Treating Substance/Opioid Use Disorders via Medication-Assisted Treatment (MAT) in Community Health

Offered through NACHC’s Billing, Coding, Documentation, and Quality Webinar Series

Taught by the Association for Rural & Community Health Professional Coding (ArchProCoding)
Metro-Atlanta, GA

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~1900 educational sessions taught in-person in 46 states over 26+ years

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Introduction, Expectations, and Course Outline
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Primary Resources and References You Need

- There will be numerous references made to the American Medical Association’s 2022 CPT® Professional Edition whose symbols, definitions, and documentation guidelines are copyrighted by the American Medical Association. All rights reserved by the AMA.
  - Coding software and non-AMA CPTs sold by other publishers simply DO NOT contain the educationally valuable clinical documentation guidelines that should make up the core of your coding knowledge.
  - Therefore, you need a printed version of the CPT EVERY YEAR!
TARGET AUDIENCE

Clinical Providers
Document 100% of what is done (CPT/HCPCS-II) and why (ICD-10-CM) per the official guidelines?

Facility Leadership
Code 100% of your services by facilitating effective communications with clinical and business staff via the “encounter form.”

Billing & Quality
Get paid 100% of what you should (and no more than allowed) by understanding differing payer rules?

MORE INTERNAL CONTROL :::::::::: LESS INTERNAL CONTROL
Clinical Providers

How will **YOU** share key information with those who could not attend this session?

Notes

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How will **YOU** share key information with those who could not attend this session?

Facility Leadership

Notes

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How will YOU share key information with those who could not attend this session?

Notes

Billing and Quality
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
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, Transitional Care Management, Virtual Communication Services, Behavioral Health Integration, and the Psychiatric Collaborative Care Model
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.”
Preparing for SUD-OUD-MAT Patient Visits
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.
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.
Check out SAMSHA’s MAT Website for More Resources

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.
### Opioid Agonist Therapy (OAT)

#### General Suggestions on Treatment Options

<table>
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<th>Comparison of OAT (buprenorphine/naloxone and methadone)</th>
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<td><strong>Mechanism of action</strong></td>
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<td><strong>FDA approved for OUD</strong></td>
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<td><strong>Reduces cravings</strong></td>
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<td><strong>Best for mild, moderate, or severe OUD?</strong></td>
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<td><strong>Candidates and history of failed treatment attempts</strong></td>
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<td><strong>Recommended for OUD candidates with pain conditions requiring ongoing short-acting opioids?</strong></td>
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<td><strong>Psychosocial intervention recommendations</strong></td>
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</tbody>
</table>

*OTP = Opioid Treatment Program; MM = Medical Management

*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).

**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)"
Prerequisites for Providing Medication-Assisted Treatment

- 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 (SAMSHA).
- Buprenorphine can only be prescribed by a licensed clinical provider who has received additional training (ex. 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.
- 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.
Could You Use $3000 Per RHC/FQHC Provider Who Got Their DATA 2000 Waiver Since January 2019?
On April 27, 2021 HHS gave positive news on expanding MAT!

HHS Releases New Buprenorphine Practice Guidelines, Expanding Access to Treatment for Opioid Use Disorder

In an effort to get evidenced-based treatment to more Americans with opioid use disorder, the Department of Health and Human Services (HHS) is releasing new buprenorphine practice guidelines that among other things, remove a longtime requirement tied to training, which some practitioners have cited as a barrier to treating more people.

Signed by HHS Secretary Xavier Becerra, the Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder exempt eligible physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and certified nurse midwives from federal certification requirements related to training, counseling and other ancillary services that are part of the process for obtaining a waiver to treat up to 30 patients with buprenorphine.

Providers typically have had to obtain a waiver requiring completion of a training program (ex. DATA2000 waiver)
Additional Resources for “NEW” Buprenorphine Clinical Providers

• Check out SAMHSA’s website for more details and how you can treat up to 100 patients with buprenorphine instead of the 30-patient limit at https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner

• Eligible practitioners for the “Waivered Practitioner” can include NP, PA, CNS, CRNA, and CNM and must follow guidance in the new Practice Guidelines found here: https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder

• You must complete a Notification of Intent to meet this new exception as found here: https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php

• After 1 year using this new waiver, you can increase the 30 patient limit by completing the previously available waivers such as the Data2000 waiver.
A Resource for Evaluating Readiness for MAT Created by the National Council for Behavioral Health

“Medicare billing will differ from Medicaid which will differ from commercial insurance billing which may differ from...”

- **State-specific research you should perform** – Gather state details for Medicaid policies, FDA, scope of license issues, “authorized” providers and more needs to be researched carefully!

- For detailed state-specific information on MAT services be sure to look in your **Medicaid Behavioral Health Manuals (or similar title)**.

- Work closely with staff leaders and your state rural/primary care association and expect differences or seemingly conflicting information.
GOOD NEWS on Medicaid Coverage from CMS!

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid
Services 7500 Security Boulevard, Mail Stop 52-26-12
Baltimore, Maryland 21244-1850

SHO# 20-005
RE: Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment

December 30, 2020
Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing the following guidance about section 1006(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (herein referred to as the SUPPORT Act) (Pub. L. No. 115-271). To increase access to medication-assisted treatment (MAT) for opioid use disorders (OUD), section 1006(b) of the SUPPORT Act requires states to provide Medicaid coverage of certain drugs and biological products, and related counseling services and behavioral therapy.¹ This State Health Official Letter (SHO Letter) also describes available opportunities for increasing treatment options for substance use disorders (SUD) generally. CMS encourages states to consider these opportunities when implementing the mandatory MAT coverage under section 1006(b) of the SUPPORT Act. The new required

“...to require state Medicaid plans to include coverage of MAT for all eligible to enroll...”
Areas of interest in this CMS/Medicaid document

Be sure to follow any footnotes you see!

• Page 1 – “the new required benefit will be in effect for the period beginning October 1, 2020, and ending September 30, 2025.”

• Page 2 – “Currently, the FDA has approved the following drugs used for MAT to treat OUD: methadone, buprenorphine, and naltrexone.”

• Page 3 – Details on Buprenorphine/Suboxone (“partial agonist....weakly activating the opioid receptor”) and Naltrexone (“opioid antagonist...not addictive...blocks opioid from binding to receptors”)

• Page 4 – Breakdown of required MAT benefit to include counseling and behavioral therapy – including Peer Support!

• Page 16 – Appropriateness of “telemedicine as a tool to expand Buprenorphine-based MAT for OUD treatment...in rural areas...”
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 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.
Research Your Utilizing of “Non-Licensed” SUD/OUD Providers

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
COMPARE :: CMS 1500 form
(aka the “HCFA” or 837p)

Used by doctor’s offices when reporting claims to commercial and Medicare carriers expecting to receive a Fee-for-Service payment services.

CONTRAST :: CMS 1450 form
(aka the “UB” or 837i)

Used by RHC/FQHC submitting claims to Medicare (and some Medicaid carriers) for “valid encounters” when expecting the AIR/PPS rate and unlike the other form requires _______________________________.

Used by doctor’s offices when reporting claims to commercial and Medicare carriers expecting to receive a Fee-for-Service payment services.

Type of Bill Codes and Revenue Codes
Sample FFS Claim for a Primary Care Provider
Giving a Shot for SUD/OUD

- **Opioid Dependence**: F11.20
- **Depression**: F33.1
- **Obesity**: E66.9

Office visit: J0592, Drug code: 96372, Non-surgical injection given: 210.00, 180.00, 15.00
Sample FFS Claim for a Mental Health Provider
Performing Therapy and Additional Assessments

Opioid Dependence: F11.20
Depression: F33.1
Screening for Mental/Behavioral Disorder: Z13.39
Same Day Services by a Medical Provider & a Mental Health Provider in a FQHC to Medicare

Sample CMS 1450

CMS FQHC “medical” billing code
- Office visit (med)
- Injection (med)
- Inj., buprenorphine hydro, .01mg

CMS FQHC mental health billing code
- Psych therapy (mental)
- Brief behavioral assessment, per

We will review these CMS FQHC billing codes later!

CPT & HCPCS-II and ICD-10-CM are NOT LINKED and 2 encounter rates will be paid!

- G0467
- 99214 – CG
- 96372
- J0592 (x2)
- G0470
- 90832
- 96127 (x2)

Opioid Dependence: F11.20
Depression: F33.1
Screening for Mental/Behavioral Disorder: Z13.39
Obesity: E66.9
Sample Medical CPT Codes for SUD/OUD/MAT

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

Sample Medical HCPCS-ll Codes Used for Billing?

G0210/G2250 + G0212/G2251-2 – Virtual Communication Services (VCS) for commercial commercial/Medicaid claims and RHC/FQHC to Medicare

J0570, J0571-J0575 – Buprenorphine implant 74.2 mg and Buprenorphine/naloxone, oral, various dosages

J0592 – Injection, Buprenorphine Hydrochloride, per .1 mg

J2310-J2315 – Injection, Narcan, and/or Naloxone/Naltrexone per 1mg (used to report the supply of the drug(s))

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

Modifiers - be aware of the potential need to add HCPCS-II modifiers –HF for a substance abuse program vs. –HG for an opioid program
Sample Behavioral Health CPT Codes for SUD/OUD/MAT

G0210/G2250 + G0212/G2251-2 – Virtual check-ins and “store and forward” virtual check-ins for commercial commercial/Medicaid claims

G0511-G0512 – Behavioral Health Integration, and/or Psychiatric Collaborative Care Model (RHC/FQHC-specific)

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

Sample Behavioral Health HCPCS-II Codes Used for Billing?

+ 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)
Possible H-code Billing Options Unique to Medicaid

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...

<table>
<thead>
<tr>
<th>H0001-H0007</th>
<th>H0015</th>
<th>H0038</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and/or drug assessments, behavioral health counseling and therapy, case management, crisis interventions</td>
<td>Alcohol/drug intensive outpatient treatment at least 3 hours a day, 3 days per week, includes assessment, crisis eval, activity therapy, etc.</td>
<td>Self-help/peer services, per 15 minutes. Consider using for Peer Support Services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>H0033, H0034</th>
<th>H0047-H0050</th>
<th>H2010-H2037 – Time and Per Diem Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral medication administration with direct observation, medication training and support</td>
<td>Examples include alcohol/drug services NOS, drug testing collection &amp; handling non-blood specimens, screening, brief interventions</td>
<td>Medication services, day treatments, community services, wrap-around services,</td>
</tr>
</tbody>
</table>
Possible T-code Billing Options Unique to Medicaid

Be sure to carefully research these and other codes for various Medicaid nursing assessments, “all inclusive” encounter rate/per diem clinic visits, if applicable

- **T1001**
  - Nursing assessment/evaluation

- **T1002 and T1003**
  - RN or LPN/LVN services, up to 15 minutes

- **T1006-T1007**
  - Alcohol and or substance abuse services including family/couple counseling and assorted treatment plan development and/or modification

- **T1015**
  - Clinic visit/encounter, all-inclusive

- **T1023**
  - Screening to determine appropriateness of participation in a program/project or treatment protocol, per encounter

- **T2048**
  - Behavioral health, long-term residential treatment program usually more than 30 days with room/board, per day
What may be next for RHC/FQHC/CAH/small rural hospitals?

Check out CMS’ Opioid Treatment Program (OTP) *bundled payment codes* G2067-G2079 effective as of January 2020 used by FFS and other providers most likely for methadone clinics.

Source: *MLN #8296732 Billing & Payment Fact Sheet (May 2020)*
Diagnostic Documentation and Coding for SUD/OUD/MAT
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

**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.
Translating DSM-5 Terms to Proper ICD-10-CM Code Usage

DSM-5 Use Disorder Criteria

- **Mild**
  - Presence of 2-3 symptoms

- **Moderate**
  - Presence of 4-5 symptoms

- **Severe**
  - Presence of 6 or more symptoms

**ICD-10-CM Code as Abuse**

**ICD-10-CM Code as Dependence**

**Source:** VA Opioid Use Disorder Clinician’s Guide – link provided on an earlier slide
Compare/Contrast: DSM-5 vs. ICD-10-CM

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

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.

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 located 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)
  Hypertension is in this Section (I10-I15) but see also R03.0 for elevated BP w/out hypertension
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)
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.
Sample of ICD-10-CM Opioid Dependence Codes

- **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)
### Clinical Examples

<table>
<thead>
<tr>
<th>Non-Specific Documentation</th>
<th>Specific Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Example 1</strong></td>
<td><strong>Example 1</strong></td>
</tr>
<tr>
<td>Assessment: Alcohol use disorder&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Mild alcohol use disorder with alcohol-induced impotence&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Example 2</strong></td>
<td><strong>Example 2</strong></td>
</tr>
<tr>
<td>Patient is being admitted to the treatment center with a history of opioid dependence.&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Patient is being admitted to the treatment center for treatment of opioid dependence. He has been an IV heroin user for five years.&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup> "Disorder" is not sufficient; the documentation must identify the type of disorder caused by the alcohol use (e.g., anxiety, delusions, intoxication, liver disease).

<sup>b</sup> Specify the severity of the disorder with "abuse," and the manifestation as sexual disorder, specifically, impotence.

<sup>c</sup> 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.

<sup>d</sup> Here we have quantified the time the patient has been an opioid user without making the mistake of using "history of."

---

**Source:**

Social Determinants of Health

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z58 Problems related to physical environment
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances
Social Determinants of Health

• Those were only the main categories of codes – each section on the previous slide contains anywhere from 6-12 specific codes that may be needed for state/federal grant projects, limited Medicaid coverage restrictions, or any other administrative reason to identify how a patient’s social factors can influence their overall health.

• Consider their possible impact in 2021 on documentation of Medical Decision Making!

• Research NACHC’s PRAPARE tool for SDoH including webinars, templates, and additional resources to capture key data by clinical staff for inclusion on claims https://www.nachc.org/research-and-data/prapare/
Q & A
Documenting SUD/OUD/MAT Visits
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/
Sample Coding 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, 15 minutes

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

SOURCE: VA Opioid Use Disorder Clinician’s Guide – hyperlink provided on an earlier slide
MAT Screening, Assessment, and Interventions Coding

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?**

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).
Induction and Follow-up Visits Coding

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. 99354) for patients that are in your facility way longer than normal. Some carriers will pay 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.

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 if you paid for the meds.
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.
Overview of 2021/2022 E/M Changes

- Required levels of history and physical examination became obsolete in 2021 only when selecting codes 99202-99215. 99201 was deleted for 2021.

- Clinicians will be able to select new and established patient office/outpatient visits based on time or medical decision making (MDM).

- Medical Decision Making documentation details were greatly expanded in the AMA’s CPT and will require the most research, EHR template adjustments, and updated training for providers.

- Time is now defined as “total time spent on the date of the encounter”, and may include many non-face-to-face services done on the same day, and will no longer require time to be dominated by counseling and/or coordination of care.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td></td>
<td>15-29</td>
</tr>
<tr>
<td>99203</td>
<td></td>
<td>30-44</td>
</tr>
<tr>
<td>99204</td>
<td></td>
<td>45-59</td>
</tr>
<tr>
<td>99205</td>
<td></td>
<td>60-74</td>
</tr>
<tr>
<td>99212</td>
<td></td>
<td>10-19</td>
</tr>
<tr>
<td>99213</td>
<td></td>
<td>20-29</td>
</tr>
<tr>
<td>99214</td>
<td></td>
<td>30-39</td>
</tr>
<tr>
<td>99215</td>
<td></td>
<td>40-54</td>
</tr>
</tbody>
</table>
What’s included in Office/Outpatient “time”?

• preparing to see the patient (e.g., review of tests)
• obtaining and or reviewing separately obtained history
• performing a medically appropriate examination and/or evaluation
• counseling and educating the patient/family/caregiver
• ordering medications, tests, or procedures
• referring and communicating with other health care professionals (when not separately reported)
• documenting clinical information in the electronic or other health record
• independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
• care coordination (not separately reported)
Updated Terms for Medical Decision Making

01
Number of Diagnosis and Management Options
Is Revised to:
“Number and Complexity of Problems to be Addressed at the Encounter”

02
Amount and/or Complexity of Data to be Reviewed
Is Revised to:
“Amount and/or Complexity of Data to be Reviewed and Analyzed”

03
Overall Risk of Complications and/or Morbidity or Mortality
Is Revised to:
“Risk of Complications and/or Morbidity or Mortality of Patient Management”
<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM</th>
<th>Number and Complexity of Problems Addressed</th>
<th>Elements of Medical Decision Making</th>
<th>Amount and/or Complexity of Data to Be Reviewed and Analyzed</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99202</td>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or new</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99203</td>
<td>Low</td>
<td>Low</td>
<td>Limited</td>
<td>Most meet the requirements of at least 3 of the 6 categories:</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment:</td>
</tr>
<tr>
<td>99212</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Most meet the requirements of at least 3 of the 6 categories:</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment:</td>
</tr>
<tr>
<td>99212</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Most meet the requirements of at least 3 of the 6 categories:</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment:</td>
</tr>
<tr>
<td>99225</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Most meet the requirements of at least 3 of the 6 categories:</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment:</td>
</tr>
<tr>
<td>99225</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Most meet the requirements of at least 3 of the 6 categories:</td>
<td>High risk of morbidity from additional diagnostic testing or treatment:</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Evaluation and Management Code (E&amp;M Level)</th>
<th>Number and Complexity of Problems Addressed at the Encounter</th>
<th>Complexity/Level of Medical Decision Making (MDM)</th>
</tr>
</thead>
</table>
| 99202 99212                               | • 1 self-limited issue  
• 1 minor problem                                              | Straightforward                                   |
| 99203 99213                               | • 2+ self-limited problems  
• 2+ minor problems  
• 1 stable chronic illness  
• 1 acute uncomplicated illness/injury                         | Low                                              |
| 99204 99214                               | • 1 or more chronic issues with exacerbation  
• 2+ stable chronic illnesses  
• 1 Undiagnosed problem with uncertain prognosis  
• 1 Acute illness with systemic symptoms  
• 1 Acute complicated illness                               | Moderate                                         |
| 99205 99215                               | • 1+ chronic illnesses with severe exacerbation/progression or side effect of treatment  
• 1 acute or chronic illness or injury posing threat to life/function | High                                             |
<table>
<thead>
<tr>
<th>Evaluation and Management Code (E&amp;M Level)</th>
<th>Amount and/or Complexity of Data to be Reviewed and Analyzed (NOTE: Each unique test, order, or document contributes to determining MDM!)</th>
<th>Complexity/Level of Medical Decision Making (MDM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202 99212</td>
<td>Minimal or none</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203 99213</td>
<td>Limited <em>(Must meet at least 1 of the following 2 categories)</em></td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>• Category 1: Tests and Documents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Any 2 of the following: 1. review prior external notes, 2. review results of EACH unique test, 3. order of EACH unique test</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Category 2: Assessment requiring “Independent Historian(s)”</td>
<td></td>
</tr>
<tr>
<td>99204 99214</td>
<td>Moderate <em>(Must meet at least 1 of the following 3 categories)</em></td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>• Category 1: Tests, Documents and Independent Historian(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Any combination of 3 from the following: 1. review of prior external note(s) from each unique source, 2. Review results of each unique test, 3. order of each unique test, 4. Assessment requiring independent historian(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Category 2: Independent interpretation of test performed by another provider (not billed)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Category 3: Discussion of Management or test interpretation with outside provider (not billed)</td>
<td></td>
</tr>
<tr>
<td>99205 99215</td>
<td>Extensive <em>(Must meet at least 2 of the following 3 categories)</em></td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>• Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: 1. Review of prior external note(s) from each unique source*, 2. Review of the result(s) of each unique test*, 3. Ordering of each unique test*, 4. Assessment requiring an independent historian(s) or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Category 2: Independent interpretation of tests 1. Independent interpretation of a test performed by another physician/other qualified health care professional (not billed); or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Category 3: Discussion of management or test interpretation 1. Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not billed)</td>
<td></td>
</tr>
<tr>
<td>Evaluation and Management Code (E&amp;M Level)</td>
<td>Risk of Complications and/or Morbidity or Mortality of Patient Management</td>
<td>Complexity/Level of Medical Decision Making (MDM)</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>99202 99212</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
<td>Straightforward</td>
</tr>
<tr>
<td></td>
<td>• Rest, gargles and bandages</td>
<td></td>
</tr>
<tr>
<td>99203 99213</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>• OTC</td>
<td></td>
</tr>
<tr>
<td>99204 99214</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>• <em>Prescription drug management (rx)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Decision for minor surgery with identified patient or procedure risk factors (0, 10 days)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Decision for <em>elective</em> major surgery without identified patient or procedure risk factors (90 days)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <em>Diagnosis or treatment significantly limited by social determinants of health (SDoH)</em></td>
<td></td>
</tr>
<tr>
<td>99205 99215</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>• Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents, etc.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <em>Decision regarding elective major surgery with identified patient or procedure risk factors</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Decision regarding emergency major surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Decision regarding <em>hospitalization</em></td>
<td></td>
</tr>
</tbody>
</table>
Perform a medically appropriate history and/or exam.

Use time OR medical decision making whichever is the higher code and support with medical record documentation.

Understand which service are included in the updated definition of “time” and review the detailed revisions to Medical Decision Making.

Review the CPT Errata and Technical Corrections document updated in March 2021 for updates and detailed clarification of the new E/M terms:


For example – hospital visits, observation, ER, nursing facility, consultations, etc.

Determine if a category of E/M service requires “2 of 3” or “3 of 3” key components.

Use the existing 1995 and 1997 guidelines that remain intact for all non-Office/Outpatient visits.

View them here and be prepared to apply them:

What Documentation is Required for Diagnostic Interviews (90791-90792)?

• 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 Psychiatric Therapeutic Procedures (90832-90838, 90845, 90865)

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

Therapeutic Procedures (Psychotherapy)

• 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 (e.g., one medical encounter and one mental/behavioral health encounter).
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

Other SUD/OUD Treatment Services

Transitional Care Management, Virtual Communication Services, Behavioral Health Integration, and the Psychiatric Collaborative Care Model
Compare/Contrast various Telemedicine Services

Telehealth visits and Other Telephone Visits

• Depending on the carrier, use modifier -95 and/or Place of Service code 02.
• For Medicare, RHCs and FQHCs must refer to G2025 (Modifier -95 not required).
• Refer to CPT (Appendix P) for approved synchronous (real-time) telemedicine service codes and know that Medicare approved services may not be the same as other commercial payers.

Virtual Check-in/ Online Digital E/M Services + “Store and Forward” Audio/Video

• Via telephone (HCPCS II code G2012 or G2051-2) – RHC/FQHC use G0071 to Medicare.
• Patient-provided stored video/images sent and reviewed by a provider (HCPCS II code G2010 or G2250) - RHC/FQHC use G0071 to Medicare.
Other Telehealth Considerations

• Q3014 is still used for “originating site” telehealth services (not for distant site) paying around $32.

• G2061-G2063 - Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during a 7-day period; 5–10 minutes

• Check out CPT Codes 98966-98972 for telephone visits by a non-physician as well for other telehealth options and compare/contrast the definitions for consideration with various payers who may want different codes.

• List of all CMS covered services that can be reported via telehealth can be found at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
There are many codes on this list that we are NOT used to getting paid for as a RHC/FQHC. Also – what about audio-only visits?
Documentation & Coding for VCS “Virtual Check-in”

• VCS refers to providers who receive contact via non-face-to-face “communication technology-based” (i.e. a virtual check-in via phone) from an established patient lasting more than 5 minutes or more regarding a condition(s) NOT related to a visit in the past 7 days and that does not result in an appointment in the next 24 hours or next available appointment slot.

• The contact must be initiated by the patient if using the “virtual check-in” element.
Another type of VCS refers to providers who interpret and follow-up with patients within 24 hours of when patients send them pictures/video for conditions NOT originating from a related E/M service within the previous 7 days and does not lead to an E/M service or procedure within the next 24 hours or soonest appointment slot.

ACOs often utilize a patient portal where they can send information/pictures/videos to their provider – if you are using this “store-and-forward” technique to report VCS the information must be reviewed within 24 hours of its submission by the patient.
Behavioral Health Integration

• Similar to Chronic Care Management (CCM), a primary care provider will track the total time per calendar month they spend supervising and directing the care plan for patients with a mental/behavioral/psychiatric condition (including substance use disorders).

• **NOTE:** Depending on which carrier you are billing, you may need to use either CPT code 99484 for Care Management Services for Behavioral Health or if you are a RHC/FQHC use HCPCS-II code G0511 to Medicare.

• BHI is reported if at least 20 minutes a month is documented according to the guidelines when the *provider directs and supervises integrative treatment* that may optionally utilize a Behavioral Health Manager and a Psychiatric Consultant.
Psych CoCM (99492-99494) is based on a model made popular by the University of Washington.

- “Collaborative care requires a team of professionals with complementary skills who work together to care for a population of patients with common mental conditions such as depression or anxiety.”
- It involves a shift in how medicine is practiced, the creation of entirely new workflows, and frequently the addition of new team members.
- In usual care, the treatment team has two members: the primary care provider and the patient.
- Collaborative care adds two more vital roles: the care manager and the psychiatric consultant.

Check out their website for great additional info! https://aims.uw.edu/collaborative-care/team-structure
• **CPT Research:** The 2020-2022 CPT has many paragraphs that describe the specific roles and documentation needs of each type of provider doing Psych CoCM.
  • Some providers may be offsite and not often, if at all, provide direct patient care.

• Psych CoCM considers the total team’s work during a calendar month performing such coordination between team members.
Behavioral Health Care Manager - Psych CoCM

• The CPT codes tend to focus on the total monthly time for this professional in coordination with the PCP and Consultant.

The CPT identifies that a Behavioral Health Care Manager must be a masters/doctoral-level staff member who provides care at your facility as well as an assessment of needs.

• If the BH Care Manager performs face-to-face services to the patient – that time cannot be considered for Psych CoCM.

• Per the CPT - Psychiatric consultation with the Psych Consultant is usually non-face-to-face and provided weekly at a minimum.

• Check out the University of Washington’s website for sample job descriptions and caseload guidelines – for example – usually not overseeing more than 120 patients.
Psychiatric Consultant - Psych CoCM

- The Psych Consultant is a medical professional trained in psychiatry or behavioral health and qualified to prescribe the full range of medications, though the prescription will likely come from the PCP.
  - U of W recommends a .075 FTE which is around 3 hours a week for a standard case load by a BH Consultant of PCP.
- This medical professional **may** never set foot in your office and is available for the PCP and the Behavioral Health Consultant during business hours to get help in how to update or adjust a plan of care that has not seen at least a 50% improvement after 10-12 weeks under a plan of care.
- Again – the U of W’s website has sample job descriptions, case load recommendations, and a deeper dive into their role.
The CPT identifies 3 codes for Psych CoCM:

- **99492** = First 70 minutes in the first calendar month of behavioral health care manager activities
- **99493** = First 60 minutes in a subsequent month of behavioral health care manager activities
- **+ 99494** Initial or subsequent each additional 30 minutes of behavioral health care manager activities
Closing Comments and Wrap-up
ACTION ITEMS

Determine level of training needed by job role and train together!

Review participation contracts with key carriers and seek out specific answers to MAT-specific questions.

Make your superbill/encounter forms dynamic and show providers the entire definition of a code.

Create routine and effective communications between clinicians and coding/billing staff!

Have providers review the CPT’s documentation guidelines for key information about coding E/M non-office visits and behavioral health services.

GET RESULTS

Use internal audit results to train staff with a focus on compliance and profitability.

Identify educational opportunities from your state/national professional associations on SUD/OUD/MAT.

Educate all staff on the differences between documentation>coding>billing and ensure that all providers are “coding” on encounter forms rather than “billing.”
ACTION ITEMS

Review the newly updated 2021/2022 E/M documentation guidelines from AMA and CMS.

Update the encounter form a minimum of twice a year and consider adding carrier-specific H-codes for Medicaid.

Have providers review key areas of the ICD-10-CM Official Guidelines for Coding & Reporting for F-codes and coexisting conditions.

Identify codes that have both CPT and HCPCS-II options that look similar and may help overturn denied claims that required usage of the alternate codes to Medicare and other payers.

GET RESULTS

Make your electric superbill a fully functional and usable document rather than a list of favorite codes.

Establish a process for providers to report codes not on the superbill.

Report diagnoses in order of importance and link diagnoses for all patients internally even if not required on a CMS1450 form.

Focus on chief complaints and “stand-alone” documentation.
ACTION ITEMS

Confirm that all encounters are fully ‘coded’ before applying billing rules in order to accurately capture your “costs.”

Ask your major carriers to clarify their coverage for prescriptions used in MAT and if patient financial assistance options are available.

Determine if Peer Support Specialists can be a part of the care team and how their service may be billed if performed by themselves or as a part of a team visit on the same day.

GET RESULTS

Perform periodic audits of key areas discussed in this class with a focus on compliance and profitability.

Educate providers using their actual encounters and provide them with the source documents to gain knowledge that can be strategically applied.

Identify what services Medicaid may pay for that “regular Medicare” may not.
Q & A
Thanks for your attention and participation!
This is our time to shine!

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