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

Part 2 of 2: January 27, 2022

Speaker

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Vice President - Education

University of Georgia – Bachelor of Business, Marketing (1994)
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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!

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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**

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

Clinical Providers

Notes

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

Facility Leadership

Notes

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

Billing and Quality

Notes

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General Course Layout

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

Documenting
SUD-OUD-MAT visits

Preparing for
SUD-OUD-MAT Patient Visits

Diagnostic Documentation and
Coding for SUD/OUD/MAT

Getting Paid for
Non-Face-to-Face Visits

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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

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Section Overview

Diagnostic Documentation and Coding for SUD/OUD/MAT

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

Documenting SUD-OUD-MAT visits

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

Getting Paid for Non-Face-to-Face Visits

Telehealth, Transitional Care Management, Virtual Communication Services, Behavioral Health Integration, and the Psychiatric Collaborative Care Model

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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.*

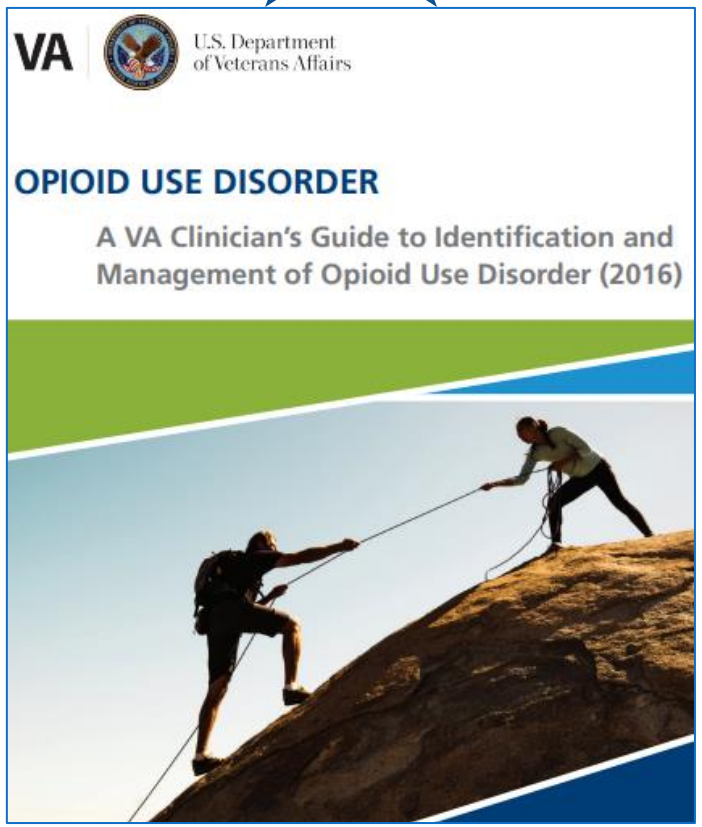
Patients with OUD can achieve full remission.**

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."

HYPERLINK



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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.

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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.

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Check out SAMSHA's MAT Website for More Resources

SAMHSA
Substance Abuse and Mental Health Services Administration

MEDICATION-ASSISTED TREATMENT (MAT)

MAT Medications

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

Alcohol Use Disorder Medications

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

Opioid Dependency Medications

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

Opioid Overdose Prevention Medication

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

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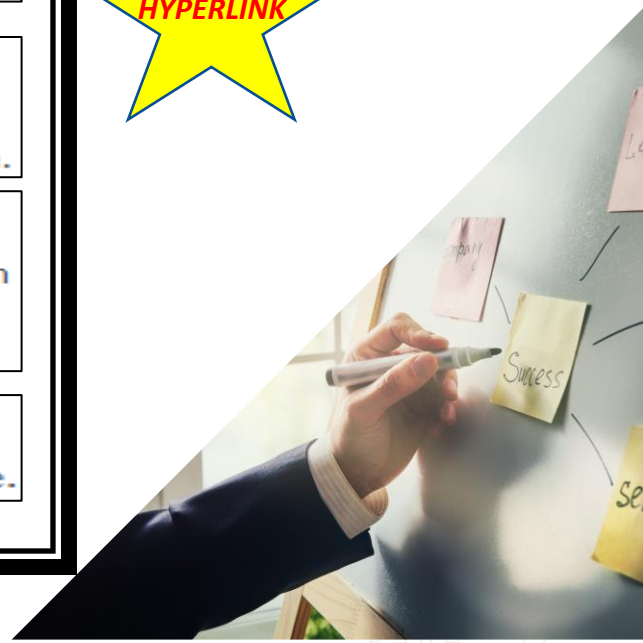


Table 4. Comparison of OAT (buprenorphine/naloxone and methadone ← **Opioid Agonist Therapy OAT)**

General Suggestions on Treatment Options

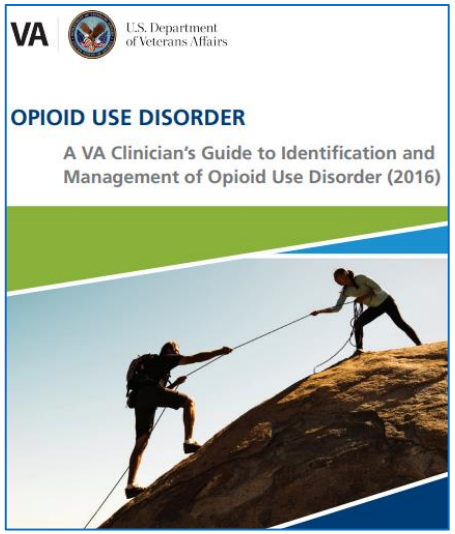
	Buprenorphine/Naloxone**	Methadone
Treatment setting	Office-based	Specially licensed OTP
Mechanism of action	Partial opioid agonist*	Opioid agonist
FDA approved for OUD	Yes	Yes
Reduces cravings	Yes	Yes
Best for mild, moderate, or severe OUD?	Mild—Moderate	Mild, Moderate, and Severe
Candidates and history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

OTP = Opioid Treatment Program; MM = Medical Management

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

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

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



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..

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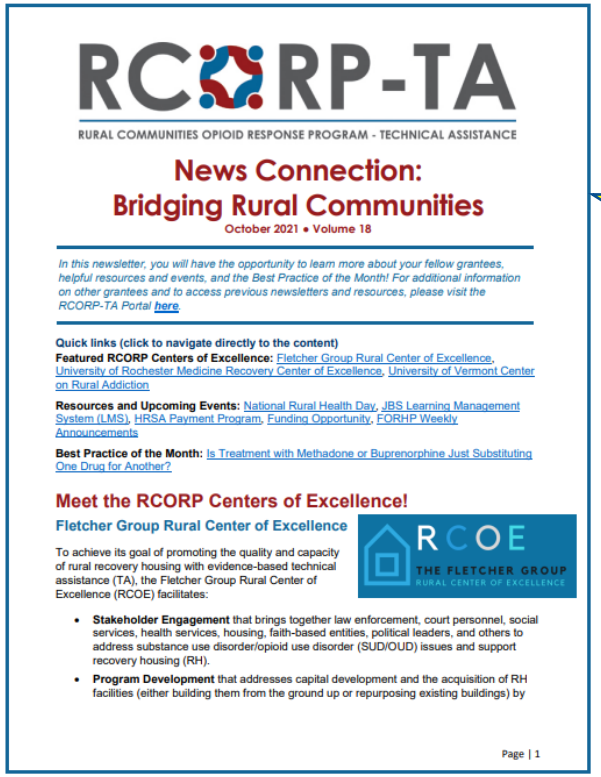
Could You Use $3000 Per RHC/FQHC Provider Who Got Their DATA 2000 Waiver Since January 2019?

RCORP-TA

RURAL COMMUNITIES OPIOID RESPONSE PROGRAM - TECHNICAL ASSISTANCE



RCORP-TA

RURAL COMMUNITIES OPIOID RESPONSE PROGRAM - TECHNICAL ASSISTANCE

News Connection: Bridging Rural Communities

October 2021 • Volume 18

In this newsletter, you will have the opportunity to learn more about your fellow grantees, helpful resources and events, and the Best Practice of the Month! For additional information on other grantees and to access previous newsletters and resources, please visit the RCORP-TA Portal here.

Quick links (click to navigate directly to the content)

Featured RCORP Centers of Excellence: Fletcher Group Rural Center of Excellence, University of Rochester Medicine Recovery Center of Excellence, University of Vermont Center on Rural Addiction

Resources and Upcoming Events: National Rural Health Day, JBS Learning Management System (LMS), HRSA Payment Program, Funding Opportunity, FORHP Weekly Announcements

Best Practice of the Month: Is Treatment with Methadone or Buprenorphine Just Substituting One Drug for Another?

Meet the RCORP Centers of Excellence!

Fletcher Group Rural Center of Excellence

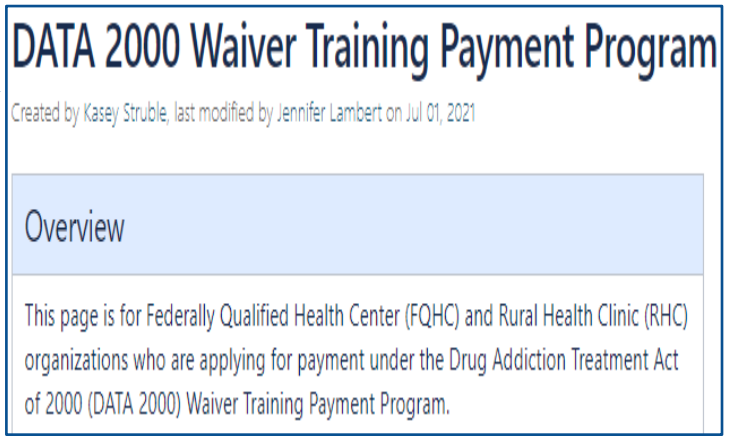
RCOE THE FLETCHER GROUP RURAL CENTER OF EXCELLENCE

To achieve its goal of promoting the quality and capacity of rural recovery housing with evidence-based technical assistance (TA), the Fletcher Group Rural Center of Excellence (RCOE) facilitates:

- **Stakeholder Engagement** that brings together law enforcement, court personnel, social services, health services, housing, faith-based entities, political leaders, and others to address substance use disorder/opioid use disorder (SUD/OUD) issues and support recovery housing (RH).
- **Program Development** that addresses capital development and the acquisition of RH facilities (either building them from the ground up or repurposing existing buildings) by

Page | 1

3 HYPERLINKS



DATA 2000 Waiver Training Payment Program

Created by Kasey Struble, last modified by Jennifer Lambert on Jul 01, 2021

Overview

This page is for Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) organizations who are applying for payment under the Drug Addiction Treatment Act of 2000 (DATA 2000) Waiver Training Payment Program.

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On April 27, 2021 HHS gave positive news on expanding MAT!

FOR IMMEDIATE RELEASE
April 27, 2021

HYPERLINK

Contact: HHS Press Office
202-690-6343
media@hhs.gov

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.

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A Resource for Evaluating Readiness for MAT Created by the National Council for Behavioral Health

Financial and Regulatory Readiness

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

Question/Area of Consideration	Not Ready	In progress	Ready
What do Medicaid and commercial insurers require for the use of MAT in your state? • Are there limitations on who can prescribe MAT, the length of time patients can use MAT, and/or the type(s) of formulations patients may receive?			
Does your state's Medicaid plan cover the MAT formulations that you would like to start offering (e.g., injectable naltrexone, sublingual buprenorphine)?			
Does your state view the use of MAT as an evidence-based practice? (Some states require that clinicians follow evidence-based practices to be reimbursed under Medicaid and private insurance.)			
Are you aware of the typical out-of-pocket cost for the medications, and are your patients able to afford these costs? • If not, are you aware of ways you may be able to offset these costs for patients who need assistance?			
Are clinicians eligible to receive Medicaid or commercial insurance reimbursement? • Are they on preferred provider lists for commercial insurers and Medicaid managed care programs?			

SOURCE: https://www.thenationalcouncil.org/wp-content/uploads/2020/02/MAT-Readiness-Checklist-Fall-2019-007.pdf?daf=375ateTbd56

HYPERLINK

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"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.

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GOOD NEWS on Medicaid Coverage from CMS!

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid
Services 7500 Security Boulevard, Mail
Stop S2-26-12
Baltimore, Maryland21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 20-005

HYPERLINK

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…"*

DEPARTMENT OF HEALTH & HUMAN SERVICES
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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

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

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

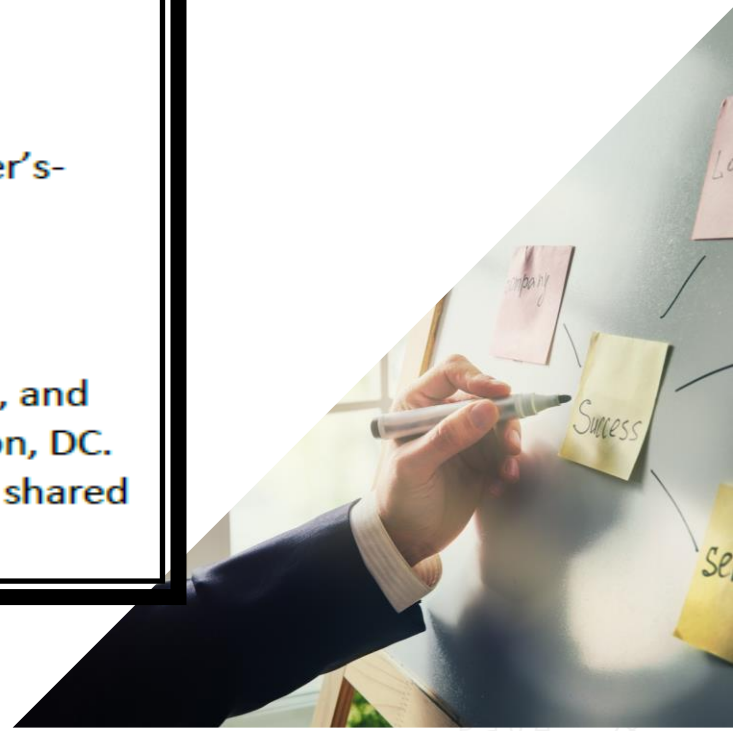
By Eliza Mette, Charles Townley, Kitty Purington November 2019

HYPERLINK

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.



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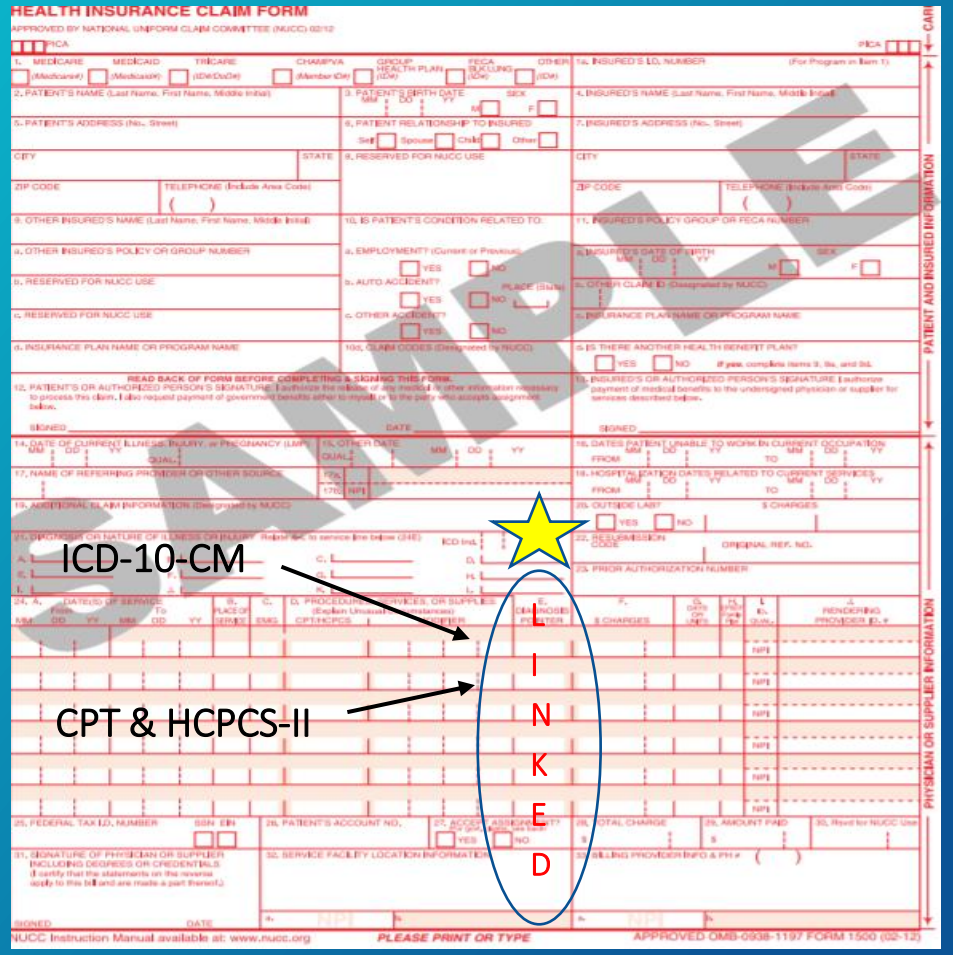
Q & A

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

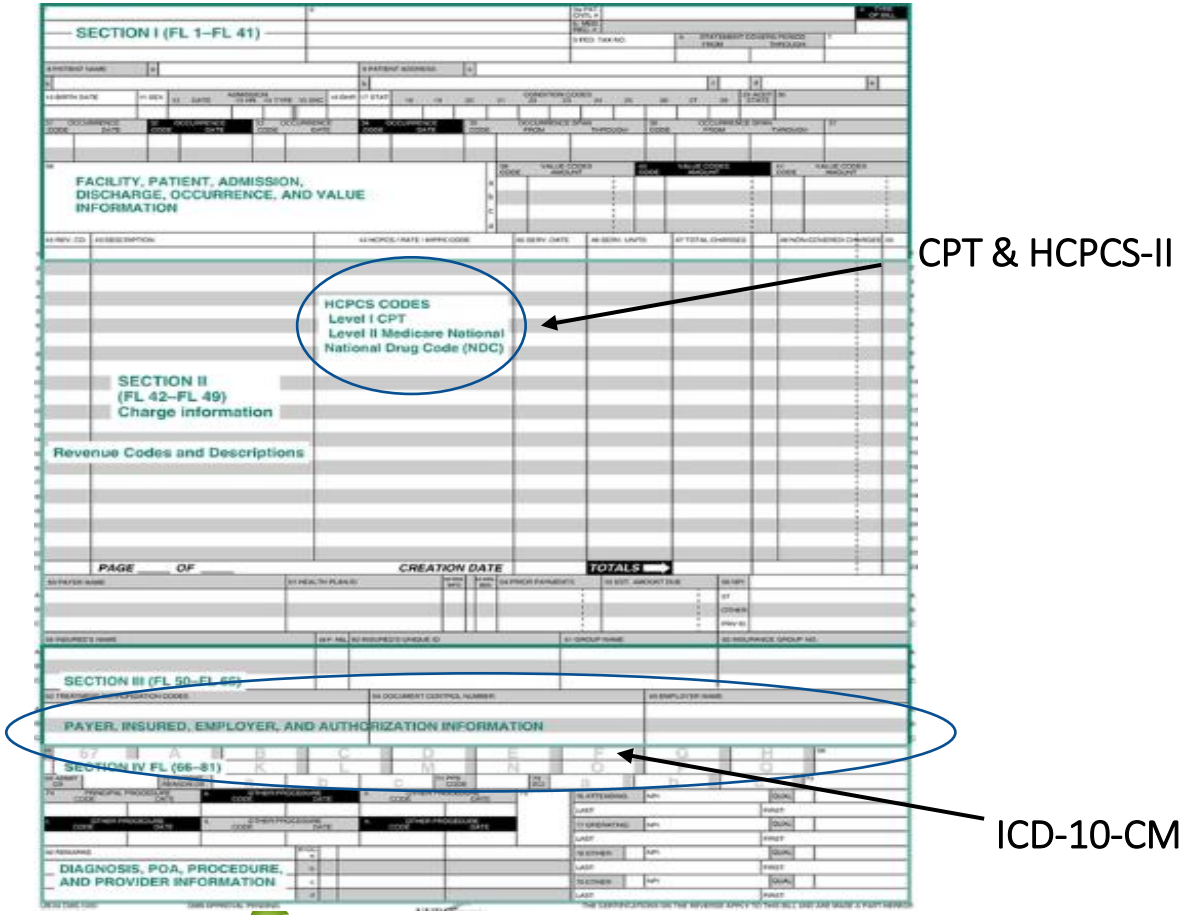
COMPARE :: CMS 1500 form
(aka the "HCFA" or 837p)

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 Type of Bill Codes and Revenue Codes.



Sample FFS Claim for a Primary Care Provider Giving a Shot for SUD/OUD

Sample CMS 1500

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO W MM DD YY FROM

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

18. HOSPITALIZATION DATES RELA MM DD YY FROM

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO

Opioid Dependence **Depression** **Obesity**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A **F11.20** B **F33.1** C **E66.9** D

E F G H

I J K L

22. RESUBMISSION CODE ORI

23. PRIOR AUTHORIZATION NUMBE

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSD Family Plan	
1	07	01	21	07	01	21	11		99214		A	210.00		
2	07	01	21	07	01	21	11		J0592		A	180.00	2	
3	07	01	21	07	01	21	11		96372		A	15.00		

99214 ← **Office visit**

J0592 ← **Drug code**

96372 ← **Non-surgical injection given**

Sample FFS Claim for a Mental Health Provider Performing Therapy and Additional Assessments

Sample CMS 1500

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO W MM DD YY FROM

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

18. HOSPITALIZATION DATES RELA MM DD YY FROM

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO

Opioid Dependence **Depression** **Screening for Mental/Behavioral Disorder**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A.	F11.20	B.	F33.1	C.	Z13.39	D.	
E.		F.		G.		H.	
I.		J.		K.		L.	

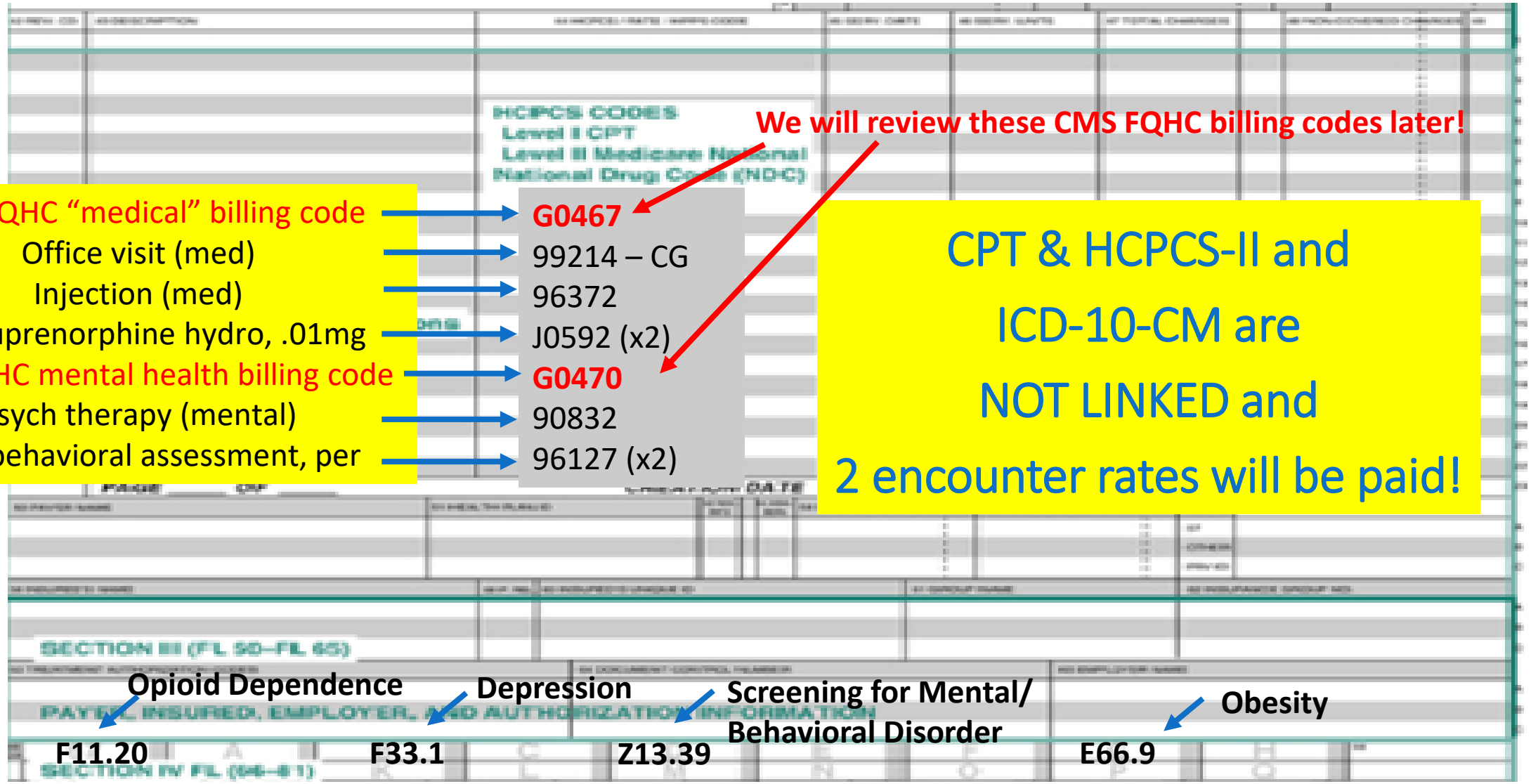
22. RESUBMISSION CODE ORI

23. PRIOR AUTHORIZATION NUMBE

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSD Family Plan
1 07	01	21	07	01	21	11		90832		B, A	210.00		
2 07	01	21	07	01	21	11		96127		C	20.00	2	
3													

Same Day Services by a Medical Provider & a Mental Health Provider in a FQHC to Medicare

Sample CMS 1450



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-II 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

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Sample Behavioral Health CPT Codes for SUD/OUD/MAT

+ 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)

Sample Behavioral Health HCPCS-II Codes Used for Billing?

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

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…

H0001-H0007

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

H0015

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

H0038

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

H0033, H0034

Oral medication administration with direct observation, medication training and support

H0047-H0050

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

H2010- H2037 – Time and Per Diem Codes

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

Possible 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.

G2067 Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a medicare-enrolled opioid treatment program)

G2068 Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)

G2069 Medication assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)

HYPERLINK

Source: *MLN #8296732 Billing & Payment Fact Sheet (May 2020)*


Q & A

Diagnostic Documentation and Coding for SUD/OUD/MAT

Basics of Substance/Opioid Use, Abuse, and Dependence

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

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

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

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

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

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

DSM-5 Diagnostic Criteria for OUD

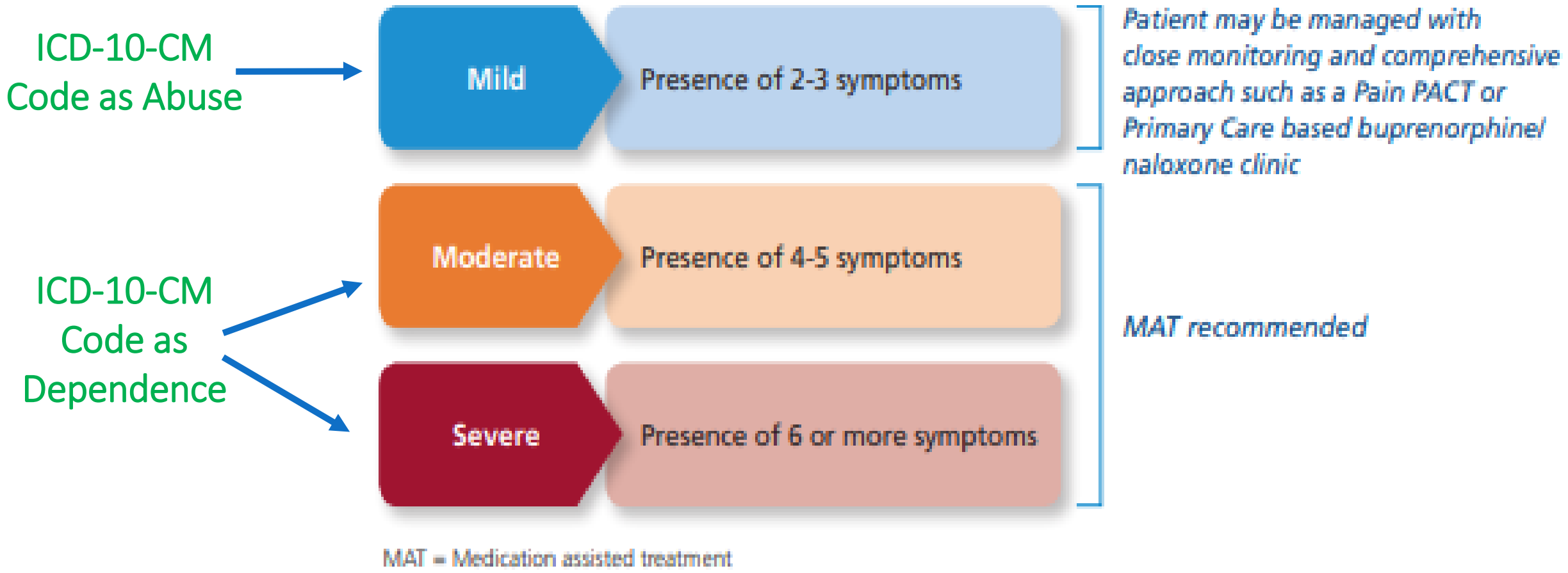
In order to confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period:

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



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

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Compare/Contrast: DSM-5 vs. ICD-10-CM

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

American Psychiatric Publishing
A Division of American Psychiatric Association

Criteria and Terminology

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

+

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

HYPERLINK

SOURCE:
https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM_Changes_from_DSM-IV-TR_-to_DSM-5.pdf

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Official ICD-10-CM Guidelines Review

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)

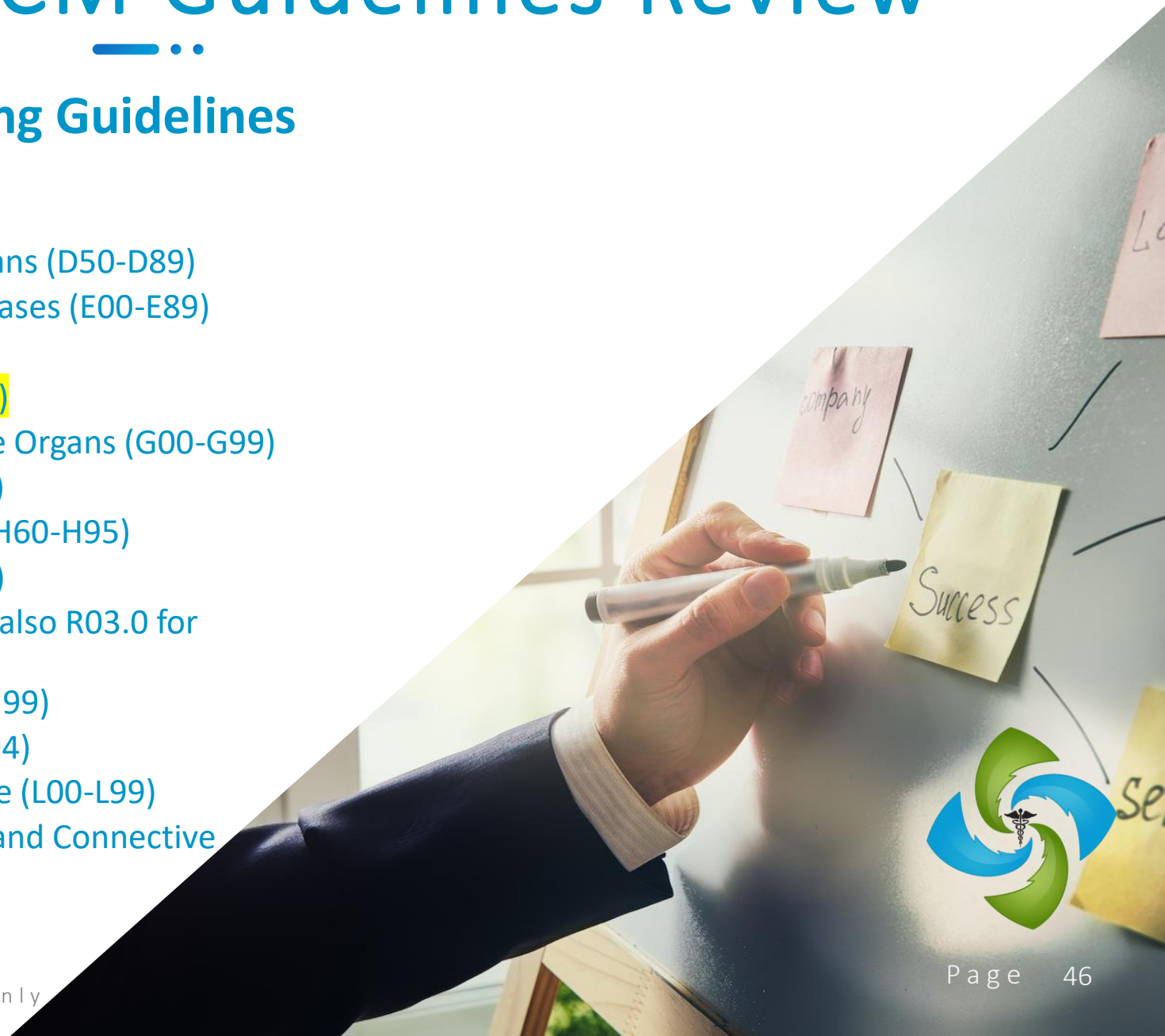
- Hypertension is in this Section (I10-I15) but see also R03.0 for elevated BP w/out hypertension

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)



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Highlights of Chapter 5 – ICD-10-CM Guidelines - Section I-C

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.

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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

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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.

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

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

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

Get More Documentation Samples

CLINICAL EXAMPLES

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

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

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

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

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

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

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

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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/

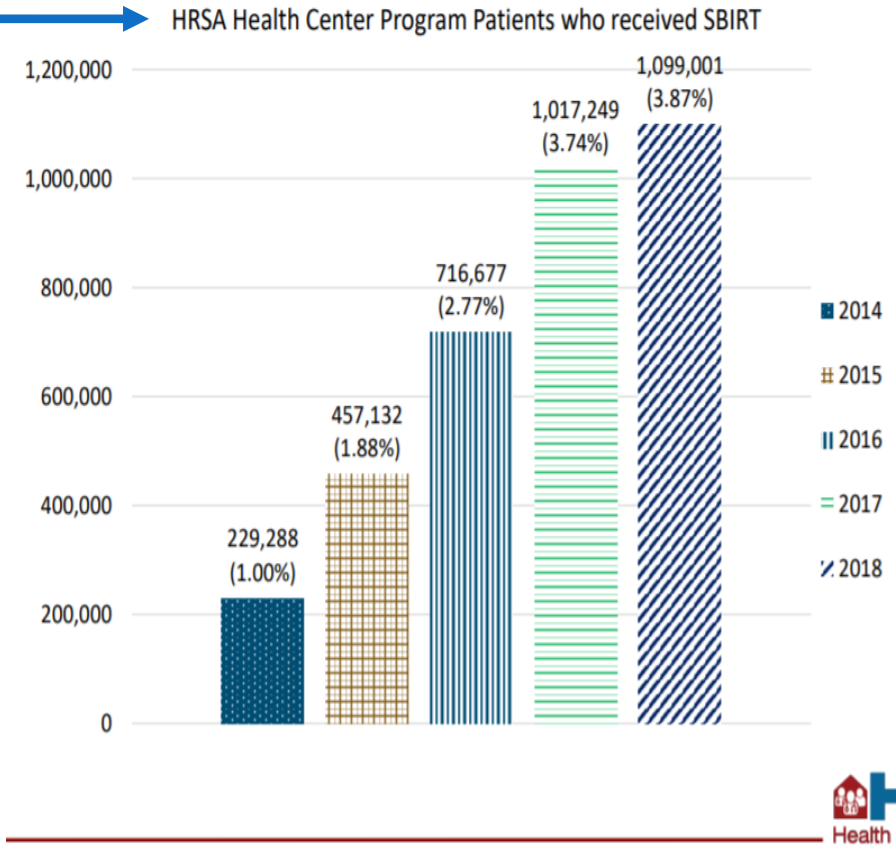

Q & A

Documenting SUD/OUD/MAT Visits

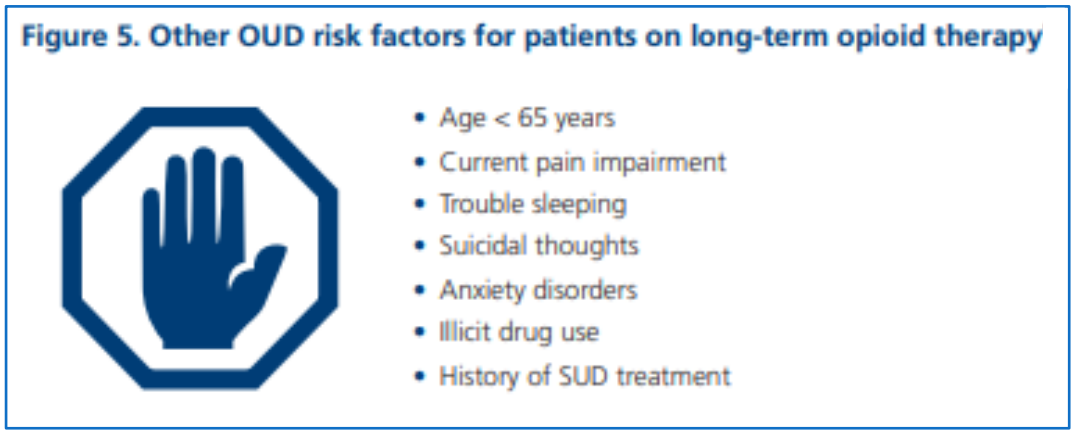
Common Screening Tools for SUD and/or OUD

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/

HYPERLINK



Sample Coding Options for Screening for SUD/OUD



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

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

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MAT Screening, Assessment, and Interventions Coding

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

SAMPLE CODING vs. BILLING

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

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

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

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

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Induction and Follow-up Visits Coding

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

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.

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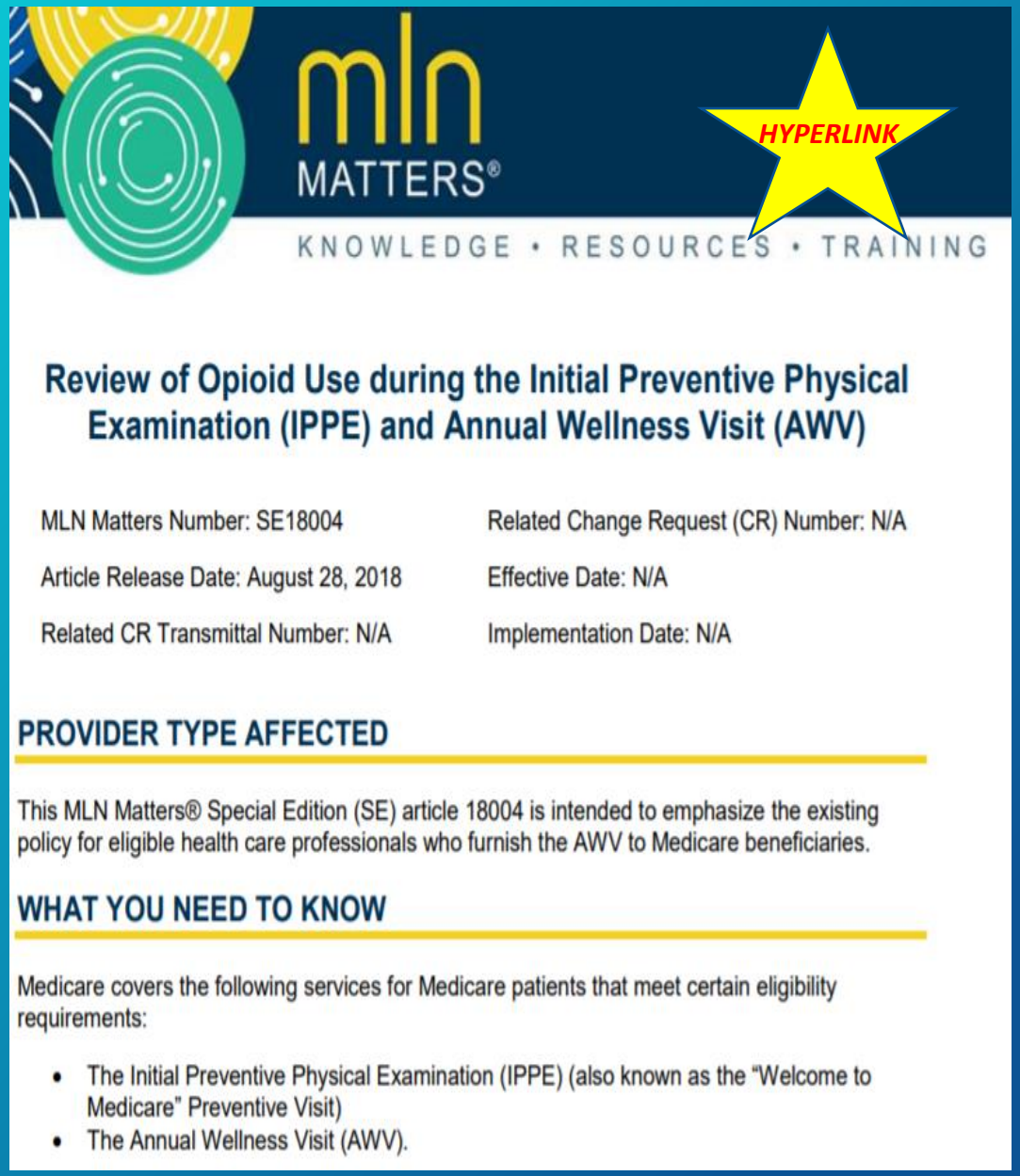
Screening during IPPE/AWV



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

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

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

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

PROVIDER TYPE AFFECTED

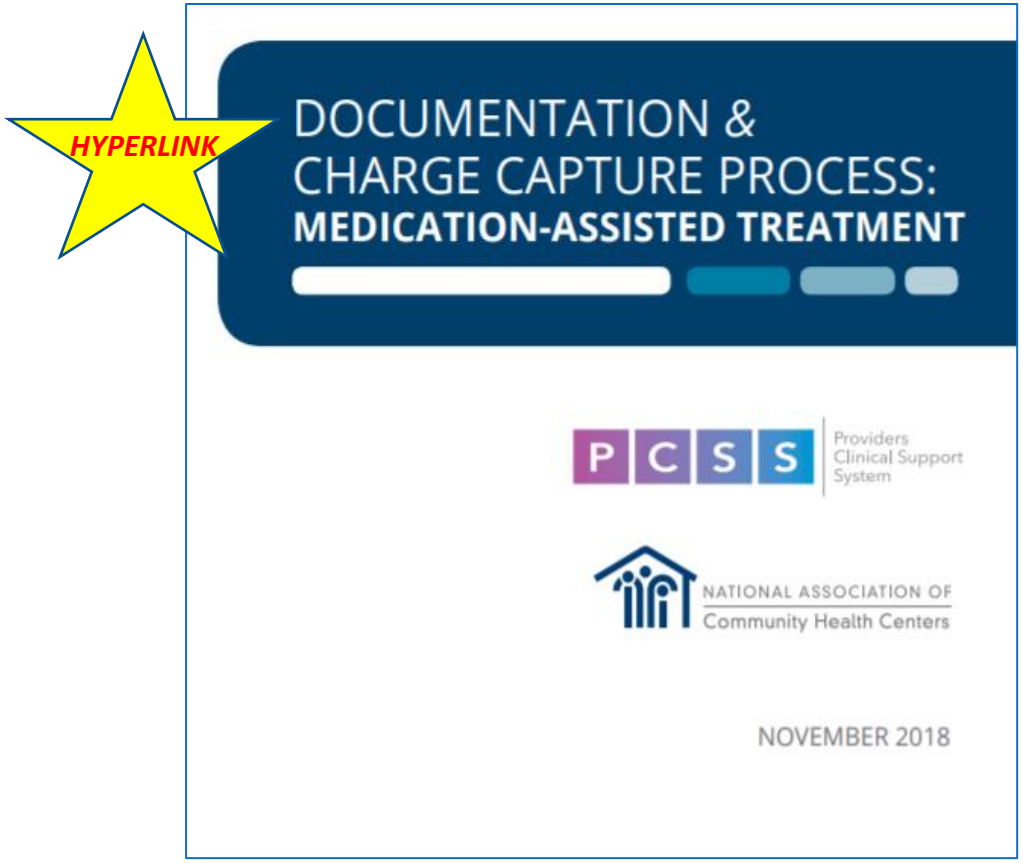
This MLN Matters® Special Edition (SE) article 18004 is intended to emphasize the existing policy for eligible health care professionals who furnish the AWV to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

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

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

NACHC's guide to MAT



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

PCSS Providers Clinical Support System

NATIONAL ASSOCIATION OF Community Health Centers

NOVEMBER 2018

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

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.

Times Associated with 2021/2022 Outpatient E/M

What is “included” in the new definition of time?

99202 15-29 minutes	99203 30-44 minutes	99204 45-59 minutes	99205 60-74 minutes
99212 10-19 minutes	99213 20-29 minutes	99214 30-39 minutes	99215 40-54 minutes

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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*)

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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"

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AMA's Trifold Medical Decision Making Tool

Table 2 – CPT E/M Office Revisions Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

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Evaluation and Management Code (E&M Level)	Number and Complexity of Problems Addressed at the Encounter	Complexity/Level of Medical Decision Making (MDM)
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

Evaluation and Management Code (E&M Level)	Amount and/or Complexity of Data to be Reviewed and Analyzed (NOTE: Each unique test, order, or document contributes to determining MDM!)	Complexity/Level of Medical Decision Making (MDM)
99202 99212	**Minimal or none**	**Straightforward**
99203 99213	**Limited (Must meet at least 1 of the following 2 categories)** • **Category 1: Tests and Documents** • Any 2 of the following: • **1.** review prior external notes, **2.** review results of EACH unique test, **3.** order of EACH unique test • **Category 2: Assessment requiring "Independent Historian(s)"**	**Low**
99204 99214	**Moderate (Must meet at least 1 of the following 3 categories)** • **Category 1: Tests, Documents and Independent Historian(s)** • Any combination of 3 of 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) • **Category 2: Independent interpretation of test performed by another provider (not billed)** • **Category 3: Discussion of Management or test interpretation with outside provider (not billed)**	**Moderate**
99205 99215	**Extensive (Must meet at least 2 of the following 3 categories)** • **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*** • **Category 2: Independent interpretation of tests** **1.** Independent interpretation of a test performed by another physician/other qualified health care professional (not billed); ***or*** • **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)	**High**

Evaluation and Management Code (E&M Level)	Risk of Complications and/or Morbidity or Mortality of Patient Management	Complexity/Level of Medical Decision Making (MDM)
99202 99212	**Minimal risk of morbidity from additional diagnostic testing or treatment** • Rest, gargles and bandages	Straightforward
99203 99213	**Low risk of morbidity from additional diagnostic testing or treatment** • OTC	Low
99204 99214	**Moderate risk of morbidity from additional diagnostic testing or treatment** • ***Prescription drug management (rx)*** • Decision for minor surgery with identified patient or procedure risk factors (0, 10 days) • Decision for elective major surgery without identified patient or procedure risk factors (90 days) • ***Diagnosis or treatment significantly limited by social determinants of health (SDoH)***	Moderate
99205 99215	**High risk of morbidity from additional diagnostic testing or treatment** • Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents. etc.) • ***Decision regarding elective major surgery with identified patient or procedure risk factors*** • Decision regarding emergency major surgery • Decision regarding hospitalization	High

COMPARE :: CPT Guidelines for codes 99202-99215

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 :

- https://www.ama-assn.org/system/files/cpt-corrections-errata-2021.pdf

CONTRAST :: CMS’ Guidelines for all other E/M codes

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:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

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

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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

HYPERLINK

SOURCE: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34616&ContrId=268&ver=32&ContrVer=1&CntrctrSelected=268*1&Cntrctr=268&s=50&DocType=2&bc=AAQAAAIAAAAA&

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**

HYPERLINK

SOURCE: https://pcssnow.org/wp-content/uploads/2021/07/Utilization-Management-Toolkit.pdf

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Q & A

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

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.**

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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

Excerpt From CMS Approved Telehealth List

LIST OF MEDICARE TELEHEALTH SERVICES		
Code	Short Descriptor	Status
99201	Office/outpatient visit new	
99202	Office/outpatient visit new	
99203	Office/outpatient visit new	
99204	Office/outpatient visit new	
99205	Office/outpatient visit new	
99211	Office/outpatient visit est	
99212	Office/outpatient visit est	
99213	Office/outpatient visit est	
99214	Office/outpatient visit est	
99215	Office/outpatient visit est	
99217	Observation care discharge	Temporary Addition for the PHE for the COVID-19 Pandemic
99218	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99219	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99220	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99221	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic
99222	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic
99223	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic

HYPERLINK

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.

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Documentation & Coding for VCS "Store and Forward" of audio/video

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

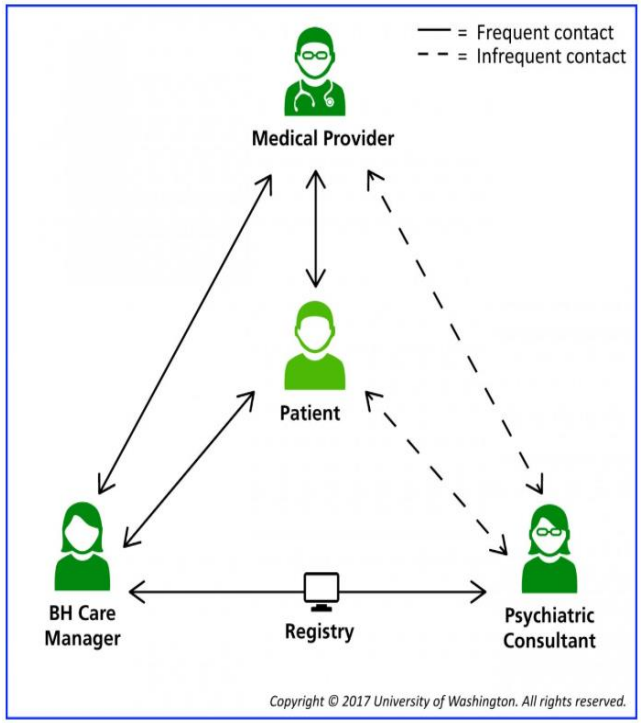
- Similar to Chronic Care Management (CCM), a primary care provider will track the total time per calendar month they spend supervising and directing the care plan for patients with a mental/behavioral/psychiatric condition (*including substance use disorders*).

- **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.



HYPERLINK

Check out their website for great additional info! https://aims.uw.edu/collaborative-care/team-structure

Documentation of a Psych CoCM Program

- **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.

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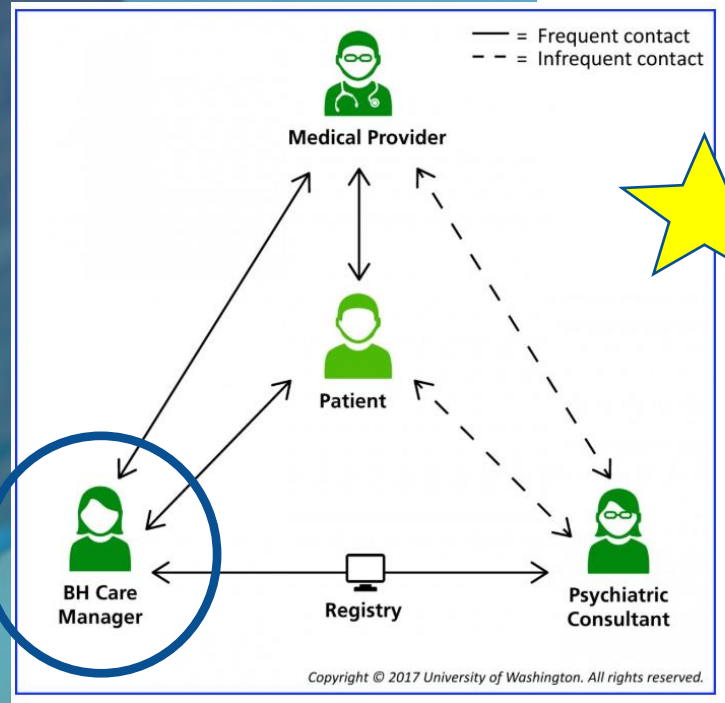
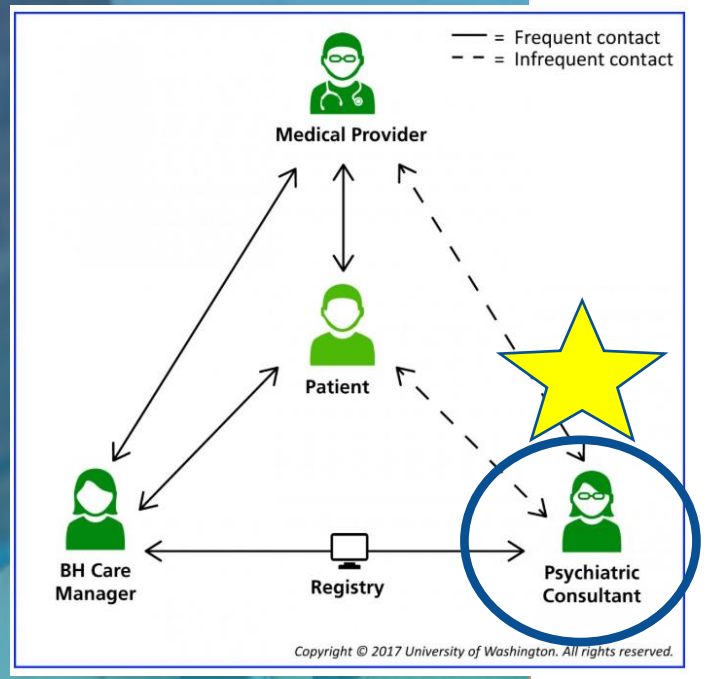
Behavioral Health Care Manager - Psych CoCM



- 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.

Coding for Psych CoCM

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

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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."

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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.

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Q & A

Thanks for your attention and participation!
This is our time to shine!

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