



PAYMENT

Reimbursement Tips:

FQHC Requirements for Medicare Behavioral Health Integration (BHI)

The general Behavioral Health Integration (BHI) model of care refers to the integration of physical and behavioral health services similar to core services offered under the Psychiatric Collaborative Care Model (CoCM), but without several additional components.

Program Requirements

General Behavioral Health Integration (BHI) covers models of care that focus on integrative treatment for patients with mental or behavioral health conditions that do not require, though they may use, the services of a behavioral health care manager or psychiatric consultant as required under the Psychiatric Collaborative Care Model (CoCM).

Patient Eligibility & Consent

Eligible patients are those requiring integrated behavioral health and primary care services, but not a psychiatric consultation or designated behavioral health manager. The patient must provide consent prior to initiating services. Consent may be verbal but must be documented in the medical record. The billing provider must inform the beneficiary that cost sharing (e.g., co-insurance) applies.

Timeframe & Services

Start-up An initiating visit with the billing provider (separately billable) is required for new patients or patients not seen within one year prior to the start of BHI services.

Subsequent Months Minimum of 20 minutes of behavioral health services.

BHI services are billed based on the calendar month rather than per 30 days. Reporting can occur any time in the calendar month after the 20-minute time threshold is met. Face-to-face services are not required during the calendar month. Patients should periodically be reminded that BHI services are performed by authorized staff (via phone, online, or other means of communication and coordination), even if the patient does not come to the FQHC for a visit.

Initiating Visit

A comprehensive initiating visit (e.g., IPPE, AWV, or E/M) within the past 12 months is required before the start of BHI services. The initiating visit is not part of

BHI services and is billed separately. BHI services do not have to be discussed during the initiating visit, but this visit must occur during the year (12 months) prior to the start of BHI.

- At FQHCs under **Medicare**, a new patient is someone who
- has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service.
- Dental service would not count as dental is not covered by Medicare. This definition differs from the traditional CPT definition of a new patient. FQHCs are encouraged to educate staff of the variance and may choose to use a single definition.

Authorized Provider/Staff

Only one practitioner/facility can furnish and be paid for BHI during a calendar month, though it involves a team-approach led by the primary care provider.

| Treating (Billing) Provider | | | | Behavioral Health Care Manager* | Psychiatric Consultant* |
|-----------------------------|-----------------------------|----|-----|---------------------------------|-------------------------|
| Physicians (MD or DO) | Non-Physician Practitioners | | | | |
| | NP | PA | CNM | | |
| x | x | x | x | | |

- *Medical Doctor (MD) or Doctor Osteopathy (DO)*
- *Non-Physician Practitioners include: Nurse Practitioners (NP), Physician Assistants (PA), and Certified Nurse Midwives (CNM).*
- *Behavioral Health Care Manager: Designated individual with formal/specialized training in behavioral health (i.e., social work, nursing, psychology) and at least a bachelor's degree, working under the oversight and direction of the billing practitioner.*
- *Psychiatric Consultant: Medical professional trained in psychiatry and qualified to prescribe the full range of medications.*
- **Not required as part of the BHI model although such personnel may provide general behavioral health services.*

Services not provided personally by the billing practitioner are provided by other authorized staff under the direct supervision of the billing practitioner (i.e., "incident to" or "within shouting distance" oversight by the billing provider). Other services by the care management team are permitted under general supervision (the billing practitioner provides overall direction and control, but their direct physical presence is not required during provision of services). All services and supervision requirements (regardless of CMS/Medicare policy)

Reimbursement Tips: FQHC Requirements for Medicare Behavioral Health Integration (BHI)

are subject to applicable State law, licensure, and scope of practice definitions.

Documentation

BHI services are time-based and require proper documentation in the medical record. A list of services that count towards the 20-minute threshold are listed in the documentation requirements below. Once the patient has consented to services, the initial assessment by the behavioral health manager is counted towards the initial month's BHI services. Even **non-clinical staff time used to perform authorized BHI services may be counted towards the 20-minute threshold**. Since some ancillary staff may not have clearance to access and enter information in the medical record, provision should be made to capture and credit essential and potentially reimbursable services.

BHI documentation requirements:

- Initial assessment and ongoing monitoring using validated clinical rating scales
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including time spent modifying plans for patients who are not progressing or whose status changes
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation
- Continuity of care with a designated member of the care team

Coding & Billing

A comprehensive initiating visit (e.g., IPPE, AWV, or E/M) within the past 12 months is required before the start of BHI services. In addition to IPPE, AWV, or E/M visits, the face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) qualifies as a comprehensive BHI service initiation visit.

For Medicare, FQHCs **bill BHI using G0511** which, for non-Medicare payers is the equivalent of CPT 99484. It is recommended that **providers select 99484 for BHI and that the revenue cycle management team crosswalk to G0511**. CPT 99484 is defined as: "Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month", and requires the elements reviewed in the preceding Documentation section.

The payment rate for HCPCS G0511 is the average of the national non-facility PFS payment rate for FQHC

care management and general behavioral health codes (CPT codes 99490, 99487, 99484, and 99491) and the new Principal Care Management codes (G2064 and G2065).

| WHAT PROVIDER CODES | Services | What FQHC bills to CMS | CMS/Medicare 2021 Fees |
|---------------------|---|------------------------|------------------------|
| 99484 | 20 minutes of behavioral health services in subsequent months | G0511 | \$65.25 |

Notes: Rates here are based on the 2021 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.

Medicare will pay an FQHC for only one Care Management service per month. Therefore, if BHI is provided in the same month as Chronic Care Management (CCM), Principal Care Management (PCM), Transitional Care Management (TCM), and/or Psychiatric CoCM, report only one Care Management service.

Since this service is reported by calendar month, the date of service may be set for the date when billing requirements have been met, or any date after that, as long as it is on or before the last day of the calendar month.

References

- American Medical Association's CPT® 2021 Professional Edition.
- CMS. Benefits Policy Manual, Chapter 13. Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). FAQ. December 2019. Accessed at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf>
- CMS. Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf>
- CMS Medicare Learning Network. Behavioral Integration Services. Accessed at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>
- CMS. Frequently Asked Questions about Physician Billing for Chronic Care Management (CCM) Services. Accessed at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/payment-chronic-care-management-services-faqs.pdf>
- CMS 2021 PFS Final Rule. Accessed at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeeschedpfs-federal-regulation-notices/cms-1734-f>