HRSA
Health Resources & Services Administration

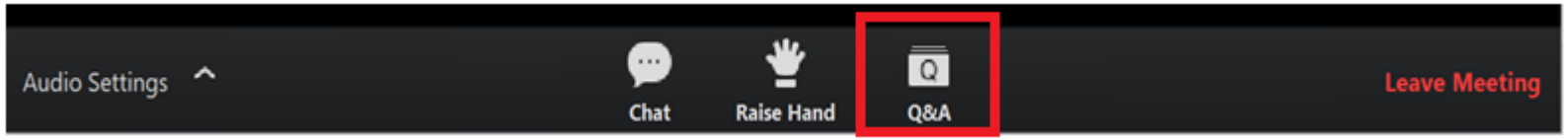
Documentation, Billing, and Coding for Behavioral Health Integration (BHI)

Monday, May 15, 2023
1:00 – 2:00 p.m. ET

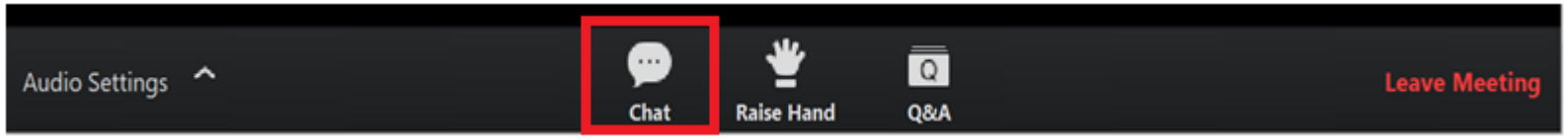
Vision: Healthy Communities, Healthy People

Submitting Questions and Comments

- Submit questions by using the Q&A feature. To open your Q&A window, click the Q&A icon on the bottom center of your Zoom window.



- If you experience any technical issues during the information session, please message us through the chat feature, or email healthcenter_BHTA@jbsinternational.com.



Continuing Education (CE)

- We will be offering **1 CE credit** for attending today's session.
- You **must** complete the Health Center Satisfaction Assessment at the end of the workshop.
- We will provide more information about how to complete the Satisfaction Assessment and details about applying for CEs at the end of the session.

This course has been approved by JBS International, Inc. as a NAADAC Approved Education Provider, for educational credits. NAADAC Provider #86832, JBS international, Inc. is responsible for all aspects of their programming.

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Access Intensive Technical Assistance for Sustainable Behavioral Health Integration (BHI)

- Documentation, Billing, and Coding for BHI Services
- Screening, Brief Intervention, Motivational Interviewing in Primary Care Settings
- Effective Clinical Workflows
- Sustainable Training Strategies
- Addressing Health Center Staff Secondary Trauma

Request form link:
https://bphc-ta.jbsinternational.com/ta-request-form

Request form QR Code:

Advancing Health Equity

Health centers provide affordable, high-quality primary health care to more than 30 MILLION people in the U.S. each year. That includes:

1 in 9
children & adolescents

1 in 5
rural residents

1 in 3
living in poverty

63%
identify as racial and/or ethnic minorities

Nearly **1.3M** experiencing homelessness

1M+ agricultural workers

Nearly **770K** school-based health center patients

Nearly **390K** Veterans

HRSA
Health Resources & Services Administration

Source: Uniform Data System, 2021 - Table 3A, Table 3B, Table 4, Table 6A

*Poverty defined as having income ≤100% Federal Poverty Guidelines

HRSA Health Center Program

Presenter and Facilitator for Today's Webinar

Gary Lucas, MS, Vice President of Research and Development, Association for Rural & Community Health Professional Coding (ArchProCoding)

Aylin Edelman, MD, RHIA, CCS, Technical Assistance Manager, JBS International, Inc.

HRSA Health Center Program

Health Center Technical Assistance (TA) Satisfaction Assessment

- **You MUST complete the Health Center Satisfaction Assessment after this session to receive CEs.**
- The link to the Satisfaction Assessment will automatically open in your browser at the conclusion of this webinar.
- You can also click the link for the Satisfaction Assessment provided in the Zoom chat feature; click the link now to have the browser open.
- We will also email you a link to the Satisfaction Assessment.

Please take 2–3 minutes to complete the Satisfaction Assessment directly following this session.

THANK YOU!

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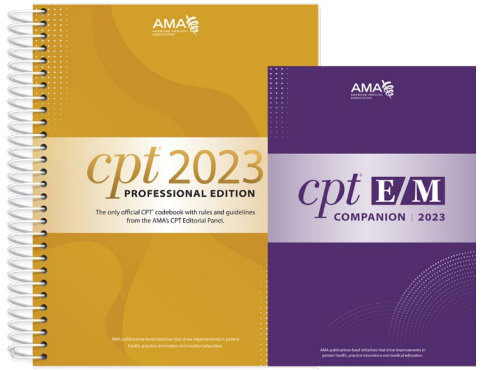
Coding software and non-AMA CPTs simply **DO NOT** contain the educationally valuable clinical documentation guidelines that should make up the core of your CPT coding knowledge. Therefore, you need a **printed version of the CPT every year** unless the AMA releases all CPT documentation guidance in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



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Today's Focus: HRSA Health Centers and Behavioral Health Integration (BHI)

Rural Health Clinics (RHC)

Can be either independent or provider-based and receive an ***All-Inclusive Rate (AIR)*** from Medicare and some Medicaid payers.

Federally Qualified Health Centers (FQHC)

AKA Community Health Centers that operate in rural or urban health professional shortage areas and receive a ***Prospective Payment System (PPS) rate*** from Medicare and some Medicaid payers.

Critical Access Hospitals (CAH)

Also includes small rural hospitals and new Rural Emergency Hospitals who receive CAH Method I/II or PPS payments from Medicare and some Medicaid payers.

ArchProCoding serves RHC, FQHC, and CAH

Target Audience Members

Clinical Providers

Clinic and Health Center Managers

Coders

Billers

Electronic Health Records and IT/Billing System Integrations

Coding and Billing Are Not the Same!

Coding and billing are not the same!	Coding turns medical documentation into useable data regardless of whether it generates revenue or not.	Professional coding guidelines related to CPT and ICD-10-CM codes apply equally to all types of medical facilities.
Just because you got paid doesn't mean you get to keep the money. + Just because you didn't get paid doesn't mean you did it wrong.	Predicting varying commercial insurance and Medicaid billing rules is very tricky especially since some payers see us as a regular doctor's office rather than a FQHC.	**We will, therefore, focus on CMS/Medicare FQHC billing rules since they can be taught at a national level. Expect variations and different billing codes and reimbursement rules!**

Question 1 – Facility Readiness

Does each facility have the current federally-mandated HIPAA code sets?

A) Yes, our facility has the current HIPAA code sets

B) No, our facility is completely dependent on software

C) Don’t know

Question 2 – Access to/Understanding of Key Information

Do the necessary staff have access to and understand the contents of key Medicare updates for your facility (for example, FQHC CMS Policy and Benefits Manuals, Chapters 9, 13)?

A) Yes, staff have access to and understand the contents of key Medicare updates

B) No, the staff do not have access to and/or do not understand the contents of key Medicare updates

C) Don’t know

Question 3 – Individual Contract Billing Requirements

Do the necessary staff have full awareness of how each of the participation contracts (examples Medicaid, and Managed Care) require the health center to bill differently for services (central to maximizing revenue)?

A) Yes, the necessary staff have full awareness of how each participation contract bills differently

B) No, the necessary staff do not have this awareness

C) Don’t know

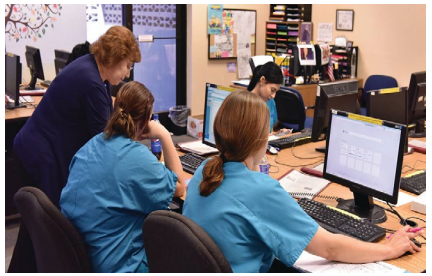
Billing Will Differ Depending on the Carrier

Medicaid

Automobile & Worker's Comp

Medicare
Parts A, B, C, and D

Commercial Insurers



Self-Pay/No Insurance
"Pure Coding"

There are Several Medicare Coverage Options

Part A

In general, Part A covers hospital care, skilled nursing facility, nursing home care, etc. Sometimes called “facility services”. RHC/FQHC are Part B providers who usually get paid for encounter rates via Part A claims.

Part B

FQHC are Part B providers even though we primarily use a claim form associated with Part A.

FQHCs bill Part B also for many services!

Part C

Combines Parts A & B (and maybe Part D) into one plan and is generically likely referred to as a Medicare Managed Care Organization (MCO) and is run by a private insurance company.

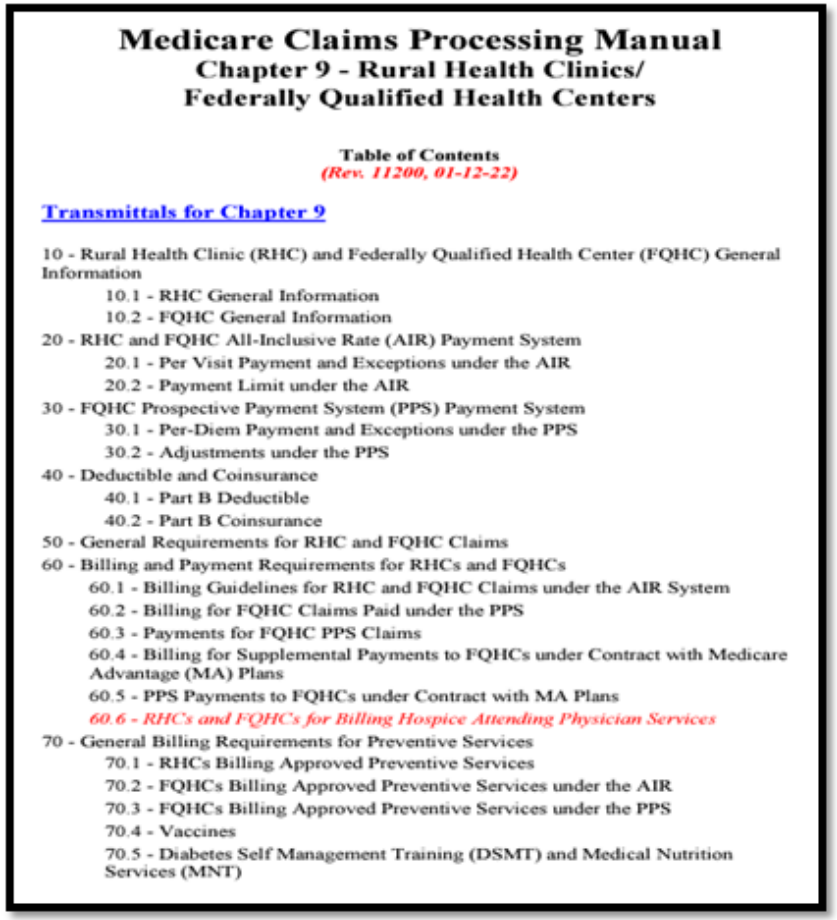
Don’t assume that traditional Medicare billing rules apply!

Part D

A broad term for Medicare Prescription Drug coverage. There are various Part D plans. When combined with a Medicare MCO it may be called a Medicare Advantage –Prescription Drug (MA-PD) plan.

Claims Processing and Benefits Policy Manuals

Chapter 9 - CMS Claims Processing Manual



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

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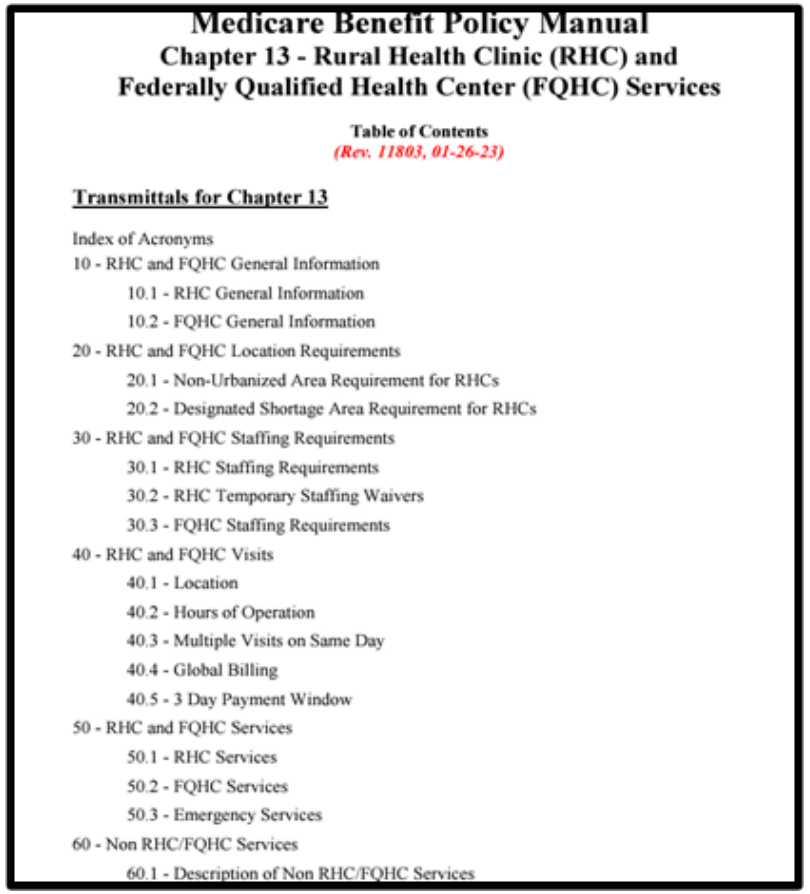
Chapter 13 - CMS Benefits Policy Manual



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

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Claims Processing and Benefits Policy Manuals

Chapter 9 - CMS Claims Processing Manual

Chapter 13 - CMS Benefits Policy Manual

Sample Information on BHI Visits from CMS' FQHC Policy Manual

- *What are the 3 exceptions?*
- *When should we use modifier -59 for FQHCs for multiple encounter rates on the same patient on the same day?*

40.3 - Multiple Visits on Same Day

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

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

Coding Incident-to-Services
When Nurses Perform Visits On Their Own

Examples of common nurse/medical assistant services performed under direct supervision without an authorized provider performing a face-to-face service that will likely be billed using the supervising provider's NPI#, if required.

- Non-surgical injection-only visits (ex. B-12) use codes 96372 and J3420 under the supervising provider. Similarly, allergy injections will likely be reported via 95115 and 95117, for example.
- Vaccine-only visits use a vaccine administration code such as **90471** and a code for the vaccine product itself such as **90700** for DTaP.
  - Use **G0008-G0009** for flu and pneumo and various Covid administration codes. These are not directly reimbursed, rather they go to the Cost Report.
- Visits for lab draws only nurses can code **36415**, for example, and the code for the lab itself such as **80050** for a general health panel.
- Dressing changes, suture-only visits, prescription refill visits and similar services use **99211**.

Billing Incident-to-Services
When Nurses Perform Medicare Visits On Their Own

If any of the services on the previous slide occur without a CMS-authorized RHC/FQHC provider seeing the Medicare patient face-to-face, the services should be documented, coded, and stored in your EHR/IT environment but should not go on a claim form for AIR/PPS payments.

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

120.1 – Provision of Incident to Services and Supplies
(Rev. 263, Issued: Effective: 01-01-20, Implementation: 01-23-20)

When services and supplies are furnished incident to an RHC or FQHC visit, payment for the services are included in the RHC AIR or the FQHC PPS rate. An encounter that includes only an incident to service(s) is not a stand-alone billable visit for RHCs or FQHCs.

Compare/Contrast:
CPT and HCPCS-II codes for FQHC Medical Health Providers

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

80305-80307 and 80320-80377 – Presumptive and Definitive Drug Tests

96372 – Giving a therapeutic injection (ex. Buprenorphine for Medication-Assisted Treatment and "BHI")

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.

99484-99494 – Principle/Chronic Care Management, Behavioral Health Integration, Psychiatric Collaborative Care Model

New for 2023 - G3002-+G3003 – Monthly Chronic Pain Management

G0511 – FQHC-specific code covering Chronic Pain Management, Principle/Chronic Care Management, and/or "Behavioral Health Integration" to the monthly billing meeting minimum time thresholds

G2025 – FQHC-specific code for Medicare patients when a CMS-covered MEDICAL telehealth service is performed

J0570, J0592, J0571-J0575, J2310-J2315 – Buprenorphine implant 74.2 mg and Buprenorphine/naloxone, oral, various dosages, Narcan/Naloxone/Naltrexone per 1mg

- *J-codes are used to report the supply of the drug(s) in addition to an injection code ex. 96372)*

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

Compare/Contrast:
CPT/HCPCS-II codes for FQHC Behavioral Health Providers

+ **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)

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

H0038 – Self-help peer services , per 15 minutes (Medicaid?)

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

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

Sample Billing Code Options for Screening Substance Use and Opioid Use Disorders

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

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

H0049: for Alcohol and/or drug screening

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

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

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

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

FQHC's Providing Intensive Behavioral Therapy for Obesity (Ch. 18 §200)

CMS coverage for Federally Qualified Health Center (FQHC)

IBT for obesity should be consistent with the "*5-A framework*" (per USPSTF)

- ***A**ssess, **A**dvise, **A**gree, **A**ssist, **A**rrange*

CPT/HCPCS II Code(s): G0447- Face-to-face behavioral counseling for obesity, 15 minutes

ICD-10-CM Code(s): ICD-10-CM code for obesity are found in code family E66.-

Coverage: Medicare beneficiaries with obesity who are "*competent and alert*"

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg weight loss requirement during the first six months

Care Management Documentation for FQHC Clinical Providers

AMA CPT Guidelines

According to the CPT these are "management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional....(that) include"

TIPS: Develop templates in your EHR, track monthly time, document care plan updates and consider external care managers.

"Establishing, implementing, revising, or monitoring the care plan

Coordinating the care of other professionals and agencies

Educating the patient or caregiver about the patient's condition, care plan, and prognosis"

Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Management (CoCM) Coding

- 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*).
- 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.
- **NOTE:** Depending on which carrier you are billing, you may need to use either CPT code 99484 or HCPCS-II code G0511 to Medicare if you are a RHC/FQHC.

Care Management Documentation for Clinical Providers

Get patient verbal/written consent to be their ONLY care manager

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

Chronic Care Management

99487-99491, +99439

+

Principal Care Management

99424-99427

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

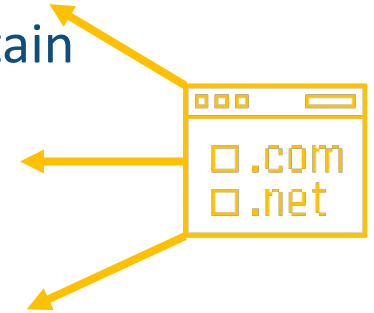
99484, 99492-99494

New for 2023 Chronic Pain Management

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

BHI and Psychiatric Collaborative Care Management Key FQHC Billing Resources and References

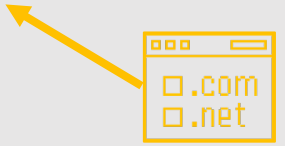
- As always – your AMA CPT® has a ton of information that is ONLY found in their version of the coding manual – encoder software or other publishers will not contain the same valuable info you need to be aware of.
- For Medicare's guidelines for reporting BHI please review the CMS Benefits Policy Manual Chapter 13 – section 230.2
- For additional CMS information, review the Frequently Asked Questions on Care Management Services from CMS.



BHI and Psych CoCM
Additional Information for HRSA Health Centers

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

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



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

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

Care Management
Coding/Billing Information for Consideration

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

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

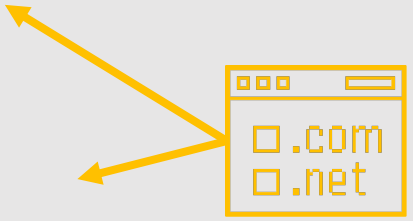
G0512 = Rural Health Clinic or Federally Qualified Health Center only, Psychiatric Collaborative Care Model, 60 minutes or more of clinical staff time for psychiatric CoCM services directed by a RHC/FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health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

Additional Information Care Management Options

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

- For more details on RHC/FQHC updated payment info related to **Advanced Care Planning** and codes 99497-99498 see page 5.

    - See the updated documentation requirements and when it may be reported ***as a part of an AWV service*** and the impact of modifier -33.



Access Medicare's New Interactive Preventive Services Tool for Periodic Payment for HRSA Health Centers Providing BHI

INCLUDES:

Intensive Behavioral Therapy (IBT) for Obesity

Alcohol Misuse Screening and Counseling

Counseling to Prevent Tobacco Use

Depression Screening

IBT for Cardiovascular Disease

And more…

COMPARE: DSM-5 Substance/Opioid "*Use Disorders*" to ICD-10-CM "*Use, Abuse, and Dependence*"

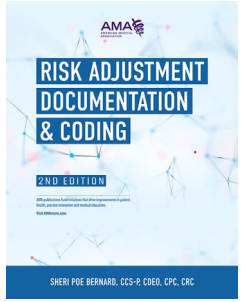
Be aware of the possible need to have your clinical staff compare the DSM-5 definitions of mild, moderate, and severe disorders and the number of criteria documented to help make decisions on proper reporting of ICD-10-CM codes.

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

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

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

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



Highlights of Section I-C Chapter 5 of the "2023 Official Guidelines for Coding & Reporting"

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.

Diagnostic & Statistical Manual of Mental Disorders, 5th Edition (DSM-5) Opioid Use Disorder Criteria

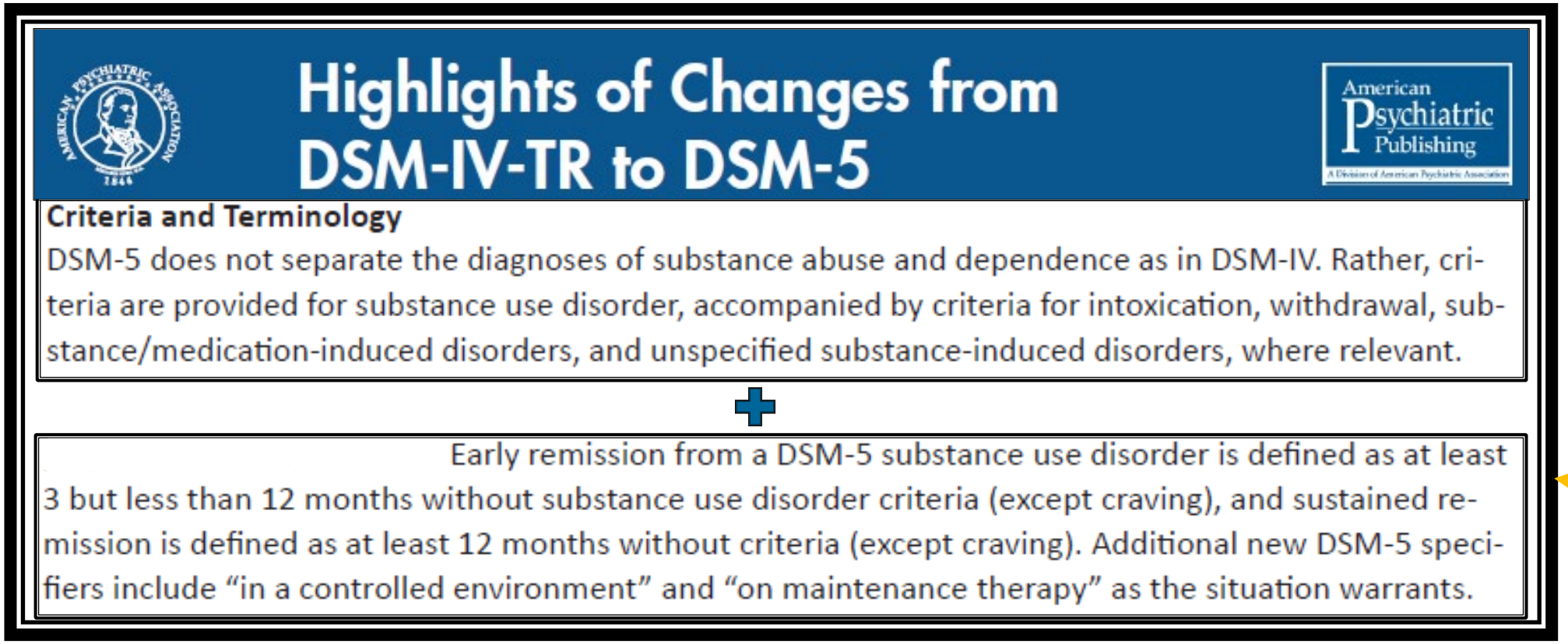
DSM-5 Diagnostic Criteria for OUD

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

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

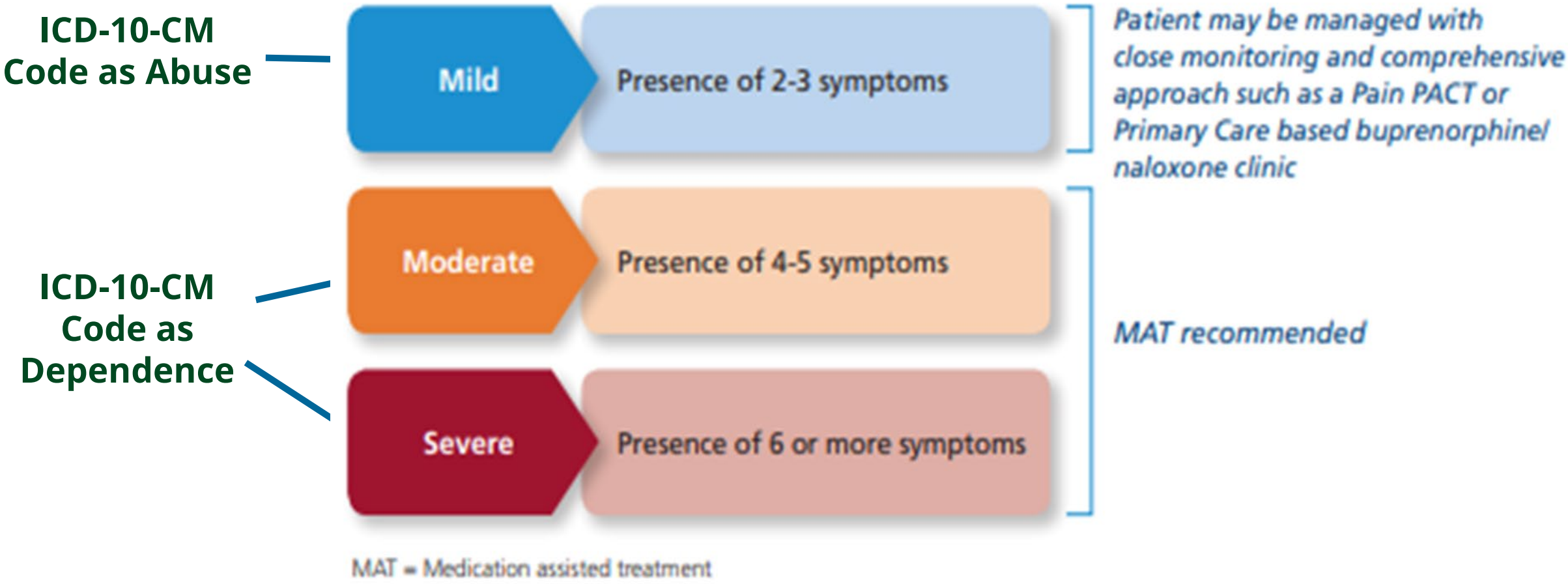
FYI - SUD has its own similar list of 11 items to establish a clinical diagnosis

Compare/Contrast: DSM-5 and ICD-10-CM Terminology



Translating DSM-5 to ICD-10-CM Code Usage

DSM-5 "Use Disorder" Criteria



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

ICD-10-CM Social Determinants of Health (SDoH)

- 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

Consider their possible impact on your level of E/M services when coding based on your documentation of Medical Decision Making! Stand by…

Research the “PRAPARE” tool for a ton of valuable SDoH information from national leaders including webinars, templates, and additional resources to capture key data by clinical staff for inclusion on claims at: https://prapare.org/

Sample additional areas for more intensive technical assistance, coaching sessions, and/or site visits

- E/M documentation guidelines that have been updated since 2021-now emphasizing Medical Decision Making or Time.
- In depth review of ~30 “sometimes-covered” CMS preventive medicine services.
- Coding/billing for minor surgical procedures performed in your FQHC and how the “global surgical package” definition can change by carrier!
- How to report post-op visits for major surgeries performed outside of your FQHC.
- Defining CMS “valid encounters” and how it may impact Medicaid billing.
- Build in-depth awareness of the “2023 Official Guidelines for Coding & Reporting.”
- Nuances of using the CMS1500/837p versus CMS1450/837i claim forms.
- And more…..

Questions and Answers

Access Intensive T/TA for Sustainable Behavioral Health Integration (BHI)

- Documentation, Billing, and Coding for BHI Services
- Screening, Brief Intervention, Motivational Interviewing in Primary Care Settings
- Effective Clinical Workflows
- Sustainable Training Strategies
- Addressing Health Center Staff Secondary Trauma

Request form link:
https://bphc-ta.jbsinternational.com/ta-request-form

Request form QR Code:

HRSA Health Center Program

Health Center Training / Technical Assistance (T/TA) Satisfaction Assessment

- **You MUST complete the Health Center Satisfaction Assessment after this session to receive CEs.**
- The link to the Satisfaction Assessment will automatically open in your browser at the conclusion of this webinar.
- You can also click the link for the Satisfaction Assessment provided in the Zoom chat feature; click the link now to have the browser open.
- We will also email you a link to the Satisfaction Assessment.

Please take 2–3 minutes to complete the Satisfaction Assessment directly following this session.

THANK YOU!

HRSA
Health Resources & Services Administration

Thank You!

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Vision: Healthy Communities, Healthy People