Integrating Behavior Health

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Behavioral Health Talking Points

Behavioral Health is closely linked to social determinants of health, one of the drivers drive healthcare demand

Rural providers want to develop behavioral health programs, but have many barriers to overcome

Behavioral health services can be revenue and growth generators

Recent legislative reforms have improved the ability for mental health service growth and improved reimbursement potential

Behavioral health can be integrated with primary care and should be a component of care coordination

Nebraska Statistics

The National Alliance on Mental Illness published some startling statistics

- 257,000 adults in Nebraska have a mental health condition
- In February 2021, 33.8% of adults reported symptoms of anxiety or depression. 21.5% of this population were unable to get needed counseling or therapy.
- 22,000 Nebraskans age 12-17 have depression. 60.1% of this population did not receive any care.
- In Nebraska, 271 lives were lost to suicide at the time of this study with another 61,000 adults having thoughts of suicide in the last year.
- Inadequate mental health care delivery systems have significant impacts on individuals, families and communities.

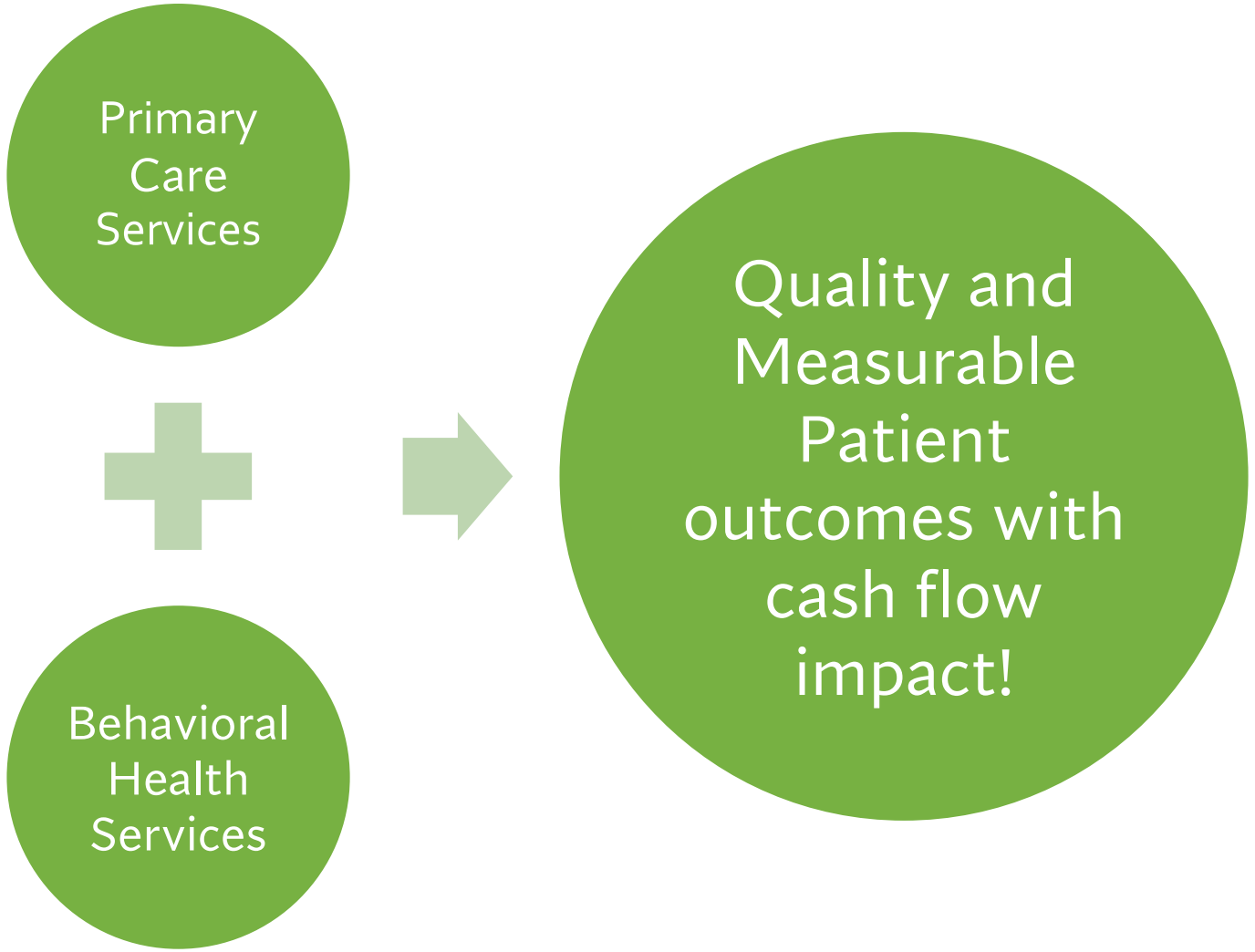
Reference/Resource – National Alliance on Mental Illness report

RHC Behavioral Health

"Access to services promoting behavioral health, wellness, and whole-person care is key to helping people achieve the best health possible," says CMS Administrator Chiquita Brooks-LaSure in a press release. "The Physician Fee Schedule final rule ensures that the people we serve will experience coordinated care and that they have access to prevention and treatment services for substance use, mental health services, crisis intervention, and pain care."

In light of the current needs among Medicare beneficiaries for improved access to behavioral health services, CMS has considered regulatory revisions that may help to reduce existing barriers and make greater use of the services of behavioral health professionals, such as licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs). Therefore, CMS is finalizing the proposal to add an exception to the direct supervision requirement under our "incident to" regulation at 42 CFR 410.26 to allow behavioral health services to be provided under the general supervision of a physician or non-physician practitioner (NPP), rather than under direct supervision, when these services or supplies are furnished by auxiliary personnel, such as LPCs and LMFTs, incident to the services of a physician (or NPP).

CMS is also clarifying that any service furnished primarily for the diagnosis and treatment of a mental health or substance use disorder can be furnished by auxiliary personnel under the general supervision of a physician or NPP who is authorized to furnish and bill for services provided incident to their own professional services. CMS believes that this change will facilitate access and extend the reach of behavioral health services. Finally, CMS indicated in the final rule that we intend to address payment for new codes that describe caregiver behavioral management training in CY 2024 rulemaking.


Primary Care Services
Behavioral Health Services
Quality and Measurable Patient outcomes with cash flow impact!

General Behavioral Health Integration

General Behavioral Health Integration Services

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BHI integrates behavioral health services WITH primary care treatment.

BHI is an example of Care Management services similar to Principal/Chronic Care Management.

BHI and CCM can be billed concurrently – meaning BHI can be billed in addition to other care management services.

Patient Eligibility for Behavioral Health Integration

Patient must present at least ONE behavioral health condition.

General Behavioral Health Conditions by definition include

- Mental Health Diagnosis
- Substance Abuse Disorders
- Stress related physical symptoms
- General Health Behaviors
- Other common routine stressors as identified by assessment

Patients do not require any other comorbid, chronic or principal medical condition to be managed. A single BH diagnosis qualifies the patient for this program.

Patients must consent and enroll in the program.

Written consent is not required but cost sharing must be identified to the patient upon enrollment.

Monthly cost sharing equates to approx. $15 per month.

Core Elements for General Behavioral Health Integration

Monthly service – 20 minutes or more of documented care management

- A systematic assessment
- Continual Patient Monitoring
- Care plan creation and revision
- Facilitation of Behavioral Health Treatment
- Coordination of Behavioral Health Treatment
- Patient/Care Team continuous relationship and communication
- BHI is primarily managed by the patient's primary care team or physician
- Psychiatric consultants can assist in the management of the program but an appointed behavioral health care manager may deliver general BHI services.

CMS allows services to be rendered remotely.

General BHI CPT Codes

- G0511 – General Care Management
- This is the same code utilized for PCM/CCM
- Reimbursement $77.94 per month
- Medicare allows patients can be enrolled in both programs.
- When billing for both PCM/CCM and BHI, patients must be enrolled and agreeable to both programs.
- Documentation must be separately identifiable for each program.
- Time cannot be counted for both and should be separately documented.

Barriers to Mental Health treatment

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STIGMA

- Reluctance to seek help or treatment.
- Concerns over lack of understanding/acceptance by family, friends, employers or others.
- Concerns over violence or harrassment.

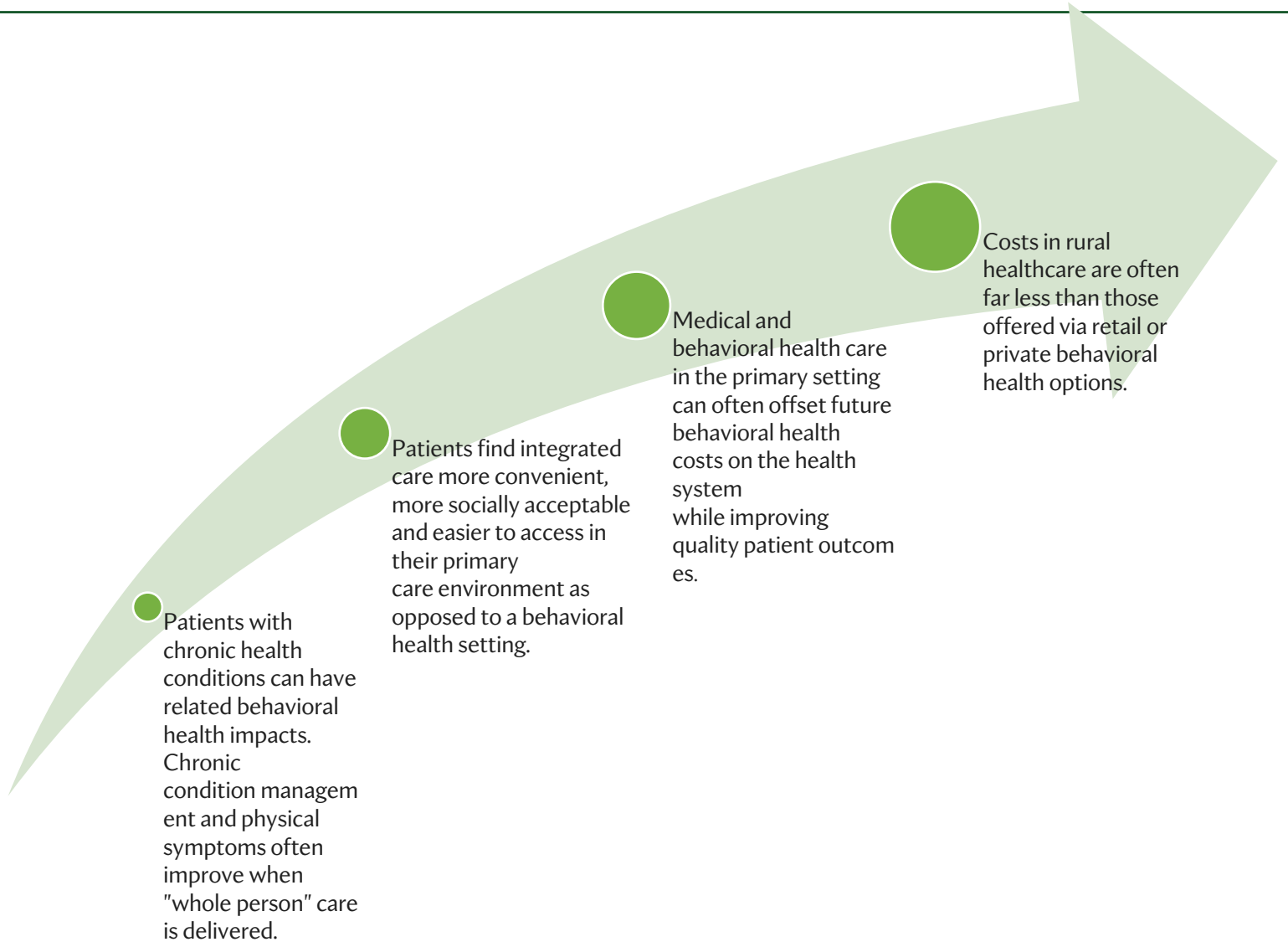
ACCESS

- Lack of mental health treatment facilities and providers.
- Lack of transportation, specifically in rural areas and elderly populations.
- Language Barriers

COST

- Uninsured
- Lack of Adequate Health insurance coverage or underinsured.

Benefits to Mental Health treatment through integration



Behavioral Health Integration
Beyond the Basics

RHC Common Mental Health Billing Codes

Many clinics are billing mental health services as Evaluation and Management or with inappropriate codes.

Initial Assessment Diagnostic & Treatment Plan 90791	Crisis Intervention - 15 min H2011
Initial Assessment Diagnostic & Treatment Plan with Medical Services 90792	Injectable Med Admin with Monit & Edu H2010 Injection Only 96372
Psychiatric Assessment - 30 mins New 99202-99205 or Established 99212-99215 Psychiatric Assessment - 30 mins - ADD ON 90833	Self-help/peer services, per 15 minutes H0038 Self-help/peer services, per 15 minutes - Group H0038
Psychiatric Assessment - 45-50 mins New 99202-99205 or Established 99212-99215 Psychiatric Assessment - 45-50 mins - ADD ON 90836	Psychotherapy - Indiv 30 mins 90832 Psychotherapy - Indiv 45 mins 90834 Psychotherapy - Family 30 mins 90846 Psychotherapy - Family & Client 1 hr 90847 Psychotherapy - Family Group 1hr 90849 Psychotherapy - Group 1 hr 90853 School Based - Group <1 hr 90853
Developmental Testing - limited 96110 Developmental Testing - First Hour 96112 Developmental Testing - Additional 30 min. 96113 Psychological Testing Evaluation - First Hour 96130 Psychological Testing Evaluation - Additional Hour 96131 Psychological Testing Admin and Scoring - First Hour 96136 Psychological Testing Admin and Scoring - Additional Hour 96137 Psychological Testing - Neurobehavioral First Hour 96116 Psychological Testing - Neurobehavioral Additional Hour 96121	Health Monitoring - 15 mins 99401 Health Monitoring - 30 mins 99402 Health Monitoring - 45 mins 99403 Health Monitoring - 60 mins 99404 Health Monitoring Group - 30 mins 99411 Health Monitoring Group - 60 mins 99412
Alcohol and/or Drug Screening H0049 Alcohol and/or Drug, brief intervention, per 15 mins H0050	

Transitional Care Management

Transitional care management services are designed to help eligible patients transition back to a community setting after a stay at certain facility types.

Services required following discharge from inpatient hospital setting . There is a 30-day allowable billing period beginning date of discharge.

Mental Health Inpatient stays are frequent and on the rise. Can you incorporate TCM into you RHC Behavioral Health Integration?

The following requirements must be met:

Physician/NPP accepts care of beneficiary post discharge from facility setting without gap

Physician/NPP takes responsibility for beneficiary's care

Medical/psychosocial issues require moderate or high/complexity medical decision making.

If TCM visit occurs same day as another billable visit, generally only one visit billed

As of 1/1/2022 can bill TCM and general care management services for same patient during same time period. RHC must meet requirements for billing each code and only one health care professional may report TCM services.

One TCM visit covered per beneficiary per post discharge period and services provided must not be in post-op global period.

DOS = day face-to-face visit takes place

Revenue code = 0521

Qualifying visit HCPCS codes

99495 for moderate-complexity decision making

99496 for high-complexity decision making

Subject to Part B coinsurance

Reference/Resource – Transitional Care Management

Virtual Communication Services

RHCs virtual communication services are at least five minutes of communication technology-based or remote evaluation services and can be beneficial in mitigation revenue loss of no shows or for homebound or transportation limited patients.

Evaluate how these services could be beneficial to behavioral health integration. I.e. No Show mitigation, staff utilization based upon licensure.

In order to bill for virtual communication, please ensure that both of the following conditions have been met:

- Patient had at least one face-to-face billable visit within previous year

Medical discussion or remote evaluation must meet both of the following requirements

- Condition not related to RHC service provided within last seven days
- Does not lead to RHC visit within next 24 hours or soonest available Appointment.

Virtual communication services can be billed alone or with other payable services.

Submit claim with HCPCS code G0071

RHC face-to-face requirement waived

Medicare coinsurance and deductible apply

Do not confuse virtual communication and telehealth as they have separate requirements.

Many providers use telephone visit codes as opposed to virtual communication or telehealth codes, potentially causing a reduced receipt.

Reference/Resource -Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (cms.gov)

SE22001 - Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers (cms.gov)

Telehealth Services

Evaluate how these services could be beneficial to behavioral health integration. I.e. No Show mitigation, staff utilization based upon licensure.

RHC is originating site and this service is billed separately, no other visit reported. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. RHCs with this capability can provide and be paid for telehealth services to patients covered by Medicare.

HCPCS Q3014

Subject to Part B deductible and coinsurance

RHCs not authorized to serve as distant site except PHE waived.

Do not confuse virtual communication and telehealth as they have separate requirements.

Many providers use telephone visit codes as opposed to virtual communication or telehealth codes, potentially causing a reduced receipt.

PHE Distant site provisions through 12/31/2024

Distant site telehealth services can be furnished by any health care practitioner working for the RHC within their scope of practice. Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS).

Reference/Resource - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

SE22001 - Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers (cms.gov)

Behavioral Health Integration

Why?

Behavioral Health Integration involves better resource utilization and scheduling.
Group Services are often underutilized but can be effective revenue generators.
Holistic care in RHC's will improve health outcomes and the quality of care to the patients served.
This will also help to achieve long term sustainability for RHC's.

RHC Behavioral Health

Behavioral Health Integration into Rural Health Clinics has long been a topic of improved access to care and demonstrated need, specifically in Rural communities affected by both social and economic disparities.

Behavioral Health Services can be billed in an RHC currently, but many facilities fail to appropriately capture and identify the claims data, facing multiple denials and revenue loss, which hinders the needed expansion of these services.

The Centers for Medicare and Medicaid Services (CMS) published final rules that allow Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to bill for Behavioral Health Integration services, Chronic Care Management, and the Collaborative Care Model.

Behavioral Health integration can be a new source of revenue for RHC's and if implemented and monitored, will improve patient outcomes and use of behavioral health services.

RHC's are instrumental in both access and monitoring this care and have a very marketable strategy as patients can have one visit and achieve medical and behavioral treatment, studies have shown that this engages and promotes utilization of behavioral health services.

Behavioral Health Integration

RHC Behavioral Health Integration

How to get started or optimize existing services:

Identify patients that could benefits from integrated services and/or service coordination.

Tip: Run a report of the existing empanelment to determine potential patients by dx code range(F codes).

Establish a scheduling protocol for patients engaged in medical and behavioral health to incorporate patient simplicity and overlap. ***Tip: Create a matrix for schedulers to identify appointment types and booking guidelines.***

Use Virtual Communication/Telehealth options as a means to mitigate no shows as this population has a high no show rate.

Tip: Assign a Care Manager/Nurse or other QHP to contact patients whom no show to generate a virtual billable visit and mitigate revenue loss.

Use Telehealth expansion as leverage and to compete in the virtual market.

Tip: Get marketing involved to complete with Teladoc, amazon, retail health clinics.

Educate billing/coding staff on appropriate use of modifiers/CPT codes and payment expectations.

Tip: Make sure billing staff are aware of third-party administrators for commercial or managed care products. I.e., United Healthcare Medicaid Managed Care uses Optum Behavioral Health, Cigna uses Evernorth, Beacon Health Strategies is used for several managed care plans. Many behavioral health providers receive denials as they are just not directing the claim appropriately and those denials are never reworked or understood.

Ensure your contracting and provider enrollments are up to date for services, provider types, etc.

USE GROUPS this will maximize volumes.

Enroll all patients in Care Management services. Remember that every minute counts of documented and this is a great way to utilize LMHC, LMFT, LMHC, etc. that may not be otherwise billable.