Diving into Behavioral Health Documentation, Coding, and Billing Part 2

Monday, September 29, 2025

2:00 to 3:00 p.m. ET

Submitting Questions and Comments

- Submit questions by using the questions-and-answer (Q&A) feature.
- If you experience any technical issues during the webinar, please message us through the Q&A feature or email bphc-ta@bizzellus.com.

Continuing Education (CE)

- We offer behavioral health (BH) continuing education units (CEUs) for participation in BH/substance use disorder (SUD) integration technical assistance (BH/SUD TA) events.
- You must attend the event and complete the online Health Center TA Satisfaction Assessment Form after the event (2–3 minutes).
- A link with instructions will be provided at the end of the session.
- CE certificates will be sent within 5 weeks of the event from the Health Center BH/SUD TA Team via Smartsheet <user@app.smartsheet.com>.

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Presenter

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

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Objectives

- Apply Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System Level II (HCPCS-II), and ICD-10-CM codes to appropriately code and bill for medication assisted treatment with concurrent behavioral health diagnostic/therapeutic services.
- Demonstrate the ability to apply evaluation and management (E/M) guidelines in different clinical scenarios, including telehealth and virtual communication services.
- Identify scenarios of overlap between medical and behavioral health related to CMS-covered preventive services for appropriate coding.
- Evaluate the documentation requirements for each type of care management service.

Polling Question

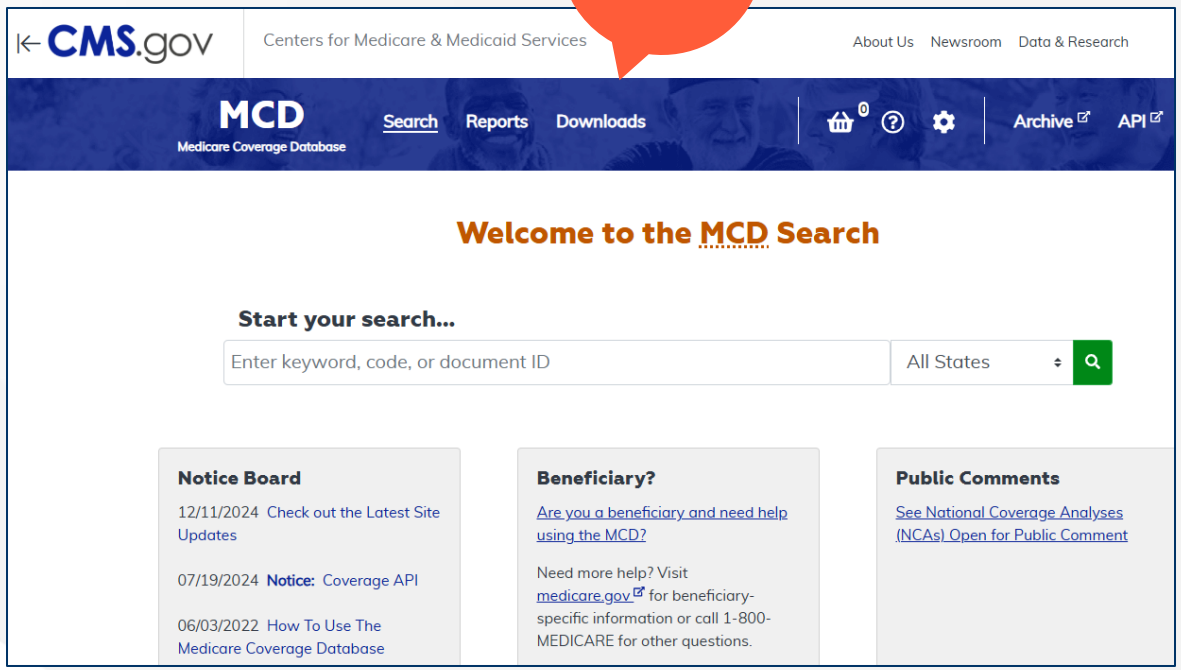
What is your primary administrative challenge when integrating medical and behavioral health services?

a) Understanding CMS preventive services
b) Applying codes for medications for opioid use disorder and behavioral health
c) Using E/M guidelines
d) Telehealth vs. virtual communication
e) Documentation requirements
f) Other – tell us in the Q&A

Get Training on, and Then Access to, the Medicare Coverage Database (MCD)

Step 1

Step 2



Federally Qualified Health Center (FQHC)/Community Health Center Prospective Payment System (PPS) Basics

Instead of getting paid Fee-for-Service (FFS), Medicare likely pays you 80% of a **Prospective Payment System** rate for "valid encounters." Some services like care management and medical telehealth may currently pay via special payment rules and labs are paid via the clinical lab fee schedule on a CMS1500 form.

- You are required to perform, document, and bill a code on the ***Qualifying Visit List (QVL)*** ***preceded*** by at least one of ***5 FQHC-only billing G-codes,*** G0466-G0470, that must be listed first on the CMS1450/837i claim form.
  - **G0466-G0467** – New vs. established (medical) face-to-face service(s) with an authorized provider
  - **G0468** – A visit ***that includes*** either the Initial Preventive Physical Exam (IPPE) or an Initial/Subsequent Annual Wellness Visit (AWV)
  - **G0469-G0470** – New vs. established mental health face-to-face/telehealth visit

FQHC/Community Health Centers Impact of the Qualifying Visit List

- "Detailed Healthcare Common Procedure Coding System (HCPCS) coding with the associated line-item charges ***listing the visit that qualifies the service for an encounter-based payment and all other FQHC services furnished*** during the encounter are also required." – SOURCE: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf
- It is not clear at this time if there are other CMS-covered services that may generate valid PPS payments since ***the list has not been updated since 2017***. An example is performing structured screenings for alcohol and substance abuse (99408-99409) as stand-alone services for FQHCs.
- Use caution, as the QVL document has ***codes on the current list that were deleted*** from the CPT manual many years ago such as 99201 and 99324-99328 (domiciliary/rest home codes) as well as "outdated" services such as Psychoanalysis (90845).

FQHC/Community Health Centers QVL Samples – When would a behavioral health provider use a "medical" code"?

Qualifying Visits
The qualifying visits that correspond to the specific payment codes are as follows:

G0466 - FQHC visit, new patient

HCPCS	Qualifying Visits for G0466	Effective Date
92002	Eye exam new patient	
92004	Eye exam new patient	
97802	Medical nutrition indiv in	
~~99201~~	~~Office/outpatient visit new~~	
99202	Office/outpatient visit new	
99203	Office/outpatient visit new	
99204	Office/outpatient visit new	
99205	Office/outpatient visit new	
99304	Nursing facility care init	October 1, 2016
99305	Nursing facility care init	October 1, 2016
99306	Nursing facility care init	October 1, 2016
99324	Domicil/r-home visit new pat	
99325	Domicil/r-home visit new pat	
99326	Domicil/r-home visit new pat	
99327	Domicil/r-home visit new pat	
99328	Domicil/r-home visit new pat	
99341	Home visit new patient	
99342	Home visit new patient	
99343	Home visit new patient	
99344	Home visit new patient	
99345	Home visit new patient	
99406[2]	Behav chng smoking 3-10 min	October 1, 2016
99407[2]	Behav chng smoking > 10 min	October 1, 2016

Heads-up, code 99201 was deleted in the 2021 CPT.

G0469 – FQHC visit, mental health, new patient:

HCPCS	Qualifying Visits for G0469
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt &/family 30 minutes
90834	Psytx pt &/family 45 minutes
90837	Psytx pt &/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

G0470 – FQHC visit, mental health, established patient:

HCPCS	Qualifying Visits for G0470
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt &/family 30 minutes
90834	Psytx pt &/family 45 minutes
90837	Psytx pt &/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

See the full medical visit list by accessing the link at the end of the presentation.

Documentation for Psychiatric Diagnostic Interviews (90791 and 90792)

- Elicitation of a complete medical and psychiatric history (including past, family, social)
- Mental status examination (MSE)
- Establishment of an initial diagnosis
- Evaluation of the patient's ability and capacity to respond to treatment
- Development of an initial **plan** of treatment
- Requirement of a report once per day and NOT on the same day as an E/M service performed by the same individual for the same patient
- Affirmation of coverage once at the outset of an illness or suspected illness

Psychotherapy Therapeutic Services

- CPT® codes 90832 - +90838 represent psychotherapy for the treatment of mental illness and behavioral disturbances.
- The times listed refer to *face-to-face* time (*with patient and/or family)* and the time does *not* need to be continuous.
  - ✓ 90832 and +90833 [“30 minutes”] **(16–37 minutes)**
  - ✓ 90834 and +90836 [“45 minutes”] **(38–52 minutes)**
  - ✓ 90837 and +90838 [“60 minutes”] **(53+ minutes)**
- A “unit” of time is met once the “midpoint” has been reached.
- Remember: It is possible in the FQHC for two visits to be claimed for the same patient on the same date of service for Medicare (e.g., one medical encounter and one mental/behavioral health encounter).

Finding an ICD-10-CM Code isn't enough. Can you access key instructional notations also?

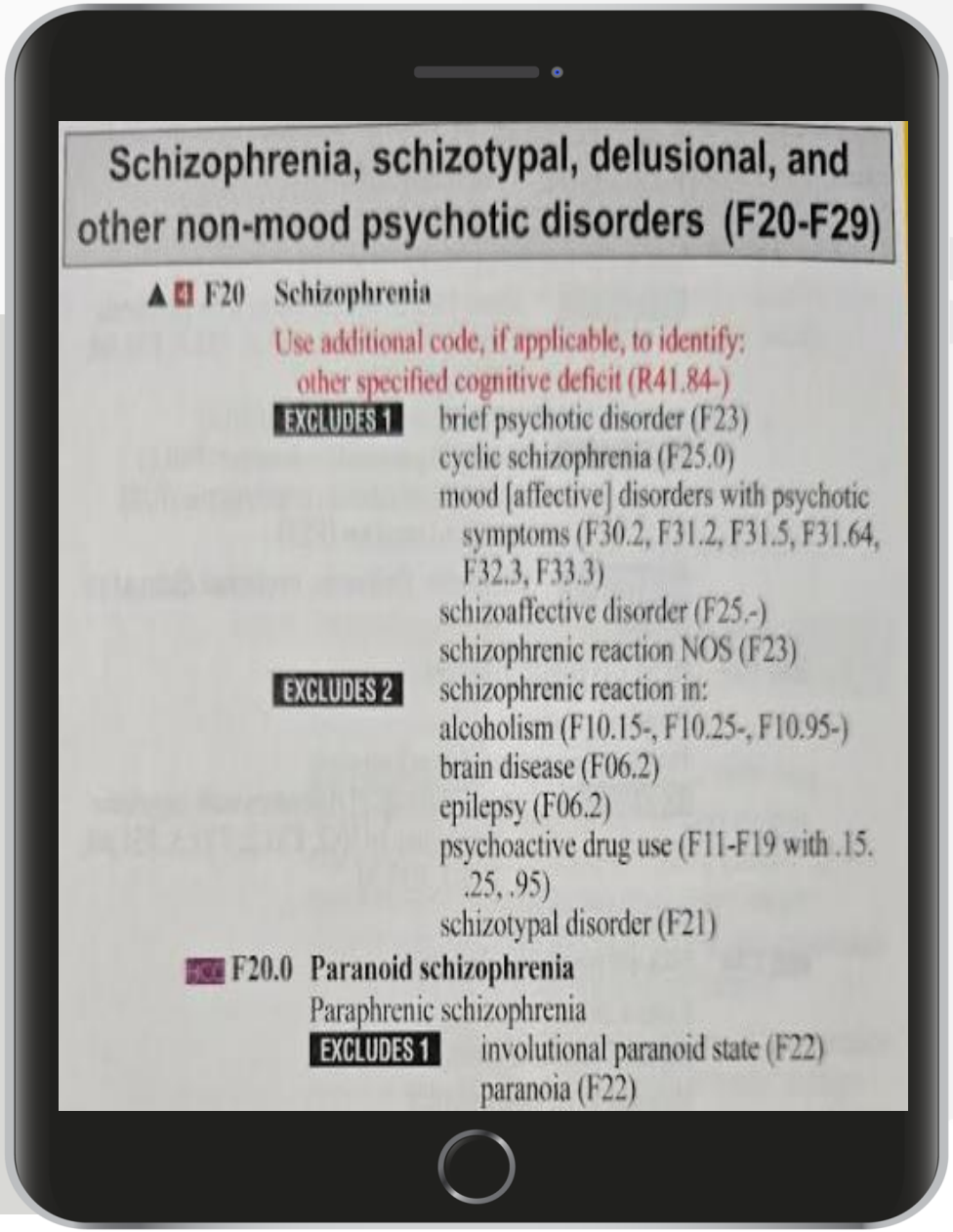
International Classification of Diseases –
10th Revision, Clinical Modification (ICD-10-CM)

Ensure that clinical providers and coders/billers can also go beyond the code definitions to view key instructional notations crucial to establishing ***"medical necessity"*** and getting credit for mandatory and voluntary quality reporting.

The ***"ICD-10-CM Official Guidelines for Coding and Reporting FY 2025 October 1, 2024 – September 30, 2025"*** provides the foundation for all diagnosis code knowledge. It is vital that providers be aware of these guidelines before learning how to operate various EHR/IT systems where they document and/or select ICD-10-CM codes.

How much detail can your clinical providers/coders see when assigning ICD-10-CM codes?

1. Punctuation – (xxxxxxx) is different than [xxxxxx]
2. Definition of the word(s) "**and**", "**code also**", "**code first**", "**use additional code**",
3. **Excludes 1** vs. **Excludes 2** – what is the difference?
4. For injuries, poisonings, and trauma – how do we define **Initial** vs. **Subsequent** vs. **Sequela** episodes of care?
5. When should "**unspecified**" codes be properly used?
6. What about **signs or symptoms** vs. conditions that are/are not **integral** to disease processes?



"ICD-10-CM Official Guidelines for Coding and Reporting" Identify Common Denials and Educate Providers

ICD-10-CM diagnostic code set guidelines for self-study/exercises:

- Review ***Section I. Subsection C. Chapter 5*** for how to properly code when encountering substance ***"use, abuse, or dependence"*** and specifically in Volume 1's Tabular instructional notes for substance-specific tobacco dependence coding *(F17.xxx codes)*.
- Review ***Section I. Subsection C. Chapter 21. Paragraphs 4, 5, 7, 13, 16, and 17*** for great information on *"history of" screening, aftercare and routine/administrative exams*.

Compare/Contrast: Diagnostic and Statistical Manual of Mental Disorders (DSM)-5-TR vs. ICD-10-CM

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

American Psychiatric Publishing
A Division of American Psychiatric Association

Criteria and Terminology

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

✚

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

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

2) Psychoactive Substance Use, Abuse and Dependence

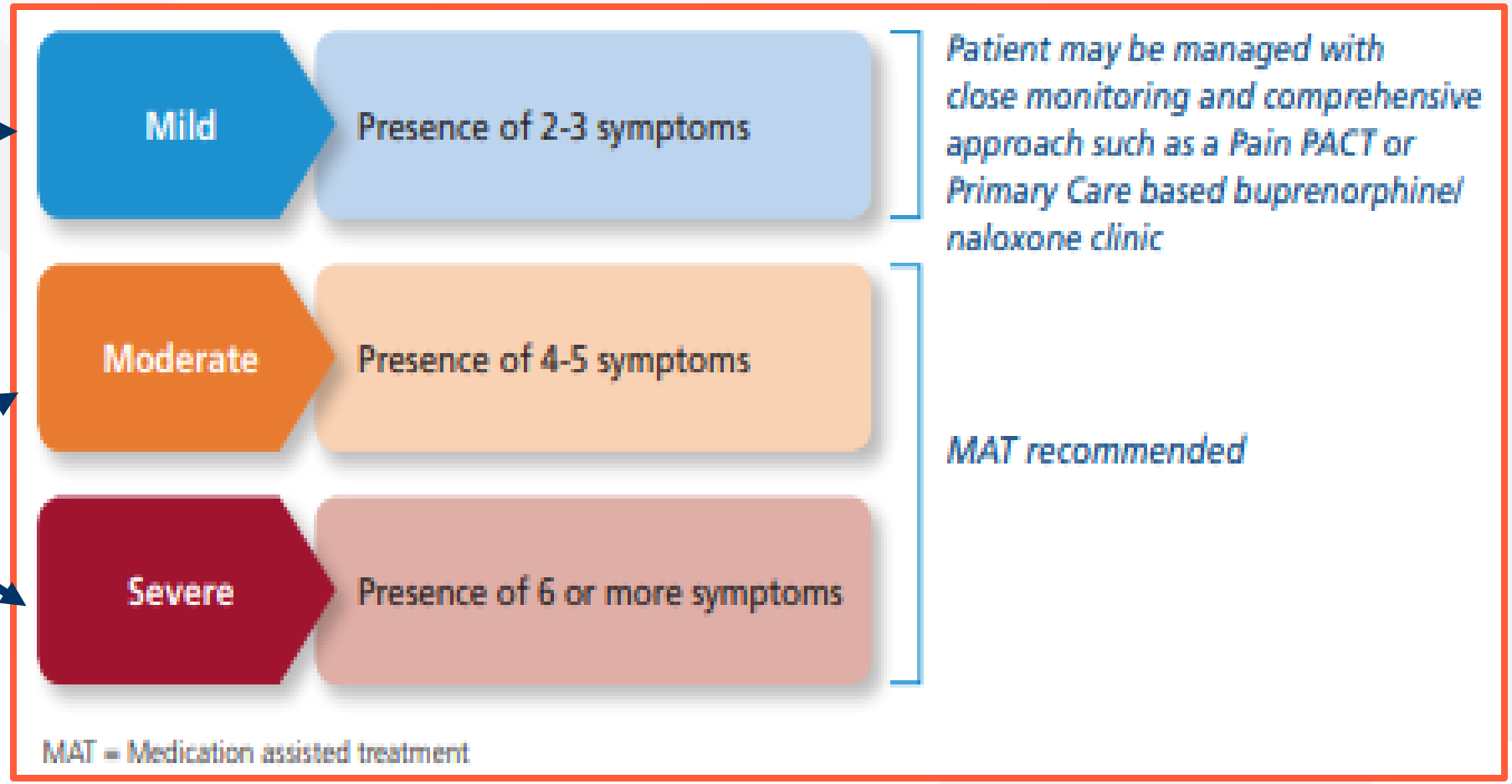
When the provider documentation refers to use, abuse and dependence of the same substance (e.g. alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

- If both use and abuse are documented, assign only the code for abuse
- If both abuse and dependence are documented, assign only the code for dependence
- If use, abuse and dependence are all documented, assign only the code for dependence
- If both use and dependence are documented, assign only the code for dependence.

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

ICD-10-CM Code as Abuse

ICD-10-CM Code as Dependence



Sample Billing Code Options for Screening for SUD/OUD and MAT/MOUD

G2011: Alcohol and/or substance abuse (other than tobacco) misuse screening structured assessment and brief intervention, 5–14 minutes

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

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

H0049: Alcohol and/or drug screening

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

G0442: Annual alcohol misuse screening, **5–15 minutes**

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

G0444: Annual depression screening, **5–15 minutes**

Selecting the Proper Evaluation & Management Code. Use BOTH Medical Decision Making or Time, Whichever Gets You to the Highest Level

History

"medically appropriate"

Exam

"medically appropriate"

Medical Decision Making (MDM)

OR

Time

Nature of Presenting Problem

Counselling

Coordination of Care

You will need to learn and apply both options!

For Prescribers Spending Time on the Items Below, Track Time *if Done on the Date of Service*

- Preparing to see the patient (*e.g., Review of tests*)
- Obtaining and or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (*when not separately reported*)
- **Documenting clinical information in the electronic or other health record**
- Independently interpreting results (*not separately reported*) and communicating results to the patient/family/caregiver
- Care coordination (*not separately reported*)

Elements of Medical Decision Making (MDM)

Study Medical Decision Making!

Please review and study pages 8–13 of your American Medical Association (AMA) Professional Edition CPT manual to find helpful updates and information that clinical providers should be familiar with when documenting in the medical record.

You will use the *highest 2 of the 3 elements* to determine Straightforward, Low, Moderate, or High complexity of MDM.

- **Number and Complexity of Problems Addressed at the Encounter**
- **Amount and/or Complexity of Data to be Reviewed and Analyzed**
- **Risk of Complications and/or Morbidity or Mortality of Patient Management**

AMA's CPT Medical Decision Making (MDM) Chart

		Choose MDM Based on 2 of 3 Elements		
Code	**Level of MDM**	**1) Number and Complexity of Problems Addressed**	**2) Amount and/or Complexity of Data to be Reviewed and Analyzed** **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below*	**3) Risk of Complications and/or Morbidity or Mortality of Patient Management**
99211	**N/A**	N/A	N/A	N/A
99202 99212	**Straightforward**	Minimal	Minimal or none	Minimal
99203 99213	**Low**	Low	Limited	Low
99204 99214	**Moderate**	Moderate	Moderate	Moderate
99205 99215	**High**	High	Extensive	High

We will take a closer look at each column on the next 3 slides and will use this chart to help "score" medical decision making

Evaluation and Management Code (E&M Level)	Number and Complexity of Problems Addressed at the Encounter	Complexity/Level of Medical Decision Making (MDM)
99202 **99212**	• 1 self-limited or • 1 minor problem	**Straightforward**
99203 **99213**	• 2+ self-limited or minor problems • 1 **stable chronic** illness • 1 **stable acute** illness • 1 **acute uncomplicated** illness/injury requiring hospital inpatient or observation level of care	**Low**
99204 **99214**	• 1 or more **chronic** issues with exacerbation, progression, or side effects of treatment • 2+ stable **chronic** illnesses • 1 Undiagnosed problem with uncertain prognosis • 1 **Acute** illness with systemic symptoms • 1 **Acute** complicated illness	**Moderate**
99205 **99215**	• 1+ **chronic** illnesses with severe exacerbation/progression or side effect of treatment • 1 **acute or chronic illness** or injury posing a threat to life or bodily function	**High**

Evaluation and Management Code (E&M Level)	Amount and/or Complexity of Data to be Reviewed and Analyzed *(Each unique test, order, or document contributes to the combination of 2/3 in categories mentioned below!)	Complexity/Level of Medical Decision Making (MDM)
99202 99212	**Minimal or none**	**Straightforward**
99203 99213	**Limited (Must meet at least 1 of the following 2 categories)** • **Category 1: Tests and Documents*** • Any combination of 2 from the following: • **1.** review prior external notes, **2.** review results of EACH unique test, **3.** order of EACH unique test • **Category 2: Assessment requiring "Independent Historian(s)"**	**Limited**
99204 99214	**Moderate (Must meet at least 1 of the following 3 categories)** • **Category 1: Tests, Documents and Independent Historian(s)** • Any combination of 3 of the following: • **1.** review of prior external note(s) from each unique source, **2.** Review results of each unique test, **3.** order of each unique test, **4.** Assessment requiring independent historian(s) • **Category 2: Independent interpretation of test performed by another provider (not billed)** • **Category 3: Discussion of Management or test interpretation with outside provider (not billed)**	**Moderate**
99205 99215	**Extensive (Must meet at least 2 of the following 3 categories)** • **Category 1**: **Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: **1.** Review of prior external note(s) from each unique source*; **2.** Review of the result(s) of each unique test*; **3.** Ordering of each unique test*; **4.** Assessment requiring an independent historian(s) ***or*** • **Category 2: Independent interpretation of tests** **1.** Independent interpretation of a test performed by another physician/other qualified health care professional (*not separately reported*); ***or*** • **Category 3**: **Discussion of management or test interpretation** **1.** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (*not separately reported*)	**High**

Each lab test counts toward the combination requirement below.

How does your EHR "capture" that you reviewed prior labs?

Evaluation and Management Code (E&M Level)	Risk of Complications and/or Morbidity or Mortality of Patient Management *(Based on risks associated with diagnostic/therapeutic procedures)*	Complexity/Level of Medical Decision Making (MDM)
99202 99212	**Minimal risk of morbidity from additional diagnostic testing or treatment** • Ex. Rest, gargles and bandages	**Straightforward**
99203 99213	**Low risk of morbidity from additional diagnostic testing or treatment** • Ex. OTC	**Low**
99204 99214	**Moderate risk of morbidity from additional diagnostic testing or treatment** • ***Prescription drug management (rx)*** • Decision for minor surgery with identified patient or procedure risk factors (0, 10 days) • Decision for elective major surgery without identified patient or procedure risk factors (90 days)	**Moderate**
99205 99215	**High risk of morbidity from additional diagnostic testing or treatment** • ***Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents. etc.)*** • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • ***Parenteral controlled substances***	**High**

CMOs – determine your definitions of these key terms!

New 2025 CPT Telemedicine E/M Section Added Synchronous Audio-Only and Audio/Video Visits

New E/M codes for 2025

Not for Medicare Billing in an FQHC

There are 17 new E/M codes for telemedicine and virtual check-ins.

Previous telephone E/M codes

99421-3 were deleted for 2025.

You will need to determine if these new codes are on your ***2025 fee schedules for non-Medicare plans*** or if you should continue to use modifiers-93/-95, G2250-G2252, or T1014.

NEW telemedicine with synchronous *audio and video*

98000-98003 (new)

98004-98007 (est.)

+

NEW telemedicine with synchronous *audio-only*

98008-98011 (new)

98012-98014 (est.)

Brief patient-initiated "virtual check-in"

Bill 98016 (*5-10 minutes, not related to an E/M w/in 7 days, does not result in an immediate visit*)

2025 FQHC Medicare Billing Thoughts for 2025 Until September 30, 2025 Pending Future Updates

Medicare Billing 2025 Updates

On March 15, 2025, Congress ***extended Medicare telehealth flexibilities until 9-30-25,*** which expanded the geographic requirements and eligible practitioners for FQHC services that were due to expire 3-31-25.

Expect upcoming clarifications in the new 2025 Congress and CMS educational materials

FQHC Medical Telehealth

Report code ***G2025 for all non-mental health telehealth services*** if on the most recent CMS-approved list to get paid via special payment rule ***flat fee ~$96 split 80/20***.

FQHC Mental/Behavioral Telehealth

List the ***CPT/HCPCS-II codes performed and add a modifier*** (ex. -93/-95) identifying audio-only or audio/video, etc. generating your AIR/PPS rate and applicable coinsurance.

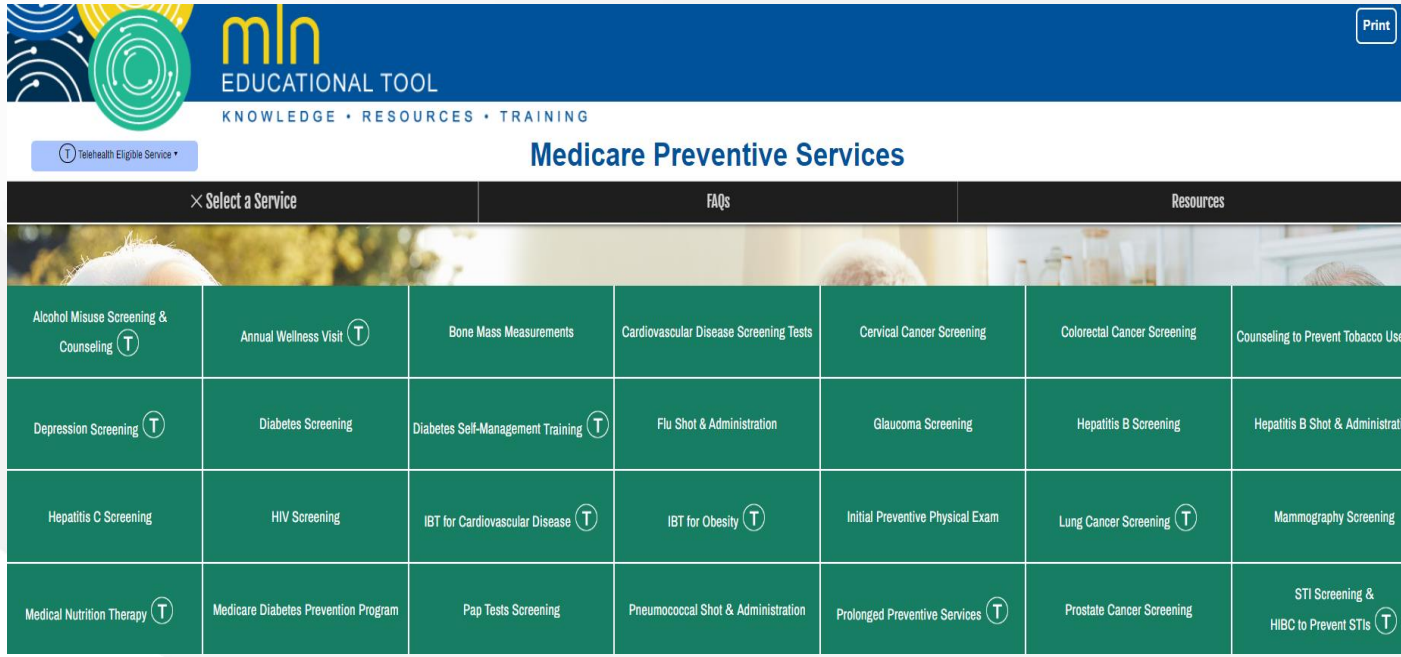
Brief *patient-initiated* "virtual check-in"

Expect to continue using the ***FQHC-specific code G0071***.

Access the Medicare Preventive Services Tool for Medical/Behavioral Health CMS-Covered Preventive Services

INCLUDES:

- Intensive Behavioral Therapy (IBT) for Obesity
- Alcohol Misuse Screening and Counseling
- Counseling to Prevent Tobacco Use
- Depression Screening
- IBT for Cardiovascular Disease
- and more…



Care Management Services Documentation for Clinical Providers

AMA CPT Guidelines

"management and support services provided ***by clinical staff***, under the direction of a physician or other qualified health care professional….(that) include"

The 2025 AMA Professional Edition ZERO CHANGES and 2+ pages of text on care management documentation guidelines. *Providers must be familiar with these guidelines* rather than how we get paid!

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

Coordinating the care of other professionals and agencies

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

“General Care Management” Coding for Medical and Behavioral Health Providers Managing Care Plans

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

Perform an “Initiating Visit” within 1 year prior to first billing General Care Management.

Chronic Care Management

99487-99491, +99439

+

Principal Care Management

99424-99427

Behavioral Health Integration (BHI)

99484

OR

Psychiatric Collaborative Care Model (Psych CoCM)

99492-99494

Monthly Chronic Pain Management

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

Many more related monthly care management options for FQHC were added by CMS in 2024 including Community Health Integration, Principal Illness Navigation that may allow for billing for services performed by community health workers, peer support, and patient navigators!

BHI and Psych CoCM Additional Information for Medical and Behavioral Monthly Interactions Between Patient Visits

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

- To distinguish general BHI services from the Psych CoCM, please visit the *CMS Fact Sheet for Behavioral Health Integration Services* for details on the CoCM model and how it differs from general BHI.
- BHI ***optionally*** includes a Behavioral Heath Manager and a Psychiatric Consultant, whereas the Psych CoCM ***requires*** their active participation. BHI is 20 minutes per month, Psych CoCM is 60 minutes.
- Check out code **G0323** for ***"Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month"***

For Medicare, G0511 Can Continue To Be Used 1 or More Times for General Care Management but Must End September 30, 2025

NOTE that the term "*general care management*" is used in the definition of G0511 rather than naming each of the 20+ options.

Transitional Care Management and the Psychiatric Collaborative Care Model are NOT included, although they are in the CPT Care Management section.

G0511 = Rural Health Clinic or FQHC only, ***general care management services 20 minutes*** or more of clinical staff time for chronic care management services directed by an RHC or FQHC practitioner (medical doctor [MD], nurse practitioner [NP], physician's assistant [PA], or certified nurse-midwife [CNM]), per calendar month.

- "**General care management" =** principal/chronic care management, monthly chronic pain management, assorted remote monitoring services, community health integration, principal illness navigation, various time-based add-on codes, OR behavioral health integration.
- Payment is made via a special payment rate rather than the PPS rate at the average of what CMS pays FFS providers for all general care management services until October 1, 2025, at **~$54.67.**

Go to https://www.cms.gov/files/zip/rhc/fqhc-cy-2025-payment-rates-non-facility.zip **for CMS' individual FFS 2025 rates for care management services.**

RHC/FQHC May Use Either Code G0511 or the Actual CPT/HCPCS-II Codes from Now Until the End of September 2025

- ***If you already bill*** commercial and/or Medicaid carriers for Care Management services ***using the CPT/HCPCS-II codes*** – it seems as though that would be a logical option on January 1, 2025.
- This would allow you to **also report the *"…additional (XX) minutes"*** codes to be paid and patients know what they are being charged for.
  - Be very careful to charge the patient's coinsurance correctly based on your choice!
- The reimbursement from Medicare if using the actual CPT/HCPCS-II code(s) will be ***paid at the non-facility physician fee schedule*** (i.e., fee-for-service) for each code range via a special payment rate ***rather*** than the PPS rate.

Or consider the OPTION to use the new 2025
Advanced Primary Care Management (APCM) Services

Advanced Primary Care Management (APCM) Monthly Service Options

2025 NEW APCM Codes

Per CMS – "…***incorporates elements of several*** existing care management and communication technology-based services ***into a bundle*** that reflects the essential elements of the delivery of ***advanced primary care,*** including principal care management, transitional care management, and chronic care management."

Conditions must significantly increase risk of death, acute exacerbation/decompensation, or functional decline.

G0556 ~$15

Persons with one chronic condition.

G0557 ~$50

Persons with two or more chronic conditions.

G0558 ~$110

Persons with two chronic conditions **AND** a status as a dual-eligible Medicare and Medicaid patient.

References (1)

Slide 8: Get Training on, and Then Access to, The Medicare Coverage Database (MCD)
MCD Help and Resources. (2024). CMS.gov. https://www.cms.gov/medicare-coverage-database/help/help-and-resources.aspx

Slide 10: FQHC/Community Health Centers Impact of the Qualifying Visit
Centers for Medicare & Medicaid Services. (n.d.). *Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS)*. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

Slide 11: FQHC/Community Health Centers QVL Samples – When would a behavioral health provider use a "medical" code"?
Centers for Medicare & Medicaid Services. (n.d.). *Medicare Coverage Database*. Retrieved June 16, 2025. https://www.cms.gov/medicare-coverage-database/search.aspx

Slide 14: Finding an ICD-10-CM Code isn't enough. Can you access key instructional notations also?
Centers for Medicare & Medicaid Services. (2024). *ICD-10-CM Official Guidelines for Coding and Reporting*. (2024). https://www.cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf

Slide 17: Compare/Contrast: Diagnostic and Statistical Manual of Mental Disorders (DSM)-5-TR vs. ICD-10-CM
American Psychiatric Association. (2013). *Highlights of changes from DSM-IV-TR to DSM-5*. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM_Changes_from_DSM-IV-TR_-to_DSM-5.pdf

References (2)

Slide 30: Access the Medicare Preventive Services Tool for Medical/Behavioral Health CMS-Covered Preventive Services
Centers for Medicare & Medicaid Services. (n.d.). *Medicare preventive services quick reference chart*. Retrieved June 16, 2025. https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#AWV

Slide 33: BHI and Psych CoCM Additional Information for Medical and Behavioral Monthly Interactions Between Patient Visits
Centers for Medicare & Medicaid Services. (2025, April). *Behavioral Health Integration Services*. (2025, April). https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf

Centers for Medicare & Medicaid Services. (2019). *Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions*. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Slide 34: **For Medicare, G0511 Can Continue to be Used 1 or More Times for General Care Management but Must End September 30, 2025**
Centers for Medicare & Medicaid Services. R*NC_FQHC CY2025 Payment Rates_Non-Facility.* (n.d.). Retrieved July 11, 2025, from https://www.cms.gov/files/zip/rhc/fqhc-cy-2025-payment-rates-non-facility.zip

Q&A

Accessing Training and TA Opportunities

EMAIL US
bphc-ta@bizzellus.com

VISIT THE TA PORTAL
bphc-ta.bizzellus.com

SUBSCRIBE TO THE HUB IN FOCUS
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Scan the QR code to subscribe and watch for updates in the Hub in Focus regarding additional TA opportunities

Continuing Education (CE) Opportunity

- We offer BH CEUs for participation in BH/SUD TA events.
- You must attend the event and complete the online Health Center TA Satisfaction Assessment form after the event (2–3 minutes).
- CE certificates will be sent within 5 weeks of the event from the Health Center BH/SUD TA Team via Smartsheet <user@app.smartsheet.com>

NAADAC Approved Education Provider

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

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JBS International, Inc. has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6442. Programs that do not qualify for NBCC credit are clearly identified. JBS International, Inc. is solely responsible for all aspects of the programs.

Health Center Satisfaction Assessment

We'd love your feedback on today's session!

Please take 2 minutes to complete the Health Center TA Satisfaction Assessment.

Thank you for your time!

https://www.surveymonkey.com/r/DBCWebinar

Thank you!