# Diving into Documentation, Coding, and Billing: Behavioral Health Integration

September 29, 2025

**Moderator:** Welcome to the Behavioral Health Substance Use Disorder Integration Technical Assistance webinar, Diving into Documentation, Billing, and Coding. Behavioral Health Integration Part 2. 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 questions and answer feature. To open the Q&A, click on the Q&A icon at the bottom of your Zoom window. Our presenter, Gary Lucas, will answer as many questions as he can during our time together. You may also email your questions to bphc-ta@bizzellus.com if we run out of time. 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. The slides, recording, and transcript will be available on the TA portal following this webinar. We offer 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. 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 BH/SUD TA Team via Smartsheet. We're excited to share that we have more Continuing Education opportunities coming up for you. Please register for the new fall events. We'll add these links to the events in the chat momentarily, so you can take a closer look. I am pleased to introduce you to today's presenter.

Gary Lucas is the Vice President of Research and Development of ArchProCoding, maintaining and administering its rural health clinic and Federally Qualified Health Center certification programs. Mr. Lucas has conducted more than 1,900 national seminars on medical records, documentation for physicians, and outpatient-based medical centers over 30 years in 46 states. His specialties include 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, hello, and thank you for attending today. My name is Gary Lucas, located here in Atlanta, Georgia, and I serve as Vice President, as you mentioned, of Research and Development for the Association for Rural & Community Health Professional Coding, shortened to ArchProCoding. A couple of quick disclaimers here. The content that we're teaching, of course, is based on our research. We'll be very factual with what we present.

We'll share with you how to access the resources that we're using to base this information on. I may have a couple professional opinions thrown in there, but please, because you deal with

commercial insurance, you deal with Medicaid, you deal with commercial insurance, managed care programs, we have to be very conscious that billing rules will change based on the payer. Please be cautious and ensure that if you use the information from this session, that it applies to your compliance rules for that individual carrier.

We will give you ways to access some of this information, in order to keep track of the inevitable changes that will occur. Some, believe it or not, this Wednesday, this is being recorded September 29th, there are potential changes we may expect this afternoon, if not by October 1st. Please be sure to double-check if there's been any updates. Our goals and objectives are to use the CPT book, your HCPCS Level II manual, and of course, the ICD-10, to not just code and bill for these services, but ensure that the documentation is present in the medical record, by the way, which is owned by the patient.

As we bring medication-assisted treatment here, that obviates the integration of medical and behavioral health services, not just being co-located, but as you seek to truly integrate those operations through substance use disorders, opioid use disorders. Your medical providers tend to lean for MAT services versus concurrent behavioral health opportunities to determine through diagnostic, or even therapeutic procedures to give that patient full support for the challenges they face.

Now, the primary vehicle that you're going to use during the various phases of medication-assisted treatment, starting with your screenings, your brief interventions, and your referrals for treatment. They have codes for those that are going to differ by payer. We'll present towards the end of the presentation, but during the induction, and stabilization, and maintenance phases, your primary billing vehicle are evaluation and management services, whether done face-to-face, or via telehealth.

We'll touch on those guidelines at a high level, and break down potential issues we may see and face at the end of 2025, and potentially, 2026 related to telehealth. Not just focusing on acute and chronic conditions, or patients that have symptoms, signs, abnormal test results, pre-existing conditions, but behavioral health professionals can also participate in various scenarios on preventive medicine.

When we say FQHC, Federally Qualified Health Center, or use the term "community health centers" interchangeably, realize you know automatically we're talking about Medicare. We will focus on the Centers for Medicare and Medicaid Services. We're not going to get into detail on the medical ones, but we'll point out those that might involve behavioral health issues, and/or behavioral health staff.

Then, finishing with an overview of care management, especially when medical and mental health professionals are spending time in between patient visits, coordinating that patient's care to update, and revise a treatment plan, or as Bethany asks in the Q&A box, a case



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conference with a counselor, or a schools' system or a teacher. Bethany, that would likely be considered a type of care management service depending upon how long it occurred.

I would not report that as an individual service, expecting the patient's insurance to pay, when they're not seeing the value, nor did they participate. Bethany, as we finish today in care management, the time spent in those types of services would be captured that way. If you would please launch the poll. We're going to ask you a couple of quick questions. We'll spend probably 60 seconds on this.

If you would go ahead and answer that, and I don't recall if you can answer more than one. Oh, it's a single choice. All of these items are going to be relative to today's discussion at some point. I'm seeing, and expect to see a variety of approaches here. Understanding the preventive services, applying the codes for opioid use disorder. Documentation requirements, of course, goes back to our session 1.

If you did not attend our part 1, I think it was back in the first week of September, you may want to consider reviewing that webinar first prior to this, because we set the table on where to locate documentation requirements. Telehealth and virtual communication will be one of the next-to-last issues we talk about. We'll spend about 20 more seconds on the poll, but overwhelmingly-- Well, somewhat overwhelmingly, documentation requirements actually serves as the underpinning for almost all of those items.

I'll do my best if we can go ahead and slow down, and/or end the poll. Thank you for that. That also gives our friends at HRSA who are attending an understanding of future offerings that might be provided via this, or other opportunities. If at all possible, let's keep the questions relative as much as possible to today's subjects. Since some of those issues discuss how and when we may-Excuse me, get reimbursed, documentation is one thing.

Coding exists, so you can tell the patient what was done, whether it's reimbursable or not. It's so that we can share with our colleagues on the medical and behavioral side everything we've done, not just what we got paid for, so documentation, separate from coding, completely separate from billing, which might vary by payer, and require you to make alternate codes available on a claim that you use with different payers.

Understanding the Medicare coverage database is one of those key central issues for any service you're thinking of. How often is the service reimbursed? Is there a list of covered diagnoses for various services? The left-hand side will provide you with the ability to learn how to use the database. When you see the symbol down here on the bottom for hyperlinks, there is enough information either with a picture of the website, or an explanation of what we're looking for. Please realize, we also have the hyperlinks available at the very end of the presentation to make it easier for you to access that. As a foundational item, this is a wonderful site managed by CMS to provide us with guidance as things change.



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Over time, FQHCs, of course, do not primarily get paid fee-for-service like you were used to probably at the beginning of your career. Assuming we meet the definition of what's called a "valid encounter," we would expect to generate a PPS rate. Prior to 2016, we got paid what was referred to as an all-inclusive rate, now it's called the PPS rate. We don't get paid that PPS rate for everything we do.

Care management services, from today backwards for the last six or seven years, we don't get paid fee-for-service, and we don't get paid, primarily, I should say, via an encounter rate. We typically get paid the average of what about 30 different services pay fee-for-service folks. Currently, care management, using the G-code we'll talk about later, pays us the average of what Medicare pays fee-for-service providers.

Other things get paid via what are called special payment rules like medical telehealth as it exists today, has a $96 flat rate. That's not fee-for-service. That's not PPS. That's a special payment rule. Of course, lab services are done on that fee schedule. We have a wide variety of approaches. If you meet the definition of a valid encounter, which is as follows, a face-to-face visit with an authorized provider that meets medical necessity, and is performed at an approved location, assuming your medical record contains the documentation to support that from Chapters 9 and Chapter 13 of the CMS benefit and claims manuals that we discussed in Part 1. Should you need information for that, again, refer to Part 1.

It ends up, the primary code that's going to go on your claim. Again, when I say FQHC, you know I'm talking Medicare, Blue Shield, Aetna, Metro Health, United, they probably don't know, or care, or even understand what an FQHC is. They just see you as a traditional doctor's office. We get paid through MACs, your Medicare administrative contractors, your PPS rate, if and only if we use one of five FQHC-only, what I call magic billing codes.

That code must be first on that claim, on that UB claim form. It's like putting the bat signal up in the sky, except for it being a bat, it's a dollar sign. Now, that tells them we promise we've met the definition of a valid encounter. The next code on that claim better be on what's referred to as a qualifying visit list. Our friends in RHCs don't deal with that. We must live and breathe, and understand the impact of that list on Medicare, and potentially, Medicaid reimbursement depending upon your state.

Now, those five codes are broken into either a new, or established medical service. Either the welcome to Medicare physical, or the no naked, no touch, keep your clothes on annual wellness visit. We touched on that in part 1. Of course, relevant to you in behavioral health, along with traditional medication-assisted treatment programs. Again, during the induction, stabilization, and maintenance phases, G0469 and G0470 identify either a new, or established mental health service.



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It should be noted, ladies and gentlemen, that the definition of new versus established that's in the CPT book is not used by you as an FQHC when reporting services to Medicare. Remember, once that patient is established with any provider of any specialty in any location of your organization, once a patient has received a Medicare-covered service, medical, dental, or mental health, they are established to your institution, so please be sure you're not reporting a new versus established patient on a Medicare patient as an FQHC.

Do not use the CPT definition. Use the definition found in Chapter 13. I think it's in Section 70. The good news is, if you do report a new medical, or mental health service, your PPS rate should go up by 34.16%. Assuming we've met the definition, and documented a valid encounter, we put one of the five magic G-codes on there, attesting that we've done one or more services, we then refer to the qualifying visit list.

In order to give you the reference that is used to make this the clear regulatory guidance, we have detailed HCPCS coding listing the visit that ding, ding, ding, here we go, qualifies the service for an encounter-based payment, and look at the kicker here, and all other services furnished. Please remember from Part 1, the abbreviation HCPCS does not just refer to the CPT book.

The abbreviation HCPCS refers to a family of codes, namely HCPCS Level 1, your CPT book from the AMA, and then CMS's HCPCS Level 2 codes. If you see a code beginning with a number, CPT code. You see a code beginning with a letter, HCPCS Level 2. Just use caution when you see that abbreviation that you don't just automatically assume we're only talking about HCPCS Level 2 codes.

Now, as we look here in a moment at the qualifying visit list, it should be noted that the last update was in 2017. There are services that it feels and seems to me, from my research, and my 30 years in the industry, that there are services that may be encouraged to be provided, potentially even as standalone services, such as a structured screening for alcohol and substance abuse.

However, folks, those codes are not on the qualifying visit list. Because it has not been updated since 2017, there are codes that are no longer in existence on the list. Although I encourage a heavy review of, and heavy awareness of the contents of the qualifying visit list, join me with a hope that we will see an updated list with current codes, and potential additional opportunities beyond the list that came in 2017.

The QVL, again, has some services on it. This is a quick snapshot of what it looks like. This is a huge, huge issue there. When you look at the left-hand side, you see that G0444, assuming we've met the proper definition of a new patient, not using the CPT definition. The next code on my claim better be an intermediate, or a comprehensive eye exam, office visit, nursing facility.



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You notice there's a code on the list that was deleted many years ago. As a heads up, read the list with rose-colored glasses. As the codes I just circled, half of them have been deleted, and they've been unified together. Now, the full list is not present in the presentation. You do see the 99406 and 99407, bringing in the worlds of medical, and/or mental health with behavior change and smoking cessation visits.

Heck, folks, if you document a proper 99406, you may have a five-minute encounter that generates your full PPS rate. Now, the full list, if you'll bear with me a moment to give you a quick little visual on it, goes beyond that behavior changing and smoking cessation to include several codes that we will review in the mental health, or behavioral health preventive medicine arena that brings medical and behavioral health together.

Things like annual alcohol screening, brief alcohol misuse, depression screening. Now, notice depression screening here is on the medical side. You should expect your psychiatrists, or your psych nurse practitioners, or anybody that is authorized and working under state scope of license rules, they might be a mental health professional, but when they perform services on the medical qualifying visit list, we need to report the appropriate G-code for a medical service, even though it was a mental health professional. It was a mental health professional.

Heck, you have psychiatrists that are going to do the office visits that we'll talk about. Yes, they're in mental health, but they're doing a medical service. Behavioral health almost in some cases jumps on both sides, and whether it's intensive behavioral counseling for sexually transmitted diseases, cardiovascular disease, or even behavioral counseling for obesity. When you're able to go beyond our time today, you'll see there's upwards of 18, almost 20, reimbursable encounters for behavioral counseling related to obesity, which again could have an influence in why they use certain substances, and may have challenges that requires your services.

Now, the behavioral health side, the mental health. Qualifying visit list is relatively quick, straight to the point. We'll show you the two primary codes, 90791 and 90792, are going to be your psychiatric diagnostic evaluations. The only difference in those two codes is the 90792 shares the words "psychiatric diagnostic evaluation," but it adds the words "with medical services."

Picking up on that theme a moment ago, if you interpret that as with medication services, that will help give you the idea of what level of licensure is allowed to report that service. I must have prescriptive authority, in order to report a diagnostic evaluation with medication services. Again, you're going to put psychologists, clinical social workers, licensed marriage and family therapists, and kind of the catch-all term "mental health counselors" outside of that 90792, but they likely can perform depending upon where you're at, 90791.



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Now, at that moment, the diagnostic evaluation identifies a mental, or behavioral issue that might justify delegating psychotherapy to an approved provider. Now, you're talking counselors, therapists, et cetera. Those codes are time-based. You live and breathe on those codes. Then, a code that is often forgotten, we mentioned last in part 1, psychotherapy for crisis, and the code psychoanalysis.

I haven't found anybody in 20 years, the last 20 years, that's told me they've even done psychoanalysis. If there are mental health services that you would like to see here, or otherwise, continue to work to make your voices heard by identifying reimbursable opportunities, but until included on the QVL, I'm not confident you should be able to generate PPS reimbursement.

Now, the documentation requirements for those psychiatric diagnostic interviews are pretty straightforward. The focus, of course, is eventually determining an initial plan of treatment, defining expected, hopefully quantifiable, subjective, but more objective goals over a period of time. You don't see 90791 or 90792 reported more often than once a year, unless there's a significant change that occurs, the addition of a new diagnosis that may complicate the treatment plan.

Again, typically, at the onset of an illness, not usually reimbursed more than once a year, although it's not prevented-- Excuse me, unless you're really making an overhaul of the treatment plan. This is not a time-based service. This is the kickoff portion. Any provider doing medication-assisted treatment should be able to offer an opportunity to see if there are mental, or behavioral issues that can impact their recovery.

Now, the service codes for therapy are well-known, 90832, 90834, and 90837 for 30 minutes of therapy. However, these time-based services are face-to-face time only. In this scenario, whether the patient, and/or a family member, or a caregiver there is fine, but the patient does need to be physically present. Now, you'll notice next to the 90832 code, there's a little plus, a 90833.

Those services are reported if a provider, again, that has prescriptive authority, is performing an evaluation and management service, plus, performing 30, 45, or 60 minutes of therapy. If there's an E&M service in therapy, you use a different code than would have been done over here by a therapist that does not have an E&M reporting capability. Because the CPT book shares that once you meet the midpoint, once you reach halfway over to the next code, you may round up, or round down, which is why I indicated there that if you get to 16 to 37, you can report that service.

Once you get to the 38th minute, you've now jumped to the next code. A reminder from part 1 at the bottom of this slide, remember that one of the exceptions to the rule, which typically says, even though you do multiple visits on the same day, and you report them all, you should



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usually expect one reimbursable encounter. Well, the list of exceptions we discussed in part 1 had a perfect relevant issue here, which is you may get two PPS rates if you have a valid medical, and a valid mental health service.

Again, using those magic G-codes, following the qualifying visit list, and not just listing the codes that identifies what you've done to generate reimbursement, but by listing everything you provided, so it can support your cost report, and be shared with the patient. Now, all of this, of course, is being done both on the medical and mental health side through the International Classification of Diseases 10th Revision, Clinical Modification.

Now, by the way, you and I all know that the way your providers, heck, maybe even your coders, are locating a diagnosis code is by searching an electronic alphabetic index. However, a bit beyond our subject today, ICD-10 codes have gone far beyond just establishing medical necessity. Hey, is this a valid diagnosis that should cover this service? Medical necessity actually defined in Section 1862, paragraph A, Section 1 of the Social Security Act, but using the Medicare coverage database that I presented in my first slide, might give you those covered diagnoses if they exist.

Of course, the impact on mandatory, or voluntary quality reporting, that impact is huge. The need to go far beyond how do I find a code, is going to be how do I properly report and support a service, but the new guidelines go into effect in two days, please make sure you realize again that the new ICD-10 goes into effect October 1st of the previous year. Note, last year, the guidelines were created by the cooperating parties, that's the American Hospital Association, that's the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, and the American Health Information Management Association, they can, and they did, last year, update these guidelines, for example, in April.

The changes weren't overly significant, but please, beyond helping providers locate a diagnosis code, let's make sure they know the guidelines. When they're searching, what level of detail are they seeing? They might find a diagnosis down here, but the question is, do your providers, do your coders, when and where appropriate, find some of these explanatory phrases, or instructional notations, they call them, here to, "Use an additional code, if applicable, to identify other specified cognitive deficits," that they give you a quick heads-up.

Does your provider see that? Does that impact reimbursement? It depends on the service you're performing, but instead of getting denied, and they say the diagnoses do not support necessity, maybe in a denials process, or denials management, my coder says, "Aha, we needed to use an additional code, and we need to go peek at this. We re-addendum the medical record, if necessary, and report the claim and get paid."

We'd want that done as soon as possible to get paid the first time, not having to get denied, and figure it out later. Without diving too deeply, when you get the chance to present this to



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your folks, do they know what the differences with words in parentheses compared with brackets? Do they know, for example, when you read the word "and" in the ICD-10, you have to say, "And, or, or."?

Like we saw over there, use additional code doesn't necessarily tell me the order those diagnoses go on the claim form, but instead of use additional code, what happens if it says, "Code first," the underlying condition? They're telling you that you're going to need another diagnosis, and they're telling you the order they may need to be reported in. What's the difference between excludes one and two?

Heck, folks, we could spend an hour just going over these items, but I present some of these questions for you, for your providers and coders to build a shared platform of knowledge that goes beyond finding the code, but tells them the rules of the road, and those are the official guidelines that we referenced.

Giving you a couple little quick areas to look at. One, very relevant to our work with medication-assisted treatment and substance and or opioid use disorders, because from a coding perspective, Section 1, Subsection C, Chapter 5 describes the need to use one code, either use, abuse, or dependence when coding SUD and OUD work and or MAT work. The issue here is that many professionals were trained on terms that don't appear in the ICD-10, and you may find the medical record saying mild, moderate, or severe use disorder.

There's going to be a communication issue here where a coder says, hey, wait a minute, I don't see those in the ICD-10. I don't want to choose use, abuse, or dependence, so I go down the hallway, find the provider, and I say, silly provider, I know that you have a list of 11 or 12 questions that you ask. If you use a multiple-question approach to determine if the patient has a use disorder, but I can't find mild, moderate, or severe, I need you to tell me use, abuse, or dependence.

The provider says, silly coder, if you go look in what's called the DSM-5, the Diagnostic and Statistical Manual of Mental Health Disorders, Technical Revision, you will see, for example, that the DSM-5 and now the DSM-5-TR, about a year before we went from the ICD-9 to the ICD-10-CM book, they went from the DSM-4 to the DSM-5, at which point they no longer make a clinical distinction between abuse and dependence, but you better believe that the ICD-10 guidelines do. It's not surprising. It's just natural part of the world here, but you're going to have clinical terms that may not agree with the diagnosis terms, and we need to have those discussions because, again, only one code should be identified.

Even if use, abuse, and dependence are all documented, you only code to the highest level there, in this case, dependence. That's a potential challenge for diagnosis coding on medical and mental health. When you go through the guidelines, perform research, et cetera, you'll find, based on the list of 11 or 12 questions they ask the patient, that based on the yes answers



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to either two to three of those symptoms, that's mild, which should get coded as abuse. However, if the patient gives positive responses to four or five, if not six or more, that is typically coded as dependence.

Now, I need to be cautious on the right-hand side, folks. Of course, I'm not making recommendations, nor is the project, but the clinical decision to make a diagnosis and either have more behavioral counseling versus formal screenings and interventions, I, of course, leave that to the clinicians, but that might help bring clinical and coding terms together.

You're starting with what people mainly call your SBIRT, of course. However, SBIRT, screening, brief intervention, and referrals for treatment, they do require that you're using a structured screening tool. This is not a free-form documentation. There are specific elements that need to be reviewed. Although the SBIRT tool says the words, and the definitions of your screenings, brief interventions, hinting at referrals for treatment, you're not required to use the SBIRT tool.

As long as your providers are using a structured, preexisting tool that's on the United States Preventive Service Task Force list of approved tools, you're going to likely report 99408 or 99409. That's your starting spot. If you did 15 to 30 minutes, that's face-to-face time only. Or greater than 30 minutes. Well, welcome to the wonderful, wacky world of billing, y'all. I'm in Atlanta. I say, y'all.

Some carriers and some payers, instead of the 99 codes, want the G codes, which, guess what, has the exact same definition as the 99 codes. Now, if you ever call a carrier and say, hey, wait a minute, you were paying us those 99 codes for years, but we're getting denied. Did you stop paying for these screenings? They're going to say, I'm not allowed to give you billing information on the phone. Please refer to your contracts and your fee schedules. We have to do the work to determine if or when they change what code they want.

Oh, by the way, that's going to change by carrier, but look at these codes for similar services based on how much time that begin with the letter H. H codes are only for Medicaid consideration. That does not mean each of your payers are going to want them. Heck, we have four or five different managed care Medicaid programs here in Georgia. Some might want the 99, some might want the G, but Medicaid may say, you know what, we'd rather use the H codes.

Now, some of those codes related to mental health and medical behavioral health preventive services are at the bottom. We know the G0442 for annual alcohol misuse, covered once a year, it says annual, but wait a minute. What if the patient screening does not result in abuse, if not dependence? There is alcohol misuse, but it hasn't risen to the level of dependence. The Medicare coverage database and other wonderful CMS materials that are out there will tell you if that happens, then you go to code G0443, but your deeper research, not found in the definition of the code, is that they will allow four brief face-to-face behavioral counseling



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services up to 15 minutes over that next year. Annual depression screening, of course, again, face-to-face.

Assume we have now defined and diagnosed a patient with substance or opioid use disorders. The patient gives us the authority to provide this type of care, understanding what it entails. At that first, if not subsequent encounter, over time, we're going to have office visits, both for medical and or mental health professionals. Now, the time that we have here together, we could do an hour just on the next couple slides, but note the old world of talking about how much history and exam you've documented has gone away. We now focus on medical decision-making, which we'll give you some tips on here, or the amount of time that you spend with the patient.

Because in the past, and I mean prior to 2021 and 2023, you only used the time that you spent with the patient when doing your 9-9 codes, your E&M codes, your office visit codes. You were only allowed to use the time spent if and only if counseling and coordination of care dominated greater than 50% of your encounter. Now, we have to learn how to code based on either decision-making or time, and just put the focus here, whichever gets you to the highest level of service.

Providers and coders will need to learn how to document decision-making, and we need to know when the clock is ticking because office visits, hospital visits, nursing facility visits, if you're using time rather than medical decision-making, we need to know when the clock's ticking because it involves way more than just face-to-face services. There are pre-work, pre-I should say encounter, and potentially post-encounter work that is countable towards time, and it's listed on page 13 of the AMA CPT book in 2025, probably close in 2026. Heck, folks, the time you spend preparing to see the patient. The clock's ticking.

Obviously, the time we spend doing the history and the exam is there. The time we spend educating the patient and the family member. Heck, folks, I might go at my desk at lunch and order the patient's medications, tests, and procedures, and the clock was still ticking. The time I spend referring and communicating with other professionals, again, on the Date of Service is included, and maybe I go home at the end of the day, have dinner, put the kids down, and it's if I log on at ten o'clock, it might take me 10 more minutes to even finish that note. Guess what? The clock was still ticking. There is an incentive of sorts if necessary to document on that date of service to give our providers that opportunity.

If we're going to medical decision-making, again, this is an overview of what's needed, but pages 8 through 13 of the CPT book are used to help us understand what the number and complexity is of the problems we're addressing. What's the amount and complexity of the data that we're looking at in terms of diagnostic tests? Based on our diagnostic or therapeutic services, what are the risks of complications and or morbidity and mortality of patient management?



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Now, we're going to do this obviously at a higher level. There's a need to review that content, see what changes we might find in 2026, but the good news is if one of these elements ends up being lower than the other three, it's not going to bring our level of service down. In order to determine whether there is straightforward, low, moderate, or high decision-making, we're going to need to use our highest two of those elements. We're going to go take a little closer look at each of those three columns, numbered one, two, and three there. I'm going to bring some results over making some assumptions, are you ready, on what your average MAT patient is going to be, whether it's medical or mental health. We'll come back to this tool and very quickly show you the level of service.

We have the number and complexity of problems. What we know are MAT patients, especially at the onset of their SUD and OUD care, that's not self-limited or minor, that is not assuming a stable chronic illness. You're probably between the moderate and high area, substance use disorders, of course, and opioid use disorders. Although those diagnoses are found in the mental and behavioral health section of the ICD-10, they are not behavioral health conditions or a weakness of character. It is a chronic brain disorder dealing with the wiring and chemical makeup of your brain, as well as behavioral factors, genetics, and things of that sort.

My assumption, I need you to work with me here, is that we're likely talking, at least at the onset, as we get into the induction phases, we're dealing with a chronic illness. Now, whether there's exacerbation or a severe exacerbation, I don't know, but if we have a patient who may lose their life or liver function, we're going to begin with that number of complexity of problems being high.

If we document, that is an acute, in this case, chronic illness that poses a threat to their life or bodily function, in the first column, I'm going to start with high. Without diving too detailed, maybe I look at last week's lab and I do a lab test this week. Either using quantitative or qualitative lab studies. If that's all we did, or maybe did one of those in review of a note, we're going to have limited here. Although I don't want to rule out moderate and high on the behavioral health side, you're usually talking about different interpretations of results and independent historians.

In general, for this example, I'm going to put limited there. Just realize, again, that each lab you order contributes towards this one. By the way, it's about a 15-minute discussion just between your providers on this slide to determine what the traditional focus is and make sure if we're using the review of last week's labs as a potential element to impact our coding, I've got to document it.

Now, we'll stick right here with prescription drug management because absolutely slam dunk medication-assisted treatment, especially at the onset when we determine the proper dosage for buprenorphine, suboxone, or other alternatives. We're dealing heavily with trying to determine during the stabilization and maintenance phases how and why we're adjusting the



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meds. I encourage a review of the CPT book to gather all of the items underneath moderate, but in this case, I'm going to stick with prescription drug management, although you may need to look and find out what drugs might fall into the first and last bullet that for some might pull it to a higher level.

I go back here. I know this is quick, but I have to have two of the three elements. If I look at level five, both a new and an established patient, I don't have enough to support level five because I only have one item. Hey, wait a minute. Here's one. I'm at the second item. I have an absolutely rock-solid level four service in this example. Now, over time, their condition is going to move to hopefully not have complications, to be a stable illness. You see what that might do to our level of service over the care continuum. Understanding what's needed and when the clock is ticking for time, understanding what to review and what your coders and what your billers need to review in order to calculate decision-making because, heck, folks, you might have a nine-minute visit that's level five, not based on the time, but the complexity of the problems you're dealing with.

Now, if your visits are occurring via telehealth, we're waiting until Wednesday. Today is Monday. By Wednesday, if we do not receive congressional approval to extend telehealth in an FQHC, we will not have the capabilities. We'll go back to what happened prior to COVID where we did not have capabilities for telehealth and extending where patients and providers can be.

We did, in 2025, get new CPT codes for live audio and video or audio-only telehealth. Now, these are not to be used for Medicare because they recreate some in the CPT book. They're likely used for commercial insurance only, and those are typically prescheduled versus what's called a patient-initiated check-in. Be aware that all of the codes in the E&M chapter no longer begin with 99 automatically. There are some 98 codes. If I ask you to place your focus in two places, notice that these are not used for Medicare and your commercial payers and Medicaid may want these codes on the right-hand side or some of the options or alternatives listed at the bottom left side of the slide.

How do we report telehealth in an FQHC? Until we hopefully, fingers crossed, receive an extension or even most beautifully, a permanent extension of medical and behavioral health telehealth where we get paid what we would have done had we done that service in person. That is my dream land. Telehealth was due to expire because the public health emergency that gave us that authorization was supposed to end at the end of 2024. It got pushed to March. It then got pushed to this Wednesday. All those CMS and other authorities have expressed their desire to continue to let those of us providing care in underserved areas to get paid for telehealth.

As of today, if it's a medical telehealth service, we just report one code. If it's on the CMS list of approved services and we get paid a flat fee instead of what everybody else gets paid, which is what they would have been paid if they did it in person, but there we are. If it's a mental or



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behavioral telehealth service, we now tell them what we've done and billing adds a modifier to tell them whether it was live audio and video, or just audio. Rather than using the CPT code for those patient-initiated check-ins, we have an alternative code to report as an FQHC, G0071.

In order to access the list as we wind our way down here in about three to four minutes, here are those services I mentioned that bridges the world of medical and behavioral health. The link at the back of the presentation, rather than going to Chapter 18 of the CMS preventive manual, that's about a 280, 290-page document that gives the best detail, CMS created a wonderful interactive tool where you can see the details about alcohol misuse and screening. It's going to tell you if the patient has misuse, but it doesn't rise to the level of dependence, how many additional behavioral health services for will be covered throughout the next year. Wonderful interactive site constantly being updated.

I finish, ladies and gentlemen, with what about the work we do in between visits. When we're talking about the time that our clinical staff spends in between patient visits. I feel strongly that our ability to report care management services obviates the time we spend in between visits to work for the patient, to update, if not revise and monitor their care plan. The patient's getting value.

The time we spend coordinating the care of other professionals and agencies. For example, Ms., I think it was Brittany there, or Bethany, excuse me, at the very beginning. That time spent coordinating the care of other professionals, reaching out to that nurse at the school or the school system, if I read your question correctly, or that counselor. I can't bill the patient for that directly because they weren't there. However, that work we do, that 10 minutes, that 15 minutes can go together with the time we spend revising and monitoring, along with the time spent educating the patient or their caregiver about their condition.

If we reach the minimum time thresholds for each of the various types of care management services, I got to be careful there because when I say care management or chronic care management, that really only identifies one little set of codes. Chronic care management, meaning the patient has at least two or more chronic conditions expected to last at least a year or until the end of their life.

Folks, we say chronic care management. The correct term up here is general care management. That not only includes chronic care management, but the management of patients who might have a single high-risk condition that might result in decompensation or hospitalization. Hello, SUD and OUD. That's principal care management. When we see medical and behavioral health professionals working together on that patient, you're living in the neighborhood of the codes, not the concept, the codes for behavioral health integration and the University of Washington Psychiatric Collaborative Care model.



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Folks, care management is an umbrella that covers pain management and many, many, many other items that are described briefly in the bottom blue box, but accurate and relevant to you. We encourage you to locate the link that distinguishes behavioral health integration from the collaborative care model to give you guidance on how to make that time appropriately and compliantly reimbursable.

The staffing model for the psych collaborative care model is a little different. It requires the participation of a psych consultant and behavioral health manager. The time limits are different, but it should have been noted. I should have pointed out on the previous slide, the CPT has two full pages on what care management means. As I wind down here to get us to the Q&A, I did want to pull out one of those 30-something codes, namely G0323, if the care management services are not traditionally, as should be, reported by the medical provider. If that care management is led by a psychologist or social worker, I wanted you to have those codes.

The key change to occur this Wednesday is the elimination of code G0511. Unless we see a change that extends it later, code G0511, that's described as an RHC or FQHC-only general care management, includes all of, most of those other services. The point is in two days, even though we could use G0511 all year, and you're going to get paid the average of what CMS pays those fee-for-service providers for using the link at the bottom. If you're already billing commercial and Medicaid payers using the individual codes, as we're likely going to do on Wednesday, that seems an obvious good choice. You can report multiple services, and you're going to get paid what fee-for-service providers get paid. That's going to range from somewhere from $19 to about $139.

Last slide is that in addition to or to supplement care management, there are new codes, G0556, G0557, and G0558. Based on the terms of CMS, we might have the opportunities to report these non-time-based codes in addition to some general care management services.

We have a lot of information to help with. I had this one hour, folks. I invite you to the references that are located here. With over 200 folks in the room, I appreciate the opportunity to go through the slides directly. At this point, I'm going to slide up and answer relevant questions that I see in the chat box.

David, "Are there any minimal standard forms available for CMS to be in compliance with billing requirements?" Not sure what specific information or what forms you're looking at there, David. One of the websites at the beginning of the presentation is where you can send that question. If it's more specific, they can forward it to me.

Let's see here for Medicare. Let's see. "If we do a service that is not on the qualifying list of CPT under the G codes, we cannot bill under the G code. Is this still correct?" You can. I just would not expect reimbursement for the code if it's not on the qualifying visit list. If it's a service that



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you did standalone that's not on that list, I absolutely am required to submit it, just like I'm required to submit a CPT preventive medicine code. I know they won't pay, but the denial might come back with the letters PR. Hey, thanks for telling us. We don't pay for that service, but it's the patient's responsibility.

Josh also, or whoever that was, I'm sorry. The questions just scrolled up on me there. The primary issue there is making sure that the guidance may change slightly over time there. It really depends on where we're at. Sorry, the questions just flew on me. Josh reads, "Just to confirm the new versus established." By the way, remember Josh and everybody, this is CMS, Medicare only when billing as an FQHC. His question, "This is not restricted to our specialty, but to any service in our FQHC." That's correct.

The moment a Medicare patient sees anybody of any specialty in any location of your organization for a Medicare covered service, they are now established to the institution. The UB claim form you report your services on contains the services that all providers did on that same day. Heck, the name of the claim form is the 837I form, I for institution. You're correct, Josh. We don't think about whether they've seen somebody of our specialty because in an FQHC, you don't use the CPT definition of new versus established.

Ms. Venus, that would also apply to your vision services. Venus says, "For new and established patients for FQHC, are vision services included along with medical, dental, and mental health?" They really, in the guidelines, only say medical and mental health. Putting dental under the medical side, and yes, vision under the medical side, assuming that the only service the patient got was not a screening service, that's not paid by Medicare. If it wasn't a Medicare covered vision service, if it wasn't a Medicare covered dental service, then we have a new patient. All right.

Tanya, that deals with your question as well. Becky, "We've been told that patients cannot see the medical provider and the BH provider in the same day and receive our PPS rate." Becky, please refer to Chapter 13 of the FQHC CMS Benefit Policy Manual, Section 40.3, bullet number 3 or bullet number 5, where it points out that both a medical and behavioral health, you can generate two encounter rates. The key, Becky, is they have to go on the same claim form.

If the medical office is on First Avenue, the behavioral health office is on 7th Street, and they do their own billing, whoever gets the claim out first is going to be the only one to get paid. You don't bill for each facility. You bill as the entire institution. If both put on the claim form, absolutely, it would generate two PPS payments. I would never, ever, never, never, and in case I forget to mention it, ever, change the way we treat our patients, whether we get paid or not.

There are a lot of other good questions there, folks. In order to honor your time, I'm going to turn it back over to Bizzell and the closeout for this session. They'll let you know where you can send other additional questions or get follow-up help on. Thank you for your time.



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**Moderator:** Thank you so much. 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 and Focus. Please consider joining us for other upcoming fall events. We're adding the topics and registration links to the chat again for your convenience.

The slides, recording, and transcript will be posted to the TA portal. References are included so you can delve more deeply into this topic. Don't forget, we offer behavioral health continuing education units for participation. You must complete the online Health Center TA Satisfaction Assessment to receive credit. We'll add the link in the chat for your reference. CE certificates will be sent within five weeks of the event from the Health Center BH/SUD TA team via Smartsheet.

Thank you all so much for your attendance today. This does conclude today's webinar, and you may now disconnect.



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