April 17, 2018

Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services

This document answers frequently asked questions about billing behavioral health integration (BHI) services to the Physician Fee Schedule (PFS). Beginning January 1, 2017, four new Medicare Part B billing codes are available to report BHI services furnished to beneficiaries during a calendar month service period. As of January 1, 2017, Medicare makes separate payments to physicians and non-physician practitioners for BHI services they furnish to beneficiaries over a calendar month service period. Beginning January 1, 2018, these services will be reported using new CPT codes. CPT codes 99492, 99493, and 99494 will be used to bill for services furnished using the Psychiatric Collaborative Care Model (CoCM). CPT code 99484 (General BHI) will be used to bill services furnished using other BHI models of care.

1. **For patients with multiple chronic conditions, including behavioral health conditions, how should one decide when to bill chronic care management (CCM) services versus BHI services?**

   As noted in the CY 2017 PFS final rule (81 FR 80233, 80247), CCM and BHI are distinct services although there is some overlap in eligible patient populations. There are substantial differences in the potential number and nature of conditions, types of individuals providing the services, and time spent providing services. CCM involves care planning for all health issues and includes systems to ensure receipt of all recommended preventive services, whereas BHI care planning focuses on individuals with behavioral health issues, systematic care management using validated rating scales (when applicable), and does not focus on preventive services. CCM requires use of certified electronic health information technology, whereas BHI does not. In most cases, we believe it would not be difficult to determine which set of codes (BHI or CCM) more accurately describe the patient and the services provided. As we state in the final rule, the code(s) that most specifically describe the services being furnished should be used. If a BHI service code more specifically describes the service furnished (service time and other relevant aspects of the service being equal), then it is more appropriate to report the BHI code(s) than the CCM code(s).

2. **Can the BHI codes be billed in the same month as CCM? What about other non-face-to-face care management services?**

   As discussed above (see #1), CCM and BHI are distinct, differing services even though there is some overlap in eligible patient populations. There may be some circumstances in which it is reasonable and necessary to provide both services in a given month. The BHI codes can be billed for the same patient in the same month as CCM if advance consent for both services and all other requirements to report BHI and to report CCM are met and time and effort are not counted more than once. Billing practitioners should keep in mind that cost sharing and advance consent apply to each service independently and there can only be one reporting practitioner for CCM each month. If all requirements to report each service are met, both may be billed.

3. **Can the General BHI code be billed for the same patient in the same month as the CoCM codes?**

   No, as noted in the CY 2017 PFS final rule, (81 FR 80242), a single practitioner must choose whether to report the general BHI code or the CoCM codes in a given month (service period) for a given beneficiary. However, in many cases, it may be appropriate for a single practitioner to report the general BHI code or the CoCM codes for the same beneficiary over the course of several months.

4. **For CoCM, must the psychiatric consultant and the billing practitioner be in the same practice? What about the behavioral health care manager and the billing practitioner?**

   The psychiatric consultant and behavioral health care manager may, but are not required to be, employees in the same practice as the billing practitioner. As noted in the CY 2017 final rule (81 FR 80235), these other care team members are either employees or working under contract to the billing practitioner whom Medicare directly pays for BHI. However, the behavioral health care manager must be available to provide services on a face-to-face basis (though face-to-face services do not necessarily have to be provided). Under the current CoCM model of care, the psychiatric consultant is commonly (but not required to be) remotely located.

5. **What qualifications are required for the behavioral health care manager role?**

   As noted in the CY 2017 PFS final rule, (81 FR 80231), the behavioral health care manager is a designated member of the care team with formal education or specialized training in behavioral health (which would include a range of disciplines, for example, social work, nursing, and psychology), but Medicare did not specify a minimum education requirement. They may or may not be a professional who meets all the requirements to independently furnish and report services to Medicare. The behavioral health care manager must be available to provide services face-to-face with the beneficiary, have a continuous relationship with the beneficiary, and have a collaborative, integrated relationship with the rest of the care team. He or she must also be able to engage the beneficiary outside of regular clinic hours as needed.

6. **If a General BHI model of care includes provision of services by a behavioral health care manager or similar qualifying clinical staff other than the billing practitioner, do these other staff have to be available to provide their services on a face-to-face basis?**

   No, general BHI does not require face-to-face provision of services by clinical staff, nor availability of clinical staff for face-to-face services.

7. **Can the behavioral health care manager bill for psychotherapy and other similar codes separate from BHI?**

Yes. As noted in the CY 2017 PFS Final Rule, (81 FR 80231-80232) if the behavioral health care manager is eligible to independently furnish and report services to Medicare, then that individual could report separate services furnished to a beneficiary receiving BHI services in the same calendar month such as psychiatric evaluation, psychotherapy, and alcohol or substance abuse intervention services. Time spent by the behavioral health care manager on activities for services reported separately could not be included in the time applied to any BHI service code (in other words, time and effort cannot be counted more than once).

8. **Can a psychiatrist that is non-participating with Medicare serve as the psychiatric consultant?**

   Yes, since Medicare makes payment to the billing practitioner for the service, the third party they contract with does not necessarily have to be participating with Medicare.

9. **Are the BHI codes limited to Medicare beneficiaries with certain behavioral health conditions/diagnoses?**

   No, as provided in the CY 2017 PFS Final Rule (81 FR 80232), the BHI codes may be used to treat patients with any mental, behavioral health or psychiatric condition that is being treated by the billing practitioner, including substance use disorders. We did not limit billing and payment for the BHI codes to a specified set of behavioral health conditions. The services require that there must be a presenting mental, psychiatric or behavioral health condition(s) that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time.

10. **What date of service (DOS) should be used on the professional claim and when should the claim be submitted?**

    The BHI service period is one calendar month. Centers for Medicare and Medicaid Services (CMS) expects the billing practitioner to continue furnishing services during a given month, if medically necessary, even after the time threshold to bill BHI is met. However, after completion of the minimum clinical staff service time required to bill, the practitioner may submit the claim and need not hold the claim until the end of the month.

11. **What place of service (POS) should be reported on the professional claim?**

    The BHI codes are priced in both facility and non-facility settings. The billing practitioner should report the POS for the location where he or she would ordinarily provide face-to-face care to the beneficiary.

12. **Can BHI be billed if it is provided to a beneficiary who spends part or all of the month in a facility stay or institutional setting?**

Yes, the BHI codes are priced in both facility and non-facility settings. The POS on the claim should be the location where the billing practitioner would ordinarily provide face-to-face care to the beneficiary.

13. **Which specialties can report BHI services? Can BHI be billed by specialists other than "traditional" primary care specialties?**

The BHI codes can be billed (directly reported) by physicians and non-physician practitioners whose scope of practice includes evaluation & management (E/M) services and who have a statutory benefit for independently reporting services to Medicare. This includes physicians of any specialty, physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives. Generally, we would not expect psychiatrists to bill the psychiatric CoCM codes, because psychiatric work is defined as a sub-component of the psychiatric CoCM codes. However, General BHI could be billed by a psychiatrist who furnished the services described by the general BHI code and met all requirements to bill it.

14. **Who can provide BHI services?**

For all BHI codes, the billing practitioner performs aspects of the service him or herself. For CoCM, other specified individuals (namely the behavioral health care manager and the psychiatric consultant) provide parts of the service under very specific roles and qualifications. CoCM is by definition provided by a team of three individuals rather than a single individual.

In contrast, services included in the General BHI code may be provided solely by the billing practitioner. Alternatively, the practitioner billing General BHI may (but is not required to) use other qualified individuals termed "clinical staff" to provide certain aspects of the service in a team-based approach to care. The term "clinical staff" is defined by CPT (see the Introduction to the CPT manual) and also means an individual who is clinical (not strictly clerical or administrative) and performs their services "incident to" (as an integral part of) services of the billing practitioner, subject to applicable state law, licensure, scope of practice and supervision. The clinical staff may, but are not required to, include individuals who meet the qualifications for the CoCM behavioral health care manager or psychiatric consultant. For example, for General BHI, a behavioral health consultant who is not authorized to prescribe medication, such as a psychologist, could participate in the care team. Clinical staff may be employees of the billing practitioner or may be a contracted "third party." Refer to the BHI Fact Sheet and governing regulations for a complete description of BHI staffing requirements.

15. **In every month in which one bills BHI, does one also need to bill at least one E&M visit?**

No, the only required visit is the initiating visit, which is only required for new patients or patients not seen within a year of commencement of BHI services, and could be furnished

the preceding calendar month. For CoCM, the behavioral health care manager must be available to provide his or her services face-to-face service with the beneficiary as needed, but there is no other requirement for in-person care.

16. Is written consent required?

Prior beneficiary consent is required for all of the BHI codes, recognizing that any applicable rules continue to apply regarding privacy. The consent will include permission to consult with relevant specialists, including a psychiatric consultant, and inform the beneficiary that cost sharing will apply to in-person and non-face-to-face services provided. Consent may be verbal (written consent is not required) but must be documented in the medical record.

17. Is a new patient consent form required each calendar month or annually?

No, a new consent is only required if the patient changes billing practitioners, in which case a new consent must be obtained and documented by the new billing practitioner prior to furnishing the service.

18. What services qualify as a BHI initiating visit?

For new patients or patients not seen within a year prior to the commencement of BHI services, BHI must be initiated by the billing practitioner during a "comprehensive" Evaluation & Management (E/M) visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). This face-to-face visit is not part of the BHI service and can be separately billed under the PFS, but is required before BHI services can be provided. The billing practitioner must discuss BHI with the patient at this visit. While informed patient consent does not have to be obtained during this visit, it is an opportunity to obtain the required consent. The face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) qualifies as a "comprehensive" visit for BHI initiation. Levels 2 through 5 E/M visits (CPT codes 99202-99205 and 99212-99215) also qualify; CMS is not requiring the practice to initiate BHI during a level 4 or 5 E/M visit. However CPT codes that do not involve a face-to-face visit by the billing practitioner or are not separately payable by Medicare (such as CPT code 99211, anticoagulant management, online services, telephone and other E/M services) do not meet the requirement for the visit that must occur before BHI services are furnished. If the practitioner furnishes a "comprehensive" E/M, AWV, or IPPE and does not discuss BHI with the patient at that visit, that visit cannot count as the initiating visit for BHI.

19. Why is there cost sharing for BHI? Does CMS have any mechanism for removing the cost sharing to encourage patient engagement?

Part B cost sharing applies to the services described by the BHI codes, consistent with statutory requirements. .

20. **Will Medigap cover the beneficiary cost sharing for BHI?**

    Yes. If services are covered under Medicare Part B, Medigap insurers do not have authority to deny the coinsurance, copayments or other benefits that are payable on behalf of the beneficiary under the provisions of the Medigap insurance contract. Private insurers providing standardized Medigap plans agree to accept a notice of Medicare payment as a claim for the payment of benefits under the Medigap plan, unless the Medigap policy itself has a deductible that has not yet been met (e.g., high deductible Plan F).

21. **Will Medicaid cover the beneficiary cost sharing for BHI for dually eligible beneficiaries?**

    CMS wishes to ensure that Medicare-Medicaid dually eligible beneficiaries have access to BHI services. The majority of dually eligible beneficiaries (approximately 64%, or 7 of the 11.4 million dually eligible beneficiaries) are Qualified Medicare Beneficiaries who will not be responsible for BHI cost sharing. For Qualified Medicare Beneficiaries, Medicaid is responsible for deductibles/co-insurance for Medicare services, including these services, even if the services are not covered in the State Plan. However, as permitted by federal statute, most states limit payment of Medicare cost-sharing to the "lesser-of" Medicaid or Medicare rates. If the service is not covered in the State plan, States can set other reasonable payment limits, approved by CMS, for the service. In states where there would be coverage of some or all of the beneficiary cost-sharing, providers need to be enrolled as Medicaid providers to be paid for the Medicare-cost-sharing; however, Medicare automatically "crosses over" claims to states for dual eligible beneficiaries, so providers need not submit their own bill.

22. **Do the BHI codes allow for BHI furnished via telehealth?**

    The BHI codes allow for remote provision of certain services by the psychiatric consultant and other members of the care team. For CoCM, the behavioral health care manager must be available to provide face-to-face services in person, but provision of face-to-face services is not required. The BHI codes do not describe services that are subject to the rules for Medicare telehealth services in the narrow meaning of the term (under section 1834(m) of the Social Security Act).

23. **Does there have to be an ICD 10 diagnosis of a mental health condition to bill for the BHI services or can a referral be made based on identified risk factors to rule out a mental health condition?**

    The BHI services require that there must be a presenting psychiatric or behavioral health condition that, in the clinical judgment of the treating physician or other qualified health professional, warrants "referral" to the behavioral health care manager for further assessment and treatment through provision of psychiatric CoCM services or General BHI.

24. Can addiction specialists serve as the consulting physician in furnishing CoCM?

In cases where a substance use disorder is being treated, medical professionals who specialize in addiction medicine and are qualified to prescribe the full range of medications may function in the consultant role, for purposes of meeting the billing requirements for the CoCM services.

25. Where can I find more guidance on BHI payment provisions?

A Fact Sheet and other materials on BHI will be available on the CMS website on the Physician Fee Schedule (PFS) page under the "Care Management" hyperlink at (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/). The governing regulation for BHI is the CY 2017 PFS final rule, which is also available on the CMS Physician Fee Schedule web page.