CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12418	**Date: December 21, 2023**
	Change Request 13470

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 CY 2024 Physician Fee Schedule Final Rule and the CY 2024 Hospital Outpatient Prospective Payment System Final Rule.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 24, 2024

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	39/30/30.2/Requirements for an Episode
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

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: 12418	Date: December 21, 2023	Change Request: 13470

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

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I. 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 2024 Physician Fee Schedule final rule.

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

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13470 - 04.1	Medicare contractors shall be aware of changes to the Medicare Claims Processing Manual contained in this CR.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. 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

V. CONTACTS

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

VI. 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)

30.2- Requirements for an Episode

(Rev. 12418; Issued: 12-21-23; Effective: 01-01-24; Implementation: 01-24-24)

In recognition that there is a range of service intensity depending on the severity of a patient's OUD and stage of treatment, a "full weekly bundle" may consist of a very different frequency of services for a patient in the initial phase of treatment compared to a patient in the maintenance phase of treatment, or based on other factors such as pregnancy or relapse.

The threshold to bill the weekly episode is the delivery of at least one service in the weekly bundle (from either the drug or non-drug component) to the patient during the week that corresponds to the episode of care. If no drug was provided to the patient during that episode, the OTP must bill the G-code describing the weekly bundle not including the drug (HCPCS code *G*2074) and the threshold to bill would be at least one service in the non-drug component. If a drug was provided with or without additional non-drug component services, the appropriate G-code describing the weekly bundle that includes the drug furnished may be billed.

For OTP intensive outpatient services, the threshold to bill HCPCS code G0137 for these services is a minimum of nine services furnished over a 7-continguous day period. These services are described in § 410.67(b)(ix) in the definition of "OTP intensive outpatient services." A minimum of nine OTP intensive outpatient services, regardless of the length or time duration of these services, meets the threshold to bill, including if services of the same type are furnished more than once a week as long as all services are medically reasonable and necessary for the treatment of OUD. However, an OTP may not count an intensive outpatient program service for the purposes of the nine-service threshold if that same service is being used to qualify for billing other weekly bundles and add-on codes under the OTP benefit. Additionally, to bill HCPCS code G0137, a physician or non-physician practitioner (as defined in section 1842(b)(18)(C) of the Act) 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. A physician or non-physician practitioner, as permitted by state law and scope of practice requirements, must also meet requirements for certification, plan of treatment, and recertification requirements as set forth in § 424.24(d)(1) through (3) for the purposes of furnishing OTP intensive outpatient services.

30.5 - Site of service (telecommunications)

(Rev. 12418; Issued: 12-21-23; Effective: 01-01-24; Implementation: 01-24-24)

OTPs can use two-way interactive audio-video communication technology, as clinically appropriate, to furnish the substance use counseling and individual and group therapy services included in the bundled payment, as well as the add-on code for additional counseling and therapy. During the Public Health Emergency (PHE) for the COVID-19 pandemic, *and following the end to the PHE on May 11th, 2023,* 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, and the OTP intake add-on code for the initiation of treatment with buprenorphine (but not methadone), may be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology if beneficiaries do not have access to two-way audio/video communications technology, provided all other applicable requirements are met. This includes instances when the beneficiary is not capable of, or does not consent to, the use video technology for the service.

Beginning January 1, 2021, periodic assessments may be furnished via two-way interactive audio-video communication technology, as clinically appropriate, and in compliance with all applicable requirements, and in cases where a beneficiary does not have access to two-way audio-video communications technology, periodic assessments can be furnished using audio-only telephone calls during the PHE *and through the end of CY 2024* if all other applicable requirements are met.

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.

After the conclusion of the PHE for the COVID-19 pandemic*, which ended on May 11, 2023*, 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. 12418; Issued: 12-21-23; Effective: 01-01-24; Implementation: 01-24-24)

The codes describing bundled payments made to OTPs are HCPCS codes G2067-G2075. There are add-on codes described by HCPCS codes G2076-G2080, HCPCS codes G2215, G2216, G1028*, and G0137.* 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, injectable buprenorphine, buprenorphine implants (insertion, removal, and insertion/removal), extended-release injectable naltrexone, 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.

NOTE: Some of the bundled payment codes describe a drug that is typically only administered once per month, such as the injectable drugs, or once in a 6-month period, in the case of the buprenorphine implants. 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 notes that as HCPCS codes G2067 – G2075, *and G0137*, 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. Additionally, consistent with FDA labelling, CMS does not generally expect the codes describing bundled payments including the injectable drugs (HCPCS codes G2069 and G2073) to be furnished more than once every 4 weeks. Similarly, consistent with FDA labelling, CMS does not generally expect the codes describing bundled payments including insertion of the

buprenorphine implants (HCPCS codes G2070 and G2072) to be furnished more than once every 6 months.

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.

30.6.1 - Adjustments to Bundled Payment Rate

(Rev. 12418; Issued: 12-21-23; Effective: 01-01-24; Implementation: 01-24-24)

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, and for take-home supplies of naloxone.

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.

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); 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 G2070: Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program).

● HCPCS code G2071: Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program).

● HCPCS code G2072: Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (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 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 a complete, fully documented physical evaluation and initial assessment conducted by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician or qualified personnel that includes preparation of a treatment plan that includes the patient's short-term

goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psycho- social, economic, legal, or other supportive services that a patient needs, conducted by qualified personnel (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.

● HCPCS code G2077: Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.

● 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.

30.8 - Locality Adjustments

(Rev. 12418; Issued: 12-21-23; Effective: 01-01-24; Implementation: 01-24-24)

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, *and intensive outpatient program services* (HCPCS codes G2067-G2077, G2080*,* G2215, G2216, G1028, and G0137) 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. 12418; Issued: 12-21-23; Effective: 01-01-24; Implementation: 01-24-24)

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, *and intensive outpatient program services* (HCPCS codes G2067- G2077, G2080*, and G0137*) will be updated annually using the Medicare Economic Index.

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

(Rev. 12418; Issued: 12-21-23; Effective: 01-01-24; Implementation: 01-24-24)

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-G2075, *and G0137,* 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 are add-on codes that are billed in addition to one of the base bundle codes described by HCPCS codes G2067-G2075.

Consistent with FDA labeling, HCPCS codes G2069 and G2073 should not be used more than once every 4 weeks and HCPCS codes G2070 and G2072 should not be used more than once every 6 months.

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 and G2216 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 dispensed by the OTP to the extent that it is medically reasonable and necessary to furnish additional naloxone. If an additional supply of naloxone 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. 12418; Issued: 12-21-23; Effective: 01-01-24; Implementation: 01-24-24)

For the codes that describe a weekly bundle (HCPCS codes G2067-G2075) *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*, and G0137*), 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.