CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10521	**Date: December 16, 2020**
	Change Request 11856

Transmittal 10266, dated August 6, 2020, is being rescinded and replaced by Transmittal 10521, December 16, 2020 to add the Provider Type "34", note that CAH's are paid via the OTP fee schedule, and clarification on the 2020 OTP fee schedule file (attachment 1) versus the 2021 OTP fee schedule file (new attachment 3). This correction revises business requirement 1856-4.1 and only impacts publication 100-04. All other information remains the same.

SUBJECT: New Medicare National Uniform Billing Committee (NUBC) Type of Bill (TOB), Condition Code and implementing Billing Codes for Opioid Treatment Programs

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to establish coding and payment rates as authorized by Section 2005 (Medicare Coverage of Certain Services Furnished by Opioid Treatment Programs) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. These payments begin January 1, 2021.

All Opioid Treatment Programs billing Medicare will be required to enroll with Medicare as an Opioid Treatment Program and submit claims to FISS using an institutional claim form.

EFFECTIVE DATE: January 1, 2021 - For claims received on or after 01/01/2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021 - For all BR's except those noted for April 2021; April 5, 2021 - For BR's 04.8, 04.9, 04.9.1, 04.10, 04.10.1, 04.11, 04.11.1, and 06.1

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	6/20/20.3/Type of Bill
R	6/60/60.3/Type of Bill

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. 100-06	Transmittal: 10521	Date: December 16, 2020	Change Request: 11856

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I. GENERAL INFORMATION

A. Background: Section 2005 of the SUPPORT Act established a new Medicare benefit category for Opioid use Disorder (OUD) treatment services furnished by Opioid Treatment Programs (OTPs) under Medicare Part B, beginning on or after January 1, 2020. Currently, OTPs enroll in the Medicare program with a CMS-855B and submit claims using the CMS-1500. These payments began January 1, 2020. The purpose of this CR is to allow OTPs who have applied on the CMS-855-A to bill on an institutional claim form.

Health care organizations may apply on the Medicare enrollment application (CMS-855A) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. The provider types listed on the form describe the specific/unique types of Institutional provider. Provider types are used by the CMS for programmatic and claims processing purposes.

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted institutional implementation guide for the Accredited Standards Committee (ASC) X12N 837 standard requires that each electronic claim transaction include a TOB code from the TOB code set maintained by the NUBC. As a payer, Medicare must be able to recognize as valid any valid code from the TOB code set that appears on the HIPAA standard claim transaction.

This CR implements the current TOB code set by adding new TOB code 087x for "Freestanding Non-residential Opioid Treatment Program." Additionally, for "Provider Based Non-residential Opioid Treatment Program," this CR implements the current Condition Code set by adding new Condition Code "89." Services include methadone and other forms of Medication Assisted Treatment (MAT). Additionally, this CR will implement the systems and local contractor level changes needed for Medicare to adjudicate claims with the new TOB code and new Condition Code. Local contractors shall develop policies as needed to adjudicate claims containing new TOB code 087x in accordance with Medicare national policy.

B. Policy: Sections 1861(s)(2)(HH) and (jjj) of the Act require that covered opioid use disorder treatment services include the Food and Drug Administration (FDA)-approved opioid agonist and antagonist treatment medications, the dispensing and administration of such medications (if applicable), substance use disorder counseling, individual and group therapy, toxicology testing, and other items and services that the Secretary determines are appropriate. Section 1861(jjj) defines OTPs as those that enroll in Medicare and are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), accredited by a SAMHSA-approved entity, and meet additional conditions as the Secretary finds necessary to ensure the health and

safety of individuals being furnished services under these programs and the effective and efficient furnishing of such services.

The NUBC has established a new TOB code for Freestanding Non-residential Opioid Treatment Programs (OTP) (087x) and a new Condition Code for provider-based OTP (89).

TOB 087x: Freestanding Non-residential Opioid Treatment Program.

Condition Code 89: Opioid Treatment Program/Indicates claim is for opioid treatment program services.

Valid OTP service Revenue Codes: 090x – 091x, 0949, 0953.

Valid OTP service HCPCS: G2067-G2080.

Unless prohibited by national policy to the contrary, Medicare not only recognizes valid TOB codes from the TOB code set but also adjudicates claims having these codes. Although the Medicare program does not always have the same need for setting specificity as other payers, including Medicaid, adjudicating the claims eases the coordination of benefits for Medicaid and other payers who may need the specificity afforded by the entire TOB code set.

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	
11856 - 06.1	Contractors shall include TOB (087x) with their submission Monthly Workload Report (Form CMS-1566 and CMS-1566a) as "other," in accordance with Publication 100-06, Chapter 6.	X				X				CROWD
11856 - 06.2	Contractors shall include TOB (087x) and create a new report type within the Provider Statistical and Reimbursement System (PS&R) for freestanding OTPs.					X				PS&R

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

Pre-Implementation Contact(s): Joseph Shultz, 410-786-2656 or Joseph.Schultz@cms.hhs.gov, Lindsey Baldwin, lindsey.baldwin@cms.hhs.gov , Fred Rooke, fred.rooke@cms.hhs.gov.

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

20.3 - Type of Bill

(Rev. 10521; Issued: 12-16-20; Effective: 01-01-21; Implementation: 01-04-21)

The A/B MAC (A) includes provider bills in the following columns of the report:

Column (1) **Total - All provider bills.**

Column (2) Inpatient Hospital - CMS-1450s submitted by hospitals for inpatient services with the following two-digit classification codes in Form Locator 4: 1-1 (inpatient hospital); and 4-1 (Religious Nonmedical Health Care Hospital- inpatient).

Column (3) Outpatient - CMS-1450s submitted by hospitals or SNFs for outpatient services with the following two-digit classification codes in Form Locator 4: 1-3 (Hospital-outpatient); 2-3 (SNF-outpatient); 4-3 (Religious Nonmedical Health Care Hospital-outpatient); 5-3 (Religious Nonmedical Health Care-SNF-outpatient); and 8-3 (Hospital-outpatient-surgical procedures-ASC).

Column (4) SNF - CMS-1450s with the following two-digit classification codes in Form Locator 4; 1-8 (hospital swing-bed); 2-1 (SNF-inpatient); 2-8 (SNF-swing bed); and 5-1 (Religious Nonmedical Health Care-SNF-inpatient).

Column (5) HHA - CMS-1450s submitted by HHAs, with the following two-digit classification codes in Form Locator 4: 3-2 (HHA-Part B visits and use of DME); 3-3 (HHA-Part A visits and DME); 3-4 (HHA-Other-Part B benefits). Include HH PPS Requests for Anticipated Payment (RAPs) with three-digit classification code 3-2-2 or 3-3-2 with dates of service 10/01/2000 and greater in addition to claims in this column.

Column (6) Other - CMS-1450s with the following two-digit classification codes in Form Locator 4:

1-2 (hospital inpatient-Part B benefits),

1-4 (hospital-Other-Part B benefits),

2-2 (SNF-inpatient-Part B benefits),

2-4 (SNF-Other-Part B benefits),

4-2 (Religious Nonmedical Health Care-inpatient-Part B benefits),

4-4 (Religious Nonmedical Health Care-inpatient-other),

5-2 (Religious Nonmedical Health Care-SNF inpatient-Part B benefits),

5-4 (Religious Nonmedical Health Care-SNF inpatient-other),
7-1, 7-2, 7-3, 7-4, 7-5 (Clinics-provider and independent RHCs, ESRD hospital-based or independent renal dialysis facilities, FQHCs, CMHCs, ORFs, and CORFS), and

8-1 and 8-2 (Hospices)

8-7 (Opioid Treatment Facility)

60.3 - Type of Bill

(Rev. 10521; Issued: 12-16-20; Effective: 01-01-21; Implementation: 01-04-21)

The A/B MAC (A) reports counts in total and by type of bill as shown below:

Column	**(1)**	**Total--All provider bills.**
Column	(2)	Inpatient Hospital--CMS-1450s submitted by hospitals for inpatient services, with the following two-digit classification codes in Form Locator 4: 1-1 (inpatient hospital); and 4-1 (Religious Nonmedical Health Care Hospital-inpatient).
Column	(3)	Outpatient--CMS-1450s submitted by hospitals or SNFs for outpatient services with the following two-digit classification codes in Form Locator 4: 1-3 (hospital-outpatient); 2-3 (SNF-outpatient); 4-3 Religious Nonmedical Health Care Hospital- outpatient); 5-3 (Religious Nonmedical Health Care SNF-outpatient); and 8- 3 (hospital- outpatient surgical procedures - ASC)
Column	(4)	SNF--CMS-1450s with the following two-digit classification codes in Form Locator 4: 1-8 (hospital-swing-bed); 2-1 (SNF-inpatient); 2-8 (SNF swing- bed); and 5-1 (Religious Nonmedical Health Care-SNF-inpatient).
Column	(5)	HHA--CMS-1450s submitted by HHAs with the following two digit classification codes in Form Locator 4: 3-2 (HHA-Part B visits and use of DME); 3-3 (HHA-Part A visits and DME); 3-4 (HHA-other-Part B-benefits)
Column	(6)	Other--CMS-1450s with the following two-digit classification codes in Form Locator 4: 1-2 (hospital inpatient-Part B benefits); 1-4 (hospital-other-Part B benefits); 2-2 (SNF-inpatient-Part B benefits); 2-4 (SNF-other-Part B benefits); 4-2 (Religious Nonmedical Health Care-inpatient-Part B benefits); 4-4 (Religious Nonmedical Health Care-inpatient-other); 5-2 (Religious Nonmedical Health Care-SNF inpatient-Part B benefits); 5-4 (Religious Nonmedical Health Care-SNF inpatient-other); 7-1, 7-2, 7-3, 7-4, 7-5 (Clinics - provider and independent RHCs, FQHCs, ESRD hospital- based or independent renal dialysis facilities, FQHCs, CMHCs, ORFs and CORFs); 8-1 and 8-2 (Hospices); and 8-7 (Opioid Treatment Programs)