FOR LPCS, LLPCS, MFTS & MHCS · 2026 EDITION

The Medicare Billing Guide

A step-by-step guide to independently enrolling with and billing Medicare in Michigan: choosing your status, the five enrollment steps, codes, telehealth, claims and coordination of benefits.

Michigan Mental Health Counselors Association

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BEFORE YOU START

Counselors have been eligible Medicare providers since January 1, 2024.

Licensed Professional Counselors, Marriage and Family Therapists, and Mental Health Counselors can enroll and bill Medicare independently. Credentialing typically takes 60 to 90 days from a complete PECOS application, so begin before you need the revenue. Enrollment is not one decision but a choice among three arrangements with different financial and administrative consequences. Switching later is possible, and disruptive.

THE CRITICAL DECISION

Recommended for most Michigan practices

Participating (PAR)

You accept Medicare's approved amount as full payment and bill Medicare directly. The client owes only the 20% coinsurance and any Part B deductible. Claims are simplest, payment is predictable and direct, and you appear in the Medicare directory, which brings referrals.

More work, modest upside

Non-participating

You may charge above the approved amount within a limiting charge, and may bill the client directly. More administrative work, and the client carries more of the cost. Not the right fit if your Medicare caseload is small.

Private contracting only

Opt-Out

You leave Medicare entirely and contract privately with each Medicare beneficiary. Requires a valid private contract with every client and an opt-out affidavit, and lasts two years. Do not opt out if you see Medicare Advantage clients.

A note on sliding scale: enrolled providers may still offer sliding-scale or pro bono care, but not for Medicare-covered services billed to Medicare. If you are not enrolled and have not opted out, you cannot lawfully take cash from a Medicare beneficiary for a covered service.

THE ONE-SENTENCE VERSION

Most Michigan counselors in outpatient private practice should enroll as participating providers through PECOS, register with WPS (Michigan's Medicare contractor), and set up electronic claims before their first Medicare client, not after.

ENROLLMENT

Five steps, in order.

1 Obtain or confirm your NPI

- Apply free at nppes.cms.hhs.gov; new NPIs usually issue within days.
- Confirm your National Provider Identifier taxonomy reflects mental health counseling. A wrong taxonomy code is the single most common reason an application stalls.

2 Enroll with Medicare via PECOS

- pecos.cms.hhs.gov · complete Medicare enrollment as an individual practitioner (and for your group, if you have one; group claims carry the group's billing information in Box 33).
- Select your status here: participating, non-participating, or opt-out.
- Upload licenses and diplomas as requested. Processing typically runs 60 to 90 days.

3 Receive your PTAN and register with WPS

- After PECOS approval you receive a Provider Transaction Access Number.
- WPS Government Health Administrators is Michigan's Medicare Administrative Contractor (Jurisdiction 8). Register a provider portal account at wpsgha.com with your NPI and PTAN; enroll in EFT so payment arrives by direct deposit.

4 Complete CAQH credentialing

- Register or update your profile at proview.caqh.org and authorize access.
- Original Medicare does not use CAQH, but every Medicare Advantage plan credentials you separately, and nearly all of them pull from CAQH. Keep the profile current and re-attest quarterly.

5 Begin billing

- Verify each client's eligibility before the first session (next page).
- Submit claims electronically through your EHR or a clearinghouse; paper CMS-1500 remains possible but slower.
- Retroactive billing is allowed only back to your PECOS approval date, and only within 12 months of the date of service.

CODES

The five codes that carry a counseling practice.

CPT	SERVICE	TYPICAL DURATION	NOTES
90791	Psychiatric diagnostic evaluation	60–90 min	Initial intake with a new client, or again after a break in care. Medicare generally expects it before ongoing psychotherapy. Not a substitute for therapy codes.
90834	Individual psychotherapy	45 min	Mid-length sessions (38–52 minutes).
90837	Individual psychotherapy	60 min	Full-length sessions (53 minutes or more). If you bill it routinely, document start and stop times and the medical necessity of the longer session.
90847	Family psychotherapy, client present	50 min	Family or couples work with the identified client in the room.
90853	Group psychotherapy	60–90 min	Per client, per group session.

What Medicare pays

Counselor reimbursement is set at 75% of the psychologist rate. Dollar amounts change every January with the Physician Fee Schedule and vary by locality, so this guide does not print them. Look up the current Michigan non-facility amount for any code at **cms.gov/medicare/physician-fee-schedule/search** or through the WPS portal, and expect the client to owe 20% coinsurance after the Part B deductible.

Documentation that survives review

Every note should support the code billed: session length with start and stop times, symptoms and status, the intervention used, and the plan. Time-based codes fail audits on missing times more than anything else. Notes must be signed, dated and legible in the record you would produce on request.

Telehealth rules, updated.

Congress extended Medicare's telehealth flexibilities through **December 31, 2027**. For behavioral health specifically, the important rules are permanent, and they favor counseling practices.

Permanent, for behavioral health

- Clients may receive behavioral telehealth **at home**, anywhere in Michigan. No rural or facility requirement.
- **Audio-only** sessions are permanently allowed when video is not feasible for the client.

Through December 31, 2027

- The broader pandemic-era flexibilities remain in place.
- The in-person visit requirement for behavioral telehealth (within six months, then annually) is **waived through December 31, 2027**. Watch this date; it is the one most likely to matter later.

Billing a telehealth session

ELEMENT	HOW TO USE IT
Modifier 95	Real-time audio-video session. Append to each eligible CPT code: a 60-minute video session is 90837 + 95.
Modifier 93	Audio-only session, when video is not feasible. Document why.
Modifier GT	Legacy telehealth modifier. Some older platforms still require it; confirm with your clearinghouse. CMS has largely replaced it with 95.
Place of service	POS 10 for a client at home; POS 02 for telehealth elsewhere. Your billing platform should set this with the modifier.

Telehealth policy is the fastest-moving part of Medicare. Before relying on any date in this section, check the status dashboard at mmhcanow.org/regulatory-guides or telehealth.hhs.gov.

CLAIMS

Verify, submit, track.

Verify eligibility before every first session

- **WPS portal** (wpsgha.com): the official source for Part B eligibility by date of service, enrollment details, and secondary insurance on file.
- **Ask for every card**: the Medicare card, any Medicare Advantage card, a Medicaid card if dually eligible, and any Medigap or supplemental card. An Advantage plan replaces original Medicare and is billed as primary; original Medicare is not billed at all.
- Re-check eligibility periodically; plan changes each January are common.

Submit electronically

- Electronic claims through your EHR or a clearinghouse pay in roughly 14 to 21 days; paper takes far longer and rejects more.
- On the CMS-1500: your NPI in Box 24J, the billing entity in Box 33 (the group's information if you bill through a group), correct place-of-service, diagnosis pointers, and modifiers. Most rejections are field errors, not coverage decisions.

Track and get paid

- Enroll in **EFT** and electronic remittance (ERA) with WPS so payment and the explanation arrive without paper.
- Work denials weekly. Common, fixable causes: eligibility not checked, wrong primary payer, missing modifier, missing time documentation.
- Appeals have deadlines; a denied claim left alone becomes unrecoverable.

Who pays first, when a client has two coverages

CLIENT SITUATION	PRIMARY PAYER
Over 65 and retired	Medicare
Over 65, still working, employer coverage	Employer plan first, Medicare second
Under 65 on SSDI	Medicare
Dually eligible (Medicare + Medicaid)	Medicare first, Medicaid second
Medicare Advantage	The Advantage plan, which replaces Medicare

When you become a Medicare provider, tell every commercial payer you are paneled with, in writing, and ask for their coordination-of-benefits policy. Stale COB records at the commercial payer are a leading cause of wrongly rejected claims.

SPECIAL SITUATIONS

Worth knowing before they cost you.

Headway and national networks

Many national contracting platforms are not approved to bill Medicare. If you work through one, you must still enroll in Medicare independently to see Medicare clients lawfully, and you bill those clients under your own NPI, PTAN and billing setup, outside the platform.

Group practices

The group must be credentialed too, and claims must reflect the group's billing information in Box 33. An individually enrolled clinician in a non-enrolled group cannot route Medicare claims through the group.

Medicare Advantage

Advantage plans credential separately, plan by plan, usually through CAQH. Enrollment in original Medicare does not put you in any Advantage network.

Cash and non-enrollment

Unless you have formally opted out, you cannot accept cash from a Medicare beneficiary for a covered service. Enroll, or opt out; there is no lawful middle position.

BRING YOUR QUESTIONS

The monthly Medicare and Medicaid private practice Q&A is free and open to members.

Register at mmhcanow.org/member-news, or email MMHCABoard@MMHCAnow.org.

Helpful links

NPI application	nppes.cms.hhs.gov
PECOS enrollment	pecos.cms.hhs.gov
WPS GHA (Michigan MAC)	wpsgha.com
Physician Fee Schedule lookup	cms.gov/medicare/physician-fee-schedule/search
CAQH ProView	proview.caqh.org
CMS-1500 forms	nucc.org
Telehealth policy	telehealth.hhs.gov

About this guide. Published by the Michigan Mental Health Counselors Association, July 2026, updating the 2025 edition. This guide is educational information for licensed clinicians, not legal, tax or billing advice, and it does not establish a professional relationship. Medicare policy, rates and deadlines change; verify current requirements with CMS, WPS Government Health Administrators, and your own advisors before acting. Corrections and questions: MMHCABoard@MMHCAnow.org.