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Navigating Billing and Documentation for Behavioral Health Services in FQHCs

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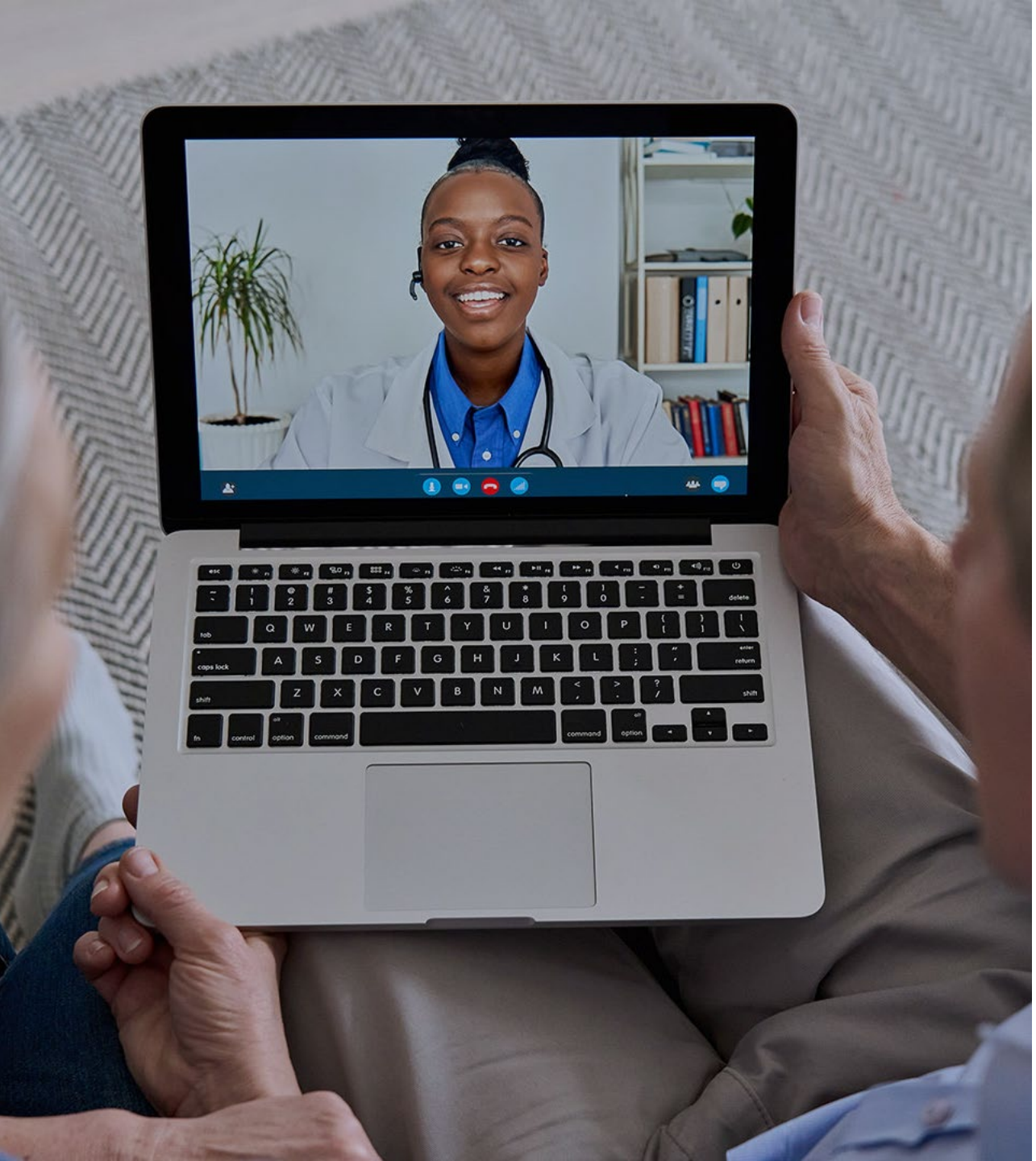

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Objective

Unlock the secrets to effective billing and documentation for behavioral health services within FQHCs

Today's Presenters

- Mimi Vier
  - Provider Outreach and Education Consultant
- Kathy Gates
  - Part A Case Management

Agenda

- FQHC Program Basics
- Behavioral Health Billing
- Medical Review Background
- TPE
- TPE: FQHC Behavioral Health Treatment/Services
- ADR Tips: Using FISS and NGSConnex
- References and Resources
- Questions

FQHC Program Basics

FQHC Encounters

Encounters defined

Medically necessary, face-to-face interaction between patient and core practitioner during which FQHC covered service is performed

FQHC reimbursement per day

Encounters with more than one health professional on same day = one encounter

FQHC core practitioners

Physician, NP, PA, CNM, CP, CSW, MFT, MHC

FQHC Billing

- Bill Types (77X)
  - 770 = nonpayment/zero claim
  - 771 = admit through discharge
  - 777 = claim adjustment
  - 778 = claim cancel
- DOS
  - Cannot overlap calendar years
    - Billing periods that overlap calendar years should be split into two claims

FQHC Revenue Codes

Revenue code	Description
0519	Supplemental MAO payment
0521	Clinic encounter
0522	Home encounter
0524	Encounter for beneficiary in covered Part A SNF stay
0525	Encounter for beneficiary in noncovered Part A stay (or other residential facility)
0527	Visiting nurse service at beneficiary's home when in home health shortage area
0528	Encounter at other non-FQHC site (scene of accident)
0900	Mental health services provided by CP, CSW, MFT, MHC

FQHC Payment Codes

- Identify each billable encounter using appropriate FQHC G-code
  - G0466 – Medical encounter, new patient
  - G0467 – Medical encounter, established patient
  - G0468 – IPPE or AWV
  - G0469 – Mental health encounter, new patient
  - G0470 – Mental health encounter, established patient
- Report with billable encounter revenue code
  - 052X – Medical encounter
  - 0900 – Mental health encounter
  - 0519 – Supplemental MAO payment

Qualifying Visit

- Qualifying visit
  - Same billable encounter revenue code
  - Qualifying visit HCPCS code in HCPCS field
  - One (1) unit
  - Charges

Subsequent Claim Lines

- Incident-to services
  - Appropriate revenue code for HCPCS code
  - Appropriate CPT/HCPCS code in HCPCS code field
  - One (1) unit
  - Charges
  - Revenue code 001 = Total of all charges on claim (ensure calculated properly)

Behavioral Health Billing

Behavioral Health Billing Codes

- FQHC payment specific code
  - G0469 – Mental health new patient
  - G0470 – Mental health established patient
- Qualifying visit
  - 90791 – Psychiatric diagnostic evaluation
  - 90792 – Psychiatric diagnostic evaluation w/medical services
  - 90832 – Psychotherapy patient &/family 16-37 minutes
  - 90834 – Psychotherapy patient &/family 38-52 minutes
  - 90837 – Psychotherapy patient &/family 53 or more minutes
  - 90839 – Psychotherapy crisis initial 60 min
  - 90845 – Psychoanalysis
- Revenue code 0900

Example: Mental health encounter – established patient

Revenue Code	Description	HCPCS/CPT	Service Date	Service Units	Total Charges
0900	FQHC visit, mental health established patient	G0470	010125	1	$175.00
0900	Psychiatric evaluation	90791	010125	1	$140.00
0001	Total	NA	NA	NA	$315.00

Medical and Mental Health Encounters on Same DOS

- Patient has medical and mental health encounter on same DOS
  - Report second encounter on additional claim lines
    - Payment code line
    - Corresponding qualifying visit HCPCS code line

Claim Example: Medical and Mental Health Encounter

Revenue Code	Description	HCPCS/CPT	Service Date	Service Units	Total Charges
0521	FQHC visit, established patient	G0467	010125	1	$150.00
0521	Office/outpatient visit, established patient	99213	010125	1	$135.00
0900	FQHC visit, mental health established patient	G0470	010125	1	$175.00
0900	Psychiatric evaluation	90791	010125	1	$140.00
0001	Total	NA	NA	NA	$600.00

Medical Review Background

MR Objectives

- Reduce payment errors by preventing initial payment of claims that don't comply with Medicare's coverage, coding, payment and billing policies
- Identify errors through claims analysis and/or medical record review activities
- Appropriately pay for covered services
- Provide education to providers to help ensure future compliance

MR Process

- Leverage data analysis to identify
  - Providers and suppliers who have high claim error rates or unusual billing practices
  - Items and services with high national error rates and high financial risk to Medicare
- Verify if issue approved by CMS via “CMS Approved Review Topics” list
- Consider
  - CERT findings
  - Referrals from other entities: OIG, UPIC, RAC

TPE

TPE Process

Round 1	Round 2	Round 3	CMS Referral for Corrective Action
Provider notification	ADRs: 45-56 days after education	ADRs: 45-56 days after education	Extrapolation
ADR request	Validation	Validation	Referral to UPIC or RAC
Validation	Calculation	Calculation	100% pre-payment review
Calculation	Review results letter	Review results letter	List not all-inclusive
Review results letter	One-on-one education	Referral (if applicable)	NA

Responding to an ADR: Time Matters!

- Avoid clams processing delays!
- Provider has 45 days to respond to request for medical records
  - We recommend responding by 35-40 days
  - Use NGS ADR Timeline Calculator

- 45 days includes mail time and contractor processing time to a medical review location

Post-Probe Education

- Request education via email within two weeks from results letter date
- Discussion topics include
  - Claim denials
  - Related Medicare regulations
  - Best practices to ensure proper payment
- Recommended attendees
  - Representatives from compliance, clinical, billing, coding, finance areas, and any additional staff that would benefit from attending
- Next round of TPE review initiated no earlier than 45 days after education session

TPE: FQHC Behavioral Health Treatment/Services

TPE for FQHC Psychiatric/Psychology Services

- Revenue code
  - 0900 – Psychiatric/psychological treatment and services that are subject to outpatient mental health limitations
- Type of Bill
  - 77X

Top Denials for Psych Services in FQHC

- 55B00 - Claim denied because plan of treatment missing or evidence of physician supervision/evaluation not documented
- 55B31 - Incomplete/insufficient information
  - CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3 – Verifying Potential Errors and Taking Corrective Action, Section 3.2.3.8 C
  - Social Security Act 1833 (E)
  - 42 CFR 424.5(A)(6)

Denial: 56900

- Requested medical records not received within 45 days
- Medical necessity not determined without review of documentation
- If less than 120 days after denial notification on RA, submit records to contractor requesting records
  - Do not resubmit claim
  - Appeal denial if provider can support medical necessity in documentation

Psychiatric and Psychology Services

LCD L33632: Psychiatry and Psychology Services

- Outlines medical necessity requirements for Part A and Part B services
  - Psychiatry, psychology, clinical social work, and psychiatric nursing for diagnosis and treatment of various mental disorders and/or diseases
- FQHC providers have unique coverage requirements not specifically addressed by the LCD

Coverage: Mental Health Visits

- Mental health visit is a medically-necessary face-to-face encounter between an FQHC patient and an FQHC practitioner during which time one or more FQHC mental health services rendered
- Must qualify as stand-alone billable visit
  - Services furnished must be within practitioner's state scope of practice
- Group mental health services do not meet criteria for one-on-one, face-to-face encounter in FQHC
- Visits for medication management not billable as mental health visits

Approved Mental Health Providers

- To provide and bill for mental health services in FQHC, clinician must be one of the following
  - Physician
  - Nurse practitioner
  - Physician assistant
  - Certified nurse midwife
  - Clinical psychologist
  - Clinical social worker (LCSW or LICSW)
  - Marriage and Family Therapist (MFT)
  - Mental Health Counselor (MHC)

Coverage Criteria

- Individualized treatment plan
  - Type, amount, frequency, and duration documented
  - Indicate diagnosis and anticipated goals
  - Not required if only a few brief services furnished
- Reasonable expectation for improvement
  - Purpose must be a diagnostic study or reasonably expected to improve patient's condition
  - At minimum, designed to reduce or control psychiatric symptoms to prevent relapse or hospitalization
  - Improve or maintain level of functioning

Coverage Criteria continued

- Frequency and duration
  - No specific time limits for coverage
  - Evidence supports patient's improvement according to individualized treatment plan
  - Frequency within accepted norms of medical practice
- Factors affecting outcome of treatment
  - Nature of illness
  - Prior history
  - Goals of treatment
  - Patient's response

Treatment Plan Requirements

- Individualized treatment plan
  - Type – Individual psychotherapy or group psychotherapy
  - Amount – Length of session(s) (30 minutes, 45 minutes, 60 minutes)
  - Frequency – Interval of session(s) (weekly, monthly)
  - Duration – Timespan the plan will be in effect or due for update
  - Diagnoses – Psychiatric diagnosis treated in the plan
  - Anticipated – Goals – outcomes to be achieved by interventions

Psychiatric Diagnostic Procedures

- Documentation requirements
  - Complete medical and psychiatric history
    - Past, family, social
  - Thorough mental status examination
  - Establishment of initial diagnosis
  - Evaluation of patient ‘s ability and capacity to respond to treatment
  - Initial plan of treatment
- Information may be obtained from not only the patient, but also other physicians, healthcare providers, and or/family if patient is unable to provide complete history

Documentation Required by Medical Review

- Medical records sent in response to ADR should include
  - All recent physician orders and progress notes with clear history of reason for treatment and progress
  - Signed current treatment plan containing all required elements
  - Relevant medical and psychiatric history
  - Clinic note for date(s) of service billed which summarizes diagnosis, symptoms, functional status, mental status, and interventions used
    - Ensure signature and credentials of the treating clinician
    - Any documentation supporting medical necessity
  - Type and total time spent
    - Supporting CPT code billed
  - If ABN was issued, include signed/dated copy

Tips for Successful TPE

- Provide a point of contact with name, phone number and email address
- Ensure address in PECOS is accurate for all mailed communications, including the address for Medical Review ADRs to be sent
- Coordinate response to ADR with your medical records department and clinical staff to ensure that a complete response with all information requested in ADR letter is submitted to NGS
- Reach out to J6Acasemanagement@elevancehealth.com any time during the TPE process for questions or concerns related to the TPE process, denials, etc.

ADR Tips: Using FISS and NGSConnex

Additional Documentation Request

System Issues ADR

- Claims suspend to status location SB6001
- ADR sent to provider
- Provider has 45 days to return records to MAC

Records NOT Received Timely

- Claim will deny on day 46
- Claim moves to status location DB9997
- Provider receives 56900 denial

Records Received Timely

When records received, claim will move to status location SM5REC

Using FISS: Check for Pending ADRs

- Enter 01 (inquiry)
- Enter 12 (claims)
- Type SB6001, SB6098 and SB6099 in S/LOC field and press enter
  - List of claims provided showing an ADR has been issued (F6 moves to next page for multiple pages)
- Screen print each page for tracking purposes

Using FISS: Print the ADR

- From the SB6001, SB6098, SB6099 S/LOC, select individual claim
- Go to page seven to view ADR
- Print page one and hit F8 to view page two
- Requested records and due date are listed

Using FISS: Track Receipt of Records

- Enter 01 (inquiry)
- Enter 12 (claims)
- Enter MBI and DOS for which records have been submitted
- Continue to monitor claim ADRs through the process to the remittance advice

Using FISS: Determine Denial Reason

- Enter 01 (inquiry)
- Enter 12 (claims)
- Enter MBI and DOS for which records have been submitted
- On page two, review lines with noncovered charges

Using FISS: View Remarks

- Go to Remarks section to see a brief narrative in cases where a denial occurred
  - Ensure appropriate clinical personnel are provided this information
- This narrative will not appear for 56900 denials as no records have been reviewed

Using NGSConnex: Check MR ADR Portal

- Use MR ADR portal to
  - View ADR letter content to help ensure you submit required documentation
  - Respond to MR ADRs
  - Submit supporting documentation electronically
  - Obtain detailed status information on MR ADR

Using NGSConnex: View ADR Information

- *View detailed ADR status information including:*
  - *Documentation receipt date*
  - *Date the reviewer started/completed review of documentation*
  - *Reviewer decision*
  - *Appeals outcome*
- *Not yet registered for NGSConnex?*
  - *Visit NGSConnex and click 'Create Account' to register*
- *Registration instructions are available in our NGSConnex User Guide and video tutorials are available on our YouTube channel*

References and Resources

TPE Resources

- NGS website
  - Resources > Medicare Compliance > Targeted Probe and Educate
    - TPE Manual
    - How to Find and Respond to TPE ADR
    - Medical Review: Targeted Probe and Educate Review Topics
  - Education > News
    - Targeted Probe and Educate Letters – An Informational Overview

NGS Resources

- Assistance with general questions
  - Interactive Voice Response System
- Complex inquires and assistance
  - Provider Contact Center
- *NGSConnex User Guide*
- Medical Review Portal in NGSConnex
- MR FAQs

CMS Resources

- CMS website – Medical Review and Education
  - Targeted Probe and Educate
  - Targeted Probe and Educate Flow Chart
  - CR 10249: Targeted Probe and Educate

YouTube Video Resources

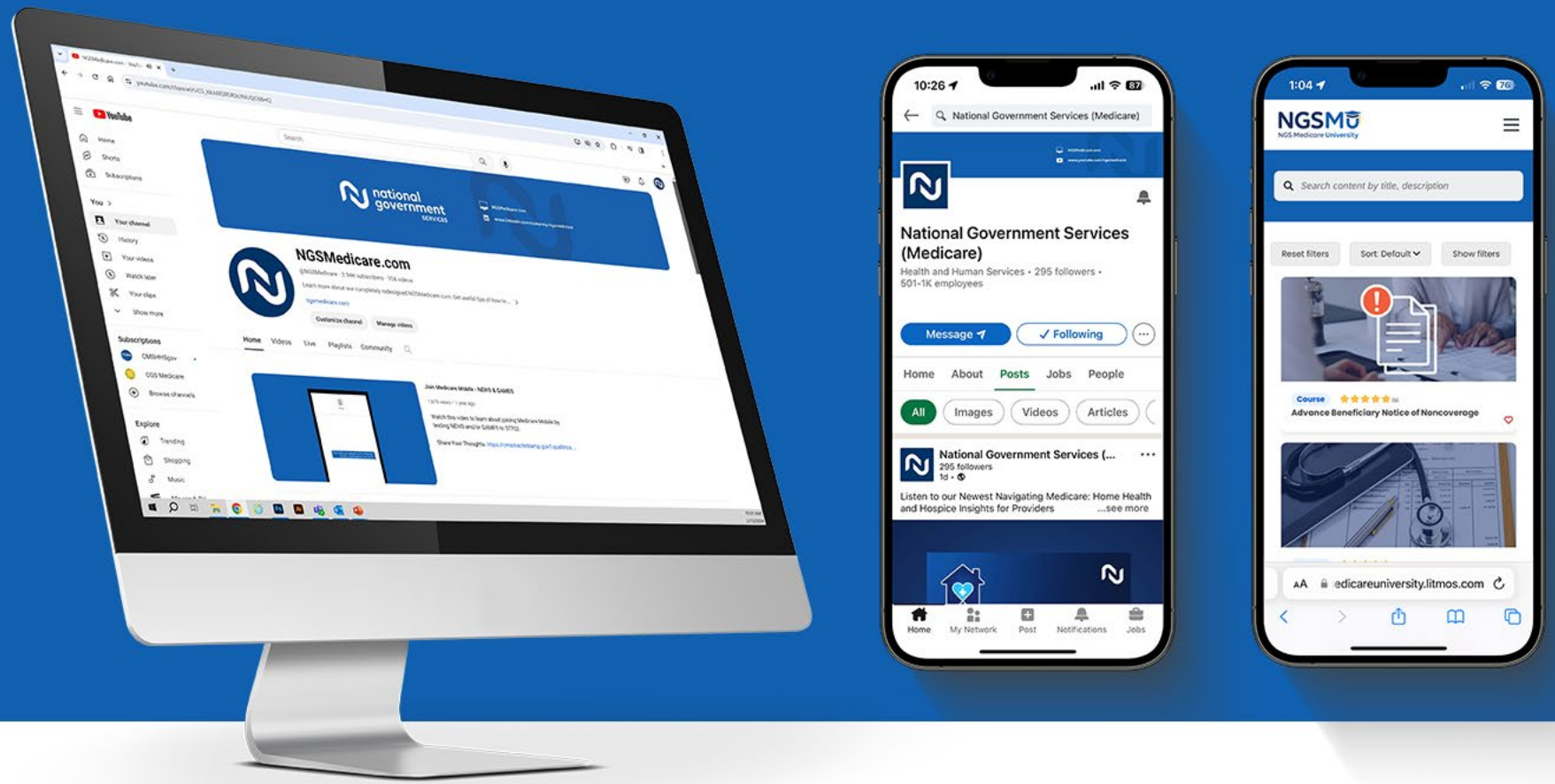
- CMS YouTube Videos
  - Targeted Probe and Educate – 2019 CMS National Provider Compliance Conference
  - Targeted Probe and Educate
  - Provider Minute: The Importance of Proper Documentation
- NGS YouTube Video
  - Targeted Probe and Educate (TPE) Medical Review Strategy

FQHC Additional Resources

- Federally Qualified Health Centers (FQHC) Center
  - FQHC GAFs 1/1/2025-12/31/2025
  - CY 2025 Payment Rates Update to the FQHC PPS
  - FQHC PPS Payment Specific Codes
  - FQHC PPS Frequently Asked Questions
  - Telehealth FAQ Calendar Year 2025
  - FQHC Preventive Services
- MLN® Booklet: *Federally Qualified Health Center (MLN006397)*
- CMS IOMs
  - Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services
  - Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers

Questions?

Thank you!



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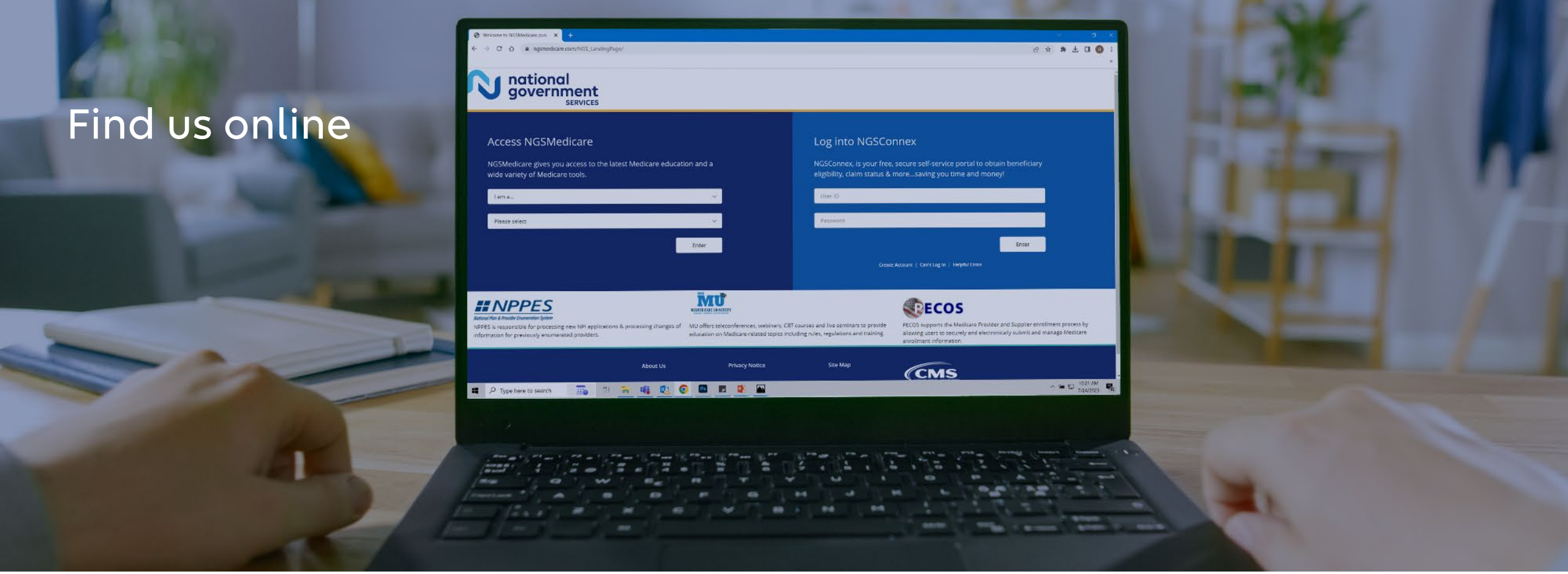

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