Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov

MEDICAID MEMO

Last Updated: 07/08/2022

SUPPORT Act Established Medicare Part B Benefit for Opioid Use Disorder Treatment Services by Opioid Treatment Programs, Effective January 1, 2020

The purpose of this memorandum is to notify Opioid Treatment Programs (OTPs) as defined in section 8.2 of title 42 of the Code of Federal Regulations, of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) changes for Medicare coverage of OTPs. On October 24, 2018, the SUPPORT Act became law and included Section 2005, which amends section 1861 of the Social Security Act, to expand Medicare Part B coverage for opioid use disorder (OUD) treatment services furnished by OTPs on or after January 1, 2020.

The law defines "OUD treatment services" to include the following:

Items and services that are furnished by an OTP for the treatment of OUD, including:

1. Opioid agonist and antagonist treatment medications (including oral, injected, or implanted versions) that are approved by the Food and Drug Administration under section 505 of the Federal Food, Drug, and Cosmetic Act for use in the treatment of opioid use disorder;
2. Dispensing and administration of such medications, if applicable;
3. Substance use counseling by a professional to the extent authorized under State law to furnish such services;
4. Individual and group therapy with a physician or psychologist (or other mental health professional to the extent authorized under State law);
5. Toxicology testing, and
6. Other items and services that the Secretary determines are appropriate (but in no event to include meals or transportation)."

The Centers for Medicare and Medicaid Services (CMS) requires Medicaid to accommodate OTP providers during the process of Medicare enrollment while serving dually eligible Medicare and Medicaid members. The accommodation allows for OTP providers to choose to 1) hold their claims for dually eligible members until they are Medicare-enrolled or 2) bill Medicaid during this period.

1. OTPs may choose to hold their claims until Medicare enrolled. When enrolled, OTPs will bill Medicare as the primary payor for the OUD treatment services and Medicaid for any services not included in the Medicare bundled rate as well as any Medicare deductibles. The Medicare Part B deductible will apply for OUD treatment services, as mandated for all Part B services by section 1833(b) of the Social Security Act. See the instructions in this memorandum for billing on the CMS-1500 for Medicare deductibles. CMS has set the copayment at zero for fee-for-

service Medicare Part B for OUD treatment services. The Department of Medical Assistance Services (DMAS) requires the Medicaid Managed Care Organizations (MCOs) to allow providers up to 365 calendar days from date of service to file claims to be considered for payment. OTPs should review their contracts with each MCO to confirm timely filling agreements. Thus, if the OTP contract with the MCO allows up to 365 days to file a claim, then the OTP can hold claims for up to 365 calendar days for dually eligible Medicare and Medicaid members while the OTP enrolls in Medicare.

2. OTP providers may choose to submit their claims to Medicaid before they are Medicare-enrolled, and Medicaid will pay the claim. Once the provider is Medicare enrolled, Medicaid will recoup those Medicaid payments made to the OTP, back to the date the provider can begin billing Medicare (30 days prior to the effective date of the OTP's Medicare enrollment). The OTP would then bill Medicare for those services.

CMS issued an Information Bulletin on December 17, 2019 to inform states that starting on January 1, 2020, Medicare will pay Opioid Treatment Programs (OTPs) through bundled payments for opioid use disorder (OUD) treatment services, including medication-assisted treatment (MAT), toxicology testing, and counseling. The Information Bulletin is available at:

https://www.medicaid.gov/federal-policy-guidance/downloads/cib121719.pdf.

Additionally, on December 12, 2019, CMS released a Tip Sheet for Opioid Treatment Program (OTP) Providers Serving Dually Eligible Individuals: State Coverage of the Medicare Part B Deductible. The tip sheet is a primer on the Part B deductible and the process to receive Medicaid payment for the Part B deductible for dually eligible individuals. The tip sheet also gives information about enrolling in Medicare and Medicaid, the Medicare claims crossover process, and where to go for additional information. The tip sheet is available at:
https://www.cms.gov/files/document/otp-crossover-tip-sheet.

Additional guidance from CMS is forthcoming regarding Medicare Advantage Plans.

Please note the SUPPORT Act requires Medicaid to pay OUD treatment services for OTPs who choose not to enroll in Medicare. OTPs who are not enrolled with Medicare and submitting claims directly to DMAS, the Behavioral Health Services Administrator or the MCOs for members with Medicare as the primary insurance, will need to attach a letter to the claim stating that the provider is not enrolled with Medicare.

INSTRUCTIONS FOR COMPLETING THE PAPER CMS-1500 (02-12) FORM

FOR MEDICARE AND MEDICARE ADVANTAGE PLAN DEDUCTIBLE,

COINSURANCE AND COPAY PAYMENTS FOR PROFESSIONAL SERVICES

The Direct Data Entry (DDE) Crossover Part B claim form is on the Virginia Medicaid Web portal. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at:

www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5 p.m. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

For specific instructions on billing the deductible, please reference the DMAS Physician/Practitioner Provider Manual-Chapter IV located at:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

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Medicaid Expansion

Medicaid coverage for the new expansion adult group began January 1, 2019. Providers may use the Virginia Medicaid Web Portal and the Medicall audio response systems, as shown in the table below, to verify Medicaid eligibility and managed care enrollment, including for the new adult group. In the Virginia Medicaid Web Portal, individuals eligible in the Medicaid expansion covered group are shown as "MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the "MED4" (Medallion 4.0) or "CCCP" (CCC Plus) managed care enrollment segment. Eligibility and managed care enrollment information is also available through the DMAS Medicall eligibility verification system. Additional Medicaid expansion resources for providers are available on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996

KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627