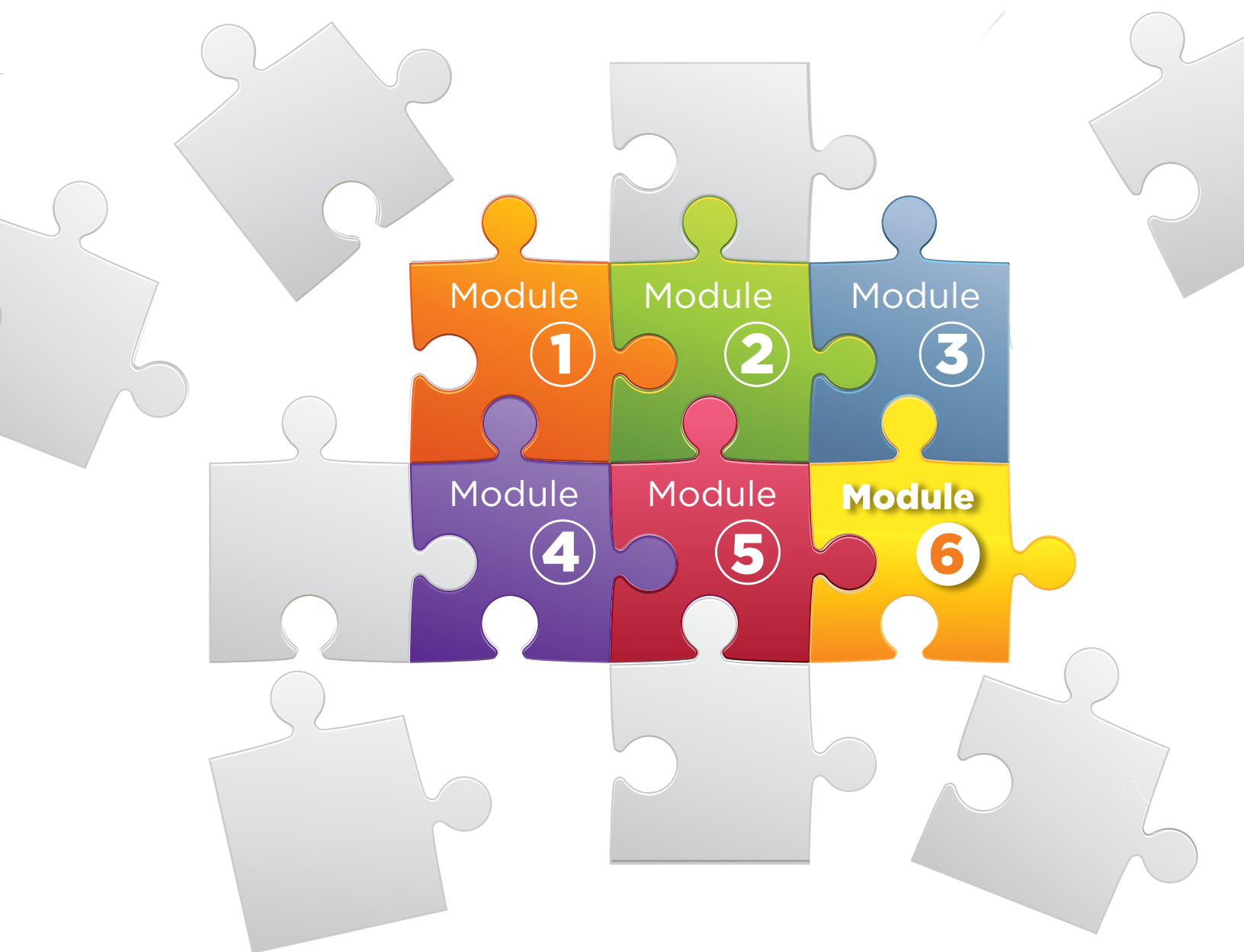




# Module 6

## **Incorporating Behavioral and Mental Health Services in a Rural Health Clinic (RHC)**

**Rural Health Clinic Technical Assistance  
Educational Series**



# MODULE 6

## Incorporating Behavioral and Mental Health Services in a Rural Health Clinic (RHC)



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## MODULE 6

# Incorporating Behavioral and Mental Health Services in a Rural Health Clinic (RHC)



## Target Audience and Objectives

This module is designed for State Office of Rural Health (SORH) staff with some experience and interest in working with RHCs to provide information and models for successfully supporting or incorporating behavioral health (BH) and mental health (MH) services into an RHC. In addition, this module will increase the general knowledge of rural BH. For the purposes of this module, BH and MH will be used interchangeably.

Objectives for this module include:

1. Identify current RHC regulations regarding the provision of BH services in an RHC setting.
2. Review current requirements in the RHC regulations regarding the types of BH providers eligible for reimbursement in an RHC.
3. Discuss how an integrated PC/BH model can be implemented to effectively meet patient needs.
4. Identify the benefits and challenges of integrating BH services in an RHC.
5. Review the Medicare, Medicaid, and commercial reimbursement policies for the use of telehealth services in an RHC.
6. Provide a list of BH resources.

## Introduction

### Definition of BH

For this module, the term “BH” is used to encompass the treatment of MH disorders such as depression, anxiety, post-traumatic stress disorder (PTSD), phobias, and other developmental and mood disorders, as well as the treatment of conditions related to behavior (e.g., substance abuse and other addictions and psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems (e.g., diabetes, hypertension).

### BH in an RHC

Basic PC services are typically provided in an RHC setting by PC physicians, advanced practice nurses, or physician assistants; however, BH providers are also eligible for cost-based Medicare and Medicaid reimbursement under the RHC program. BH services play an important role in the overall health status

of rural residents. Without adequate access to BH services, conditions such as depression, anxiety, substance abuse, and more serious mental disorders go unchecked and may lead to behaviors that can be detrimental to the well-being of the patient and others. At the same time, BH specialists can play an important role in supporting patients in making and maintaining health behavior changes (such as medication compliance, smoking cessation, weight loss, or exercise) necessary to maximize the health of patients with chronic physical health conditions.

Rural PC providers are equipped with limited training in BH and may not have access to resources for consultation and referral. An RHC can serve as a medical home, integrating physical and BH to diagnose conditions and provide a team of physician and non-physician practitioners to develop a plan of care to address the patient’s comprehensive needs. Additionally, telehealth services can be used effectively when more serious BH disorders require outside assistance.



## Eligible BH Providers

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 added reimbursement for psychology services provided by doctoral-level psychologists in RHCs. In 1989, reimbursement for clinical social workers was added as well. The current RHC billing guidelines are published in [Chapter 13 of the Medicare Benefits Policy Manual, CMS publication 100-2](#).

The types of BH providers who are eligible to provide reimbursable services in an RHC include:

- Doctoral level Clinical Psychologists (CP);
- Licensed Clinical Social Workers (LCSWs);
- Nurse Practitioners (NPs) with proper BH training;
- Certified Nurse Midwives (CNMs) with proper BH training;
- Physicians Assistants (PAs) with proper BH training; and
- Physicians with proper BH training.

The following excerpt from Section 150 of Chapter 13 of the Medicare Benefits Policy Manual outlines the required qualifications for Clinical Psychologists and Clinical Social Workers eligible for reimbursement in an RHC setting:

### A CP is an individual who:

- Holds a doctoral degree in psychology, and
- Is licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

### A CSW is an individual who:

- Possesses a master's or doctor's degree in social work;
- After obtaining the degree, has performed at least 2 years of supervised clinical social work; and
- Is licensed or certified as a clinical social worker by the state in which the services are performed; or, in the case of an individual in a state that does not provide for licensure or certification, meets the requirements listed in 410.73(a)(3)(i) and (ii)

While these regulations are specific to services provided to Medicare beneficiaries, state Medicaid programs and commercial insurers typically reimburse for BH services provided by CPs, CSWs, NPs (with proper BH training), and physicians (with appropriate BH training). Some state Medicaid programs and commercial insurers will also reimburse for other types of master-prepared BH professionals, such as licensed clinical professional counselors (LCPCs), licensed professional counselors (LPCs), and licensed marriage and family therapists (LMFTs).

Although it is usually preferable to hire BH specialists with the credentials that are reimbursable across the widest range of third-party payers that an RHC works with (typically CSWs/LCWS or CPs), this may not always be possible given recruitment and retention issues in rural communities. It is important for clinic administrators to analyze their payer mix and the needs of their dominant payer populations when making hiring decisions. LPCs/LCPCs may be suitable for RHCs with significant Medicaid and/or commercially insured populations. Before making hiring decisions, it is important to check state licensing laws and payment policies for the clinic's primary third-party payers.



## Description of Services

### Billable Services

Section 150 of Chapter 13 of the Medicare Benefits Policy Manual identifies the BH services covered (billable and reimbursable) in an RHC:

(Rev. 252, Issued: 12- 07-18, Effective: 01-01-19, Implementation: 01- 02-19)

Services may include diagnosis, treatment, and consultation. The CP or CSW must directly examine the patient, or directly review the patient's medical information. Except for services that meet the criteria for authorized care management or virtual communication services, telephone or electronic communication between a CP or CSW and a patient, or between such practitioner and someone on behalf of a patient, are considered CP or CSW services and are included in an otherwise billable visit. They do not constitute a separately billable visit. CSWs are statutorily authorized (1861(hh)(2) of the Act) to furnish services for the diagnosis and treatment of mental illnesses only.

Services that are covered are those that are otherwise covered if furnished by a physician or as an incident-to a physician's professional service. Services that a hospital or SNF is required to provide to an inpatient or outpatient as a requirement for participation are not included.

Services performed by CPs and CSWs must be:

- Furnished in accordance with RHC or Federally Qualified Health Center (FQHC) policies and any physician medical orders for the care and treatment of a patient;
- A type of service which the CP or CSW who furnished the service is legally permitted to furnish by the state in which the service is rendered; and
- Furnished in accordance with state restrictions as to setting and supervision, including any physician supervision requirements.

### “Incident To” Services

The following excerpt is from Section 160 and outlines the services and supplies incident to CP and CSW Services.

(Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01- 02-19)

Services and supplies that are incident to a CP or CSW service must be:

- Commonly rendered without charge or included in an RHC or FQHC payment;
- Commonly furnished in an outpatient clinic setting;
- Furnished d under the direct supervision of the CP or CSW, except for authorized care management services which may be furnished under general supervision; and
- Furnished by a member of the RHC staff.

NOTE: The direct supervision requirement is met in the case of a CP or CSW who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing an RHC or FQHC. Services and supplies covered under this provision are generally the same as described in section 120 as incident to a physician's services and include services and supplies incident to the services of a CP or CSW.

### MH Visits

Section 170 outlines MH Visits

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

A MH visit is a medically necessary face-to-face encounter between an RHC patient and an RHC practitioner, during which time one or more RHC MH service is rendered. MH services that qualify as standalone billable visits are listed on the [RHC center website](#). Services furnished must be within the practitioner's state scope of practice.

Medicare-covered MH services furnished incident to an RHC visit are included in the payment for



a medically necessary MH visit when an RHC practitioner furnishes a MH visit. Group MH services do not meet the criteria for a one-on-one, face-to-face encounter in an RHC.

A MH service should be reported using a valid HCPCS code for the service furnished, a MH revenue code. For detailed information on reporting MH services and claims processing, refer to Pub. 100-04, [Medicare Claims Processing Manual, chapter 9](#).

Medication management, or a psychotherapy “add on” service, is not a separately billable service in an RHC. Rather, they are included in the payment of an RHC medical visit. For example, when a medically necessary medical visit with an RHC practitioner is furnished on the same day a medication management or psychotherapy add-on service is also furnished by the same or a different RHC practitioner, only one payment is made for the qualifying medical services reported with a medical revenue code.

## Categories of BH Services

BH services in the PC setting fall into two broad categories. The first category involves services designed to address the needs of patients with a specific BH diagnosis. These services include psychiatric diagnoses and assessments, patient, family, and group psychotherapy; medication management; crisis psychotherapy; psychoanalysis; and transitional management services. These services are billed using psychiatric current procedural terminology (CPT) codes (See Figure 1) or evaluation and management codes (See Figure 2).

The specific code used will depend on the service provided and the credentials of the servicing provider. For example, evaluation and management codes are typically reserved for physicians, NPs, and physician assistants who, depending on the situation and services provided, may also use the relevant psychiatric procedure codes. Typically, services rendered by CPs, CSWs/LCSWs, LCPCs/LPCs, and LMFTs are billed using the relevant psychiatric procedure codes. Clinic administrators should investigate the reimbursement policies of the third-party payers with whom they work to determine which codes to use in given situations.

**FIGURE 1: Psychiatric Codes for BH Services**

90791	Psychiatric diagnostic evaluation-no medical services
90792	Psychiatric diagnostic evaluation-with medical services
90832	Psychotherapy, 30 min. (16-37 min.) — with patient
90834	Psychotherapy, 45 min. (38-52 min.) — with patient
90837	Psychotherapy, 60 min. (53+ min.) — with patient
90839	Psychotherapy for crisis, 1st 60 min. (high distress patients with complex/life threatening circumstances requiring immediate attention)
90845*	Psychoanalysis
90846*	(50 minutes), Family psychotherapy without the patient present
90847*	(50 minutes), Family psychotherapy, psychotherapy with patient present
90849*	Multiple-family group psychotherapy
90853*	Group psychotherapy
90833	30-minute psychotherapy add-on code (may be used for 16-37 minutes)

\*Not changed since 2012

CONTINUED





**FIGURE 1: Psychiatric Codes** (CONTINUED)

Psychotherapy provided in combination with E/M services (Psychotherapy service must be “significant and separately identifiable” from the E/M service provided)	
90833	30-minute psychotherapy add-on code (may be used for 16-37 minutes)
90836	45-minute psychotherapy add-on code (may be used for 38-52 minutes)
90838	60-minute psychotherapy add-on code (may be used for 53 + minutes)
Add-on psychiatric codes	
90785	Interactive complexity (factors are present that complicate the delivery of the evaluation or session). Code 90785 is an add-on code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when performed with an evaluation and management service (90833, 90836, 90838, 99202-99255, 99304-99337, 99341-99350) and group psychotherapy (90853). Used in combination with diagnostic evaluation and psychotherapy codes for primary service: psychiatric diagnostic evaluation (90791); psychotherapy (90832, 90834, 90837); group psychotherapy (90853) (Interactive complexity)
90863	Pharmacologic management when used in combination psychotherapy services (90832, 90834, 90837)
90840	Add-on for each additional 30 minutes of psychotherapy for crisis, used in conjunction with code 90839

**FIGURE 2: Evaluation and Management Codes**

Physicians (including psychiatrists) are now expected to bill using the appropriate E/M code and a timed add-on code for the psychotherapy instead of using the previous psychotherapy codes with E/M services (90805, 90807).

Office/outpatient services	99201-99205	New patient office visit
	99211-99215	Established patient office visit
Inpatient/hospital services	99221-99223	Initial hospital care
	99231-99233	Subsequent hospital care
Nursing facility services	99304-99306	Initial nursing facility care
	99307-99310	Subsequent nursing facility care
Domiciliary, rest home, or custodial care services	99324-99328	Domiciliary or rest home visit for a new patient
	99334-99337	Domiciliary or rest home visit for an established patient
Home services	99341-99345	Home visit for a new patient
	99347-99350	Home visit for an established patient

The second BH services category includes health and behavioral assessment and intervention (HBAI) services. HBAI services are services provided to patients not diagnosed with a psychiatric problem but whose cognitive, emotional, social, or behavioral functioning affects the prevention, treatment, or management of a physical health problem, including chronic health issues (e.g., diabetes, obesity, or hypertension). Examples of HBAI services include working with patients on issues related to medication compliance, diet, stress issues, smoking cessation, etc.



Typically, these services can be provided by physicians, NPs, and PAs. Depending on the state Medicaid and third-party payer policies, they may also be provided by CPs, CSWs/LCSWs, and clinical nurse specialists. As reimbursement policies and rates vary from payer to payer, it is important to investigate these issues before developing the services. HBAI services are billed using a specific set of codes (See Figure 3).

**FIGURE 3: BH assessment and Intervention Codes**

96150	Initial health and behavior assessment. Health-focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires, each 15 minutes face-to-face with the patient: initial assessment to determine the biological, psychological, and social factors affecting the patient's physical health and any treatment problems
96151	Health and behavior re-assessment. Each 15 minutes face-to-face with the patient. 96152: Health and behavior intervention service. Modify psychological, behavioral, cognitive, and social factors affecting the patient's physical health and well-being. Examples: Increasing the patient's disease awareness; using cognitive/behavioral approaches to initiate prescribed diet and exercise regimens. Each 15 minutes, face-to-face; individual.

## Reimbursement

BH services provided in an RHC by the eligible providers listed previously (physicians, NPs, PAs, CNMs, doctoral-level CP, and CSWs/LCSWs) are covered as part of the RHC benefit and are reimbursed under cost-based reimbursement. State Medicaid agencies are required to reimburse RHCs for BH services provided by the Medicare-eligible providers practicing within the scope of their licenses under applicable state law. Commercial insurance reimbursement policies vary by carrier.

It is important to note Medicare policies allow for the provision and reimbursement of both a physical health and BH service on a single day (with the exception of HBAI services). The extent to which this is allowed by Medicaid and commercial insurers varies considerably. As has been discussed previously, it is important to investigate and verify the payment policies of the clinic's primary payers before making implementing integrated services.

For the use of time-based psychiatric procedure codes, most third-party payers require a face-to-face encounter with the patient for the service to be eligible for reimbursement. The level of coding for evaluation and management codes is based on the service provided and the intensity of the encounter.

## Integrating BH and PC

Integrated models are emerging across the US focused on comprehensive, coordinated systems of care that incorporate PC, BH, preventive programs, and other services. Under the integrated practice model, in the simplest of terms, a provider sees a patient to perform a medical evaluation, and the patient is also seen by a BH provider.

## Defining Integration

Integration should be viewed as a continuum with collaborative models (without co-location) on one side of the continuum to fully integrated co-located models on the other. For practices seeking to collaborate without co-location (horizontal integration), the focus is on integrating services across practices and providers. Barriers to this model of integration include communication challenges, sharing of patient information, lack of integrated IT systems, care coordination, and limited availability of referral sites. On the other end of the continuum is the model of co-location within practices (vertical integration). Practices hire and fully integrate BH specialists into their practice settings. Barriers to this model include the assumption of financial risk related to hiring staff and building the service, reimbursement issues, staffing/workforce, billing and coding, space, practice culture, viability, and charting/





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The evidence tells us that no single model is right for all providers and settings as the model chosen depends on a complex mix of available resources, local infrastructure, risk tolerance, and patient needs. Decisions regarding levels of integration are driven by a variety of complex factors including:

- Available financial, human resource, and administrative resources to develop integrated strategies;
- Trust/rapport between PC and BH organizations;
- Providers and patient needs;
- Willingness of providers to put aside cultural and practice differences;
- Available reimbursement and/or grants to fund and sustain integration activities;
- Administrative and billing capacity to manage integrated services;
- Space issues;
- Local market/competition issues; and
- Willingness of providers to share control and management of patients.

Integration at the provider level should best be viewed as a work in progress. Clinics should assess

their current readiness for integration and implement an appropriate model of integration as appropriate. With experience, the clinic can move further along the continuum. Clinics are urged to take a pragmatic approach to integration based on patient needs and desired goals rather than focus on a specific model of integration. Figure 4 describes the functional aspects of integration that must be considered.

**FIGURE 4: Functional Aspects of Integration**

<b>Clinical — more easily implemented in rural areas</b>
<ul style="list-style-type: none"><li>● Regular communication</li><li>● Use of critical pathways or practice guidelines</li><li>● Internal referral process</li><li>● Common screening tools, treatment plans, and models</li><li>● Shared medical information</li><li>● Collaborative decision making</li><li>● Consultation and education</li></ul>
<b>Structural — less easily implemented without resources</b>
<ul style="list-style-type: none"><li>● Co-location (e.g., shared space)</li><li>● Fully integrated (one organizational structure/employed staff)</li><li>● Single medical record</li><li>● Shared billing and scheduling systems</li><li>● Shared risk</li></ul>
<b>It is also necessary to work with providers to develop a common understanding of how the proposed integrated service is designed to work. For example, PC providers and other medical staff should understand:</b>
<ul style="list-style-type: none"><li>● What types of patients to refer;</li><li>● What to say to patients when referring;</li><li>● How to integrate behavioral feedback into a medical care plan;</li><li>● How to co-manage patients with a BH team member;</li><li>● How to integrate BH into the PC team; and</li><li>● Population management strategies for patients with mental disorders.</li></ul>

CONTINUED



**FIGURE 4: Functional Aspects** (CONTINUED)

**Fitting into an integrated setting is also a challenge for BH staff, who must adapt to a different style of practice than traditional MH settings: BH staff should understand how to:**

- Adapt to a PC practice's mission, roles, and culture;
- Adjust to the PC work pace;
- Provide curbside and written consults;
- Chart for medical records;
- Develop and evaluate population-specific treatment programs; and
- Co-manage patients.

## Benefits of Integration

Unlike a traditional practice, an RHC is well positioned to be a leader in the implementation of integrated care models. Benefits include:

- In addition to medical problems, a patient may have BH issues contributing to the same or different issues. These problems can be identified, and a comprehensive care plan can be coordinated using a team approach.
- Typically, PC providers are not well versed in the diagnosis and treatment of BH problems, thus the addition of the BH provider provides an improved level of expertise.
- Chapter 13 of the Medicare Benefits Policy Manual specifically states that medical and BH providers may be reimbursed for services performed on the same day at the same location in an RHC. This generates revenue for an RHC and provides convenience and a more holistic experience for the patient.
- Patients have access to BH services in a familiar environment without the stigma of visiting a practice specific to BH.
- Patients are not required to make a separate appointment to access BH services. The patient's body and mind are treated, in one location, during one visit.

## Challenges of Integration

**Co-Payments:** When an RHC bills for two visits (encounters) on the same day in the same location, the patient is subject to two co-pays on the same day, which may discourage some patients from receiving integrated care.

**Un-Compensated Care:** Many individuals in need of BH services are unemployed, uninsured, and/or low-income. An RHC may wish to consider implementing a sliding fee scale to offer discounted care based on income. In addition, an RHC should have mechanisms in place to assist patients with Medicaid enrollment or enrollment in the state's health insurance marketplace.

**Cost Report Considerations:** BH professionals' salaries are included in the Medicare cost report, as are the patient visits conducted by these providers. CMS does not enforce minimum productivity standards for BH providers, yet the visits are included in the total visits to determine the average cost per visit for an RHC.

**Provider Recruitment:** As with all types of providers, recruitment to rural communities may be challenging. RHCs may be committed to developing an integrated PC/BH model but unsuccessful in recruiting BH providers.

RHCs may consider participating as a National Health Service Corps (NHSC) site. The NHSC loan repayment and scholarship programs are available for qualified BH practitioners working in Health Professional Shortage Areas.

## Telehealth

Occasionally patients may require consultation, psychotherapy, or another BH service by a provider not available in an RHC. Telehealth services may be provided to patients at an RHC, and an RHC can be reimbursed for the use of the equipment to transmit the session; however, there are limitations. First, it is important to understand telehealth terminology. The originating site is where patients are located. The distant site is where the provider of services is located.



Currently, during the Federal Public Health Emergency declaration for the COVID-19 pandemic, Medicare reimburses for telehealth services when an RHC is the originating as well as the distant site. Once the Federal Public Health Emergency declaration ends, a provision was passed to allow 151 days before pre-Federal Public Health Emergency declaration regulations are reinstated.

Pre-pandemic, RHCs were only permitted to be originating sites (where the patient is located). They must also be in a Health Professional Shortage Area (HPSA) or in a county that is outside of any Metropolitan Statistical Area (MSA), as well as those located in rural census tracts as determined by the Federal Office of Rural Health Policy. Geographic eligibility for an originating site is established for each calendar year based upon the status of the area as of December 31st of the prior calendar year. RHCs located in Medically Underserved Areas rather than HPSAs, or located within an MSA, are not eligible originating sites.

Under Medicare, the originating site is eligible to bill for a facility fee to cover the cost related to “hosting” the encounter with the patient. The originating site fee is subject to a patient copay. For purposes of reimbursement, the originating site fee is not considered an “RHC service” for billing and cost reporting services. RHCs bill the originating fee to Part B Medicare and are reimbursed based on the Medicare fee schedule. RHCs may also serve as a distant site for other providers if they employ the appropriate BH staff. They may not be reimbursed on a cost basis for the delivery of services provided through telehealth technology. Rather, they may bill Medicare Part B for these services and are reimbursed based on the Medicare fee schedule. State Medicaid programs and commercial carriers vary in their policies on telehealth. For additional information, visit the Center for Telehealth & e-Health Law at <http://ctel.org>.

During the Federal Public Health Emergency declaration and 151 days thereafter, RHCs may provide audio-only and audio-visual visits. Details were published in the MLN Matters: SE22001 - <https://www.cms.gov/files/document/se22001-mental-health-visits-telecommunications-rural-health-clinics-federally-qualified-health.pdf>

Effective January 1, 2022, you may provide mental health visits using interactive, real-time telecommunications technology.

RHCs and FQHCs can provide telecommunications for mental health visits using audio-video technology and audio-only technology. You may use audio-only technology in situations when your patient can't access or doesn't consent to use audio-video technology. You can report and get paid in the same way as in-person visits.

Audio-video visits: Use modifier 95 (Synchronous Telemedicine Service Rendered via RealTime Interactive Audio and Video Telecommunications System).

Audio-only visits: Use new service-level modifier FQ.

### FIGURE 5: RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

### FQHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	G0470 (or other appropriate FQHC Specific Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only)
0900	90834 (or other FQHC PPS Qualifying Mental Health Visit Payment Code)	N/A

These visits are different from telehealth services provided during the COVID-19 Public Health Emergency (PHE). Don't bill HCPCS code G2025 for a mental health visit you provide via telecommunications. See [MLN Matters Article](#)



**SE20016** for information on billing G2025 for professional telehealth distant site services other than mental health visits during the COVID-19 PHE.

### **In-Person Mental Health Visit Requirements:**

These in-person visit requirements apply only to a patient getting mental health visits via telecommunications at home:

- There must be an in-person mental health visit 6 months before the telecommunications visit
- In general, there must be an in-person mental health visit at least every 12 months while the patient is getting services from you via telecommunications to diagnose, evaluate, or treat mental health disorders.

NOTE: **Section 304 of the Consolidated Appropriations Act (CAA), 2022**, delayed the in-person visit requirements under Medicare for mental health visits that RHCs and FQHCs provide via telecommunications technology. For RHCs and FQHCs, in-person visits won't be required until the 152nd day after the end of the COVID-19 PHE.

Exceptions: We'll allow for limited exceptions to the requirement for an in-person visit every 12 months based on patient circumstances in which the risks and burdens of an in-person visit may outweigh the benefit. These include, but aren't limited to, when:

- An in-person visit is likely to cause disruption in service delivery or has the potential to worsen the patient's condition
- The patient getting services is in partial or full remission and only needs maintenance level care
- The clinician's professional judgment says that the patient is clinically stable and that an in-person visit has the risk of worsening the patient's condition, creating undue hardship on self or family
- The patient is at risk of withdrawing from care that's been effective in managing the illness

With proper documentation, the in-person visit requirement isn't applicable for that 12-month period. You must document the circumstance in the patient's medical record.

## **How to Begin**

Developing an integrated BH service in an RHC is a complex undertaking. This can be facilitated by working through the process, gathering information on key issues impacting the decisions about the selection of an appropriate model of integration, and using that information to make informed decisions. Figure 6 provides an overview of these key decisions:

**FIGURE 6: Key Decisions Related to the Development of an Integrated BH Service**

<b>Decide what your goals are and prioritize them:</b>
<ul style="list-style-type: none"><li>● Expand access to MH services?</li><li>● Provide direct care vs. consultative services for PC Providers?</li><li>● Improve PC provider productivity?</li><li>● Improve coordination of care?</li></ul>
<b>Determine the best ways to achieve each goal:</b>
<ul style="list-style-type: none"><li>● Start simply and evolve with experience</li><li>● Avoid competition for necessary resources</li></ul>
<b>Understand MH reimbursement policies:</b>
<ul style="list-style-type: none"><li>● Understand the MH procedure and diagnostic codes and managed care systems (e.g., prior authorization, limitations on numbers of visits, paperwork requirements, etc.)</li><li>● Recognize which types of providers are reimbursable by payers</li></ul>
<b>Focus on services that are reimbursable</b>
<b>Understand different treatment models</b>
<b>Remember: it is specifically written in the Federal Code of Regulations / federal law, an RHC is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases. <a href="#">42 CFR 491.2</a></b>
<ul style="list-style-type: none"><li>● As long as 51% of the services provided by an RHC are PC, this will not be an issue.</li></ul>



Explore different service lines that can potentially be added to an RHC that will allow for reimbursement outside of the All-Inclusive Rate (AIR) to cover the cost of adding a BH professional. Adding [Chronic Care and Principal Care Management](#), as well as [Transitional Care Management](#) may be the best action for your clinic and patients.

Lastly, since it is highly likely your RHC is already doing part of this work, explore becoming an accredited Patient-Centered Medical Home (PCMH).

\*Please note: there are several PCMH accrediting organizations to choose from.

## BH Integration How the SORH Can Help

1. Provide RHCs with examples of successful models of integration. The [Substance Abuse and MH Services Administration \(SAMHSA\)](#) provides a number of articles on several types of models that have been implemented across the country, presentations on lessons learned, discussion on the business case for integration, and several tools.
2. Offer educational opportunities via webinar, workshop, or conference to ensure that the RHCs in your state understand the Medicare rules for reimbursement of BH services in an RHC.
3. Distribute information on Telehealth services and Medicare reimbursement guidelines.
4. Reach out to the state Medicaid agency to find out about reimbursement for BH services and Telehealth for RHCs in your state and distribute information to RHCs.
5. Identify a coding/billing expert who can assist RHCs with technical assistance and Q&A related to reimbursement.

## Resources

### Websites

**Code of Federal Regulations: Title 42, Part 491, subpart A – Conditions for Certification:**  
<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-491>

**CMS Medicare Benefits Policy Manual**, CMS Publication 100-2 – Chapter 13, Rural Health Clinics/ Federally Qualified Health Centers — Revised April 2021.  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf>

**CMS Medicare Claims Processing Manual**, CMS Publication 100-4, Chapter 9, Rural Health Clinics/ Federally Qualified Health Centers — Revised January 2022  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf>

*See specifically Section 60 regarding the outpatient MH limitations*

**CMS Medicare Claims Processing Manual**, CMS Publication 100-4, Chapter 12, Physicians/Non-physician Providers — Revised March 2022  
<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf>

*See Section 210 for information on reimbursement of MH services*

*See Section 190 for information on reimbursement of telehealth services*

**American Medical Association: BH Integration Collaborative**  
<https://www.ama-assn.org/system/files/bhi-compendium.pdf>

**Rural Health Research Gateway**  
<https://www.ruralhealthresearch.org/>

**Substance Abuse and MH Services Administration (SAMHSA)**  
<http://www.samhsa.gov>







## Acronyms

BH	Behavioral Health
HBAI	Health and Behavior Assessment/Intervention
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CP	Clinical Psychologist
CSW	Clinical Social Worker
FORHP	Federal Office of Rural Health Policy
FQHC	Federally Qualified Health Center
HPSA	Health Professional Shortage Area
HRSA	Healthcare Resources and Services Administration
LCPC	Licensed Clinical Professional Counselor
LMFT	Licensed Marriage and Family Therapist
LPC	Licensed Professional Counselor
LCSW	Licensed Clinical Social Worker
MH	Mental Health
MUA	Medically Underserved Area
NHSC	National Health Service Corps
ONC	Office of the National Coordinator for Health Information Technology
ORHP	Office of Rural Health Policy
PC	Primary Care
PCMH	Patient Centered Medical Home
SAMHSA	Substance Abuse and MH Services Administration
SAS	Substance Abuse Services
SNF	Skilled Nursing Facility
SBIRT	Screening, Brief Intervention, and Referral to Treatment

