

DOCUMENTATION & CHARGE CAPTURE PROCESS: MEDICATION-ASSISTED TREATMENT



Providers
Clinical Support
System



NATIONAL ASSOCIATION OF
Community Health Centers

NOVEMBER 2018

PCSS Note: Following this reports' development, we were given approval to change the term "Medication Assisted Treatment (MAT)" to "Medications for Addiction Treatment (MAT)" or "Medications for Opioid Use Disorder (MOUD)." We support this change and have begun to implement throughout our educational trainings, resources and website as we move forward.

Documentation & Charge Capture Process: Medication-Assisted Treatment was developed by Shellie and Patrick Sulzberger at Coding & Compliance Initiatives, Inc., in collaboration with the National Association of Community Health Centers.

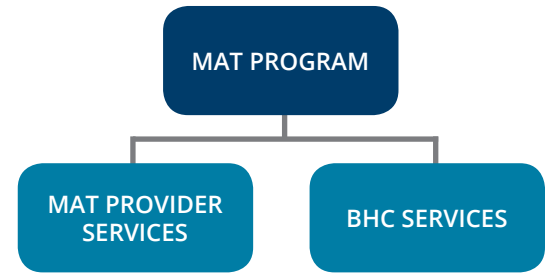
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MAT PROGRAM

Throughout this document the term “MAT Program” is used to mean the integrated delivery of medication-assisted treatment (MAT) and counseling/behavioral health services rendered for patients struggling with opioid addiction. The MAT Program will require prescribing physician(s)/provider(s) and professionals serving as behavioral health consultants (BHC). For purposes of this document, the prescribing physician/provider is defined as the “MAT Provider.” The BHC function is further defined in the glossary of key terms (**Appendix J**).



Since each patient’s treatment plan is individually developed by the respective physician(s)/provider(s), there will be variation in the medically necessary volume and scope of MAT related services rendered across the MAT Program patient population.

Primary care services can also play a significant role in the success of the MAT Program by screening patients for potential substance use disorders. Thus, a process flow between primary care and the MAT Program as it pertains to screening, brief intervention, and referral for treatment is outlined. Virtually all payers are emphasizing the key role of preventive services in the early detection of potential chronic conditions.

ESTABLISH MAT PROGRAM LEADERSHIP

Establishing a core group of individuals with “ownership” of the MAT Program, ideally representing a few key functional areas of MAT service delivery (see next page), is recommended. A leadership team will be focused on successful execution operationally, as well thinking strategically about the MAT Program and its role within the health center overall. Benefits derived from having a MAT Program leadership team include the following:

- Evaluation of resource needs (# of prescribers, BHCs, etc.)
- Improvement and refinement of processes impacting the MAT Program
- Understanding data analytics needed around the MAT Program—coordinating with IT and others as needed
- Facilitating communication with primary care services
- Facilitating communication with the Board
- Facilitating regularly scheduled meetings within the key functional areas (see next page)

DATA REPORTING

The MAT Program leadership team will be integral in determining the data reporting required to support the MAT Program operations. Customized reports will likely need to be developed to address the unique aspects of MAT Program services. Below are examples of various types of metrics that may be relevant for tracking.

PATIENT METRICS

- Name, medical record #, DOB, address
- Start date in MAT Program
- Last appointment
- MAT Provider & primary care provider
- Last urine drug screen
- Date of last substance use
- Date & duration of last buprenorphine prescription
- Insurance status, grant, etc.

**NOT AN
ALL-INCLUSIVE
LIST**

ACCESS METRICS

- Wait list
- Average length of time to get an appointment

NOT AN ALL-INCLUSIVE LIST

OUTCOME METRICS

- Patient engagement (i.e. attending MAT Provider visits, therapy visits)
- % of patients not lost to care (or relapsing)
- % of negative urine drug screens

NOT AN ALL-INCLUSIVE LIST

In addition to determining the data reporting needs, the leadership team will also determine the frequency in which specific information needs to be reported/accessible. For example, MAT Program patient tracking may include how many patients are currently in the program, their related prescription information (i.e. date and duration of last buprenorphine prescription), date of last urine drug screen, etc., and will likely be updated daily or multiple times each week since this information is critical to the daily operation of the MAT Program.

FUNCTIONAL MAT WORKFLOW

Below is an outline of the functional workflow ultimately impacting the MAT Program:

UPSTREAM FUNCTIONS

- Case management
- Scheduling and pre-registration
- Patient check-in

APPENDIX A SERIES
APPENDIX C

DELIVERY FUNCTIONS

- Initial assessment
- MAT induction
- Follow-up visits with MAT Provider
- Group and/or individual therapy sessions
- Medication counts (as applicable)
- Patient outreach

APPENDIX B & D

DOWNSTREAM FUNCTIONS

- CPT coding
- Diagnosis coding
- Billing
- Claims follow-up
- Review/re-work rejections & denials
- Communication with upstream and delivery

APPENDIX E SERIES
APPENDIX F
APPENDIX G & H

UPSTREAM FUNCTIONS: These are critical steps performed prior to the patient being seen for health care services, and have a significant impact on clinical workflow, provider productivity, and insurance billing accuracy.

- **Case Management** – this process is focused on increasing patient access to health services.
- **Scheduling and Pre-registration** – these functions are focused on getting patients scheduled with a provider and obtaining pertinent insurance information and other demographic information needed for billing and health care delivery purposes.
- **Patient Check-in** – the first team members to “engage” with the patient face-to-face at the health center, setting the tone for the visit. The check-in process has a significant impact on patient satisfaction and clinic efficiency.

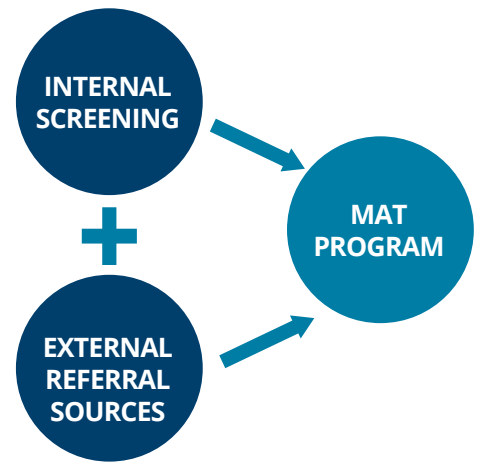
DELIVERY FUNCTIONS: The core health care services rendered by clinicians, clinical support team members, and physician and mid-level providers.

DOWNSTREAM FUNCTIONS: A key component of the revenue cycle process, the downstream functions support the cash flow of the health center. Accurate and timely coding, billing, and insurance follow-up are critical to the health center’s financial health. The downstream functions are impacted significantly by the accuracy of the demographic and insurance information collected during scheduling and pre-registration (**upstream functions**) and the accuracy of the diagnosis and CPT coding (often captured by the physicians and mid-level providers as part of the **delivery function**). From a compliance perspective, it is important for the coding and billing to be supported by the underlying medical record documentation (also part of the **delivery function**).

CASE MANAGEMENT FUNCTIONS - MAT PROGRAM

CASE MANAGEMENT GOAL – Identify individuals at risk for opioid abuse or already suffering from addiction and create access for those individuals into the health center’s MAT Program as an integrated component of effectively managing the patient’s overall health.

There are two predominate sources for MAT program “referrals” as illustrated to the right:



INTERNAL SCREENING – TEAM BASED CARE

The internal screening process will often begin with primary care service delivery. This is the health center’s opportunity to identify patients who may be at risk for developing substance use disorders and facilitate medically necessary intervention in a timely manner.

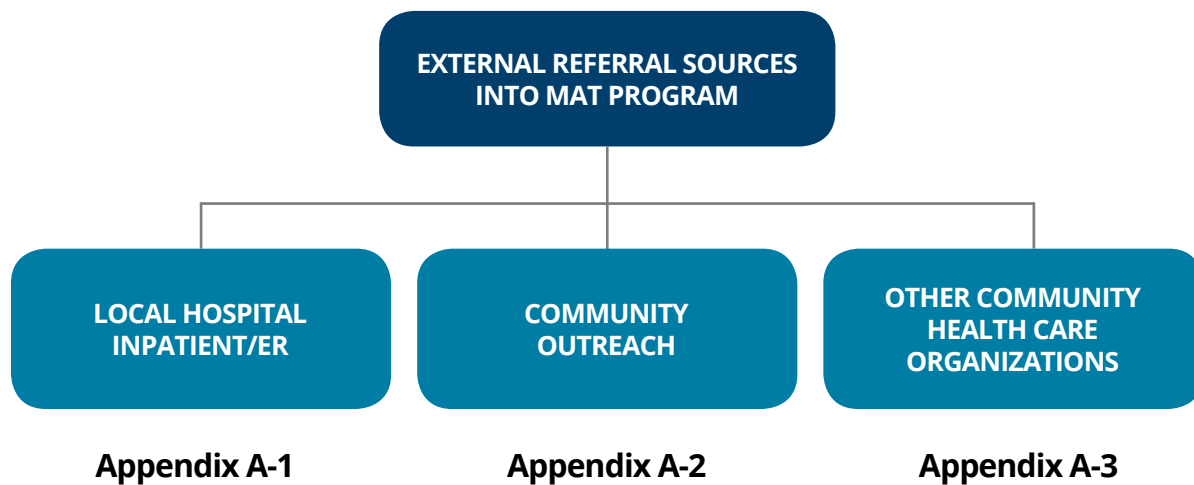
Identifying at-risk patients early can be accomplished through a consistently utilized screening process - Screening, Brief Intervention, Referral for Treatment (SBIRT).

- Several screening tools are available (**Appendix I**)

See **Appendix B** for an outline of the integration of primary care and MAT Program services facilitated by the screening process.

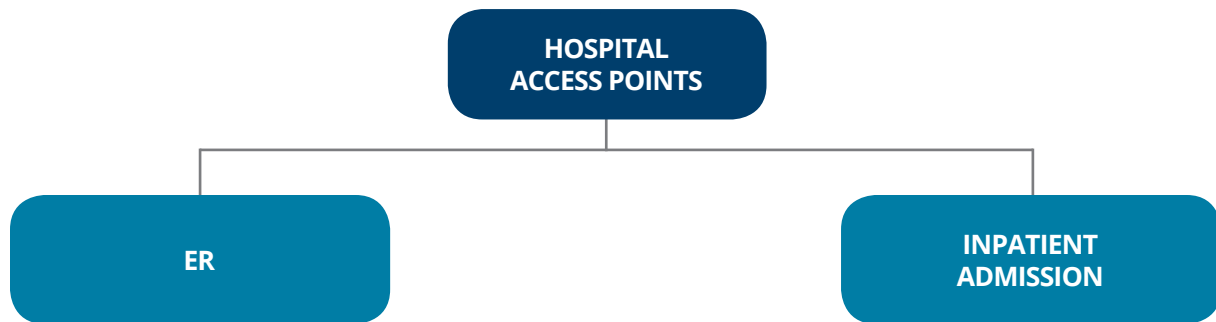
EXTERNAL REFERRAL SOURCES

A health center’s opportunity to deliver medically necessary treatment for individuals at-risk for substance abuse, as well as those already addicted, does not reside exclusively within the existing patient population. If a health center desires to expand the reach of its MAT Program services, collaborating with a variety of community partners may be valuable. Specific examples of external referral partners may include the following:



CASE MANAGEMENT FUNCTIONS - MAT COLLABORATION WITH HOSPITALS

Health centers may benefit from a collaborative relationship with local hospitals for improving and expanding MAT Program services and access. Outlined below are key process steps based upon two probable access points for MAT eligible patients.



<p>Patient presents with medical diagnosis of opioid addiction</p> <p>OR</p> <p>Patient presents with a medical condition and the ER determines the patient has an underlying opioid addiction</p> <p>ER determines an admission is not warranted</p> <p>ER contacts designated health center clinician (liaison)</p> <p>Health center clinician discusses the MAT Program with the individual</p> <ul style="list-style-type: none"> • May be physically present • May be via phone <p>Health center clinician contacts scheduling directly if the patient consents to MAT Program services*</p>	<p>Patient is admitted with a medical diagnosis and during intake it is determined the patient is at risk of opioid addiction</p> <p>OR</p> <p>Patient currently has a diagnosis of opioid addiction</p> <p>OR</p> <p>Patient is admitted with a condition due to opioid addiction</p> <p>Hospital notifies designated health center clinician liaison about the admission (for both health center patients and non-patients)</p> <p>Health center clinician visits with the patient prior to discharge to discuss the MAT Program</p> <ul style="list-style-type: none"> • A face-to-face discussion with the patient is recommended given their already inherent risk level <p>Health center clinician contacts scheduling directly if the patient consents to MAT Program services*</p>
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*The clinician should make the contact with scheduling for two important reasons:

1. The clinician is trained and knows health center protocols, resulting in better communication with scheduling
 - key upstream outcome → gather accurate information
2. Less risk the patient will fail to schedule

ESTABLISHING A COLLABORATIVE MODEL

1. Consider the health center's current MAT program capacity. It is important to be armed with accurate information about internal resources before taking on additional patient volumes.
2. Facilitate a meeting with the hospital to understand its needs and challenges related to populations it serves suffering from substance use disorders, and its goals for managing this population safely and effectively.
3. Considering the hospital's stated needs and goals (from step 2 above), develop and recommend a strategy for how the health center may be part of the solution, facilitating greater patient access to MAT services.
4. Establish designated MAT Program liaisons between the health center and hospital. Relationships are important for establishing trust; providing the hospital with consistency will promote collaboration.

REASONS FOR HOSPITAL COLLABORATION – ER & INPATIENTS

- Expanded health center outreach to patients suffering from substance use disorders
- Earlier notification of relapses for existing patients

CASE MANAGEMENT – COMMUNITY OUTREACH

PURPOSE: If a health center’s goal is to expand access to MAT Program services for individuals suffering from opioid addiction, or at risk of becoming addicted, facilitating community outreach efforts targeting shelters, soup kitchens, and similar locations can be a valuable process.

RECOVERY COACH (PEER) MODEL

Successfully expanding community outreach efforts requires finding the right individual(s) to serve in this capacity. A “recovery coach” may be a good fit for this function, as these individuals commonly possess the following attributes:

- Typically is in recovery (i.e. a peer)
- Have acquired knowledge about how to successfully sustain recovery
- Non-clinical role – this person is not diagnosing or treating addiction or mental health issues
- Able to remain engaged with patients throughout the recovery process

The recovery coach can be valuable in a case management role and in assisting patients with sustaining their recovery. Below are some examples of specific roles a recovery coach can fulfill as a MAT Program resource.

CASE MANAGEMENT	PATIENT LIAISON/MENTOR
<p>Spends time at shelters & soup kitchens engaging with individuals, eating meals with them, etc.</p> <p>Establishes rapport as a peer over time</p> <p>Facilitates scheduling willing patients for an assessment at the health center</p> <p>Stays engaged with individuals on a waiting list for the MAT Program</p> <p>Communicates regularly with the MAT Program team</p> <p>Helps develop the recovery plan</p>	<p>Helps to initiate and sustain an individual/family in recovery from substance use</p> <p>Helps client find transportation, housing, clothes, employment, child care, etc.</p> <p>Promotes recovery by removing barriers</p> <p>Serves as a personal mentor for people seeking recovery assistance</p> <p>Works with individuals beyond the recovery phase through stabilization and into maintenance</p>

For more information about recovery coaches: <https://www.oasas.ny.gov/recovery/coach/index.cfm>

RECOVERY COACH ACADEMY

Specific training for individuals serving as a recovery coach are available, including through the Center for Addiction Recovery Training (CCAR Recovery Coach Academy): <https://addictionrecoverytraining.org/recovery-coach-academy/>

CASE MANAGEMENT – COLLABORATION WITH OTHER HEALTH CARE ORGANIZATIONS

PURPOSE: If a health center’s goal is to expand access to MAT Program services for patients suffering from opioid addiction, or at risk of becoming addicted, other health care organizations can become potential referral partners for the health center.

POTENTIAL HEALTH CARE ORGANIZATION REFERRAL PARTNERS

This group would represent any health care organization that may be in a position to identify at-risk patients through its normal interaction with its patients. The decision to discuss MAT services would be solely at the organization’s discretion. Applicable organizations might include:

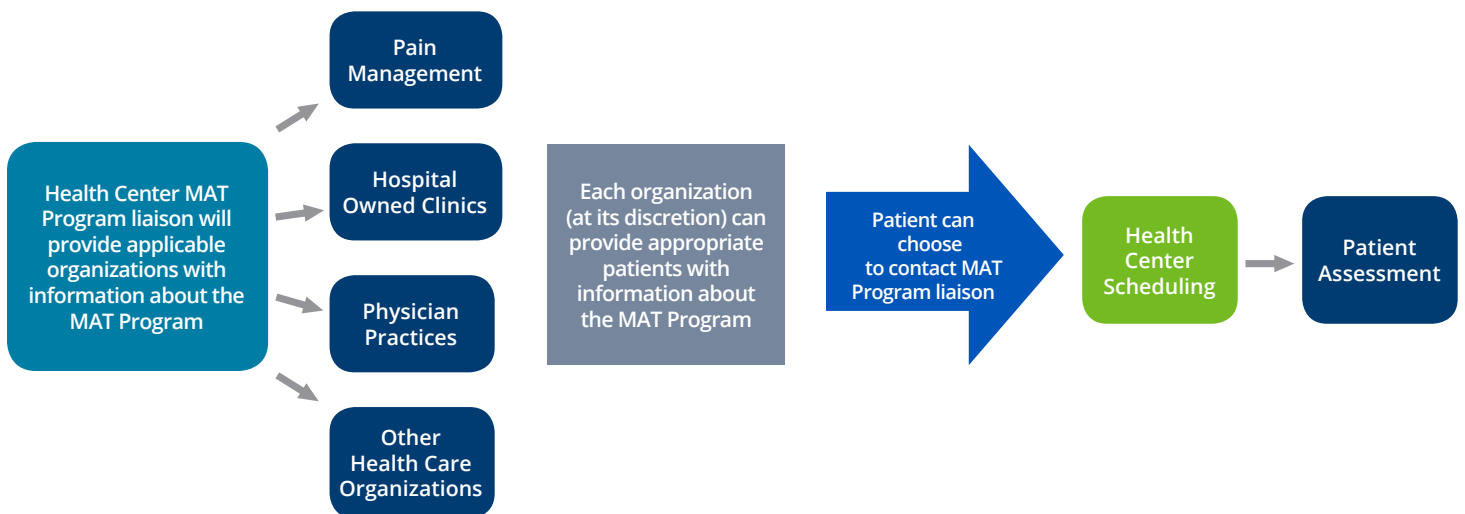
- Pain management specialists
- Independently owned physician clinics
- Hospital owned clinics (hospital employed physicians/providers)

A visual flow of this process is outlined below.

MAT PROGRAM COMMUNICATION

Successfully expanding access to MAT services requires communication about key facets of the health center’s MAT Program. This can be accomplished by creating educational content that addresses the following:

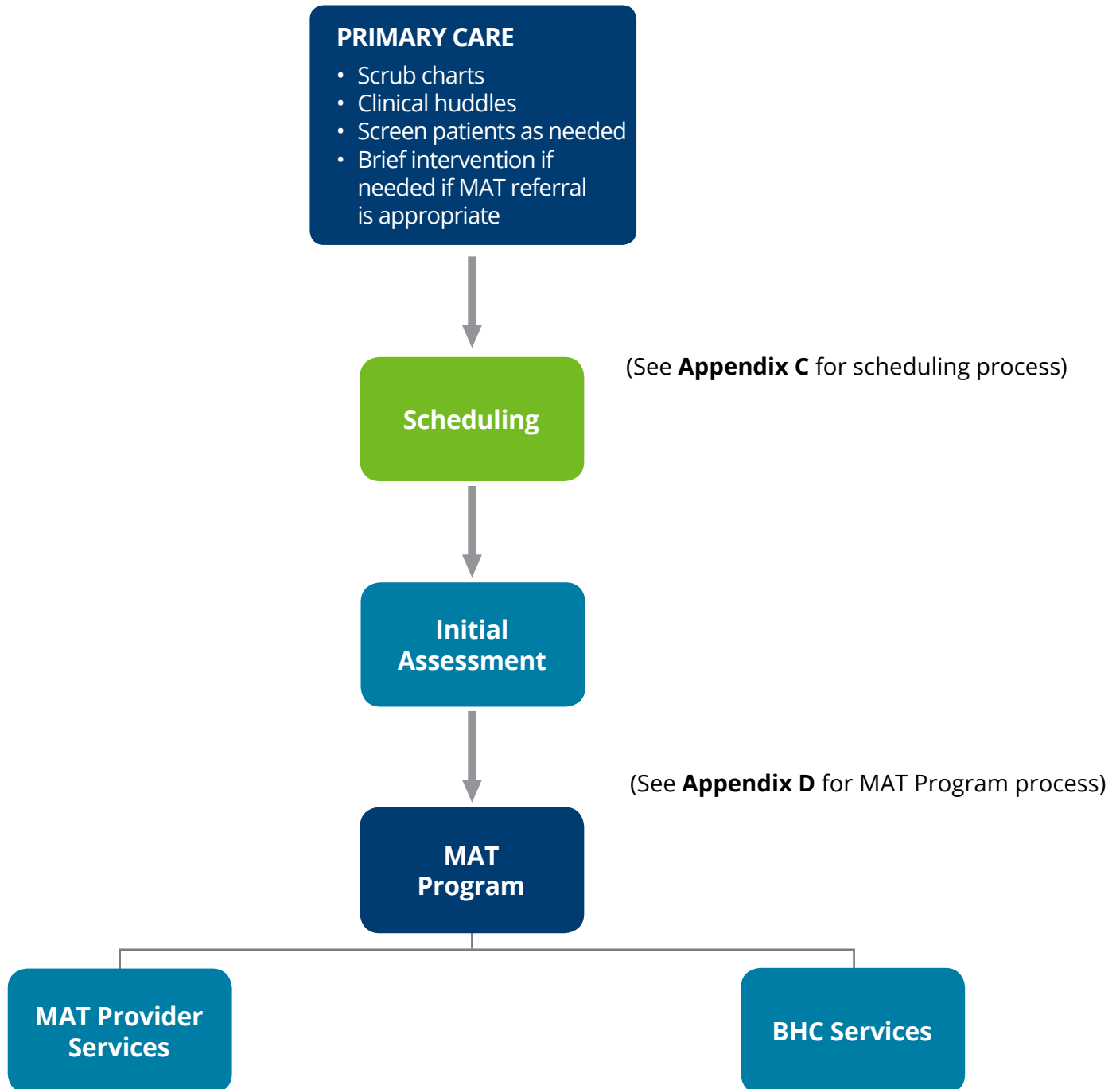
- Succinct outline of the health center’s “MAT Program” including:
 - Assessment
 - Induction process
 - Therapy services
- Support services integral to the program
- Benefits of an integrated approach between medical and behavioral health
- How to contact a MAT Program clinician with questions



COORDINATION OF PRIMARY CARE AND MAT – TEAM BASED CARE

A key source for identifying patients who may benefit from MAT Program services is the health center’s own primary care service providers. Primary care providers are at the core of managing and coordinating their patient’s overall care, and screening for early detection of potential substance use disorders is a component of overall care management.

Outlined below is a visual flow of how the internal screening process can be utilized to coordinate with the MAT Program.



DESCRIPTION OF PRIMARY CARE PROCESS STEPS

PRIMARY CARE PROCESS	BENEFIT
<p>Clinicians scrub charts two to three days prior to appointment dates to determine if SBIRT has been completed during this calendar year for all patients 18 years and older**.</p> <p>During the morning clinical huddle, discuss those patients needing SBIRT completed.</p> <p>Patient is roomed, screening is done by the clinician. If patient screening score is positive, the provider or a BHC can facilitate the “brief intervention” during the encounter.</p> <p>If the provider/BHC believes the patient can benefit from MAT, the patient should receive information about the MAT Program during this visit.</p> <p>If the patient consents to MAT services, the provider or BHC will contact scheduling directly before the patient leaves the clinic.</p>	<p>Key part of the health center’s internal identification of potential at-risk patients.</p> <p>Allows the clinicians rooming the patients to be prepared to facilitate the screening.</p> <p>Allows multiple patient issues to be addressed during the same encounter, improving clinical and provider efficiency and patient convenience.</p> <p>Increases the probability of getting patients needing MAT services scheduled immediately.</p> <p>Improves communication with scheduling regarding the patient’s service needs and reduces the risk of the patient failing to schedule.</p>

** Scrubbing the charts for patients needing the SBIRT is a component of the overall chart scrubbing process that should be done routinely to proactively identify patient needs and potential gaps in care that can be addressed during the visit. It is recommended to perform the screening annually.

Medicare released MLN Matters SE18004 on August 28, 2018 entitled “Review of Opioid Use during the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)” stating the following with regard to the review of medical and family history: “Medicare would like to emphasize that review of opioid use is a routine component of this element, including OUD.”

MAT SERVICE SCHEDULING

The process begins when a referral is made to scheduling.

- Referral could come from multiple sources, including:
 - Internal primary care screening process
 - Recovery Coach
 - Hospital ER or inpatient process
 - Patient

SCHEDULING PROCESS	BENEFIT
<p>Schedule patient intake assessment and physical exam (initial assessment).</p> <p>This will typically be done by a primary care provider prior to induction unless the MAT Provider prefers to do it during the first induction visit.</p> <p>Schedule induction visit(s) including first follow-up visit with MAT provider. *</p> <p style="text-align: center;">↓</p> <p>MAT provider and BHC should both be scheduled for the first induction visit.</p> <p>After the first follow-up visit, the MAT Provider will determine the subsequent visit schedule. (Appendix D)</p>	<p>Ensures the patient is physically healthy enough for treatment and verifies if there are any other co-morbidities that require attention.</p> <p>Scheduling the first follow-up visit at the same time as the induction visit(s) ensures a spot is available on the MAT Provider’s schedule – <u>important for patient access.</u></p> <p>Allows the patient’s therapy counseling needs to be evaluated at the start of MAT services - facilitating integrated treatment.</p> <ul style="list-style-type: none"> • A significant percentage of patients with substance use disorders also have a co-occurring mental health disorder.

* Some health centers will facilitate one induction visit, others may facilitate two to three as part of their MAT service process **(Appendix D)**

SCHEDULING TO REDUCE PATIENT BARRIERS

Health centers should schedule services in a way that will be efficient for the patient and minimize the number of separate trips required for MAT Program services. For example, try to coordinate at least two of the following three during the same visit:

- Therapy sessions
- Urine drug screen
- Follow-up visits with MAT Provider
- Follow-up visits with primary care providers

MAT SERVICE DELIVERY

DAY 1 INDUCTION

Patient seen by BHC and MAT Provider separately.

- Recommendation: The BHC sees the patient first to get the intake process done before being seen by the provider.

MAT PROVIDER	BHC
<p>Induction by MAT Provider</p> <ul style="list-style-type: none"> • Discusses treatment protocol • Addresses patient questions • Writes prescription • Observes patient taking Suboxone (or other approved medication) 	<p>Reviews patient assessment and history, discusses patient's feelings, discusses the MAT Program and expectations, discusses therapy services and options, completes applicable paperwork, etc.</p>

DAY 2 AND DAY 3 INDUCTION

Whether a patient needs to be seen for two or three consecutive days as part of the induction process is a medical decision made by the MAT Provider. All health centers will not have an identical induction approach.

FOLLOW-UP VISITS

Follow-up visits will normally be weekly initially, then taper down as the MAT Provider deems medically appropriate.

MAT PROVIDER	BHC
<ul style="list-style-type: none"> • Verifies how the patient is progressing – ensuring they are on track • Decides if a urine drug screen is needed • Refills prescriptions as needed • Determines when next visit should be scheduled 	<p style="background-color: #cccccc;">[Empty]</p>

THERAPY COUNSELING SESSIONS

Concurrently while the patient is being seen for follow-up visits with the MAT Provider, the patient will also engage in group and/or individual therapy.

MAT PROVIDER

BHC

Key considerations for group therapy sessions:

- Optimal group size – verify payer restrictions on maximum size
- Number of sessions per week
- Number of sessions per day
- Time slots for sessions

Patient access is a key goal

Monitors success of group therapy sessions over time

- Do specific time slots or days of the week drive higher attendance?

MEDICATION COUNT

For patients receiving Suboxone (or any medication not injected), it will be important to verify the patient is compliant in taking the medication as directed.

STEP 1. This will normally require the patient to bring in Suboxone wrappers to be counted. Three options for accomplishing this include:

1. Randomly select patients from a list of those prescribed Suboxone (frequency will be partially dependent on population size). A recovery coach or equivalent (peer support) can initiate contact with the patient.
 - Standardize a timeline around when the patient must bring in the wrappers (e.g. within four hours if the patient does not work, or anytime that day during normal clinic hours if the patient has a job, etc.).
2. Require the patient to bring the Suboxone wrappers to every visit with a MAT Provider.
3. If pharmacy is in-house, the wrappers can be counted by the pharmacist before prescriptions are refilled.

STEP 2. The MAT Provider's clinician (or in-house pharmacy) will count the wrappers and document it in the patient's chart. If a discrepancy exists, an alternative person can verify the count (i.e. another clinician, peer support, a BHC, etc.).

- If a discrepancy still exists, a BHC or MAT Provider can counsel the patient

PATIENT OUTREACH CALLS

Given that patient engagement is critical to the success of MAT Program services, a standardized patient outreach process that considers the following is recommended:

- Who will make patient outreach calls?
 - Recovery coach (peer support) may be valuable in this role
- How many "no-shows" for either therapy sessions or follow-up visits trigger a call?
- Can outreach calls also be supplemented with an EMR driven auto-text?

CPT CODING FOR MAT PROGRAM SERVICES

INDUCTION VISIT

The following codes can be billed for the induction visit(s) by the MAT Provider depending upon the patient status and level of service performed:

- **99201–99205:** New patient*
- **99212–99215:** Established patient

Note: Medicare also requires one of the following G codes to be billed with the evaluation and management visit codes above depending upon the patient status:

- **G0466:** New patient
- **G0467:** Established patient
- Prolonged visit
 - **99354:** 30–74 minutes
 - **99355:** each additional 30 minutes (in addition to the prolonged service 99354)

Prolonged service codes are billed **in addition to** E/M codes for services that extend beyond the typical service time with face-to-face patient contact. Time spent does not need to be continuous, but Medicare does require the start and stop time to be documented.

* If the patient is a new patient, and the facility performs more than one induction visit, only the first induction visit could be billed as a new patient visit

FOLLOW-UP VISITS

Follow-up visits with the MAT Provider are also known as “maintenance visits” and will be billed based upon the level of service performed:

- **99212–99215:** Established Patient
 - Bill on key components **or** time for counseling and coordination of care since in many instances counseling and coordination of service with addiction specialists comprise the majority of the follow-up visits

Recommendation: Report services based upon time for counseling in lieu of the key components (history, exam and medical decision-making) when more than 50% of a visit is dedicated to counseling or coordination of care. Coding is then based on the total visit time, not just the time spent counseling or coordinating care.

BHC SERVICES

Behavioral health services are also an integral part of the MAT Program. Some of the services commonly performed by BHCs in association with MAT include the following**:

- **90791:** Psychiatric diagnostic evaluation without medical services (New or established patient)
- **Individual Psychotherapy**
 - **90832:** Psychotherapy with patient (16-37) minutes
 - **90834:** Psychotherapy with patient (38-52) minutes
 - **90837:** psychotherapy with patient (53+) minutes
 - **90839:** psychotherapy for crises, first 60 minutes

Note: Medicare also requires one of the following G codes to be billed with the psychotherapy codes above depending upon the patient status:

- **G0469:** New patient
- **G0470:** Established patient
- **Group Psychotherapy**
 - **90853:** Other than multiple family member group
- **Family psychotherapy**
 - **90847:** With the patient present

Note: Medicare does not currently pay for group therapy or family therapy. Health centers will need to check with each of their major payers regarding coverage of group and family therapy services.

Reference the link below for more information on Medicare PPS billing rules for FQHCs

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf>

** Health centers will need to verify coverage of specific behavioral health services with each major payer

CPT CODING FOR SCREENING & INITIAL ASSESSMENT

The screening and initial assessment are key components to the team-based care model and typically precede MAT Program services.

SCREENING & BRIEF INTERVENTION

The screening and brief intervention can be billed using the following codes depending upon the time involved and payer**:

- **99408:** Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes
- **99409:** Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes

Medicare

- **G0396:** Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes
- **G0397:** Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes

If performed with a service that has a qualifying code, G0396 and G0397 are paid as a component of the Medicare PPS rate. If performed alone, these codes are not payable by Medicare.

INITIAL ASSESSMENT

The initial assessment can be billed using the following codes depending upon the patient status and level of service performed:

- **99201–99205:** New patient evaluation
- **99212–99215:** Established patient evaluation
- **90792:** Psychiatric diagnostic eval. with medical services

PURPOSE: Enable a comprehensive medical and behavioral assessment to be performed so an appropriate treatment plan can be developed.

**Health centers will need to verify coverage of screening services with each major payer

ICD-10 CODING FOR MAT PROGRAM SERVICES

The following ICD-10 codes will commonly represent conditions diagnosed by the MAT Provider related to opioid abuse and opioid dependence. Additional diagnoses may also be appropriate based upon the patient's condition.

OPIOID ABUSE

<u>ICD-10 CODE</u>	<u>DESCRIPTION</u>
F11.10	Opioid abuse uncomplicated
F11.11	Opioid abuse in remission
F11.12	Opioid abuse with intoxication
F11.181	Opioid abuse with opioid induced sexual dysfunction
F11.182	Opioid abuse with opioid induced sleep disorder
F11.188	Opioid abuse with other opioid induced disorder
F11.19	Opioid abuse with unspecified opioid induced disorder

OPIOID DEPENDENCE

<u>ICD-10 CODE</u>	<u>DESCRIPTION</u>
F11.20	Opioid dependence uncomplicated
F11.21	Opioid dependence in remission
F11.23	Opioid dependence with withdrawal
F11.281	Opioid dependence with opioid induced sexual dysfunction
F11.282	Opioid dependence with opioid induced sleep disorder
F11.288	Opioid dependence with other opioid induced disorder
F11.29	Opioid dependence with unspecified opioid induced disorder

Report all diagnosis codes that are addressed or impact decision-making, care and risk of the patient, and all diagnoses should be reported at the highest level of specificity.

BILLING SCENARIOS - MAT SERVICES AND SCREENING

We have outlined billing scenarios below related to both MAT services and the primary care screening services. We have included scenarios for Medicare and commercial insurance since they are billed on different claim forms. Each health center will need to verify specific billing coverage for MAT services and screening services with their Medicaid, managed care and commercial payers.

SCENARIO 1

Day 1 Induction - patient seen by a MAT Provider and a separate BHC on the same day

MEDICARE PATIENT

<u>HCPCS/ CPT Code</u>	<u>DESCRIPTION</u>	<u>REVENUE CODE</u>	<u>ICD-10</u>	<u>DATE OF SERVICE</u>	<u>CLAIM FORM</u>
G0469	FQHC visit, mental health, new patient	0900	**	7/28/2018	UB-04
90834	Psychotherapy, individual	0900	**	7/28/2018	UB-04
G0467	FQHC visit, established patient	0521	**	7/28/2018	UB-04
99213	Established patient visit	0521	**	7/28/2018	UB-04

Note: The above example assumes the patient is a new patient to the MAT Program and is first seen by the BHC (the patient is also a new patient to the FQHC). If the patient had previously been seen by any provider in the FQHC within the last 3 years the claim would be reported with HCPCS code G0470 in lieu of G0469.

Billing - The health center will receive two PPS payments when submitted on the same claim form (one for the mental health provider and one for the medical (MAT Provider)).

** The health center will report the applicable primary and secondary diagnosis codes at the highest level of specificity

BILLING SCENARIOS - MAT SERVICES AND SCREENING

SCENARIO 2

Day 1 Induction - patient seen by a MAT Provider and a separate BHC on the same day
COMMERCIAL INSURANCE

<u>CPT/HCPCS Code</u>	<u>DESCRIPTION</u>	<u>REVENUE CODE</u>	<u>ICD-10</u>	<u>DATE OF SERVICE</u>	<u>CLAIM FORM</u>
90834	Psychotherapy, individual	Not applicable on a 1500 claim form	**	3/9/2018	1500
99203	New patient visit	Not applicable on a 1500 claim form	**	3/9/2018	1500

Note: The above example assumes the patient is a new patient to the MAT Program and is first seen by the BHC and is also a new patient to the FQHC. If the patient had previously been seen by any provider of the same specialty at the FQHC within the last 3 years CPT code 99213 would be reported in lieu of 99203.

Note: The services would be reported on two separate claim forms

Billing - The above services will be billed on two separate claim forms because the patient is being seen by two separate providers. The health center would receive payment for each of the services reported.

** The health center will report the applicable primary and secondary diagnosis codes at the highest level of specificity

BILLING SCENARIOS - MAT SERVICES AND SCREENING

SCENARIO 3

Primary care visit with a screening done during the same encounter
MEDICARE PATIENT

<u>CPT/HCPCS Code</u>	<u>DESCRIPTION</u>	<u>REVENUE CODE</u>	<u>ICD-10</u>	<u>DATE OF SERVICE</u>	<u>CLAIM FORM</u>
G0467	FQHC visit, established patient	0521	**	7/28/2018	UB-04
99213	Established patient visit	0521	**	7/28/2018	UB-04
G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	0521	**	7/28/2018	UB-04

Billing - The health center will receive one PPS payment for all services reported above on the same claim form.

** The health center will report the applicable primary and secondary diagnosis codes at the highest level of specificity

BILLING SCENARIOS - MAT SERVICES AND SCREENING

SCENARIO 4

Primary care visit with a screening done during the same encounter
COMMERCIAL INSURANCE

<u>CPT/HCPCS Code</u>	<u>DESCRIPTION</u>	<u>REVENUE CODE</u>	<u>ICD-10</u>	<u>DATE OF SERVICE</u>	<u>CLAIM FORM</u>
99213 *	Established patient visit	Not applicable on a 1500 claim form	**	6/2/2018	1500
99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	Not applicable on a 1500 claim form	**	6/2/2018	1500

* Some payers may require modifier 25 on the E/M code

Billing - The health center will report both services on the same claim form and will receive payment for both services if the screening services are covered under the commercial plan.

** The health center will report the applicable primary and secondary diagnosis codes at the highest level of specificity

MAT SERVICE BILLING CONSIDERATIONS

QUALIFIED PROVIDERS

Verify which professionals are considered “qualified providers” covered by each payer.

Billing Issue → Not all payers have the same rules regarding which professionals are considered qualified providers for billing under their NPI number. Medicare rules may differ from State Medicaid, managed care plans, etc.

Medicare Rules

The following professionals are considered qualified providers for Medicare billing purposes:

- Physician, Nurse Practitioner, Physician Assistant, Clinical Psychologist, Certified Nurse-Midwife & Licensed Clinical Social Worker

CARE MANAGEMENT SERVICES

Centers for Medicare & Medicaid Services (CMS) published a frequently asked questions document in February 2018 specifically outlining billing guidance for FQHCs and Rural Health Center (RHCs) as it pertains to care management services. The following care management services are addressed:

- Transitional care management (**TCM**)
- Chronic care management (**CCM**)
- General behavioral health integration (**BHI**)
- Psychiatric collaborative care model (**CoCM**)

Many patients with opioid use disorders also have other chronic conditions being managed by a health center. Medically necessary care management services provided to Medicare beneficiaries are paid in addition to the PPS reimbursement and can represent a valuable additional revenue source.

The applicable CMS link below contains a more comprehensive explanation of the billing rules around care management services.

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf>

PATIENT ASSISTANCE PROGRAMS

Ensure revenue cycle team members understand patient assistance programs (PAP) for buprenorphine that may be available through the pharmaceutical manufacturer/distributor.

Patient Payment Issue → Medication costs can be a barrier for uninsured patients or those lacking pharmacy coverages who could otherwise benefit from MAT Program services. Such patients can apply for a PAP.

PRIOR AUTHORIZATIONS

For health centers with in-house pharmacies that will be billing for MAT medications, verify which payers require prior authorizations.

Billing Issue → Multiple medications are currently approved for use in MAT Program services, but not all major payers have the same rules regarding when a prior authorization is required before billing each approved medication.

REVENUE CYCLE COMMUNICATION

As outlined earlier in this report under “Functional MAT Workflow,” there are “upstream” functions and “downstream” functions that ultimately support the health care “delivery” functions. The revenue cycle team is part of both the upstream and downstream functions, and as a result is an integral part of the MAT Program team. There are several coding and billing related complexities that must be managed by the revenue cycle team, including:

- Coverages and coding will vary by payer
- Billing for services covered under a grant will vary from traditional payer rules
- Qualified providers will vary by payer

Immediate implications include cash flow and compliance risk. Accordingly, it is recommended that at least one representative from the revenue cycle team attend meetings facilitated by the MAT leadership group to communicate any consequences identified downstream that require improvement.

SUBSTANCE USE DISORDER SCREENING TOOLS

Examples of screening tools available include the following:

ASSIST	Alcohol, Smoking, and Substance Involvement Screening Test
CAGE-AID	Cut down, Annoyed, Guilty, Eye-opener – Adapted to Include Drugs
CRAFFT	Car, Relax, Alone, Forget, Friends, Trouble
DAST	Drug Abuse Screening Test
DUDIT	Opioid abuse with opioid induced sleep disorder
RAFFT	Relax, Alone, Forget, Friends, Trouble
RAGS	Reduce, Annoyed, Guilty, Start
RPDS	Rapid Drug Problems Screen
SSI-SA	Simple Screening Instrument for Substance Abuse

Note: The above list is not intended to represent all screening tools relevant for substance use disorders. The above screening tools for illicit drug use were evaluated by the United States Preventive Services Task Force (USPSTF): <https://www.ncbi.nlm.nih.gov/books/NBK43363/>

GLOSSARY OF KEY TERMS

Below are some terms used throughout this document that are specifically identifiable with the delivery of MAT services. For the sake of clarity, the meaning of each respective term as it is used throughout this document is given.

BHC – BEHAVIORAL HEALTH CONSULTANT

- The BHC provides treatment for a variety of mental health, psychosocial, and substance use disorders. The treatment may include individual and / or group therapy services.
- The following professionals specializing in behavioral health most commonly serve as a BHC:
 - Physicians
 - Mid-level providers
 - Licensed professional counselor (LPC) **
 - Licensed clinical social worker (LCSW)
 - Licensed alcohol & drug counselor (LADC) **
 - Licensed marriage family therapist (LMFT) **

MAT PROGRAM – the combination of services rendered by the MAT Provider and BHC for those patients being treated for opioid use disorder

MAT PROVIDER – the prescribing physician/provider

RECOVERY COACH – a non-clinical position typically held by an individual who is successfully managing his or her own recovery (i.e. a peer)

** These positions are not considered a qualified provider by Medicare for billing purposes (**Appendix H**)