Phillip Stringfield (00:00:04):

Awesome. Thank you so much, Olivia. Hello everyone. As Olivia stated, my name is Phillip Stringfield. I serve as the Manager of Health Center Operations Training. I'm also joined by my colleague Ahma Johnson who serves as the Manager of Health Center Finance training within Next Training and Technical Assistance Division and we're definitely excited to join you all as we start our part two of our coding and documentation webinar series. As we get started, I just wanted to let you all know of a couple of upcoming events. First things first, next 2023 policy and issues form. That's going to be happening March 6th through the 11th. We have a couple of the committee meetings starting those first couple of days with the main conference starting on the eighth and it will be a hybrid offering, so we definitely look forward to seeing you there. Next slide. And also wanted to go ahead and put in a plug for next Practical Art of Health Center Operations Training.

(00:00:58):

This is really dedicated to operations managers, C-suite level folks, board members, all of the folks that really handled the operations within your health center will definitely look forward to having you there as well. It's a two day event from 12:00 PM to 5:00 PM and some of the topics include improving the patient experience population health strategy. We'll be talking a little bit about credentialing leadership topics and change management, so if you do are interested in that, you can always send me an email. I can always send you some of our promotions or the link to the page so that way you can find more information.

(00:01:35):

And moving right along, I'll go ahead and wrap things up and pass things over to Gary, but as we get started, I did want to go ahead and just note Olivia's message that please make sure that you're staying through the entire duration of today's webinar in order to receive that index code. We will not be able to share that with you all via email and I will be in the chat just reminding you all periodically. So if you have a colleague that's going to be on the call, just make sure to let them know that as well. We really appreciate your real cooperation there to make sure everyone gets what they need. Austin, with that I'll be handing things over to Gary Lucas with ArchPro Coding to get us started with part two.

Gary Lucas (00:02:15):

All right, thank you to everybody as always on the NACHC team who are getting you information that we hope is highly relevant and will be actionable for you to go back and increase your, not just your clinical capabilities of course, but your documentation, coding and billing as it relates to those of you treating substance and opioid use disorders. The key here is via medication assisted treatment. I'm making the assumption in this course that we probably have folks that are pretty experienced in the FQHC in the community health center world, but maybe in different phases of considering to provide this type of treatment or you're in the process or trying to sustain and maintain the positive issues related to this issue that affect not only your patients but your community. There have been some updates here in 2023 that are coming out. As always, please following class, feel free to email me at Gary ArchPro Coding.

(00:03:19):

The Arch stands for the Association for Rural and Community Health Professional Coding. Our focus here today is on a subject that I actually teach a four hour version of. Also, as this is brought to you through NACHC and HRSA, et cetera, HRSA also sponsors this training through JBS International for any of you that are involved in the what's called the RCORP grant, R-C-O-R-P, the Rural Community's Opioid Response Program. And so we've taken some of the highlights out of the full course to present to you

today. We'll start with an overview as this is an hour and a half version of a class, we typically teach for about four hours. What are we going to do to prepare for these type of visits? I mean, just to confirm when we're saying medication assisted treatment, we're talking about the provision of medical services by medical personnel to help a patient who's received a diagnosis of a type of substance or opioid use disorder.

(00:04:21):

Now key to this is that you have participation in and cooperation between medical professionals that are giving pills, dissolvable tablets or even injections of an opioid or a substance agonist or what's called an antagonist. While at the same time, medication assisted treatment indicates the patients had the opportunity to and/or is currently receiving concurrent behavioral health for maybe any of the underlying issues related to their addiction or medical condition that has caused the disorder that they've had with a substance and or an opioid. So we'll provide an overview of what you need to consider from a management perspective as we move to the basic foundations of documentation, coding and billing. With the focus on our topics, we will have to stop and really be careful and conscious of the difference between the clinical language that your providers may use when screening for substance or opioid disorders, that they have a bookshelf in their office that is dedicated to the clinical world of understanding how to determine and diagnose such disorders.

(00:05:36):

They have terminology they use mild, moderate, or severe use disorders. Well, you ready for the fun part? The ICD-10 has not used those same terms. So on the other side of the provider's offices, of course, the CPT ICD-10 and HCPCS level two codebook, but the ICD-10 book uses the terms use abuse and dependence and as recently as a very large meeting of with four or 500 people in Denver that I was at recently, a lot of coders express some concerns with them having to translate the terms used by the clinicians, which are a hundred percent accurate clinically, but having some necessary feedback and communication loops with providers on ensuring that the ICD-10 code matches what's being done. There's a very common code that's out there, particularly for opioids. It's F11.20 opioid dependence, uncomplicated of ... had the joy of working with several states and different consortiums related to this type of work, and they were dumbfounded because the diagnostic information they received from their grant or from their payers or their carriers really was pretty limited to very few diagnoses with F11.20 being the most common.

(00:06:57):

Now that is opioid dependence uncomplicated. However, again, by being involved with medication assisted treatment, the patient was likely receiving concurrent behavioral health. So it's vital that we maintain communications between the primary care folks and behavioral health when focusing on these diagnoses because, hint hint there are no opioid use codes because, of course, they're properly prescribed in many settings. So how do we translate the clinical terms from what's called the DSM-5, the Diagnostic and Statistical Manual Fifth Edition to ICD-10 will be our focus there. I'll tell you right now that just like there are not a lot or very few E&M codes that are focused for evaluation and management codes, I should say, that are focused on treating hypertension or diabetes or gout. Similarly, there are few codes for the ongoing common phases of medication assisted treatment. Now we will start by sharing various options that are out there for the first step, which is a screening, a brief intervention and/or a referral for treatment.

(00:08:05):

You may perform those screening services with a variety of clinical tools will lay out for you in today's session. But moving into what's called the induction and stabilization and maintenance phases, that will

define in the second chapter, E&M codes is your primary vehicle for the majority of what you're doing now, you might determine the patient's diagnosis with a visit specifically for looking for use disorders or it could be a patient receiving a general preventive medicine service or requesting two frequent prescription refills of pain meds, et cetera. But E&M is going to be the primary vehicle there. Of course, in last week's session we gave a highlight and of course, there's necessary training on the 2021 and 2023 E&M updates that you'll need to supplement, of course, with today's session. And I'm going to give you a couple highlights of how you get paid for non-face-to-face visits, primarily telehealth, what are called virtual communication services and the care management services similar to principal and chronic care management that medical providers are used to using.

(00:09:15):

What happens when you do have the integration of primary care and behavioral health such as medication assisted treatment and you have a medical provider overseeing in between visits the patient's mental or behavioral health plan. So we'll see some FQHC specific coding options for those non-face-to-face visits. Let's jump in and get started. Again, I want to thank Phillip, Ahma and Ms. Olivia for getting today's session off to the races and they'll be sending, in case you weren't present when she said it earlier, the recording and the slides to you down the road here, I'm just going to say within a week, sorry Olivia, I don't recall the time. So just in case you need to have a discussion internally, we'll start with that first chapter. Really focusing on the phases and the medications that are used in some administrative issues you need to be aware of, such as how or if your providers may need to receive additional training in order to provide buprenorphine or buprenorphine and suboxone, which is one of the primary types of medications used for opioid addiction will also mention varying provider types.

(00:10:27):

You may have what are called peer support counselors or peer recovery coaches people who have been through addiction in the past and are valuable members of the clinical team. They may have, depending upon your state, already earned some certification or credential and in some small state, in some small cases in some states a credential. But determining whether or not a valued member of the clinical team is a reimbursable member of the clinical team, of course, will vary by insurance and we'll help describe some options there. Pretty much already covered what's going to be mentioned as a highlight here, but what I've done is outline what the full four hour classes will be focusing on in order to kind of help organize your thoughts and organize your questions. One thing I'll highlight in the ICD-10 section is that there's actually a full set of diagnoses from the category F10 through F19 that provide very detailed options on substance specific ICD-10 codes, and we'll add that to our previous discussion, finishing the next to last chapter with a little info on behavioral health and again, highlights about some of those non-face-to-face services.

(00:11:44):

We'll make references, of course, to the AMA CPT book as you heard me state last week, of course. Make sure you get the printed versions so that you can get access to the documentation guidelines that only appear in the printed version of the CPT. All right, so just basic disclaimers folks, I'm going to encourage you to review those. I'll give you facts and opinions, but you maintain responsibility to submit claims based on validated documentation and encouraging you to meet the rules and regulations of each insurance claim. So nothing that we teach in this class supersedes the rules and regulations of your participation contracts. Just like the last session, I'll be presenting this from a variety of perspectives, the clinicians that need to document the work issues that managers need to be aware of in order to coordinate clinical and revenue goals, professional coders to understand how to properly extract the data from a medical record, whether a service is billable or not.

(00:12:46):

Obviously the billers, making sure you're maximizing your revenue and some potential EHR issues that you need to maybe just do a quick review and analyze your existing IT landscape. So let's go ahead and boogie into the first chapter. I will be looking at the questions in the Q and A box at the end of the session, especially if it's a little bit longer there, but rest assured we'll do our best to get to them and be available. So the primary phases so that we're utilizing the same terms that our clinicians are primarily starts with a screening, brief intervention and/or referral for treatment. Now, you'll hear some providers talk about that as an expert. That is an actual tool that kind of creates a forced set of documentation and steps to encourage a standardized approach to screening and getting the patient's approval and informed consent to not only receive the treatment but to adhere to random and or schedule drug tests, et cetera.

(00:13:52):

But I'll show you later on in the presentation, there are other tools you can use for the SBIRT process as long as they're on the United States Preventive Service Task Force. So I have heard clinicians indicate, Hey, I thought we had to use the SBIRT tool. We'll share some good information with you there. Now, the patients agreed to accept treatment depending upon what the best time to start was. They're going to induce the patient and through the stabilization period in the first week, try to determine the proper dosage for your patients. Maintain that with, of course, the goal of attaining either early, partial or sustained remission. So whether you're using the expert tool, the dash tool, the cage assist tool, all of which I'll reference a little bit later, or you did it during a preventive visit or an already existing acute or chronic care visit, et cetera.

(00:14:44):

The key is that we've determined that a provider has come up with a diagnosis from that category of F10 to F19 that will outline for you coming up. Now, the induction phase can be at a variety of times, but usually over the first week, depending upon the methodology, excuse me, utilized the idea here is that opioid, partial opioid agonists can reduce the ability, forgive me clinicians if I'm stating this wrong, but a partial agonist kind of prevents the opioid to stick on those for a moment from having the same effect on the patient that it would, and so that gradually reduces those cravings. Of course, the positive medications being given by the provider have very minimal side effects and are easier to wean off of once they've received their stabilizing doses, they move to the maintenance phase. Should be no shocker here, that's primarily via E&M visits.

(00:15:46):

But folks, what diagnosis is used over here? Although the generic, let's say F11.20 opioid dependence, unspecified, although that may get a claim paid, it may be looked at from a pre-approval perspective from the insurance company and maybe that diagnosis authorizes, let's say, a four to six week plan. But what if we had a true diagnosis code that gave a more accurate reflection of what the patient has, which is opioid dependence with other behavioral conditions associated? When we look at them there, well, that diagnosis automatically might justify or authorize, who knows, an eight week, nine week, or 12 week program, even in some cases the need for some patients to move to a rehab facility for a month and so forth. The key here is that following an agreement between the patient and the provider, the maintenance phase ends with a gradual tapering of MAT treatments.

(00:16:44):

And although we are pretty confident that your providers are using a streamlined and standardized definition of early rial and sustained remissions, you'll note that some of the substance specific categories do mention these words and some do not. So you're going to see some challenges or some

issues and some needed education between providers and coders and billers alike related to the initial determination and how we are identifying through time that the patient is maintaining remission there. And so working with your program leadership to get clearly defined processes and workflows, I'm going to share with you a wonderful MAT document that MAT created and released around December of 2019 that really goes deeply into community health specific information, not just on the coding documentation and billing side, but how to scrub charts before the patients arrive to determine when and how we might need to do a screening for substance or opioid use disorders.

(00:17:49):

How do we create internal and external referrals so that the emergency department, law enforcement and other providers in the community know that we provide this type of work? So though beyond the scope of documentation, coding and billing, I want to make sure you have access to that as well as several other perspectives, one from the American Society for Addiction Medicine, the other from CMS. Be prepared for me to give you hyperlinks so you can perform some additional research on how your program's going. Now, if we've been in class together before, or depending upon who you may have heard from before, or if you're a clinician and a manager not as familiar, let's make a very careful distinction, not only in the question and answer boxes, but every day in the practice that there's a difference in how we capture information from a medical record that's called professional coding versus how we turn in, turn that into compliant billing.

(00:18:47):

You're going to see different codes and different approaches based on what type of facility you're in and which insurance entity you're billing in particular, some differences with Medicaid. We'll talk about H codes and T codes that are specifically reserved for use by Medicaid only. Well, here's the fun part. Different carriers want those codes from Medicaid. If you have multiple Medicaid plans in your state, some may want one and some may want the other. So be prepared for me to give you options and alternatives to the standard professional coding approach that might, excuse me, be needed by payer. So each of these items I've provided here in particular on slide 12 is sometimes used to give providers insight into the coding process, whereas this item, excuse me, is going to be useful for those of us on the non-clinical side to get an understanding of the verbiage, jargon, terminology and process.

(00:19:52):

And as the son of two combat veterans here, I was pleased to see a pretty good guide though created in 2016. That might be useful, especially if you are right now at the beginning or considering providing this kind of care. There's a lot of background information that would be valuable and that might be helpful. You see a reference down here at the bottom in some cases to some various medications like methadone, buprenorphine, and we'll be careful to make those distinct from each other. Similar additional general suggestions on treatment options, folks. These are clearly not clinical recommendations, but based upon the type of ... they call mechanism of action or the drug use to overcome the addiction, that partial opioid agonist might be better suited by having the patient get an opioid agonist, which essentially eliminates the ability of the existing opioid to have any impact whatsoever.

(00:20:55):

So this isn't tried and true, but you'll start seeing those phrases you heard me mention when it comes to the ICD-10, mild, moderate, excuse me, or even severe opioid use disorders, and the various types of counseling and treatments that are offered now in order to go deeper into the medications that are used for your clinical purposes from ordering the right meds or reaching out to a managed care company to find out if the preferred drugs your providers want to give the patient is on that insurance

company's formulary. And so when we say substance use disorders, it's not just alcohol, it can be methamphetamines, heck, it could be caffeine, it could be tobacco, it could be cocaine, it could be a variety of those diagnosis codes we'll talk about. So whether you want to look at alcohol use, opioid dependency, et cetera. The substance abuse and mental health services administration is an unbelievably valuable resource to use.

(00:21:57):

When you get the slides, by the way from NACHC, please be prepared that anytime you see this little symbol, the little .com symbol there, that the hyperlink is the picture that's next to it. But if you open the slides and try to access the hyperlinks, they won't work. They won't work. You'll have to make sure to open the slides the first time, save it somewhere, then when you reopen it, the hyperlinks will be available. And so buprenorphine is the one that's usually on the tips of people's tongues when describing medication assisted treatment. But there have been barriers in the past to getting buprenorphine in the hands of providers, let alone providers in rural areas where there are not a lot of other options or alternatives for medication assisted treatment. I have some good news related to the ability of your providers to provide buprenorphine that just came out within the last couple weeks.

(00:22:56):

And so the prerequisites that you have for providing medication assisted treatment is being prepared to determine based on your facility type, whether you're going to give methadone suboxone/buprenorphine. There's different formulations there, naltrexone are the most common, but be cautious here. Methadone is essentially only dispensed via what's called a certified opioid treatment program. That is a specific designation given by SAMHSA. But a couple years ago when I started diving down this very niche area of coding and billing, I made some mistakes when I was doing my research because I assumed everybody I was going to be teaching has an opioid treatment program when in fact that is a very, very different designation. It's a methadone clinic or some other rare exceptions depending upon facility types and some state laws there. Here is a recent update, okay? Prior to, let's just call it the beginning of 2023 in order to prescribe buprenorphine, whether it's injectable or a dissolvable tablet or a pill, et cetera, could only be prescribed by a provider who went and earned a waiver.

(00:24:08):

Some of them were called the X waiver or the Data 2000 waiver. That meant that although those providers could prescribe the opioids, they couldn't prescribe the medication that was designed to help overcome opioid addiction. So they had to attain that waiver by going through an eight hour training if they're an MD or a DO, or of course in our world of health centers, a PA or an MP had to get 24 hours of training while folks who has, we've been going through COVID and having a lot of challenges in the healthcare system, that was very difficult and likely prevented many facilities from offering buprenorphine. So what Medicare and CMS and HHS did last year is they gave you the opportunity to go through a process to ask for, I know this is going to sound weird, to ask for an exemption from having to get a waiver to be able to provide buprenorphine.

(00:25:05):

So it was about a 60 day process last year. You filled out some forms even though your providers hadn't gone through that eight hour training, let's say, or 24 for PAs and NPs, if they hadn't gone through that training, they had the ability last year to get an exception from having to get the waiver so they could treat up to 30 concurrent patients with buprenorphine. So that was a positive move that helped buprenorphine get into a lot of communities and into community health. Well, that was a positive change, but there's an even better one right now, and that is according to an update made to the

Controlled Substances Act signed into law at the very end of last year, we're going to have some expanded capabilities effective now to get buprenorphine out there. And so as I mentioned at the very bottom, it's not commonly located in rural areas and as a barrier.

(00:25:54):

So what I have here are two links, actually, there's one down here too for if your providers have a current and authorized and existing, an active would be the word I'm looking for, DEA Schedule Three registration. You may now immediately begin to prescribe buprenorphine as long as there's no state rule or law that's going to override anything out there that likely won't happen. So if you want to get an understanding and a little deeper understanding as to what that expansion of access entailed, follow the SAMHSA article, which will give you some good background. Obviously, I could only give you a little splash there, ending a decades long requirement. All right? Now on the right hand side there, it should be noted that that is not necessarily anything that is going into perpetuity because it should be noted that if you have new providers who are beginning their care and starting to fill out new DEA applications, they will be required to receive that eight hours of training.

(00:27:01):

I've heard kind of different numbers, but if you have an existing DEA Schedule Three, at least Schedule Three license, those are usually good for three years. So let's say you got it last week, at the end of the three years, you'll still have to, when you're renewing your controlled substance license, to get that training. So it's buying you a little time for additional information on how this concept works, check out that second website on slide 16. All right, so medications for the addiction treatment is where we were kind of focused on. I have a wonderful resource from the newly rebranded National Council for Mental Wellbeing, part of the Opioid Response Network. And really it's a guide that in this case does more than just talks about financial and regulatory readiness. There are statutory issues, there's staffing issues, there's a lot of different categories, but I just pulled out as a screenshot, one that confirms coverage and reimbursement for MAT, of course, varies from state to state for both public sector, Medicare, Medicaid, and private insurance marketplaces.

(00:28:15):

And really that kind of applies to almost every single service that's provided in a community health center as well. But they're reminding us that sometimes before you're beginning or initiating this treatment, there's a need for pre-authorization. Again, a more careful attention to the ICD-10 code might help get more pre-authorized quicker. You're going to have to determine which types and formulations of medications can be provided and research your state's Medicaid plans. So for example, Charlene has a question in the Q and A box. Can a mental health peer support specialist bill Medicaid for telehealth? The answer, and I'm not trying to be goofy here, is maybe. Now, there's a code that I'm going to give you, Charlene, here in a little bit that is the only code that I'm pretty confident in, the only available for peer support services. You would be able to hopefully in all states, take the code that yes, I'm going to make you wait for here for a moment.

(00:29:14):

Take that code and see if it's on that specific Medicaid plans allowed list. Are they allowed providers or can they provide peer support incident two? So my gut says at a major general Medicaid or national level, they are, again, valuable members of the care team, but may not be reimbursable unless you look at this H code I give you later and find out that it can be provided either by that individual and we'll give you actually two resources to get an idea in your state where credentialing and licensing for those folks will take place. So I did want to mention that there. So before, during and after MAT services, I hinted at

the need to facilitate referrals and transitional care management in the hour and a half version. We're doing this here today. I just left these in here to give you food for thought when you hit the slides here.

(00:30:12):

But each of the items I've mentioned here, of course, we've told you when we're going to talk about them. There was a recent change to Medicare guidelines that is basically was released in the 2023 final rule that adds licensed professional counselors. Now, by the way, they also added marriage and family counselors to this, but wanted to focus on LPCs. So LPCs are not, for example, listed in chapter 13 of the RHC and FQHC benefits payment manual as authorized providers yet.

(00:30:51):

As a matter of fact, again remembering, they put our colleagues in friends in rural health in the same document as they do for us in FQHCs. And although Medicare has added LPCs who are very often involved in the behavioral side of medication assisted treatment here, we are unsure as to how that's going to impact FQHCs. But when you hear that Medicare is going to add these folks as an authorized provider, they're really kind of more focused on the fee for service folks, but it's going to likely take six months, nine months, or heck, unfortunately, even a year for your LPCs to be credentialed and enrolled as providers that get their own number. All right?

(00:31:32):

Now the good news is as Medicare adds these folks, maybe a lot of other commercial insurance companies, maybe they have quicker enrollment and credentialing processes. Maybe you're able for them to provide care, not under incident two, but unsupervised, et cetera, et cetera. Just keep your ears open. We're looking for those changes. But if an LPC in your FQHC is the only provider seeing the patient on a day, and you're not going through traditional incident two rules, they don't need their own provider number to be included. But we are still awaiting guidance to open up the revenue options there. Though added in 2023, my gut says it'll be mid-year, if not next year, to when it functionally changes our billing for Medicare, maybe Medicaid and commercials out there. So you will need to go into and look at contractual language because medical providers that are performing medication assisted treatment are using a subset of ICD-10 codes under the mental health umbrella.

(00:32:40):

Well, if you as a medical provider reported a service with depression as the primary diagnosis, that claim will likely get denied. So if you're looking for information when providing medication assisted treatment, naturally as a family practice provider, I'm going to go online and I'm going to look at their medical billing manual on the website. Well, guess what? You don't find much information there. So you may need to go into, even though you're a medical provider, go into the mental health billing website to get information, which kind of runs counter to how we usually focus on these issues. Now, whether we are using, if we have medical and mental health in the same health center, really being careful how to separate mental health notes from medical notes to maintain HIPAA compliance, how we release medical records to not only patients but to other providers is a little different for mental health than it is with medical.

(00:33:43):

And there's another recent update to how we are able to share and be careful with mental health notes. So please be aware of recent updates of what's called the 42 of the Code of Federal Register, generically referred to as Part Two Regulations. The full announcement down here is the proposed changes to the confidentiality of substance use disorder patient records under 42CFR Part Two. So I've provided some information both on this new keyword, proposed rules to increase care coordination and confidentiality

along with a fact sheet from SAMHSA on what Part Two has been in the past, what is not likely to change with this new rule, what will change. But again, our focus is going to be for the majority of the remainder of the course on documentation, coding and billing. But these are some good and positive updates you need to be aware of, kind of from an administrative perspective to balance clinical and revenue goals.

(00:34:49):

So for Ms. Charlene or anybody else that has questions on LPCs or peer support counselors, and we have an LCSW that's not billable, but a CSW, that is what I liked to hear from the National Academy of State Health Policy is a couple years ago they did a 50 state scan where they looked at Medicaid provider and billing manuals, state laws, and other policy documents, and they broken it down by state to assist you in understanding how you potentially may get reimbursed for non-licensed, non-masters level workforce. And I think the peer support would fall into there. Now, granted it's a couple years old, but it's a pretty good breakdown of the past, the present, and the likely future since again, we have clinical folks that aren't always specifically licensed to provide care, but you're obviously going to see positive improvements of this as you move forward there.

(00:35:51):

So anonymous attendees says, so if an insurance rejects a claim for medical records, we are then able to attach medical records to the claim. Well, I'm not your HIPAA guy, but there are items and ways that you can release protected health information without getting a business associate agreement and going through a lot of the processes. And it's traditionally referred to as TPO, treatment, payment and operations. So that insurance company almost assuredly, falls into the payment area so that yes, you may release records to them, but you should have an internal checklist and an internal process and/or approval before that's done, especially with mental health records. All right, moving ahead. And so I'll get to the number, the first anonymous attendees up there in a bit, but it's a tad too long for me to read at the moment. So moving into the foundations here, I want to give you a compare and contrast between sample CPT codes that you might be looking at in this area versus some sample HCPCS level two codes, whether it's your facility or some in your community.

(00:36:59):

Now, I'm not seeing a lot of folks insert a non biodegradable drug delivery implant, but there is a future there as a treatment alternative, especially in rural areas where patients would have a hard time if they needed to come into the office for us to observe them taking their meds, getting a drug test presumptive and definitive drug test from them. But just like when we give an injection of something, we report an injection code plus a J code. Similarly, you'll see if the insertion or removal with a reinsertion of a non-bio drug delivery implant is there. I've given you a link to or not a link there. I've given you a reference, I should say, to some implant J codes as well as common J codes for buprenorphine oral and/or various dosages. So J codes are not just injectable drugs. It can contain, in some cases, oral dosage and oral drug delivery implants.

(00:38:07):

But all codes for buprenorphine and so forth are not found in the J code listing. Look over here, there's some Q codes, Q9991 to Q9992 for an extended release option. So when you're on the drug test side, that tends to be pretty clear. If you were breaking down drug testing, coding and so forth, you'd say you're sometimes taking a qualitative drug test or a quantitative drug test. Qualitative means you're literally determining if the patient says, "Nope, I haven't had any of the substance, methamphetamines, cocaine, opioids, whatever," that type of drug test determines if there's any of it in the patient system, but doesn't tell you how much. If it is a quantitative drug test that's telling you how much might be in

the patient system there, of course your providers have a pretty good lock on that while you're setting up a patient for MAT, somebody especially on the behavioral health side, might perform some health and behavioral assessments and interventions.

(00:39:14):

Of course, the giving of an injection could fall back to those J codes, E&M, ED services, et cetera. I realize you're not a hospital outpatient department, but they actually get paid on a PPS system as well. So if you have a friend that works in a hospital outpatient department, you've got the codes at the top and some insurance companies, and I have absolutely no way of knowing who some insurance companies might want you to add to the office visits or other diagnostic or therapeutic services modifiers HF to indicate that this service is a part of a substance abuse program or HG for an opioid program. Again, today we're giving options. Similarly, on the medical side here we have behavioral health. I might have even touched on this last week, I don't recall, but if you have a patient that is receiving what's called interactive complexity because the provider as having to use toys, dolls, physical aids, or the patient is pre-dementia or pre-Alzheimer's, et cetera, there's an add-on code to generate revenue on top of your diagnostic evaluations and or therapy services, please reference your CPT.

(00:40:25):

There's over a page of information on code 90785, a brief emotional or behavioral assessment, 96127, and then the collaborative care and those care management codes on the bottom left side. Now we'll end with some coding options for both non-Medicare and Medicare virtual communication services. And you should be familiar with code G0511, which if you're performing principle chronic or behavioral health integration, rather than using the CPT codes as you do to most payers, Medicare wants a health community health center to use code G0511. G0511 includes most care management services and behavioral health integration. But for a 2023 update, y'all, by the way, I'm in Georgia, sorry, I'm going to say y'all, for a 2023 update included in a health center's reporting of code G0511 for monthly billing of care management services. It doesn't just include principle and chronic care management and behavioral health integration.

(00:41:39):

It also includes two new HCPCS codes, G3002 to G3003, which are codes for chronic pain management. Now you can see how that fits into this concept of medication assisted treatment. So we have some information on that. Excuse me. Here is Miss, I think it was Candace again there, the H code, H0038, which is likely appropriate only for Medicaid, though remember, H codes are only reserved for Medicaid for 15 minutes, each of self-help services and other crisis interventions that may exist. So what I've done here is just pulled out some G codes that are going to hit a variety of locations. But opioid treatment programs, you heard me mention them earlier. They have weekly bundled codes. So instead of reporting each day's visits, they have codes that they use to report each week based on the medications. And it kind of includes everything, provision of the medications, the counseling, and it really smooths out the billing.

(00:42:44):

Well, the HCPCS level two code book, I want to say two years ago, created codes G2086 through G2088, and I'm going to urge you to reach out to your non-Medicare any plan non-Medicare to see if they'll reimburse these codes. Look at their fee schedule amount, see if it covers what you believe your traditional costs would be, because these are per calendar month options. But the creation of a code does not automatically mean any insurance company's going to pay for it. They still may want individual services split up and build on a provider by provider day by day option, but that could make life easier. Just showing you some other codes. Your emergency department, while you're building external referral

relationships with the ER, you want to throw that out at them. "Hey, make sure just that y'all are doing your billing there when you initiate OUD treatment to contact us and try to get this patient to us. Don't forget, emergency department. There's an add-on code for you to bill. You might make their day."

(00:43:57):

If you're given a take home supply of methadone, buprenorphine, or oral or nasal naloxone, an alternative code for the insertion of a non biodegradable drug delivery implant, those OTP codes only, and then additional screening options for you to review. Because remember, I've never heard of an insurance company saying, "Nope, we denied that code, but had you used these, we would've paid you." It's up to us to do that research. So this is what's maybe in the future if you have in your network or your community or your accountable care organization or opioid treatment program, all they'd have to do to make these applicable to FQHCs is remove the little parentheses statement down here. If they remove that in theory, community health can report weekly services instead of on a daily basis, but just showing you that in case you had external referral relationships with these programs.

(00:44:58):

So we're going to need you to go look at the full definitions of every H code, folks, because I only selected a handful here. H codes are specific to Medicaid. That doesn't mean they have to use, it means they can. And H codes, excuse me, that we have here are very specific to mental, excuse me, to substance use disorders. So please take a look at more than just the H0001 to H0007 for assorted alcohol or drug assessments, counseling, pace management, crisis interventions. Some of you may have patients depending upon your setup and what's called an Intensive Outpatient Program where they're getting more care because of their needs. And this is referred to as intensive outpatient treatment of at least three hours a day, three days a week. And again, when you see the full definition, you'll see includes the majority of the types of global work being done.

(00:46:00):

Your peer support code there, as we mentioned earlier, and some oral medication administrations. I'm not aware of other options in the book out there, but for Medicaid, it may not be a visit that required an otherwise authorized provider. It may not have just been a nurse visit that maybe goes out with code T1001 or T1002 or T1003. It may literally just be, "Look, we need to watch you take your pill." Now, maybe medication adherence is an issue. We'll talk about how the pharmacy folks might be able to get involved in that. And so just a couple other options there that may be needed. When you get the opportunity to go through and review your slides, you'll see some similar T code options that could apply. These were the nursing visits that are time-based codes, additional counseling services for family and or counsel, family and or couple counseling, excuse me, a possible option for telehealth beyond the usual approaches, T1014.

(00:47:10):

Many of you, if you're reporting to Medicaid to get a PPS rate is familiar with T1015. And if you have a friend that works at a long-term residential facility, they'll probably see that code. So when we're talking medication assisted treatment, especially for RHCs and FQHCs, obviously your focus there, we still have to have a face-to-face visit. We still have to have an authorized provider that meets medical necessity and that it's performed in an authorized location.

(00:47:41):

The reason I kept this slide up there is if you need to get a listing of the local or national coverage decisions, use this link to follow the Medicare coverage database separated by part A and part B by your location, and see if they have lists of covered diagnoses or how often they'll pay for key services.

Because if we're having both a medical visit and a mental health visit on the same patient on the same day in an FQHC, all right, at the very bottom of this section 40.3, it confirms that both you'll generate a PPS rate for medical and mental health on the same day, but not for multiple medical visits or multiple mental health visits unless the patient left the office and had to come back for additional diagnosis or treatment.

(00:48:39):

And there's a reminder that you're going to use a modifier 59 for the multiple encounters on the same day. Even today, I've answered a question in the email where I referenced and sent somebody to section 40.3, but that's just a brief reminder. All right, so as you're looking on slide 31 here, a sample fee for service claim for a medical provider giving an injection, we will likely, as we talked last week, I think we had 670 folks last week, it was an awesome session. Doesn't matter to me what order these diagnoses go in because there's too much variety in how providers are doing it. We see patients for different reasons on the same day. This focus area is the real emphasis. I'm going to do an office visit, but the primary diagnosis for that medical provider given an injection here is opioid dependence in block A.

(00:49:32):

Now, if we also mentioned and performed obesity services during that visit, it needs to be listed as letter C on that same line item. Now, we mentioned that the patient had depression. We mentioned they have a type of anemia, but they were not used as primary or even secondary diagnoses for the office visit, the injection and/or the drug code. So if opioid dependence was put in block B, then this better say B, A. So the linking of the diagnosis codes is just a very, very important issue because similarly, we have a mental health provider seeing a fee for service patient billing on the 1500 form, not the UB we use for Medicare, but they perform 30 minutes of psychotherapy, even though opioid dependence is listed as the primary diagnosis, it's not the primary reason for the therapy. Depression has to be the first option along with any other diagnosis referenced as affecting that care.

(00:50:36):

And yes, depression, excuse me, the opioid dependence is an issue, but if we performed a medically necessary additional brief emotional or health assessment, that was being done for the diagnosis in this case of Z13.9, so the order of and placement of and linking of those diagnoses is vital. But when we're doing that, let me just go back for a brief moment. If this was a patient getting both a medical visit and a mental health visit on the same day, I don't need to process their claims at the same time. Dr. Medical did his or her visit on Monday, got the note completed, got the note closed, the coder did their work, the biller did their work, and the claim went out on Monday, maybe let's just say Tuesday. The mental health provider also saw the same patient at your health center on Monday, but they were out of the office for a couple days.

(00:51:34):

Things were a little backed up, no big deal. We sent the medical claim out on Tuesday, but we don't send the mental health claim out until Friday, no problem, because we're using each provider's individual number on the claim. They don't have to go out at the same time. Oh, wait a minute, you better believe they have to go out at the same time without some significant administrative challenges here on the same date. So we've got to be conscious and careful in billing. Although medical providers says they sent their PAs note in or vice versa, we've got to make sure they're both done at the same time. We use our established magic billing code for a medical patient, our established mental health patient. Good news is 99214 is on the qualifying visit list. And then we list the injection in the J code 90832 is on the FQHC qualifying visit list.

(00:52:29):

And then we list the behavioral assessment, and we should get two encounter rates. There's no need for modifier 59 on this. All right? We likely perform them all, but notice that the diagnoses at the bottom are not linked. We literally just put all of the diagnoses by each provider that document and care on that date, and we're not linking them. So it's a totally different process in how providers are giving that preliminary coding data to the coders and the billers. So in order to continue here, so we can work towards our Q and A session. We talked about, and I've already introduced the differences between the DSM-5, mild, moderate, and severe disorders. As I mentioned, although one book talks about early and late in remission, some ICD-10 codes group them in the same definition. But I wanted to reference Ms. Bernard's book that I think I referenced last week, because this is a great phrase, especially if you live in a state where let's say recreational drugs are allowed Oregon, multiple states with marijuana, et cetera.

(00:53:39):

"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." So examples would be a septal ulcer due to cocaine use. Yes, that needs to be listed. But a patient that comes in for a physical, you ask them if they take any drugs in this case, but you didn't perform or you did perform a review and find it it's just use, it's not abuse, it's not dependence, it doesn't make it on a claim. It stays in the health record. It doesn't go out when you're coding it tachycardia due to methamphetamine use, et cetera. So what I've done on slide 36 is given you an overview of a set of 11 questions that providers will use in addition to other clinical techniques that if at least two of these are observed in a 12 month period, it'll lead to a diagnosis.

(00:54:36):

Now, you'll notice this is opioid use disorders, whereas SUD has a similar list to this. But bottom line, there have been some changes. Not only that we've obviously dealt with from the ICD-9 to the ICD-10, but there were some changes from the DSM-4 when it transitioned to the DSM-5 at around the same time we got our ICD-10. So what I chose to do here is outline from the American Psychiatric Association, that you'll have some interesting discussions with providers who are going to say, wait a minute, our current clinical tool doesn't separate the diagnoses of substance abuse and dependence, which better believe the ICD-10 will. Says rather criteria are provided for substance use disorder, which that word does not appear in the ICD-10, along with criteria for intoxication, withdrawal and so forth, and a little discussion when you get the chance to follow that link on some differences between what's happening.

(00:55:42):

So we've outlined in numerous sessions the need to be aware of the ICD-10 official guidelines that appear at the beginning of the printed book, but I highly doubt your providers have held an ICD-10 in their hands. But I would encourage you to go look at chapter five of section one, subsection C for the specific information that the cooperating parties, the people that write the ICD-10 book, what they describe, and I'll present a highlight and snippet from here, which is that they refer to psychoactive substance use, abuse and dependence. But it should be very, very carefully noted regardless of how the clinical terms are put into the record, if both use and abuse are documented, you go to the higher, same idea. If abuse and dependence are documented, only assign a code for dependence, and heck, if all three are documented, only code for dependent.

(00:56:42):

So that hierarchy from the ICD-10 perspective is important. So it's likely that your providers are needing to translate the DSM terms to the ICD-10 terms. And based on, and I'm just using that guide of 11 questions, I realize there will be additional diagnostic work going on by that clinician. But what we're posing is that if you have two to three of those, if it's a mild use disorder that goes to abuse with the presence of two to three symptoms with four to five or six or more, what they're describing as moderate

or severe may change the methodology of treatment. But the ICD-10 codes for each should be tied together for dependence. Unlike that seminar I was at, I was attending in Denver, three, 400 people in the room, a lot of people started complaining that they weren't comfortable as a coder listing it as use abuse or dependence.

(00:57:38):

I grabbed the microphone and taught this tip, and several people came up to me and just kind of gave me a little pat on the back. But hey, somebody had to teach me before I learned it. I hope this eases some of the burden coders and billers have been carrying for years to have to come up with it. Because if they went to the providers, they might get different answers from providers on should it be abuse or dependence because they weren't trained on those words. So a couple samples of ICD-10 opioid dependence codes, the one that I mentioned earlier, F11.20.

(00:58:18):

Let's just say that the folks that are becoming more and more aware of the more detailed options, whether it's opioid dependence with intoxication or with an opioid induced psychotic disorder or other opioid induced disorder, we will see that more careful ICD-10 work will obviously help revenue, will obviously help pre-approval. What we want to do is provide our city, our county, our state, the nation and the world with accurate data from patients. And using non generalized diagnoses is probably the first step there, folks.

(00:58:59):

So when you get the slides here, folks, I'm not going to read each and every one of them, but rest assured, I've gone through and yes, I mean gone through every single page of the ICD-10 from the category of F10 to F19, and I've pulled out some tips, things that are called base code notes to provide you with some guidance on how cannabis related disorders are coded a little differently than alcohol related disorders. Some other codes that might be seen, whether or not you're talking sedatives, hypnotics, or anxiety drugs that just like opioids have no use codes, but intoxication or prolonged E&M visits showing the patient was intoxicated might be beneficial if it's cocaine or other stimulants now, including bath salts, an absolutely horrific drug that did not have ICD-10 codes until a couple years ago under the category of F15, whether it's hallucinogen related disorders, very, very detailed options for nicotine dependence, by the way, especially in a community health center reporting, what is it?

(01:00:08):

99, I want to say 406 and 407. It may be 99408, and 409 off the top of my head, for tobacco cessation. You got to be real careful. Is it cigarettes, chew, dip, e-cigarettes, vapes? A lot of different options are out there. Inhalant related disorders and other psychoactive substance related disorders who include polysubstance or indiscriminate drug use, which was, by the way, removed from the transition from the DSM-4 to DSM-5, but lives in the category of F19. All right, so giving you a little bit of information there, not trying to give you slides too far, but look at all of the different options that are out there. And just like I showed you with opioids, there's a ton of more clearly defined options, whether there's withdrawal, perceptual disorders or disturbances, sleep disorders and all of that, especially if we have them getting concurrent behavioral health, it's assured that several of these options would be better than the uncomplicated option.

(01:01:17):

So I do want to reference you to Ms. Bernard's book on helping turn non-specific documentation into specific documentation. I did this for the folks last week, but in this case, I've shown examples here for additional documentation samples of physician documentation tips and or coder abstraction tips specific

to this subject today. And if I put every piece of information on a slide but didn't put the AMA's logo on it, I venture to say that providers, if they saw the AMA logo on it's going to carry a little bit more weight. And so that's another reason we like this to help give additional clarity for diagnostic coding. So when I promised earlier folks that there were other tools besides the SBIRT tool that are allowable in reporting the screenings services here, notice from HRSA, the use of screening brief intervention has gone up tremendously as opioids and were declared a, I don't think it was a public health emergency, but I think it was an epidemic years ago.

(01:02:30):

So you're seeing an increase. Please let providers know that if they have another preferred screening tool, as long as it's listed on the United States Preventive Service Task Force, it's going to be an allowable tool. It doesn't have to be documented. The same with everybody. And there's two great documents that I promised you earlier, I had one person raise a hand in a class saying, "Why in the world are we ... Is it going to be really odd to ask this 77 year old woman who was there," I think she said was, "My piano teacher and my elementary school teacher who's the sweetest lady in town when she's coming in for her annual wellness visits or initial preventive physical exams. It's going to be really odd when she's here for her bad foot and her shoulder to ask her about opioids."

(01:03:20):

And a provider in the back corner of the room raised her hand and said, "You know what? You would never believe it. But that is in many cases, the people that would otherwise never be asked those questions because nobody assumes it's a problem." So to have access to clear guidance where you can look somebody in the eye and say, "Hey, don't be surprised that this year, we're going to ask you questions that may seem unrelated to the existing care you're getting, but Medicare and Health and Human Services is making this a focus, and that's where hopefully that process gets easier." This November 2018 document is absolute pure gold and was provided by NACHC in conjunction with a well-respected consultant in the industry I hope to work with one day, but here it says it's recommended that you review NACHC's appendices, EFNG specifically now for proper documentation and coding info. Now there have been a couple little codes here and there that have popped up since 2018, but the guide is wonderful.

(01:04:31):

Okay, so minus just a couple teeny coding updates here and there. The first half of that and the first three quarters of that entire manual is just a wonderful guide from NACHC specific to documentation and charge capture with medication assisted treatment. I'm not sure if there's an update expected on this at some point, but it's a pretty darn good resource to take with you in addition to what we're talking about. So here are is on here is I should say on one page a set of many options for reporting various services. I gave the tobacco cessation earlier, but here's the 99408 and 409 for alcohol and/or substance abuse structured screening. Well, guess what, folks? They're including opioids in the word substance, sometimes in diagnosis codes, of course, they separate them, but here, we've got to look here, that substance in this case does include opioids.

(01:05:31):

Well, I don't know any other way to say it than some carriers want the 99 codes. Others might want the G codes. Oh yeah. By the way, Medicaid, don't forget, they might have some options that they want for alcohol and/or drug screening here based on the full definitions. Now, codes G0442, 444 have 2023 updates to them. That changes the amount of time we performed an annual covered, CMS covered annual alcohol misuse screening and/or depression screening that ties together a lot of what we're talking about. Be sure your providers are aware of the definition change as well as your coders and

billers. Working our way to 315 here, put up a guide here for the original assessments and interventions. We mentioned a variety of places and times when you might be doing that screening, and this has essentially those same codes as the previous slide, but it's kind of organized a bit differently.

(01:06:31):

Maybe this is something you can copy and pass on in a meeting. The induction stabilization and maintenance phases are mainly E&M visits, injection services. We gave you those options on a previous slide, but reminders here of the new add-on codes. If a patient comes in intoxicated, it used to be 99354 or 99355, those are deleted from the CPT in 2023 and are now you look at a lean towards a code 99417. Well, if they're in their office for two or three hours until let's just say they sober up, for lack of a better way of saying it, that diagnosis code you chose better show intoxication also. And so some additional just items here, questions that you might want to go ask in terms of coding, mental and behavioral health. If you wanted to perform some self-study, this is a way to go through that and many of these questions are answered on the subsequent slides.

(01:07:37):

So I like giving slides more than what we can teach, especially because it might kickstart the review, for example, of looking in the Medicare coverage database I mentioned earlier so that we are aware that the therapy codes cover what's called insight oriented behavior modifying supportive and interactive therapy. By the way, the CPT used to have different codes for those. Now they're all unified. Information on reporting psychotherapy services, not a primary focus here, but I felt it would be appropriate to give some options for the additional practitioners such as pharmacists who may be performing time-based face-to-face assessments and interventions upon request. Look at this to "optimize their response to meds or manage," ding, ding, ding, "treatment related medication interactions or complications," because they may be on other meds while receiving medication assisted treatment. So check in with your payers for their coverage. Looking very carefully at the CPT definitions because there's a lot more than I have on the slide is going to lead us here in the last couple minutes.

(01:08:49):

As a reminder that I talked earlier about care management services when you have a medical provider overseeing a patient's behavioral or mental health plan, receiving substance abuse services, here are the codes for commercial payers as well as the new codes for chronic pain management that I described. In that case, these are for non-Medicare because, of course, Medicare wants us to report behavioral health integration and the psychiatric collaborative care model a bit differently from Medicare than with other payers. I would encourage those of you that have clinical psychologists and/or clinical social workers to check out the new codes for 2023 that are care management services for behavioral health conditions when supervised by a psychologist or clinical social worker. I don't feel those are included really here in the G0511 code. Whoops. These are just some good websites for behavioral health integration and care management for your research.

(01:10:00):

I don't feel that those behavioral health integration done by psychologists and social workers qualifies in here. I am still researching that to find out, but as I promise to share with you the FQHC only general care management services and/or the psychiatric collaborative care model. The links on the previous pages should provide you with some background information on those. Same thing with the last couple slides. I noticed we will have a question here related to telehealth soon. I talked about that in last week's session, I believe, and it should be noted, and to clarify again that medical telehealth visits to Medicare that are on the approved list use code G2025, and we split a flat fee with our patients versus

the update mid-year last year, actually a little earlier for mental health telehealth services to Medicare to use and bill for that service as though you did it in person.

(01:11:02):

But the difference is adding a new modifier 93 or the older modifier 95 to get your PPS rate. That is a positive change and I applaud NACHC and other state societies that really pushed for that to happen. If you need updates and additional research for telehealth here, CMS Med Learn Matters is there, even though the CPT has new place of service codes, Medicare says we don't use them until the public health emergency is listed. If you want information on reporting mental health telehealth in an FQHC. Another great document, SE2201 for you, an additional background for FQHCs on virtual communication services along with telehealth, whoops, along with telehealth got us to 315. The last slide here, as I promised and hopefully not only gave you good accurate validated information here and different options is if American Society of Addiction Management, my colleague at JBS International with whom we run the billing and coding training under the RCORP grant, was kind enough to get this to me and gives you a similar look and similar set of information with some clinical examples and state Medicaid policies.

(01:12:32):

A little bit of a crosswalk between a DSM-5 diagnosis and the ICD-10. So folks, that takes us to the end of this session if you are a member of the Rural Community's Opioid Response Program, okay, in addition to today's session graciously provided by NACHC, there is free training that full four hour training session, if you contact your, what's called your TEL, your technical expert lead who works with JBS International, please, I'm not involved in the setting up process, but if you reach to them or if you need this information from me later, there's additional training available. So at this point, Phillip, let me see. Let me undo my spotlight. I've got too many monitors going on here if you'll bear with me. How did you want to handle the Q and A process or if you stall for a brief moment, here we go. Let me get my spotlight.

Phillip Stringfield (01:13:35):

There you go. You can go ahead and get it up and I'll just say thanks to Gary as he's getting those questions up. And then just a reminder to folks, we'll be going ahead and releasing that index number at 3:28 if you're able to hold on. That's the only way you'll be able to get it, and if you send a question via the chat and we grant, if you're able to copy and paste it into the Q and A so that way we can answer them for you, I am unable to do it on my end. So if you could help me out, I'd be greatly appreciative of that and I'll pass it back to Gary to answer the question.

Gary Lucas (01:14:05):

All right, I'll do my best to answer these folks, but if I need more information from you and I'm not able to get it today, folks, I love getting emails and we can set up a brief chat and talk about solving your issue. One anonymous attendee says they've been fighting with their EHR representative regarding which revenue code needs to be billed. "Does the revenue code matter when billing behavioral health claims to straight Medicare, Medicare Advantage, commercial Medicaid and Medicaid advantage?"

(01:14:32):

Well, a revenue code is only needed when you're billing an insurance company on the CMS 1450 form, the electronic version known as the 837I for my established billing veterans, you call it the UB. So the answer is yes, for Medicare, behavioral health services tend to be in the 0900 revenue code section, refer to your carrier's website to get details. Medicare Advantage, it depends on do they see you as an FQHC or a regular office? If you're submitting a claim on a 1500 form, you don't need revenue codes.

The same applies to the other carriers that were mentioned. Yes, Phillip or it says underneath there, Phillip Stringfield would like to answer this question. That might just be how you delete it.

Phillip Stringfield (01:15:16):

Yeah, I was just going to get rid of it once you were done. Sorry.

Gary Lucas (01:15:20):

Okay. Yeah, no, no, no, I just saw that pop up. Next, what resources recommended as a free general review of all codes and billing MAT and general chronic disease for non-coding and non-billing specialist? So if I'm understanding that, beyond MAT, a free general review of all, I'm not aware of free general reviews of all codes. If there's a specific that you're looking for, I mean, the answer is the ICD-10 and NACHC has wonderful webinars on their website that other folks in addition to us at ArchPro Coding have provided. We'll need that anonymous attendee to reach either to NACHC and/or me for details. How do you ... I just missed it. How do you bill a telehealth medical and behavioral health visit on the same day? G20, I think the 50, go ahead.

Phillip Stringfield (01:16:07):

I was going to say Susan provided some additional context about two questions down.

Gary Lucas (01:16:11):

Let me slide down. That's my understanding. Yes, Susan, you said the key part, the G2025 for the medical service might carry like a 521. The behavioral health might carry a 900. Modifier 59 is really overused and misunderstood. It will likely be of assistance though in that section 40.3 Medicare identifies that FQHC should use modifier 59 to get that second PPS example. So I would lean towards yes, G2025 there, remembering that you're not even required to use the NPI number when you're submitting a UB claim form, but it wouldn't hurt on that one if you included where you can provide informational extras, the provider number of each just so they see it. So I think that should work. If you build both services on the same day, do they have to be on the same note? It's kind of a broad question.

(01:17:11):

I'm not positive what that one means. If you build both services on the same day, do they have to be on the same note? My assumption is if we're talking about a medical and a mental health visit, those need to be absolutely and completely separate. Note, one's a medical encounter that has a different amount of HIPAA privacy attached to it than a mental health encounter. So I would recommend a very separate note. Now how you do that in your EHR is literally making sure there's two appointments, not one provider opening a note and closing it and then another provider opening and closing a note. It may, depending on your IT system, need to be a different note there. Can FQHCs get paid two encounter rates regardless of which combination of providers are seen on the same day or is it limited to a specific combination of providers?

(01:18:02):

Please review section 40.3 of chapter 13 of the CMS benefits policy manual for that answer. Quick answer, medical and mental health. All right. A medical visit followed by the patient leaving and coming back to the office for additional treatment. We don't see that happen much or medical encounter and the patient leaves and comes back. But if it's a three medical appointments, one's at 11, one's at 11:30, and one's at 12, that is billable as one encounter, paragraph one, sentence one, section 40.3, chapter 13, Medicare benefits policy manual. So I'm trying to do these quickly here, folks, but I want to get you

out on time at 3:30. Throughout the course of treatment, should the ICD-10 code be updated to in remission or stay dependent as we have seen denials for in remission? You might even see, depending upon whether or not they're in remission for the MAT or the opioid or substance use, though they still may continue to have the additional behavioral health conditions.

(01:19:09):

I think that's probably going to be substance specific since some substances don't have those options in there. But let's just put it this way, as the patient's condition changes, so may the ICD-10 code. We don't want to use ICD-10 codes that were applicable last month if they're not applicable now. Next, if we have an LOPC for Medicare in 2023, can we be using general supervision until further guidance provided by CMS? I want to find that document that says just that. I've only heard speculation and conjecture and gut feels for that one. My gut says that's just like taking an LCSW or somebody that's not AMDEPA and MP and saying, "Well, let's go ahead and put them and bill them under another provider's number." Until you get specific guidance with the LPCs, folks, I'm going to hang off on that one. Good question. We're all waiting to monitor that one.

(01:20:13):

Next, can I review how the IPPE differs from an annual wellness visit? Well, I hope they're cutting the Q and A off of the webinar, so I'll just say it this way. They might take their clothes off for an IPPE and they better keep their clothes on for an annual wellness visit. All right, so I'm not just trying to be silly here. Okay, one is initial preventive physical exam, by definition. Well, folks, when you look in chapter 18 of the preventive service manual, an annual wellness visit doesn't even have a physical exam component. So they each have completely different documentation requirements. Look to chapter 18 of Medicare's preventive service list. It's a 250 page document with numerous pages on each, as well as some CMS guidelines that compare IPPE to annual wellness visit to the CPT codes.

(01:21:06):

Let's keep them rolling. What are your thoughts on a provider billing a sick visit and a MAT visit on the same day? Well, MAT is a sick visit. They do have a diagnosis that authorizes treatment. So what are your thoughts on a provider billing a sick visit and a MAT visit on the same day for a non-Medicare patient? Well, if you're going to use the H code in the Q and A, that tells me it's a Medicaid patient and probably, if done by the same provider, should be reported in one encounter. But if you need to reach out to me to confirm whether we're talking Medicaid or possible options with commercial care, there might be difference. But before you delete that one real quick, a sick visit and a MAT visit, let's just generically say that if I come in for hypertension, diabetes, gout, and a boo boo on my shoulder, that's one visit.

(01:21:54):

If I come in for diabetes, hypertension and opioid dependence, it's one visit. So it depends on what was done from an E&M perspective or did we do counseling or other types of services, they're, again, valid question, but if you have a specific, let's speak after this. RCORP, good, let me ... Is the Rural Community's Opioid Response Program a HRSA run wonderful grant that's gone on for several years, and if you're involved in that RCORP grant, one of the elements HRSA wants you to do is get coding and billing training in order to maximize revenue across insurance types and ensure compliance with diagnosis, coding, et cetera, separate from this, but because HRSA is a unifying body for this subject between NACHC and the RCORP program, just letting you know folks talk with your technical expert lead of your consortium, there's a way to get additional training.

(01:22:58):

Can LPs, I'm not sure what an LP is, bill for a behavioral visit to Medicare? I've got a lot of ABCs, EIOs and BINGOs in my head. I'm not sure what the LP was. If it's LPC, I defer to the previous answer. Let's keep them going. As a behavior health provider, can I bill for both medication management and an appointment at the same visit? Yes. Look to the add-on codes that are underneath each of the therapy codes for when med management is done at the same time of another visit. I want to say 90835, 90837 and 90839. That's off the top of my head. But look in the CPT book at the codes after each of the therapy services. Questions that say, "So you are saying," make me scared. All right, so I haven't got beyond so you are saying here. So you're saying that the patient cannot have an appointment at 10:00 AM with their PCP for medical and then an appointment with behavioral health at 11 and both be billable.

(01:23:59):

Now, that's the exact opposite of what I said. I said you can do that. Again, please refer respectfully to section 40.3 of chapter 13. So that's why I love these sessions. I never indicated you can't do that, but it's important to get those exceptions down and I encourage a pretty good review of that page and a half. Last two, Philip, I think I'll get it before 3:30, man. So this is good. We've had a few scenarios where one patient was seen at our clinic but then was seen at another clinic the same day. Does only one clinic get paid? In essence, folks, the intent there is that the FQHC is the one providing the service, whether it was building A or building B across the street or the next county over. Keep that one up for me. I don't know if you can pop that last one up for me, Philip. If it's gone, no big deal. I thought I saw a little nuance in there. If it's gone, no problem.

Phillip Stringfield (01:24:53):

Listen, we had a few scenarios where one patient was seen at our clinic but then was seen at another clinic the same day, that only one clinic get paid.

Gary Lucas (01:25:01):

Yeah, well, if they're at another clinic, you are one FQHC, although you're at different locations. Okay? So it's kind of going to depend on what was done there. If it's the medical and mental health, whether it was at the same facility or another, I'm much more comfortable with that because it's a medical and a mental health visit. The problem is, and the issue may be for a compliance perspective that if they need to come see their cardiologist and their other primary care provider who is at another clinic, but they're not located in the same building, that could have been done in one building if we had that specialist there. I am not aware of an exception that says and deals with that issue. So my gut says if they had to go to the other facility because one was medical and one was mental health, I'm feeling pretty good about that.

(01:25:54):

If it's just to see a provider of another specialty and they're both medical, my gut says they only want you to report that as one encounter as though it was in the same office. Because if I see somebody in exam room one and that patient goes to exam three to see another provider, that's one billable visit, but that's a pretty interesting nuanced question. I will say that I'm not aware of a guideline that specifically references that. Although there's an old FAQ I haven't seen in about two years. If you shoot me that on email, I'll see if I can go to some slides for a couple of years ago and see if that question is in the FQHC. Last two. Well-

Phillip Stringfield (01:26:39):

All right. Just in the essence of time, Gary, I am sorry. We're going to have to cut Ronald's question off. Ronald, Gary's email is right here on the screen, so sorry about that. We're going to go ahead and just with the last few seconds, make sure we get out the index number for you all to utilize and self report to your respective entities. All right?

Gary Lucas (01:26:58):

Yep. Ronald, you don't need modifier 25 because code 96372 doesn't carry a global period. You don't need 25.

Phillip Stringfield (01:27:06):

And we'll go ahead and close things out. We want to thank Gary at our ArchPro Coding for leading this coding webinar series this month and for being our trusted partner. I want to thank all of you for your attention, for your engagement, and for attending our sessions today. I definitely take a moment to go ahead and complete our evaluation so that way we can better serve you in the future. So we definitely look forward to seeing you at our future training event. Everyone stay safe, take care, and we'll see you again.

Gary Lucas (01:27:33):

Thanks, everybody. Be well.