Transcript: Documentation, Coding, and Billing for Behavioral Health Integration
September 3, 2025

Kayla Baker: Welcome to the Behavioral Health Substance Use Disorder Integration Technical Assistance webinar, Documentation, Coding, and Billing for Behavioral Health Integration Part 1. This webinar is supported by the Bureau of Primary Health Care of the Health Resources and Services Administration. Participants have entered in a listen-only mode. Submit questions by using the question-and-answer feature. To open the Q&A, click the Q&A icon at the bottom of your Zoom window.

If you experience any technical issues during the event, please message us through the chat feature or email bphc-ta@bizzellus.com. This event is being recorded, and slides will be available on the TA portal following this event. We offer Behavioral Health Continuing Education units for participation in BHSUD integration technical assistance events. You must attend the event and complete the online Health Center TA Satisfaction Assessment Form after the event. A link with instructions will be provided at the end of the session.

CE certificates will be sent within five weeks of the event from the Health Center BHSUD TA team via Smartsheet. We're excited to share that we have more Continuing Education opportunities coming up for you. Please register now for the fall webinars, including Part 2 of Documentation, Coding, and Billing. There is also space available to join the current communities of practice. We'll add these links to the events and chat momentarily so you can take a closer look.

I am pleased to introduce you to today's presenter, Gary Lucas, Vice President of Research and Development, ArchProCoding. Gary provides strategic and tactical direction as well as maintains and administers ArchProCoding's Rural Health Clinic and Federally Qualified Health Center certification programs. Mr. Lucas has conducted more than 1,900 in-person national seminars on medical records documentation for physician and outpatient-based medical centers. These seminars address professional coding, medical billing, Medicare compliance, and practice management. It is now my pleasure to turn the webinar over to Gary. Gary, please go ahead.

Gary Lucas: Well, thank you very much, Kayla. Thank you very much, Bizzell and HRSA, and the Bureau of Primary Health Care, for giving me the opportunity to share some information with you that will assist in you sustaining a successful community health center, both with medical and behavioral health services. Of course, as you know, I wrote most of that introduction. I'm actually now over 2,200 courses feet on the ground in 49 of our 50 states. I'm honored, again, that ArchProCoding, which stands for the Association for Rural and Community Health Professional Coding, remains a trusted source of education and training content.

We have a few things to do before we start today's session in order to get us oriented to not only today's session, but the one that will be held on September 29th, going a tad deeper into some of the areas we're presenting today. Today is, somewhat at a high level, not as many slides as you should expect us to review on the session on the 29th, but the opportunity for you to utilize the resources that we will include today with this presentation via the hyperlinks that

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are located at the very end of the presentation rather than being embedded into the slides that you're going to look at.

I will always tell you when I bring up a piece of information where I got it from, who is the reference source, what is the document from a commercial carrier or Medicaid that might help guide you to a different answer than you would in terms of how you bill Medicare. Because keep in mind, when I say FQHC, we're talking Medicare and Medicare only. You also operate, from a coding and a billing perspective, as a traditional medical office to commercial carriers, but to some managed care entities, there are different approaches.

That will be a theme that we have today, if you'll go back up to the top of the training disclaimers, in addition to the hard content and the technical resources we'll share with you. Don't be surprised, even though we're only together today for an hour, I do have some opinions. We would love to hear today or via email if there are any issues that makes your facility a bit unique. We might need to adjust some of our content.

Please join us today by reviewing and being aware of our objectives. Number one, to analyze, the keyword here, varying requirements imposed by different insurance payers. Now, coding doesn't change based on your facility type. Billing absolutely changes. The idea, believe it or not, in my 30-plus years of doing this, is the words coding and billing actually mean something different to folks. Now, if you're doing the job, you know the difference, but we are hopefully going to provide some insight into the needs of coding that goes beyond getting reimbursed for your services, beyond getting 100% of the revenue you're entitled to, but no more than you're allowed.

We have cost report issues in a community health center. Of course, we'll use the terms FQHC and community health center interchangeably, but when it comes to billing, this idea that "I thought we had to bill everybody the same" is factually incorrect. What we have to do is charge everybody the same. When I go through the content, I'll help support objective number one.

Also, by identifying key elements in clinical documentation that are crucial for coding and billing in health centers, in essence, folks, to not rely on an EHR's shortcuts or software rather than on building a shared platform of knowledge for various staff members. Third, how to outline our clinical documentation practices to support ongoing sustainability. It is true, FQHCs are essentially nonprofit entities, but if you don't earn a profit, you can't reach your mission. Our goal is to do so, keeping the patient at the center of everything, but recognizing the different roles that people have.

Ms. Kayla, may I ask for your assistance in putting up the poll and the quiz? This is a live poll. As you're answering these questions, we'll await to hopefully get a couple of hundred replies here. We'll make a few comments on that before we move into the information.

Question number one, and you may begin answering now, please. Even though this is just a single choice, and I think it's a pretty safe bet that all of these are, of course, vital and important, whether you're looking at it from your individual perspective or your responsibilities as a facility leader, which of these would be your primary, I guess we can say, administrative challenge, non-clinical, when integrating behavioral health services into your health centers?

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As we are looking to these answers, I'm not sure if we can see the results as they're popping up live. I do want to go to the Q&A box to answer those questions while you answer the Q&A chat. There we go. The web education is being recorded. At the very end of the session, they will remind you where it's going to be located as we continue bringing in the results from the poll. Ms. Arcelia, yes, and you may have just joined a second after Kayla brought it up earlier, but she will provide a reminder that the slides will be available, and I don't want to mispeak to where they're located, but in the TA area where you're used to getting resources.

We see at the very top, a nice bit of responses, 260 responses from you. That documentation piece is vital because when we outline the resources, your clinical providers likely have not gotten access to the detailed documentation rules they need because the software in Electronic Health Records does not go into the level of detail that they need, and we'll help with that today. The coding and billing processes, of course, are imminently dependent upon your workflow and how you stay organizationally aligned in order to maintain both your clinical goals and your revenue goals. Insurance pay and requirements, of course, just about up there at the top. They change, and they are different.

For those that might be new to this, and I've been informed that a fair bit of you are new to this issue and new to this arena, you may have been involved as either a provider, revenue cycle manager, CFO, CMO, coder, or biller in a traditional office. You're used to getting paid fee for service for most services that you provide to the insurance companies. Boom, automatically, you're now at an FQHC or a community health center. That means you know we're talking Medicare, and we now, for the majority, not all of what we do, we get paid $1 amount, referred to as an encounter amount. You'll see later why I don't call it a per deal.

Staying up with the regulations, the insurance payer requirements up there, knocking almost 40%, is going to be absolutely an important issue. In the other area, it could be which providers are authorized to get paid by Medicare. It could be different than it is with Medicaid and different with other payers. We welcome those questions. Kayla, it looks like we've reached a pretty good cap there. I believe she can share those results. I don't see anything too surprising there, but I hope you notice how interrelated each of these are. See where your answers are compared to others.

I'm not sure, Ms. Kayla, how I can have that removed to not cover the screen there. What I'd like to do is move forward and begin to outline the responsibilities that we have at this level. Let's see. I'm just going to X out of the screen there, bear with me just a moment, so I don't see the poll results. All right. Perfect. Who needs education in this arena? The answer is everybody. Software does not support anything beyond the code number and the code definition to your clinical providers. We absolutely want to make sure that the work they do is never impacted, that they maintain the ability to care for their patients the way they believe is best, according to the policies of your office.

It literally sometimes comes down to what the word annual means. A provider is told they need to do an annual wellness visit on a patient, and they do a comprehensive exam. Folks, the annual wellness visit, your coders will tell you, does not even have a physical exam component. Sometimes these highly semi-complicated issues comes down to coding and billing or different issues. An annual visit doesn't have an examination element.

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We're going to bring these together starting today, continuing on the 29th, because facility leadership has a very tricky job, of course. That is to ensure that we meet both our clinical and our revenue goals to include, now, in all of your free time, cost reporting, which is a yearly issue unique to rural health clinics or rural or urban community health centers designated as a federally qualified health center.

Your billers have a very complicated job that is 100% dependent, 100% dependent on the accuracy of the information in the medical record, and is it documented according to the AMA guidelines in our CPT book, the HCPCS Level 2 codes, which are created and maintained by CMS, and of course, the International Classification of Diseases 10th revision, clinical modification?

Our goal is listed under the light bulb. Organizational alignment is a focus. Revenue capture. Optimal quality reporting requires us to build a system over time that guarantees that no matter what we learn today, September 3rd, 2025, as everybody in this industry is likely aware, something can change in one week. If you're watching this recording, be sure to follow and track the resources that we're presenting here or in other sessions so you can stay up to date with the inevitable changes that are going to occur.

Now, when we start, we have to start with the CPT manual. Yes, I'm actually referring to the printed version of this manual that although the AMA licenses these code numbers and the code definitions to other entities, there are other publishers that have CPT manuals, but none of them, to my knowledge, actually contains the information in between the codes, the educational guidance that might precede a set of codes, in particular with behavioral health.

The good news, if you consider it good news from the CPT perspective, is as it ties into behavioral health, there's only about six or seven pages in the CPT book that applies to the services you provide. Now, if that's the good news, the bad news is you only have about six or seven pages in the CPT book that identifies what you've done, and it doesn't get into the level of detail that other payers, such as Medicare and Medicaid, need. The CPT book is the start. The Professional Edition is the one that has pictures and diagrams that will prove helpful for clinical providers, professional coders, and medical billers, but all codes in the CPT book are numbers.

When we talk here in a little bit, for example, about a behavioral health concept called interactive complexity that might be added as a code to a traditional psychiatric evaluative interview or an intake, or might be added to a traditional therapy service, whether it's insight-oriented, behavior-modifying, interactive, or cognitive therapy that might be needed to add to the codes. If we're dealing with a commercial insurance company that pays us a fee for each service we provide, that is appropriate revenue.

If documented according to the four paragraphs that you'll never see in your software, unless you have a program called Codify, or, to my knowledge, a program called SelectCoder, the only way to get access to those four paragraphs and other similar information is to get the AMA CPT book or one of those programs. Now, the key here is there's not one word in that manual that has anything to do with money or insurance. That is a coding book. Professional coding extracts data out of the medical record to describe what was done, what supplies were used, and, of course, when we get down to the ICD-10, what diagnoses are applicable to our diagnostic and our therapeutic services.

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When the CPT book doesn't have something that Medicare needs, and as you well know, where Medicare goes with billing rules and billing regulations, a lot of other non-Medicare payers follow suit or use that as a foundation, we now need to be aware of codes that begin with the letters A through Z. These are referred to as HCPCS code. Now, you can get a HCPCS book from a variety of publishers. You can get it from any book because it's literally just code number and code definition. It does not contain detailed descriptive documentation guidelines, code number, code definition writ large.

Specifically, to mental health and or substance abuse or substance abuse services, they have codes just for use for Medicaid. I'll show you here shortly some H codes, which are reserved for Medicaid payers, but it does not mean they're going to want them. It means they could choose for you to use an H code as a substitute for a CPT book. Again, I know we have some coders and billers that know this stuff in depth.

I'm going to start at this higher level before showing some of these variations, but the research we need to do as it relates to CMSs, or the Centers for Medicare & Medicaid Services HCPCS Level 2 Codebook, we have to go do research into key documents we'll present to you today. They are Chapters 9 and Chapter 13 of the CMS Claims Manual and Benefit Policy Manual.

Now, you'll notice it's written for both RHCs and FQHCs. You heard me mention earlier, federally qualified health centers, community health centers, can be in either a rural or an urban health professional shortage area. 92.6% of the rules, I made that number up, apply equally to our friends in RHCs and FQHCs. They publish it all together, but we have to be really careful as a community health center to watch out the research we do with what's called the Medicare Learning Network and a variety of other resources that you gather on the internet.

We have to be careful when doing our research on how we get reimbursed that PPS, or what's called that prospective payment system amount. I called it an encounter rate. I would like to dissuade you politely from calling it a per diem. For those content we'll see on the last slide. When you go look up either national or local coverage decisions in something that we will present to you on the September 29th session, called the Medicare coverage database, that will allow you to take your CPT codes, HCPCS codes, and diagnosis codes, and get an idea about likely Medicare coverage.

We're providing a B12 injection on the same day that our mental health folks are doing a psychotherapy. Which diagnoses cover that service? How often will that service get covered? As I, for example, use the example of the annual wellness visit, folks, excuse me, and that it doesn't require a physical examination, you can find all over the internet that a nurse, for example, or a pharmacist, are allowed by CMS to perform the annual wellness visit, codes G0438, G0439. We'll present those in more detail on the 29th.

Well, folks, that is a Medicare document, that is a Medicare release that applies to only fee-for-service providers, not us. We have to be real cautious as a community health center doing research on even Medicare guidance because we have to make sure it applies to us, because we are different than fee-for-service providers. Based on everything we just talked about, of course, folks, I have no knowledge of each of your insurance companies, let alone Medicaid. There's at least 130, if not 140 different Medicaid programs. Some of them might want an H code for certain mental health services, others want a CPT code, and heck, there might even be

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a G code that has the words federally qualified health center in it that changes the way we bill for a service.

All right. Got Kristen in the Q&A box. Do we still want to add the higher-paying codes even if we're getting or charging a PPS rate? Excellent question, Kristen. The key here, and what we'll review in a little bit more detail, but I'm going to give you the resources to look at, is you have to indicate on a claim, let's say if we're talking Medicare because you did bring up PPS rate, we have to, first of all, have a code on the claim form that coders and providers will never see. You're going to hear me refer to it in a little bit as a bat signal. The first code that goes out to Medicare is a bat signal, but instead of it being a bat, it's a dollar sign.

Well, the next code on the claim better be on what's called the qualifying visit list. Kristen, well-timed question there. One of the last things we'll talk about, especially on the session on the 29th, and we'll give you a hint at it here, is that code must be the next code on that claim. However, you are then required to list all other services provided down low. It's true if you did an office visit, 99213, you'll get paid by Medicare. The patient has coinsurance.

Even if you also did a couple of other services, it likely will not add more coinsurance, and there are exceptions. Yes, we have to list everything we've done as long as it does not violate the billing software referred to as the National Correct Coding Initiative, which I will share with you as we move forward. Good question there for Kristen. I just want to be conscious when you say higher paying codes, there might be an example where you do a four-minute smoking cessation visit, and you get paid the same amount as if you did a behavioral health service, a psychotherapy service, and even another on that same day. It could just depend on what the issue is there.

In order to show, especially those non-coders and non-billers, that there are often codes in the CPT book that fit what we need, alcohol and or substance abuse screening, those are time-based codes, either 15 to 30 minutes or 30 minutes or more. Most of the time, we see times included in the definition. That is face-to-face time, patient and the authorized provider. What's okay for Medicare, because we'll go talk about that qualifying visit later, we'll show you and talk about those, what I refer to as magic billing codes, like they put up a dollar sign in the air. When we said that code must be first on the claim, the next code must be on the qualifying visit list, and these codes 99408 and 409 are there.

For Medicare, we don't have as much of an issue, but, oh, wait a minute, now we're dealing with Blue Shield, we're dealing with Aetna, Travelers, Metro Health, United, et cetera. There may be other codes they want, like G0396 for alcohol or substance screenings and interventions that, look at that, have the exact same definition. Facility leaders, one of the jobs we need your assistance with is when we sign a contract and become a participating provider with a commercial insurance company, we must make sure that each year, at a minimum, once a year, we get their fee schedules to go do a compare and a contrast.

In this one example, for those of you looking to alcohol or substance abuse screening, that can be done on both the medical and the behavioral health side. That's very important. One of them might want a G0396 or G0397, and heck, they might cover the G2011 code that is only a 5 to 14-minute screening. Go down to the second item. The reason the brand new codes for 2025 are highlighted in red is they are not going to be used by you as an FQHC currently, according

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to current policy, for telemedicine, typically pre-scheduled telehealth, or a patient-initiated, what's called a virtual communication service, a brief check-in.

The patient initiates the reach-out to you. If it lasts 5 to 10 minutes, if it's unrelated to an evaluation and management service you've done in the previous 7 days, and does not result in an immediate visit, there are codes for you, but those are, I should say, codes you will not use to Medicare as an FQHC because anytime you have a medical telehealth service that's on CMS's list of approved services, because we're still coding and billing based on the waivers that we got during the public health emergency, we're only using one code to report medical telehealth services that are on CMS's list of approved services.

Similar to that, the 98016 on the left-hand side has a counterpart code, G0071. Both of the codes, G2025 and G0071, are specific to FQHCs only. Now, one thing you don't see there is how do you report a mental health telehealth service. At the beginning of COVID, both medical and mental telehealth were all under the single G2025 umbrella. About May to June of 2023, CMS, writ large, let everybody know, "Hey, wait a minute, if it is a mental health telehealth service, just tell us what you did." We'll review on the 29th a couple of modifiers that your billing staff will add to identify whether it was audio only or both audio and video.

There's a great example of we can't bill everybody the same. Some carriers want things on the traditional 1500 form. Others, like Medicare, want these services on a claim form typically associated with a hospital, generically referred to as that UB. Now, oftentimes, we see mental health professionals reporting alcohol or substance abuse screening, of course, reporting telehealth, possibly reporting virtual communication services. These are not exclusive to medical. We just need to watch out which providers are authorized to give certain services.

We might give a subcutaneous or intramuscular injection of a drug that typically starts with the letter J, whether it's used for substance or opioid use disorders or other traditional medical or mental health issues. Obviates the need to sometimes, instead of an either-or, either we're using these 99 codes or we're using these G codes. This is a both. Using both a CPT code and a J-code if doing injections by medical or mental health providers. Now, your office visits there on the bottom left may also be used by your mental health professionals if they have typically prescriptive authority. Your same office visits that a family practice provider is going to use will be used by a mental health professional using medication management issues.

We'll give you a bit more of an expanded understanding of how we pick those levels of service based on either time or what's called medical decision making in the next session. This is our first one-hour overview. Then, of course, the codes that our billers are going to add indicating, "Hey, we promise we've met the definition of what's called a valid encounter," meaning you have an authorized provider doing a face-to-face visit, meeting medical necessity guidelines, in an approved location.

Now, there are small exceptions for some of those we're not going to dive into now, but I did want to make sure you were reminded, or if community health is new to you, codes G0466 and 467. It's either a new or an established medical visit. Right up there in the middle is the annual wellness visit, or what's called the Welcome to Medicare physical exam. The last two codes, G0469 and G0470, will always go on a Medicare claim promising that we've met that definition of a valid encounter, and then followed by codes on the qualifying visit list.

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Let me go to the chat. Ms. Natalie, "What about behavioral health providers billing E&M codes? Is telehealth for management?" Yes, ma'am, that is a G2025 because that E&M code, let's say 99213, let's just pick the Goldilocks code there in the middle, is on the medical telehealth list. That is an interesting issue, and you brought it up before I planned on it, but your timing is excellent. Mental health professionals with prescriptive authorities may find themselves providing services that are on the medical qualifying visit list, to include alcohol and substance abuse screenings and E&M codes.

Excellent question, Natalie. As we move forward to focus on behavioral health options, let's read Ms. Cheryl's question. Okay, there you go. I think that both questions were the same thing. Ms. Wilson, if I missed something there, do let me know, but I believe that is covered for both. That would be on the medical side. Now, by the way, all that's pending changes that are due to potentially expire here at the end of this month.

Even though some documentation came out in chapters 9 and 13 that it was extended to the end of the year, factually, the only extension that can be authorized for telehealth has to be by Congress. CMS does not have the statutory authority to extend anything beyond a public health emergency, which is over. I was on Capitol Hill meeting with some senators' offices, along with 100 other folks, two months ago, to advocate for this type of work.

As we continue on the behavioral health option, I've probably done 250 courses under what's called the Rural Communities Opioid Response Program, the RCOR Program, bringing this same subject, how to use medical and behavioral health to treat the whole patient. Top services here, 90791 or 90792, really only differ by a couple of words, but they're going to kickstart most behavioral health encounters, multiple encounters. The patient is coming in for an intake, they're coming in for a psychiatric diagnostic evaluation. The code definition is just that, psychiatric diagnostic evaluation.

The second code, 90792, says psychiatric diagnostic evaluation with medical services. The interesting piece there is if they would have just, in the CPT book, called that with medication services, it would make it a bit more obvious. Actually, that ties together the previous two questions to confirm that medication management type service is traditionally referred to by those standard E&M codes, but can be provided by mental health professionals.

Now, we'll review in a bit more detail on the 29th that this service is usually provided once a year. If done more than once a year, we need to have documentation supporting a new diagnosis, a new set of challenges that likely requires a new treatment plan. That diagnostic evaluation really sets the treatment plan up. It's where we delegate services to marriage and family therapists, psychologists, maybe even peers. We're likely assuming the psychologist and the counselors, mental health counselors, are then going to be reporting traditional psychotherapy. Yes, those are also time-based codes, either 30, 45, or 60 minutes.

Well, something interesting with these codes, different than the time-based codes we looked at a moment ago, is we actually get to round up or round down depending upon whether we've met the midpoint of those services. If I get to 35 minutes, I'm not halfway to 45. I've got to round down and report 30 minutes of therapy. Now, the type of therapy you provided in the past changed the therapy code you use. Not any longer. It's very generic. There might be 20 different approaches of different types of therapy, but they're all underneath this area. However,

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not enough, let's just generically say, facilities are aware of the options for psychotherapy being performed for crisis.

Now, again, that's the whole definition. You would have to open the CPT book up to find the information about rounding up or rounding down. It's not going to probably be in the software, and sure as heck is not going to be where the provider is looking at it while documenting that service, most likely with the patient present. There's four bullets that describe when psychotherapy for crisis is needed. For example, the patient is at significant risk for decompensation and maybe require hospitalization, or there's a risk of suicide or a required reporting to a third party. People in Florida and other states with things like the Baker Act and things like that.

Now, if this is Medicare, since we just report one of the magic G codes in the sky, and both of these types of psychotherapy services are on the qualifying visit list, but we need the CPT book to tell us what must be in the medical record to support psychotherapy for a crisis. Now, we're going to get the same as we did for regular therapy, but folks, when we're billing commercial insurance companies, I don't know how much more that pays. I've done this for 30 years, but 10 years ago, I said I don't care what the dollar amounts were, but I know it's more. I know it's represented by a better set of codes that many providers aren't aware of.

Now, believe it or not, the first code, you see the third box here, related to interactive complexity, is actually the first code in the mental health chapter. It's, again, just defined by two words. We need four paragraphs and four bullets again to tell us what needs to be in the record in order to justify adding-- Notice the little plus sign. Then I'll hit the chat box here in a minute.

Interactive complexity gets added to some codes in the CPT, but we have to do the research in the manual to see that it can only be added to the psychotherapy codes or one of the diagnostic evaluations when we are overcoming barriers to communication with patients who have maybe not developed or have lost expressive language skills in order to understand what's being asked of them and to get the information back.

Many, many moons ago, it included translators there, but they took that out of the CPT years and years ago. I do run into people that still use it that way, and they could run into some compliance issues. Finishing the left-hand side here, we have care management options, namely behavioral health integration, which is a term used by different people to refer to how we're bringing them into our office. Not just co-locating them in our offices, but truly integrating the care.

Care management, behavioral health services, and the psychiatric collaborative care model are usually reported under the medical professional's numbers, but captures the amount of time per calendar month that we spend coordinating the care of those behavioral health patients between medical and mental health between visits to update, revise, or monitor the treatment plan. To reach out to other providers that the patients may see to keep them informed about the patient's care, and to even maybe reach out to the patient to let them know about changes to their treatment plan for the better or worse, before that next visit.

Now, those are codes you'd likely use for commercial carriers, but the way we report care management for about 30 different services, similar to the way we use that G-code for

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telehealth on the medical side, covers many, many different types of care management services. Chronic care management, remote patient monitoring. Deeper subject for a deeper day, but notice there are still, as of today, September 3rd, 2025, codes G0511, that's supposed to go away at the end of this month. We'll see, which would then require us to go use the proper CPT or HCPCS codes there rather than the umbrella code, or maybe rather than some new codes called advanced primary care management.

This overview leaves the top three items on the right side to you and outlines possible H-code options. Remember, H-codes are Medicaid-only considerations. They are reserved for Medicaid use. I know you can't read this, but I go in every year and I circle and highlight key services that mirror codes on the left-hand side of this screen or the previous one. For example, self-help peer services, individuals who themselves have gone through substance use disorders, or HIV, or other medical conditions as substance and opioid use disorders. Although the diagnosis codes are found in the mental health arena, it's a chronic brain disorder, not a behavioral issue.

When providing medication-assisted treatment, we would typically expect to see concurrent treatment by somebody, psychiatrist or MD, giving injections of opioid agonists or antagonists with parallel support on the behavioral health side. Be aware that those self-help folks will likely see additional reimbursement coming down the road, but there are services called community health integration, and in particular, I know we're using a lot of abbreviations here, for what's called principal illness navigation.

Please review those and join us on the 29th, as well as alternatives over there for crisis interventions rather than using the codes on the left. That's why managers, we've got to get these fee schedules. Because no insurance company is going to tell you how to get paid if you're using the wrong code, and they wanted an H code. They're going to say, "Look, we can't tell you how to bill. Refer to your fee schedules and refer to your contracts."

Pamela, in the chat box, "Can the mental health provider use the E&M visit codes for substance abuse along with another provider?" Well, it's that race to the mailbox. In that case, that's no different. Anybody trying to report the same diagnosis on the same date, depending upon if that was a fee-for-service claim, Pamela, or one involving our encounter rates, that answer could change.

Ms. Meg, "Can 90791 be billed in the same year if an LCSW's done it?" It is typically once a year, and that's a tricky word. If you're reporting again, be prepared to support why you needed to redo the treatment plan. Did things get better? Did other conditions come into play? Why did we need to do it again? That's a frequency issue, Meg, that you may need to look to. As far as residents and teaching physicians, unfortunately, way too varied for us to get into on this time.

Dominique, "Can you provide information on codes like 90833?" Excellent there. 90833, just like you see these codes I'm highlighting, 30, 45, and 60 minutes, can be done by non-prescription folks, psychologists, social worker, et cetera. If that medical or psychiatric professional with medication and prescription capabilities does that E&M service and therapy on the same day, Dominique's code is correct. There are add-on codes that say either 30, 45, or 60 minutes of psychotherapy when done on the same date as psychotherapy.

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Josh, I'm going to have to get to your question here in a bit, but one of the documents I'd like you to access, folks, that helps with many, many of these is checking out Medicare's document, most recently updated in April of 2025. I bring it here to you. I encourage you to review this before you join us on the 29th. Oh, I recognize Tracy's name. Well, 99484 is a set of codes that covers care management for a month. E&M 99213, for Tracy's question, is a service provided on one date. Yes, they can go on the same claim, and since they are covering two completely different services, you're probably fine.

Look at some of these issues those folks have brought up in the Q&A box. Perfect. We only have a few more slides to go before we fully do Q&A, but I wanted to show you right here. They updated some telehealth requirements focused on us in FQHCs. There's going to be a need for in-person mental health telehealth visits, but unlike the rest of the fee-for-service world, we are likely not starting that until January.

They've made some updates on digital mental health treatments, expanding-- whoops, I didn't mean to hit that one, expanding usage of options like Brixadi and requirements for marriage and family therapists, et cetera. I'd love, if you have not already accessed that document, which in many of the examples that we've had in the chat box will be discussed there.

Finishing the presentation today, you heard me mention Chapter 9 and Chapter 13 of the claims manual or the benefit policy manual. We did not have updates really in 2024. One of these was slightly updated, but it was 2023 for most of this. I would like to acknowledge the hard work that folks have done, where the rubber meets the road, to take information out of Chapter 9, which hasn't been in effect for eight or nine years. They've done a great cleanup job getting rid of historical information that conflicts with current guidance.

If you want an understanding, for example, let me grab this for you so you can see it. Remember, the links to these documents, ladies and gentlemen, are at the very last slide here. For example, we don't have a deductible for Medicare patients in an FQHC. Boom, Chapter 9, Section 40 will answer that for you. Questions about that initial preventive exam or those virtual communication services or those care management services, or even telehealth can be answered here.

You'll see in red information that has been changed or updated in the document. It's far too detailed to get into today. This was issued in March. It didn't come out until May or June, by the way, but they made a nice change to Chapter 13 when we talk about when can you bill for multiple visits on the same day. The reason I don't like calling our PPS payment, prospective payment system, a per diem, is because there are some exceptions to the rule on when we can get paid for multiple visits on the same day.

One quick example that tells those of you in the coding world how different this is. For example, everything you knew about the global billing rules on the fee-for-service world with Medicare, meaning that certain procedures we do include the office visit, and the office visit should not be reported separately, does not apply to us in FQHCs. The quickest way to do it is to highlight the words, the global billing requirements don't apply to us. There's a little hint.

Right up here before it is the information I want to review as our last item for today, encouraging that deep dive into the reference documents, urging caution on general Medicare education that

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may not apply to us, recognizing Medicaid wants things differently than even Medicare, and Medicare might want them differently than commercial insurance, requires that organizationally aligned cross-functional training on these same areas. Because here's the rule. Well, they're telling you there's an exception. Except as noted below, encounters with more than one of our practitioners on the same day or multiple encounters with the same practitioner on the same day, here we go, constitutes a single FQHC visit and is payable as one visit.

Again, I will not skip your questions in the Q&A box, but I do want to make sure I get this done first. The majority of the rest of this slide ties into the issues, but I want to focus on those exceptions that were expanded upon in the, let's say, March to May recent updates from CMS's Chapter 13, Section 40.3. First bullet, if the patient "subsequent to the first visit."

Now, if I had any influence on revising this slightly, I want to make it clear that, subsequent to the first visit, from my understanding, means the patient hasn't just left my front door, but they've left our property. The patient got a ten o'clock visit in the morning for anxiety. They went home, and they now require additional diagnoses or treatment on the same day, whether it was the same or a similar, or an unrelated issue, because the patient had left your facility and came back. Then we have an opportunity for two reimbursable visits.

If they had a ten o'clock appointment for hypertension and a 10:30 appointment for another medical condition, that's one reimbursable encounter, even though you list both of them on the same claim form to make sure, for things like cost reporting purposes, that we've told them everything we've done. We know both codes may not get reimbursed, but we did them.

Well, for my billers, we'll end with these three items. They want you to add modifier 59 to that second encounter. Well, folks, if you go read the CPT definition of modifier 59, it says in three separate places to never, ever add it to an evaluation and management code. What did we just get asked to do? Add it to an evaluation and management code. Folks, key point to take away as we finish this slide. Go to the Q&A, get ready, and study and prepare for our revisit on many of these issues in more detail on the 29th.

I'll say it this way. Proper and compliant FQHC billing to Medicare might violate professional coding standards. I happen to teach an 11-hour class on community health coding and billing. I happen to write a certification exam in the field for folks to make that distinction between coding and how it could differ in the billing arena. Well, look at the second one, folks. It's perfect for us. The patient has both a medical visit and a mental health visit on the same day. We can get reimbursed for both, but as some of the ladies earlier brought up a question, if that mental health person reports a medical code, then that looks like a medical visit and another medical visit that will be one encounter. That is just an issue to be thinking of.

Now, if you are engaged in what's called an intensive outpatient program, newer to us in the FQHC world by about 14 months, if you're providing two, maybe three, even up to four concurrent mental health covered services on the same day, those intensive outpatient services don't just generate your PPS rate like this document is getting into. You actually get reimbursed as though the service was done in a partial hospitalization setting, and that could be $200, $300, $400. On the mental health side, you may want to do some research.

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In that mental health document I gave you on what an intensive outpatient service is, they added dental and medical. Outside of our scope, but important to see that it was added. Then something for only our friends in RHC, and it does not apply to us, and it does not apply to that annual wellness visit. Many of the questions folks have can be found in these documents. We encourage you, when making updates, changes, revisions, or new billing processes, that you can always back it up with a resource. Those three resources found on slides 12, 13, and, I think, 14 and 15 there, we've given you those links to pull those documents up.

For the last few minutes we have here, Josh, that's a big one, bud. We may need to have you send that one in for the first one. Can I clarify more on 99484 and the box? I was told very explicitly, it cannot be billed in FQs, but I'm seeing conflicting information. Short hand, Josh, that 99484 as a chronic care management service, on January 1st of this year, you had a choice. Either continue to use G0511 as an umbrella code for about 30 different types of care management, or starting on January 1st, you could have started using the individual codes like 99484. That was supposed to end mid-year, but it was extended until the end of September. We essentially have three choices.

Number one, continue to use G0511 until the expiration date, potentially at the end of this month. Number two, starting January 1st, all the way up until today and tomorrow, don't use the G0511. Use the individual codes, but realize when you get paid for G0511, you're getting the average of what fee-for-service providers get paid for each of those individual codes. If you choose now or after the expiration of the G0511 to report the individual code, you'll find that reimbursement, between $15 and $132, essentially getting paid at the rate that a fee-for-service provider gets paid for that, and coinsurance is going to be a tad different.

The third option I'll touch on the 29th would be for what are called advanced primary care options. Still a little unclear about how that would work, but you will see conflicting information, especially when you see from a fee-for-service perspective compared to FQHC. That's an interesting theme there.

Manuela, "For 90785, if the patient speaks a different language than the provider, and they can use an interpreter, can the code be used?" No, ma'am. They took interpreter out of those four paragraphs many years, and it's part of our requirement of being in FQHC to provide culturally appropriate language-sensitive services. "We're hauling now. "BHI Services for Medicare Advantage would be billing G0511 and other payers 99484." Ms. Scherer, it just depends. G0511 has traditionally been a pure Medicare, traditional Medicare-only option. If Medicare Advantage plans had wanted the umbrella code, it's up to them whether they'll allow the CPT codes and/or if they're going to abide by CMS's decision on when or if that code gets deleted.

"Is the H0038 similar to G9012?" I don't know G9012 off the top of my head, but it's going to be peer support. I'd have to look up G9012 for Centers of Excellence if that's what I'm reading there. Ms. Amanda, the answer for your question is once a month. The behavioral health consultant provides behavioral health integration using time-based codes. That 99484 is one of 30 monthly care management services where we're capturing the time. The clinical staff overviews and reviews the treatment plan and makes updates, but it's reported, typically, by the medical provider. Your participation, Amanda, in conversations with the medical side is going to be the issues there.

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Maria, the psychological testing services, many of them are covered under the code 96127, but that's not on the qualifying visit list. Unfortunately, well, I'm going to say unfortunately, that's my opinion, the qualifying visit list has not been updated since 2017. I know there are services that CMS and others want us to perform that's not on that list, but the performance of annual depression screening, I think that's G0444, is an excellent example of billable, allowable psychological testing along with the GAD-7 for anxiety. You would likely have those done at the same time as an otherwise billable service, but if standalone for Medicare, those codes are not on the qualifying visit list.

From my contact with some folks responsible for this area, the last communication I received a few weeks ago was, there are no plans to update the qualifying visit list. We're stuck in the middle there. I appreciate you all letting me do this rapid fire. Anna asks, "Do I provide coding and billing information for Medicaid?" I literally can't. I'm in Georgia. There's 5 Medicaid programs, 140 nationally. Use CMS guidelines as the foundation to review your contracts, hopefully before signing, to get an understanding of some of the unique billing issues. The key is to get the list of allowable codes broken down by provider type so you can see what a psychologist can report, what a marriage and family therapist can report, et cetera.

A lot of looking in there. Go to billing, we're going to leave. Not sure, Ms. Anna. Apologies, when you say, does that apply to Medicare Advantage plans? Not positive. Ms. Leanne, "For a patient receiving telehealth therapy, will the required annual in-person visit need to be provided by the same provider?" They address that in that new document. The intent is typically that it's done with the same provider, but if you think of school-based folks, they may not even work from the office.

It's possible the patient's going to have to go to the physical office, but there are two exceptions listed in that mental health document that just got updated in April that addresses that exact same issue and puts a couple little key items around which provider can do it. My strong feeling, by the way, is that shouldn't be a huge deal. There are two exceptions when the in-person requirement does not have to be met. They just published what those guidance rules are. I encourage you to review that on your own.

Beth Sater says, "We're a behavioral health center, not FQHC. Does that change any of the coding?" Definitely changes the billing because you will not use the FQHC only, what I call magic G-code, to put the bat signal up there in the air. You would not use a code like G0511 that has federally qualified health center in the title if you're not a federally qualified health center.

Again, coding doesn't necessarily change based on facility type. The billing most certainly does. Your staffing requirements might be slightly different. Supervision requirements for, let's just say, physicians, et cetera, may be different. That coding and who provides the service is tremendous. I don't have it listed as a resource, folks, but the National Council for Mental Wellbeing has something they call a decision support tool. It hasn't been updated to my knowledge since May of 2024, but it will help go into some Medicaid issues and give you at least another set of guidance for those of you that may have questions. That answers Ms. Beth's.

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I will defer to Ms. Kayla, who will be closing us out. In 15 seconds, Kayla will be ready for you. I know they're great questions, folks. The recording will be available. Ms. Kayla, would you please join to help those folks whose questions, based on the time, I couldn't get to? I hope this was an engaging overview, and it's just that. Review the materials. Some of these issues we'll dive into more deeply on the 29th. I thank you for your valuable time and appreciate being part of the community health community. Thank you.

Kayla Baker: Thank you so much, Gary. You can access more behavioral health substance use disorder integration technical assistance opportunities by emailing the team, visiting the TA portal, and scanning the QR code to subscribe to the Hub in Focus. Please consider joining us for the upcoming fall webinars, including Part 2 of *Documentation, Coding, and Billing* on September 29th. There is also space available in the current communities of practice. We're adding the topics and registration links to the chat for your convenience.

[silence]

Remember that we are offering behavioral health continuing education units for participation in BH/SUD integration technical assistance events. You must attend the event and complete the online Health Center TA Satisfaction Assessment form after the event. We've dropped a link to the assessment in the chat, and you can also scan the barcode here. CE certificates will be sent within five weeks of the event from the health center BH/SUD TA team via Smartsheet.

Gary Lucas: If you need any assistance filling out that evaluation, I've got really good at filling those out over the years. Let me know, I can.

Kayla Baker: [chuckles] Thank you all so much for your attendance today. This does conclude today's webinar. You may now disconnect.

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