Cheat Sheet on Medicare Payments for Behavioral Health Integration Services

Updated: February 7, 2018

Medicare pays for services provided to patients participating in a collaborative care program or receiving 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.

The codes described below are not billable by Federally Qualified Health Centers or Rural Health Clinics. For information on BHI codes for FQHC and RHC practices; see http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs.

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

- *Fact Sheet*: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
- *FAQ*: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf

The codes for the Collaborative Care Model (CoCM) are billed by the treating provider as “incident to” codes and incorporate the services of all three members of the collaborative care team: the treating provider, the behavioral health care manager, and the psychiatric consultant.

99492 (formerly G0502) – First 70 minutes in the first calendar month for behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating provider. Must include:

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

99493 (formerly G0503) – First 60 minutes in a subsequent month for behavioral health care manager activities. Must include:

- Tracking patient follow-up and progress;
- Participation in weekly caseload review with psychiatric consultant;
- Ongoing collaboration and coordination with treating providers;
- Ongoing review by psychiatric consultant and modifications based on recommendations;
- Provision of brief interventions using evidence based treatments;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning and preparation for discharge from active treatment.

99494 (formerly G0504) – Each additional 30 minutes in a calendar month of behavioral health care manager activities listed above.
Listed separately and used in conjunction with 99492 and 99493.

Payment for General Behavioral Health Integration Services
CMS provides a separate payment for behavioral health integration services that are delivered outside of the CoCM benefit. A behavioral health care manager with formal or specialized education is not required. CMS rules allow "clinical staff" to provide these services using the same definition as applied under the Chronic Care Management benefit.

99484 (formerly G0507) – Care management services for behavioral health conditions - At least 20 minutes of clinical staff time per calendar month. 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.

Medicare CPT Payment Summary 2018*

CPT	Description	**Payment/Pt (Non-Facilities)** Primary Care Settings	**Payment/Pt (Fac)** Hospitals and Facilities
99492	Initial psych care mgmt, 70 min/month - CoCM	$161.28	$90.36
99493	Subsequent psych care mgmt, 60 min/month - CoCM	$128.88	$81.72
99494	Initial/subsequent psych care mgmt, additional 30 min CoCM	$66.60	$43.56
99484	Care mgmt. services, min 20 min – General BHI Services	$48.60	$32.76

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

Initiating Visit, Consent, and Co-Payments
An initiating visit is required prior to billing for the 99492, 99493, 99494, and 99484 codes. This visit is required for new patients and for those who have not been seen within a year of commencement of integrated behavioral health services. This visit will include the treating provider establishing a relationship with the patient, assessing the patient prior to referral, and obtaining broad beneficiary consent to consult with specialists that can be verbally obtained but must be documented in the medical record. Medicare beneficiaries must pay any applicable Part B co-insurance for these billing codes.

Behavioral Health Care Manager Qualifications
The behavioral health care manager has formal education or specialized training in behavioral health, which could include a range of disciplines including social work, nursing, and psychology, but need not be licensed to bill traditional psychotherapy codes.

Provision of Psychotherapy and Psychiatric Services in Addition to Psychiatric CoCM
Behavioral health care managers qualified to bill traditional psychiatric evaluation and therapy codes for Medicare recipients may bill for additional psychiatric services in the same month. However, time spent on these activities for services reported separately may not be included in the services reported using time applied to 99492, 99493, 99494, or 99484. Similarly, psychiatric consultants working in the CoCM model may also furnish face-to-face services directly to the patient but may not bill for the same time using multiple codes.

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