Non-residential Opioid Treatment Facility (Place of Service 58)

Policy REIMB-024

Origination Date: 05/27/2020

Reviewed/Revised Date: 07/31/2023

Next Review Date: 07/31/2024

Current Effective Date: 07/31/2023

Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial, CHIP and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.
3. Services requiring prior-authorization may not be covered, if prior-authorization is not obtained.
4. This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.

Description:

Opioid Treatment Programs (OTPs) are defined by Medicare law as those who are enrolled in Medicare, are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), are accredited by a SAMHSA-approved entity, meet additional conditions to ensure the health and safety of individuals being furnished services under these programs and the effective and efficient furnishing of such services and have in effect a provider agreement with CMS.

Place of Service -58 is a descriptor code used to describe services provided at a location that administers treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT). OTPs are intended to fill access gaps in care and typically perform a narrow band of services.

Policy Statement and Criteria

1. Commercial Plans/CHIP

University of Utah Health Plans covers the following services when provided by Opioid Treatment Programs (OTPs) billing with Place of Service -58.

A. FDA (Food and Drug Administration)-approved opioid agonist and antagonist treatment medications;

B. Dispensing and administering medications (if applicable);

C. Substance use disorder counseling;

D. Individual and group therapy;

E. Toxicology testing;

F. Intake activities;

G. Periodic assessments.

Coverage Requirements include the following (ALL must be met):

A. Provider billing for service must be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA); **and**

B. Provider must be accredited by a SAMHSA-approved entity;

C. Billing is submitted using HCFA-1500 claim form; **and**

D. Codes billed represent series G2067-G2078. No other claims for other CPT codes will be accepted/reimbursed.

HCPCS codes G2067 - G2075 will only be allowed with a maximum frequency of 7 contiguous days and cannot be billed for the same patient more than once per that 7 day period.

HCPCS codes G2069 and G2073 will not be reimbursed more than once every 4 weeks.

HCPCS codes G2070 and G2072 will not be reimbursed more than once every 6 months.

HCPCS code G2076 is an add-on code reflecting new patients starting treatment in the OTP and will only be reimbursed one time based on the following guidelines:

A. Member is considered new to the OTP with no previous claims for services within a timeframe of ≥ 6 months; **and**

B. It is billed with additional covered codes.

HCPCS code G2078 is an add-on code reflecting take-home doses of methadone medication. This code 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 a month supply) with all the following guidelines:

A. Code is billed with additional G2067;

B. Maximum of 3 units will be reimbursed for each 30 day period;

C. No other codes billed for other services during the 30 day period.

HCPCS code G2079 is an add-on code for take-home supplies of oral buprenorphine, 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 a 1 month supply). SAMHSA allows a maximum take-home supply of one month of medication; therefore, we do 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). This is covered with all the following guidelines:

A. Code is billed with G2068;

B. Maximum of 3 units will be reimbursed for each 30 day period;

C. No other codes billed for other services during the 30 day period.

HCPCS code G2080 may be reimbursed only based on documentation provided with the claims demonstrating counseling or therapy services are furnished that substantially exceed the amount specified in the patient's individualized treatment plan.

2. **Medicaid Plans**

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at: https://medicaid.utah.gov/utah-medicaid-official-publications/ or the Utah Medicaid code Look-Up tool

CPT/HCPCS codes covered by Utah State Medicaid may still require further evaluation to determine medical necessity for coverage.

Clinical Rationale

In 1962, Dr. Vincent P. Dole, a specialist in metabolism at The Rockefeller University, became chair of the Narcotics Committee of the Health Research Council of New York City. After studying the scientific, public health, and social ramifications of addiction in the city, he received a grant to establish a research unit to investigate the feasibility of opioid maintenance. In preparing for this research, he read The Drug Addict as a Patient by Dr. Marie E. Nyswander (Nyswander 1956), a psychiatrist with extensive experience treating patients who were addicted to opioids. She was convinced that these individuals could be treated within general medical practice. She also believed that many would have to be maintained on opioids for extended periods to function because a significant number of people who attempted abstinence without medication relapsed, in spite of detoxifications, hospitalizations, and psychotherapy (Brecher and Editors 1972; Courtwright et al. 1989). Dr. Nyswander joined Dr. Dole's research staff in 1964. Among others joining the team was clinical investigator Dr. Mary Jeanne Kreek.

In 1965, the initial research project on methadone safety and efficacy was transferred to Manhattan General Hospital in New York City (Brecher and Editors 1972). Because Dole and his colleagues knew that an independent evaluation of this new treatment would be necessary, a team headed by Dr. Frances Rowe Gearing was formed at Columbia University School of Public Health to evaluate patient progress as this treatment expanded. In general, the team found that patients' social functioning

improved with time in treatment, as measured by elimination of illicit-opioid use and better outcomes in employment, school attendance, and homemaking. Most patients were stabilized on methadone doses of 80 to 120 mg/day. Most patients who remained in treatment subsequently eliminated illicit-opioid use.

In 1994, the California Department of Alcohol and Drug Programs published the results of a pioneering large-scale study of the effectiveness, benefits, and costs of substance abuse treatment in California. Using State databases, provider records, and follow-up interviews with treatment participants, the study detailed the effects of treatment on participant behavior including drug and alcohol use, criminal activity, health, health care use, and income; the costs of treatment; and the economic value of treatment to society. Treatment was cost beneficial to taxpayers, with the cost averaging $7 returned for every dollar invested. “Each day of treatment paid for itself (the benefits to taxpaying citizens equaled or exceeded the costs) on the day it was received, primarily through an avoidance of crime”. “Regardless of the modality of care, treatment-related economic savings outweighed costs by at least 4 to 1”. Methadone treatment was among the most cost-effective treatments, yielding savings of $3 to $4 for every dollar spent. This was true for each major methadone treatment modality, but costs were lower in an outpatient OTP than in a residential or social modality (Gerstein et al. 1994).

Opioid addiction is a problem with high costs to individuals, families, and society. Injection drug use-associated exposure accounts for approximately one-third of all AIDS cases diagnosed in the United States through 2003 (National Center for HIV, STD and TB Prevention 2005) and for many cases of hepatitis C (National Institute on Drug Abuse 2000; Thomas 2001). In the criminal justice system, people who use heroin account for an estimated one-third of the $17 billion spent each year for legal responses to drug-related crime. Indirect costs from lost productivity and overdose also are high (Mark et al. 2001), and people with opioid addictions and their families experience severe reductions in their quality of life. The increasing abuse of prescription opioids is another major concern, both for their damaging effects and as gateway drugs to other substance use.

Methadone maintenance became a major public health initiative to treat opioid addiction under the leadership of Dr. Jerome Jaffe, who headed the Special Action Office for Drug Abuse Prevention in the Executive Office of the White House in the early 1970s. Dr. Jaffe's office oversaw the creation of a nationwide, publicly funded system of treatment programs for opioid addiction. Since then Congress has enacted several significant statutes to limit and control the availability of psychoactive drugs and their use to treat addiction.

Controlled Substances Act (1970) The Controlled Substances Act of 1970 (National Academy Press, 1995) requires all manufacturers, distributors, and practitioners who prescribe, dispense, or administer controlled substances to register with the Drug Enforcement Administration (DEA). A physician seeking registration must meet certain standards established by the Secretary of Health and Human Services and must comply with regulations established by the U.S. Attorney General regarding security of opioid stocks and maintenance of records.

Narcotic Addict Treatment Act (1974) In passing the Narcotic Addict Treatment Act (NATA) of 1974 (National Academy Press, 1995), which amended the Controlled Substances Act, Congress recognized the use of an opioid drug to treat opioid addiction as critical and, for the first time in Federal law, defined “maintenance treatment.” To promote closer monitoring of programs that use opioids for maintenance treatment, the law required separate DEA registration by medical practitioners who dispense opioid drugs in the treatment of opioid addiction. Previously, any physician with a DEA registration could prescribe methadone for pain management or addiction treatment. NATA increased coordination between the U.S. Department of Health and Human Services (DHHS) and DEA. Under its

provisions, before a practitioner can obtain registration from DEA, DHHS must determine that the practitioner is qualified according to established treatment standards. NATA also established the National Institute on Drug Abuse (NIDA) an organization independent of the National Institute of Mental Health. Authority to regulate the treatment of opioid addiction was split between NIDA and the FDA. NIDA became responsible for determining appropriate standards for medical, scientific, and public health aspects of drug abuse treatment. FDA received the authority to determine the safety and effectiveness of drugs and approve new drugs for opioid addiction treatment.

Drug Addiction Treatment Act (2000) The Drug Addiction Treatment Act of 2000 (DATA [P.L. 106–310 div. B]) amended that portion of the Controlled Substances Act mandating separate registration for practitioners who dispense opioids in addiction treatment. It allows practitioners who meet certain qualifying criteria to dispense or prescribe schedule III, IV, or V controlled substances specifically approved by FDA for MAT.

The new Federal regulations preserve States' authority to regulate OTPs. Oversight of treatment medications remains a tripartite system involving States, DHHS/SAMHSA, and the U.S. Department of Justice/DEA.

States can monitor the same areas as Federal agencies, but State rules do not always echo Federal regulations. Some States have established medical recertification requirements for continuation of comprehensive, long-term MAT after a specified period. Other State and local requirements, such as certificates of need, zoning, and licensure, can affect the number, size, and location of OTPs. These regulations are not affected by the change in Federal regulations.

Applicable Coding

CPT Codes

No codes applicable

HCPCS Codes

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)

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)

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)

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)

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)

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)

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)

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)

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)

G2076 Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment by a program physician or a primary care physician, or an authorized health care professional under the supervision of a program physician 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

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

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

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

G2080 Each additional 30 minutes of counseling 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

References:

1. Anglin M D. The efficacy of civil commitment in treating narcotic addiction. In: Leukefeld, C.G., and Tims, F.M., eds. Compulsory Treatment of Drug Abuse: Research and Clinical Practice. NIDA Research Monograph 86. NIH Publication No. 94-3713. Rockville, MD: National Institute on Drug Abuse, 1988, reprinted 1994, pp. 8–34.
2. Brecher E M, the Editors of Consumer Reports Licit and Illicit Drugs: The Consumers Union Report on Narcotics, Stimulants, Depressants, Inhalants, Hallucinogens, and Marijuana—Including Caffeine, Nicotine, and Alcohol. Boston: Little Brown & Company, 1972.
3. Courtwright D T, Joseph H, Des Jarlais D. Addicts Who Survived: An Oral History of Narcotic Use in America, 1923-1965. Knoxville, TN: University of Tennessee Press, 1989.
4. Gearing F R, Schweitzer M D. An epidemiologic evaluation of long-term methadone maintenance treatment for heroin addiction. American Journal of Epidemiology. 1974;100:101–112.
5. Gerstein D R, Johnson R A, Foote M, Suter N, Jack K, Merker G, Turner S, Bailey R, Malloy K M, Williams E, Harwood H J. Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA): General Report. Sacramento, CA: California Department of Alcohol and Drug Programs, 1994.
6. Institute of Medicine. Federal Regulation of Methadone Treatment. Washington, DC: National Academy Press, 1995. Available at: https://www.ncbi.nlm.nih.gov/books/NBK232105/#:~:text=Narcotic%20Addict%20Treatment%20Act%20of,amended%20the%20Controlled%20Substances%20Act.
7. Joseph H, Dole V P. Methadone patients on probation and parole. Federal Probation June 1970, pp. 42–48.
8. Kaltenbach K, Silverman N, Wapner R. Methadone maintenance during pregnancy. In: State Methadone Treatment Guidelines. Treatment Improvement Protocol (TIP) Series 1. DHHS Publication No. (SMA) 02-3624. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1993, reprinted 2000, 2002.
9. Kleber H D. Concomitant use of methadone with other psychoactive drugs in the treatment of opiate addicts with other DSM-III diagnoses. In: Cooper, J.R.; Altman, F.; Brown, B.S.; and Czechowicz, D., eds. Research on the Treatment of Narcotic Addiction: State of the Art. NIDA Treatment Research Monograph Series. DHHS Publication No. (ADM) 83-1281. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1983, pp. 119–148.
10. Kosten T R. Client issues in drug abuse treatment: Addressing multiple drug abuse. In: Pickens, R.W.; Leukefeld, C.G.; and Schuster, C.R., eds. Improving Drug Abuse Treatment. NIDA Research Monograph 106. DHHS Publication No. (ADM) 91-1754. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1991, pp. 136–151.
11. Mark T, Woody G E, Juday T, Kleber H D. The economic costs of heroin addiction in the United States. Drug and Alcohol Dependence. 2001;61:195–206.
12. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs Center for Substance Abuse Treatment Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. Report No.: (SMA) 12-4214. SAMHSA/CSAT Treatment Improvement Protocols. PMID: 22514849 NBK64164
13. MLN 8296732 May 2020, Opioid Treatment Programs (OTPs) Medicare
14. National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. Basic Statistics. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2005. www.cdc.gov/hiv/stats.htm
15. National Institute on Drug Abuse (NIDA). NIDA Community Drug Alert Bulletin—Hepatitis. Rockville, MD: NIDA, 2000. www.drugabuse.gov/HepatitisAlert/HepatitisAlert.html
16. Nurco D N, Stephenson P, Hanlon T E. Contemporary issues in drug abuse treatment linkage with self-help groups. In: Pickens, R.W.; Leukefeld, C.G.; and Schuster, C.R., eds. Improving Drug Treatment. NIDA Research Monograph 106. DHHS Publication No. (ADM) 91-1754. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1991, pp. 338–348.
17. Nyswander M. The Drug Addict as a Patient. New York: Grune and Stratton, 1956
18. Substance Abuse and Mental Health Services Administration (SAMHSA). Drug Addiction Treatment Act of 2000. Rockville, MD: SAMHSA, 2003a.
19. Thomas J. Drug injectors sharing cookers and cotton increase their risk of hepatitis C. NIDA Notes 16(3):9–11, 2001. www.drugabuse.gov/NIDA_Notes/NNVol16N3/Drug.html

Disclaimer:

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. 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.

U of U Health Plans makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. U of U Health Plans updates its Coverage Policies regularly, and reserves the right to amend these policies and give notice in accordance with State and Federal requirements.