Behavioral Health Provider Types

In the behavioral health profession, there are several different types of providers with varying degrees and credentials. Third-party payer coverage, billing requirements, and reimbursement vary depending on the practitioner's professional type or specialty. It is also important to be aware of individual state scope of practice laws.

The information presented here is primarily based on the official Medicare definitions of providers, along with coverage information from a variety of sources, such as Local Coverage Determinations (LCDs). Many payers adopt policies and guidelines similar to Medicare, but be sure to verify with individual payers to ensure accuracy. Interestingly, information regarding the behavioral health care manager and psychiatric consultant are included in the CPT code book as of January 1, 2018.

Website: Go to FindACode.com to review code-specific LCDs for your area.

Store: See the *Reimbursement Guide for Behavioral Health* for diagnoses and procedure codes, as well as essential billing and claims submission information. Available at FindACode.com/store.

Disclaimer: The non-Medicare information in this chapter contains general information and is the opinion of the authors. It should not be interpreted by providers/payers as official guidance. As such, this information should not be used for claim adjudication. Third party payers should utilize their own payment policies based on clinically sound guidelines.

Index

Instruction Conventions

Find-A-Code information is in regular text like this.

Information from official sources, such as Medicare National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs), are in a box and text style like this.

Coverage and NonCoverage

Covered and noncovered services are defined in payer policies. It should be noted that for Medicare (and many other payers) coverage is based on individual payer policies. The information included in these segments is primarily from Medicare coverage statements. More comprehensive information about billing Medicare noncovered services is included in Find-A-Code's specialty-specific *Reimbursement Guides*. It should be noted that even if a service is within a particular provider's scope of practice, it may still be noncovered by the payer. For example, the following statement talks about Clinical Psychologists (CPs) specifically, but the wording regarding "reasonable and necessary" applies to all types of providers:

> **D. Non-covered Services**—The services of CPs are not covered if the service is otherwise excluded from Medicare coverage even though a clinical psychologist is authorized by State law to perform them. For example, §1862(a)(1)(A) of the Act excludes from coverage services that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Therefore, even though the services are authorized by State law, the services of a CP that are determined to be not reasonable and necessary are not covered. Additionally, any therapeutic services that are billed by CPs under CPT psychotherapy codes that include medical evaluation and management services are not covered.

Incident To Services

One special consideration when it comes to coverage is understanding the incident to provisions of the Medicare program. Throughout this chapter, coverage refers to "incident to services" which are described as follows:

> Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.

Incident to services must always be within the provider's scope of practice and under the supervision of a physician. In these situations, the service is billed under the supervising physician or other qualified healthcare provider's NPI.

Resource: See Resource 209 to review the complete *Medicare Benefit Policy Manual*.
Resource: See Resource 504 for more information on incident to services.

Note: The information presented in this document does not represent the official policies of all types of payers. Always verify coverage prior to claims submission.

Behavioral Health Care Manager

Qualifications

The behavioral health care manager must have formal education or specialized training in behavioral health. The CPT code book states that it refers to "clinical staff with a master-/doctoral-level education or specialized training in behavioral health." CMS recognizes the following as acceptable disciplines:

- Social work
- Nursing
- Psychology

Note: May or may not be a professional who meets all the requirements to independently furnish and report services to Medicare.

Role/Responsibilities

The behavioral health care manager works under the oversight and direction of the billing provider to perform proactive, systematic follow-up using validated rating scales and a registry (where applicable). According to CMS, they perform the following (required for collaborative care services, optional for general behavioral health integration (BHI) services):

- Provides assessment and care management services, in consultation with the psychiatric consultant, including
  - The administration of validated rating scales
  - Assessment of adherence, tolerability, and clinical response of beneficiary to treatment

  - Behavioral health care planning in relation to behavioral/psychiatric health problems, including revising plans for patients who are not progressing or whose status changes
  - Provision of brief evidence-based psychosocial interventions
  - Ongoing collaboration with the billing practitioner
  - Maintenance of the registry
- Available to provide services face-to-face with the beneficiary; has a continuous relationship with the beneficiary and a collaborative, integrated relationship with the rest of the care team
- Able to engage the beneficiary outside of regular clinic hours as necessary to perform the behavioral health care manager's duties

Book: See Chapter 6.3 — Common Procedure Codes & Tips in the *Reimbursement Guide for Behavioral Health* for information about codes for billing these services. Available at FindACode.com/store.

Resource: See Resource 607 to review the CMS Behavioral Health Integration Services Fact Sheet.

Reimbursement

Reimbursement is based on the "incident to" rules and regulations, as well as state law, licensure, and scope of practice. The "incident to" regulation was revised to allow general supervision (rather than the more stringent direct supervision standard in place for most "incident to" services) for the Psychiatric Collaborative Care Model (CoCM) and general BHI codes as well as the non-face-to-face portion of other designated care management services such as complex chronic care management. Behavioral health care manage time does not include administrative or clerical staff; time spent in strictly administrative or clerical duties is not counted towards the time threshold to bill the BHI codes.

Additional psychiatric services (e.g., psychotherapy, intervention services) may be reported separately, but if they are reported separately, the time DOES NOT count towards CoCM or BHI reporting.

Note: CoCM services are reported based on a calendar month. There must be a minimum of weekly services which are typically non-face-to-face.

Clinical Nurse Specialist (CNS)

Qualifications

A Clinical Nurse Specialist (CNS) must meet the applicable state requirements governing the qualifications for CNSs and meet all of the following requirements:

1. Be a registered nurse who is currently licensed to practice in the State where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with State law;
2. Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and
3. Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for CNSs.

Coverage

Coverage is based on state law or regulations regarding a CNS' scope of practice where the services are furnished. Examples of the types of services that a CNS may furnish include services that traditionally have been reserved for physicians, such as:

- Physical examinations
- Minor surgery
- Setting casts for simple fractures
- Interpreting x-rays
- Other activities that involve an independent evaluation or treatment of the patient's condition
- Services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician and if authorized under the scope of his or her state license
  - Services are performed in collaboration with a physician; In the absence of State law governing collaboration, collaboration is to be evidenced by the CNS documenting his or her scope of practice and indicating the relationships that the CNS has with physicians to deal with issues outside the CNS' scope of practice.

    The collaborating physician does not need to be present with the CNS when services are furnished or to make an independent evaluation of each patient seen by the CNS.
  - Assistant-at-surgery services furnished by a CNS are covered;

As a Qualified Healthcare Professional (QHP), they may also provide the following under certain circumstances (if allowed by law and under the 'incident to' provision):

- Therapy services
- Diagnostic psychological and neuropsychological tests

Reimbursement

CNSs are paid at 85% of the Medicare Physician Fee Schedule (MFPS) for most services. For assistant-at-surgery services, a CNS is paid at 85% of 16% of the amount paid a physician under the MPFS for assistant-at-surgery services.

A CNS may bill directly and receive direct payment for their services.

Assignment

Assignment is required for Medicare.

Clinical Psychologist (PsyD, PhD)

Qualifications

A Clinical Psychologist (CP) must meet the following requirements:

- Hold a doctoral degree in psychology;
- Be 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.

Coverage

CPs are treated the same as physicians as long as state licensing requirements are satisfied. They are classified as "Nonphysician Practitioners" by Medicare. If you do not qualify as a Clinical Psychologist, see the instructions under Independently Practicing Psychologist.

Resource: See Resource 209 to review the complete *Medicare Benefit Policy Manual*.

B. Qualified Clinical Psychologist Services Defined—Effective July 1, 1990, the diagnostic and therapeutic services of CPs and services and supplies furnished incident to such services are covered as the services furnished by a physician or as incident to physician's services are covered. However, the CP must be legally authorized to perform the services under applicable licensure laws of the State in which they are furnished.

C. Types of Clinical Psychologist Services That May Be Covered:

Diagnostic and therapeutic services that the CP is legally authorized to perform in accordance with State law and/or regulation. Carriers pay all qualified CPs based on the physician fee schedule for the diagnostic and therapeutic services. (Psychological tests by practitioners who do not meet the requirements for a CP may be covered under the provisions for diagnostic tests as described in §80.2.

Services and supplies furnished incident to a CP's services are covered if the requirements that apply to services incident to a physician's services, as described in §60 are met. These services must be:

- Mental health services that are commonly furnished in CPs' offices;
- An integral, although incidental, part of professional services performed by the CP;
- Performed under the direct personal supervision of the CP; i.e., the CP must be physically present and immediately available;
- Furnished without charge or included in the CP's bill; and
- Performed by an employee of the CP (or an employee of the legal entity that employs the supervising CP) under the common law control test of the Act, as set forth in 20 CFR 404.1007 and §RS 2101.020 of the Retirement and Survivors Insurance part of the Social Security Program Operations Manual System.
- Diagnostic psychological testing services when furnished under the general supervision of a CP.

Tip: This "reasonable and necessary" requirement is practiced by all insurance carriers and can vary from state to state.

E. Requirement for Consultation—When applying for a Medicare provider number, a CP must submit to the carrier a signed Medicare provider/supplier enrollment form that indicates an agreement to the effect that, contingent upon the patient's consent, the CP will attempt to consult with the patient's attending or primary care physician in accordance with accepted professional ethical norms, taking into consideration patient confidentiality.

If the patient assents to the consultation, the CP must attempt to consult with the patient's physician within a reasonable time after receiving the consent. If the CP's attempts to consult directly with the physician are not successful, the CP must notify the physician within a reasonable time that he or she is furnishing services to the patient. Additionally, the CP must document, in the patient's medical record, the date the patient consented or declined consent to consultations, the date of consultation, or, if attempts to consult did not succeed, that date and manner of notification to the physician.

The only exception to the consultation requirement for CPs is in cases where the patient's primary care or attending physician refers the patient to the CP. Also, neither a CP nor a primary care nor attending physician may bill Medicare or the patient for this required consultation

Store: Note that CPs should typically bill with modifier "AH." See the *Reimbursement Guide for Behavioral Health* for information on completing the 1500 Claim Form and more information about modifier usage. Available at FindACode.com/store.

Note: The provider's NPI must be on the claim form. See Resource 703 to search the provider NPI Registry.

Reimbursement

Services are paid at 100% of the amount a physician is paid under the Medicare Physician Fee Schedule (MPFS).

Assignment

Assignment is required for Medicare.

Clinical Social Worker (CSW)

Qualifications

Medicare classifies CSWs as "Nonphysician Practitioners." They must meet the following requirements:

- Possesses a master's or doctor's degree in social work;
- Has performed at least two 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, has completed at least 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, SNF, or clinic.

Coverage

B. Clinical Social Worker Services Defined—Section 1861(hh)(2) of the Act defines "clinical social worker services" as those services that the CSW is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed for the diagnosis and treatment of mental illnesses. Services furnished to an inpatient of a hospital or an inpatient of a SNF that the SNF is required to provide as a requirement for participation are not included. The services that are covered are those that are otherwise covered if furnished by a physician or as incident to a physician's professional service.

C. Covered Services—Coverage is limited to the services a CSW is legally authorized to perform in accordance with State law (or State regulatory mechanism established by State law). The services of a CSW may be covered under Part B if they are:

- The type of services that are otherwise covered if furnished by a physician, or as incident to a physician's service. (See §30 for a description of physicians' services and §70 of Pub 100-1, the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, for the definition of a physician.);
- Performed by a person who meets the definition of a CSW (See subsection A.); and
- Not otherwise excluded from coverage

Tip: State laws or other regulatory agencies may differ in your area. Be aware of services that are within your state scope of practice.

Reimbursement

Payment is made only on an assignment basis and are paid at 75% of the amount paid a clinical psychologist under the Medicare Physician Fee Schedule (MPFS).

Assignment

Assignment is required for Medicare.

Independently Practicing Psychologist (IPP)

Qualifications

Independently Practicing Psychologists (IPP) must meet the following qualifications:

- Be a psychologist who is not a clinical psychologist. This generally means that they have a doctoral degree in psychology from a program not focused on clinical psychology (e.g., educational, counseling).
- Be licensed or certified to practice psychology in the State or jurisdiction where furnishing services or, if the jurisdiction does not issue licenses, if provided by any practicing psychologist.

Psychologists are practicing independently when:

- They render services on their own responsibility, free of the administrative and professional control of an employer such as a physician, institution, agency;
- The persons they treat are their own patients; and
- They have the right to bill directly, collect and retain the fee for their services.

A psychologist practicing in an office located in an institution may be considered an independently- practicing psychologist when both of the following conditions exist:

- The office is confined to a separately-identified part of the facility which is used solely as the psychologist's office and cannot be construed as extending throughout the entire institution; and
- The psychologist conducts a private practice, i.e., services are rendered to patients from outside the institution as well as to institutional patients

Coverage

Diagnostic psychological and neuropsychological testing (CPT codes 96101-96120) is typically covered in an office setting when a physician orders such testing. Individual payer policies regarding medical necessity must be met. Psychological services provided in a Medicare-certified Community Mental Health Center (CMHC) must be billed to the fiscal intermediary.

Reimbursement

Claims are paid at 100% of the Medicare Physician Fee Schedule (MPFS) amount.

Assignment

For Medicare, IPPs are not required by law to accept assignment except when performing psychological tests. However, regardless of whether the psychologist accepts assignment, he or she must report, on the claim form, the name and address of the physician who ordered the test.

Note: The referring provider's NPI must be on the claim form. See Resource 703 to look up a provider's NPI.

Master's Level Psychologist

Medicare does not have a specific category for this level of psychologist.

Qualifications

A master level psychologist must meet the applicable State law which governs the qualifications for non-doctorate psychologists for the state in which they will be practicing. Check with the Division of Occupational and Professional Licensing of the applicable state to ensure that all current qualifications are met.

Coverage

Coverage will vary between payers. Therefore, it is always wise to verify coverage before seeing the client because payer-specific limitations may apply. For legal purposes, it might be wise to adopt a policy to have a percentage of your cases reviewed by a doctoral level psychologist or psychiatrist on an annual basis. This demonstrates concern for optimal quality of care for clients. Your malpractice insurance carrier may also have guidelines that would be beneficial for you to follow.

Nurse Practitioner (NP)

Qualifications

A Nurse Practitioner (NP) must meet all of the following conditions for Medicare:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; or
- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

The NPs applying for a Medicare billing number for the first time on or after January 1, 2001, must meet the requirements as follows:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

The NPs applying for a Medicare billing number for the first time on or after January 1, 2003, must meet the requirements as follows:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law;
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; and
- Possess a master's degree in nursing

Coverage

1. **General** The services of an NP may be covered under Part B if all of the following conditions are met:
    - They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
    - They are performed by a person who meets the definition of an NP (see subsection A);
    - The NP is legally authorized to perform the services in the State in which they are performed;
    - They are performed in collaboration with an MD/DO (see subsection D); and
    - They are not otherwise precluded from coverage because of one of the statutory exclusions. (See subsection C.2.)
2. **Incident To**—If covered NP services are furnished, services and supplies furnished incident to the services of the NP may also be covered if they would have been covered when furnished incident to the services of an MD/DO as described in §60.

Coverage is based on state law or regulations regarding an NP's scope of practice where the services are furnished. Examples of the types of services that an NP may furnish include services that traditionally have been reserved for physicians, such as:

- Physical examinations
- Minor surgery

- Setting casts for simple fractures
- Interpreting x-rays
- Other activities that involve an independent evaluation or treatment of the patient's condition.
- Services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician and if authorized under the scope of his or her state license

Additionally, the following are also covered:

- Services performed in collaboration with a physician

> **D. Collaboration—**Collaboration is a process in which an NP works with one or more physicians (MD/DO) to deliver health care services, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished. In the absence of State law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice.
>
> The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.

- Assistant-at-surgery services furnished by the NP
- Diagnostic psychological and neuropsychological tests in collaboration with a physician as required under the NP benefit and to the extent permitted under State law

Note: Medicare noncovered services should not be billed to Medicare even if they are within the state scope of practice for an NP.

Reimbursement

NPs are paid at 85 percent of the Medicare Physician Fee Schedule for most services. For assistant-at-surgery services, NPs are paid at 85% of 16% of the amount paid a physician under the Medicare Physician Fee Schedule for assistant-at-surgery services. Note that direct billing and payment for NP services may be made to the NP.

Assignment

Assignment is mandatory for Medicare.

Physician (MD, DO)

Qualifications

A physician must meet the following requirements:

- Holds a medical doctorate degree
- Meets licensing standards as a physician in the state(s) in which he/she practices

Coverage

Physician coverage includes Evaluation and Management (E/M) services, pharmacological management, psychiatric interview procedures, individual and group psychotherapy, and other psychiatric therapy provided in any setting (e.g., office, institution, patient's home). Services can either be personally performed by the physician or by an employee under the physician's direct supervision as an "incident to" service.

Reimbursement

Payment is based on the Physician Fee Schedule (PFS). Some services are based on the Medicare Physician Fee Schedule (MPFS).

Assignment

- Assignment for Medicare is not required, unless the physician has entered into a participating agreement.
- Physicians must acquire and use their National Provider Identifier (NPI) to submit claims.

Store: See the *Reimbursement Guide for Behavioral Health* for more information on Evaluation and Management coding, Medicare participation, and NPIs. It is available in the online store. Available at FindACode.com/store.

Physician Assistant (PA)

Qualifications

A Physician Assistant (PA) must meet the following conditions:

- Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA); or
- Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and
- Be licensed by the State to practice as a physician assistant.

Coverage

B. Covered Services—Coverage is limited to the services a PA is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law).

1. General: The services of a PA may be covered under Part B, if all of the following requirements are met:
   - They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
   - They are performed by a person who meets all the PA qualifications,
   - They are performed under the general supervision of an MD/DO;
   - The PA is legally authorized to perform the services in the state in which they are performed; and
   - They are not otherwise precluded from coverage because of one of the statutory exclusions.
2. Incident To—If covered PA services are furnished, services and supplies furnished incident to the PA's services may also be covered if they would have been covered when furnished incident to the services of an MD/DO, as described in §60
3. Types of PA Services That May Be Covered—State law or regulation governing a PA's scope of practice in the State in which the services are performed applies. Carriers should consider developing lists of covered services. Also, if authorized under the scope of their State license, PAs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests if furnished under the general supervision of a physician.

   Examples of the types of services that PAs may provide include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition.

   See §60.2 for coverage of services performed by PAs incident to the services of physicians

Store: "Incident To" information is included in the *Reimbursement Guide for Behavioral Health* available in the online store. Available at FindACode.com/store.

Reimbursement

PAs are paid at 85% of the Medicare Physician Fee Schedule (MFPS) for most services. For assistant-at-surgery services, PAs are paid at 85% of 16% of the amount paid a physician under the MFPS for assistant-at-surgery services.

Additionally, payments may be made only to the PA's qualified employer or contractor who is eligible to enroll in Medicare under existing provider/supplier categories.

Assignment

Assignment is required for Medicare.

Store: See the *Reimbursement Guide for Behavioral Health* for more information on Evaluation and Management coding, Medicare participation, and NPIs. Available at FindACode.com/store.

Psychiatric Consultant

Qualifications

A psychiatric consultant must be a medical professional (e.g., a psychiatrist or an NP with psychiatry board-certification) trained in psychiatry and qualified to prescribe the full range of medications. This type of provider plays an integral role in the Psychiatric Collaborative Care Model (CoCM) providing Behavioral Health Integration (BHI) services.

Book: See Chapter 6.3 — Common Procedure Codes & Tips in the *Reimbursement Guide for Behavioral Health* for information about codes for billing these services. Available at FindACode.com/store.

Resource: See Resource 607 to review the CMS Behavioral Health Integration Services Fact Sheet.

Role/Responsibilities

The psychiatric consultant advises and makes psychiatric and other medical care recommendations (e.g., treatment strategies, medication management) that are communicated to the treating physician, typically through the behavioral health care manager. The psychiatric consultant does not typically provide services to the patient or prescribe medications, except in rare circumstances. Instead, their primary role is to facilitate any referrals for psychiatric or other types of care (e.g., specialized services, medical treatment) as clinically indicated. According to the CPT code book, they may provide E/M services or psychiatric evaluations which could be reported separately from the collaborative care management services.

According to Medicare, the psychiatric consultant's responsibilities include the following:

- Participates in regular review of clinical status of patients receiving BHI services.
- Advises the billing practitioner (and behavioral health care manager) regarding diagnosis;
  - indicates options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment;
  - makes adjustments to behavioral health treatment for beneficiaries who are not progressing;
  - manages any negative interactions between beneficiaries' behavioral health and medical treatments.
- Can (and typically will) be remotely located;
- Is generally not expected to have direct contact with the beneficiary, nor prescribe medications or furnish other treatment to the beneficiary directly.
- Can and should facilitate referral for direct provision of psychiatric care when clinically indicated.

Reimbursement

Reimbursement is based on the "incident to" rules and regulations, as well as state law, licensure, and scope of practice. The "incident to" regulation was revised to allow general supervision (rather than the more stringent direct supervision standard in place for most "incident to" services) for the CoCM and general BHI codes as well as the non-face-to-face portion of other designated care management services such as complex chronic care management.

Psychiatric Nurse Practitioner (PNP)

Psychiatric Nurse Practitioners must meet all the qualifications for NPs. See page 8 for coverage and assignment requirements. In addition, they must also:

- Be licensed as a nurse practitioner certified in psychiatric nursing by the state or jurisdiction.