HUB & SPOKE SYSTEM FOR OPIOID ADDICTION TREATMENT PILOT PAYMENT POLICY
Corporate Payment Policy
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Document Precedence

The Blue Cross and Blue Shield of Vermont (BCBSVT or Plan) Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member/employer contracts, provider contracts, BCBSVT corporate medical policies, and Change Healthcare's ClaimCheck logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract/employer benefit document language shall take precedence.
2) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language shall take precedence.
3) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy shall take precedence.
4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the Change Healthcare's ClaimCheck audit solution, the Change Healthcare's ClaimCheck audit solution shall take precedence.

Payment Policy

Background

The following payment policy applies to a pilot reimbursement program for services rendered by the Hub & Spoke System. The Hub and Spoke System is Vermont's system of Medication Assisted Treatment (MAT) supporting people in recovery from opioid use disorder.[1] Regional, State-designated Hubs (also referred to as Opioid Treatment Programs (or OTPs)) offer daily support for patients with complex addictions. In Spokes (also referred to as Office-Based Opioid Treatment (OBOTs)) located in communities throughout Vermont, doctors, nurses, and counselors offer ongoing addiction treatment fully integrated with general healthcare and wellness services.

[1] Information in this "Description" section of the policy is taken from The State of Vermont Blueprint for Health website, under "Hub and Spoke," available at http://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke (visited June 5, 2018).

The Hubs offer intensive treatment for complex addictions. Each Hub is the source for its area's most intensive opioid use disorder treatment options. Hubs offer the treatment intensity and staff expertise that some people require at the beginning of their recovery, at points during their recovery, or all throughout their recovery. Hubs provide daily medication and therapeutic support. All methadone treatment is provided in Hubs. Patients receiving non-methadone treatment (i.e., buprenorphine or naltrexone) may move back and forth between Hub and Spoke settings over time, as their treatment needs change. Hubs offer all elements of MAT, including assessment, medication dispensing, and individual and group counseling. Additional Health Home supports are available at Hubs including case management, care coordination, management of transitions of care, family support services, health promotion, and referral to community services.

Spokes are mostly primary care or family medicine practices, and include obstetrics and gynecology practices, specialty outpatient addiction programs, and practices specializing in chronic pain. Prescribers in Spoke settings are physicians, nurse practitioners, and physician's assistants federally authorized to prescribe buprenorphine. They may also provide oral naltrexone or injectable Vivitrol. Individuals with less complex needs may begin their treatment at a Spoke, while other patients transition to a Spoke after beginning recovery in a Hub. Spoke care teams include one nurse and one licensed mental health or addictions counselor per 100 patients. The Spoke staff provide specialized nursing, counseling, and care management to support patients in recovery (sometimes referred to as "Spoke staff services" or "Health Home services").

The Hub and Spoke concept was designed and implemented by the State of Vermont through the Blueprint for Health, the Department of Vermont Health Access (DVHA), and the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs. The State of Vermont provides oversight for the program. BCBSVT's Hub and Spoke program is modeled after the state's program and was developed in collaboration with DVHA.

Policy

I. Hub

BCBSVT reimburses for Hub services in the form of a single monthly rate, per member. The Hub provider initiates a claim for the monthly rate by billing the appropriate code and modifier combination listed in the coding table contained in this policy.

Full monthly reimbursement is permissible as long as the member received at least one Hub service and one Health Home Service during the month. As used in this payment policy, a Hub service is defined as "one face-to-face typical treatment service encounter (e.g., nursing or physician assessment, individual or group counseling, observed dosing)". A Health Home Service is defined as "comprehensive care management, care coordination, health promotion, transition of care, individual and family support, or referral to community services."

This policy applies to all members (as defined in the provider's contract) receiving services in the Hub, for either methadone and buprenorphine, within the limits of the member's benefits

II. Spoke Services.

All Spokes may bill, and receive payment for, MAT-related services when billed as office visits, laboratory services (if applicable), and therapy services and in accordance with the terms and conditions of the Spoke's provider contract with BCBSVT, provided such services are covered by the member's benefits.

Starting in 2018, BCBSVT will begin a pilot program involving reimbursement for the services provided by the nurse and/or counselor (the Spoke staff services). There are two possible types of billing entities for this pilot: (1) the Spoke or (2) the AE.

In either scenario, the billing entity must enter a specific contract with BCBSVT that outlines expectations and obligations. In the scenario where the Spoke bills, the Spoke submits the claims for each member to BCBSVT. BCBSVT may contract with the Spoke directly regardless of whether the Spoke employs the nurse and/or counselor or whether the clinicians are employed by the AE. In the scenario where the AE bills, the AE submits claims for each member receiving services in the HSA covered by the AE. The AE coordinates with the Spokes in the HSA to determine which BCBSVT members received Spoke staff services.

BCBSVT reimburses for Spoke staff services in the form of a single monthly rate, per member. As noted above, the Spoke or AE initiates a claim for the monthly rate by billing the appropriate code and modifier combination listed in the coding table contained in this policy.

This policy applies to all members (as defined in the provider's contract) receiving Spoke services, within the limits of those members' benefits

Not Eligible for Payment

The Hub rate is for a full month's worth of services for the treatment of substance use disorder. As such, services billed with HCPCS Level II Code H0020 for "Methadone services" (e.g., administration and/or service (provision of the drug by licensed program)) are not eligible for reimbursement where Hub services have also been delivered and billed for that member for that month.

Eligible Services

Hub, Health Home Services, and Spoke Services, as defined in the "Policy" section, above.

Benefit Determination Guidance

Payment for Hub & Spoke services are determined by the member's benefits. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible Hub & Spoke services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Provider Billing Guidelines and Documentation

I. Hub Services

A. General

Claims for Hub services are only accepted on the CMS-1500 (paper version 0938-1197 or HIPAA compliant 837P) format for professional claims.

Hub providers must submit the appropriate HCPCS Level II codes and modifier combinations (see coding table) when submitting claims for Hub services.

Claims for Hub services must be billed with POS 11 (office).

Providers must bill once per calendar month. The "From" date should be either the first date of treatment or the first of the month. The "To" date should be either the last date of treatment or the last day of the month. Use only one claim line when billing the date span for this service.

Providers with multiple locations must bill BCBSVT only once for the monthly service even if the member happens to receive treatment in a different Hub than his/her "home Hub".

B. Buprenorphine Billing

To ensure correct processing and payment for buprenorphine, the following data elements are required in addition to the submission of the J-code and name of drug:

1. Paper Claim Submission

For CMS 1500 (version 0938-1197):

- Item number 24a shaded area (above dates of service) report in order:
  - N4 product id qualifier,
  - 11-digit NDC (National Drug Code) (no hyphens),
  - unit of measure (UoM),
  - quantity (limited 8 digits before the decimal and 3 digits after the decimal).

- Item number 24d continue to report applicable HCPCS code with modifier –HG when applicable (see addendum).
- In item number G (days or units) continue to report applicable HCPCS units and not the NDC units.

2. Electronic Claim Submission

For HIPAA-compliant 837P, BCBSVT uses the institutional and professional implementation guides, section 1.11 for NDC submission requirements. Please refer to those documents for full details. Note that the HCPCS code still need to be submitted in addition to the NDC.

C. Modifier -GY where Medicare is Primary

To the extent that the services being provided are Medicare statutorily excluded services (such as outpatient methadone treatment services, for example), modifier –GY modifier (Item or service statutorily excluded does not meet the definition of any Medicare benefit for non-Medicare insurers, is not a contracted benefit) allows our system to recognize the service as such and bypasses the Medicare explanation of payment requirement. Inter Plan Program (or BlueCard) claims with a -GY modifier need to be submitted directly to BCBSVT.

Claims that cross over to another Blues Plan from Medicare and contain services with a -GY modifier will not be processed by the local plan. Instead, either a letter or remittance denial will be issued alerting you the claim must be submitted to BCBSVT.

In addition to the -GY modifier, the claim submission (paper or electronic) must indicate that Medicare is the member's primary carrier.

The submission of these claims to BCBSVT allows us to apply your contracted rate so the claims will accurately process according to the member's benefits.

Hubs must submit modifier -GY as modifier 2 when billing **H0020-HG or H0047-HG *(Hub*** service **and one** Health Home Service).

Hubs must submit modifier -GY as modifier 3, when billing **H0020-HG-52 or H0047-HG-52** (***Hub*** service only).

II. Spoke Services

a. Office Visits/Laboratory/Therapy

A Spoke is eligible to bill for office visits, laboratory services, and therapy services using the appropriate CPT/HCPCS codes for the services, in accordance with the terms and conditions of the Spoke's provider contract with BCBSVT.

b. Spoke staff services

The Spoke staff services are those services provided by the nurse and counselor embedded in the practice and include specialized nursing, counseling, and care management to support patients in recovery. Regardless of whether the Spoke or the AE bills for the service (as per a specific contract with BCBSVT), the following guidelines and requirements apply:

- Claims for Spoke staff services are only accepted on the CMS-1500 (paper version 0938-1197 or HIPAA-compliant 837P) format for professional claims.
- The billing entity must submit HCPCS Level II code H0047 (Alcohol and/or other drug abuse services, not otherwise classified) with the –HH modifier (integrated mental health/substance abuse program) when submitting claims for the Spoke staff services.
- Claims must be billed with POS 11 (office).
- The billing entity must bill once per calendar month, for each member. The "From" date should be either the first date of treatment or the first of the month. The "To" date should be either the last date of treatment or the last day of the month. Use only one claim line when billing the date span for this service. It does not matter how many times the member came in for services during the month – so long as at least one service has been provided by the nurse or counselor to the member, the Spoke/AE may submit a claim for that month for that member.
- To the extent a member receives Spoke staff services from more than one Spoke, the billing entity or entities should coordinate to ensure BCBSVT is billed only once for that member for that month.
- There are no diagnosis limitations for the service code H0047-HH, but the expectation is that a diagnosis of substance use disorder will be utilized.
- BCBSVT will pay the Spoke or AE a monthly, per member, per month rate.
- The Spoke/AE must confirm member benefits prior to submitting a claim. Not all members have benefits for the H0047-HH service code.
- To the extent a member has Medicare primary coverage, modifier -GY should be used in the second modifier position on the claim form.
- If the Spoke is the billing entity, the Spoke must collect any cost share due per the member's benefits, and the Spoke may do so at the time of service.
- If the AE is the billing entity, the AE is responsible for collecting any cost share due per the member's benefits. The AE may bill the member via U.S. Mail after the member has received treatment at the Spoke.

- BCBSVT does not dictate how funds must be allocated between the Spoke and the AE where the AE employs or provides funding for the Spoke staff. BCBSVT expects that in situations where the AE is the billing entity and is not responsible for either employing or funding the employment of the nurse and/or counselor, an AE acting as a billing entity will work with the Spokes in the AE's HSA to determine an equitable distribution or allocation of funds to best provide continued support for the Hub and Spoke model. In cases where the Spoke is the billing entity and the nurse and/or counselor is/are employed by the AE or funded by the AE, BCBSVT expects the Spoke to work with the AE to determine an equitable distribution or allocation of funds between the Spoke and AE to best support further advancement of the Hub and Spoke model.

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at http://www.bcbsvt.com/provider-home for the latest news and communications.

Other Information

Methadone Services Only: Pharmacy costs for methadone itself, **are included** in the Hub case rate. No additional reimbursement will be provided.

Buprenorphine Services Only: Pharmacy costs for buprenorphine, **are not included** in the Hub case rate and must be billed separately. Claims for buprenorphine must include the National Drug Code (NDC) and other required data elements noted above (under paper claims submission or Electronic Claim Submission – HIPAA compliant 837P). Suboxone® (buprenorphine) film in 2, 4, 8, and 12 mg quantities is the preferred product. Reimbursement is subject to all terms, limitations, and conditions of the member's benefit.

Eligible Providers

For Hub Services, this policy applies to those providers recognized as Hubs by the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs and DVHA Blueprint for Health that are also contracted with Blue Cross and Blue Shield of Vermont.

For Spoke Services, specifically the office/laboratory/therapy services, this policy applies to those Spokes that hold a provider contract with BCBSVT. For Spoke staff services (specialized nursing, counseling, and care management services provided by the nurse and counselor), this policy applies to those Spokes or AEs that are participating in the Spoke pilot, as documented in a letter of agreement or amendment to the provider's existing contract with BCBSVT.

Employer Group Exclusion(s):

N/A

Audit Information:

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Legislative Guidelines

Act No. 159 (2017-2018) (An act relating to pilot programs for coverage by commercial health insurers of costs associated with medication-assisted treatment)

Related Policies

N/A

Policy Implementation/Update Information

This policy replaces CPP_05 Hub & Spoke System for Opioid Addiction Treatment Pilot Payment Policy approved 09.26.2017, effective date: February 1, 2018.

Approved by
Health & Value Improvement Committee (HVIC)

Date Approved: 12.14.2018

Josh Plavin, MD, MPH, MBA, Vice President & Chief Medical Officer

Andrew Garland, Vice President Client Relations and External Affairs

Addendum - Coding Tables[2]

Please Note: *Codes listed may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*

Eligible ***Hub*** providers will be compensated only for the services (codes and modifier combinations) listed below:

Code Type	Code/Modifier	Description	Unit Designation (S = single / M = multiple)
When a member received at least one ***Hub*** service **and one *Health Home Service*** during the month, Provider shall bill the following codes **with** the -HG modifier(Opioid addiction treatment program):			
CPT®/HCPCS Codes	**HCPCS Code Description**	Alcohol and/or drug services; **methadone administration and/or service (provision of the drug by a licensed program)**	
	H0020-HG	*Hub Methadone Services to Adults*	S
	H0020-HG	*Hub Methadone Services to Adolescents*	S
	HCPCS Code Description	Alcohol and/or **other drug abuse services, not otherwise classified**	
	H0047-HG	*Hub Buprenorphine Services to Adults*	S
	H0047-HG	*Hub Buprenorphine Services to Adolescents*	S
If the member **did not** receive ***a Health Home Service***, the provider will be reimbursed at a lower rate because ***Health Home Services*** **were not** provided. Modifier -52 (Reduced Services) should be applied in addition to the -HG modifier (Opioid addiction treatment program) .			
	HCPCS Code Description	Alcohol and/or drug services; **methadone administration and/or service (provision of the drug by a licensed program)**	
	H0020-HG-52	*Hub Methadone Services to Adults*	S
	H0020-HG-52	*Hub Methadone Services to Adolescents*	S
	HCPCS Code Description	Alcohol and/or **other drug abuse services, not otherwise classified**	
	H0047-HG-52	*Hub Buprenorphine Services to Adults*	S
	H0047-HG-52	*Hub Buprenorphine Services to Adolescents*	S
Buprenorphine Services Only: Claims for buprenorphine itself must be submitted using the following procedure code and modifier combination for the NDCs listed below:			
	HCPCS Code Description		
	J0571	Buprenorphine, oral, 1 mg *Use for 2mg tablet; NDCs 50383-0924-93, 00228-3156-03, 00378-0923-93, 00054-0176-13, 00093-5378-56*	M

[2] *Current Procedural Terminology CPT® codes and descriptions are the property of the American Medical Association Healthcare Common Procedure Coding System (HCPCS) code set and descriptions are the property of CMS.*

Code Type	Code/Modifier	Description	Unit Designation (S = single / M = multiple)
	J0571-HG	Buprenorphine, oral, 1 mg *Use for 8 mg tablet; NDCs 50383-0930-93, 00054-0177-13, 00093-5379-56, 00228-3153-03, 00378-0924-93*	M
	J0572-HG	Buprenorphine/naloxone, oral, less than or equal to 3 mg *Use for 2mg film; NDCs 12496-1202-01 and 12496 1202 03*	M
	J0573-HG	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg *Use for 4 mg film; NDCs 12496-1204-01, 12496-1204-03*	M
	J0574-HG	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg *Use for 8 mg film; NDCs 12496-1208-01, 12496-1208-03*	M
	J0575-HG	Buprenorphine/naloxone, oral, greater than 10 mg *Use for 12 mg film; NDCs 12496-1212-03, 12496-1212-01*	M
***Note:** See section Professional Claims for the required data elements that must be billed in addition to the submission of the HCPCS "J"-code and name of drug.*			
Modifier(s)			
HCPCS Level II	-HG	Opioid addiction treatment program	
CPT®	-52	Reduced Services	

Eligible ***Spokes or Administrative Entities*** will be compensated per the terms of their contracts with BCBSVT for Spoke staff services as (codes and modifier combinations) listed below:

Code Type	Code/Modifier	Description	Unit Designation (S = single / M = multiple)
CPT®/HCPCS Codes	**HCPCS Code Description**	Alcohol and/or **other drug abuse services, not otherwise classified**	
	H0047-HH	*Spoke Care Management Services*	S
Modifier(s)			
HCPCS Level II	-HH	**Integrated mental health/substance abuse program**	