Integrating Behavioral Health Into Your RHC

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SPEAKERS:

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Nathan Baugh 00:07

Hello, everyone. Thank you for joining today's webinar. My name is Nathan bomb, the Executive Director of National Association of rural health clinics and along with Sarah Holman, the director of government affairs for the National Association of rural health clinics, we are the moderators for today's call. Today's topic is integrating behavioral health into your rural health clinic. And our speaker is Charles James, who not only is the NARHC board president and valued RHC consultant, but he's also the president of North American HMS, which is his day job. And Charles is going to discuss all things related to billing for behavioral health services in your RTC. This webinar series is sponsored by HRSA's Federal Office of Rural Health Policy or fork, and is done in conjunction of course within the RHC. We're supported by this cooperative agreement, as you can see on your screen that allows us to bring you these webinars free of charge. The purpose of the series is to provide RSC staff with valuable technical assistance and RFC specific information, we would ask that you help us spread the word about these free webinars by encouraging anyone who may benefit from this information to sign up to receive announcements regarding dates, topics and speakers at our website and irc.org. We will we have the chat disabled. But there is a q&a box. And when we get to the q&a portion, which we're going to do at the end, we're going to hold that to the end, the will will start answering those questions that have come in. As with all webinars, were at the mercy of good bandwidth for all parties. And we all know that connectivity can go up and down. So if you have any audio or visual freezes, we suggest restarting zoom. And that usually fixes the issue. If you continue to have issues do not worry, because a recording of today's presentation will be posted on our website. And there will be links to the side and trainees transcript on our website as well. So without further ado, I want to turn it over to Charles Charles, the floor is yours.

Charles James 02:25

Thank you very much. So thank you Federal Office of Rural Health Policy. Nathan, Sarah, Cate, for all you all do appreciate being here. I'm going to go ahead for the sake of bandwidth and turn off my video. Since now we've made introductions. And theoretically I can get past the first slide. And again, introduce our topic behavioral health billing for Rh C's. If any of you or any of your loved ones, have you ever tried to gain access to behavioral health services, you'll know it can be difficult. Of course, for many of the wrong reasons, behavioral health is all too much in the news. And unfortunately, as always, is the shortage of particular services in rural areas. On this topic, of course, is where we all

converge. So we're here to talk about a subject honestly, near and dear to my heart, on many levels. And these are the things that we're going to go ahead and we will talk about today. We know in the rural health clinic world we can do nothing without variety of rules and what ifs and if thought if if then we have this What does primarily engaged in primary care meet. That's right in some of the text of our conditions for participation, as well as of course the statutes that created rural health. We can argue about their origin, but there's not a lot of argument about their existence. And when surveyors are on site. We want to know what they expect when they ask are you primarily engaged in primary care services? We have a new definition of an RHC visit which is expanded to include some behavioral health benefit. Of course, telehealth and behavioral health have been a key marriage. Of course, indeed, that's one of the places that behavioral health and rural health have are introduced, or in order to be done via telehealth and then we need to talk about what providers are eligible. And I'll just say from here, my To the gap. And I think many of you will know what I mean. And we'll get there momentarily. As Nathan had mentioned, if we could hold all questions to the end, it should get through plenty of time to leave room for for a few questions, excuse me. So get my clicker work in here. There we go. Term rural health clinic has in the statute that created us the term primarily engaged in furnishing outpatient outpatient services described in these paragraphs, which goes on to say that this facility is not a rehabilitation agency, or a facility, which is primarily for the care and treatment of mental illness. So this public health statute, I'm probably referring to this incorrectly. No, I'm not us code right there, somewhere a lawyer is going to correct me in our existence cannot be primarily for the care and treatment of mental diseases. So that's where we get our primarily engaged in primary care, we get some of our 51% specific language, because one thing that you've heard, and, of course, the topic here is primarily engaged has been interpreted to mean, it's a key word, right? Their interpretation that more than 50% of the clinic's hours, involve for his provision, I can't speak today, excuse me, I haven't had enough coffee provision of RHC services. The appendix G of the State Operations Manual is the CMS interpretation of the statutes and the conditions for participation that were created by those Code of Federal Regulations, etc. So the 51% is not necessarily cooked into the law. The 51% comes from State Operations Manual, Appendix G. And those are interpretive guidelines. And if all of us healthcare geeks slice and dice this language really carefully, we can poke a lot of holes in some of this language. But we're not here to do that. Today, the current interpretation of the ability to provide behavioral health services in a rural health clinic is that primary care services have to be 51% of the services. And a surveyor, when they show up, they're going to base that on ours and involve RHC services. That largely means they're going to come in. And excuse me, I didn't mean to go to that slide quite yet, a surveyor will come in, and they'll count your provider hours to determine which providers are primary care which providers are behavioral health, we're going to count their hours. In the event that we can't tell, the surveyor can't tell the alternate mechanism that they have to gauge the 51% is often we're going to start looking at encounters. And we'll just see by ICD 10 code, which encounters are or are not behavioral health or primary care. As you can imagine, when you're on site in front of a surveyor, that is not the time to be coming up with your answers. So that's what we're here to resolve today, how to structure your policies and procedures in your clinic to resolve some of these questions. But let me go further, before we get to some of those recommendations. First, we have to start with encounters. What are encounters? And how do we define those? You can't talk about that without talking about our new encounter definition, which is interesting for rural health clinic policy purposes, as well as for behavior provision of behavioral health, because it's the first time that we've had some of our rules, where we change what something

means in the encounter or change the definition of the encounter. And then it's like, here's where a lot of those rules are, but we have this new encounter definition, which buried within all that says, in one place, a rural health clinic encounter is a visit and then another play So we're at 405 Point 2463. I have links to all of these resources in the presentation here. This It now includes a mental excuse me, a mental health visit now includes face to face encounter, also provided via interactive real time audio and video telecommunications technology. So we have face to face, or an encounter using interactive technology. I'm a breathing, abbreviating the language. So I don't have to read to you, or, or the patient is not capable of or does not consent to the use of video technology, we have the ability to provide some of this audio only. I think I've just mixed up my slides a little bit on myself today. It's amazing how many times these presentations evolve a couple of different versions of it going so pardon my stuttering a little bit. So, Constitution through what constitutes a visit, the definition has been changed. The providers who may constitute who may provide an encounter have not changed. At the Medicare level. Our definition of a mental health visit changed. Our definition of the providers who may provide them has not changed. If we back up here as well, we notice only the definition of a mental health visit has changed. A clinical encounter from medically necessary clinical diagnosis non behavioral health oriented still only includes face to face. The expansion of the encounter definition to include the interactive telecommunications is only for behavioral health visit. make that distinction. This is only telecommute telehealth has opened up as an encounter only for behavioral health visits, our providers have not changed. Which means those same providers who were previously qualified to provide behavioral health visits in the rural health clinic are the same clinical psychologist licensed clinical social worker, you will see what are not here and that many of us have at the state level. And the main question many of you are going to have How about LC PCs? How about licensed marriage and family therapists? How about licensed mental health therapist or all of us have different variations of the acronyms in our states at the Medicare level, those are not those providers are not yet eligible to provide. rural health clinic encounters. The Medicare level, these are your providers at the Medicaid level, you might have a different set, you'd likely do have a different set of providers who in your state Medicaid law, your state Medicaid policies do recognize other expanded providers from this list. This is our Medicare qualified RHC providers. So behavioral health to be repetitive. We're limited to clinical psychologist licensed clinical social workers at the Medicare level, we a National Association of Rural Health Clinic. This is an active conversation we're having to try to expand to some of these other well, we'll say master's level providers, but to date, that's an ongoing consideration. And of course, those are big hoops to jump through. But part of our wish list. We have as part of our qualified visit list, a set of seven codes on the Medicare qualified visit list, which are generally going to be considered the behavioral health visits that qualify as behavioral health services. So that hasn't changed either. The same initial diagnostic evaluation one time I had a provider asked they wanted to introduce themselves to patients and say hey, and that of course is not a psychiatric diagnostic evaluation. We have to go through our CPT manual and make sure that the services we're documenting in our chart, substantiate these codes. But these are our seven behavior. Direct Behavioral Health Service encounter codes that were allowed to bill under a revenue code 09 100. Remember behavioral health? I don't think I have that directly. On a slide. I have a couple claim examples. 09 100 for behavioral health line items, oh, look at that, what am I thinking about, of course, I have to slide. So by itself, it's an old encounter at this point, on its face, nothing has changed. This is the same that a behavioral health any of those sevens could codes we just demonstrated here could be included. And we have the 09 100 on the revenue code. And of course, we're going to have a charge that probably goes up every

year. And of course, one of the things we're talking a lot about is inflation. So we want to be sure we're maintaining our fee schedule. And here we have this particular encounter pharmacological management, CG modifier, pretty straightforward stuff. Now, in our definition of rural health clinic encounter, that this part has not has remained static, this has not changed. We have a couple of different reasons that we can bill, a dish and additional encounter, to that which the patient presents. So we have a sick visit. patient comes in, we have the ability, if they subsequently injure or suffer from an additional illness, we have the ability on the same day to bill for two visits. The same goes we have a multiple encounter rule that covers a behavioral health visit and a sick visit on the same day. And yet we have a third exception. That allows us to Bill multiple rural health clinic visits on the same day, if we have a welcome to Medicare, we have a behavioral health, and we have a sick visit on the same day, subsequent illness or injury. But in reality, for visit in Canada, it's not going to work very well. We frequently have, of course, subsequent illness or injury that happens often. We also fairly often, if we have behavioral health, we hope so because we really want to treat the patient entirely when they're on site. We don't want to have to be in a position to send patients home and come back for another encounter. We can have them see their LCSW and receive a therapeutic visit on the same day as we receive a sick visit and be paid twice for those. Now behavioral health and preventive visits on the same day. That's a whole different ball of wax. But the norm, and no I should I should a frequent occurrence. It's usually not the norm is that we'll have a sick to behavioral health, a clinical and behavioral health isn't on the same day. 900 Revenue Code distinguishes the behavioral health service. In reality, what may happen on this your system will probably spit out to you system will generate pardon me generate two different claim forms one for the clinical visit one for the behavioral health visit. And it's the same difference, you're going to get an encounter for each one. The distinguishing factor, again is the revenue code. But they because they both this is the one instance where you're going to by definition submit to CG modifiers on the same day. So you can do your system is not likely going to generate one claim form like this. It's going to look like two separate claims. No problem. So our ability to provide a behavioral health visit via telehealth and be paid our rural health clinic encounter began on January 1 2022. It was with the recently released Physician Fee Schedule even though we're not paid on the physician fee schedule. A lot of our rules generally come out in the Hospital Outpatient Prospective Payment System release every year, as well as the Medicare Part B Physician Fee Schedule, Final Rule release every year. This particular language you'll see of course came from right there at the top of the CMS rural health clinic Center, which is always a good place to watch for new information to come out. That's where we get and sit and watch. And it sounds like a lot of fun, but it's important stuff. So that beginning on January one RH C's can receive a behavioral of rural health clinic encounter rate for behavioral health visits. So i e, we're billing these not billing these as a G 2025. Now part of the big source of consternation with these is what does an in person visit me and and when does it apply? Well, for right now during the Ph D, and for 151 days, post Ph D. The in person requirement is going to be waived. Now, for the 151 days post PHP, remember I mentioned the GT zero to five, part of what's going to be happening during that post PHP period, which doesn't look like we're anywhere close to this point for the moment, yet again, different conversation. A lot of that period is going to be taken, at least on our side trying to figure out what happens to the G two, zero to five. So what happens to G 2025 For the rest of our rural health clinic encounters that are rendered via telehealth. But back to behavioral health, that's been rendered moot, because we're not going to build GT zero to five anymore for behavioral health, telehealth visits. The in person visit when it comes back, if it comes back is going to be a requirement within six months prior to the furnishing of the

telehealth visit. And an in person visit every month after it's waived doesn't apply right now have your telehealth visits. Even without there was an ability to make exceptions. And we're all running around trying to figure out what the the exceptions might cover. So behavioral health visits, there will be an allowable. So if the patient has transportation insecurity, and there's no way for them to get to the clinic, that's a big issue. If the patient has as part of their treatment or diagnosis or situation, and ability and inability to get that's an exception to if the patient if coming to the clinic would affect the patient's treatment, and they're just not able to do it. So made on a case by case basis, ie documented in your clinic medical record. We have already mentioned the revenue code 09 100, which distinguishes our behavioral health visits from our clinical visits. Our behavioral health visits do are built with modifier CG that's going to indicate our encounter will use a modifier 95 where we have audio and video like we have the potential to today we're just not using the video and F q modifier FQ if it's audio only ie telephone only. There are two different examples of what those line items would look like with a 95 modifier and active audio video or FQ telephone only. One important discussion we cannot miss in any behavioral health integration conversation is that of coordination of care services. With ACOs which of course right now I'm actively involved with development of an ACO. One of the big questions we get is How does behavioral health integration affect quality of care? Where do behavioral health services fit into care coordination? And what are some additional ways that we can provide behavioral health services outside of just the face to face visit in our Rolf clinic, encounter definitions? coordination of care, general care management services is one new avenue Avenue. Couple different things I want to point out. This is right out of the two 30.2 general care management services. This would be out of the Medicare benefit policy manual chapter 13. Discussing care management services in general. I don't want to spend a lot of time we've all had conversations at nauseam, I think about the components of care management services. What I want to point out are some of the things that I in my view typically we haven't gotten to yet or we're still integrating behavioral health services. And we're just not that advanced yet but look Get the bottom of this. We have general behavioral health integration and psychiatric collaborative care model for our is one type of coordination of care management services who a lot of acronyms there, but I think you're still with me. So look, behavioral health and psychiatric coordination of care is built into our care management services. I think a lot of these are forgotten. Under that they're not It's not forgotten, but perhaps we haven't gotten there yet. The bhi behavioral health integration, part of our requirement when we're some of these services require that we have a behavioral health integrated team based collaborative approach, make sure we're, for example, we have an LCSW in a primary care shop. Who is the quote unquote, behavioral health director for those services. That's part of what our team based collaborative approach is meant to address. So we know under care, man, and this is panning out. So really, we have initiating visit, or care management services, that's one of our central requirements to eventually having billable services, we're not going to spend a lot of time talking about the initiating visit, I do want to talk about the comprehensive care plan. So that of course, one of the things we're about to mention is we're how do we integrate this with primary care? Well, one of the places we integrate it is where we have a comprehensive care plan. And we have a big anxiety and depression and substance abuse diagnoses that are coming through on our patient evaluations. And of course, we have resources for these folks as part of the whole point, then not necessarily every time they come in just for an encounter. We have a care plan that addresses those patients. Documented health needs. This is where we roll the ACO and quality care. Considerations in this patient has serious mental health issues that we have the resources to address, and it's built in to a comprehensive care plan that

includes a problem list, expected outcomes, etc. Down below you see, we have a person centered electronic care plan based on their physical, mental, cognitive, psychosocial, functional and environmental assessment. That's one of the things I think telehealth has has opened up is perhaps a view of what are that patient's physical environment? What's their physical environment? Condition, like what is their psychosocial environment look like? And of course, status of their mental health based on that. So we have to have this care plan, how are we interacting with other resources. And of course, it's all in our electronic health record, right? To have redundancy there. We know 12 months of a patient that has it used to be two or more chronic conditions on a clinical set of diagnoses. Now, CCM services may be furnished to patients with multiple or a single chronic condition expected to last 12 months. There's that familiar timeframe suspected last 12 months and it puts that puts them at significant risk and risk of exacerbation decompensation, functional decline and death. Two or more chronic conditions is how many we had when this came out. And of course, I've it's always pointed to PT, I don't like to talk about it. It's distressing to say that many of our providers when care management services came out to two chronic conditions. That's a healthy patient. So to chronic condition, there are lots of patients that qualify for this. And of course, again on the ACO side, quality care if you're going into that area, we're trying to identify our sickest patients and get them in, get them a care plan and see if we can keep them out of the emergency room and out of the hospital and get them healthy. That's the point. So the other point for behavioral health that we generally miss, in addition to the familiar language of two or more chronic conditions now one or primary, any qualify by General behavioral health intervention service during a calendar month furnished to patients with one or more new or pre existing conditions being treated by the RHC, or FQHC primary care provider, including substance abuse, that warrants behavioral health intervention services, that is a broad definition of how our primary care providers can establish care for these behavioral health services for a range of issues just including right, regular old substance abuse disorders. So we have a lot of ability to use this as a care management service for our patients, any behavioral health or psychiatric condition being treated by the RHC or FQHC. practitioner. So, g 0511. There's the service requirements, again, that become a billable visit, once you meet all the service requirements on option B, we've all talked about all those are standard service requirements. On option B, we need to have initial assessments follow up monitoring, here's the big key. Some our providers are using applicable validated rating scales. That's LCSW, and clinical psychologist speak and mum already out of my water, my depth on that. But these are our set of service requirements where we're billing g 0511. for behavioral health intervention services, we have to be able to address those patients who are not progressing and whose treatment is not working. And typically we're going to have a third party, there's a team member involved because we have behavioral health and behavioral health intervention team back on that CMS Rural Health Center website. That's the fastest way to get the announcements of what the current G 0511 is paying. And remember, I've already talked about a G 02025. Talked about g 0511. Exclude preventive visits for me. But think about any codes that don't pay the rural health clinic encounter. G 0511 is one of those, it is an aggregate code. G 0511. The payment for which that third bullet there is set at the national average of the non facility Physician Fee Schedule payment amount for this slide is out of date there actually now five, I think seven codes that are included in the you're accurate, don't quote me on that. Look at the CMS rural health web center, I think it's five now that comprise the 7925. It's not an encounter payment, due to zero to five, not an encounter, g 0511. These are not encounters. And remember, these include any clinical activity by licensed people. receptionists coordinating appointments with no clinical certification doesn't count

any clinical activity by licensed personnel for the 20 minutes per month, g 0511. Including the psychiatric conditions. And we have the elevated psychiatric coordination of care. This is where our behavioral health team comes into count. We have a 70 minute in the first calendar month 60 minute and the second calendar month to qualify for the G 0512. And that's under our RFC primary care provider could be solo nurse practitioner, solo FP could be you know, whatever your situation is. And we've got lcsd LCSW that's coming in providing visits. There's also a behavioral health care manager that we have, basically to refer to if we if we need that. But for g 0512. We do need that 70 months in the first month, 60 minutes in the subsequent month. The rate for these is 151 23. So there's an elevated payment there and of course, all of the provision of these services Geez, you're 511 G 0512 will have a big impact on your quality programs, they'll have a big impact on your patients able to provide the kind of care that they need on a G 0511. Forget behavior Hall for a moment. One referral coordination is generally, if your LPN is doing that, or an MA is doing that, that's a G 0511. Now, of course, back on the quality side, we have a lot of big promises being made on all these care managers have been replaced in your clinics, and a lot of that works swimmingly. So we're having a lot of conversation about how we're integrating care management services into our clinics, behavioral health of both the G 0511. And elevated level here offers avenues to be have a lot of flexibility with those. So again, patient comes on comes in anxiety and depression. And we're coordinating referral for that patient, maybe we're not even the one doing the therapy, of course, that's a different question, coordinating the referral, coordinating those community resources. Those all count, it's not just the time that your billing provider spends seeing that patient, that's the counterpart. This is the coordination of care. So we have a lot of flexibility, in my view, with what we can do with these in the rural health clinic, Behavioral Health Manager is the person who's got the designated individual with formal education or specialized training, including social work, nursing cetera, et cetera, there's pretty wide latitude and who can be that behavioral health care manager? I don't have all that answer. A lot of that is your state law. But what including RNs and LPNs, can be that behavioral health care manager, so it doesn't have to be a clinical psychologist has to be someone that's designated in your policies. Here we go. That's that behavioral health care manager. So they can furnish both face to face and non face to face services. In general supervision. That's a big change that allows us flexibility, we're helping these people, these folks can provide these under General Supervision, which means our provider can be out of the clinic, at the time that the service is being rendered. They don't have to be there in the clinic, under General Supervision, we have a lot of considerations. With those terms under incident to billing, of course, not going to read the rest of that to you, psychiatric consultant, this is all on G 0512. Back to our aggregate coats. None of our aggregate codes right now include remote patient monitoring. That means we don't have a way to build them. This could be g 0511. This could be built at the same time as an encounter or not. So I have this Miss applied up the top TCM services was a coordination of care services. But again, remote patient monitoring is not included in the aggregate of these coats minding the gap, been a lot I've been blessed to travel. It's been many been a couple lifetimes since I've been blessed to go to London. I actually never rode the tube while we were there. But I think mine the gap is a big thing on the tube. You don't wanna step in between the railway and the gap on the platform or anywhere you go. Remember, when we talked about our Medicare providers versus in a lot of states, this is Indiana, we have a lot of those quote unquote, master's level providers that are eligible to provide rural health clinic encounters where they're not at Medicare. So that may be a benefit if you have an LPC that you know, can only provide services to Medicaid patients, but maybe that's still workable and there are other benefits you might get. That are non line

item. Let's call them on the quality side. But look, we have those addiction, Marriage Family Therapist, mental health counselors LPCs and many of our states have also written telehealth into their encounter definition. So encounter definitions. almost across the board. I can think of a few states that haven't expanded their encounter definitions to include telehealth have encounters, but many, many states have Kentucky, Indiana, Illinois, Ohio has don't want to talk about others, other states are moving towards, and other states aren't quite there. But check your own state of mind the gap. How do we distinguish our 51% primary care services? All the way back to the beginning? I want to end on the big topic we started on now that we've laid all of the groundwork for the things that behavioral health includes and how we may or may not build them. How do we make sure we're staying under 51% primary care? And some of the difficulties that we encounter are? How do we count an advanced practice nurse who's a psychiatric advanced practice nurse? She's solo nurse practitioner? Well, let's talk through some examples. First, I came up with some hypotheticals and just, you know, I typically only ask trick questions. So how about 990 134? Anxiety, hypertension, COPD? I'm reading to you, Anna med rec, but our family nurse practitioner provides the service. Here's the trick part of my question. I'm not going to answer it. We're gonna wait. We're gonna wait for a second. My nerve Family Nurse Practitioner sees that patient and she's diagnosed anxiety, hypertension, COPD, and doesn't matter EC as a 99213. Thank you, if you're looking at nine I do a three is digital, kind of like not a behavioral health service. Its clinical evaluation and management service. Starting to answer the question that said I wasn't going to do that. How about a med rec, an individual therapy session by an LCSW? Well, of course, that's going to go in the behavioral health column. What if I have a suboxone clinic? Well, that's a good question too, because suboxone clinic and FERS and applies a lot of things to a lot of people. And I will tell you, among surveyors, back when I don't think we're using the term suboxone clinic as much. It was kind of a big red flag for just another pill pushing operation, which of course, I don't want to equivalent, equate them to, but let's do we really have a suboxone clinic? Let's talk about that. How about a nine nine to one three, for anxiety with med rec wooed by as a psychiatric advanced practice nurse? And who came up with these really fantastic questions. So, of course, I'm being silly. I come up with these hypotheticals, because these are some of the questions that we get from a lot of clients. And how do we navigate that? Here's the magic answer was not the magic answer yet. I wanted to raise one more question about that psychiatric advanced practice nurse bands, practice nurse rec providers. In many instances, we gotta be careful with that term. They're not automatically, as long as they meet the RHC requirements, a nurse practitioner can build them as an RHC encounter. I'll tell you what, if a surveyor comes in, and we have all of our visits are example number four, you're going to be that's if a surveyor comes in and you're being asked a question, you don't have any answers for these, you're probably the surveyor is going to go through and the surveyor is going to count, oh, every I shouldn't generalize. It's highly likely that a surveyor is going to come in, in any med rec, you've done any diagnosis of anxiety, any diagnosis of depression, they're gonna put in the non rural health clinic and count that against you. And there have been big problems when a rural health clinic can easily be considered solely a suboxone treatment clinic. Those are problems. How do we get around it? Have your own policy? Why said I'm not going to answer all of those questions is because those are questions that we talked about earlier for you to decide. That family nurse practitioner that diagnosed anxiety, hypertension, COPD, let's put in our policy. No, that is not a bad gave her a health service. It is a behavioral health service when our LCSW comes in, does their initial evaluation provides further treatment? Those are behavioral health services, our advanced psyche, or psychiatric advanced practice nurse, is she or he 100% Behavioral Health? Probably not.

And that's the case where you need to define much more clearly. You know, if you can, I don't have the answer. I'm an MBA type of guy. That's why you all need to have it defined for yourselves. Because then when the surveyor is on site, you say, here's how we measure it. Now, define the general circumstances individual site APRNs. Consider that person acting as primary care, initial diagnosis. What part of psychiatric care coordination and behavioral health and of course, if you're providing that level of care coordination services, they would have input on when should we define in our policy, what is or is not primary care, here's a suggestion I would make potential resources, evaluation and management services, talk to one very smart person who I rely on greatly. And they have used the definition of primary care services to coincide with evaluation and management service go. So 992123215, those are not behavioral health services are RFC qualifying visit list we saw here are behavioral health services. So you define them for yourselves. And of course, then we have to say, hey, if we're the most common diagnosis, we see when we do our program, evaluations, anxiety and depression are always at the top. So if we define it by only people with anxiety and depression, we're gonna be way over the 51%. Mark. So that's why we need to not have it defined for us. If you and this is only if you think you're close. You know, the, these are the questions we see folks come to us with on this topic. Benjamin Franklin, flawed, complicated person, had a lot of good expressions did some interesting things. And a lot more ounce of prevention is worth a pound of cure. The pound of cure is when the surveyor is there, and you don't have a definitive policy now and all the time you were on the line, treat the whole patient, and initial evaluation, all of those diagnoses needed their treatment paths, right. Part of our whole dig on the quality level, is to make sure that our ICD 10 ICD 10 coding is substantiated in the documentation that our ICD 10 coding in our documentation fully reflects that we've treated all of our patient conditions. That's why do we have suboxone clinics anymore? I don't know. Don't treat solely psychiatric conditions in your rural health clinic. That's where you'll run into problem when a surveyor comes in finds that you do indeed exceed 51% of your services, and are non raw 40 out no more than 49% of your services can be deemed behavioral health. So again, common way for servers to do is count by just number of provider hours. That's a typical way they'll do it. And if that's not effective, they'll likely switch to let's count diagnosis codes. And so your job is to define your behavioral health clinic program for your own clinic. Using a lot of the tools that we just talked about. Care Management Fact Sheet is a great resource. It's a lot of where I took my information from. And of course, these are all of the typical places that I have open at any given time on my desktop. That is my cell phone number. We'll be happy to answer questions offline. Perhaps we don't want to ask in a public forum. But of course, I'm always here at your service. So we did indeed Leave about 10 minutes for questions. So,

Nathan Baugh 50:05

and we have several. Great, so, Charles, I'm just gonna go ahead and start knock knocking some of these off and we'll just get to it. So Laurie Bush asks, is a psychiatric in P? Are they eligible to Bill and the RHC? Absolutely. Easy one, okay carry as kind of psychiatric psychiatrists, Bill and office visit e&m and RHC.

Charles James 50:34

Psychiatrist is an MD, right? Yep.

Nathan Baugh 50:39

So easy one there. Stephanie asks, How should we bill for a psychiatric NP who is doing medication management if the patient resides in a nursing home?

Charles James 50:52

The same way you do it if you're seeing the clinic and the patient, patient in the clinic?

Nathan Baugh 50:59

Same way, okay. Do you use? Go

Charles James 51:02

ahead? No, please do you use what

Nathan Baugh 51:06

do you use that new modifier GV.

Charles James 51:12

That's a bad point. Ask your coder.

Nathan Baugh 51:15

Okay. Got it. Got it. Okay. Next question from Tammy is could we bill a 99213? office visit with a 900 revenue code for a med check for behavioral health visit? And then a 992? And three with a five to one revenue code for a med check on family med issues like diabetes on the same date of service?

Charles James 51:40

No, I wouldn't think so. I mean, that's both. Those are both. I think that's overcomplicating the question. Right? No, I wouldn't do that that way.

Nathan Baugh 51:53

Yeah, it's I'm questioning Tammy, why she would be billing on 992 and three for behavior. And then considering that a behavioral health visit, if

Charles James 52:01

you just did the med check. I mean, I could see that but if you're doing a 2131 Yeah, I first I talked with your coder. But now I I try to keep it the reverse of that. Okay. But that's also the reason we're defining our own policy. Yeah, if you've got a system that makes sense, but in a from a payment perspective,

you're gonna get one, right? I don't know how that would pay, actually, probably because you got a 900 Revenue Code and a five to one at the same might get two encounters out of that. But yeah, but

Nathan Baugh 52:37

would you would you make that your policy? What if you had a behavioral health visits? So like that multiple visits slide that you had, right? Where you had a behavioral health visit and a medical visit? Encounter on the same day? Could those do you think it's possible that they could both be e&m nine to one threes?

Charles James 52:59

I guess, I guess it's possible but if honestly, if they're both to one threes, and that's really that's one encounter, in my view,

Nathan Baugh 53:05

okay. So that was a tough one, Tammy, gray gas, will mental health telehealth still be paid if we're in a metropolitan statistical area

Charles James 53:19

that is a weakness. I can help system and yes, it will be paid. But this is a great caution. And we do not want to have a situation where a rural health clinic has an exceptional number is a vague term of so I use be literal. Just like on the in person visit you have exceptions. It would be exceptional. That you have many telehealth encounters in an MSA, I know you're gonna throw back at me 15 different ways that can happen. But this is a weak spot that all of the regulators are nervous about being abusive of being abused is an obvious door for fraud. I would say with difficulty of saying this, this really has to be in your I think it's pretty easy to say and make some distinctions in a rational service area from that rural health clinic. Really be in a rational service area for that rather than just in the exact same way a nursing home would be treated. So I wouldn't be hung in mental health visits via telehealth and an MSA all day every day. No, sir. Yeah.

Nathan Baugh 54:55

And Greg, I think we would need more to to really dive into this scenario you're talking about here, but I will just add that Congress has already passed coverage for mental health telehealth for Medicare writ large. Post PHE. Right. So like, people in fee for service settings in the city, you know, Medicare is going to cover telehealth for mental health, like that's already been passed by Congress. I don't know if that's what you're asking. But that will continue. All right. Next question. From Jeff, as I interpret one of the first slides, a psych trained nurse practitioner is not an approved provider for delivering mental health services to a Medicare patient question mark.

Charles James 55:42

I did not mean to give that impression. So know that that? That would be some you know, what it was one of the things I said is APR ends there. There can be depending on APRN. Some issues, necessarily, but no, I did not mean indicate a site trained nurse practitioner. Certainly the key there being the nurse practitioner, would be an approved provider.

Nathan Baugh 56:10

Great. Next question from Mark is can the same MD MP RPA? Provide a 992? And three and a 90832 on the same day and be paid the Ayar? Does it have to be a different provider can be the same provider? I think that's the

Charles James 56:27

No, I would I don't think you the same provider there. I would think that's one encounter, really. And, you know, probably be paid. I think they'd probably request a note on it. But, you know, paid and correct are two different things as we both know, and Hello, Mark. But I think that certainly violates the spirit. Now if it's but again, is that going to be a subsequent illness or injury? I don't know.

Nathan Baugh 57:04

Yeah. Well, we'll do one more than have some closing comments. And then Charles, it'll be up to you. If you want to stick around for a little longer FAQ. Laurie says can you please clarify? Who staff are able to watch staff are able to complete the work under CCM? And she says a recent call, this might be me here indicated that BSW could provide the 20 minutes of work billed under the provider.

57:40

That's true.

Nathan Baugh 57:42

Yeah, I would agree with that. Okay, great.

Charles James 57:46

It's, it's well, okay, let's see, now we're really going to get down into Minson terms. But the fact sheet says any clinical personnel, yep. And in my view, I will say, for my shop, that that LCSW certainly counts as part of their clinic licensed clinical social worker. And, indeed, it's not so that it's the same as an RN, if an RN was doing it, it would certainly be so. And there's certainly no prohibition building anywhere in the language is that person couldn't be an LCSW. I was absolutely.

Nathan Baugh 58:34

Yeah, I want to say, Charles, tell me if you think this sounds right, clinical staff working under the direction. Alright. And it's that that that phrase has been very vague. And

Charles James 58:51

very restrictive. Yeah, you could interpret it that way. And maybe if you have 1000 claims that way, but you know, most of many of us are not going to be, I'm not saying to purposely do something wrong. I'm saying that's an argument, I would make an LCSW providing those referral services? Absolutely. Hey, I paid a student loan off on an LCSW that I was blessed enough to marry. And so they, you know, that is a licensed clinical social worker, I'd argue all day.

Nathan Baugh 59:31

Charles, so Are you okay, with

Charles James 59:35

an extra few minutes? All right, but for folks who are outstanding ones out?

Nathan Baugh 59:37

Sure. I just I want to go ahead and just inform everyone that if you're waiting for the CEU code, if you want when you exit the presentation, you will be prompted with a three question survey. And after you do that, those three questions you'll be able to get your CEU code so that's where that's going to be but We are gonna go for another 10 minutes and answer as many of these questions as we can. So Scott Brown gives you a scenario here. He says the patient is at the RHC for a mental health visit. Can my MSW be off site and the visit be done via telemedicine?

Charles James 1:00:21

Yes, as long as that Msw is on the cost report is basically the gauge. Now, look, I got a massive target for abuse right there. Yes, in the way I read it, the intent is to eliminate the distance site and originating site distinction for behavioral health visits is the intent of making these encounters. Now, we're going to come up with scenario scenarios for me that that MSW never sets foot in the RHC. Is that acceptable? I don't know. There's nothing I read to prohibit it. What I want my client to be in that situation? No, I would advise them not to be. So there's a lot of stuff that is for me, in the way I would advise our clients is opportune for abuse, which is mistakenly doing things you shouldn't. And the policy

Nathan Baugh 1:01:41

shifting right now, like the policy is a Ph. D. policy that's temporary. It's something is gonna happen before that 151 day period. And so the policy will be evolving.

Charles James 1:01:54

Now, let me make another suggestion. First of all, I think one of the other questions in and down the row was about remote patient monitoring. And I just want to say once again, no, in my view, remote patient monitoring, we have no way to bill out of a rural health clinic, and I would not advise billing that park be the so that's a policy evolution. And, and on the effort totally forgot my train of thought now and why brought up remote patient monitoring, because those G codes G here's a massive issue that's aiming at people that we don't know about, that we're not recognizing, unless your cost report prepare the G 051 ones, and G excuse me, the G 2025 are non encounters. So those must be taken out of your productivity count. Those are not encounters where the behavioral health visit I was just asked about yes would be encounters. Now. That's the whole gig payment count as encounters. You're going on the productivity count and converting all of our telehealth visits directly to encounters. Look at your cost report and see that what that's going to do to you because there's a cost reporting impact there. So let's not just be so fast or run out and say we automatically want to have at the policy level. All telehealth encounters as encounters. I would suggest I was previously saying that I would say not so fast. Let's take a look at it. Let's take a look at it. Okay, let's go ahead.

Nathan Baugh 1:03:46

Okay, next question from Colette, this is the incident to question. She was having difficulty getting an answer. They recently hired an LM SW, who needs two years of supervision before moving to the LCSW. For Medicaid and Medicare and other clinic settings, the LM SW can build incident to an LCSW. But they need to know if that is also the case and a RHC this is one don't Yeah.

Charles James 1:04:17

And here's

Nathan Baugh 1:04:18

a specific Charles, what's that? Would it be state specific or

Charles James 1:04:25

theoretically but but Medicare is not going to look at it that way. So yeah, possibly at the state level. You could bill that Licensed Master social worker. Yes. At the state level, frequently could build that as encountered but man, we're not talking about that. And as a biller, that's what we are. That's what I have come into this even though when other settings Yes, the LCSW can Oh See that LMS W, and, quote unquote, build that? Man, I wouldn't do it as real health clinic encounters. Because what you're saying is, is that Ella LCSW had a face to face encounter, right? With that patient. And the only way I would do that, honestly, is if they're sitting next to one another. And then what's the point? In my view, it's kind of the same thing as when we have a student in our rural health clinic. The student has to be the only way you can build that students encounter is a physician asked to sign off on it, and I had to be present in the examination. And so I think that that is the answer. I've gotten into huge

fights with people over that, that I would not build it that way. And that's the line we drew. And now I don't think you're going to find a definitive answer is your problem. So let's hit the next one there.

Nathan Baugh 1:06:05

So Carrie asks, this isn't necessarily mental health, but Carrie asked What's up should be billed when a family member is seen during guide patient's visit instead of the patient.

Charles James 1:06:17

And this gets a little more specific on those CPT codes. I think, under the CPT code definition, where it says, family member, man, we have a problem with the billing under the patient. Because we're billing for that patient. I want to put an asterisk on it and say, hey, get the same answer someplace else. But I think there's provision for us to build that family counseling now. But as an got to be careful and say, you know, as we wouldn't encounter for the patient, but I'd want to get my coder. And I'd want to, I'd want to go to like Patti or Shannon or somebody and ask their opinion. Right? Before I just released 1000 claims do.

Nathan Baugh 1:07:11

Right. Generally group visits have been not

Charles James 1:07:16

allowed visits are definitively not and they're expressly stated in RFC, non RFC service.

Nathan Baugh 1:07:23

Right? This wouldn't count as a group visit Charles.

Charles James 1:07:28

Yeah, and it could. The, the issue is, for example, IDPA, Illinois Department of Public aid. Yes, we do cover group. So, so check your state. Medicare's definitively no group? I think there is. And of course, it would be an exceptional situation where you're counseling the family member, out outside of the presence of the patient, but I again, I think that's going to be an exceptional situation. Unique and not common?

Nathan Baugh 1:08:12

Yeah. Okay. Let's do maybe let's just do two more Charles, and then go ahead and wrap it up. So Peggy is our clinical psychologist is called a medical psychologist, since she has been doing it so long and no longer has to be under a supervising provider. Is that an eligible provider?

Charles James 1:08:32

Peggy? Hello, I'm so glad you're listening. Good to hear from you. This goes to part of what I was trying to give a on the APRN conversation. Because at the state level, as statutes and laws evolved, you know, some of these terms get grandfathered in, shall we say. And absolutely one state where the may be able to call yourself a nurse practitioner, you would not meet the requirements in another state and I'm not going to name names or pick on it. And no offense to nurse practitioners. But so pegging on that I saw yet medical supervision question floating out there. So at the state level, if that person qualifies at the state level, as a medical director, for, for example, nurse practitioner, let's say they're called something different, totally different. Medicare does have the basic provisions, here's what you have to be to be a nurse practitioner, it's this much school, this much clinical, etc. That's why we get into the problem with the clinical social workers, they have clinicals they have to go through. So generally, the short version of that is those terms are typically grandfathered in and the kind of governing operative guidance would be state law and that that corresponds with Medicare's definition of a medical director.

Nathan Baugh 1:10:06

Perfect. All right, Charles, last question. I think this is going to be an easy one. Okay. Can registered dieticians? Are they a part of the qualified Medicare

Charles James 1:10:17

providers? Man? I love this question. No.

Nathan Baugh 1:10:22

Nice and easy, right? But,

Charles James 1:10:25

but, but go ahead elaborate. Sure. First of all, not to set up antagonism FQHCs these are encounters. Absolutely other policy differential that I've been, you know, when the subject comes up, I beat my shoe about. But right now that registered dietitian, you could build that incident to it says, you build that incident to you get registered as a diabetic Senator, I think it's fairly easy to do that. And there are a couple of things in there. But then that registered dietitian would be incident to in the quality world and on your commercial payers, and perhaps on some of your Medicaid quality endeavors that registered dietitian, you may not be getting a line item reimbursement on, but in my view, they're a crucial critical part of our patient team. So just because you don't get that line item, they're on that Medicare visit, which you do not they don't qualify as an encounter, they do qualify as an incident to just unfortunately, like an injection would be. But man, I see many folks opting to go ahead and introduce those providers into their practices in that knowledge, because there are a lot of other ways to benefit our patient population and our reimbursement.

Nathan Baugh 1:11:48

Excellent. Well, Charles, gonna go ahead and wrap the questions here. We are going to a couple of announcements. We are going to have office hours every every Wednesday, and including tomorrow. So some folks that might not have got their questions our asked or answered here can feel free to join us on office hours tomorrow. And I believe next month, we are planning a our next webinar on the therapeutics. And by therapeutics, I mean the antiviral, Pax COVID. And Manu Sera, how do you pronounce the other one? That's not a fair thing to call on me for talks of it and the other one in terms of the distribution of that to our ACS, which was sort of sort of formally opened up in a big way earlier this week. And so we'll be going into really all of the COVID supply programs and just an update on where we are on that, as unfortunately, we look to be headed into another yet another wave of COVID. So just be on the lookout for that, those those webinars and the office hours. And of course, I want to thank you all for joining us today. And especially, of course, Charles, for his presentation today. And we have to thank the Federal Office of Rural Health Policy, of course for sponsoring this webinar series. Again, we just want to encourage everyone to sign up on neic.org And if you have topics that you would like to suggest for the future, please email myself which is nathan.ba at nar hc.org and let me know what you would like us to potentially do a webinar on.

Charles James 1:13:49

Thanks for having me. I appreciate it.

Nathan Baugh 1:13:50

Thank you all for the for your participation that will conclude today's call. Thanks. Thanks, Charles.