# Cheat Sheet on CMS Medicare Payments for Behavioral Health Integration Services in Federally Qualified Health Centers and Rural Health Clinics

*Updated: November 14, 2017*

Beginning January 1, 2018, CMS will allow Federally Qualified Health Centers and Rural Health Clinics to bill for Behavioral Health Integration services (BHI), Chronic Care Management (CCM), and the Collaborative Care Model (CoCM) using two new codes. These rules appear in the 2018 Physician Fee Schedule; CMS guidance on the new codes can be found online on pages 515-551 of the Schedule: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-23953.pdf.

Useful online resources describing this Medicare benefit in 2017 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 can be billed for general behavioral health integration services (BHI) and Chronic Care Management (CCM) services that were previously billed using CPT codes 99490 or 99487.
Service elements must include:

- All elements of CCM services billed previously under CPT codes 99490 or 99487
  **OR**
- 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.

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.

**G0512 – Psychiatric Collaborative Care Model services: Minimum of 60 minutes per calendar month**
Service elements provided by the members of the CoCM team 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.

G0512 may only be billed once per month per beneficiary and may not be billed at the same time as G0511.

**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 one 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 2018**

| Code | Description | Payment |
|---|---|---|
| G0511 | General Care Management Services - Minimum 20 min/month | $62.28 |
| G0512 | Psychiatric CoCM - Minimum 60 min/month | $145.08 |

Both codes, G0511 and G0512, are intended to incorporate the services of all members of the care team as "incident-to" services of the treating provider. Treating providers may bill only one of the two codes for an individual Medicare beneficiary in the same month.

**Psychiatric CoCM Team**

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 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 is expected to 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 and Psychiatric Services 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. Similarly, the psychiatric consultant may also furnish face-to-face services directly to the patient but may not bill for the same time using multiple codes.