Phillip Stringfield (00:00:02):

All right. Hello, everyone. Want to go ahead and welcome you into part two of NACHC's Coding and Documentation training. My name is Phillip Stringfield and I serve as the manager of health center operations training here within NACHC's Training and Technical Assistance Division. Glad to have you all here with us today and as we get everyone trickling in. I'm just going to go ahead and go through a couple of announcements and give you some housekeeping reminders to navigate you throughout today's webinar. As we start, just want to go ahead and give you a reminder of NACHC's mission founded in 1971 to promote efficient, high quality comprehensive healthcare that is accessible culturally and linguistically competent community directed and patient centered for all. And of course, that work cannot be completed without all that you do and all that you provide to your community. So, we thank you here at NACHC and go ahead and move on.

Phillip Stringfield (00:00:55):

So as we get started, just wanted to remind you in just a couple of weeks, we'll be kicking off our conference season with the 2022 Policy and Issues Forum. That's going to be held February 14th through the 17th and if you haven't heard yet, it will be in all virtual offering. So, we definitely look forward to having you join us. We definitely have a lot of great sessions for you as well. So you can visit nachc.org. If you haven't registered already, you can also find the schedule at a glance as well for your review. And then just wanted to also put in a reminder for our upcoming event, you can move on to the next slide. The Practical Art of Health Center Operations Training. So this is our operations cohort, one of three trainings that we have coming this year.

Phillip Stringfield (00:01:42):

So our first one is kicking off the week after P&I that's going to be February 22nd through 23rd, and we're going to be talking a lot about wealth of different operations activities and things that you can focus on, strategies to retain staff and reduce burnout, strategies to assess your operations, and also looking at some [inaudible 00:02:04] strategies as well.

Phillip Stringfield (00:02:06):

So definitely looking forward to that. And if you want to find out more or pass it around to members of your team, we'll go ahead and drop a link in the chat for you to access that. And then you can go ahead to the next slide.

Phillip Stringfield (00:02:21):

So as we get through today's call, we do have a lot of folks on the line. We want to make sure that if you do have questions, you're putting them into the Q&A feature, and please make sure that you're able to logically put out your questions. So that way we can ask them to our presenter today. And if we're not able to get to your question, please make sure to hold it. And we'll be able to give you the contact information of today's presenter and I'll provide my email address in the chat as well. So that way, if you do have questions, we can work through those together offline. So we'll get through as many questions as we can, but with the amount of folks that we have, I can understand that we may not get through all of them. So put your questions in the Q&A, and we'll make sure to get to them.

Phillip Stringfield (00:03:06):

You can go ahead to the next slide. And so without further ado, I'm about to hand things over to Gary Lucas, with the Association for Rural and Community Health Professional Coding. Who's going to be diving into treating substance and opioid use disorder via a medication assisted treatment in community health. And I just want to go ahead and put the reminder out here that we will be providing the CEU index information at the end of today's call. We'll provide it in the chat and will also verbalize it for those that may be calling in, but you definitely have to make sure you stay towards the end. So I do see a question that someone says they haven't received the CEU, I'll check the email unless I haven't responded to you, but I've been trying to make sure I'm being instrumental in getting those responses back to you all.

Phillip Stringfield (00:03:51):

But that is how we're issuing these CEUs. You have to stay on the line to receive them. And then if you have any other questions, we can handle those offline as well. So with that, I'll go ahead and hand things over to Gary to get us started.

Gary Lucas (00:04:04):

I see here, I should be able to share my screen here in just a brief moment there. If you'll allow me a moment that requires me to move a couple of things onto the larger screen for those who I have not had the opportunity yet to provide instruction for. My name is Gary Lucas, and I serve as vice president of education for ArchProCoding, what stands for the Association for Rural and Community Health Professional Coding, shortened to ArchProCoding here after a couple years of being called ARHPC and the ACHPC. So we've summarized association for rural and community health as Arch Professional Coding. As you see on my initial slide, this is part 2 of the two-part NACHC webinar series on billing, coding, documentation, and reporting quality in this webinar series. So I want to thank Philip, Olivia, Brandon, Gervean, everybody at NACHC for giving ArchProCoding the opportunity to share what we get up every morning to do.

Gary Lucas (00:05:17):

And that is to serve you to assist both rural health clinics. Obviously, our focus is today on federally qualified health centers and community health. With information that's going to assist you in properly documenting, accurately coding and maximizing your billing and revenue finally gets you a hundred percent of what you're entitled to, excuse me. But no more than you're allowed. As Philip did mention here is my email address. First of all, I don't see the chat box or the Q and A as I'm speaking. So if there are pertinent or individual questions, depending upon where we are at the end of the session, please be sure to go ahead and grab from the slides you likely got prior to this session, or go ahead and grab it now. You can reach out to me at Gary@ArchProCoding.com. I'm here in Metro Atlanta, and I've been lucky enough as some of you may have known over the years to teach about 1900 full day courses on site in 46 different States.

Gary Lucas (00:06:25):

But even in the last seven days, this will likely be about 1500 people that I've had the opportunity to teach both through NACHC and the R core grant where we teach this full four hour course on the same subject we're talking about today, as well as our full certification bootcamp that I did over the last two days to a hundred people in 23 different States. So folks, this is wonderful that NACHC has given us the ability to share this information with you. And I want to just briefly identify and give you an introduction, some expectations and awareness of the course outline because I've been speaking a ton here over the

last week. Occasionally, I'm going to take a little sip here. And what I just realized this is also a reminder for me to let you know that the Atlanta Braves won the world series. I thought I'd throw that in really quickly.

Gary Lucas (00:07:18):

But in all seriousness folks, we're going to give you the information today based on research, experience and our training, but nothing we talk about today should substitute for any legal or consulting guidance that you may need. The needs you have, for example, as it relates to Medicaid carriers, widely varies even within your State, let alone with other folks.

Gary Lucas (00:07:41):

When you talk about commercial insurance companies, it depends often if the patient has the bronze plan, the silver plan or the premium platinum plan. For example, as to whether some of the medications utilized, if you're giving an injection or buprenorphine, Suboxone, et cetera, is going to differ. So we'll have to be really careful there. Many hyperlinks that we're going to give you could have been updated today. So if you have any issues with some of those hyperlinks, we're going to give you access to a lot of additional information, somewhat at a programmatic level, but definitely at the documentation coding and billing area that you can utilize to print a three ring binder, full of good information for your providers, your managers, and the coders and billers, to be able to give you some information, not only for existing folks, but maybe those who show up and are not used to, or haven't participated in either treating or reporting these extremely valuable rules, please, of course, do not distribute these slides to anybody else.

Gary Lucas (00:08:50):

It's only for those of you that signed up through this course. Of course, we'll be making numerous recommendations in references to the AMA, CPT book. I've got my book back here behind me and it is vital. And in every single class I teach, I want to point out to folks that coding software and non-AMA CPTs simply do not contain the same valuable information as far as documentation guidelines are that you get from the manual, the AMA licenses, their code numbers and code definitions to a variety of coding software vendors, to other publishers who print CPTs, et cetera. But the printed version of the CPT, for example, is the only place you'll find the 18 pages of information the AMA used to update their evaluation and management guidelines last year for the first time, since 1992. If you're in behavioral health and you're providing concurrent behavioral or mental health services to patients receiving medication assisted treatment from their primary care provider, you need to find out, maybe for example, how to report interactive complexity.

Gary Lucas (00:10:04):

There's over a page in the CPT about telling you what you need to document in order to potentially generate additional revenue. So I want to make sure you're aware of the references and resources. You should absolutely get your CPTs from the AMA because they only share code numbers and definitions with other vendors, not their documentation guidelines. As with all of our courses, we hope we have a fair representation of providers, who of course, from the clinical perspective, that's their primary job, but as it deals with the issue we're talking about today, the goal is of course, to document what they do and why. But the key as you notice me highlight here is that it's done per the official guidelines. And that's going to be maybe what we expose them to today. We hold facility leadership responsible for

coding because you are the ones making the policies and procedures that unify your community health center, via policies and procedures and workflows.

Gary Lucas (00:11:08):

You're signing contracts with insurance companies that might not give you enough detailed information that you need to properly submit claims and facility leaders can be the guides in soliciting that information from Medicaid, from your commercial carriers. And although we realize that coding is primarily done via a team session where the clinical providers finish their work, document what they've done, and they maybe fill out an encounter form or a charge ticket that is given to billing, sometimes before the note is closed. And so establishing these processes is important, and we're going to give you slide seven, eight and nine, to be able to take notes, to be able to jot down, a slide number, Hey, my providers were not able to join today, my facility leaders were not able to join today, or my billers were not able to join today, but this is where you can identify the concepts, materials, slides or detailed information that you may need with them by taking these notes.

Gary Lucas (00:12:16):

Please do keep in mind that I am not able to see the chat box nor the Q and A while I'm teaching, depending upon the time we have left and the volume of information that is in the Q and A box, I should say, not the chat box, the Q and A box, I will get to some of those questions today and give you our contact information to help out. Should that be important for you? So you should have been able to get, depending upon when you signed up access to the course slides, if not, we can have our esteem panelists assist you either now or following the course. Now I want to point out, this is the general course layout of a full four hour course. Believe it or not that I just got done teaching today. That to a particular grantee of what's called the R core grant, and we're doing a shortened version of that in the interest of your time today.

Gary Lucas (00:13:12):

So believe me, there are additional items to fill many of the areas we're talking about, but we'll first start talking about some of the items you need to do to prepare for these types of visits, things that you need to do before you open your doors. And then we'll move to the foundations of substance use disorder, opioid use disorder and medication assisted treatment, documentation, coding and billing. Interestingly enough, when you see the letters SUD and OUD, substance use disorder, opioid use disorders. What you'll see in the third section is an information that's going to clarify the fact that your clinicians may often use the term substance use disorder, opioid use disorder based on what's called the DSM-5. It is a clinical tool, mental health professionals and others use in order to determine the clinical diagnosis.

Gary Lucas (00:14:15):

But the facts of the world are that the same terms that are utilized in that DSM-5, from a clinical perspective may not match and likely do not match the diagnostic documentation rules as listed forth in the ICD 10 guidelines. For example, poly substance use was removed from the DSM-5 when they moved from the DSM-4 to the DSM-5, about the same time you and I moved from the ICD 9 to the ICD 10. So the ICD 10 actually takes use, abuse and dependence, and will be able to distinguish and identify more specific documentation items that may allow you to get the appropriate amount of prior approval for an extended course of treatment by using specific diagnosis codes, rather than for those of you familiar with this content, the F11.20, which is opioid dependence, uncomplicated. Next, we'll get into the documentation for these visits, and let's go ahead and establish it now.

Gary Lucas (00:15:28):

The vast majority of medication assisted treatment visits besides the screening and so forth are going to be captured via E&M codes. We don't have different evaluation and management codes for treating diabetes, hypertension, gout, psoriasis, et cetera. Similarly, with some very few exceptions near the screening, the brief interventions and/or the referrals for treatment, the majority of our visits here are done on E&M and there's a four hour course just on E&M that can be taught, but we'll present at a high level how to code the screenings, the induction, the maintenance, and the stabilization portions of your various visits, where you're either giving the patient a pill, an injection, or maybe even implanting a non biodegradable subdermal rod inside the patient that delivers the appropriate medication your providers felt was appropriate. And what we'll do to end is identify some options on and getting paid for non-face-to-face visits. We will compare telehealth to virtual communication services.

Gary Lucas (00:16:40):

We'll mention the behavioral health integration and the psychiatric collaborative care model because by definition, medication assisted treatment involves not only a medical provider for the most part, providing those medical treatments to the patient, but there's also concurrent behavioral health. So in that chapter for documenting SUD and OUD visits, we will also present a couple highlights on how you report psychiatric diagnostic, evaluative interviews or psychotherapy, et cetera. But we have about 90 something slides. And with 90 minutes in the course here, I will not be describing each slide in depth. As a matter of fact, several of them, I'm just going to present to you to give you a hyperlink. And it might be something that we've already talked about near the beginning of class, or may identify some options we wanted to include to you or for you to review for self-study.

Gary Lucas (00:17:44):

So the section overview of each of the items I've talked about are presented to you for the first two chapters on slide 11 here, and we'll touch on what an FQHC valid encounter is. What happens if you're using peer support coaches or peer recovery coaches, or how different provider types may be reporting services differently. What about insurance companies that you submit claims on the 1500 form, they're going to differ than things like billing Medicare on the old UB form. And so each of the items we've discussed, or at least we brought out to you there, are going to be described at a high level on slide 12 folks, and really matches what we do in the full four to four and a half hour course, but we'll provide an overview of during this presentation. So one of the things I wanted to do is make sure to establish some foundational principles for your providers and managers, for example, that may not be intimately familiar with some of the detailed differences between professional coding and medical billing.

Gary Lucas (00:19:02):

Well, similarly, I wanted to provide some of those billers and/or quality folks that report quality, a little brief background on the primary stages of when and why medication assisted treatment may be the appropriate type of care that is recommended by your providers. So, without going into each slide, I really found this VA opioid use disorder booklet, if you will, granted it was created in 2016, but it's not really focused on the billing and the coding rather to give care managers, front office staff, billers alike, an understanding that when you have an OUD program, one of the first things we focus on is making sure there's not a stigma that substance and/or opioid use is not a moral weakness or a willful choice. That based on genetics, based on your environment, based on a lot of other things, you may be more susceptible to addiction.

Gary Lucas (00:20:06):

And this concept of using an opioid agonist or a partial agonist to either prevent the opioids that the patients are using from being received, or to partially prevent those receptors from working by giving them, please forgive me clinicians, these substitute medications like buprenorphine, Naloxone, Suboxone, depending upon whether you're using the generic or the brand name as a substitute. And we'll go through those phases here in a moment. But I thought it was beneficial to give a little bit of information on the general issues associated with both substance and here in particular with opioid use disorders. So let's dive into that first section preparing for SUD-OUD and MAT visits. So without getting into each item specifically, if you've attended courses that I've taught out of the past, I'm not just going to read slides with you. I hope we can keep this somewhat conversational, a little bit interesting.

Gary Lucas (00:21:16):

I might even bring up a couple things. Yep. In a coding and billing class that might make you laugh. The day I don't have fun at work is the day I need to look for another job. But to maintain clearly defined policies and processes is not unique to this issue, but by getting and establishing regular communications between providers and revenue staff, specifically on the idea that professional coding is simply extracting usable data out of the medical record, whether we get paid or not for any of y'all. And by the way, I live in Atlanta, I'm going to say y'all, for any of y'all that are in a community health center, for example, on bill Medicare, you know, they don't pay for everything, but like they don't pay 99211 that's nurse visit, but we still did it. We still documented it. We should still capture it.

Gary Lucas (00:22:12):

We should still put it into our system in order to identify what was done. Same idea with medical billing here. Billing often requires us to translate existing codes, maybe from the CPT into different options for different carriers. Excuse me, depending upon which claim form they want, recognizing that some are paying you fee for service, some pay you per member per month, and some insurance entities like Medicare, and usually pay you via your PPS rate. Some people call it a per [inaudible 00:22:50] diem. I'm going to call it an encounter rate. So we'll make sure as it gets down to the billing to focus on community health centers, we'll have to lean towards Medicare, even though that may only make up 20 -

PART 1 OF 4 ENDS [00:23:04]

Gary Lucas (00:23:03):

... leaning towards Medicare, even though that may only make up 25, 20%, maybe even less of your patient population in this area, but where they go with billing, where Medicare goes I should say with billing, many or most other carriers follow. So getting that buy-in from providers and leadership at this type of training is necessary is of course, inherently vital to your success. So the primary phases involved here would be the screenings and brief interventions and or referrals for treatment. Towards the end of the presentation I'll give you a variety of codes, depending upon the insurance entity your billing that you may need to use. Now, once the patient agrees, and once we received informed consent to provide this type of care, we're going to induce the patient with one of these substitute medications, again, whether it's an injection, or a dissolvable pill, or even an implantable rod, we're going to induce them for the first week or so, and then over time, determine the appropriate stabilizing dose of the substitute medication, and then maintain them over time as we begin to wean dependence on the substances that may have contributed to the addiction.

Gary Lucas (00:24:21):

And then because these other positive drugs used in MAT are not addictive or are easy to wean off of, we'd work towards early or partial and or sustained remission. Now just alone right there, some providers may have different definitions that may or may not conform with the ICD-10's guidelines. So various tools, as you see here on slide 16 can be utilized to do that. Screenings or brief interventions now that abbreviation is SBIRT, but you don't have to use the SBIRT tool. There are other options out there that you can utilize, different structured of assessment tools that you can utilize to help determine maybe during a regular preventive medicine visit, maybe during that IPPE or the annual wellness visit, or maybe just during a regular old office visit for low back pain or during a traditional mental health visit.

Gary Lucas (00:25:21):

So we'll go review some details around the primary diagnoses used in this neighborhood codes F10 through F19. We've identified on slide 16 in the middle items what I briefly mentioned related to the induction stabilization and maintenance phases, and then on the bottom of 16, following an agreement between the patient and the provider, the maintenance phase may end with a gradual tapering of those visits. So very interesting and necessary area for you to gather information based on whether you're a provider or a manager or a bill or et cetera. And what I thought was a good material to use comes from SAMHSA, the Substance Abuse and Mental Health Services Administration. Now, these are just little screenshots, of course, of a much larger document that they've created, but nobody better than to go to HHS and HRSA and SAMHSA and so forth for the specific information here that doesn't necessarily go into details on the coding, but can help provide some of that background to understand the different approved medications that are used to treat opioid use disorders, alcohol use disorders, et cetera.

Gary Lucas (00:26:44):

Now, when you see on my slides please, one of these little yellow stars, that means that not the star, the star itself is not a hyperlink, but whatever picture or underlined item I have of on the slide is the hyperlink. For some of you, when you open a PDF, if your browser opened the PDF, those hyperlinks may not be active. You should be able to download a free what's called Adobe Reader, which will make those hyperlinks active. But if you have any issues with those or a hyperlink has changed, we're giving the email address for myself and for Philip at MAT, should you need any assistance down the road. Now for any clinician here, we're not asking slide 18 to be used as a clinical guide, but it's comparing general opioid agonist therapies, whether it's buprenorphine or buprenorphine used in conjunction with Naloxone, which is traditionally office based, it partially prevents the other opioid from attaching itself to a receptor.

Gary Lucas (00:27:58):

You'll notice here that whether it's the left hand column or the right hand column, whether it's appropriate traditionally for either what's called mild or moderate opioid use disorder, whereas methadone is more on the mild, moderate and or severe opioid use disorders. But please keep in mind when it comes to ICD-10 codes, you will not find words like mild, moderate, or severe, rather you're going to find ICD-10 codes for use in some cases, abuse and or dependence. So when we get to that diagnosis area, I want to make sure that we've already described and discussed potentially what your clinical providers will find the most value with, and that is how to translate clinical terminology to coding terminology. Now, even though when you see up there on methadone, right there, it says specially licensed OTP. You will find in many cases, as it's listed on the bottom there, that the phrase OTP is an opioid treatment program.

Gary Lucas (00:29:07):

Let's be careful with that term because as a community health center, or even if you have other types of facilities in your network, you do have a program that treats opioid dependence. But an OTP program essentially is certified by SAMHSA, and you'll hear many people call it a methadone clinic. So there's a variety of different coding approaches and billing approaches. Our focus is going to be on that blue column. And I think those general suggestions for treatment may be beneficial for many of you to be aware of the need, not only for this medication assisted treatment, but for addiction focused medical management and or behavioral counseling that occurs at the same time. So some prerequisites that you should anticipate for providing medication assisted treatment is to, first of all recognize the primary medications used. We're going to focus on Suboxone slash buprenorphine and or naltrexone, whether you're using the generic or brand name of some of these drugs.

Gary Lucas (00:30:15):

As I mentioned a moment ago, methadone is only dispensed via a certified OTP program. So it is almost assuredly not your community health center. But here's the fun part. And by the way, anytime I say, here's the fun part, whatever I'm about to say is not going to be that fun. And that is although your MDs and your, PAs and your NPs, et cetera, are able to prescribe opioids, able to prescribe under key conditions, morphine or Brompton's cocktails, and some really, really super heavy duty medications, in order for your provider even though they're licensed as an MD or a DO or a PA or an NP, they likely have to get additional training eight hours for docs, excuse me, or about 24 hours for PAs and NPs. Are you ready? Here's my highlight to get a waiver that allows them to provide buprenorphine. So, I'm not the clinical guy, but it's kind of confused me how I can provide medications that cause addiction but I have to go through specialized training for those that are going to hopefully help the patient on their road to recovery.

Gary Lucas (00:31:38):

But keep in mind if your providers have already earned or received a what's called a DATA 2000 waiver, an X-DEA waiver, they are authorized to provide buprenorphine. But many community health centers are located in urban health professional shortage areas. But as you are likely aware, high urban areas also have health professional shortage areas. I'm about five miles east of downtown Atlanta, city of eight, 9 million people, but I'm in a health professional shortage area. And so what we're locating is at the very bottom here is that there is a large national effort of foot to expand buprenorphine providers that are not commonly located in rural areas and or even urban health professional shortage areas. There's the barrier to get care with that buprenorphine. There's a stigma that we have to overcome for how we treat and handle patients coming in with these concerns.

Gary Lucas (00:32:46):

I've had several providers over the years tell me, look, there's even a stigma in our community of us being a buprenorphine provider. So slowly but surely, I should say in my opinion, there are movements of foot to expand the utilization of buprenorphine to providers maybe for a year without having to get that waiver to be able to prescribe it. So, for example, for those of view that are already, or I should say already have buprenorphine providers who got their DATA 2000 waiver since January of 2009, follow these hyperlinks folks. As I mentioned, in addition to MAT, and as I do for arch pro coding. Arch pro coding provides all of the coding and billing training for what's called the Rural Communities Opioid Response Program. It is a massive brand coordinated by HRSA to help bring opioid response programs to

rural areas. And this training that we provide through our corp is free if you meet the terms and guidelines there.

Gary Lucas (00:34:04):

So if you are part of a consortium or you are an R Corp grantee, please reach out to your HRSA case officer who will get you in touch with a company named JBS International and we may be able to provide the full four hour course to you through the RCORP grant, potentially at no cost to you. But I wanted to use their newsletter, which is helpful and beneficial for all that came out back in October of 2021. And I've seen NACHC put emails out about this and other organizations, there's a bunch of money put out there first come first served. As of today, to my knowledge, this money is still available that if you fill out the forms and you achieved your DATA waiver prior to 2019, and you work in an FQHC, there's $3,000 per buprenorphine provider that is available right now. Another wonderful situation is if you do work in a community health center that has a valid and approved MAT program, those providers will likely be eligible for more federal loan repayment programs.

Gary Lucas (00:35:20):

So I don't know the exact number, I think there are three to four of them. Should you provide a valid medication assisted treatment program in your community health center, those providers might be eligible for up to 75,000 or maybe even a $100,000 of loan repayments, which should entice and bring in more providers to the communities where it's needed. So use these hyperlinks, be aware of those opportunities to attract high quality providers who are providing this service and are authorized to do so, even money's available out there. Well, on April 27th of last year, there was some positive news. I'm here to give you some positive news as well. HHS released an opportunity, hold on to your chairs here, this is going to get a tad confusing. Remember how we had to go get that waiver in order to provide buprenorphine? Well, effective on this release April 27th what the HHS press office released is you can actually apply, are you ready for this to get an exemption from needing a waiver.

Gary Lucas (00:36:35):

To speed up the opportunities for providing buprenorphine there, look at the bottom of this slide 21, please. You can get an exemption from the waiver that would allow you to treat up to 30 patients with buprenorphine and not having gone through that waiver process. So what we wanted to do here on the next slide is give you information from SAMHSA, the Substance Abuse and Mental Health Services Administration, with some details on how you can treat up to a hundred patients with buprenorphine instead of that 30 patient limit. But in addition to the SAMHSA kind of a summary, if you will, I also wanted to give you access to the actual what's called the federal register. The federal register, anytime HHS, or somebody in Congress or a new regulation or rule comes out, these are published to the public via the federal register.

Gary Lucas (00:37:34):

It's a much longer document, it's very detailed, but depending upon your needs or the impact this could have on your facility and thus on your patients, this is where they say, "Okay, here were the proposals we put out. Here is a summary of the public's response to what should have been there. Okay? And then here's their final decision and their rationale." So that's going to be the deep source information. And by the way, I'm kidding here but if you can't get to sleep at night, start reading the federal register. You'll get a little tired after a couple pages, but I did want to give you not only the SAMHSA summary, but to give you access to the source documents of particular importance. And even for those of you that

maybe didn't get the slides or it went into your spam folder, or you signed up after the slides were sent, make a note about slide 22, because this is where you would create a notification of intent to fill the forms out that would prevent you from needing the waiver and would allow you to provide buprenorphine to 30 patients.

Gary Lucas (00:38:49):

But after a year using this waiver, you can increase that 30 patient limit by going ahead and completing the eight hour training for MDs and DOs and or the 24 hour training for PAs and MPs. But that buys you a little time for those patients that might need this service. And clearly as we have COVID and a significant change in our patient flows, et cetera, this can help. All right, next, slide 23. Couple years ago, as I started doing some of this particular, very subspecialty work here, I found this readiness guide and created by the. National Council for Behavioral Health. There's 8, 10, 12 pages of stuff here broken down by clinical issues.

Gary Lucas (00:39:43):

What I picked was the financial and or regulatory readiness information, which instead of me being the coding and billing and documentation guy, let's just establish very clearly as Philip was kind enough to put on the introductory slides, coverage and reimbursement for MAT is going to vary between both the public sector, I think Medicare and Medicaid and the private insurance marketplace. Whether they require some form of pre authorization these are the kinds of questions you want to ask. So whether or not I should say you are in a grant such as RCORP grant or another state or local, or even another national guide, these are good issues to help you determine your readiness for how you're doing. Do we know what Medicaid and commercial insurance companies require? Do we know which formulations they will cover? Have we made arrangements with internal or external pharmacies?

Gary Lucas (00:40:51):

Are we purchasing the medications, et cetera? What are the out of pocket costs for the meds, so that if the patient may not have the financial capability to pay for it themselves, if it's appropriately billable, you may be able to contact the manufacturer orders to see if they have patient assistant programs, et cetera. We are pretty confident that our MDs and DOs should get paid, less confident but pretty darn good that our NPs and PAs by us being a community health center are going to get paid for appropriately medically necessary services. But what other clinicians are allowed? Clinical psychologists, clinical social workers should be able to continually as of this moment report the concurrent behavioral health of it being provided. But what about things like what are called peer recovery coaches often call peer support specialists or a variety of different names out there, it kind of depends on where you're located? But these are individuals that may have taken some classes. They might have earned a certificate. Heck they might have even earned a credential and depending upon your state, maybe even a licensed to be a authorized part of your clinical team. Question is they may be authorized and licensed by the state, but which insurance companies find them reimbursable members of the team. And so this was just what three or four questions here. And there are more, and this short of amount of time that we get to spend with each other I hope you get the opportunity to go review these in more detail to provide some help. So slide 24 is really covering everything we just said. You're going to need to gather state specific details for Medicaid, who the authorized providers are and oh, by the way, don't be surprised, especially when it comes to billing guidance. When you look at a Medicaid behavioral health manual, even though medication assisted treatment is normally provided by a medical provider rather

than behavioral health, don't be surprised when you see different approaches from different payers. Some might want to see PT code.

Gary Lucas (00:43:15):

Some might want some of the HCPCS level two codes like G codes or H codes or T codes out there. Many of which I'll provide you here in upcoming slides, but as we shared in last week's course, depending upon what either you were with us or not and as I do in any course I teach, we need to be able to recognize that you cannot bill people the same. This concept that we have to bill everybody the same is just factually incorrect. We got to treat everybody the same. We got to document everybody the same, but depending upon the claim form I used and how that insurance entity is paying me, the billing may absolutely be different. Now, if you have to convert a CPT code to a HCPCS code, your charge for those services has to be the same. That's what has to be consistent. Work closely with your staff leaders.

Gary Lucas (00:44:13):

And of course not only MAT who is the main entity for you out there, but work closely with your state primary care associations. I've worked with Michigan, South Carolina, a variety of different state associations, where this full course has been taught as well. So hopefully this summary is going to provide you with some beneficial information. Next kind of keeping the pace, moving here, slide 25. I love this word, mandatory. Mandatory Medicaid state plan coverage of medication assisted treatment. Now notice this came out in December of 2020. And what they're looking to do is increase access to medication assisted treatment. And what I've highlighted on this slide for you is that the support act requires states to provide Medicaid coverage of, I love this word it's dangerous, certain drugs and biologicals and related counseling services and behavioral therapy.

Gary Lucas (00:45:24):

So the intent of this was from CMS to your state health officials to require Medicaid plans, to include coverage of MAT for all who are eligible to enroll. So granted, this is just half of one page there. So what I've provided you on slide 26 are at least a couple items that at least jumped out to me. Some of which may be beneficial for providers, some for managers, some for billers, but what caught my eye is that the new required benefit was supposed to go back all the way to October of 2020.

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Gary Lucas (00:46:03):

The higher benefit was supposed to go back all the way to October of 2020. So if you have legislative folks in your state or political advocacy folks that work at a state Medicaid level to increase coverage for community health, this may be valuable polite ammunition that you keep, another arrow in your quiver, and maybe they've made positive reimbursement changes, but they didn't come into effect until mid last year. Maybe you can go back and figure out how it can be included in a cost report, maybe reimbursed later, et cetera. So which drugs they traditionally provide reimbursement for, what the sum of the details on what buprenorphine/Suboxone does. It's a partial agonist. It weekly activates the receptor for the opioid versus an opioid antagonist, not addictive, that actually blocks the receptor from processing the opioid. And that may be more for the billers, of course, clinicians are aware of this.

Gary Lucas (00:47:05):

And then on page four, a breakdown of the MAT benefit to include counseling and services provided by those peer support specialists. I should have mentioned peer support specialists or peer recovery coaches are individuals who have been through this themselves. They have reached the road to recovery. They've gone through the issues and the problems, and they want to be able to be a member of the care team. The only issue I found with this is the footnote that I followed on page four took me back to a 2006 or a 2007 document. So hang tight for a moment because I will provide you a link to a document that might help you update your visibility into your state's appreciation, understanding, and/or coverage of these viable and valuable team members.

Gary Lucas (00:48:01):

And then on page 16, so that tells you, of course, how long this document is. It does discuss and talk about the appropriate usages of telemedicine as a tool to expand buprenorphine-based treatment for OUD treatment and so forth, particularly in rural areas. And remember, we'll end this.

Gary Lucas (00:48:21):

Class with that section that compares telehealth versus virtual communication services. So I'm going to leave the majority, excuse me, of slide 27 to you, which you may be able to utilize after this course to generate and initiate conversations with your colleagues who may be couldn't attend. So, one of the things I had already mentioned earlier, just to make sure there's no surprises here, that the traditional billing for MAT provision relies on a team approach, led by a medical provider, probably reporting E/M visits and/or a mental health professional at the same time. And then just what I stated earlier that we will discuss at the very end, what you may refer to as kind of the care management services. You'd likely have heard of principal care management or chronic care management. Those are for medical providers directing their clinical staff time in between patient visits. And if I get to 20 minutes, for example, a month, I can get paid for a lot of that work that I do directing the care of my patients' medical problems. Well, the behavioral health integration concept and the psychiatric collaborative care model are kind of like the care management services for your MAT provider or your primary care provider overseeing the patient's mental or behavioral work, or maybe it's a 20-minute minimum threshold per calendar month for behavioral health integration or even a 60-minute minimum threshold for psychiatric collaborative care.

Gary Lucas (00:50:10):

At the very end of the presentation, we're going to give you some content that will help you distinguish which one of these has a 20 minute, which one has a 60-minute threshold, which one of these could optionally utilize the services of a behavioral care manager and let's say a psychiatric consultant, an MD, or an NP with specific psych training that can help update and adjust psychiatric medications. Well, which one of them requires the participation of a behavioral care manager and a psychiatric consultant?We'll touch on that at the end. But this has kind of given you an idea from how do we initiate referrals all the way through how do we manage things that are going on in between patient visits.

Gary Lucas (00:51:02):

So here is a way to utilize or research using "non-licensed" providers. They may be credentialed by your state. They may have earned a certificate in your state. But what this organization did, the National Academy for State Health Policy, at least the last version that I could locate in November of '19, is they went to different Medicaid agencies to see how different services are performed to understand state education training, and educational requirements and this information back then was also shared with

Medicaid and other state leaders. Particularly use that to research your peer support specialists or peer recovery coaches, but it may include additional providers who may not be licensed but should be and can be a viable part of your treatment team, if not that team that can get reimbursed. So I'm going to put the Q&A up there, folks, but we are going to move ahead due to this being a one-and-a-half-hour version, of course, of a full four-hour course. So we will handle questions at the end. And for those that maybe did not join when we first signed on, the CEUs will be given out at the very end part of class.

Gary Lucas (00:52:23):

So here's a comparison of the 1500 form that you're going to use when you're just looking for fee-for-service payments from commercial insurance companies. All right. On the right-hand side, of course, what you're going to be using as an FQHC to submit claims to Medicare. What I want the clinicians and the managers to look at is how differently you're going to bill. I'd like you to focus on how the diagnosis codes may or may not be linked to the codes in order to receive payment. And I'll show you an example here in a moment. On the left-hand side, I list my ICD-10-codes. On the left-hand side at the bottom, I list my what did I do. But the key is this star, how do I link each diagnosis listed to the particular service that I'm reporting, here's the kicker, in order of importance. All right. In order of importance.

Gary Lucas (00:53:22):

But I want you to use the example for the next slide I'm going to put up. Let's assume that you have both medical and mental health providers in your community health center, and that you do a medical visit for Matt on the same day as behavioral health. Now, if you did that to a commercial insurance company or another carrier expecting you to bill fee-for-service, you're going to submit two claims, one for medical, one for behavioral health. Well, those established billing veterans in the audience know that FQHCs when we're billing Medicare and maybe even some Medicaid carriers, we put the what did we do codes up here for both providers. We put the diagnoses down here that were documented by both providers. Whoops.

Gary Lucas (00:54:13):

And notice that I did not need to point the diagnosis codes specifically to what was done. So this idea we're going to bill everybody the same is shot out of the conversation. When you see a sample fee-for-service claim for a provider maybe giving a shot for substance and opioid use, and folks, it doesn't matter to me what order these diagnoses go in up here. It doesn't matter. The primary reason these services were provided was opioid dependence. However, the diagnosis rules indicate that I must also list additional diagnoses that were documented as affecting care. And during that medication-assisted treatment, we mentioned the patient has depression, we identified their receiving care, and obesity was also mentioned. But notice that only in this particular case did diagnosis A make it to the claim. I did the office visit for opioid dependence. I injected the drug for opioid dependence and the drug code.

Gary Lucas (00:55:18):

Now, if you'd have reversed those diagnosis codes and had obesity, then depression, and then opioid dependence, well, I would just have put the letter C, over here. So again, I don't care what order the diagnoses go in, it's what am I linking and bringing it down. Well, here's your sample fee-for-service claim for a mental health provider that listed similar diagnoses up top, but what is the primary reason they provided 30 minutes of therapy? Well, the first reason is depression; therefore, it needs to be listed in the block first, and oh, by the way, during that visit for depression, we mentioned that the patient and we documented they have opioid dependence, so it should be listed. And you see B, A there.

Gary Lucas (00:56:08):

What if that provider also did a health or behavioral assessment tool? And in that case, that was done for screening for mental and behavioral disorders, et cetera. So two different claims, two different ways of linking the diagnoses. But, hey, man, if you're an FQHC and you're billing Medicare ... Again, for those that weren't aware when I first taught, I've taught over 1500 people in the last seven days so forget of me for real quick if my voice is just a tad, pardon me, just a tad tough to deal with here.

Gary Lucas (00:56:47):

So when you notice all of the diagnoses listed here at the bottom on the UB form, we have very specific billing that we have to deal with in Medicare. Everybody, both the medical and the mental health providers are going to be listed here. So I'm going to have the GO467 as my primary medical billing code. I need you to do me a favor here real quick, mark out that CG, that is not correct. I apologize for that. All right. But you have your office visit, your injection, and then the J code for whatever you injected, plus the psychotherapy, plus the behavioral health assessment. But I didn't need to link those diagnoses. So a big part of this is when, in my opinion, it should be all the time, should your provider be linking these diagnoses. Now, if you're telling me to get the bill out of the door quickly, but the note is not closed, your biller probably can't look to see why these services were provided. But you notice, different codes are used, different processes are used, and those diagnoses are not linked and you should get two encounter rates from Medicare. So this is an example of a slide that I'm going to leave for you for your own self-study. If you're inserting or removing a non-biodegradable drug delivery implant, please make sure that you are also reporting the implant itself, assuming you paid for it, et cetera, using one of those J-codes. On the medical side, we'll do drug testing, maybe behavioral assessments, maybe give an injection, and a variety of E&M services. But we do want you to be aware of the J-codes for the drugs and even a couple Q-codes for buprenorphine extended-release. You may need a modifier for a particular insurance program to identify that this service was provided as a part of a substance abuse or opioid youth program.

Gary Lucas (00:58:55):

So as we work our way through, you're going to see me towards the end of the presentation. My job here is to show you the full scale of everything that needs to be done rather than reading each slide. You'll notice here on the left-hand side, we've got our psych evaluations, our psychotherapy that we might perform via what's called interactive complexity. You'll see the add-on code 90785 when your provider has to adjust their treatment for a patient to overcome barriers to communication, whether that's a language barrier, they have pre-Alzheimer's, organic brain disorders, et cetera.

Gary Lucas (00:59:36):

But one of the things my established billers out there can tell me is, hey, wait a minute, we've got, down here, behavioral health integration and the psychiatric collaborative care model and there are CPT codes for it. Well, managers and providers look at the complexity of what your billers have to deal with. If it's Medicare, they have to convert that to a GO511 or a GO512, that is defined as rural health clinic/FQHC behavioral health integration.

Gary Lucas (01:00:12):

Now, wait a minute, I'm starting to show you some H codes, where do these come from? So what we want to give to you on slide 37 is a list of H-codes that are unique to Medicaid and are very unique to substance and opioid use disorders. But what I can't tell you is we don't know which carriers are going to

require these. Some of them might want the CPT codes. Some of them might want these H-codes. My job is to identify the universe of billing options for you, whether it's HOOO1 through OOO7 for alcohol and drug assessments and case management and interventions.

Gary Lucas (01:00:55):

Maybe some of you have an intensive outpatient program that's three days a week, at least three hours a day, and it includes everything being done. Please keep in mind when I share with you the diagnostic rules if you're not aware of the difference in abuse versus dependence, maybe abuse authorizes a six-week program, maybe dependence authorizes a 12-week program, so all of this is interrelated. HOO38 is likely what is used if your Medicaid carrier considers peer services, as we've talked about reimbursable. And so whether it's the oral medication administration, drug testing, handling specimens, brief interventions, or even community services, notice that your carrier is not usually allowed to give you billing guidance unless they printed it in their manual.

Gary Lucas (01:01:53):

So understanding when these H-codes may be needed versus these T-codes that are again, absolutely specifically created for Medicaid. But depending upon your state, maybe you have three or four Medicaid programs, they might require to different codes. Maybe you have nurse evaluation services with the first two. Maybe you have family and couple counseling for Medicaid with this T-code. Maybe you get paid your PPS rate, or your all-inclusive, or your encounter rate using code T1015, and there are some additional options for screening, or even depending upon who owns your clinic, maybe you're associated with an inpatient or a long-term residential treatment program.

Gary Lucas (01:02:44):

So this is not a class for us to just read slides. I want to show you what we've got for you. And to give you an example of what might be next for us is that those opioid treatment programs, to me, have a much more simple way of billing because they bill a weekly bundle of either methadone, buprenorphine, or whatever, whether it's oral or injectable that covers everything. So possibly the future holds for us a more simplified billing process that it's going to include everything, giving the medication, the counseling, the therapy, and the testing, and all they would have to do is drop the last words in parentheses specifying this is for an OTP program. But down the road, that's a possibility. I just wanted you to be aware as you're going through.

Gary Lucas (01:03:36):

So what we have here in the last 25 minutes, folks is I wanted to present to you some of that information you can do for your research on diagnostic documentation and coding for SUD. I've already described that the clinical tool your providers use uses terms that are not often found in the ICD-10 book, particularly with early versus partial and late remission. And I did want it also point out a very important issue especially, for example, with recreational or medicinal marijuana or other opioid use. For example, there's no opioid use code in the ICD-10 because opioid use in and of itself is not an issue.

Gary Lucas (01:04:22):

If documented drug use is not treated or noted as affecting the patient's physical, mental, or behavioral health, you do not code it except in pregnancy. So examples would be a septal ulcer due to cocaine use or tachycardia due to methamphetamine use. But if it doesn't impact their physical, mental, or behavioral health, unless the patient is pregnant, it's likely not listed, definitely as a primary, let alone a

secondary diagnosis. So what I've presented to you on slide 43, maybe for the coders, maybe for the billers, maybe for the managers, is here is the criteria that your providers are likely using in order to confirm a diagnosis of what they're are going to call opioid use disorder, but we need to translate to an ICD-10 code that at least two of the following should be observed within a 12-month period.

Gary Lucas (01:05:22):

And although slide 43 is on the OUD side, notice down here, substance use disorders has a very similar list of 11 items utilized to establish that clinical diagnosis. So what we see on slide 44 is the likely determination of whether there's two to three of those symptoms is mild, four to five is moderate, and six or more may be deemed severe opioid use disorder. And what we've done here is clarified that according to the terms used in the ICD-10 if your provider documents mild opioid use disorder, that should be coded as abuse, whereas moderate and severe would be listed as dependence. And we've already given an example about how that may not just indicate or identify whether you're going to get paid or not, but it might be on that how many days or weeks should we maybe get preauthorized for. All right.

Gary Lucas (01:06:33):

And so highlights particularly for you providers is to identify that there's not a one-to-one relationship between the ICD-10 codes and the DSM-5. For example, look at this. When they went to what's called the DSM-5, the DSM-5 doesn't even separate a diagnosis of substance abuse versus dependence. But you better believe that the ICD- 10 does. There's not a necessarily consistent definition printed in the ICD-10 that early remission is less than three months. I said that wrong. At least three months, excuse me, but less than 12 months without that substance use criteria except for craving. So this is only one of several documents that are out there to assist you in understanding these high-level diagnosis issues. And the idea of use versus abuse versus dependence comes from the ICD-10 official guidelines, section one, subsection C, chapter five. And that's the resource that I'm quoting here, which confirms for those providers that may be using the terms use, abuse, and dependence. What happens if you document both use and abuse? Well, you only code for abuse. If you document abuse and dependence, you only code dependence. If you documented all three, then you code for dependence. Okay.

Gary Lucas (01:08:13):

So the impact that has on reimbursement, prior approvals, et cetera, cannot be understated. Hopefully, we're keeping this at a good pace and not keep you bored. Well, if we were to take a universal survey out there, I bet F11.20 is not just one of, but unfortunately, maybe even the only diagnosis providers are using, not through fault of their own. We have to train them. We need to give them this full set of diagnostic options. We need to show them the ICD-10 that team-based training. But look at the differences here. Maybe what used to take two or three different diagnoses in the ICD-9, maybe in one diagnosis code. Maybe it's opioid-

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Gary Lucas (01:09:03):

... One diagnosis code, maybe it's opioid dependence with opioid induced psychotic disorder with hallucinations, maybe it's opioid dependence with other opioid induced disorder or sleep disorder. So when your public health folks are, they're not worried about whether they're getting paid or not. They're really about, how are we treating patients? How often do they move from complicated opioid

dependence to in remission, in many cases. This is just with the opioids. This is just one screen of about eight pages in the ICD-10 book that are designed to give you access to more detailed coding in this particular case for opioids. But on the next several slides, what I wanted to do is share with you some basic tips here, some basic tips for the different categories of F codes that are out there. For alcohol related disorders, you may end up reporting what are called prolonged service codes because the patient wasn't in my office for the traditional several minutes, but they were intoxicated. They were here for three and a half hours.

Gary Lucas (01:10:09):

Well, in addition to alcohol related disorders, if they're intoxicated, I need to also code their blood alcohol level. Well, remember on the claim, if their blood alcohol level is linked as the first diagnosis, probably not going to get paid. But also to identify coexisting conditions as we just did and showed a quick sample of for opioids, notice it says, do not code from this section for prescribed opioid use. That word doesn't exist. We have to go to the mild being abuse and moderate and severe being coded to dependence. I bet we could do a 45 minute class just on that section F11. So there's combination codes that can combine intoxication withdrawal, excuse me, perceptual disturbances and issues related to cannabis guidelines are just like what was listed above.

Gary Lucas (01:11:13):

And as I scroll through and present to you, I'm going to give them to you. We're not reading every slide here, sections for sedatives, hypnotic and, and anxiety disorders, pain related disorders, other stimulant related disorders that could include caffeine, methamphetamines, bath salts, and so forth, all the way to hallucinogen related disorders, where we start seeing different usage as of early and or sustained remission that may require your providers to establish a consistent definition across various providers. Of course, nicotine dependence there, it changes whether it's cigarettes or vape or chewing tobacco or dip, et cetera.

Gary Lucas (01:12:03):

So we wanted to keep this fast paced. We wanted to keep this moving and we wanted it to be comprehensive. So I appreciate the hour and a half here, but you'll find differences again, as you heard me stating the introduction that indiscriminate or poly substance dependence, excuse me, although removed from the DSM is included in the ICD-10. And so each of those options is beneficial. And here's an example from a great manual that can give you hundreds of pages, maybe about four dozen, two dozen, three dozen related to you are subject today.

Gary Lucas (01:12:40):

But if you want to get an additional sample of good diagnosis information, consider accessing that manual and make sure if there are social determinants of health that are documented as affecting the patient's care there that we've look at, hey, they may have barriers to achieving recovery because they live in a home with other users. Although we gave them 10 pages of information about what it means to get medication assisted therapy, they may have problems related to education or literacy, or we're asking them to go through a lot of specific items here. These social determinants of health, each of those categories has more specific diagnosis codes. These should never, ever, ever, never, ever be used as the primary diagnosis.

Gary Lucas (01:13:43):

But as we described in last week's session, please go view that one, the impact on documentation of decision making might significantly assist you in maybe even raising E and M levels based upon inclusion of these on the claim. And hats off to NACHC, even when I'm not teaching community health centers, I send them to NACHC's PRAPARE tool, P-R-A-P-A-R-E. They're like nine YouTube videos on how you can capture social determinants of health, how valuable public health finds them, templates and how to do so and capture these so that public health can help track and monitor disease progression through our work.

Gary Lucas (01:14:35):

So in the last, what do I have here, I've got about 10, 15 minutes, I'm going to continue the process here. But for those that joined earlier, keep in mind, I do not see the Q and a box. I see a little thing flash up in the corner of my slides, but I do not have access to the chat box nor the QA box. We'll handle that, as well as the CEUs in a little bit. I did see that somebody sent me a private message. Folks, I can't see them, but we'll be sure to hang tight for questions. But with as many people as were signed up for this webinar, we may have to tackle that individually.

Gary Lucas (01:15:13):

The usage of the SBIRT tool, we've already described, which is the screening brief intervention referral for treatment, likely matches when we had a public health emergency declared for the opioid epidemic. And whether you're using the ASSIST tool, the CAGE-AID tool, or any other tool approved by the United States Preventive Service Task Force, you should be able to report one of these options depending upon the insurance company there. 99408 and 409 as I recall, should show up on our FQHC qualifying visit list, but maybe some carriers want the almost exact same code GO396, GO397. Maybe as we pointed out for patients who are coming in for even unrelated visits may need for Medicaid, remember these H codes were for Medicaid, alcohol and or drug screening, maybe there's covered preventive services for Medicare. So, that will present to you some options on how to report the screening section of your medication assisted treatment phase.

Gary Lucas (01:16:31):

Whereas the initial assessments that are provided in a community health center may have either been for a visit expressly for substance and opioid use. But, hey, as I mentioned earlier, they might be during an unrelated medical visit or one of my preventive services or the behavioral or mental health provider realizes that it's appropriate at that time, or to get them to medical for those same codes we just shared. But by presenting it this way on slide 60 and clarifying coding versus billing, you might be able to use these slides to generate good conversations with your colleagues. Same idea with the induction and follow visits. They're mainly E and M visits. Maybe I gave an injection and need to list what I injected. So not new information here, but I wanted to give you a couple options. And I do realize that for those of you that are following along on the phone, you likely will need to go back. And I'll defer to Philip and the folks from NACHC about when this class should be available, if you either didn't get the slides or are just calling in. This is definitely very much a visual presentation.

Gary Lucas (01:17:49):

And as I stated at the onset, I wanted to show you how much information is out there, such as slide 62, which confirms Medicare's desire to have you perform a review of opioid use during the welcome to Medicare physical, during the annual wellness visit and not surprising, I give it to even other folks that I teach besides community health, back in 2018, there is a wonderful document, to my knowledge, it's

not been updated yet, that goes into details on creating internal and external referrals, how to scrub charts and in particular, appendices, E, F and G giving you FQHC specific information. Although a couple codes may have been updated. I think most of them are still the same, if not all of them still the same there. And as another wonderful document, maybe to be right there on the front cover of the three ring binder, when you go look at the 20 something hyperlinks we've given you here.

Gary Lucas (01:18:57):

So what we presented last week in terms of how to report E and M visits, we did this in last week's session. So it's an hour and a half discussion on its own. But do remember please, that the way you report E and M visits have changed as of last year, and you're going to be able to report either time, and there's a lot of information we spent last week talking about what's included in the new time codes, or you can use medical decision making. And the medical decision making item is a good 30 minute discussion as well. So continue to look towards NACHC and to those that you trust for ongoing E and M visits, because a lot of providers tend to down code themselves and may be surprised to see the codes that are likely better represented for your traditional medication assisted treatment patient. And so I did want to just provide the outline of an AMA tool related to the updates on decision making. And I'll tell you right now that that patient that comes in for MAT likely has a moderate complexity in the first category, even if it's absent in the second category, but by definition, you likely, in this case, 99214s are not going to be surprising regardless of the amount of time you spend with your patients for medication assisted treatment.

Gary Lucas (01:20:36):

And so in the last couple minutes that we have, let's confirm that we now have different documentation requirements on slide 71 for office or outpatient codes. Whereas, those traditional longer E and M guidelines still exist if you go to a hospital or observation or ER, or a nursing facility. As promised on slide 72, we're giving you documentation for the behavioral and mental health folks. 72 is what's going to be required for your diagnostic interviews. And slide 73 and 74 for psychotherapy. And in particular, the idea that mental health, although defined as 30 minutes, 45 and 60, often doesn't meet those exact time limits and may be reported once the midpoint has been reached. So as I continue to wind up here and show you what we have folks, I wanted to give you an additional document from the American Society Of Addiction Medicine that adds some good clinical examples, adds an appendix on translating ICD-10 to the DSM-5.

Gary Lucas (01:21:59):

And so I anticipated this last section would be more of a bonus chapter and the full set of slides I teach for the full four hour course here, it's something like 143 slides. So I took about, what was it, 50 something slides out of this just for you. But what I'd like to do as a way of finishing up here, folks, is in this section, we do identify things like transitional care management, virtual communication services, telehealth, and those behavioral health integration and collaborative care model options. So without going too quickly through those slides, what I'd like to do is share with you on 78, that there's a comparison of those items and that the next, what is it, about dozen slides are going to help you understand other telehealth considerations. I think it's clear to you, even if you knew nothing about documentation, coding and billing for substance use, opioid use and medication assisted treatment, that there's a lot out there.

Gary Lucas (01:23:14):

We talked more carefully about telehealth considerations in last week's top 10 revenue IDOs for community health. We had 875 people last week for that one. But I felt it important to just give these couple slides to you, to outline CMSs current approach to telehealth, their current approach to virtual check-ins and what's called the store and forward technique where we've even had providers for MAT say, I'm not sure that patient's actually taking their dissolvable pill. I want them to upload video of them taking their pill. I'm not saying that's a valid clinical procedure, but it is potentially reimbursable. The last couple slides, as I've already outlined that behavioral health integration is a type of care management service, where even though the CPT gives you the code I'm highlighting here on slide 83, Medicare wants the GO511 as long as I have 20 minutes a month documented.

Gary Lucas (01:24:24):

And it may optionally utilize a behavioral health manager and a consultant. Whereas on slide 84, the psychiatric collaborative care model requires the addition of new team members, such as a behavioral care manager and site consultant. So because the University of Washington made this popular, I've given you a link that's going to give you some good programmatic information and the documentation. There's over two pages of information in the CPT that need to be reviewed. And I'm going to leave you with that comparison of the primary responsibilities of a behavioral health manager, who's got to be a masters and doctoral level staff member, the psychiatric consultant who may never even set foot in your office. And I leave you with the proper coding for commercial insurance company and Medicaid utilizing the CPT codes on slide 88.

Gary Lucas (01:25:33):

And folks, at this point, let's see if I made it. We made it with about four minutes to spare. There's a lot more opportunity for y'all to get training here. And the last several slides, what I've done, knowing that this was going to be a high paced overview, is I've captured several of those action items like, reviewing your participation contracts to get MAT specific answers, to confirm that there's a difference in coding and billing, to review the official guidelines for those F codes and to focus on linking diagnosis codes.

Gary Lucas (01:26:16):

So thank you for letting me give you a presentation that contained more information than we can go over for you to truly ingest this. But hopefully it gives you an outline and a high level understanding of the complexities involved in the work and the valuable, valuable work that you do. At this point, I'm going to stop sharing my screen. Please grab my email address because we anticipate you have questions. Now, real quick on this slide on 94, for those of you that had the slides sent to you prior to this course, down here at the very bottom, there was a little footnote that I utilized for our RCORP training. Okay? So this session was not provided as a part of the RCORP grant. That was just a little footer that in the next version of the slides and the version available for you on the recorded version of this, once it comes out, this was 100% provided to you by the National Association Of Community Health Centers, as the second of two parts of the documentation billing and coding webinar series.

Gary Lucas (01:27:27):

And at this point, I'm going to turn it over to Philip and say significantly, thank you. And I thank you for your attention. This is our time to shine. Both NACHC and ArchProCoding get up every day to serve you. I thank you for how you serve your community. Phillip, I'm going to turn it over to you, sir.

Phillip Stringfield (01:27:53):

Awesome. I want to thank you, Gary. It seems like you've been a rockstar with us the past couple of weeks in attending these other trainings that you've been leading. So we definitely want to appreciate you and thank you for your time that you committed to us and ensuring that we stay on top of decoding and documentation with our yearly series. So we definitely appreciate your partnership. So as we wrap up today's webinar, I did want to be mindful of those that were sticking on for the index code, for the CEUs, for those that are on, I have already put that in the chat. And of course, if you would like, you can go ahead and send any questions that you would like to Gary and myself, we'll make sure to get those questions answered for you. We do apologize that we did not have enough time. But as we see, there was a wealth of content we wanted to make sure we got over to you.

Phillip Stringfield (01:28:40):

And of course we want to just remind you again, that slides will be shared after today's call. This call was recorded and will not be eligible for CEUs, but we will get both recordings sent out to everyone who registered within two weeks. So I would say by the middle of next month, you should have both recordings sent to your inbox. So once again, we thank you for your time. We look forward to serving you at a future event. And thank you again. And please make sure you complete the eval when you see it in your inbox. We appreciate your feedback. So thanks again and take care.

Gary Lucas (01:29:14):

Thank you everybody.

PART 4 OF 4 ENDS [01:29:20]