ArchProCoding
RURAL & COMMUNITY HEALTH

# Treating Substance/Opioid Use Disorders via Medication-Assisted Treatment in Community Health

## NACHC's 2023 Billing, Coding, Documentation, and Quality Webinar Series

NATIONAL ASSOCIATION OF Community Health Centers®

## January 31, 2023

This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $6,625,000 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.


Instructor

# Gary Lucas, MSHI

**Vice President of Research and Development**

**Metro-Atlanta**

**Gary@ArchProCoding.com**

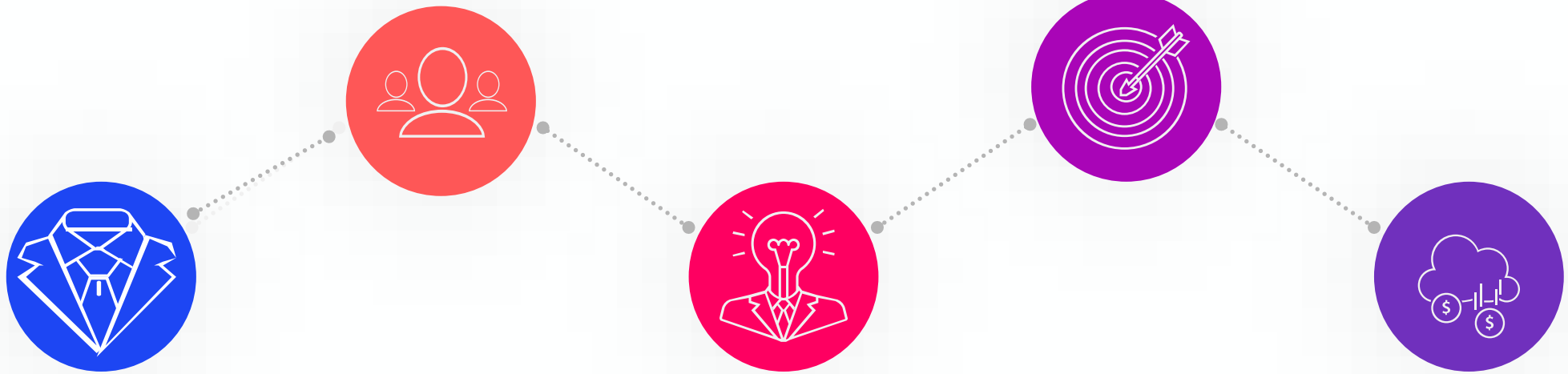
**University of Georgia – Bachelor in Business, Marketing (1994) + University of Illinois-Chicago – Master of Science in Health Informatics (2014)**

**~1900 courses taught in 46 states over 28 years**

# General Course Layout

Foundations of
SUD/OUD/MAT Documentation,
Coding, and Billing

Documenting
SUD-OUD-MAT visits



Preparing for
SUD-OUD-MAT Patient Visits

Diagnostic Documentation and
Coding for SUD/OUD/MAT

Getting Paid for
Non-Face-to-Face Visits

# Section Overview

## Preparing for SUD-OUD-MAT Patient Visits

Initiating, Staffing, and Managing SUD/OUD Revenue Cycle, MAT Phases and Meds Overview, Managing Varying Provider Types

## Foundations of SUD/OUD/MAT Documentation, Coding, and Billing

Impact of Insurance Type, RHC/FQHC Valid Encounters, CPT/HCPCS-II, Authorized Providers v. Non-licensed, and Other Revenue Options

# Section Overview

## Diagnostic Documentation and Coding for SUD/OUD/MAT

Official Guidelines for ICD-10-CM, Possible DSM-5 conflicts, and Substance-specific Coding Options

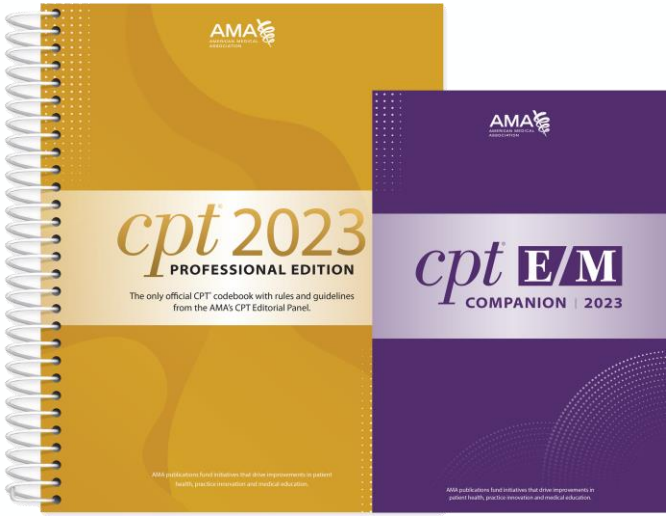
## Documenting SUD-OUD-MAT visits

Documentation Guidelines for MAT Induction/Stabilization/Maintenance Visits via E/M Services, Documenting Behavioral Health Encounters

## Getting Paid for Non-Face-to-Face Visits

Telehealth vs. Virtual Communication Services, Behavioral Health Integration, and the Psychiatric Collaborative Care Model

# Disclaimers
# American Medical Association




Coding software and non-AMA CPTs simply **DO NOT** contain the educationally valuable clinical documentation guidelines that should make up the core of your CPT coding knowledge. Therefore, you need a **printed version of the CPT every year** unless the AMA releases all CPT documentation guidance in an electronic format.

CPT® is a registered trademark of the American Medical Association. Use of the CPT codes and descriptions during this program is for educational purposes only. The CPT codes that are utilized in coding claims are produced and copyrighted by the American Medical Association (AMA). Specific questions regarding the use of CPT codes may be directed to the AMA.

ArchProCoding does not claim any ownership or authorship of any AMA CPT content and uses all AMA-owned content in an educational fair-use manner. All rights reserved by the AMA.

# Important Information

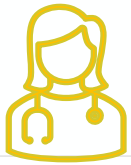
- All information presented by ArchProCoding is based on research, experience, and training and includes professional opinions that do not replace any legal or consulting guidance you may need.

- Your organization is responsible for ensuring compliance with all relevant rules and regulations you are bound to.  It is required that you verify all code selections and billing rules directly with payers to determine their specific guidance and requirements before submitting claims for payment.

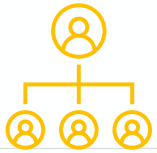
- ArchProCoding does not accept any responsibility or liability with regards to errors, omissions, misuse, or misinterpretation of the educational content presented and encourages you to frequently double-check for potential updates to hyperlinks, reference sources, payer billing rules, and reimbursement changes.

- The content presented by ArchProCoding can not be used, recreated, reproduced or disseminated to any other party without the written consent of the Association for Rural and Community Health Professional Coding (ArchProCoding). All rights reserved.

# ArchProCoding
# Main Focus Areas



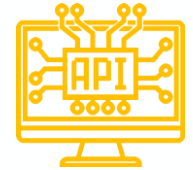
**Clinical Providers**



**Clinic and Health Center Managers**

**Coders**

**Billers**




**Electronic Health Records and IT/Billing System Integrations**

# Preparing for SUD/OUD/MAT Patient Visits

ArchProCoding
RURAL & COMMUNITY HEALTH

# Key SUD/OUD/MAT Phases

- **Screening, Brief Interventions, and Referrals for Treatment (SBIRT)**
  - Use of various clinical tools like SBIRT, DASH, CAGE-ASSIST during preventive medicine, problem-oriented, and acute/chronic care visits resulting in a diagnosis established from the ICD-10-CM's F10-F19 code section.
- **Induction vs. Stabilization vs. Maintenance**
  - ***Induction*** of MAT comprises the initial dosing during the ~first week of treatment when a clinician determines the MAT dose appropriate for the patient by adjusting the dose gradually until cravings are reduced and there is good adherence and minimal side effects.
  - Once the patient has obtained a ***stabilizing*** *dose(s),* they move into the ***maintenance*** phase of treatment as managed over time mainly by E/M visits.
- **Early vs. Partial vs. Sustained Remission**
  - Following agreement between the patient and provider, the maintenance phase may end with a gradual tapering of MAT treatments.

# Setting up Proper SUD/OUD/MAT Revenue Cycle Activities

- SUD/OUD/MAT/RCORP program leadership will need to develop and/or maintain clearly defined policies and workflow processes that focus on how clinical providers and ancillary clinical staff capture and report the diagnostic and therapeutic services they provide.

- Establish and maintain effective regular communications between key clinical and revenue staff. Focus on developing a shared understanding on the main differences in proper "*professional coding*" versus compliant "*medical billing.*"

- Gain maximum possible buy-in from clinical providers and senior leadership to make routine and periodic training on documentation/coding/billing a priority. This has a direct impact on reaching your shared clinical and revenue goals.

## Figure 1. Educate yourself on the facts

Anyone can develop opioid use disorder. OUD is a chronic disease, not a "moral weakness" or willful choice.

OUD, like other diseases (e.g. hypertension), often requires chronic treatment.*

Patients with OUD can achieve full remission.**

Using opioid agonist treatment for OUD is NOT replacing one addiction for another.

Using medication-assisted treatment for OUD saves lives.

*The goal of treatment is to produce a satisfying and productive life, not to see how fast the patient can discontinue treatment. **Methadone and buprenorphine maintained patients, with negative UDT's, and no other criteria for opioid use disorder, are physically dependent, but not addicted to the medication and can be considered in "full remission."

.com
.net

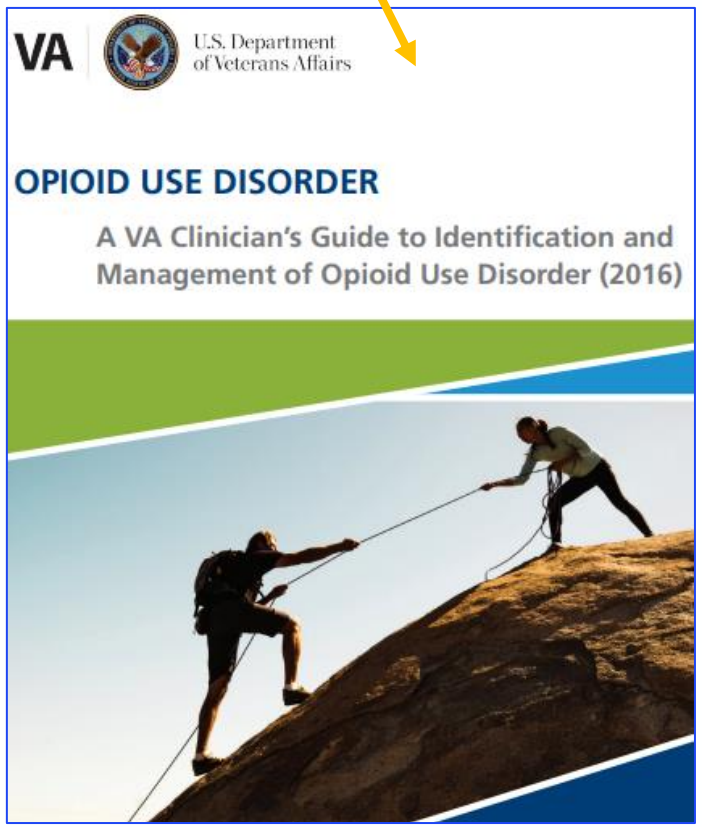


Table 4. Comparison of OAT (buprenorphine/naloxone and methadone

Opioid Agonist Therapy (OAT)

| | Buprenorphine/Naloxone** | Methadone |
|---|---|---|
| **Treatment setting** | Office-based | Specially licensed OTP |
| **Mechanism of action** | Partial opioid agonist* | Opioid agonist |
| **FDA approved for OUD** | Yes | Yes |
| **Reduces cravings** | Yes | Yes |
| **Best for mild, moderate, or severe OUD?** | Mild—Moderate | Mild, Moderate, and Severe |
| **Candidates and history of failed treatment attempts** | None/few failed attempts | Many failed attempts |
| **Recommended for OUD candidates with pain conditions requiring ongoing short-acting opioids?** | No | Yes |
| **Psychosocial intervention recommendations** | Addiction-focused MM | Individual counseling and/or contingency management |

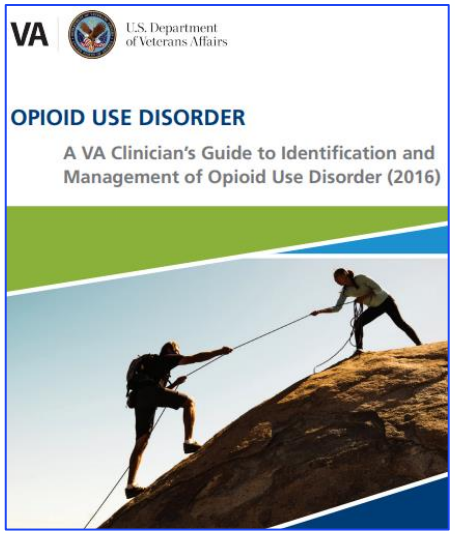
OTP = Opioid Treatment Program; MM = Medical Management

*Note:* Please see the quick reference guide for information on how to acquire a DEA-X waiver.

*Also contains naloxone which is inactive when taken as directed but will become an active opioid antagonist if used illicitly (e.g. snorted or injected).[34]

**In every clinical situation, except when pregnant or documented intolerance/hypersensitivity to naloxone, the preferred formulation of buprenorphine is buprenorphine/naloxone. Pregnant patients should be carefully educated about the benefits and risks of buprenorphine versus methadone during pregnancy. (Pharmacy Benefits Management (PBM) Buprenorphine/Naloxone Criteria For Use)[34]

# General Suggestions on Treatment Options



# Check out SAMSHA's MAT Website for More Resources

SAMHSA
Substance Abuse and Mental Health Services Administration

MEDICATION-ASSISTED TREATMENT (MAT)

## MAT Medications

FDA has approved several different medications to treat alcohol and opioid use disorders MAT medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. Medications used for MAT are evidence-based treatment options and do not just substitute one drug for another.

## Alcohol Use Disorder Medications

Acamprosate, disulfiram, and naltrexone are the most common medications used to treat alcohol use disorder. They do not provide a cure for the disorder, but are most effective in people who participate in a MAT program.

## Opioid Dependency Medications

Buprenorphine, methadone, and naltrexone are used to treat opioid use disorders to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. These MAT medications are safe to use for months, years, or even a lifetime. As with any medication, consult your

## Opioid Overdose Prevention Medication

Naloxone is used to prevent opioid overdose by reversing the toxic effects of the overdose.

# Prerequisites for Providing Medication-Assisted Treatment (MAT)

- Methadone, Suboxone/Buprenorphine, and Naltrexone are the three most common medications typically used for treating OUD via MAT.
- Methadone is essentially only dispensed via a certified Opioid Treatment Program (OTP) as certified by the Substance Abuse and Mental Health Services Administration (SAMHSA).
- **RECENT UPDATE!** Previously, Buprenorphine could only be prescribed by a licensed clinical provider who has received additional training (*ex. earning X-DEA or DATA 2000 waivers*) following completion of an 8-hour training (*for MD and DO*) or 24-hour training (*for PA and NP*) program. *See the change on the next slide signed into law on December 29, 2022, amending the Controlled Substances Act.*
- Naltrexone can likely be prescribed by any licensed authorized provider.
- Though slowly increasing, Buprenorphine providers are not commonly located in rural areas and is a significant barrier to get care where it is needed.

# Now, with a current DEA Schedule III registration you may prescribe Buprenorphine if permitted by your state

## SAMHSA Applauds Expansion of Access to Medication for Opioid Use Disorder (MOUD)

The Substance Abuse and Mental Health Services Administration (SAMHSA) applauds provisions included in the 2023 Consolidated Appropriations Act (P.L. 117-328) that will significantly expand access to medication for opioid use disorder (MOUD). The act, signed into law by President Biden on Dec. 29, 2022, amended the Controlled Substances Act to eliminate the requirement for qualified practitioners to first obtain a special waiver to prescribe medications such as buprenorphine for the treatment of opioid use disorder (OUD). This ends a decades-long requirement, originally put in place through the Drug Abuse Treatment Act (DATA) of 2000. With the new law, the patient limits associated with this special waiver also no longer apply.


**It should be noted that new DEA applications as well as renewals of a controlled substance license will be required to receive 8 hours of training on SUD, with certain exceptions.**

**For additional info check out this website also:**

***https://www.medpagetoday.com/special-reports/features/102520***

# MEDICATIONS FOR ADDICTION TREATMENT (MAT) READINESS AND IMPLEMENTATION CHECKLIST

NATIONAL COUNCIL for Mental Wellbeing

Opioid Response Network

## FINANCIAL AND REGULATORY READINESS

Coverage and reimbursement for MAT varies from state to state for both the public sector and private insurance marketplaces. Many states and commercial health plans require some form of preauthorization and some require that providers begin treatment with certain medications (step therapy). As coverage and policies may change over time, it is important to stay informed about your state's policies and private insurance options to find out where reimbursement is possible.

| QUESTION/AREA OF CONSIDERATION | NOT READY | IN PROGRESS | READY |
|---|---|---|---|
| What do Medicaid and commercial insurers require for the use of MAT in your state?<br>• Are there limitations on who can prescribe MAT, the length of time patients can use MAT and/or the type(s) of formulations patients may receive? | ☐ | ☐ | ☐ |
| Does your state's Medicaid plan cover the MAT formulations that you would like to start offering (e.g., injectable naltrexone, sublingual buprenorphine)? | ☐ | ☐ | ☐ |

# Before, During, and After MAT Services

- Focus on how to facilitate referrals from internal and external sources including a focus on enhanced hospital discharge coordination via Transitional Care Management, for example.

- Determine patient need for MAT through screening (ex. SBIRT) or by using existing documentation of acceptable diagnoses. Then make referrals for SUD/OUD treatment (*ex. MAT and/or behavioral therapy*) and establish clinical care coordination workflows between PCPs and behavioral/mental health facilities in your area or in your facility.

- Traditional billing for MAT provision relies on a team-approach led by a medical provider reporting E/M office visits (99202-99215) and/or by a mental health professional providing diagnostic/behavioral services.

- Additionally, focus on initiating Behavioral Health Integration (BHI) or the Psychiatric Collaborative Care Model (Psych CoCM) which can generate revenue for work you were already doing in between face-to-face and virtual visits.

# Medication Assisted Treatment Services Management Issues and Considerations

- It is vital to determine if your clinician's state scope of license rules and that varying insurance company payment policies differ. For example, Medicare added Licensed Professional Counselors (LPC) as authorized billing providers in 2023.  How does this affect RHC/FQHC?

- Carefully review contractual language and ask for any payment/coverage updates before re-signing participation contracts with payers, typically every year or every other year.

- Do we use (*or need to use*) separate chart notes for medical vs. mental health services to maintain HIPAA Privacy compliance?

# Be aware of recent updates to 42 CFR “Part 2” regulations designed to enhance the protection of patient records for SUD

## HHS Proposes New Protections to Increase Care Coordination and Confidentiality for Patients With Substance Use Challenges

*New Proposed Rule to Implement the Bipartisan CARES Act Legislation*

Today, the U.S. Health and Human Services Department, through the Office for Civil Rights (OCR) and the Substance Abuse and Mental Health Services Administration (SAMHSA), announced proposed changes to the Confidentiality of Substance Use Disorder (SUD) Patient Records under 42 CFR part 2 (“Part 2”), which protects patient privacy and records concerning treatment related to substance use challenges from unauthorized disclosures. Specifically, today’s proposed rule increases coordination among providers in treatment for substance use challenges and increases protections for patients concerning records disclosure to avoid discrimination in treatment.

## Fact Sheet: SAMHSA 42 CFR Part 2 Revised Rule

Monday, July 13, 2020

The 42 CFR Part 2 regulations (Part 2) serve to protect patient records created by federally assisted programs for the treatment of substance use disorders (SUD). Part 2 has been revised to further facilitate better coordination of care in response to the opioid epidemic while maintaining its confidentiality protections against unauthorized disclosure and use.

**What Has Not Changed Under the New Part 2 Rule:** The revised rule does not alter the basic framework for confidentiality protection of substance use disorder (SUD) patient records created by federally assisted SUD treatment programs. Part 2 continues to prohibit law enforcement’s use of SUD patient records in criminal prosecutions against patients, absent a court order. Part 2 also continues to restrict the disclosure of SUD treatment records without patient consent, other than as statutorily authorized in the context of a bona fide medical emergency; or for the purpose of scientific research, audit, or program evaluation; or based on an appropriate court order.

# Research how to utilize "non-licensed" SUD/OUD providers

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

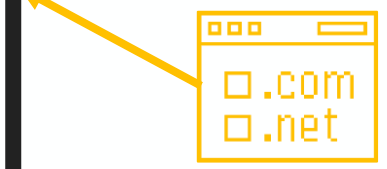
## 50-State Scan: How Medicaid Agencies Leverage their Non-Licensed Substance Use Disorder Workforce

By Eliza Mette, Charles Townley, Kitty Purington November 2019

NASHP analyzed publicly available materials to identify:

- How Medicaid agencies reimburse for SUD services provided by non-licensed, non-master's-level workforce;
- What services they provide and in what settings; and
- State education, training, and supervision requirements for non-licensed staff.

NASHP used the most recently available Medicaid provider and billing manuals, state regulations, and other public policy documents (including state plans and waivers) for all 50 states and Washington, DC. Findings were grouped and coded to allow for easier cross-state analysis. The data collected was shared with Medicaid and other state leaders.



# Foundations of SUD/OUD/MAT Documentation, Coding, and Billing

ArchProCoding
RURAL & COMMUNITY HEALTH

# Compare Sample CPT Codes

**11981-11983 –** Insertion, removal, or removal with re-insertion, non-biodegradable drug delivery implant

**80305-80307 –** Presumptive Drug Tests

**80320-80377 –** Definitive Drug Testing

**96156-96171 –** Health and behavioral assessments and interventions

**96372** – Giving a therapeutic injection

**99202-99215 –** Evaluation & Management (office/outpatient) code mainly for MAT visits

**99218-99350** – Evaluation & Management visits in observation, inpatient, nursing home, nursing facility, home visits, etc.

**99281-99285** – Emergency Department Services

# Contrast Sample HCPCS-II Codes

**C7900-C7902**–Hospital Outpatient PPS only – Diagnosis, evaluation, or treatment of mental health or substance use disorder…(time based)…provided remotely by hospital staff licensed to provide mental health services…patient in their home…when there is no associated professional service.

**J0570, J0592, J0571-J0575 –** Buprenorphine implant 74.2 mg and Buprenorphine/naloxone, oral, various dosages
**J2310-J2315** – Injection, Narcan/Naloxone/Naltrexone per 1mg - *J-codes are used to report the supply of the drug(s) in addition to an injection code ex. 96372)*

**Q9991-Q9992** - Injection, buprenorphine extended-release, less than or equal to 100 mg *or greater than 100mg*

**Modifiers** - be aware of the potential need to add HCPCS-II modifiers –HF for a substance abuse program vs. –HG for an opioid program

# Compare Sample Behavioral Health CPT Codes

+ 90785 – Interactive Complexity add-on code for more revenue when dealing with barriers to communication

90791-90792 – Psychiatric Diagnostic Evaluations

90832-99838 – Psychotherapy with or without drug management 30/45/60 minutes

96127 – Brief emotional/behavioral assessment with scoring and documentation, per instrument likely used with diagnosis code Z13.89

99492-99494 – Psychiatric Collaborative Care Model

99484 – Care Management for Behavioral Health Conditions (ex. BHI)

# Contrast Sample Behavioral Health HCPCS-II Codes

G0210-G0212 vs. G0071 – Virtual check-ins and "store and forward" virtual check-ins for commercial commercial/Medicaid claims versus RHC/FQHC-specific

G0511 – See the updated definition which adds the new Chronic Pain Management codes (*new HCPCS-II codes G3002-G3003*) and Behavioral Health Integration to the RHC/FQHC-specific general care management monthly billing

H0038 – Self-help peer services , per 15 minutes

H2011-H2013, H2018-H2022 – Crisis interventions, behavioral/psychiatric health day treatments, psychosocial rehab, community-based wrap-around services (*time-based*)

H2034-H2036 – Alcohol and/or drug abuse halfway house

# Possible G-code Billing Options Reserved for Assorted Payers/Facility Types

**Here are some additional billing options based on your facility-type.**
**As always, check with each carrier to find which they prefer and how often they are reimbursable.**

### G2086-G2088

**Office-based bundled OUD codes** includes treatment plan dev, care coordination, individual therapy and group therapy and counseling; initial/subsequent month, based on total time ***per calendar month***.

### +G2213

**Emergency Department** – Initiation of OUD treatment, including assessment, referrals, and arranging access to supportive services.

### +G2215-G2216

**Take-home supply** of methadone, buprenorphine, or oral/nasal naloxone.

### G0516

**Insertion of non-biodegradable drug delivery implants** (i.e. subdermal Buprenorphine rods).

### +G2078-G2079

**Opioid Treatment Program Only -** Take-home supply of methadone, buprenorphine, up to 7 additional days supply.

### G9621-G9624

**Screening for unhealthy alcohol use** – codes change based on findings and if you did or didn't perform the screening.

# Opioid Treatment Programs (OTP) Weekly Bundled Code Options


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)

# Possible H-code Billing Options Reserved for Possible Medicaid Use

It is necessary for your full team to review the definitions of every single H-code in the HCPCS-II manual. We can't list them all below and many may not ever be needed depending on carrier variations BUT, check out these highlights for now...

### H0001-H0007

Alcohol and/or drug assessments, behavioral health counseling and therapy, case management, crisis interventions.

### H0015

Alcohol/drug intensive outpatient treatment at least 3 hours a day, 3 days per week, includes assessment, crisis eval, activity therapy, etc.

### H0038

Self-help/peer services, per 15 minutes. Consider using for Peer Support Services.

### H0033, H0034

Oral medication administration with direct observation, medication training and support.

### H0047-H0050

Examples include alcohol/drug services NOS, drug testing collection & handling non-blood specimens, screening, brief interventions.

### H2010-H2037 Time and Per Diem Codes

Medication services, day treatments, community services, wrap-around services.

# Possible HCPCS-II T-codes RESERVED FOR MEDICAID


### T1001-T1003

Nursing Assessment and/or Evaluation, RN or LPN/LVN, time-based options

### T1006 - T1007

Alcohol and or substance abuse services including family/couple counseling and assorted treatment plan development and or modification

### T1014

Telehealth transmission, per minute, professional services billed separately

### T1015

Clinic visit/encounter, all inclusive

### T2048

Behavioral health, long-term residential treatment program usually more than 30 days with room/board, per day

# CMS Valid Encounters Defined for RHC/FQHC

01

Face-to-Face Visit?

**Exceptions?**

02

Authorized Core Provider?

**Slight differences for RHC vs. FQHC**

03

"Medically Necessary"?

**Familiar with NCDs vs. LCDs and where to get them?**

***Try this hyperlink***


04

Authorized location?

**Office, Part A SNF, patient's residence, where else?**

***"An RHC or FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC or FQHC services are rendered." – CMS Benefits Manual, Chapter 13, Section 40***

# Sample information from Chapter 13 for RHC/FQHC Visits


**40.3 - Multiple Visits on Same Day**

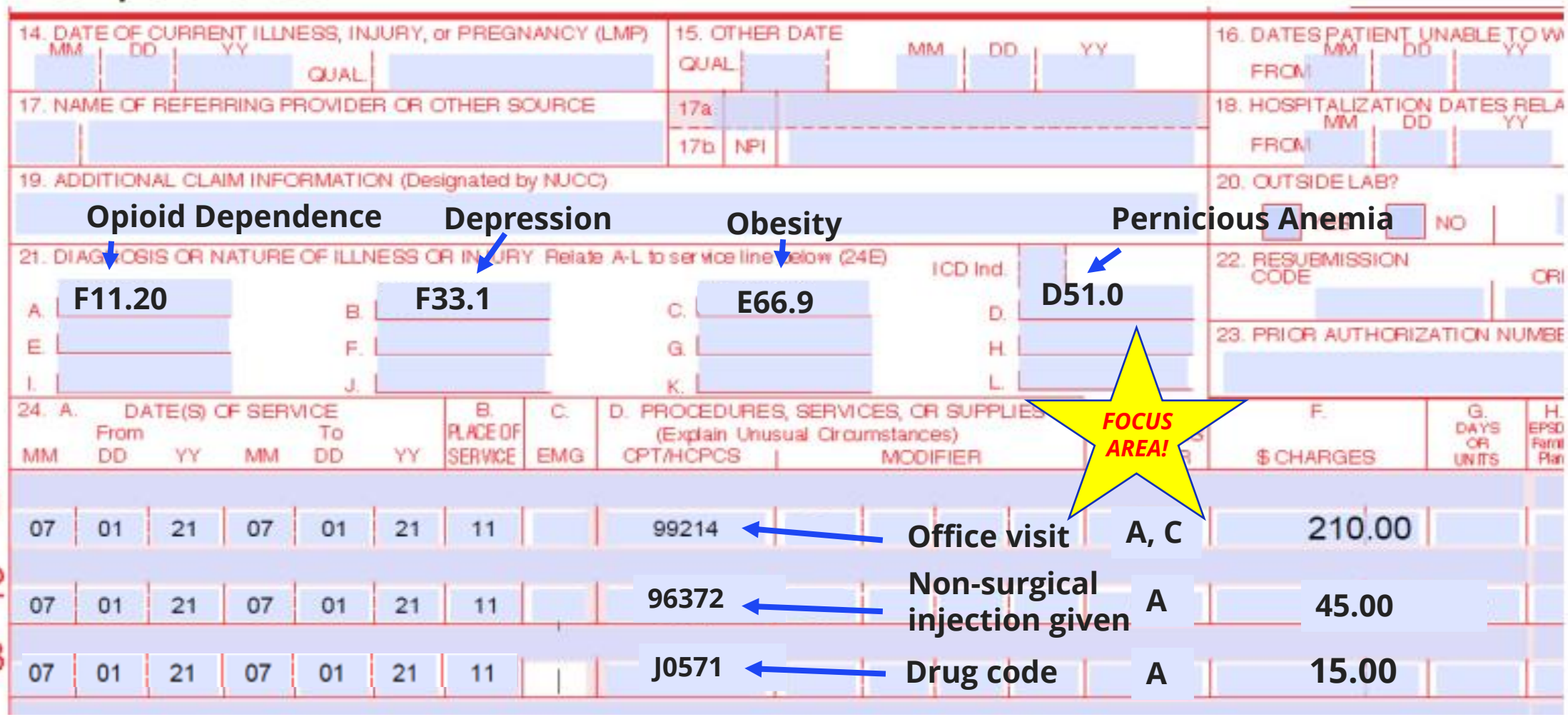
*(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)*

Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where *an* RHC or FQHC patient has a medically-necessary face-to-face visit with *an* RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner, including a specialist, for evaluation of a different condition on the same day.

*When should we use modifiers -25/-59 for RHCs or modifier -59 for FQHCs for multiple encounter rates on the same patient on the same day?*

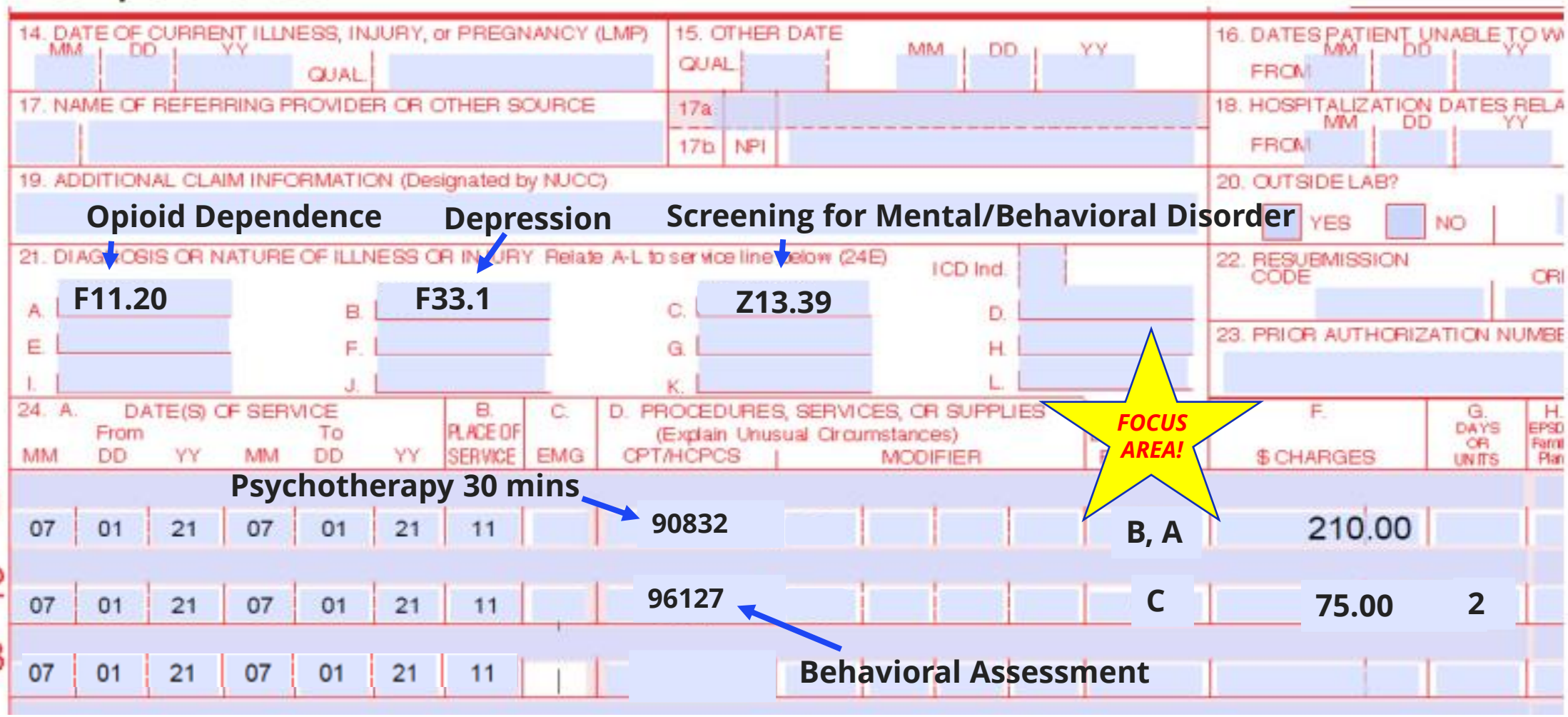
# Sample FFS claim for a medical provider giving an injection

## Sample CMS 1500

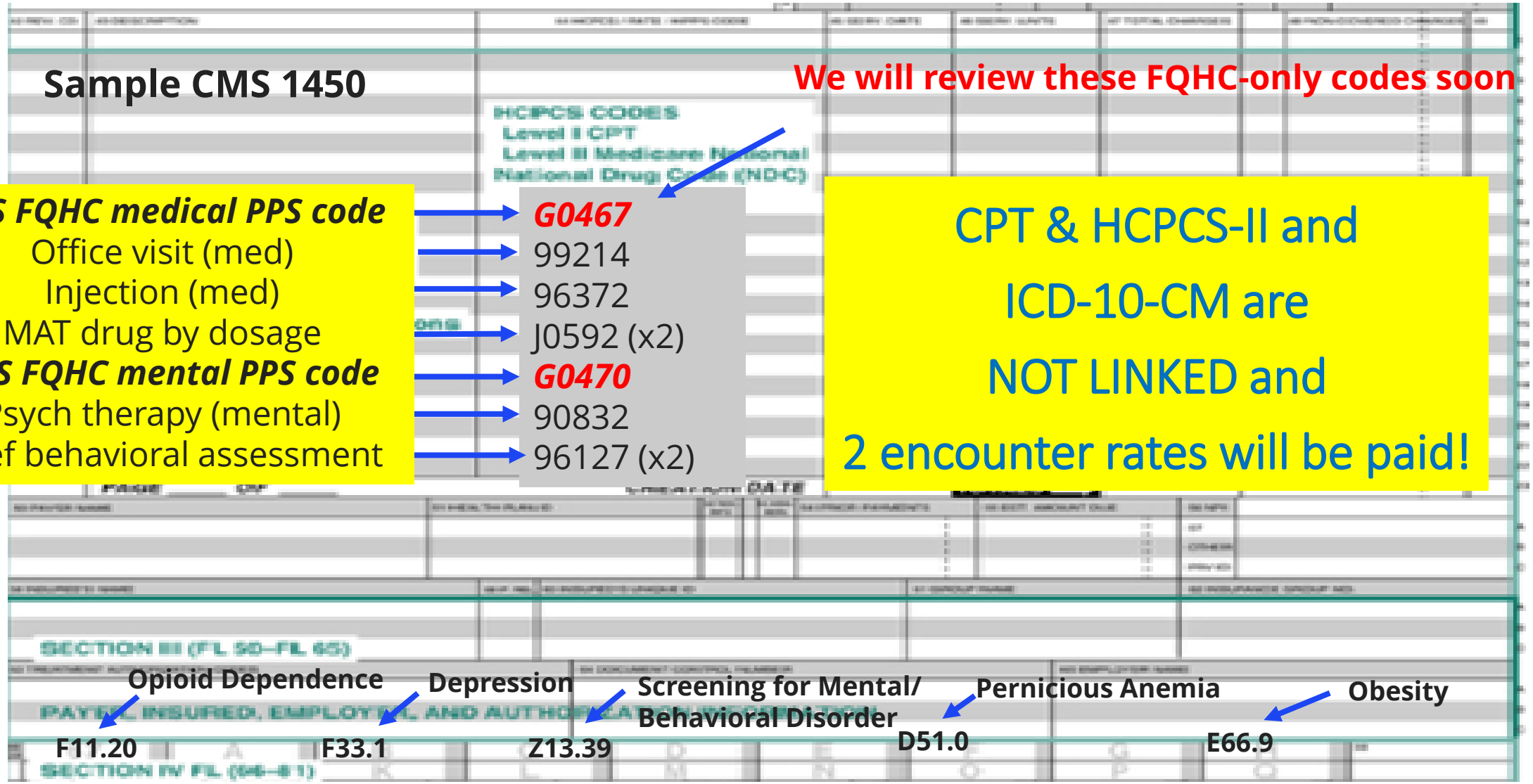


# Sample FFS claim for a mental health provider providing therapy and additional assessments

## Sample CMS 1500



# FQHC same day injection from medical & psychotherapy by mental health provider to Medicare



# Diagnostic Documentation and Coding for SUD/OUD/MAT

ArchProCoding
RURAL & COMMUNITY HEALTH

# Basics of Substance/Opioid Use, Abuse, and Dependence

Be aware of the possible need to have your clinical staff compare the DSM-5 definitions of mild, moderate, and severe disorders and the number of criteria documented to help make decisions on proper reporting of ICD-10-CM codes.

- Compare/contrast DSM-5's early vs. late remission options and notice that the ICD-10-CM may group them together into the same code.

*"If documented drug use is not treated or noted as affecting the patient's physical, mental or behavioral health, **do not** code it, except in pregnancy."*

- Ex. Septal ulcer due to cocaine use
- Ex. tachycardia due to methamphetamine use

**Source:** "AMA Risk Adjustment Documentation and Coding, 2nd Edition by Sheri Poe Bernard (2020)

# Diagnostic & Statistical Manual of Mental Disorders, 5th Edition (DSM-V)

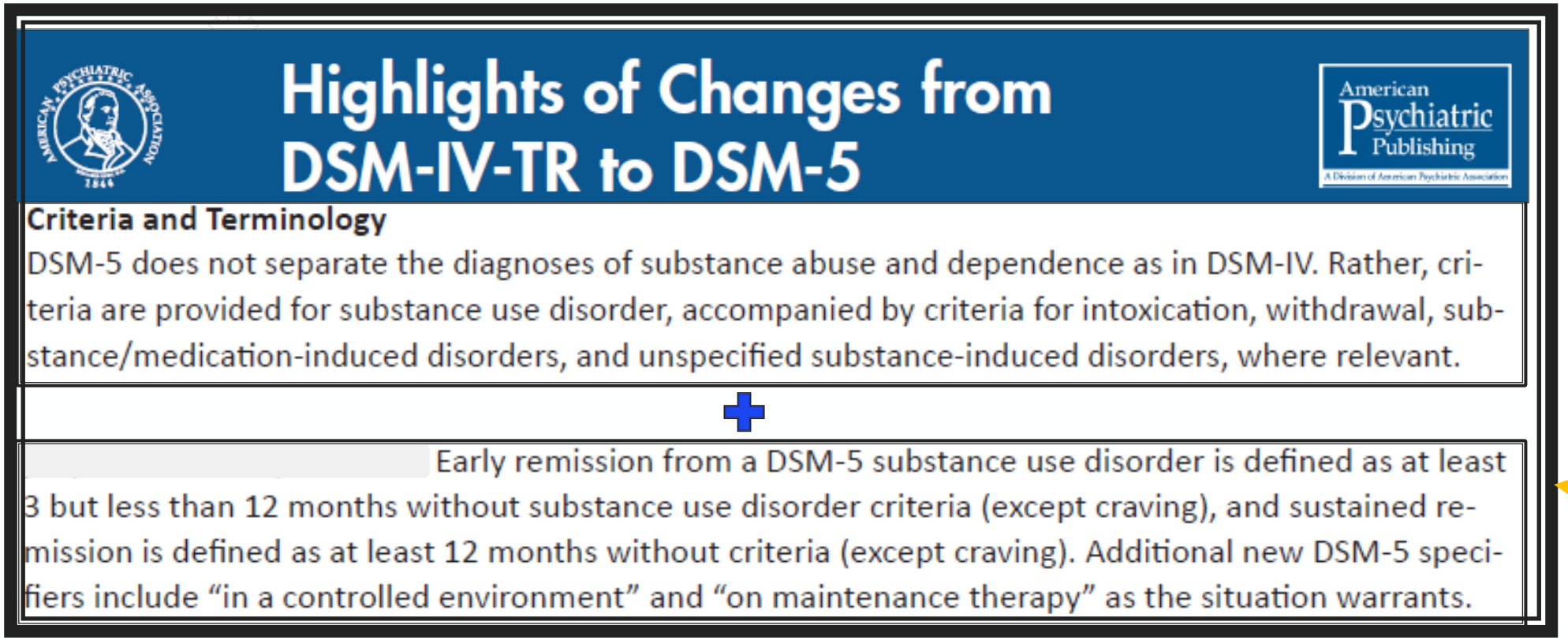
## DSM-5 Diagnostic Criteria for OUD

**In order to confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period:**

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Exhibits tolerance (discussed in the next section).
11. Exhibits withdrawal (discussed in the next section).

**FYI - SUD has its own similar list of 11 items to establish a clinical diagnosis**

# Compare/Contrast: DSM-V vs. ICD-10-CM



## Highlights of Changes from DSM-IV-TR to DSM-5

American Psychiatric Publishing
A Division of American Psychiatric Association

**Criteria and Terminology**

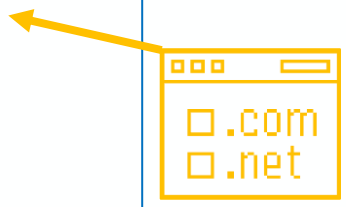
DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Rather, criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant.

Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and sustained remission is defined as at least 12 months without criteria (except craving). Additional new DSM-5 specifiers include "in a controlled environment" and "on maintenance therapy" as the situation warrants.

# 2023 ICD-10-CM Official Guidelines for Coding and Reporting

**Section I: C. Chapter Specific Coding Guidelines**

Chapter 1: Infectious and Parasitic Disease (A00-B99)
Chapter 2: Neoplasms (C00-D49)
Chapter 3: Diseases of Blood and Blood Forming Organs (D50-D89)
Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E89)
    Diabetes is in this Section (E08-E13)
Chapter 5: Mental and Behavioral Disorders (F01-F99)
Chapter 6: Diseases of the Nervous System and Sense Organs (G00-G99)
Chapter 7: Diseases of the Eye and Adnexa (H00-H59)
Chapter 8: Diseases of the Ear and Mastoid Process (H60-H95)
Chapter 9: Disease of the Circulatory System (I00-I99)
Chapter 10: Diseases of the Respiratory System (J00-J99)
Chapter 11: Diseases of the Digestive System (K00-K94)
Chapter 12: Diseases of Skin and Subcutaneous Tissue (L00-L99)
Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)



# Highlights of Section I-C Chapter 5 of the ICD-10-CM Official Guidelines

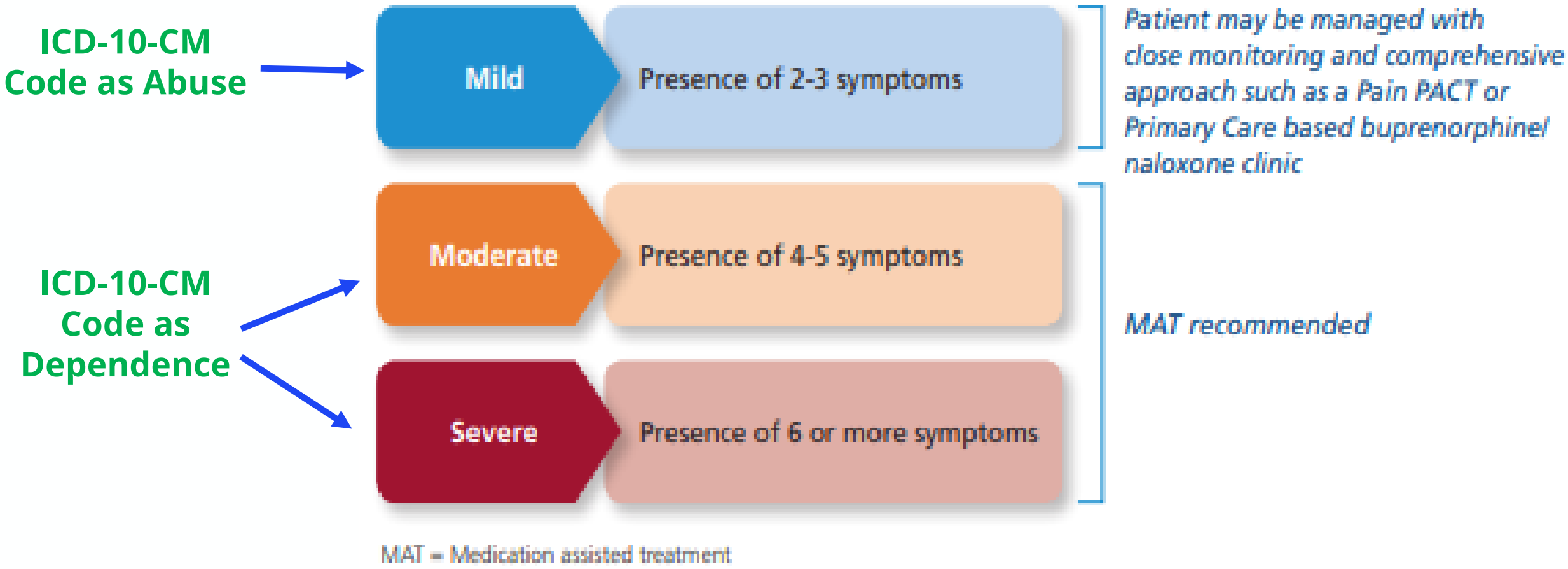
**2) Psychoactive Substance Use, Abuse and Dependence**

When the provider documentation refers to use, abuse and dependence of the same substance (e.g. alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

- If both use and abuse are documented, assign only the code for abuse
- If both abuse and dependence are documented, assign only the code for dependence
- If use, abuse and dependence are all documented, assign only the code for dependence
- If both use and dependence are documented, assign only the code for dependence.

# Translating DSM-V Terms to Proper ICD-10-CM Code Usage

## DSM-5 "Use Disorder" Criteria




***SOURCE:*** *VA Opioid Use Disorder Clinician's Guide – link provided on an earlier slide*

# Sample of ICD-10-CM opioid dependence codes with detailed coexisting conditions

- F11.2 Opioid dependence
  - F11.20 ..... uncomplicated
  - F11.21 ..... in remission
  - F11.22 Opioid dependence with intoxication
    - F11.220 ..... uncomplicated
    - F11.221 ..... delirium
    - F11.222 ..... with perceptual disturbance
    - F11.229 ..... unspecified
  - F11.23 ..... with withdrawal
  - F11.24 ..... with opioid-induced mood disorder
  - F11.25 Opioid dependence with opioid-induced psychotic disorder
    - F11.250 ..... with delusions
    - F11.251 ..... with hallucinations
    - F11.259 ..... unspecified
  - F11.28 Opioid dependence with other opioid-induced disorder
    - F11.281 Opioid dependence with opioid-induced sexual dysfunction
    - F11.282 Opioid dependence with opioid-induced sleep disorder
    - F11.288 Opioid dependence with other opioid-induced disorder
  - F11.29 ..... with unspecified opioid-induced disorder

# ICD-10-CM Code Sections for Mental and Behavioral Disorders Due to Psychoactive Substance Use (F10-F19)

- **F10 = Alcohol related disorders**
  - TIP: Use additional code for blood alcohol level, if applicable (Y90.-).
  - Uncomplicated, in remission, with intoxication/withdrawal/perceptual disturbance, or other disorders (ex. sleep or anxiety).

- **F11 = Opioid related disorders**
  - TIP #1: Do not report a code from this section alone for prescribed opioid use. It is necessary to also report an associated and documented physical, mental or behavioral disorder.
  - TIP #2: There are no codes for "use" – if documented as mild use (*2-3 DSM-5 criteria*) code to abuse. If documented as moderate (*4-5 DSM-5 criteria*) or severe (*6 or more DSM-5 criteria*) code to dependence.
  - Uncomplicated, in remission, with intoxication/withdrawal/perceptual disturbance, or other disorders (ex. psychotic).

- **F12 = Cannabis related disorders – same rule as tip #2 above.**
  - Uncomplicated, in remission, with intoxication/withdrawal/perceptual disturbance, or other disorders (ex. psychotic), or delirium.

# ICD-10-CM Code Sections for Mental and Behavioral Disorders Due to Psychoactive Substance Use (F10-F19)

- **F13 = Sedative, hypnotic, or anxiolytic (i.e. anxiety) disorders**
  - TIP: Again there are no “use” codes + be aware of options that may include intoxication or withdrawal in the documentation when coding this section.
- F14 = **Cocaine related disorders**
  - TIP: Be aware of intoxication options for more specified coding.
- **F15 = Other stimulant related disorders**
  - TIP: Includes amphetamine-related disorders, methamphetamine, caffeine, and “bath salts” abuse and dependence.

# ICD-10-CM Code Sections for Mental and Behavioral Disorders Due to Psychoactive Substance Use (F10-F19)

- F16 = Hallucinogen related disorders
  - TIP: Again be aware that “mild use” should be coded to abuse while moderate/severe should be coded to dependence. Also notice coding notes in the manual that identify which options to use with in “early remission” versus in “sustained remission.”

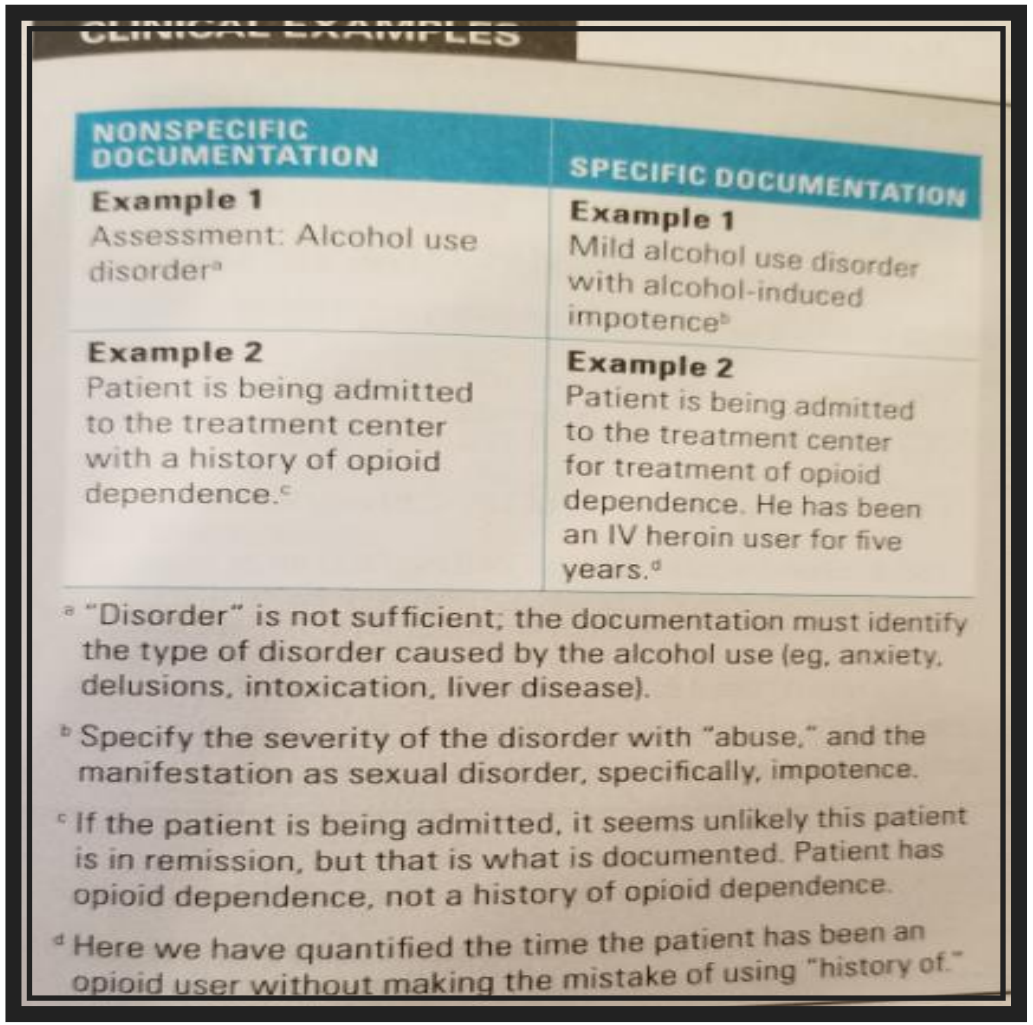
- F17 = Nicotine dependence
  - TIP: Be aware of which nicotine product is being referenced in the documentation as the codes will be different for cigarettes versus chewing tobacco and other options.
  - EXAMPLE: If using an electronic cigarette report F17.29, Nicotine dependence, other tobacco product.

# ICD-10-CM Code Sections for Mental and Behavioral Disorders Due to Psychoactive Substance Use (F10-F19)

- F18 = Inhalant related disorders
  - TIP:  Additional coding options in this section exist for associated intoxication, psychotic disorders, mood disorders, delusions, hallucinations, and anxiety.

- F19 = Other psychoactive substance related disorders – includes polysubstance/indiscriminate drug use.
  - “Polysubstance dependence” was removed as a diagnosis in the DSM-5.
  - Uncomplicated, in remission, with intoxication/withdrawal/perceptual disturbance, or other disorders (ex. anxiety).

# Get more documentation samples from this great reference!



CLINICAL EXAMPLES

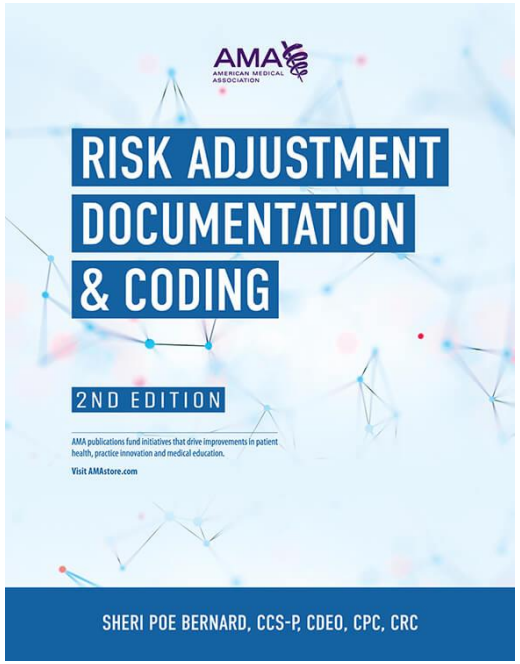
| NONSPECIFIC DOCUMENTATION | SPECIFIC DOCUMENTATION |
|---|---|
| **Example 1**<br>Assessment: Alcohol use disorder[a] | **Example 1**<br>Mild alcohol use disorder with alcohol-induced impotence[b] |
| **Example 2**<br>Patient is being admitted to the treatment center with a history of opioid dependence.[c] | **Example 2**<br>Patient is being admitted to the treatment center for treatment of opioid dependence. He has been an IV heroin user for five years.[d] |

[a] "Disorder" is not sufficient; the documentation must identify the type of disorder caused by the alcohol use (eg, anxiety, delusions, intoxication, liver disease).

[b] Specify the severity of the disorder with "abuse," and the manifestation as sexual disorder, specifically, impotence.

[c] If the patient is being admitted, it seems unlikely this patient is in remission, but that is what is documented. Patient has opioid dependence, not a history of opioid dependence.

[d] Here we have quantified the time the patient has been an opioid user without making the mistake of using "history of."




**Source:**
AMA Risk Adjustment Documentation and Coding 2nd Edition– by Sheri Poe Bernard (2020)

# Get more coding documentation samples from this great reference!



## SUBSTANCE USE/MENTAL DISORDERS

### Physician Documentation Tips

**Psychiatric conditions affect** patient health, wellness, and compliance with treatment plans. With patient care trending to a more holistic approach, psychiatric conditions and social determinants are being diagnosed or treated by primary care physicians in increasing numbers. Prevention and screening and coordination of care with behavioral health specialists help provide opportunities for earlier intervention and improved outcomes.

- **Document the recurring nature of a disorder in each encounter.** The medical record for each date of service must stand on its own. A diagnosis in the patient's problem list or past medical history cannot be abstracted unless it is addressed in the record for the current encounter.
- **Clearly state if any alcohol or drug utilization results in physical, behavioral, or mental disorders, or if any responsible, chemical use without adverse consequences, for which no any ICD-10-CM code is to be assigned.** When applicable, differentiate between drug or alcohol use resulting in consequences, mild drug or alcohol use *disorder* (classified to abuse in ICD-10-CM) or moderate-severe use *disorder* (classified to dependence in ICD-10-CM) using official DSM–5 criteria. Cite all consequences from addictive drug use, abuse, or dependence, such as withdrawal, sleep disorders, sexual dysfunction, or personality disorders. If patients successfully participate in appropriate rehabilitative activities, document when alcohol or drug abuse or dependence is in remission (more than 3 months) for the life of the patient (once an alcoholic, always an alcoholic).
- **In major depressive disorder,** note if its presence is one single episode or a recurrent pattern and its severity as mild, moderate, severe, severe with psychosis, or in partial or full remission. Differentiate sadness from an appropriate grief response, an adjustment disorder with depressed mood, dysthymia, premenstrual tension syndrome, or a major depressive disorder as defined by DSM–5.
- **In bipolar disorder (at least one episode of mania and one episode of major depression),** note whether the current episode is manic or depressive, and whether mild, moderate, severe, severe and psychotic, or in remission (ie, full or partial with a description of the most recent episode as hypomanic, manic, depressed, or mixed). Bipolar disorders with only hypomania (no mania) and major depression should be reported as bipolar II.
- **Intellectual disability affects** a patient's ability to provide a medical history or follow a treatment plan. Document it at every encounter with the disabled patient.
- **Make a note regarding the administration** and results of a depression screening, and if suicide risk was assessed. Document any suicidal ideation.
- **For patients with multiple behavioral disorders,** link prescribed psychiatric medications to the conditions they treat.
- **ICD-10-CM provides codes for behaviors** that have not yet been classified to behavioral disorders, but that may contribute to the need for further treatment or study.
- **Identify post-traumatic stress disorder (PTSD)** as acute or chronic.
- **In obsessive-compulsive disorder,** note any hoarding, skin-picking, obsessive acts, or neuroses.
- **ICD-10-CM assumes a link between alcoholism and any of the following:** persisting amnestic disorder; persistent dementia; anxiety disorder; mood disorder; psychotic disorder; sexual dysfunction; or sleep disorder. Document if the conditions should not be linked.
- **Document time** invested in counseling or care coordination.

*Risk Adjustment Documentation & Coding* Training/Teaching Tools

## SUBSTANCE USE/MENTAL DISORDERS

### Coder Abstraction Tips

**Drug and alcohol problems and behavioral disorders** are increasingly diagnosed and treated by the patient's primary care physician, and should be reported as often as they are documented and assessed or treated.

- **Documentation of "traits" is not documentation of a disorder.** For example, if a patient is said to have "borderline personality traits," the physician has not documented borderline personality disorder.
- **If alcohol or recreational drug use is not documented as resulting in a mental, behavior, or physical consequence, *do not* code it.** A patient's incidental use of drugs is only reported when the use affects treatment or care of a patient (eg, other psychiatric conditions exacerbated by drug use or liver disease documented as affected by the use of recreational drugs).
- **Do not confuse alcohol or drug use with alcohol or drug use *disorder*.** Unspecified alcohol or drug use disorders cannot be coded without being specified as mild, moderate, or severe.

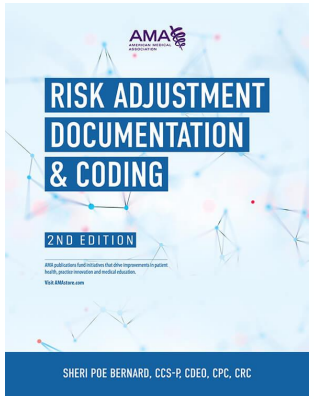
**Use, Abuse, and Dependence**

When the physician refers to use or abuse with dependence of the same substance, report only the dependence. If the physician reports use and abuse of the same substance, report only abuse.

- **Diagnoses for children** are at times found in what seems to be an "adult" area of diagnoses in ICD-10-CM, and diagnoses for adults in the "children's" section. For example, the diagnosis for an adult with new onset attention deficit disorder is reported with a code from category F90, in a section entitled "Behavioral and emotional disorders with onset usually occurring in childhood and adolescence." Confidently code behavioral disorders from the Alphabetic Index.
- **Always code intellectual disability when it is documented.** Intellectual disability always affects a patient's ability to follow a treatment plan or to provide a pertinent medical history.
- **Report postpartum depression** with code F53.0 *Postpartun depression,* rather than a code from the pregnancy chapter of ICD-10-CM. This code is new for 2020. Report other behavioral disorders with codes from category O99.34, *Other mental disorders complicating pregnancy, childbirth, and the puerperium.* ICD-10-CM guidelines say that any comorbidity affects pregnancy, so any pre-existing or newly diagnosed behavioral disorder would be reported as a complication of pregnancy, unless the physician specifically states the disorder does not affect the pregnancy.

| Assume Causal Relationship for Alcohol Dependence and These Diagnoses | |
|---|---|
| F10.24 | Alcohol dependence with alcohol-induced mood disorder |
| F10.250 | Alcohol dependence with alcohol-induced psychotic disorder with delusions |
| F10.251 | Alcohol dependence with alcohol-induced psychotic disorder with hallucinations |
| F10.26 | Alcohol dependence with alcohol-induced persisting amnestic disorder |
| F10.280 | Alcohol dependence with alcohol-induced anxiety disorder |
| F10.281 | Alcohol dependence with alcohol-induced sexual dysfunction |
| F10.282 | Alcohol dependence with alcohol-induced sleep disorder |

- **Do not make assumptions regarding the language** physicians use in describing patient conditions. Use the Alphabetic Index to look up the exact terminology from the medical record to properly abstract the diagnosis code. Never report a more complex condition than what is documented and indexed.



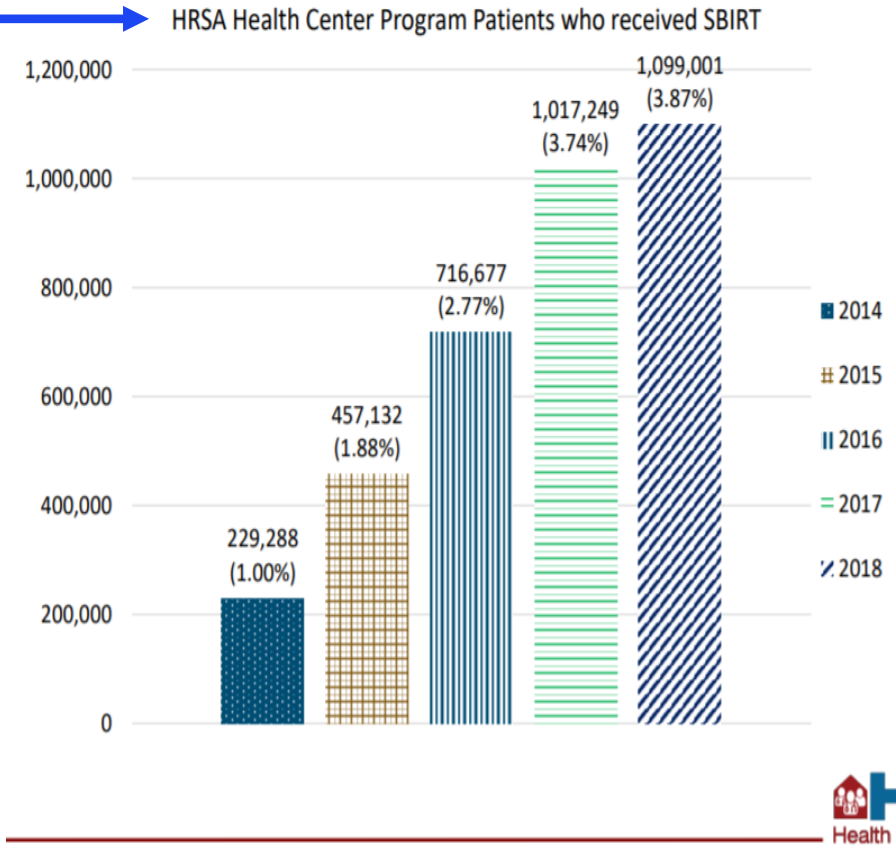

**Source:**
AMA Risk Adjustment Documentation and Coding 2nd Edition– by Sheri Poe Bernard (2020)

# Documenting SUD/OUD/MAT Visits

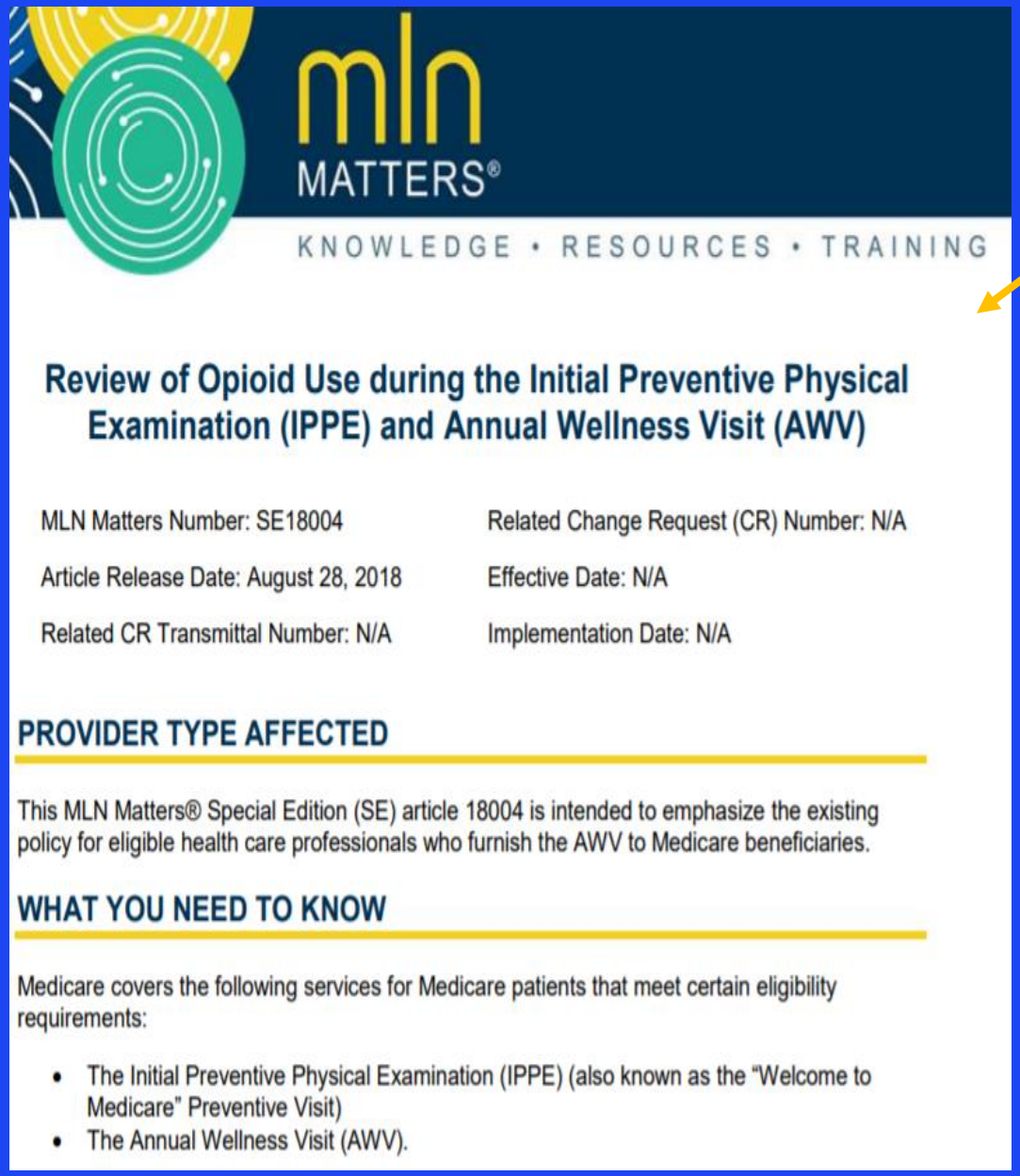
ArchProCoding
RURAL & COMMUNITY HEALTH

# Common Screening Tools for SUD and/or OUD

1. Screening, Brief Intervention, and Referral to Treatment (SBIRT)
2. Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
3. Cut down, Annoyed, Guilty, Eye-Opener – Adapted to Include Drugs (CAGE-AID)
4. These tools ***and many others*** were reviewed by the United States Preventive Task Force and can be reviewed here: https://www.ncbi.nlm.nih.gov/books/NBK43363/



# Screening during IPPE/AWV



mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

## Review of Opioid Use during the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)

MLN Matters Number: SE18004 — Related Change Request (CR) Number: N/A

Article Release Date: August 28, 2018 — Effective Date: N/A

Related CR Transmittal Number: N/A — Implementation Date: N/A

### PROVIDER TYPE AFFECTED

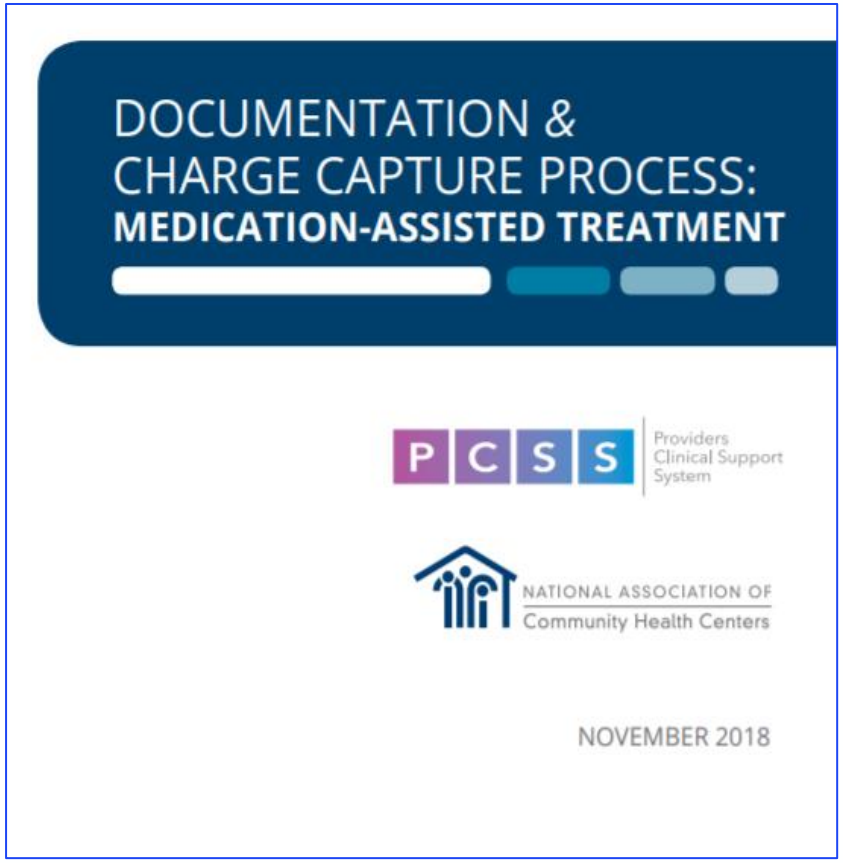
This MLN Matters® Special Edition (SE) article 18004 is intended to emphasize the existing policy for eligible health care professionals who furnish the AWV to Medicare beneficiaries.

### WHAT YOU NEED TO KNOW

Medicare covers the following services for Medicare patients that meet certain eligibility requirements:

- The Initial Preventive Physical Examination (IPPE) (also known as the "Welcome to Medicare" Preventive Visit)
- The Annual Wellness Visit (AWV).

# NACHC's guide to MAT

DOCUMENTATION & CHARGE CAPTURE PROCESS:
**MEDICATION-ASSISTED TREATMENT**

PCSS Providers Clinical Support System

NATIONAL ASSOCIATION OF Community Health Centers

NOVEMBER 2018

*It is recommended that you review NACHC's Appendices E, F, and G for a great rundown of proper documentation and coding info that applies to all facility types. Beware that the billing rules are for FQHC's only though – check with your payers for their needs depending on your facility type.*

# Sample billing code options for screening for SUD/OUD

**99408/G0396:** Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes

**99409/G0397:** Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes

**H0049:** for Alcohol and/or drug screening

**H0050:** for Alcohol and/or drug screening, brief intervention, per 15 minutes

**G0442:** Annual alcohol misuse screening, **5-15 minutes (updated for 2023)**

**G0443:** Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

**G0444: –** Annual depression screening, **5-15 minutes (updated for 2023)**

# MAT Screening, Assessment, and Interventions General Coding

**Initial assessments can be performed at a visit expressly for SUD/OUD screening and/or during unrelated medical visits (ex. 99202-99215, IPPE, AWV, Preventive Services 99381-99397) or behavioral/mental health visits (ex. 90792 or 90832).**

**SAMPLE CODING vs. BILLING**

- **CODING:** Be prepared to use **99408-99409** if billing commercial insurance
  - Alcohol and/or substance abuse screening and brief intervention services either 15-30 minutes or more than 30 minutes.

- **BILLING:** Be prepared to report **G0396-G0397** to Medicare (basically the same definition as above). What about G2011 for structured assessments and brief interventions for "other than tobacco" as a non-OUD but SUD option?

- **BILLING:** Be prepared to report **H0049** for "Alcohol and/or drug screening" and/or **H0050** for "Alcohol and/or drug screening, brief intervention, per 15 minutes" to Medicaid. Be aware of codes for "non-physicians".

- **TELEHEALTH OPTIONS? AUDIO-ONLY?**

# Induction, Stabilization, Maintenance General Coding

**These will mainly be E/M services by your medical provider and possible therapeutic injection/implant codes like 96372/11981/G0516 + a J-code such as J2315 for 1mg of Vivitrol (naltrexone) or J2310 for Narcan/Naloxone or J0592 for Buprenorphine.**

**Expect Varying Medicaid Billing Needs**

- **BILLING:** Consider checking out H-codes such as **H0032-H0034** and/or H0050 for very detailed options that Medicaid carriers may prefer. Keep in mind that their documentation and billing requirements may not be the same from other Medicaid/commercial payers?
- **BILLING:** Follow payer rules depending on if you need to meet time-based coding for Prolonged Services Codes (ex. +99417) for patients that are in your facility way longer than normal. Some carriers will pay more - others won't.
- **BILLING:** Always follow proper diagnosis coding according to the ICD-10-CM Official Guidelines for Coding & Reporting as authored by the Cooperating Parties (i.e. CMS, AMA, NCHS, AHA) rather than following EHR/IT shortcuts.

# Sample Self-Study on CPT Coding Medicine chapter Psychiatry section

## Interactive Complexity

What is an add-on code?

What other codes can this code be added to?

What needs to be in the medical record to support the coding of +90785?

## Psychiatric Diagnostic Evaluations

What is the difference between the 2 main codes and which types of providers can perform which?

What else is included in this assessment per the notes before the codes?

What if done on somebody other than the patient?

## Psychotherapy

Which provider types can code 90832, 90834, and 90838 **versus** codes +90833, +90836, and +90838?

What if the patient gets an **"urgent assessment and history of crisis state, a mental status exam, and a disposition"?**

What if the time units aren't met exactly?

## Assorted Psychiatric Codes

Check out codes for family/group therapy and expect carrier variations in payment.

Review codes +90863 for pharmacological management and 90885-90989 for assorted review of medical records to provide advice or recommendations.

# Documentation for Psychiatric Diagnostic Interviews (90791 and 90792)

- Elicitation of a complete medical and psychiatric history (including past, family, social)
- Mental status examination (MSE)
- Establishment of an initial diagnosis
- Evaluation of the patient's ability and capacity to respond to treatment
- Develop initial **plan** of treatment
- Reported once per day and NOT on the same day as an E/M service performed by the same individual for the same patient
- Covered once at the outset of an illness or suspected illness

# Psychotherapy Therapeutic Services

A. Codes 90832-90834 represent insight oriented, behavior modifying, supportive, and/or interactive psychotherapy

B. Codes 90845-90853 represent psychoanalysis , group psychotherapy, family psychotherapy, and/or interactive group psychotherapy

C. Code 90865 represent narcosynthesis for psychiatric diagnostic and/or therapeutic purposes

NOT included in these codes:

- Teaching grooming skills
- Monitoring activities of daily living (ADL)
- Recreational therapy (dance, art, play)
- Social Interaction

Check out the Medicare Coverage Database for national and local info on each of these services and more!

# Psychotherapy Therapeutic Services

- CPT® codes 90832 - +90838 represent psychotherapy for the treatment of mental illness and behavioral disturbances.

- The times listed refer to face-to-face time (*with patient and/or family*) and the time does not need to be continuous.
  - ✓90832 and +90833 [“30 minutes”] **(16-37 minutes)**
  - ✓90834 and +90836 [“45 minutes”] **(38-52 minutes)**
  - ✓90837 and +90838 [“60 minutes”] **(53+ minutes)**

- A “unit” of time is met once the “midpoint” has been reached.

- Remember: It is possible in the RHC/FQHC for 2 visits to be claimed for the same patient on the same date of service for Medicare (e.g., one medical encounter and one mental/behavioral health encounter).

# Medication Therapy Management Services by Pharmacists

- CPT codes 99605, 99606, and +99607 describe time-based face-to-face patient assessments and interventions, upon request, to “optimize the response to medications or to manage treatment-related medication interactions or complications.”
- Documentation should include review of history, medication profile, and recommendations for improving health outcomes and treatment compliance.
- Per the AMA’s CPT – “These codes are not to be used to describe the provision of product-specific information at the point of dispensing or any other routine dispensing-related activities.”
- Check coverage with each payer as well as possible frequency restrictions.

# Care Management Documentation for Clinical Providers

### Get patient verbal/written consent

For RHCs/FQHCs to bill Medicare patients it is necessary to get their approval of being their single care manager as well as **performing an "Initiating Visit" within 1 year prior** to first billing Care Management.

### Chronic Care Management

99487-99491, +99439

**+**

### Principal Care Management

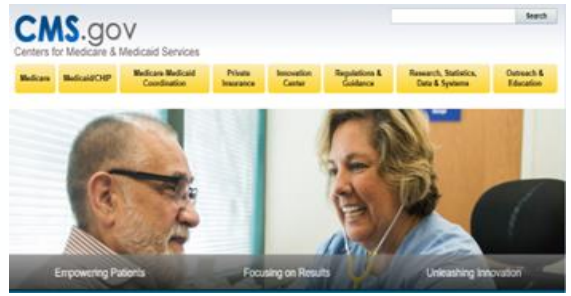
99424-99427

### Behavioral Health Integration (BHI) or Psychiatric Collaborative Care Model (Psych CoCM)

99484, 99492-99494

### New for 2023 Chronic Pain Management

See the new codes G3002 and +G3003 for consideration with commercial and non-Medicare payers.


# BHI and Psych CoCM Additional info for RHC/FQHC

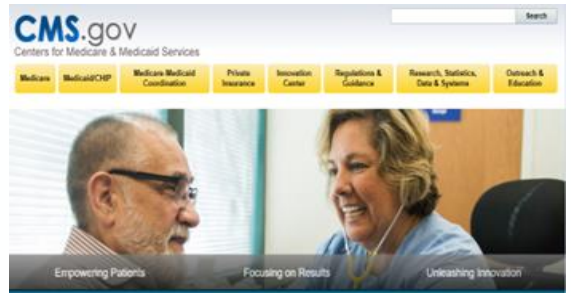
When a **medical provider supervises and directs the care plan for patients with a mental, behavioral, or psychiatric conditions** (including substance use disorders).

- To distinguish general BHI services from the Psych CoCM please visit this link CMS Fact Sheet for Behavioral Health Integration Services for details on the CoCM model and how it differs from general BHI.

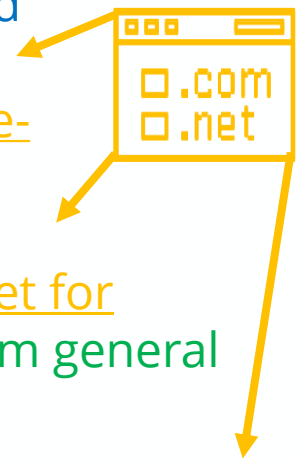

BHI ***optionally*** includes a Behavioral Heath Manager and a Psychiatric Consultant, whereas the Psych CoCM ***requires*** their active participation.

- New for 2023 - Check out code **G0323** for *Care management services for behavioral health conditions, at least 20 minutes of* ***clinical psychologist or clinical social worker time****, per calendar month* for possible use with non-Medicare payers.

# Care Management
# Additional info from CMS


- Info on principal/chronic care management, BHI, Psych CoCM, and additional services called **Transitional Care Management and Advanced Care Planning** are at this link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management




- To distinguish general BHI services from the Psych CoCM please visit this link CMS Fact Sheet for Behavioral Health Integration Services for details on the CoCM model and how it differs from general BHI.

- For Medicare's guidelines for reporting most Care Management Services please review the CMS Benefits Policy Manual Chapter 13 – section 230



# Care Management
# Coding/Billing information for consideration

**Medicare asks RHC/FQHC to report the unique G0511 or G0512 codes** that now encompass chronic/principal care management, chronic pain management, BHI, and the Psych CoCM

- **G0511** = Rural Health Clinic or Federally Qualified Health Center only, general care management, 20 minutes or more of clinical staff time for chronic care **or chronic pain management** services **OR** behavioral health integration services directed by RHC or FQHC practitioner (MD, NP, PA, or CNM), per calendar month. Pays ~$77.94 split 80/20%

- **G0512** = Rural Health Clinic or Federally Qualified Health Center only, Psychiatric Collaborative Care Model, 60 minutes or more of clinical staff time for psychiatric CoCM services directed by a RHC/FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month. Pays ~$146.73 split 80/20%

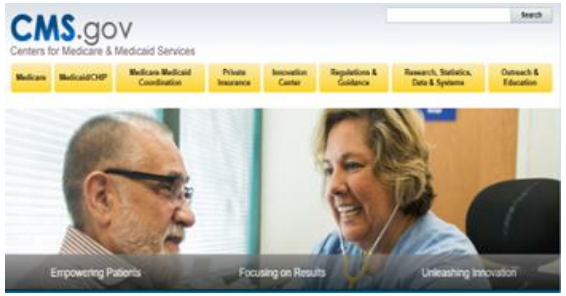
# FQHC Telehealth
# Key Thoughts for Billing

- For non-Medicare carriers it is likely that the payer just wants the CPT/HCPCS-II code performed (99213 or 90832) plus a modifier -93/-95/-FQ/-FR and/or Place Of Service code 02 or 10 on the claim.

- **MEDICAL SERVICES** – For Medicare patients, FQHC are instructed to use code G2025 for in order to receive the flat fee of $98.27 (split 80/20%) if the code is on the CMS approved services list.

- **MENTAL HEALTH SERVICES** – For Medicare patients, FQHC are instructed to report a code on the CMS approved services list as if performed in-person and billing should add a modifier -93/-95 in order to receive your AIR/PPS payments.  Medicare is not expecting us to use POS codes until after the PHE.

# CMS resources for RHC/FQHC Telehealth




- Get the CMS Med Learn Matters #SE20016 (*last updated 11-22-22*) for updates, revenue code info, modifiers, and other great billing info – https://www.cms.gov/files/document/se20016.pdf

- Track potential continuing updates to CMS' and MLN Matters #MM12427 "New/Modifications to the Place of Service (POS) codes for Telehealth" affecting POS 02 (*patient in other than in their home*) and the newly created POS 10 (*patient is in their home*), though as of this class "Medicare hasn't identified a need for new POS 10."

- *"During the PHE, Medicare does not require use of telehealth POS codes"* as per *CMS' Guidance to MACs*.

- For recent updates on reporting mental health telehealth in FQHC please use this link: https://www.cms.gov/files/document/se22001-mental-health-visits-telecommunications-rural-health-clinics-federally-qualified-health.pdf

# RHC/FQHC Details
# Telehealth and Virtual Communication Services

**Medicare Claims Processing Manual**
**Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers**

**70.7 - Virtual Communication Services**
**(Rev. 10357, Issued: 09-18-2020, Effective: 10-19-2020, Implementation: 10-19-2020)**

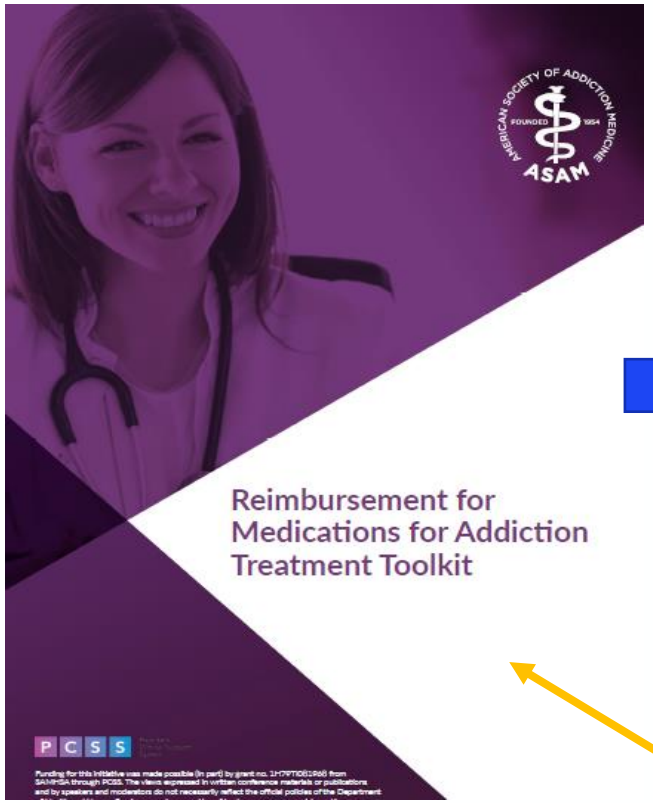
+

**Medicare Benefit Policy Manual**
**Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services**

**200 - Telehealth Services**
**(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)**

**240 – Virtual Communication Services**
**(Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01- 02-19)**

# For additional information - check out the American Society of Addiction Medicine's Reimbursement Toolkit





**CAUTION! Expect to Adjust Your Billing Based on Your Facility Type!**

- **Overview of MAT Billing**
- **Clinical Examples with Coding/Billing Options**
- **Behavioral Health Screening**
- **Telehealth Services**
- **OTP Bundled Payments**
- **State Medicaid Policies**
- **Alternate Payment Models**
- **Appendix on DSM-5 Diagnoses and ICD-10-CM Codes**


Instructor

# Gary Lucas, MSHI

**Vice President of Research and Development**

**Metro-Atlanta**

**Gary@ArchProCoding.com**