F10-F19/F11-.