

Cheat Sheet on CMS Final Rule for 2017 Medicare Payments for Integrated Behavioral Health Services

Updated: November 23, 2016

The Centers for Medicare & Medicaid Services announced final rules for Medicare payments for services provided by primary care providers for patients participating in a collaborative care program or receiving other integrated behavioral health services. The payment structure may be used to treat patients with any behavioral health condition that is being treated by the billing practitioner, including substance use disorders.

Useful online references that describe the new Medicare benefit include the following:

- <https://www.psychiatry.org/news-room/apa-blogs/apa-blog/2016/11/cms-shows-strong-support-for-collaborative-care>
- <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-11-02.html>
- <https://www.federalregister.gov/documents/2016/11/15/2016-26668/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions#h-106> (See pages 61-74 of the PDF; or 80230 – 80243 in the print version of the document)

[The following information is summarized from the Federal Register Final Rule for Docket Number CMS-1654-F]:

Beginning in January 2017, the Medicare services listed below can be billed by the treating primary care provider (PCP) and are intended to incorporate the services of all members of the collaborative care team as incident-to services of the PCP. Payment amount for each of the services are summarized in the table on the following page.

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 primary care provider. Must include:

- Outreach and engagement of patients directed by a primary care provider;
- 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.

G0503 – first 60 minutes in a subsequent month of 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 PCP and any other 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.

G0504 – each additional 30 minutes in a calendar month of behavioral health care manager activities listed above.

- Listed separately and used in conjunction with G0502 and G0503.

The CMS final rule states that the behavioral health care manager should have academic and specialized training in behavioral health, but need not be licensed to bill traditional psychotherapy codes for Medicare.

Provision of Additional Psychiatric Services

Behavioral health care managers (BH CM) 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 by the BH CM on activities for services reported separately may not be included in the services reported using time applied to G0502, G0503, and G0504. In other words, the BH CM can furnish psychotherapy services in addition to collaborative care activities, but may not bill for the same time using multiple codes.

The psychiatric consultant may also furnish face-to-face services directly to the patient but, like the BH CM, the time may not be billed using multiple codes. This is much easier to define for the psychiatric consultant, given that they do not see the patient face-to-face in their collaborative care consulting role.

Payment for Other Models of Integrated Behavioral Health Services

Beginning in 2017, CMS will provide a separate payment for integrated behavioral health services that are delivered under other delivery models, such as the behavioral health consultation model or primary care behavioral health model:

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.

G0507 can only be reported by a treating primary care provider and cannot be independently billed. For G0507, a behavioral health care manager with formal or specialized education is not required. CMS rules allow “clinical staff” to provide G0507 services using the same definition of “clinical staff” as applied under the Chronic Care Management benefit.

HCPCS Medicare Payment Summary

HCPCS	Description	Payment/Pt (Non-Fac) Primary Care Settings	Payment/Pt (Fac) Hospitals and Facilities
G0502	Initial psych care mgmt, 70 min - CoCM	\$142.84	\$90.08
G0503	Subsequent psych care mgmt, 60 min - CoCM	\$126.33	\$81.11
G0504	Initial/subsequent psych care mgmt, additional 30 min CoCM	\$66.04	\$43.43
G0507	Care mgmt. services, min 20 min – Other models of care	\$47.73	\$32.30

Initiating Visit, Consent and Co-payments

CMS expects an *Initiating Visit* prior to billing for the G0502-0507 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 PCP 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 will require beneficiaries to pay any applicable Part B co-insurance for these billing codes.