

---

RURAL HEALTH CLINIC TECHNICAL  
ASSISTANCE  
EDUCATIONAL SERIES

---

MODULE 6  
INCORPORATING BEHAVIORAL HEALTH SERVICES  
IN THE RURAL HEALTH CLINIC

44648 Mound Road, #114  
Sterling Heights, MN 48314-1322  
Phone: 586.739.9940 | Fax 586.739.9941  
teryle@nosorh.org | nosorh.org



National Organization of  
**State Offices of Rural Health**

## TABLE OF CONTENTS

<a href="#">Target Audience and Objectives</a>	3
<a href="#">Introduction</a>	4
<a href="#">Definition of Behavioral Health</a>	4
<a href="#">Behavioral Health in the RHC</a>	4
<a href="#">Eligible Behavioral Health Providers</a>	5
<a href="#">Description of Services</a>	7
<a href="#">Reimbursement</a>	11
<a href="#">Integrating Behavioral Health and Primary Care</a>	13
<a href="#">Benefits of Integration</a>	14
<a href="#">Challenges of Integration</a>	15
<a href="#">Telehealth</a>	16
<a href="#">How to Begin</a>	17
<a href="#">Behavioral Health Integration – How the SORH Can Help</a>	18
<a href="#">Resources</a>	19
<a href="#">Acronyms</a>	21

Funding for this material was possible in part by Cooperative Agreement #U14RH06357-01-01 from the Federal Office of Rural Health Policy (FORHP). The views expressed in written materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the US Government.

## 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 services into an RHC. In addition, this module will increase general knowledge of rural behavioral health. Objectives for this module include:

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

## INTRODUCTION

### DEFINITION OF BEHAVIORAL HEALTH

For the purposes of this module, the term “Behavioral Health” is used to encompass the treatment of mental health 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 problem (e.g., diabetes, hypertension).

### BEHAVIORAL HEALTH IN THE RHC

Basic primary care services are typically provided in the RHC setting by primary care physicians, advanced practice nurses, or physician assistants; however, behavioral health providers are also eligible for cost-based Medicare and Medicaid reimbursement under the RHC program. Behavioral health services play an important role in the overall health status of rural residents. Without adequate access to behavioral health 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, behavioral health 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 primary care providers are equipped with cursory training in behavioral health, and may not have access to resources for consultation and referral. The RHC can serve as a medical home, integrating both physical and behavioral health 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 behavioral health disorders require outside assistance.

## ELIGIBLE BEHAVIORAL HEALTH PROVIDERS

The Omnibus Budget Reconciliation Act (OBRA) of 1987 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](#), which is an Internet-only manual. This chapter was revised in early 2014 to

provide more detailed information related to BH services. The types of BH providers who are eligible to provide reimbursable services in the RHC include:

- Clinical Psychologists (CP);
- Clinical Social Workers (CSW), (also referred to as Licensed Clinical Social Workers, or LCSWs);
- Doctoral level clinical psychologists;
- Nurse Practitioners with proper behavioral health training;
- Certified Nurse Midwives;
- Physicians Assistants;
- Physicians with proper behavioral health 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 the RHC setting (the items in italics indicate revisions made in 2016):

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 behavioral health services provided by CPs, CSWs, nurse practitioners (with proper behavioral health training), and physicians (with appropriate behavioral health training). Some state Medicaid programs and commercial insurers will also reimburse for other types of masters-prepared behavioral health 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 behavioral health 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 a suitable fit for RHCs with significant Medicaid and/or commercially insured populations. Prior to 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 behavioral health services covered (billable and reimbursable) in the RHC:

Services may include diagnosis, treatment, and consultation. The CP or CSW must directly examine the patient, or directly review the patient's medical information. 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.

Services that are covered are those that are otherwise covered if furnished by a physician or as 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 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 (Issued 1/15/2016; Effective 2/1/2016; Implemented 2/1/2016)

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

- A type of service or supply commonly furnished in a CP or CSW's office;

- Furnished as an incidental, though integral, part of professional services furnished by a CP or CSW;
- Furnished under the direct supervision of the CP or CSW; and
- Furnished by an employee of the clinic or center.

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 the 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.

## MENTAL HEALTH VISITS

### Section 170 outlines Mental Health Visits (Issued 1/15/2016; Effective 2/1/2016; Implemented 2/1/2016)

A mental health visit is a medically-necessary face-to-face encounter between a RHC or FQHC patient and a RHC or FQHC practitioner during which time one or more RHC or FQHC mental health service is rendered. Mental health services that qualify as standalone billable visits are listed on the FQHC center website, <http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHCCenter.html>, and the RHC center website, <https://www.cms.gov/Center/ProviderType/Rural-Health-Clinics-Center.html>. Services furnished must be within the practitioner's state scope of practice.

Medicare covered mental health services furnished incident to a RHC or FQHC visit are included in the payment for a medically necessary mental health visit when a FQHC or RHC practitioner furnishes a mental health visit. Group mental health services do not meet the criteria for a one-one-one, face-to-face encounter in a FQHC or RHC.

A mental health service should be reported using a valid HCPCS code for the service furnished, a mental health revenue code, and for FQHCs, an appropriate FQHC mental health payment code. For detailed information on reporting mental health services and claims processing, refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 9,

<http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/clm104c09.pdf>

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

## CATEGORIES OF BEHAVIORAL HEALTH SERVICES

Behavioral health services in the primary care setting fall into two broad categories. The first category involves services designed to address the needs of patients with a specific behavioral health diagnosis. These services include psychiatric diagnoses and assessment; 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, nurse practitioners, 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 which they work to determine which codes to use in given situations.

### Figure 1: Psychiatric codes for behavioral health services

- 90791: Psychiatric diagnostic evaluation-no medical services
- 90792: Psychiatric diagnostic evaluation-with medical services
- 90832: Psychotherapy, 30 min. (16-37 min.) - patient or family member
- 90834: Psychotherapy, 45 min. (38-52 min.) - patient or family member
- 90837: Psychotherapy, 60 min. (53+ min.) - patient or family member
- 90839: Psychotherapy for crisis, 1st 60 min. (high distress patients with complex/life threatening circumstances requiring immediate attention)
- 90845\* Psychoanalysis

- 90846\* Family psychotherapy without the patient present
- 90847\* Family psychotherapy, psychotherapy with patient present
- 90849\* Multiple-family group psychotherapy
- 90853\* Group psychotherapy

*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 that complicate the delivery of the evaluation or session). 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

\* Not changed since 2012

## **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 behavioral health 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 who's cognitive, emotional, social, or behavioral functioning affect prevention, treatment, or management of a physical health problem including chronic health issues (e.g., diabetes, obesity, or hypertension). Examples of HBAI services include work with patients on issues related to medication compliance, diet, stress issues, smoking cessation, etc.

Typically, these services can be provided by physicians, nurse practitioners, physician assistants. 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: Behavioral health 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**

Behavioral health services provided in the RHC by the eligible providers listed previously (physicians, nurse practitioners, physician assistants, certified nurse midwives, doctoral-level clinical psychologists, and clinical social workers) are covered as part of the RHC benefit and

are reimbursed under cost-based reimbursement. State Medicaid agencies are required to reimburse RHCs and FQHCs for behavioral health 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.

Although RHCs are reimbursed under a cost-based rate per visit under Medicare Part A, it is important to note that until 2014, outpatient behavioral health services covered under Medicare Part B under the Fee for Service fee schedule were reimbursed at a rate lower than the rate for medical services. Effective January 1, 2014, behavioral health services have parity in reimbursement with medical services.

It is also important to note that Medicare policies allow for the provision and reimbursement of both a physical health and behavioral health 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 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 are based on the service provided and intensity of encounter.

## INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE

Integrated models are emerging across the US focused on comprehensive, coordinated systems of care that incorporate primary care, behavioral health, 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 behavioral health provider.

### DEFINING INTEGRATION

Integration should be viewed as 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 integrated behavioral health specials 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/record keeping. Most practices will fall somewhere between these two extremes.

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 primary care and behavioral health 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. The local service system and to identify the key issues that prevent the local service system for fully meeting the needs of patients with behavioral health issues. Figure 4 describes the functional aspects of integration that must be considered.

#### **Figure 4: Functional Aspects of Integration**

*Clinical – more easily implemented in rural areas*

- Regular communication
- Use of critical pathways or practice guidelines
- Internal referral process
- Common screening tools, treatment plans, and models
- Shared medical information
- Collaborative decision making
- Consultation and education

*Structural – less easily implemented without resources*

- Co-location (e.g. shared space)
- Fully integrated (one organizational structure/employed staff)
- Single medical record
- Shared billing and scheduling systems
- Shared risk

It is also necessary to work with providers to develop a common understanding of who the proposed integrated service is designed to work. For example, primary care providers and other medical staff should understand:

- What types of patient to refer;
- What to say to patients when referring;
- How to integrate behavioral feedback into a medical care plan;
- How to co-manage patients with a behavioral health team member;
- How to integrate behavioral health into the primary care team; and
- Population management strategies for patients with mental disorders

Fitting into an integrated setting is also a challenge for behavioral health staff who must adapt to a different style of practice than traditional mental health settings: Behavioral health staff should understand how to:

- Adapt to a primary care practice's mission, roles, and culture;
- Adjust to the primary care 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, the 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 behavioral health 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, primary care providers are not well versed in the diagnosis and treatment of behavioral health problems, thus the addition of the behavioral health provider provides an improved level of expertise.
- Chapter 13 of the Medicare Benefits Policy Manual specifically states that medical and behavioral health providers may be reimbursed for services performed on the same day at the same location in the RHC. This generates revenue for the RHC and provides convenience and a more holistic experience for the patient.
- Patients have access to behavioral health services in a familiar environment without the stigma of visiting a practice specific to behavioral health.
- Patients are not required to make a separate appointment to access behavioral health services. The patient's body and mind are treated, in one location, during one visit.

## CHALLENGES OF INTEGRATION

**CO-PAYMENTS:** When the 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 behavioral health services are unemployed, uninsured, and/or low income. The RHC may wish to consider implementing a sliding fee scale to offer discounted care based on income. In addition, the RHC should have mechanisms in place to assist patients with Medicaid enrollment or enrollment in the state's health insurance marketplace.

**COST REPORT CONSIDERATIONS:** Behavioral health 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 behavioral health providers, yet the visits are included in the total visits to determine the average cost per visit for the RHC. For provider-based clinics affiliated with hospitals with less than 50 inpatient beds, there is no cap on the interim rate per visit, which potentially provides a better opportunity to recover a greater proportion of the costs. For free standing RHCs with an interim rate per visit cap, adequate reimbursement may be provided, but costs should be monitored closely to assure that the average cost per visit is as close as possible to the cap to prevent financial loss.

**PROVIDER RECRUITMENT:** As with all types of providers, recruitment to rural communities may be challenging. RHCs may be committed to developing an integrated primary care/behavioral health model, but unsuccessful in recruiting behavioral health providers. RHCs may consider participating as a [National Health Service Corps](#) site. Through the NHCS, loan repayment and scholarships are available for qualified behavioral health practitioners working in Health Professional Shortage Areas.

## TELEHEALTH

Occasionally patients may require consultation, psychotherapy, or another behavioral health service by a provider not available in the RHC. Telehealth services may be provided to patients at an RHC, and the 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 are located.

Medicare reimburses for telehealth services only when the originating site (where the patient is located) is 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 a 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 behavioral health 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 addition information, visit the Center for Telehealth & e-Health Law at <http://ctel.org>.

## HOW TO BEGIN

Developing an integrated behavioral health service in an RHC is a complex undertaking. The process 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 to and using that information to make informed decisions. Figure 5 provides an overview of these key decisions:

Figure 5: Key Decisions Related to the Development of an Integrated Behavioral Health Service

- Decide what your goals are and prioritize them
  - Expand access to mental health services?
  - Provide direct care vs. consultative services for PCPs
  - Improve primary care provider productivity?
  - Improve coordination of care?
- Determine the best ways to achieve each goal
  - Start simply and evolve with experience
  - Avoid competition for necessary resources
- Understand mental health reimbursement policies
  - Understand the mental health procedure and diagnostic codes and managed care systems (e.g., prior authorization, limitations on numbers of visits, paperwork requirements, etc.)
  - Recognize which types of providers are reimbursable by payers
- Focus on services that are reimbursable
- Understand different treatment models

## BEHAVIORAL HEALTH INTEGRATION HOW THE SORH CAN HELP

1. Provide RHCs with examples of successful models of integration. The [Substance Abuse and Mental Health 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 behavioral health services in the 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 behavioral health 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:**

<http://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol5/pdf/CFR-2012-title42-vol5-part491-subpartA.pdf>

**CMS Medicare Benefits Policy Manual, CMS Publication 100-2 – Chapter 13, Rural Health Clinics/Federally Qualified Health Centers – Revised January 2016.**

<http://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,**

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf>

See specifically Section 60 regarding the outpatient mental health limitations

**CMS Medicare Claims Processing Manual, CMS Publication 100-4, Chapter 12, Physicians/Non-physician Providers:**

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>

See Section 210 for information on reimbursement of mental health services

See Section 190 for information on reimbursement of telehealth services

**Institute for Behavioral Health Integration**

<http://bhintegration.org>

**Rural Health Research Gateway**

<https://www.ruralhealthresearch.org/>

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

<http://www.samhsa.gov>

### ARTICLES AND PUBLICATIONS

**Encouraging Rural Health Clinics to Provide Mental Health Services:  
What are the Options?**

<http://muskie.usm.maine.edu/Publications/rural/pb/mental-health-services-Rural-Health-Clinics.pdf>

**Behavioral Health Care of the Agricultural Population: A Brief History**

[http://www.ruralsupport.ca/admin/FileUpload/files/publications/RosmannArticle\\_BHC\\_AGPop\\_BriefHistory.pdf](http://www.ruralsupport.ca/admin/FileUpload/files/publications/RosmannArticle_BHC_AGPop_BriefHistory.pdf)

**Depression literacy: rates and relation to perceived need and mental health service utilization in a rural American sample**

<http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=1803>

**Mental Health Services in Rural Jails**

<http://muskie.usm.maine.edu/Publications/rural/Rural-Jails-Mental-Health.pdf>

## 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
ONC	Office of the National Coordinator for Health Information Technology
ORHP	Office of Rural Health Policy
PCMH	Patient Centered Medical Home

SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Substance Abuse Services
SNF	Skilled Nursing Facility
SBIRT	Screening, Brief Intervention, and Referral to Treatment