Quick Guide on Payments for Behavioral Health Integration Services: Federally Qualified Health Centers and Rural Health Clinics

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Medicare pays for services provided to patients receiving collaborative care services (CoCM) or other behavioral health integration (BHI) services. The payment structure may be used for patients with any behavioral health condition being addressed by the treating provider, including substance use disorders. Since their introduction in 2018 an increasing number of private payers and state Medicaid programs are recognizing and reimbursing for these codes. Check with your local payers to determine if reimbursement is offered.

The codes described below are for Federally Qualified Health Centers or Rural Health Clinics and are billed under the treating medical provider. For information on BHI codes for other practices; see https://aims.uw.edu/resource-library/cms-collaborative-care-payment-quick-guide.

Useful online resources describing the CMS Medicare codes include the following:

- *Fact Sheet*: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10175.pdf
- *FAQ*: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

G0511 – General Care Management Services: Minimum of 20 minutes per calendar month. G0511 may only be billed once per month per beneficiary and may not be billed if other care management services such as transitional care management or home health care supervision are billed for the same time period.

Service elements must include:

- Initial assessment or follow-up monitoring, including use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

G0512 – Psychiatric Collaborative Care Model services: Minimum of 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months. Minutes counted towards the time threshold are those of the behavioral health care manager only. The valuation of the codes includes the time of the psychiatric consultant and treating medical provider, who bill usual codes for any E/M or evaluation services. G0512 may only be billed once per month per beneficiary and may not be billed at the same time as G0511.

Service elements must include:

- Outreach and engagement of patients;
- Initial assessment, including administration of validated scales and resulting in a treatment plan;
- Entering patients into a registry for tracking patient follow-up and progress;
- Participation in weekly caseload review with psychiatric consultant and modifications to treatment, if recommended;
- Provision of brief interventions using evidence-based treatments such as behavioral activation, problem-solving treatment, and other focused treatment activities;
- Tracking patient follow-up and progress using validated rating scales;

- Ongoing collaboration and coordination with treating FQHC and RHC providers; and
- Relapse prevention planning and preparation for discharge from active treatment.

Initiating Visit, Consent and Co-Payments

All services billed under the two codes require a separately billable initiating visit (E/M, AWV, or IPPE) for new patients or for those who have not been seen within year prior to commencement of these services. The beneficiary must provide consent for the service, including permission to consult with a psychiatric consultant and relevant specialists. Advance consent must also include information on cost sharing for both face-to-face and non-face-to-face services, and acceptance of these requirements must be documented in the medical record.

Medicare Codes and Payments Summary 2021*

Code	Description	Payment
G0511	General Care Management Services - Minimum 20 min/month	$66.64
G0512	Psychiatric CoCM - Minimum 70 min initial month and 60 min subsequent months	$157.35

**Please note actual payment rates may vary. Check with your billing/finance department.*

Treating providers may bill only one code for an individual Medicare beneficiary in the same month.

Psychiatric CoCM Team and Qualifications

The psychiatric CoCM team in an RHC or FQHC must include, at a minimum, the treating provider, a behavioral health care manager, and a psychiatric consultant. Specific qualifications are as follows:

Treating (Billing) Provider

The RHC or FQHC treating provider may be a primary care physician, NP, PA, or Certified Nurse Midwife.

Behavioral Health Care Manager

The behavioral health care manager must have a minimum of a bachelor's degree in a behavioral health field such as in social work or psychology or be a clinician with behavioral health training, including nurses. The behavioral health care manager furnishes both face-to-face and non-face-to-face services under the general supervision of the treating provider. The behavioral health care manager need not be licensed to bill traditional psychotherapy codes.

Psychiatric Consultant

The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of psychotropic medications. The psychiatric consultant can work remotely, is not required to be on site or to have direct contact with the patient, and does not prescribe medications or furnish treatment directly to the beneficiary.

Provision of Psychotherapy in addition to Psychiatric CoCM

Behavioral health care managers that are qualified to bill traditional psychiatric evaluation and therapy codes for Medicare recipients are allowed to bill for additional psychiatric services in the same month as billing G0512. However, time spent on activities for services reported separately may not be included in the time applied to G0512.

The University of Washington AIMS Center provides information about billing for integrated behavioral health based on our understanding of the rules and regulations from CMS and AMA CPT coding manuals. However, the AIMS Center does not employ Certified Professional Coders and we do not provide direct patient services. Final decisions about billing fall to the compliance department of each practice which bears full responsibility for use of the codes. The AIMS Center shall not be responsible or liable for any claim or damages arising from use of the information provided.