

Implementation Questions and Steps for New Medicare Behavioral Health Codes

This guide is intended to be used by provider in tandem with the [Decision Support Tool \(DST\): Integrated Care Revenue Estimator](#). The DST is a downloadable Excel workbook that includes information to help provider organizations assess specific billing, staffing and service opportunities to enhance delivery of integrated health care services. It is updated each year to include current opportunities and changes.

1. Code Review and Clinical Relevance

- What new Medicare codes will we implement?
 - Refer to the [DST worksheet](#) “2. Billing Codes” for coding details. Consider answers to these questions to help prioritize potentially appropriate services:
 - Which provider types in our organization can bill these codes?
 - What diagnoses and settings are required for code use?
 - How many current patients are potentially eligible for these services?
 - How do these services fit into our existing clinical workflows?

2. Reimbursement and Compliance Research

- What are the Medicare reimbursement rates in our state/region?
 - Use this [Center for Medicare and Medicaid Services \(CMS\) tool](#) to look up your local Medicare rates for each code.
- What are the billing restrictions for these codes?
- What documentation is required to support reimbursement?
- What are the audit risks and how can we mitigate them?

3. Stakeholder Roles and Training

- Who will lead the implementation (clinical, billing, compliance)?
- How will we train clinicians and billing staff on new code use?
- Have all staff been educated on unit/time requirements and workflows?

4. Workflow Integration

- What forms, templates or visit types need updating?
- How will caregiver involvement be documented, when applicable?



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- Are our Electronic Health Record (EHR) workflows ready to support these codes?

5. Documentation Templates

- Do our documentation templates meet CMS standards (time, content, participation)?
- Are progress notes clearly capturing skills taught and outcomes, if applicable?
- Do we need EHR shortcuts or macros for efficiency?

6. Billing and Revenue Cycle Management

- Have we added new codes to our billing system?
- How will we track and resolve denied claims?
- What system do we have to monitor code usage and revenue and cost trends?

7. Pilot and Quality Assurance

- Which providers could participate in an initial pilot?
- How will we monitor clinical and billing quality during rollout?
- How will we gather and respond to staff, patient or caregiver feedback?

8. Reporting and Evaluation

- What metrics will we track (e.g., code use, revenue, patient outcomes)?
- How will this data be shared and reviewed by leadership?

9. Communication and Outreach

- How will we inform patients and caregivers about new services?
- What updates are needed for patient consent forms and materials?

10. Policy and Compliance Checks

- Have we updated our internal policies to reflect use of these codes?
- Are we ensuring compliance with Medicare, HIPAA and state laws?

