
MFT and MHC Benefit

1. Does Medicare recognize Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)?

Section 4121 of Division FF of the Consolidated Appropriations Act, 2023 (CAA, 2023), establishes a new Medicare benefit category for MFT and MHC services furnished by and directly billed by MFTs and MHCs. Payment for MFT and MHC services under Part B of the Medicare program will begin January 1, 2024.

2. How does Medicare define MFTs?

Section 4121 Division FF of the CAA, 2023, defines MFT services as services for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital). An MFT is an individual who:

- Possesses a master's or doctorate degree which qualifies for licensure or certification as a MFT under State law of the State in which such individual furnishes marriage and family therapist services,
- Is licensed or certified as an MFT by the State in which they furnish services,
- Has performed at least 2 years or 3,000 hours of clinical supervised experience in marriage and family therapy or mental health counseling after obtaining the degree referenced above, and
- Meets other requirements as the Secretary of Health and Human Services (HHS) determines appropriate.

3. How does Medicare define MHCs?

Section 4121 Division FF of the CAA, 2023, defines MHC services as services for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital). An MHC is an individual who:

- Possesses a master's or doctorate degree which qualifies for licensure or certification as a MHC, clinical professional counselor, or professional counselor under State law of the State in which such individual furnishes MHC service,
- Is licensed or certified as an MHC, clinical professional counselor, or professional counselor by the State in which they furnish services,
- Has performed at least 2 years or 3,000 hours of clinical supervised experience in marriage and family therapy or mental health counseling after obtaining the degree referenced above, and
- Meets other requirements as the Secretary of HHS determines appropriate.

4. Where can I find more information about Medicare coverage for MFTs/MHCs?

Providers can refer to the [MFT/MHC](#) webpage and the [Medicare and Mental Health Coverage MLN Booklet](#).

National Provider Identifier (NPI) and Taxonomy Codes

5. What is an NPI?

The NPI is a unique, 10-digit identification number for covered health care providers and must be used in the administrative and financial transactions adopted under HIPAA.

To enroll in Medicare, you must first obtain an NPI and provide it on the Medicare enrollment application. NPIs are issued through the National Plan & Provider Enumeration System (NPPES). You can apply for an NPI on the [NPPES](#) website. If you are not sure if you have an NPI, search the [NPI Registry](#).

6. What taxonomy code do I select in NPPES for MFTs and MHCs?

A taxonomy code is a unique 10-character code that designates your classification and specialization. You will select this code when applying for an NPI in NPPES. The MFT taxonomy code is 106H00000X. The MHC taxonomy code is 101YM0800X.

7. I'm currently enrolled in Medicaid and have an NPI. Do I need a new NPI for Medicare?

Practitioners may only have one Type 1 NPI. Use your existing NPI to enroll in Medicare.

Enrolling as an MFT or MHC

8. What is a Medicare Administrative Contractor (MAC)?

A MAC is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) enrollment applications and Medicare Fee-For-Service (FFS) claims, respond to provider inquiries, and educate providers about Medicare FFS enrollment and billing requirements.

Find your designated MAC and their contact and mailing address at [MAC Contact Information](#).

9. When can I start enrolling in Medicare?

MFTs and MHCs can begin submitting their enrollment applications after the Calendar Year (CY) 2024 Physician Fee Schedule (PFS) final rule is displayed at the Federal Register, usually around November 1, 2023. However, as the new benefits authorized by Section 4121(a) of the Division FF of CAA, 2023, do not take effect until January 1, 2024, MFTs/MHCs will not be

granted an effective date earlier than January 1, 2024, and claims with dates of service prior to January 1, 2024, will not be payable.

10. What enrollment application do I complete to enroll in Medicare?

MFTs and MHCs can enroll electronically using the [Provider Enrollment, Chain, and Ownership System](#) (PECOS) or the paper [CMS-855I](#) enrollment application.

PECOS is the online Medicare enrollment system. It offers a scenario-driven application, asking questions to obtain the required information for your specific enrollment scenario. Use PECOS for faster and easier enrollment into Medicare.

The CMS-855I application is completed by physicians and non-physician practitioners who render Medicare Part B services to beneficiaries. This includes a physician or practitioner who (1) is the sole owner of a professional corporation, professional association, or limited liability company and (2) will bill Medicare through this business entity.

11. How do I access PECOS?

You must create a user account in the [Identity & Access Management System](#) (I&A). The I&A system allows you to:

- Use [NPPES](#) to apply for and manage NPIs
- Use [PECOS](#) to enroll in Medicare, update or revalidate your current enrollment information
- Register to get [EHR incentive payments](#) for eligible professionals and hospitals that adopt, use and upgrade, or show meaningful use of certified EHR technology

12. The paper CMS-855I application does not list the MFT and MHC specialties. How do I identify my specialty on the application?

MFTs and MHCs should select the Undefined Non-Physician Practitioner Specialty option in section 2H of the CMS-855I application and specify MFT or MHC in the space provided. A future update of the paper CMS-855I will include the MFT and MHC specialties.

The specialties are available in PECOS for online application submissions.

13. Can mental health professionals enroll as MHCs?

Per 42 CFR § 410.54(a)(3), an MHC must be licensed or certified as an MHC, clinical professional counselor, professional counselor, addiction counselor, or alcohol and drug counselor by the state in which the services are performed. Individuals who meet all the applicable statutory and regulatory qualifications to be an MHC --- even though they may be licensed or certified by

their state under a different title to furnish mental health counseling --- may enroll as an MHC. This list of mental health professionals is not exhaustive and will vary by state.

These individuals should select the Undefined Non-Physician Practitioner Specialty option in section 2H of the CMS-855I application and specify MHC in the space provided instead of the title they are licensed or certified by their state.

14. Do I have to submit multiple applications if I render services in multiple states?

A separate CMS-855I enrollment is required in each state where services are rendered. For example, the MAC’s jurisdiction consists of States X, Y, and Z. Dr. Jones is enrolled in State X with 2 locations. He wants to add a third location in State Y. A separate, initial CMS-855I application is required for the State Y location.

In addition, the practitioner must be licensed and/or certified in each state where services are rendered. The applicable license must be included on the application.

15. Does Medicare recognize compact licenses?

Medicare recognizes licenses obtained through the interstate license compact pathway as valid, full licenses for the purposes of meeting federal license requirements. For more information on compact licenses refer to [SE20008](#).

16. Who can sign the PECOS application or paper CMS-855I?

The enrolling or enrolled practitioner is the only person who can sign the PECOS application or paper CMS-855I. A practitioner may not delegate the authority to sign the CMS-855I on his/her behalf to any other person.

17. How long does it take to process an enrollment application?

Generally, all clean web applications will be processed within 15 calendar days following receipt, and all clean paper applications will be processed within 30 calendar days following receipt. The timeframes may be extended if the application is incomplete or missing information or documentation.

The MAC will send a development letter to the provider requesting the additional information. The provider will have 30 calendar days to respond. If no response is received, the application will be rejected. Providers should respond to all MAC requests for additional information timely, to avoid further delays.

18. Who can be listed as the contact person on the enrollment application?

If questions arise during the processing of the enrollment application, your MAC will contact the individual reported in the contact person section of PECOS or the paper CMS-855I. The individual practitioner may choose to designate themselves as the contact person or someone with knowledge of the application (e.g., office staff, credentialing staff).

The contact person will only be authorized to discuss issues concerning the pending enrollment application. Your MAC will not discuss any other Medicare issues about you with the contact person.

If the section is left blank, the MAC will contact the practitioner directly using the information in Section 2: Correspondence Mailing Address.

19. What risk category are MFTs and MHCs?

CMS established three levels of provider and supplier enrollment risk-based screening: limited, moderate, high. The risk levels denote the MAC's level of screening when the provider initially enrolls in Medicare, adds a new practice location, revalidates its enrollment information, or, in certain circumstances, changes all or part of its ownership.

MFTs and MHCs are limited risk. Providers and suppliers designated in the limited risk category undergo verification of licensure and a wide range of database checks to ensure compliance with all provider or supplier specific requirements.

20. Do MFTs/ MHCs have to pay an application fee?

MFTs and MHCs are not required to pay an application fee.

21. What is a Provider Transaction Access Number (PTAN)?

A PTAN is a Medicare-only number issued to providers by MACs upon enrollment. The Medicare approval letter will include the assigned PTAN.

The approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using MAC self-help tools such as the Interactive Voice Response (IVR) phone system, internet portal, on-line application status, etc.

The PTAN's use should generally be limited to the provider's interactions with their MAC.

If you enroll in multiple states, you will receive separate PTANs.

22. Am I required to receive payment through Electronic Funds Transfer (EFT)?

CMS requires that providers and suppliers, who are enrolling in the Medicare program or making a change in their enrollment data, receive payments via electronic funds transfer. Submit the [EFT Agreement](#) with your enrollment application, along with a voided check or bank letter confirming your account information.

If you reassign all Medicare benefits you do not need to submit an EFT agreement.

23. If I am enrolled in Medicaid, do I have to separately enroll in Medicare?

If you plan to provide services to Medicare beneficiaries, you must separately enroll in Medicare. Enrolling in Medicaid does not automatically enroll you in Medicare.

Reassigning Medicare Benefits

24. What does it mean to reassign your Medicare benefits?

Reassigning your Medicare benefits allows an eligible organization/group to submit claims and receive payment for Medicare Part B services that you have provided as a member of the organization/group. An eligible organization/group may be an individual, a clinic/group practice or other health care organization.

25. How do I report a reassignment on the CMS-855I?

You can report a reassignment through PECOS or the CMS-855I paper application. If submitting via paper, select the submittal reason, “You are reporting a change to your Medicare enrollment information” and complete the applicable sections. The reassignment information is reported in section 4F. The practitioner must sign section 15B and the Authorized or Delegated Official of the organization/group must sign Section 15C to establish the reassignment. If you reassign benefits to multiple organizations/groups, copy and complete section 4F and 15C, as applicable.

Both the individual practitioner and the eligible organization/group must be currently enrolled or concurrently enrolling in the Medicare program to establish the reassignment. The organization/group must be enrolled or enrolling through PECOS or the [CMS-855B](#).

26. I render services in a private practice and as an employee of a group. How do I report this in PECOS or on the paper CMS-855I?

In PECOS report your private practice in the Physical Location and Specialty Payments Address topic and the reassignment in the Reassignment topic. Complete the appropriate signatures for the practitioner and the Authorized or Delegated Official of the organization/group accepting the reassigned benefits during the submission process.

On the paper CMS-855I report your private practice in section 4B and the reassignment in 4F of the CMS-855I. Complete section 15 with the appropriate signatures for the practitioner and the Authorized or Delegated Official of the organization/group accepting the reassigned benefits.

27. Can I practice independently as an MFT/MHC but also be an owner of a group?

Yes. A provider can be enrolled as an individual practitioner and an owner of a group. The practitioner completes the CMS-855I application. The group completes the CMS-855B. Ownership information is reported in sections 5 and 6 of the CMS-855B.

28. My group is currently enrolled with a PTAN we use to bill for Licensed Clinical Social Worker (LCSW) services. Do we need a new PTAN to bill for MFTs/MHCs services as part of the group?

The group's PTAN will not change. The MAC will issue a PTAN to the individual practitioner that links them to your group once they have enrolled as an MFT/MHC.

29. Can I work for a rural health clinic and federally qualified health center and be paid by Medicare?

Services furnished by an MFT and MHC are covered when furnished in a rural health clinic and federally qualified health center.

30. Are MFT and MHC services excluded from consolidated billing requirements under the skilled nursing facility prospective payment system (SNF PPS)?

Section 4121(a)(4) of the CAA 2023, requires Medicare to exclude MFT and MHC services from SNF consolidated billing. Exclusion from consolidated billing allows these services to be billed separately by the performing clinician rather than being included in the Medicare Part A SNF payment. We finalized the regulatory text changes required to codify this new legislative requirement to exclude MFT and MHC services from SNF consolidated billing for services furnished on or after January 1, 2024, in the FY 2024 SNF PPS final rule (88 FR 53200).

31. Can MFTs and MHCs serve as members of the hospice interdisciplinary team?

Yes, the hospice interdisciplinary team is required to include at least one social worker, MFT or MHC.

32. Is Medicare enrollment mandatory?

Section 1848(g)(4)(A) of the Social Security Act requires that you submit claims for all your Medicare patients for services rendered. This requirement applies primarily to physicians, non-physician practitioners and suppliers who provide covered services to Medicare beneficiaries. To submit Medicare claims and receive payment for covered Medicare items or services, you must be enrolled under Medicare regulations.

For the mandatory claim submission requirements refer to

<https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SE0908.pdf>.

Telehealth

33. Can MFTs and MHCs perform telehealth services?

Yes. MFTs and MHCs have been added to the list of practitioners who can furnish Medicare telehealth services.

During the COVID-19 public health emergency (PHE), CMS used emergency waiver and other regulatory authorities so you could provide more services to your patients via telehealth. Section 4113 of the CAA, 2023 extended many of these flexibilities through December 31, 2024, and made some of them permanent. For more information refer to [Telehealth Services Fact Sheet](#).

34. How do I enroll to perform telehealth services to patients located in my home state or another state?

Practitioners who perform telehealth services should enroll based on their enrollment scenario. Refer to the scenarios below as a guide for completing the paper application. For faster and easier enrollment, providers are encouraged to submit their applications electronically through [PECOS](#).

a. Practitioner Only Renders Services in a Private Practice: The practitioner renders telehealth services from his/her home in Florida. The practitioner completes all applicable sections of the paper CMS-855I. In section 4B of the CMS-855I, enter the location where the telehealth service is performed (e.g., office, home). Select the practice location type as “Business Office for Administrative/Telehealth Use Only” or “Home Office for Administrative/Telehealth Use Only.” This option prevents the practitioner’s home address from being published on Care Compare, a tool for Medicare beneficiaries to find and compare different Medicare providers.

The practitioner submits the completed application to First Coast Services Options, the MAC that processes enrollment applications for Florida.

b. Practitioner reassigns all benefits to a group. Practitioner and group are in the same state: The practitioner reassigns benefits to a group in Maryland but will be rendering telehealth services from his/her home in Maryland. The practitioner completes all applicable sections of the CMS-855I. In section 4F of the CMS-855I, the practitioner lists the group accepting the new reassignment of benefits from the practitioner. If the group is already enrolled, no further action is needed. If the group is not enrolled, they will complete all applicable sections of the CMS-855B and list their office locations in section 4A. The practitioner does not list his/her home address on the CMS-855I or on the group’s CMS-855B application. The calendar year 2024 Physician Fee Schedule final rule allows physicians/practitioners who bill for Medicare telehealth services to report the place of service (POS) code that would have been reported had the service been furnished in person, through December 31, 2024.

The practitioner and group submit the CMS-855I and CMS-855B to Novitas Solutions, the MAC that processes enrollment applications for Maryland.

- c. Practitioner reassigns all benefits to a group. Practitioner and Group are in different states:** The practitioner reassigns benefits to a group in Maryland but will be rendering telehealth services from his/her home in Florida. The practitioner must enroll in the state where the group is located because they are submitting claims on behalf of the practitioner. The practitioner completes all applicable sections of the CMS-855I. In section 4F of the CMS-855I, the practitioner lists the group accepting the new reassignment of benefits from the practitioner. If the group is already enrolled, no further action is needed. If the group is not enrolled, they will complete all applicable sections of the CMS-855B and list their office locations in section 4A. The practitioner does not list his/her home address on the CMS-855I or on the group's CMS-855B application. The practitioner can continue to bill as if he/she furnished the service in person, through December 31, 2024.

The practitioner and group submit the CMS-855I and CMS-855B to Novitas Solutions, the MAC that processes enrollment applications for Maryland.

Supervision Requirements

35. Do I need two years of supervision prior to enrolling in Medicare?

Section 4121 of the CAA, 2023 requires MFTs and MHCs have 2 years of clinical supervised experience to enroll in Medicare.

36. What documentation should I submit to verify I meet the clinical supervision requirements?

Some states require the clinical supervised experience as a requirement to be fully licensed. In this case no additional action is necessary. The MAC will validate your license and clinical supervised experience during application processing.

If the clinical experience is not part of obtaining a license, the practitioner will need to submit documentation with their application confirming the 2-year requirement is met. Such documentation must include:

- A statement from the provider/supplier where the MFT/MHC performed the services (e.g., hospital, clinic) verifying that the MFT/MHC performed services at that setting for the required number of years. The statement must be:
 - On the provider's/supplier's letterhead (e-mail is not acceptable); and
 - Signed by: (1) the supervisor under whom the MFT/MHC performed the services; (2) an applicable department head (e.g., chief of psychology) of the provider/supplier; or (3) a current authorized or delegated official of the provider/supplier (i.e., the AO/DO

has already been approved as such in the provider/supplier's enrollment record if the provider/supplier is Medicare-enrolled).

- A statement verifying that the MFT/MHC meets the year or hour requirements from a:
(1) licensing or credentialing body for the state in which the MFT/MHC is enrolling; or
(2) national MFT/MHC credentialing organization. The statement can be signed by any official of the state licensing/credentialing or national credentialing body and must be on the body's letterhead (email is not acceptable).

Revalidation

37. What does it mean to revalidate?

You are required to revalidate—or renew—your enrollment record periodically to maintain Medicare billing privileges. In general, providers and suppliers revalidate every five years, but DMEPOS suppliers revalidate every three years. CMS also reserves the right to request off-cycle revalidations.

38. How are providers notified when it's time to revalidate?

You can search the [Medicare Revalidation List](#) to find your revalidation due date. CMS posts revalidation due dates seven months in advance.

Your MAC will also send a revalidation notice to you via email or U.S. postal mail about three to four months prior to your due date.

39. What happens if I don't revalidate on time?

Failing to revalidate on time could result in a hold on your Medicare reimbursement or deactivation of your Medicare billing privileges.

If your Medicare billing privileges are deactivated, you'll need to submit a complete Medicare enrollment application to reactivate your billing privileges. Medicare won't reimburse you for any services during the period that you were deactivated.

Opt-Out of Medicare

40. If I don't enroll, do I need to opt-out to continue to see Medicare beneficiaries?

Physicians and non-physician practitioners who see Medicare beneficiaries but do not want to enroll and submit claims to Medicare, are required to opt-out. Opting out means that you do not want to bill Medicare for your services, but instead want your Medicare patients to pay out-of-pocket. You enter private contracts with your Medicare patients where you agree that nobody will submit the bill to Medicare for reimbursement. To opt-out you must submit an opt-out

affidavit to your MAC. For more information refer to [Opt Out of Medicare](#).

Some Medicare Advantage (MA) plans and/or State Medicaid Agencies may require you to enroll in Medicare before enrolling in their programs. Opting out of Medicare could impact your participation in these programs. Refer to <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/opt-out-decision-matrix-%5BOctober-2015%5D.pdf> for the impacts of opting out.

Physicians and non-physician practitioners who will not see Medicare patients, are not required to enroll or opt-out of Medicare.

41. Is there a standard opt-out form?

A standard opt-out form is not available. However, some MACs have a template on their website that you can use. Find your designated MAC and their contact and mailing address at [MAC Contact Information](#).

42. How long does the opt-out period last?

The opt-out period lasts for 2 years. Your opt-out status will automatically renew every 2-years unless you terminate. To terminate your opt-out status, you must submit a written notice (no later than 30 days before the end of your current 2 year opt-out period) to your MAC indicating that you do not want to extend his opt-out status for a subsequent 2-year period. Otherwise, your opt-out will automatically renew for another 2-year period.

Physicians or practitioners who have not previously opted out may terminate their opt-out period early, but notification must be given to the MAC(s) no later than 90 days after the effective date of the initial 2-year opt-out period.

For more information on opting-out refer to [SE1311](#).