ARCHPRO
Coding and Consulting

Behavioral Health Coding & Billing for Community Health

Live Training – September 24, 2025

VIRGINIA COMMUNITY HEALTHCARE ASSOCIATION 45 YEARS 1980 - 2025

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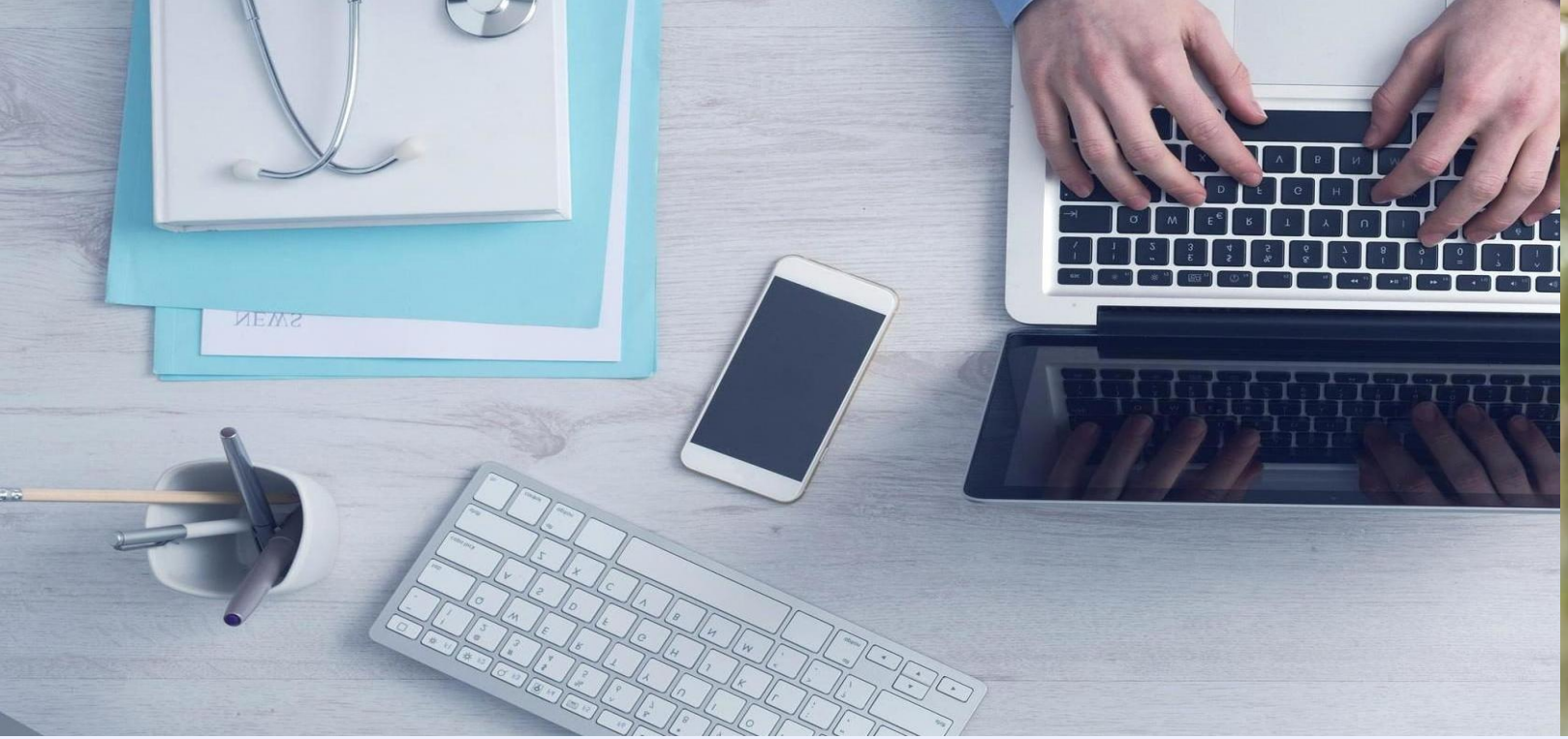

ARCHPRO
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~2200 courses taught onsite in 46 states over 30+ years

Session Overview

1. Highlight proper coding and billing for screening services, psychiatric diagnostic evaluations, psychotherapy, interactive complexity, psychotherapy for crisis, health and behavior assessment/interventions, and common billing options for screening and treatment of substance/opioid disorders and integrating Medical/Behavioral health services.

2. Provide an overview of the ICD-10-CM Official Guidelines for Coding and Reporting specific to BHI.

3. Define the unique issues related to how RHCs get paid by CMS and private payers for behavioral health services.

4. Identify various claims scenarios of overlapping between medical and behavioral health related including CMS-covered preventive services.

Training Disclaimers

Educational Intent

All information presented by ArchProCoding is based on research, experience, and training and includes professional opinions that do not replace any legal or consulting guidance you may need.

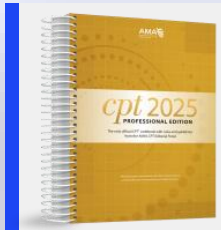
Research your Contracts

ArchProCoding accepts no liability for errors, omissions, misuse, or misinterpretation of our educational content. You maintain responsibility for your facility's compliance with all relevant rules.

Check Often for Updates

We encourage you to always double-check for potential updates to hyperlinks, reference sources, payer billing rules, and compliance changes. Please don't distribute our content outside your facility.

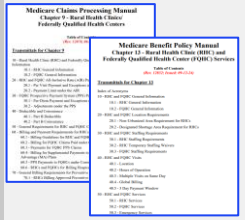
Key resources and references
vital to ongoing success and necessary for class and self-study/exercises



AMA's CPT (Professional Edition)

CMS' HCPCS-II Code Set

ICD-10-CM Code Set



CMS Benefits Policy and Claims Manuals

Access to Various CMS/Medicare Learning Updates+ NCD/LCD

Awareness of Commercial & Medicaid Billing Contract Details

CPT Medical
options for Behavioral Health

99408-99409 – Alcohol/substance (*other than tobacco*) structured screening and intervention, 15-30 or >30 minutes

98000-98015 –NEW Telemedicine E/M Services

98016 – NEW Brief virtual check-in E/M, 5-10 minute…unrelated…7 days…no immediate visit

96372 – Subcutaneous or intramuscular injection given *(also report the drug injected)*

99202-99215 – Evaluation and management (E/M) office visit codes used by prescribers for most MAT visits.

Modifiers – you may need to add modifiers –HF for a substance abuse program or –HG for an opioid program given by medical providers

HCPCS-II Medical
options for Behavioral Health

G2011 - Alcohol/substance screening …5-14 minutes

G0396-G0397 – Alcohol/substance screening (*other than tobacco*) and intervention, 15-30 or >30 minutes

G2025 – RHC/FQHC-only medical telehealth service
G0071 – RHC/FQHC-only virtual check-in **or** remote evaluation of recorded video/images, 5+ minutes

J0570, J0592, J0571-J0575 – Buprenorphine implant 74.2 mg and Buprenorphine/naloxone, oral, various dosages

G0466-G0470 – FQHC-only PPS billing "valid encounter" codes to be followed by a CPT/HCPCS-II code on the Qualifying Visit List (QVL) to Medicare only?

CMS sometimes-covered Preventive Medicine Services – Intensive Behavioral Therapy for STDs, Cardiovascular Disease, Obesity, Alcohol Abuse, etc.

CPT Behavioral Health options

90791-90792 – Psychiatric Diagnostic Evaluations (with or without a "medical" service)

90832-99838 – Psychotherapy with or without prescription management of 30/45/60 minutes
90839-90840 – Psychotherapy for Crisis

+ 90785 – Interactive Complexity add-on code for more revenue when dealing with barriers to communication

96156-96161 – Newly covered by Medicare in 2024 for Health Behavior Assessments/Interventions when the diagnosis is *physical* in nature.

99492-99494 – Psychiatric Collaborative Care Model (Psych CoCM)
99484 – Care Management for Behavioral Health Integration (ex. BHI)

HCPCS-II Behavioral Health options

G0140 - for non-Medicare claims for Principal Illness Navigation (PIN) by certified peer specialists.
G0023-G0024 PIN for Medicare and maybe Medicaid

H0001 – Alcohol and/or drug assessment
H0008 – H0033 – Possible Medicaid-only options that may replace codes used for other carriers.

G0023-G0024 for Principal Illness Navigation (PIN) for Medicare and others + check out code
G0140 for PIN in a RHC/FQHC using a peer support specialist (*likely for non-Medicare*).
H0038 – Self-help peer services , per 15 minutes for Medicaid only

G0511 – General Care Management (including BHI) **(RHC/*FQHC-specific code reported by medical provider – likely to EXPIRE October 1, 2025*)**
G0512 – Psych Collaborative Care Model

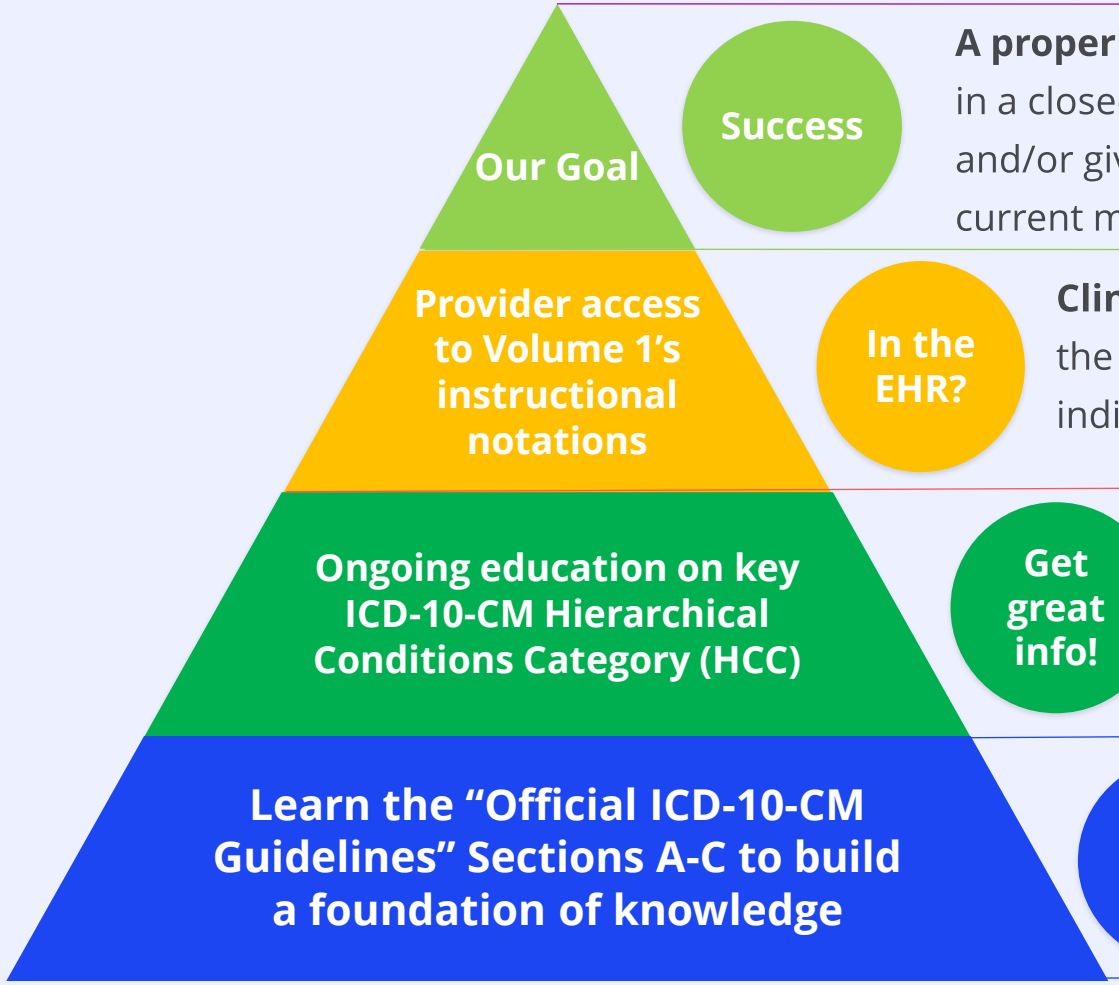
Documentation Expectations for H-Codes

- Must support medical necessity, time, and credential level.
- Often linked to care plan (H0032) or structured screening tools (i.e. SBIRT, PHQ-9).
- Templates and documentation requirements can vary WIDELY by plan — follow state and MCO guidance which could differ from any grants or other funding programs you participate with.
- Expect payer audits tied to documentation language and code used. Even county programs can require different than codes you use to get paid by insurance!

Sample Payer Codes and Notes Table

Payer	Code Used	Notes
🏥 Medicare by RHC/FQHC	**CPT code** 90832 – Psychotherapy 30 minutes 90839 – Psychotherapy for crisis	Use on CMS-1450; no H-code
🩺 State Medicaid	**HCPCS-II code** H0004 - Behavioral Health counseling and therapy, per 15 minutes H2011 – Crisis intervention services, per 15 minutes	CMS-1500 or 837P; varies based on plan
📋 Managed Care	Could vary based on the clinical licensure of whoever provided the service. They may use straight CPT/G-codes or H-codes or a mix.	Contracted edits will override any professional coding logic; Check your fee schedules carefully and ask about possible % fee reductions for non-physicians (ex. 85% for NP, 65% for CP)
🔄 Dual Eligible	Medicare G-code + Medicaid H-code? (a lot of possibilities)	Separate logic or cross-submission required

Build and maintain your ICD-10-CM educational pyramid



Success

A properly assigned ICD-10-CM code(s) that is supported by valid documentation in a closed medical encounter whether it generates revenue via "medical necessity" and/or gives the patient (and their insurer) knowledge about the patient's past or current medical condition(s).

In the EHR?

Clinical providers, coders, and billers must share access to and knowledge of the Cooperating Parties (CMS, NCHS, AHA, AHIMA) guidelines specific to individual codes and code groups key to compliance.

Get great info!

The AMA's Risk Adjustment Documentation & Coding is a well-respected book that explains how ICD-10-CM codes impacts ACO/managed care budgets and payments, and value-based care.

Step 1

Start by learning the rules of the road maintained by Centers for Medicare & Medicaid Services, the National Center for Health Statistics, the American Hospital Association, and the American Health Information Management Association.

WHAT MAKES FQHCs DIFFERENT?

What everyone needs to know about the unique nuances of being a RHC and how does it change what we do?

Check often for updates to CMS' RHC and FQHC Claims (Ch.9) and Benefits Policy (Ch. 13) Manuals

Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

Table of Contents
(Rev. 13200, Issue: May 1, 2025)

Transmittals for Chapter 9

Check out the May 2025 updates!

Although CMS groups RHC and FQHC in these 2 documents, be aware that the rules are not always the same.

Ch. 9 discusses the All-Inclusive Rate (AIR) and Prospective Payment System (PPS) billing systems.

Ch. 13 discusses staffing requirements, same day multiple visits, and global billing.

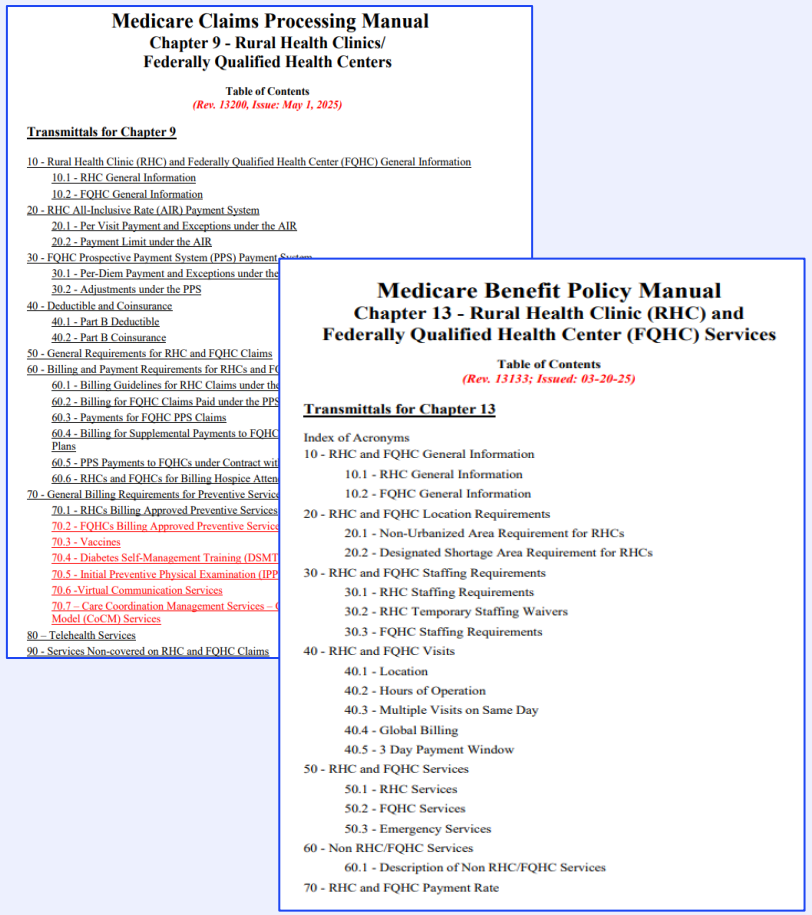
Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

Table of Contents
(Rev. 13133; Issued: 03-20-25)

Transmittals for Chapter 13

Check out the March/June 2025 updates!

Review these key sections from Claims and Benefit Policy Manuals



Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

Table of Contents
(Rev. 13200, Issue: May 1, 2025)

Transmittals for Chapter 9

10 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) General Information
10.1 - RHC General Information
10.2 - FQHC General Information
20 - RHC All-Inclusive Rate (AIR) Payment System
20.1 - Per Visit Payment and Exceptions under the AIR
20.2 - Payment Limit under the AIR
30 - FQHC Prospective Payment System (PPS) Payment
30.1 - Per-Diem Payment and Exceptions under the
30.2 - Adjustments under the PPS
40 - Deductible and Coinsurance
40.1 - Part B Deductible
40.2 - Part B Coinsurance
50 - General Requirements for RHC and FQHC Claims
60 - Billing and Payment Requirements for RHCs and FQ
60.1 - Billing Guidelines for RHC Claims under the
60.2 - Billing for FQHC Claims Paid under the PPS
60.3 - Payments for FQHC PPS Claims
60.4 - Billing for Supplemental Payments to FQHC Plans
60.5 - PPS Payments to FQHCs under Contract wit
60.6 - RHCs and FQHCs for Billing Hospice Atten
70 - General Billing Requirements for Preventive Servic
70.1 - RHCs Billing Approved Preventive Services
70.2 - FQHCs Billing Approved Preventive Servic
70.3 - Vaccines
70.4 - Diabetes Self-Management Training (DSMT
70.5 - Initial Preventive Physical Examination (IPP
70.6 -Virtual Communication Services
70.7 – Care Coordination Management Services – Model (CoCM) Services
80 – Telehealth Services
90 - Services Non-covered on RHC and FQHC Claims

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

Table of Contents
(Rev. 13133; Issued: 03-20-25)

Transmittals for Chapter 13

Index of Acronyms
10 - RHC and FQHC General Information
10.1 - RHC General Information
10.2 - FQHC General Information
20 - RHC and FQHC Location Requirements
20.1 - Non-Urbanized Area Requirement for RHCs
20.2 - Designated Shortage Area Requirement for RHCs
30 - RHC and FQHC Staffing Requirements
30.1 - RHC Staffing Requirements
30.2 - RHC Temporary Staffing Waivers
30.3 - FQHC Staffing Requirements
40 - RHC and FQHC Visits
40.1 - Location
40.2 - Hours of Operation
40.3 - Multiple Visits on Same Day
40.4 - Global Billing
40.5 - 3 Day Payment Window
50 - RHC and FQHC Services
50.1 - RHC Services
50.2 - FQHC Services
50.3 - Emergency Services
60 - Non RHC/FQHC Services
60.1 - Description of Non RHC/FQHC Services
70 - RHC and FQHC Payment Rate

Claims Manual Sections 20/60/70
Review the AIR/PPS specifics and the several updates in red text in section 70.

Claims Manual Section 30.2
Explains how a FQHC's PPS rate is determined and when it may be adjusted up by 34.16%

Claims Manual Section 40
Clarification of RHC deductible and coinsurance.

Benefit Policy Manual Section 30
Staffing requirements, employment rules, and provider coverage arrangements are described.

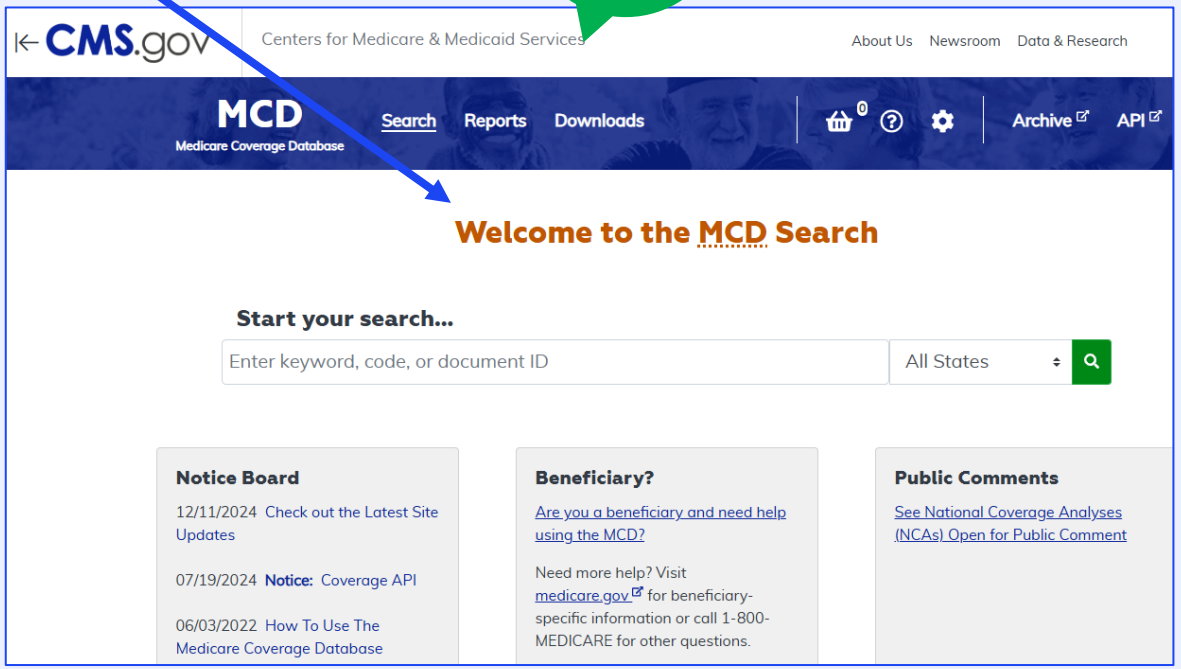
Benefit Policy Manual Section 230
General Care Management, Behavioral Health Integration, Psych CoCM, CHI/PIN services.

Benefit Policy Manual Section 250
Intensive Outpatient Program (IOP) Services that pay similar to intensive partial hospitalization services.

Get training on, and then access to, the Medicare Coverage Database

Step 1

Step 2



Check out this Medicare educational document on their approach to Mental Health coverage

FQHC/Community Health
Prospective Payment System (PPS) Basics (cont'd)

- Instead of getting paid FFS, Medicare likely pays you 80% of a **Prospective Payment System (PPS)** rate for "valid encounters." Some services like Care Management using G0511 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 "magic" 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
CMS' 5 "Magic" billing codes G0466-G0470

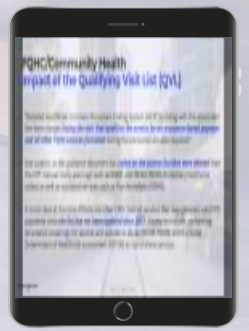
G0466 FQHC visit, New Patient A medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time ***one or more FQHC services are rendered*** and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit

G0467 FQHC visit, Established Patient A medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time ***one or more FQHC services are rendered*** and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.

G0468 FQHC visit, IPPE or AWV A FQHC visit that includes an IPPE or AWV ***and includes a typical bundle of Medicare-covered services*** that would be furnished per diem to a patient receiving an IPPE or AWV.

G0469 FQHC visit, Mental health, New Patient A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time ***one or more FQHC services are rendered*** and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

G0470 FQHC visit, Mental Health, Established Patient A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time ***one or more FQHC services are rendered*** and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.



Rural or Urban FQHC

FQHC/Community Health
Impact of the Qualifying Visit List (QVL)

- "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."

- Use caution, as this guidance 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).

- 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***. Examples include, performing structured screenings for alcohol and substance abuse (99408-99409) and the Social Determinant of Health risk assessment (G0136) as stand-alone services.

Sample from Chapter 13 section 40.3 for Multiple Visits on Same Day

40.3 - Multiple Visits on Same Day

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where an RHC or FQHC patient has a medically-necessary face-to-face visit with an RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner, including a specialist, for evaluation of a different condition on the same day.

Exceptions to the Single AIR/PPS per day guidance

Exceptions are for the following circumstances only:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has afall and returns to the RHC or FQHC). In this situation only, the FQHC would use modifier 59 on the claim and the RHC would use modifier 59 or 25 to attest that the conditions being treated qualify as 2 billable visits;
- The patient has a medical visit and a mental health visit on the same day (2 billable visits);
- *An IOP service and medical visit on the same day*
- *A dental visit and a medical visit on the same day;*
- For RHCs only, the patient has an initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 billable visits); or

Note: A mental health visit and IOP service may occur on the same day; however, if a mental health visit is furnished on the same day as IOP services, payment will only be made at the IOP rate, and the mental health visit will be considered packaged.

Recent 2015 Q2 updates!

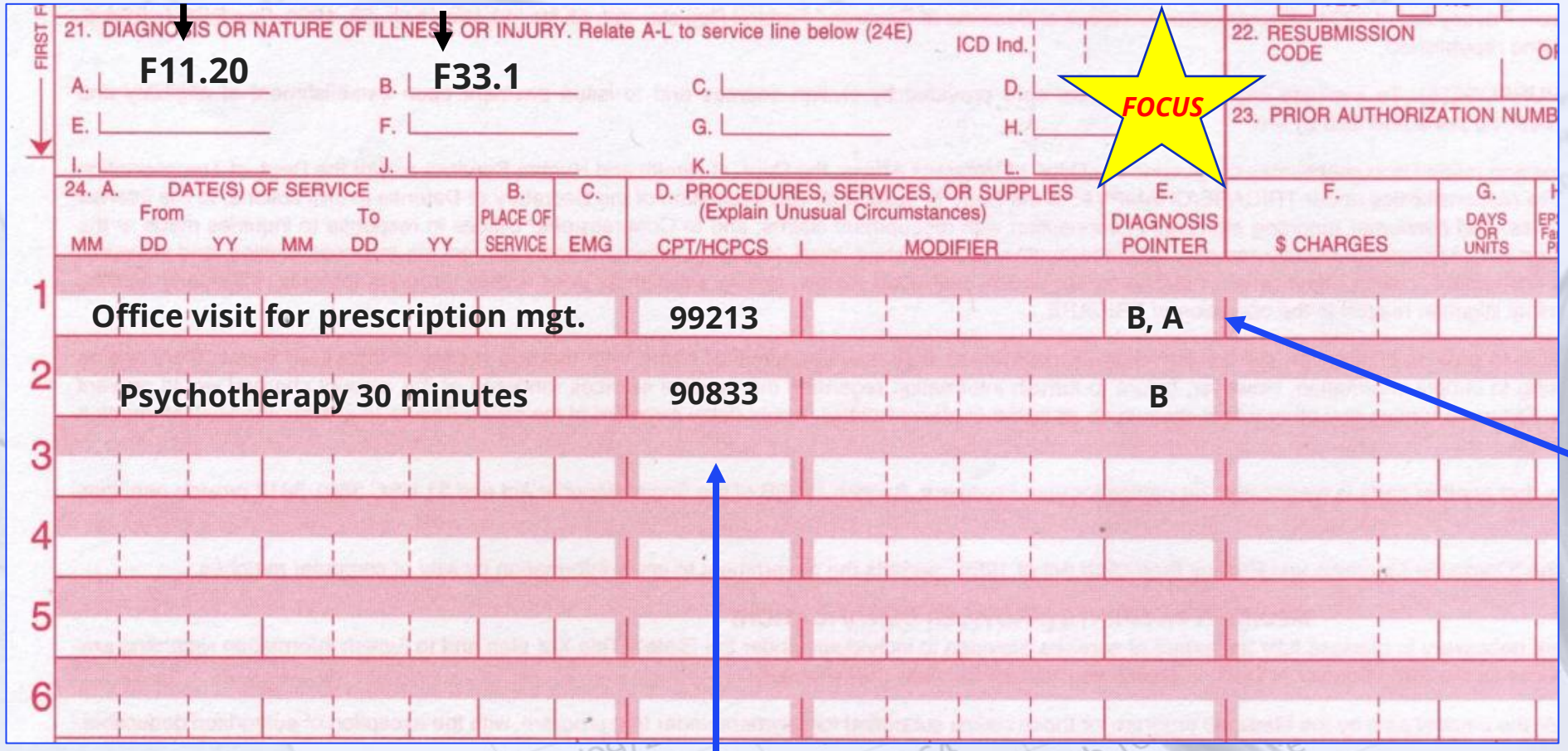
Note how RHC vs. FQHC have different ways to identify this exception to on AIR/PPS claims.

Check with all payers who pay you via encounter rates if they have the same exceptions and how to show the exception(s)?

Sample FFS 837p claim for a mental health office visit and therapy

Opioid Dependence

Depression



What would happen if we just entered "A,B" for both lines?

Why isn't this code the "normal" code 90832 for 30 minutes of therapy?

Sample FQHC 837i claim for same day medical and mental health visits

These codes are the FQHC-only "magic" billing codes that should generate 2 PPS payments

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	Est. Pt. – 1+ Medical Services	G0467					
	Medical office visit	99214					
	Non-surgical injection	96372					
	Drug injected	J3420					
	Est. Pt. – Mental Health	G0470					
	Psychotherapy 30 minutes	90832					

Followed by code(s) on the QVL.

List "…all other services provided…"

F11.20	D51.0	Z13.39	F33.1

Sample Self-Study on CPT Coding Medicine chapter
Psychiatry section

Interactive Complexity

What is an add-on code?

What other codes can this code be added to?

What needs to be in the medical record to support the coding of +90785?

Psychiatric Diagnostic Evaluations

What is the difference between the 2 main codes and which types of providers can perform which?

What else is included in this assessment per the notes before the codes?

What if done on somebody other than the patient?

Psychotherapy

Which provider types can code 90832, 90834, and 90837 **versus** codes +90833, +90836, and +90838?

What if the patient gets an **"urgent assessment and history of crisis state, a mental status exam, and a disposition"?**

What if the time units aren't met exactly?

Assorted Psychiatric Codes

Check out codes for family/group therapy and expect carrier variations in payment.

Review codes +90863 for pharmacological management and 90885-90989 for assorted review of medical records to provide advice or recommendations.

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
- Develop initial **plan** of treatment
- Reported once per day and NOT on the same day as an E/M service performed by the same individual for the same patient
- Covered once at the outset of an illness or suspected illness

Top Behavioral Health Screening Services for various payers

#	Service Description	Code(s)	When to Use	Payer Notes / Differences
1	Depression Screening – Annual	G0444	Medicare-covered once per year	Medicare prefers G0444; 96127 not for Medicare
2	Brief Emotional / Behavioral Screening	96127	For tools like PHQ-9, GAD-7, etc., multiple units allowed	Commercial & Medicaid pay; Medicare FFS does not
3	Alcohol Misuse Screening (Annual)	G0442	Annual 15-min screen for adults	Medicare only; commercial/Medicaid rarely
4	Alcohol Misuse Counseling (Brief Intervention)	G0443	Positive screen follow-up (15 min)	Medicare allows up to 4/year
5	SBIRT - Screening & Intervention	H0049 / H0050	Used for screening & brief intervention/referral	Medicaid (state-specific) and commercial
6	Tobacco Use Screening and Counseling	G0436, G0437 / 99406-99407	For tobacco cessation counseling – time-based	Medicare uses G0436/37; commercial 99406/07
7	Developmental Screening	96110	Pediatric screening (ASQ, M-CHAT)	Medicaid often reimburses; Medicare rarely
8	Autism Screening	96110	Used with autism-specific tools (M-CHAT)	May bill again if distinct tool used
9	Health Risk Assessment (HRA)	G9919, G9920	Used as part of Annual Wellness Visit	Medicare-specific (G0438/39 context)
10	Suicide Risk / SDOH Screening	96127 or visit-based	Structured risk or SDOH screening	Payer-specific rules; document tool & follow-up

Behavioral Health Screening – Coding Tips & Payer Nuances

- 96127 is not typically covered by Medicare but often paid by Medicaid and commercial payers.
- G0444 should only be used for Medicare's annual depression screening – not general depression screening.
- Time-based codes (e.g., 99406–99407, G0443) require documented minutes and patient consent.
- SBIRT codes (H0049/H0050) are Medicaid-specific in many states; verify state billing guidelines.
- Some payers bundle screening services with preventive visits – separate payment may not apply.
- Always document the screening tool used, interpretation of results, and follow-up action.
- Developmental and autism screens (96110) are reimbursed by Medicaid, rarely by Medicare.
- Health Risk Assessments (G9919/G9920) are typically part of Medicare Annual Wellness Visits only.

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 or +90833 [“30 minutes”] **(16-37 minutes)**
  - ✓90834 or +90836 [“45 minutes”] **(38-52 minutes)**
  - ✓90837 or +90838 [“60 minutes”] **(53+ minutes)**

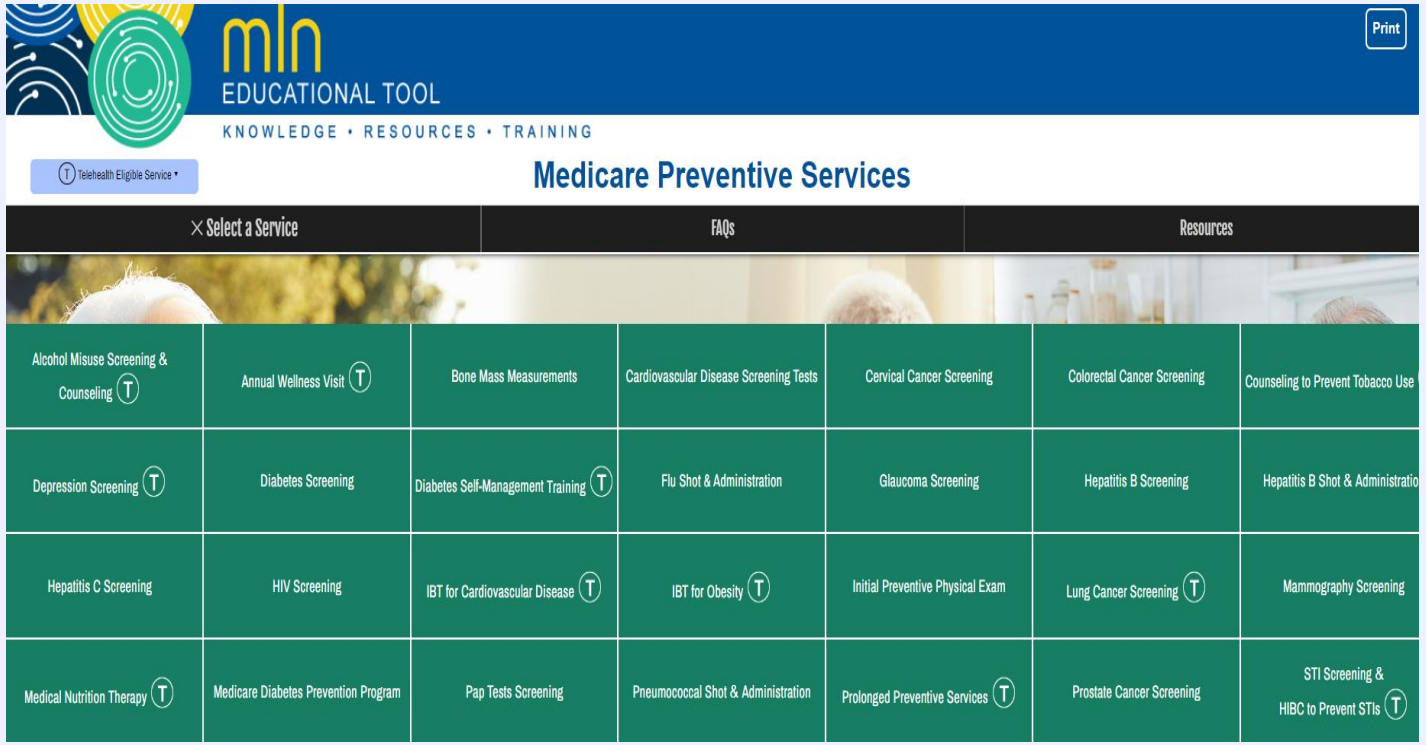
- If reporting an E/M service + a psychotherapy service add-on code you must use Medical Decision Making, not time, to select the level of E/M code – per the AMA’s CPT.

- Remember: It is possible in the RHC/FQHC for 2 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).

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…



Some Counseling Risk Factor Reduction and Behavior Change Interventions (99401-99404) may not currently covered by Medicare – but check the others!

Promoting Health and Preventing Illness/Injury

Per AMA's 2025 CPT Professional Edition page 41: *"these services are used for persons **without a specific illness** for which the counseling might otherwise be used as a part of treatment."*

Preventive Medicine Counseling

"should address issues as family problems, diet and exercise, substance use, sexual practices, injury prevention, dental health..."

Behavior Change Interventions

99406-99407 for smoking/tobacco cessation, time based.

99408-99409 for alcohol/substance (other than tobacco) abuse structured screening, time based.

Coding Bundling Rules per CPT

*"E&M services reported on the same day **must be distinct** and reported with modifier 25."*

*"Health behavior assessment and intervention services **should not be reported** on the same day as these."*

Health Behavior Assessment and Intervention Coding
Medicine/Psychiatry section (96156-96161) pg. 861

Addresses ***behavioral factors*** *"to identify and address, treat, or manage* ***PHYSICAL*** *health problems..."*

"Designed to improve the patient's health and well-being ***utilizing psychological intervention****."*

"...includes promotion of functional improvement, ***minimizing psychological and or psychosocial barriers to recovery****, and management of and improved coping with medical conditions."*

Became a Medicare benefit 2024?

But it is not clear at this time if it can be a stand-along billable service for RHCs/FQHCs as a valid AIR/PPS service if performed on its own.

Stay tuned...

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 for RHC/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 should you 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, doesn't result in an immediate visit*)

2025 FQHC Medicare Billing Thoughts for 2025

Until 9-30-25 pending future updates

Medicare Billing 2025 Updates

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

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

RHC/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***.

+

RHC/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 ***RHC/FQHC-specific code G0071***.

FQHC Non-Medicare payers may have different ways for you to bill telehealth compared to Medicare

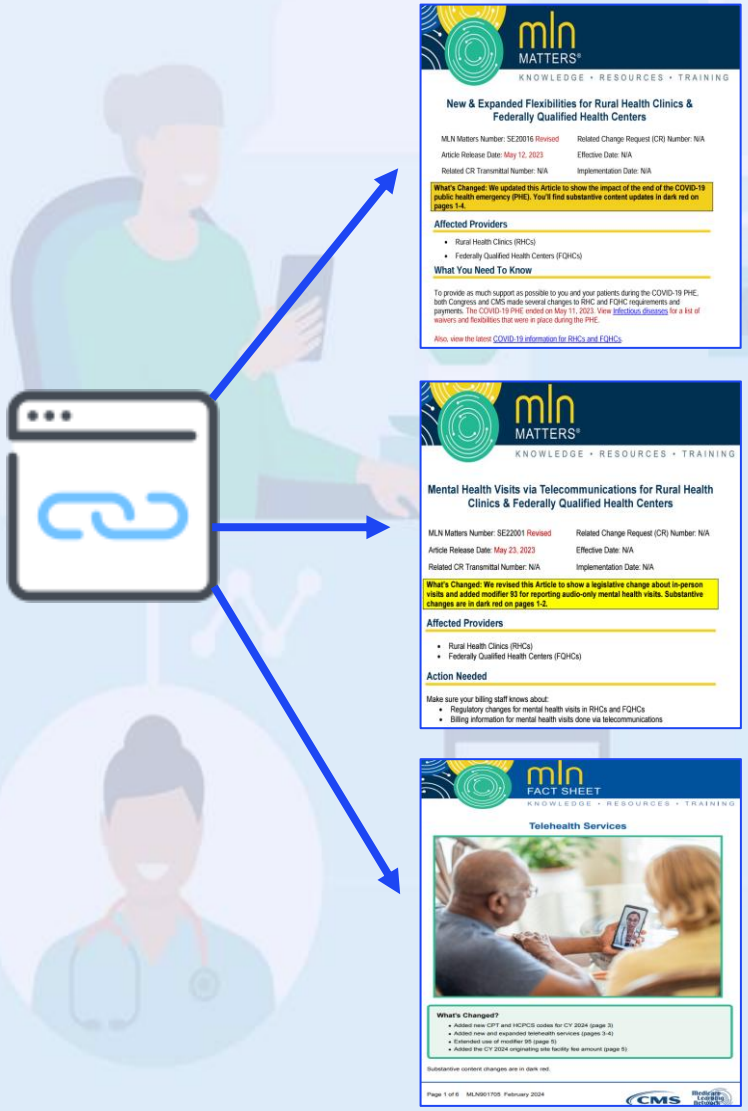
- Other non-Medicare telehealth options include the set of ***new 2025 CPT E/M telehealth codes 98000-90815*** that will likely get assigned FFS payment rates that could differ by payer.

- Some carriers ***may instead pay*** you the same for ***telehealth as if performed in person*** (ex. 99213 or 90832). Billing rules could ask you to ***add a modifier -93/-95*** (*or other*) to the service to indicate that the service was ***done via audio/video or audio-only***.

- Other commercial non-Medicare coding options include telephone assessments performed ***by non-physician Qualified Healthcare Professionals using codes 99866-98968***.

- ***Medicaid payers may want code T1014*** to be reported by the number of minutes the service(s) lasted in the units claim box.

CMS resources for FQHC Telehealth



- Get the **CMS Med Learn Matters #SE20016** for ***RHC/FQHC-specific telehealth info*** (*last updated May 2023*) for updates, revenue codes, modifiers, and other great billing info.
- For updates on reporting ***mental health telehealth in RHC/FQHC*** please this **Med Learn Matters SE#22001** document *(updated May 2023)*
- For the general **CMS Telehealth Fact Sheet MLN#901785** which ***is not focused on RHC/FQHC*** check out this document *(last update January 2025).*

“General Care Management”
Coding for Providers Managing Care Plans

TIPS: Develop templates in your EHR, track monthly time, document care plan updates and *get credit for the clinical work you do in between patient visits*. Consider external care managers to help with the workload.

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 General Care Management options for RHC/FQHC were added by CMS in 2024!

You may use code G0511 or the actual CPT/HCPCS-II codes from now until the end of September 2025 to Medicare

- ***If you already bill*** commercial and/or Medicaid carriers for Care Management services ***using the service-specific CPT/HCPCS-II codes*** – it seems as though that would be a logical option on January 1, 2025 and beyond to bill Medicare in the same way.

- 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.

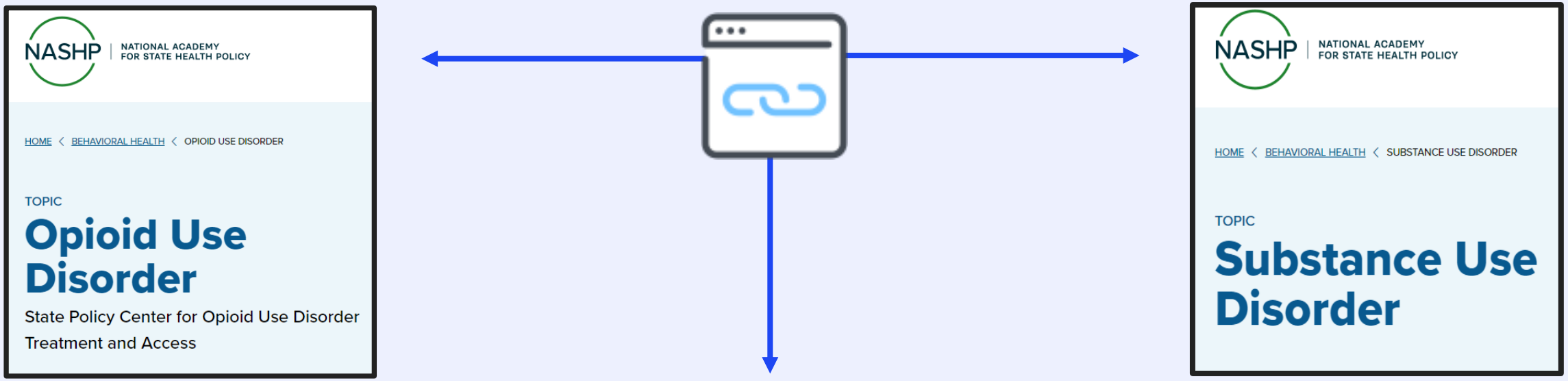
Or consider the OPTION to use the new 2025 Advanced Primary Care Management (APCM) codes.

BHI and Psych CoCM
Additional info 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 conditions** (including substance use disorders).

- To distinguish general BHI services from the Psych CoCM please visit this link **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"***.

Monitor the National Academy for State Health Policy for great information



NASHP used the most recently available Medicaid provider and billing manuals, state regulations, and other public policy documents (including state plans and waivers) for all 50 states and Washington, DC. Findings were grouped and coded to allow for easier cross-state analysis. The data collected was shared with Medicaid and other state leaders.

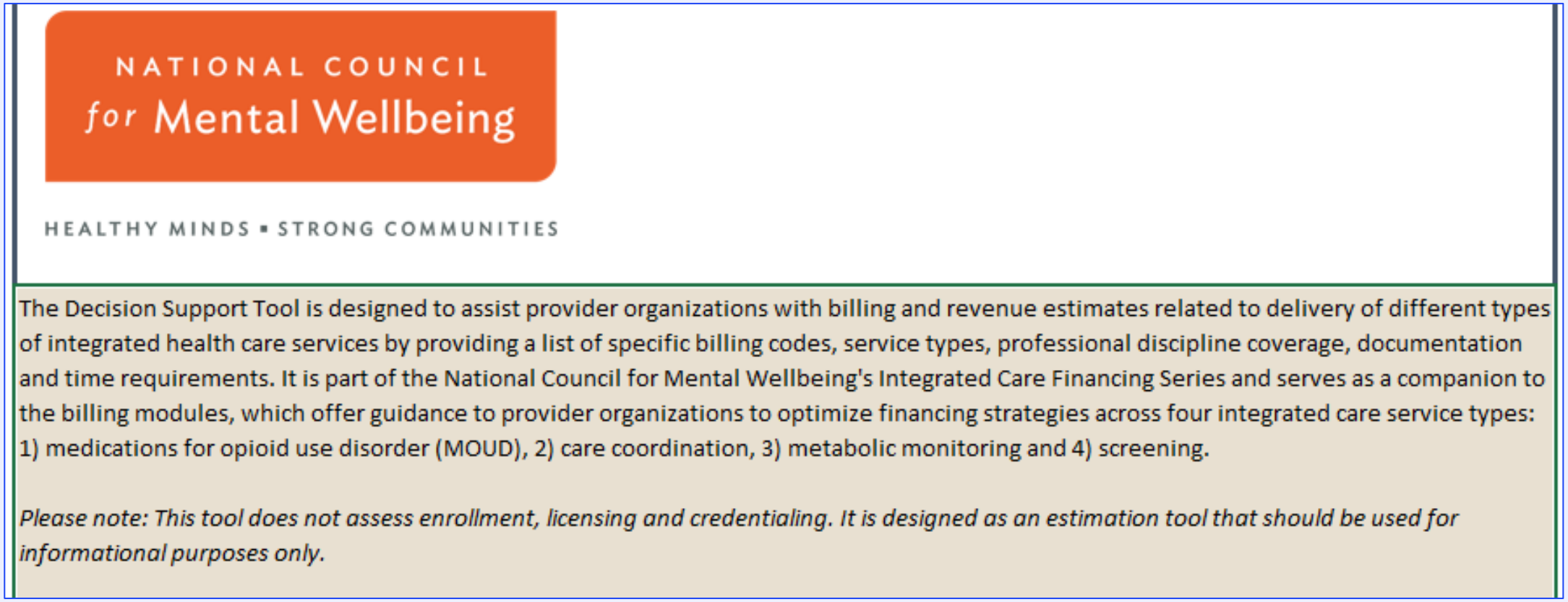
States' non-licensed workforce was categorized as:

Peers: Individuals with lived experience providing Medicaid-billable SUD services.

Counselors: Individuals providing Medicaid-billable SUD counseling or therapy services without a state license.

Other Qualified Staff: Other non-licensed professionals providing Medicaid-billable SUD services who did not meet the definition of a "peer" or "counselor."

You should also access their Decision Support Tool designed to help with Medicaid appropriate coding/billing broken out by provider type



SOURCE: National Council for Mental Wellbeing - "Financing the Future of Integrated Care"
https://www.thenationalcouncil.org/resources/financing-the-future-of-integrated-care/

References and Hyperlinks

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