Reimbursement Tips:

FQHC Requirements for Medicare Behavioral Health Integration (BHI)

Medicare provides the opportunity to deliver and bill for care management support for behavioral health needs.

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).

Effective January 1, 2023, CMS expanded access to general BHI services by allowing Clinical Psychologists (CPs) and Clinical Social Workers (CSWs) to furnish these services. Health centers need to be aware of limitations of license and scope of practice affecting some elements of general BHI care management services furnished by CPs and CSWs.

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

Prior to the start of BHI services, a comprehensive initiating visit is required for new patients or patients not seen within the last year (12 months) and must include discussion of BHI care management services (CMS, August 2022). Initiating visits can include: Initial Preventive Physical Examination (IPPE), Annual Wellness Visit (AWV), Evaluation and Management service (E/M) visits (CPT codes 99212-99215), or Transitional Care Management (TCM) services (CPT codes 99495-99496). CMS acknowledges that because these initiating visit services are not typically within State law and scope of practice of Clinical Psychologists (CP) and licensed Clinical Social Workers (CSW), they may furnish a psychiatric diagnostic evaluation (CPT 90791) to meet the initiating visit requirements. A qualifying E/M, TCM or IPPE/AWV initiating visit by the physician or non-physician practitioner which includes discussion of BHI services, meets the initiating visit requirements for BHI to be subsequently furnished by a CP or CSW. The initiating visit is not part of BHI services and is billed separately. BHI services must occur within 12 months of the initiating visit and the practitioner must discuss BHI with the patient for a visit to count as an initiating visit for BHI.

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.

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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	CP	CSW		
x	x	x	x	x	x		

- *Medical Doctor (MD) or Doctor Osteopathy (DO)*
- *Non-Physician Practitioners include: Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Clinical Psychologists (CP), Clinical Social Workers (CSW).*
- *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.*

With the exception of CSWs, 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). Licensed CSWs are only authorized to bill Medicare for services they furnish directly and personally, which means that clinical and auxiliary staff cannot provide services incident to a CSW. (Section 35 of CY 2023 Medicare Physician Fee Schedule). Other services by the care management team (i.e., RN) 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) 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 or other appropriate member of the care team, 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:

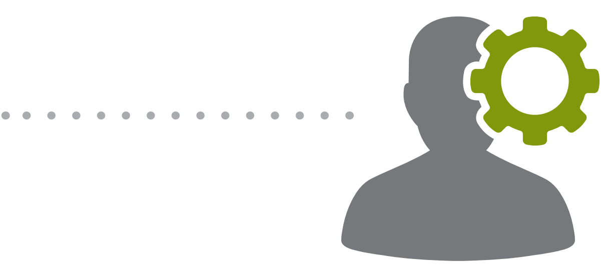
- Initial assessment and ongoing monitoring using validated clinical rating scales
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including time spent modifying plans for patients who are not progressing or whose status changes
- Facilitating and coordinating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

Coding & Billing

For Medicare, FQHCs bill BHI using G0511 which, for non-Medicare payers is the equivalent of CPT 99484. It is recommended that FQHC qualified physicians, NPs, PAs, and CNMs select 99484 for BHI and that the revenue cycle management team crosswalk to G0511.

CMS created HCPCS code, G0323 to capture general BHI services furnished by a CP or licensed CSW. All of the other elements of the G0323 code description are similar to CPT 99484. The G0323 service additionally identifies the effort needed by the CP or CSW to coordinate with physicians and practitioners, authorized by Medicare, to furnish E/M services and prescribe medications. G0323 is billed along with G0511.

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 99424, 99425, 99484, 99487, 99490, and 99491).



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WHAT PROVIDER CODES	Services	What FQHC bills to CMS	CMS/ Medicare 2023 Fees
G0323	At least 20 minutes of general behavioral health care management services furnished by a CP or CSW.	G0511	$77.94
99484	At least 20 minutes of general behavioral health care management services of clinical staff time, directed by a physician or other qualified health care professional, per calendar month.		

Notes: Rates here are based on the 2023 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.

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.

New in 2023, CMS is allowing FQHCs to bill G0511 for multiple, distinct care management services furnished for the same beneficiary during the same period. The requirements for billing each service must be separately met.

References

- American Medical Association's CPT® 2023 Professional Edition.
- CMS. Benefits Policy Manual, Chapter 13. Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) FAQ. March 2023. Accessed at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.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. January 2023. Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
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- CMS 2023 Physician Fee Schedule Final Rule. Accessed at https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

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