About this document

This guide provides essential information for medical organizations, health care providers and finance teams in California on the accurate use of Behavioral Health Integration (BHI) codes for behavioral health integrated in primary care. It offers a detailed overview of how different models and codes are utilized in BHI, aiming to streamline the billing process and maximize reimbursement for integrated behavioral health services. The document includes codes specific to:

I. Primary Care Behavioral Health Codes
II. Collaborative Care Codes
III. General Screening and Care Coordination Integration Codes
IV. Screening, Brief Intervention and Referral to Treatment (SBIRT)

How to use this document

- Review with billing/finance team to identify codes that capture services rendered
- Adapt into educational/training materials for providers, care teams and billing/finance

Disclaimer

- The guidance provided in this document is general; specific coverage and frequency limits will vary based on insurer
- For coverage and frequency, refer to the insurers' resources for guidelines (links below may become inactive or updated):
  - Center for Medicare and Medicaid Services (CMS): Medicare Behavioral Health Integration Services and Medicare & Mental Health Coverage
  - California Medi-Cal: Website with All Provider Manuals
  - Please refer to commercial health plans and managed behavioral health organizations for their guidelines
- Please note that specific details regarding patient consent are outlined in your organization's policies, as well as in your insurer's manuals and regulations. Refer to these documents for information specific to your organization.

I. Primary Care Behavioral Health Codes

- Typically billed under the patient's Behavioral Health Benefit (Cost Sharing)
- These CPT codes will require Health and Behavior Diagnosis (ICD Code). The information about CPT and ICD-10 code pairings for the Primary Care Behavioral Health (PCBH) model is based on general billing practices and guidelines commonly used in health care. For more detailed and specific information, refer to resources like the American Medical Association (AMA) CPT codebook and the ICD-10-CM guidelines provided by the Centers for Medicare & Medicaid Services (CMS).
- This list is not exhaustive of the codes which can be used in integrated behavioral health; includes common codes used to bill integrated care services for the Primary Care Behavioral Health Model.

Codes		Service	Time	Service Description	Required Documentation	Billing Provider Types
Psychotherapy Codes	90791	Diagnostic Psychiatric Evaluation	16 – 90 minutes, typically 60-minutes	Diagnostic assessment, diagnostic clarification, or a biopsychosocial assessment identifying factors of mental illness, functional capacity and additional information used for the treatment of mental illness. Determination of a person's need for mental health services, based on the diagnosis. Often, Medicare and Medicaid plans allow 90791 to be billed once per patient per provider per year. There are other plans that will allow once per six months.	Diagnosis, rationale for the diagnosis and a written treatment plan in the Subjective, Objective, Assessment and Plan (SOAP) note supported by the assessment and interview data. Prior diagnostic assessment is not required to bill psychotherapy codes below. Supportive documentation requirements can vary significantly across insurers, which may not align well with the delivery of PCBH services. Given the inconsistent restrictions on the number of times these services can be billed, please refer to the insurer's manual for billing frequency and use.	1. Independently Licensed 2. Insurer Enrollment/Credentialing Psychologist (PsyD, PhD) Social Workers (LCSW) Marriage and Family Therapist (LMFT) (Medicare 2024) Counselor (LPC) (Medicare 2024)
	90832	Individual Psychotherapy	30 minutes (16-37 min)	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, face-to- face with the patient. Typically, 1-6 visits per presenting problem (90832).	Time spent with the patient, therapeutic communication, attempts to alleviate the emotional disturbances or change maladaptive patterns of behavior. PCBH documentation mirrors primary care SOAP note.	
	90834		45 minutes (38-52 min)			
	90837		60 minutes (≥53 min)			

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Codes		Service	Time	Service Description	Required Documentation	Billing Provider Types
Health & Behavior Codes Medical diagnoses are the primary reason for this intervention	96156	Health & Behavior Assessment	Not timed Event-based	Used when identifying the psychological, behavior, emotional, cognitive and social factors important to the prevention, treatment or management of physical health problems.	Onset and history of physical illness, rationale for assessment, assessment outcome, including mental status and ability to understand or respond meaningfully, and goals and expected duration of specific psychological intervention(s), if recommended. Limited to a maximum of two units per rolling 180 days, any provider.	1. Independently Licensed 2. Insurer Enrollment/Credentialing Psychologist (PsyD, PhD) Social Workers (LCSW) Marriage and Family Therapist (LMFT) (2024) Counselor (LPCC) (2024)
	96158	Individual Intervention	30 minutes (16-37 minutes)	Health behavior intervention, individual, face-to-face; initial.	Evidence indicates that the patient has the capacity to comprehend and respond meaningfully. A psychological intervention has been planned, outlining specific goals and expectations to enhance compliance with the medical treatment plan. The frequency and duration of the services are established, with an aim to improve overall outcomes. 1 unit per day – max 8 units per rolling 180 day, by any provider.	
	96159	Individual Intervention – extended time	15 minutes add-on to 96158 (38+ minutes with 96158)	Health behavior intervention, individual, face-to-face; each additional 15 minutes (list separately in addition to code for primary service)	Must be used with 96158 as an add-on code. 2 units per day -max of 14 units per rolling 180 days, by any provider	

Key: most frequent less frequent infrequent (New to Medicare 2024) CMS 2024 Physician Fee Schedule

II. Collaborative Care Model Codes

- Typically billed by Primary Care Treating Provider and covers services provided by all team members
- Billed under medical benefit (Cost Sharing)
- Typical episode of care 3-9 months
- Requires Primary Medical Provider, Behavioral Health Care Manager and Psychiatric Consultant
- Time is tracked cumulatively over the calendar month and codes are utilized based on the calendar month
- Coding can be location specific. Check with your insurers or organization's billing specialists

Collaborative Care Codes		Service	Time	Description	Required Documentation	Billing Provider Types
Psychiatric/ mental health diagnosis including substance use disorders that warrants behavioral health interventions	99492 FQ* – G0512	Collaborative Care (CoCM) initial month	70 minutes (36-85 min) FQ – 70 min	Initial psychiatric collaborative care management: Behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician. Monthly billing of care episodes is determined by time spent by care team. Continuity of care with a designated member of the care team.	Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan. Patients identified by scores on validated rating scales. Episode of care ends when patient meets goal tracked by validated ratings scales or referred to a higher level of care. Patients progress tracked by registry. Weekly review with psychiatric consultant with modifications of the plan if recommended.	Billing must be submitted under the primary care treating provider (see treating/billing provider list below). They must have an independent licensure and be enrolled and credentialed with insurers. Team of 3 (one from each category) **Treating/Billing Provider:** Physicians (MDs and DOs) Nurse Practitioners (NPs) Physician Assistants (PAs) **Behavioral Health Care Manager**
	99493 FQ –	Collaborative Care (CoCM)	60 minutes	Subsequent psychiatric collaborative care management.	Track patients and progress using registry.	

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Collaborative Care Codes		Service	Time	Description	Required Documentation	Billing Provider Types
	G0512	subsequent month	(31-75 min) FQ – 60 min	Continuity of care with members of the care team.	Weekly case consultations with psychiatric consultant. Provision of brief interventions. Monitoring of patient outcomes.	Mental Health Counselor (Masters-level/licensure candidate/trainee): Marriage and Family Therapist (MFT, AMFT, LMFT) Social Worker (MSW, AMSW, LCSW) Registered Nurse (RN, BSN recommended) Nurse Practitioner (NP) Psychologist (PhD, PsyD) **Psychiatric Consultant** Physicians (MDs and DOs) Nurse Practitioners (NPs) Physician Assistants (PAs)
	99494	Collaborative Care (CoCM) add- on	30 minutes	Additional time per month collaborative care management.	In conjunction with 99492 or 99493, an add-on code for each additional 30 minutes in a calendar month of behavioral health care manager activities.	
	G2214	CoCM – First or Subsequent Care Management Activities	30 minutes	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities.	Initial assessment or follow-up of the patient, including administration of validated rating scales, with the development of an individualized treatment plan. Weekly review with psychiatric consultant with modifications of the plan if recommended.	
	*Codes specific to Federally Qualified Health Centers (FQHCs) are described with FQ.					

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III. General Screening and Care Coordination Integration Codes

- These codes can be utilized in Behavioral Health Integration (not model specific)
- Billed by Primary Care Treating Provider, Licensed Clinical Behavioral Health Provider and trained ancillary personnel

Codes		Service	Time	Description	Required Documentation	Billing Provider Types
Care Coordination Codes	99484 FQ* - G0511**	General Behavioral Health Integration	20+ minutes	Care management services for behavioral health conditions. BHI is a monthly service based upon several core elements, including: • A systematic assessment • Continuous patient monitoring • Care plan creation and revision • Facilitation and coordination of behavioral health treatment • A continuous relationship with a designated care team member	Initial assessment/follow up of the patient, including administration of validated rating scales, coordination with care team.	Federally Qualified (FQ) requires: 1. Independently Licensed 2. Insurer Enrollment/ Credentialing Physicians (MDs and DOs) Nurse Practitioners (NPs) Physician Assistants (PAs) Certified Nurse Midwife (CNM)
	G0323 (2024)	General Behavioral Health Integration	(20 minutes /month) clinical staff time	Initial assessment/follow-up monitoring; use of applicable validated rating scales; behavioral health care planning; facilitating, coordinating and/or referral to treatment; and continuity	Administration of applicable validated rating scale(s): Systematic assessment and monitoring, using applicable validated clinical rating scales.	1. Independently Licensed 2. Insurer Enrollment/ Credentialing Psychologist (PsyD, PhD) Social Workers (LCSW) Marriage and Family

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Codes		Service	Time	Description	Required Documentation	Billing Provider Types
				of care with a designated member of the care team. Continuous relationship with a designated member of the care team.	Care planning by the primary care team jointly with the beneficiary, with care plan revision for patients whose condition is not improving. Facilitation and coordination of behavioral health treatment.	Therapist (LMFT) Counselor (LPCC)
Principal Illness Navigation (PIN) Codes	G0023	Principal Illness Navigation services	60 minutes /month	Primarily accepted by Medicare. Follow-up with other insurers for coverage. Initial monthly person-centered services performed to better understand and support individual context of the serious, high-risk condition.	Initial visit per calendar month and additional monthly add on for: • Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that are not billed separately) • Facilitating patient-driven goal setting and	Certified or trained* auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist. *Trained or certified in the competencies of patient and family communication, interpersonal and relationship-building, patient and family capacity building, service coordination and systems navigation, patient advocacy, facilitation, individual and community assessment, professionalism
	G0024	Principal Illness Navigation services Add-on	30 minutes/ month	Add on monthly person-centered services performed to better understand and support individual context of the serious, high-risk condition.		

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Codes		Service	Time	Description	Required Documentation	Billing Provider Types
	G0140	Principal Illness Navigation services	60 minutes /month	"Peer support" for patients with behavioral health conditions. Initial monthly person-centered services performed to better understand and support individual context of the serious, high-risk condition.	establishing an action plan • Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan • Assist the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors • Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as	and ethical conduct, and developed an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness, or disease being addressed.
	G0146	Principal Illness Navigation services Add-on	30 minutes /month	"Peer support" for patients with behavioral health conditions. Add on monthly person-centered services performed to better understand and support individual context of the serious, high-risk condition.		

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Codes		Service	Time	Description	Required Documentation	Billing Provider Types
					needed to address SDOH need(s)	
Depression/ Anxiety Screening Codes	96127	Brief Emotional/Behavioral Assessment	Not timed	All ages (pediatric to adult) Used for brief emotional and behavioral assessments, including screenings for depression, anxiety, ADHD, and other behavioral health conditions.	Can be billed for each individual screening conducted. For example, if both a PHQ-9 (for depression) and a GAD-7 (for anxiety) are administered during a visit, each can be billed separately under 96127. Can be billed up to four times per patient per visit.	1. Independently Licensed 2. Insurer Enrollment/Credentialing Physicians (MDs and DOs) Nurse Practitioners (NPs) Physician Assistants (PAs) Certified Nurse Midwife (CNM) Psychologist (PsyD, PhD) Social Workers (LCSW) Marriage and Family Therapist (LMFT) Counselor (LPCC) *Other qualified healthcare professionals who are authorized to perform and bill for brief emotional/behavioral assessments under state law and within their scope of practice.
	G0444	Annual Depression Screening	Not timed Event-	Ages 18 and up Medicare-specific code is for annual depression screenings	Reimbursable once per year for Medicare patients. Ensure proper documentation of the	Physicians (MDs and DOs), Nurse Practitioners (NPs), Physician Assistants (PAs) Licensed Clinical Social

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Codes		Service	Time	Description	Required Documentation	Billing Provider Types
			based	conducted in adults. Typically used during the Annual Wellness Visit (AWV).	screening to comply with Medicare requirements.	Workers (LCSWs), Clinical Psychologists, and other qualified healthcare professionals who are authorized to perform and bill for brief emotional /behavioral assessments under state law and within their scope of practice.
Administration of Patient-Focused Health Risk Assessment Instrument	96160	Administration of Patient-Focused Health Risk Assessment Instrument (e.g., Behavioral Assessments)	Not timed Event-based	All ages (pediatric to adult) Instrument-based assessments evaluate a patient's risk for specific health conditions and behaviors that may negatively impact their health. These assessments also weigh the pros and cons of initiating behavior changes. For example, the HEEADSSS interview is a comprehensive assessment tool that focuses on: • Home Environment • Education and Employment	Record the results from these assessments to ensure comprehensive evaluation and appropriate support for patient. Must ensure that the assessment is administered and scored using a standardized instrument, and the results are documented appropriately.	1. Independently Licensed 2. Insurer Enrollment/ Credentialing Physicians (MD, DO) Nurse Practitioner (NP) Physician Assistant (PA) Clinical Social Worker (LCSW) Clinical Psychologists (PsyD, PhD) Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselor (LPCC) These professionals must ensure that the assessment is administered and scored using a standardized

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Codes		Service	Time	Description	Required Documentation	Billing Provider Types
				• Eating • Peer-related Activities • Drugs • Sexuality • Suicide/Depression • Safety from Injury and Violence		instrument, and the results are documented appropriately.
Administration of Caregiver-Focused Health Risk Assessment	96161	Administration of Caregiver-Focused Health Risk Assessment Instrument (e.g., Postpartum Depression Screening)	Not Timed Event-based	Primarily for maternal population. Evaluate the caregiver's risk for health conditions that may impact their ability to care for the patient. Assessment Tools: • Safe Environment for Every Kid (SEEK) • Caregiver Strain Index (CSI) • Edinburgh Postnatal Depression Scale (EPDS)	Record the results from these assessments to ensure comprehensive evaluation and appropriate support for caregivers. Must ensure that the assessment is administered and scored using a standardized instrument, and the results are documented appropriately.	
Annual Alcohol Misuse Screening	G0442	Annual Alcohol Misuse Screening	15 minutes	Adults aged 18 and older (Medicare only) 1 time annually	Medicare-specific code for annual alcohol misuse screening. Reimbursable once per year during a Medicare Annual	1. Independently Licensed 2. Insurer Enrollment/ Credentialing Physicians (MD, DO) Nurse Practitioner (NP)

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Codes		Service	Time	Description	Required Documentation	Billing Provider Types
					Wellness Visit (AWV).	Physician Assistant (PA) Clinical Social Worker (LCSW) Clinical Psychologists (PsyD, PhD) Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselor (LPCC) Certified Nurse Midwife (CNM) & Certified Nurse Specialist (CNS) - Accepted by Medicare Only and some Medicaid plans
Brief Face-to-Face Behavioral Counseling for Alcohol Misuse	G0442	Brief Face-to-Face Behavioral Counseling for Alcohol Misuse	15 minutes	Adults aged 18 and older (Medicare only) Counseling session for alcohol misuse. Up to 4 times annually	Document the counseling session, including the time spent and the content of the counseling. Ensure the counseling follows the Five As approach: Assess, Advise, Agree, Assist, and Arrange.	
*Codes specific to Federally Qualified Health Centers (FQHCs) are described with FQ. **G0511 can be billed multiple times in one month for distinct services (i.e. BHI, CCM, RCM)						

IV. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Codes

- Billed by Primary Care Treating Provider, Licensed Clinical Behavioral Health Provider and trained ancillary personnel
- These codes are not specific to BHI models but can be utilized in BHI programs
- Refer to the SBIRT resources to better understand the use of coding for screening and brief intervention
- American Academy of Pediatrics provides a list of behavioral health screeners for primary care here

SBRIT Codes		Service	Time	Description	Required Documentation	Provider Types
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	99408 (Commercial) G0396 (Medicare)	Alcohol and/or substance abuse structured screening and brief intervention services	15 to 30 minutes	Adolescents and adults For structured screenings and brief interventions related to alcohol and/or substance abuse. Different CPT code for Medicare and Commercial. Different CPT codes for length of time.	Ensure that the assessment is administered and scored using a standardized instrument, and the results are documented appropriately evaluation and treatment of alcohol and/or substance abuse last 15-30 minutes.	1. Independently Licensed 2. Insurer Enrollment/ Credentialing Physicians (MD, DO) Nurse Practitioner (NP) Physician Assistant (PA) Clinical Social Worker (LCSW) Clinical Psychologists (PsyD, PhD) Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselor (LPCC) Certified Nurse Midwife (CNM) & Certified Nurse Specialist (CNS) - Accepted by Medicare Only and some Medicaid plans
	99409 (Commercial) G0397 (Medicare)	Alcohol and/or substance abuse structured screening and brief intervention services	> 30 minutes	Appropriate for longer SBIRT interventions in primary care.	Ensure that the assessment is administered and scored using a standardized instrument, and the results are documented appropriately evaluation and treatment of alcohol and/or substance abuse lasting more than 30 minutes.	
	H0049 (Medicaid)	Alcohol and/or drug screening	Not timed Event-based	Adolescents and adults (Medicaid only) For structured screenings and brief interventions related to alcohol and/or substance abuse.	Ensure that the assessment is administered and scored using a standardized instrument, and the results are documented appropriately evaluation and treatment of alcohol and/or substance abuse.	
	H0050 (Medicaid)	Alcohol and/or drug screening, brief intervention	Per 15 minutes			

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