



CENTER OF EXCELLENCE for Integrated Health Solutions

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INTEGRATED CARE FINANCING SERIES ■ ■ **MODULE 3**

2026 BIDIRECTIONAL CARE COORDINATION AND INTEGRATION BILLING CODE OPTIONS

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SECTION 1: INTRODUCTION

Use this document as a “cheat sheet” for 2026 billing codes that can support bidirectional care coordination and integration. It includes:

- Billing codes that support **primary care and other medical office providers** (e.g., obstetrician-gynecologists) to better coordinate and integrate behavioral health services, including mental health and substance use treatment.
- Billing codes that support **mental health and substance use treatment providers** to better coordinate and integrate physical health care services.

This document will support a wide range of audiences with financing and sustainability of bidirectional integrated care programs, including state agencies (e.g., Medicaid and behavioral health authorities), insurers (e.g., Medicaid managed care organizations), provider organizations and academic or research institutions.

It may be particularly useful in supporting grantees under the federal Promoting the Integration of Primary and Behavioral Health Care (PIPBHC) program.¹ The PIPBHC grant program is designed to: (1) promote full integration and collaboration in clinical practices between physical and behavioral health care, (2) support improvement of integrated care models for physical and behavioral health care to improve overall wellness and (3) promote implementation and improvement of bidirectional integrated care services.

Section 2 provides general tips for building sustainable, location-agnostic integrated care programs (i.e., programs that apply to both primary care and behavioral health settings).

Section 3 and 4 provide integrated care billing code recommendations tailored for physical health/primary care providers and behavioral health providers (i.e., mental health and substance use treatment providers), respectively. States, payers and their provider partners can use this information to ensure the billing landscape supports comprehensive integrated care. The billing codes in these sections are categorized based on the PIPBHC “Requirements for Integrated Care Program Domains.”²

SECTION 2: TIPS FOR BUILDING SUSTAINABLE INTEGRATED CARE PROGRAMS

States, payers and providers should consider the following tips for building sustainable, location-agnostic integrated care programs:

- **Maximize new Medicare billing opportunities for integrated care.** Each year, the Centers for Medicare and Medicaid Services (CMS) publishes the Medicare Physician Fee Schedule final rule. It updates payment policies and payment rates for services provided by physicians and other qualified practitioners, including nonphysician practitioners (NPPs), under Medicare Part B. In recent years, CMS has expanded the types of providers that are eligible to bill for Medicare Part B services to include mental health counselors and marriage and family therapists, and has added new billing codes to support care navigation and integration (see Community Health Integration and Principal Illness Navigation billing codes in Sections 3 and 4). Other payers often adopt Medicare payment policies and services over time.

¹ Substance Abuse and Mental Health Services Administration. (2023). *FY 2025 promoting integration of primary and behavioral health care: States — Notice of funding opportunity*. <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-2024-pipbhc-states-sm-24-003.pdf>

² Ibid., see Appendix A.

- **Leverage auxiliary staff.** Auxiliary staff work under the supervision of a physician or NPP to perform or assist in service delivery, but do not independently bill for services. The types of staff that can be considered auxiliary vary by state and payer, but may include nurses, medical assistants, community health workers and certified peer specialists. In general, auxiliary staff may perform certain care management and care coordination services such as patient outreach, engagement and education; appointment scheduling and referrals; collection and documentation of patient-reported information; and monitoring care plan adherence and care gaps. In contrast, activities that typically require a licensed provider include care plan development; clinical assessment, diagnosis, and medical decision-making; and prescribing or ordering diagnostic tests. Many of the care coordination and care management billing codes listed in Sections 3 and 4 work best and most efficiently when services are rendered by auxiliary staff.
- **Increase points of access to care.** States, payers and providers should ensure that care is as easy to provide and receive as possible, including by allowing payment for mobile clinics, telehealth and home-based services. New financing opportunities for integrated care also include billing codes for digital mental health treatment and remote patient monitoring. Payers can also ensure that they fully reimburse services provided using the street medicine place-of-service code (27) as appropriate.
- **Consider using relevant billing codes to support historically unbillable services.** Billing codes have expanded in recent years to cover a wider range of staff types and services — including activities that aren't conducted with the patient present, such as maintaining patient registries and coordinating care with other providers. It's worth considering how billing codes listed in Sections 3 and 4 can support evidence-based care delivery approaches. For example, states and providers can use screening codes to support measurement-based care³ and support the use of billing codes for person-centered care delivery and robust care coordination in support of trauma-informed care.
- **Promote a comprehensive array of care coordination and care integration billing codes.** States and their provider partners can work with local payers to make a robust set of codes available to support care integration. Additionally, states and payers can routinely develop localized tip sheets with practical guidance on how to implement new billing codes.
- **Assess feasibility of implementation.** States should work with provider partners to cross-reference available provider staff and operational resources with available billing codes to assess the feasibility. This includes reviewing whether providers have sufficient care management staffing, the ability to document time-based services, and electronic health record (EHR) systems capable of tracking required elements such as registries or clinical workflows. For example, interprofessional consultation and general behavioral health integration service codes may be a more feasible implementation option than the Collaborative Care Model (CoCM) if contracting with a psychiatric consultant or supporting registry-based care is not operationally feasible.
- **Assess progress using a standardized integration framework.** States and providers should aim to leverage standardized integration frameworks to monitor and track progress toward integrated care such as the Six Levels of Collaboration/Integration⁴, the Comprehensive Health Integration (CHI) Framework⁵ or the PIPBHC integrated care program domains.⁶ (Note: The PIPBHC integrated care program domains generally follow those outlined in the CHI Framework.) In practice, these frameworks can be used to support internal self-assessment, quality improvement activities, and structure reporting on integration maturity over time.

³ See additional details on financing measurement-based care in community-based behavioral health settings at <https://library.samhsa.gov/sites/default/files/cfri-financing-measurement-based-care-pep24-01-007.pdf>

⁴ Center for Integrated Health Solutions. (2020). *Six levels of collaboration/integration*. https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?dof=375ateTbd56

⁵ National Council for Mental Wellbeing. (2025). *The comprehensive health integration framework*. <https://www.thenationalcouncil.org/resources/the-comprehensive-health-integration-framework/>

⁶ Substance Abuse and Mental Health Services Administration. (2023). *Promoting the integration of primary and behavioral health care: States — Notice of funding opportunity (SM-24-003)*. <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-2024-pipbhc-states-sm-24-003.pdf>

IMPORTANT DETAILS REGARDING SECTIONS 3 AND 4

- Section 3 contains tables with billing codes that could be considered for physical health or primary care providers coordinating or integrating behavioral health care.
- Section 4 contains tables with billing codes that could be considered for behavioral health providers coordinating or integrating physical health care.
- Billing code availability may vary by payer. Billing codes newly introduced by Medicare are flagged as “primarily Medicare” billing codes.
- The tables in Sections 3 and 4 provide average Medicare 2025 payment rates in cases where rate information was available.⁷
- Medicare payment rates can provide a proxy for commercial rates (39% more than Medicare, on average⁸) and Medicaid rates (see KFF Medicaid-to-Medicare Fee Index⁹).
- Eligible providers are categorized in four groups: (1) physicians, (2) NPPs,¹⁰ (3) licensed mental health (MH) practitioners,¹¹ (4) auxiliary staff.¹²
- State rules and regulations can vary greatly. Confirm staffing requirements with state Medicaid agencies, managed care plans, and/or Medicare contractors.
- Time requirements are provided. A unit of time is typically rounded up when the midpoint is passed (e.g., a full hour is reached when 31 minutes have elapsed).
- Add-on codes (i.e., services performed only in tandem with a primary procedure) are denoted by a “+” preceding the billing code (e.g., +99494).
- Billing codes that apply to both physical health and behavioral health settings (e.g., tobacco cessation) are listed in both Section 3 and Section 4.
- To keep the tables as short as possible, abbreviations are used in select cases (e.g., for frequently used screening tools). Section 5 contains the complete list of abbreviations, along with additional resources.

Disclaimer: Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association (AMA). CPT codes, descriptions and other data are copyright 2026. This document is not meant to be a comprehensive guide for implementing billing codes. It does not cover important details such as billing limitations, documentation requirements, modifier usage or specific availability across different states or regions. For more details on billing codes, refer to the appropriate CPT or Healthcare Common Procedure Coding System (HCPCS) manual and contact local payers. The National Council for Mental Wellbeing’s Decision Support Tool: Integrated Care Revenue Estimator¹³ also provides information about the billing codes listed in this document, including average Medicare, Medicaid and commercial payment rates for calendar year 2026 and revenue estimates for select integrated care models.

⁷ The Medicare rates are derived from the National Council for Mental Wellbeing’s Decision Support Tool: Integrated Care Revenue Estimator, available at <https://www.thenationalcouncil.org/resources/financing-the-future-of-integrated-care/>. These rates may vary slightly from other published Medicare rates.

⁸ Marshall, S., Zhou, D., Anderson, C., & Mills, C. (2024, June 19). Commercial reimbursement benchmarking: Commercial payment rates for medical services as percentage of Medicare fee-for-service rates. Milliman. <https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking-medicare-ffs-rates>.

⁹ KFF. (n.d.). Medicaid-to-Medicare fee index. Retrieved September 17, 2025, from <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

¹⁰ NPPs include certain nonphysician practitioners who can diagnose and treat illnesses, prescribe medications, and manage patient care, such as nurse practitioners, physician assistants, certified nurse midwives and clinical nurse specialists.

¹¹ Licensed mental health practitioners include psychiatrists, clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors.

¹² Auxiliary staff, such as nurses, medical assistants and community health workers, work under the supervision of a physician or NPP to perform or assist in service delivery, but do not bill independently for services.

¹³ National Council for Mental Wellbeing. (2025). *Financing the future of integrated care: Decision support tool*. <https://www.thenationalcouncil.org/resources/financing-the-future-of-integrated-care/>

SECTION 3: FOR PHYSICAL HEALTH/PRIMARY CARE PROVIDERS COORDINATING AND INTEGRATING BEHAVIORAL HEALTH SERVICES

The billing codes in this section apply to various types of integrated care models within physical health settings. They include billing codes to screen for behavioral health conditions and social needs, conduct brief interventions and provide care management, and psychotherapy codes for co-located models (physical health providers that hire licensed mental health practitioners). Select codes listed in this section may enable or require a physical health provider to contract with an external specialist (e.g., a consulting psychiatrist for the CoCM) or organizations (e.g., a community-based organization for CHI (Comprehensive Health Integration)), which may add complexity to implementation.

Copays and cost-sharing may apply, including for care management services that are conducted without the patient present. It is vital to document patient consent, partly to avoid surprise billing for such services. Additionally, providers collecting and sharing information related to substance use as part of interprofessional consultation services must follow all state and federal privacy laws regarding the exchange of patient information.

Effective in 2025, federally qualified health centers (FQHCs) and rural health clinics (RHCs) can bill many of the same CTP/HCPCS (Healthcare Common Procedure Coding System) codes listed in Section 3, due to the unbundling of G0511 (comprehensive care management for FQHCs and RHCs). Effective January 1, 2026, FQHCs and RHCs providing CoCM services may no longer bill G0512 (psychiatric CoCM); instead, FQHCs and RHCs should bill the CTP/HCPCS codes listed in Section 3 (see “Psychiatric CoCM and general care management for behavioral health” section). Providers should collaborate with local payers to confirm billing guidance, including availability of billing codes and the types of eligible providers that can bill for and render services.

Effective January 1, 2026, CMS allows providers furnishing Advanced Primary Care Management (APCM) services, including FQHCs and RHCs, to bill new optional add-on codes for Behavioral Health Integration (BHI) and CoCM using HCPCS codes G0568, G0569, and G0570. These add-on codes support reimbursement for integrated behavioral health and collaborative psychiatric care services provided as part of APCM and are paid at the national non-facility rate.¹⁴

Access, screening, referral to care and follow-up

Screening

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99202-99205	E/M (Evaluation and Management) services for new patients	Used to support integrated care by allowing clinicians to screen for behavioral health needs, initiate referrals, and coordinate follow-up as needed	Varies by CPT code; based on time or complexity	\$80.24-\$256.33	Billing: Physicians, NPPs. Rendering: N/A

¹⁴ Centers for Medicare & Medicaid Services. (2025). Medicare program; CY 2026 payment policies under the physician fee schedule and other changes to Part B payment and coverage policies (CMS-1832-F). U.S. Department of Health and Human Services. <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notice/cms-1832-f>

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99212-99215	E/M services for established patients	Used to support integrated care by allowing clinicians to screen for behavioral health needs, initiate referrals, and coordinate follow-up as needed	Varies by CPT code; based on time or complexity	\$63.07-\$209.08	Billing: Physicians, NPPs. Rendering: N/A
96127¹⁵	Developmental/behavioral screening and testing	Screening for depression (PHQ-9, PHQ-2), anxiety (GAD-7), attention-deficit/hyperactivity disorder (ADHD), with scoring and documentation	Not time-based; per instrument	\$4.68	Billing: Physicians, NPPs Rendering: Auxiliary Staff
G0136 (primarily Medicare)	Administration of standardized nutrition and physical activity screening tool	Furnished in conjunction with an E/M visit, which can include hospital discharge or transitional care management services	5-15 minutes once every six months	\$20.87	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff
96160	Health risk assessment instrument	Used to assess general health risks, including diet/activity and social needs (e.g., PRAPARE, AHC-HRSN)	N/A	\$2.89	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff
96161	Caregiver health risk assessment instrument	Used to assess parent/caregiver health risks for the benefit of patient care (e.g., ACES questionnaire, parent stress index, postnatal depression scale)	N/A	\$3.22	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff

¹⁵ Medicare uses G0444 for depression screening (“Annual Depression Screening, 15 minutes”).

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99408 ¹⁶	Alcohol and/or substance misuse assessment and intervention	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST) and brief intervention — 15-30 minutes (i.e., Screening, Brief Intervention, and Referral to Treatment (SBIRT))	15-30 minutes	\$41.06	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff
99409 ¹⁷	Alcohol and/or substance misuse assessment and intervention	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST) and brief intervention — 30 or more minutes (i.e., SBIRT)	30+ minutes	\$76.41	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff

Care access, referrals and follow-up

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0560 (primarily Medicare)	Safety planning interventions	Comprehensive risk assessment and development of safety plan for individuals experiencing a mental health or substance use crisis	20-minute units	\$51.15	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff

¹⁶ Medicare uses G0396 to cover this service; certain Medicaid programs may use H0049 and/or H0050.

¹⁷ Medicare uses G0397 to cover this service.

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0544 (primarily Medicare)	Post-discharge telephonic follow-up	Follow-up phone calls made after discharge ¹⁸ from a crisis-related encounter for a mental health or substance use condition.	Monthly bundle — 4 calls, 10-20 minutes each	\$72.69	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff
G3002	Chronic pain management and treatment	Includes diagnosis, assessment, care planning, medication review and care coordination, including integrative providers (e.g., yoga, mindfulness)	Monthly bundle, first 30 minutes	\$95.13	Billing: Physicians, NPPs Rendering: N/A
+G3003	Chronic pain management services, each additional 15 minutes	Used when services exceed 30 minutes in a month; must be billed with G3002 and reflect full 15-minute increments of personally delivered care	Each additional 15 minutes	\$34.62	Billing: Physicians, NPPs Rendering: N/A
99495	Transitional care management services, moderate medical decision making	Provide monthly management of patient care and follow-up during transition to home care or after discharge, moderate level of decision making	Within 14 days of discharge	\$235.77	Billing: Physicians, NPPs Rendering: Auxiliary Staff
99496	Transitional care management services, high medical decision making	Provide monthly care management during transition requiring high level of medical decision making	Within 7 days of discharge	\$320.28	Billing: Physicians, NPPs Rendering: Auxiliary Staff

¹⁸ Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments, 89 F.R. 97710 (proposed 2024) (to be codified at 42 C.F.R. § 401, 405, 410, 411, 414, 423, 424, 425, 427, 428, and 491). <https://www.govinfo.gov/content/pkg/FR-2024-12-09/pdf/2024-25382.pdf> (see page 97,922)

Evidence-supported prevention and intervention

Prevention

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0402	Welcome to Medicare visit	Includes medical and social history, risk factor assessment, functional ability, depression screening, end-of-life planning (if agreed)	In first 12 months of Medicare Part B coverage	\$160.76	Billing: Physicians, NPPs Rendering: Health Educators, Registered Dietitians
G0438 (primarily Medicare)	Initial annual wellness visit	Includes health risk assessment, review/update of medical and family history, medication list, screening schedule, cognitive assessment, referrals	N/A — may only be billed once per patient	\$190.30	Billing: Physicians, NPPs Rendering: N/A
G0439 (primarily Medicare)	Subsequent annual wellness visit	Subsequent annual wellness visits (used every year after initial annual wellness visit is completed)	N/A — may only be billed once per year	\$148.99	Billing: Physicians, NPPs Rendering: N/A
99381-99397¹⁹	Preventive medicine	May include annual behavioral health wellness checks	N/A — CPT codes vary by age	N/A	Billing: Physicians, NPPs Rendering: N/A

¹⁹ Part B Medicare does not cover the preventive medicine CPT codes, and instead uses G0402, G0438, G0439. Select state Medicaid programs may use the preventive medicine CPT codes to cover annual behavioral health wellness checks.

Psychiatric CoCM²⁰ and general care management for behavioral health

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99492	Initial psychiatric CoCM	Includes patient engagement, initial assessment, treatment plan, psychiatric consultant review, patient registry, monitoring and brief interventions	First 70 minutes	\$170.31	Billing: Physicians, NPPs Rendering: Auxiliary Staff, Psychiatric Consultants
99493	Subsequent psychiatric CoCM	Includes caseload review, coordination with treating provider and psychiatric consultant, brief interventions, relapse prevention planning	First 60 minutes in a subsequent month	\$157.17	Billing: Physicians, NPPs Rendering: Auxiliary Staff, Psychiatric Consultants
+99494	Subsequent psychiatric CoCM	Add-on code to 99492 and 99493	Additional 30 minutes each month	\$66.15	Billing: Physicians, NPPs Rendering: Auxiliary Staff, Psychiatric Consultants
G2214	Initial or subsequent psychiatric CoCM	Allows billing when the full 70-minute threshold of CPT 99492 or the full 60-minute threshold of CPT 99493 is not met	First 30 minutes per month	\$65.03	Billing: Physicians, NPP Rendering: Auxiliary Staff, Psychiatric Consultants
99484	General care management for behavioral health	Includes initial assessment, behavioral health care planning, brief interventions and coordinating with mental health and substance use care providers	20+ minutes per month	\$63.36	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff

²⁰ The psychiatric CoCM can generally be used to treat mild-to-moderate mental health or substance use disorders.

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0323	General care management for behavioral health, licensed social worker or psychologist	Includes initial assessment, behavioral health care planning, brief interventions and coordinating with mental health and substance use care providers	20+ minutes per month	\$63.97	Billing: Licensed Independent Social Workers; Clinical Psychologists

Addressing substance use in primary care/physical health care settings

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G2086 (primarily Medicare)	Office-based treatment for opioid use disorder bundle	Includes development of treatment plan, care coordination, individual therapy, group therapy and counseling. First calendar month of treatment.	70+ minutes (initial month)	\$544.20	Billing: Physicians, NPPs Rendering: Licensed MH Practitioners
G2087 (primarily Medicare)	Office-based treatment for opioid use disorder bundle	Includes care coordination, individual therapy, group therapy and counseling.	60+ minutes (subsequent months)	\$497.29	Billing: Physicians, NPPs Rendering: Licensed MH Practitioners
+G2088 (primarily Medicare)	Office-based treatment for opioid use disorder bundle	Includes care coordination, individual therapy, group therapy and counseling	Each additional 30 minutes	\$65.66	Billing: Physicians, NPPs Rendering: Licensed MH Practitioners

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99406	Tobacco cessation counseling; intermediate	Used when a provider spends three to 10 minutes counseling a patient on quitting tobacco, including discussing risks, triggers and cessation strategies	3-10 minutes	\$16.81	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: N/A
99407	Tobacco cessation counseling; intensive	Used when a provider spends more than 10 minutes counseling a patient on quitting tobacco, often including discussion of pharmacologic options	11+ minutes	\$32.20	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: N/A
80305	Drug tests, presumptive (e.g., urine drug screening)	Used to help monitor medication adherence for prescribed medications and use of illicit substances	N/A	\$12.60	CLIA waived provider

Note: Primary care and physical health providers may also support substance use treatment through standard E/M codes (99213-99215), as well as the CoCM and general behavioral health integration codes listed in this table.

Health behavior assessment and intervention

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
96156	Health behavior assessment or reassessment	Used to assess how psychological or behavioral factors affect a medical condition via interview of psychological history, lifestyle and health behaviors	30-60 minutes	\$126.27	Billing: Licensed MH Practitioners Rendering: N/A

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
96158	Health behavior intervention, individual	Behavioral interventions to better manage patient's physical health conditions (e.g., diabetes, chronic pain, hypertension)	First 30 minutes	\$86.84	Billing: Licensed MH Practitioners Rendering: N/A
+96159	Health behavior intervention, individual	Behavioral interventions to better manage patient's physical health conditions (e.g., diabetes, chronic pain, hypertension)	Each additional 15 minutes	\$29.91	Billing: Licensed MH Practitioners Rendering: N/A
96164	Health behavior intervention, group	Group interventions targeting health-related behaviors, such as smoking cessation, stress management, obesity and weight management	Initial 30 minutes	\$13.42	Billing: Licensed MH Practitioners Rendering: N/A

Psychotherapy

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
90791	Psychiatric diagnostic evaluation (no medical services)	Initial diagnostic evaluation of a patient's mental health — includes history, mental status exam and treatment recommendations	16-90 minutes	\$203.42	Billing: Licensed MH Practitioners Rendering: N/A
90792	Psychiatric diagnostic evaluation (with medical services)	Similar to 90791, but includes medical services such as ordering labs, prescription medications or adjusting prescriptions	Typically 60-120 minutes	\$231.98	Billing: Physicians, NPPs Rendering: N/A
90832	Psychotherapy, individual, 30 minutes	Brief psychotherapy session (e.g., cognitive behavioral strategies for stress eating)	30 minutes	\$101.10	Billing: Licensed MH Practitioners Rendering: N/A

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
90834	Psychotherapy, individual, 45 minutes	Standard psychotherapy session (e.g., relaxation techniques for generalized anxiety disorder)	45 minutes	\$133.91	Billing: Licensed MH Practitioners Rendering: N/A
90837	Psychotherapy, individual, 60 minutes	Extended psychotherapy session (e.g., trauma-focused cognitive behavioral therapy for Post-Traumatic Stress Disorder (PTSD))	60 minutes	\$196.74	Billing: Licensed MH Practitioners Rendering: N/A
90853	Psychotherapy, group (non-family)	Group psychotherapy focused on co-occurring primary care and behavioral health conditions (e.g., depression/anxiety with diabetes and hypertension)	Typically 45-60 minutes	\$35.54	Billing: Licensed MH Practitioners Rendering: N/A

Digital mental health treatment (DMHT)

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0552	Supply DMHT device and initial education and onboarding, per course of treatment	Used when a provider supplies an FDA-approved DMHT device (e.g., apps for managing anxiety, depression or substance use) and educates the patient on its use as part of a behavioral therapy plan	Per course of treatment	Contractor priced	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: N/A

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0553	First 20 minutes of monthly treatment management services for DMHT device	Used for the first 20 minutes of monthly provider time reviewing patient data from the FDA-approved DMHT device, including at least one interactive communication	First 20 minutes per month	\$57.59	Billing: Physicians, NPPs Rendering: N/A
G0554	Each additional 20 minutes of monthly treatment management services for DMHT device	Used for each additional 20 minutes of monthly provider time reviewing data from the FDA- approved DMHT device, with at least one interactive communication	Additional 20-minute increments	\$45.29	Billing: Physicians, NPPs Rendering: N/A

Multidisciplinary team

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99446-99449	Interprofessional telephone, internet, EHR consult; includes verbal and written report	Used when a consulting provider (e.g., addiction specialist) spends at least five minutes discussing a patient's case with the treating provider (e.g., primary care provider)	5-31+ minutes (CPT code selection based on time)	\$25.11-\$85.0	Billing: Physicians, NPPs; Licensed MH Practitioners bill for G0546-G0549 Rendering: N/A

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99451	Interprofessional consult with written report only (no verbal discussion)	Used when a consulting provider spends five or more minutes reviewing data and providing a written report to the treating provider	5+ minutes	\$40.08	Billing: Physicians, NPPs; Licensed MH Practitioners bill G0550 for Medicare Rendering: N/A
99452	Interprofessional referral service by the treating/ requesting provider	Used when treating provider (e.g., primary care provider) spends 30 minutes or less preparing for and participating in consultation with a specialist	16-30 minutes	\$41.69	Billing: Physicians, NPPs; Licensed MH Practitioners bill G0551 for Medicare Rendering: N/A
99211	Office visit for an established patient that may not require a physician (e.g., nurse visit)	Used for low-complexity services like vitals check, medication refill or patient education by a nurse or other qualified auxiliary staff	Typically 5-10 minutes; no strict time requirement	\$25.05	Billing: Physicians, NPPs Rendering: Auxiliary Staff

Note: Assess local coverage policies to determine whether other auxiliary staff, such as certified peer specialists, community health workers and doulas, may be billable in primary care or physical health settings.

Person-centered self-management support

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99497	Advance care planning	Discuss patient's health care wishes, medical treatment preferences and establish an end-of-life plan; includes psychiatric advance directives	First 16-30 minutes	\$96.69	Billing: Physicians, NPPs Rendering: N/A

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
+99498	Advance care planning, add-on code	Each additional 30 minutes of care planning, including psychiatric advance directives	Each additional 30 minutes	\$87.37	Billing: Physicians, NPPs Rendering: N/A
G0023	PIN services	Patient navigation, care coordination, education and support for patients with serious or high-risk conditions; typically rendered by auxiliary staff	60 minutes per calendar month	\$92.48	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff ²¹
+G0024	PIN services, each additional 30 minutes	Used to continue care coordination for patients with serious conditions (e.g., chronic pain, cancer, SUD); typically rendered by auxiliary staff	30 minutes (add-on to G0023)	\$58.39	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff ²²

²¹ Peer specialists can also provide PIN services under G0140.

²² Peer specialists can also provide additional PIN services under G0146.

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0539 (primarily Medicare)	Caregiver training in behavior management (initial 30 minutes, without patient present)	Teaching caregivers stress management, de-escalation, signs of worsening symptoms	Initial 30 minutes	\$60.57	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: N/A
+G0540 (primarily Medicare)	Caregiver training in behavior management, add-on code	Add-on to G0539 for extended caregiver instruction	Each additional 15 minutes	\$30.26	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: N/A
G0543 (primarily Medicare)	Group caregiver training (without patient present)	Group sessions for multiple caregivers on direct care techniques (e.g., wound care, meal preparation, medication administration)	Varies by session	\$23.28	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: N/A
+G2211	Visit complexity for relationship development (E/M code add-on)	Designed to recognize complexity and resource costs of longitudinal, relationship-based care.	N/A	\$19.60	Billing: Physicians, NPPs Rendering: N/A

Linkages with Community and Social Services

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0019	CHI, first 60 minutes	Addressing non-medical factors that can impact health (e.g., housing, food insecurity) via auxiliary staff under supervision	60 minutes per month	\$91.52	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff
+G0022	CHI services, each additional 30 minutes	Add-on to G0019 for extended CHI services	30 minutes (add-on)	\$58.07	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff

Ongoing Care Coordination and Care Management

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0556 (primarily Medicare)	APCM for patients with one chronic condition	Monthly care coordination for low-complexity patients, including care transitions, medication management, appointment scheduling and addressing social needs	Monthly (not time-based)	\$17.87	Billing: Physicians, NPPs Rendering: Auxiliary Staff
G0557 (primarily Medicare)	APCM for patients with two or more chronic conditions	Monthly care coordination for moderate-complexity patients	Monthly (not time-based)	\$58.42	Billing: Physicians, NPPs Rendering: Auxiliary Staff

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0558 (primarily Medicare)	APCM for Qualified Medicare Beneficiaries with complex needs	Highest complexity level for APCM services for Qualified Medicare Beneficiaries with two or more chronic conditions	Monthly (not time-based)	\$127.13	Billing: Physicians, NPPs Rendering: Auxiliary Staff
G0568 (primarily Medicare)	APCM add-on, initial month of CoCM	Includes patient engagement, initial assessment, treatment plan, psychiatric consultant review, patient registry, monitoring and brief interventions	Monthly (not time-based)	\$171.46	Billing: Physicians, NPPs Rendering: Auxiliary Staff, Psychiatric Consultants
G0569 (primarily Medicare)	APCM add-on, subsequent month of CoCM	Includes caseload review, coordination with treating provider and psychiatric consultant, brief interventions, relapse prevention planning	Monthly (not time-based)	\$157.99	Billing: Physicians, NPPs Rendering: Auxiliary Staff, Psychiatric Consultants
G0570 (primarily Medicare)	APCM add-on, general behavioral health integration	Includes initial assessment, behavioral health care planning, brief interventions and coordinating with mental health and substance use care providers	Monthly (not time-based)	\$63.68	Billing: Physicians, NPPs Rendering: Auxiliary Staff
99490	CCM services by clinical staff under physician supervision	Non-face-to-face care coordination for patients with two or more chronic conditions expected to last 12 or more months or until death	At least 20 minutes per month	\$72.24	Billing: Physicians, NPPs Rendering: Auxiliary Staff

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99491	CCM personally performed by physician or NPP	For patients with two or more chronic conditions; provider delivers 30 or more minutes/month	First 30 minutes	\$98.94	Billing: Physicians, NPPs Rendering: N/A
99487	Complex CCM by clinical staff under supervision	For patients with two or more chronic conditions and moderate/high complexity; first 60 minutes/month	First 60 minutes	\$154.46	Billing: Physicians, NPPs Rendering: Auxiliary Staff
99424	PCM personally performed by physician or NPP	For patients with one serious chronic condition; first 30 minutes/month	First 30 minutes	\$96.56	Billing: Physicians, NPPs Rendering: N/A
99426	PCM, clinical staff	For patients with one serious chronic condition; first 30 minutes/month, clinical staff	First 30 minutes	\$73.85	Billing: Physicians, NPPs Rendering: Auxiliary Staff

Note: CHI and PIN codes also provide coverage for care management and care coordination services. Add-on codes are available to support extended CCM, Complex CCM and PCM after the monthly allowable time is expended.

SECTION 4: FOR BEHAVIORAL HEALTH PROVIDERS COORDINATING AND INTEGRATING PRIMARY CARE AND PHYSICAL HEALTH SERVICES

The billing codes in Section 4 apply to integrated care models within behavioral health settings (i.e., mental health and/or substance use treatment providers). These include billing codes to screen for physical health or social needs, provide care management, deliver select physical health interventions (e.g., wound care or laboratory tests for metabolic monitoring), and evaluation and management codes for co-located models (e.g., behavioral health providers that hire physicians or other qualified health providers to address physical health conditions). Any organization performing laboratory tests on human specimens for diagnosis, prevention or treatment needs a Clinical Laboratory Improvement Amendments (CLIA) certificate. In general, behavioral health providers, particularly those who specialize in substance use disorder treatment, may have more limited access to the care coordination and care management codes listed in Section 3. Payer negotiations may be necessary to add billing codes to provider contracts.

There is generally more variability in the specific billing codes used for behavioral health services across states than there is in the billing codes used for physical health services. This is largely because certain behavioral health benefits under Medicaid are often optional and administered through state-specific plans, waivers, and managed care arrangements, resulting in differences in covered services, provider types, and coding requirements.²³ However, behavioral health providers have historically had access to a broader set of billing codes that support wrap-around services, such as psychiatric rehabilitation, supported employment and supported housing. Comparable wrap-around billing mechanisms have been more limited in traditional physical health.²⁴ Additionally, there are fewer evidence-based models integrating physical health or primary care monitoring into behavioral health, and thus fewer available billing codes listed. States and providers operating Certified Community Behavioral Health Clinic (CCBHC) programs may want to review the billing codes in this section and consider whether or how these codes are incorporated into the Prospective Payment System. Providers should collaborate with local payers to confirm billing guidance, including availability of billing codes and the types of eligible providers that can bill for and render services.

²³ Medicaid and CHIP Payment and Access Commission. (n.d.). *Behavioral health*. <https://www.macpac.gov/topic/behavioral-health/>

²⁴ Centers for Medicare & Medicaid Services. (2025, May). *Medicaid Section 1115 serious mental illness and serious emotional disturbance (SMI/SED) demonstrations: State actions to integrate supportive housing and supported employment services into treatment* (RTI International, contractor). <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/smi-rcr-oy3-social-supports.pdf>

Access, screening, referral to care, and follow-up

Screening

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
96127 ²⁵	Developmental/behavioral screening and testing	Screening for depression (PHQ-9, PHQ-2), anxiety (GAD-7), attention-deficit/hyperactivity disorder, with scoring and documentation <i>Note: : Some payers may not reimburse 96127 in behavioral health settings.</i>	Not time-based; per instrument	\$4.68	Billing: Physicians, NPPs Rendering: Auxiliary Staff
G0136 (primarily Medicare)	Administration of standardized nutrition and physical activity screening tool	Furnished in conjunction with an E/M visit, which can include hospital discharge or transitional care management services	5-15 minutes once every 6 months	\$20.87	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff
96160	Health risk assessment instrument	Used to assess general health risks, including diet/activity, fall risk and social needs (e.g., PRAPARE, AHC-HRSN)	N/A	\$2.89	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff
96161	Caregiver health risk assessment instrument	Used to assess parent/caregiver health risks for the benefit of patient care (e.g., ACES questionnaire, parent stress index, postnatal depression scale)	N/A	\$3.22	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff

²⁵ Medicare uses G0444 for depression screening (“Annual Depression Screening, 15 minutes”).

Care access, referrals and follow-up

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0560 (primarily Medicare)	Safety planning interventions	Comprehensive risk assessment and development of safety plan for individuals experiencing a mental health or substance use crisis	20-minute units	\$51.15	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff
G0544 (primarily Medicare)	Post-discharge telephonic follow-up	Upon discharge ²⁶ from a crisis encounter. Includes psychiatric inpatient and crisis stabilization.	Monthly bundle — 4 calls, 10-20 mins each	\$72.69	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff
G3002	Chronic pain management and treatment	Includes diagnosis, assessment, care planning, medication review, and care coordination, including integrative providers (e.g., yoga, mindfulness)	Monthly bundle, first 30 minutes	\$91.13	Billing: Physicians, NPPs Rendering: N/A
+G3003	Chronic pain management services, each additional 15 minutes	Used when services exceed 30 minutes in a month; must be billed with G3002 and reflect full 15-minute increments of personally delivered care	Each additional 15 minutes	\$34.62	Billing: Physicians, NPPs Rendering: N/A

²⁶ Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments, 89 F.R. 97710 (proposed December 9, 2024) (to be codified at 42 C.F.R. § 401, 405, 410, 411, 414, 423, 424, 425, 427, 428, and 491). <https://www.govinfo.gov/content/pkg/FR-2024-12-09/pdf/2024-25382.pdf> (see page 97, 922)

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0534	Coordinated care for opioid treatment programs	Coordinated care and/or referral services to address unmet social needs and recovery support	Each 30 minutes	\$41.69	Billing: Medicare-enrolled opioid treatment programs

Lab screenings (as indicated)

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
86703 ²⁷	HIV testing, rapid onsite	Useful for providers treating patients with high-risk history (e.g., injection drug use)	N/A	\$13.71	May require moderate/high complexity CLIA certificate
86803	Hepatitis C antibody	Screening recommended for pregnant women and ongoing risk factors (e.g., injection drug use)	N/A	\$14.27	CLIA waiver required
86480	Tuberculosis	May consider for people who inject drugs and those with medical conditions that weaken immune systems	N/A	\$61.98	May require moderate/high complexity CLIA certificate
81025	Pregnancy	May consider screening all women of childbearing age before prescribing certain medications for behavioral health treatment	N/A	\$8.61	CLIA waiver required

Note: This is a sample of billing codes that may be relevant for screening for physical health conditions in behavioral health settings.

²⁷ Other billing options include 86803 or 87389 or 87390 for HIV Ag/Ab combo tests.

Evidence-supported prevention and intervention

Evaluation and management

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable) ²⁸	Average 2026 Medicare Rate	Eligible Providers
99202-99205	E/M services for new patients	Used to support integrated care by enabling comprehensive evaluation, screening and follow-up of primary care-related needs, such as metabolic monitoring, cardiovascular risk assessment, and medication management	Varies by CPT code; based on time or complexity	\$80.24-\$256.33	Billing: Physicians, NPPs Rendering: N/A
99212-99215	E/M services for established patients	Used to support integrated care by enabling comprehensive evaluation, screening and follow-up of primary care-related needs, such as metabolic monitoring, cardiovascular risk assessment, and medication management	Varies by CPT code; based on time or complexity	\$63.07-\$209.08	Billing: Physicians, NPPs Rendering: N/A

Metabolic monitoring

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
83036	Hemoglobin; glycated (A1c)	May use fingerstick A1c testing as part of medication management, especially for patients on antipsychotics	N/A	\$9.71	CLIA-waived for point of care devices

²⁸ E/M code selection can be based on time or medical decision-making, whichever is more appropriate. Consult CPT manual for details.

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
82962	Chemistry procedure (e.g., blood glucose monitoring)	Perform metabolic baseline glucose testing, followed by ongoing annual testing for patients on antipsychotics	N/A	\$3.28	CLIA-waived for routine in office testing (e.g., fingerstick)
80061	Blood test, lipids	Perform baseline cholesterol and triglycerides testing and ongoing annual testing for patients on antipsychotics	N/A	\$13.39	May require moderate/high complexity CLIA certificate

Note: This is a sample of laboratory billing codes that may be relevant for metabolic monitoring. Any organization performing laboratory tests on human specimens for diagnosis, prevention or treatment needs a CLIA certificate.

Physical health-related interventions

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
97597	Wound care, first 20 square centimeters	Debridement ²⁹ of open wounds including topical application(s), wound assessment, ongoing care instructions; first 20 square centimeters or less	N/A	\$104.18	Billing: Physicians, NPPs Rendering: Auxiliary Staff
97598	Wound care, each additional 20 square centimeters	Debridement of open wounds, each additional 20 square centimeters	N/A	\$49.81	Billing: Physicians, NPPs Rendering: Auxiliary Staff
99406	Tobacco cessation counseling; intermediate	Used when a provider spends three to 10 minutes counseling a patient on quitting tobacco, including discussing risks, triggers and cessation strategies	3-10 minutes	\$16.81	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: N/A

²⁹ Debridement of wounds refers to a medical procedure that involves removing dead, infected or damaged tissue from a wound. It includes use of high-pressure waterjet with or without suction and sharp selective debridement with scissors, scalpel or forceps.

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99407	Tobacco cessation counseling; intensive	Used when a provider spends more than 10 minutes counseling a patient on quitting tobacco, often including discussion of pharmacologic options	11+ minutes	\$32.20	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: N/A

Remote patient monitoring

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99453	Initial setup and patient education for RPM device	Physician or NPP educates patient on RPM (e.g., remote scale or blood pressure cuff) to monitor physical health data (e.g., for metabolic syndrome)	Only billable after 16 days of data collection	\$20.60	Billing: Physicians, NPPs Rendering: N/A
99454	RPM device supply and data transmission	Provider sets up an RPM device (e.g., remote scale or blood pressure monitor) and collects data	16+ days in 30-day period	\$49.98	Billing: Physicians, NPPs Rendering: Auxiliary Staff
99470	RPM treatment management services	Provider reviews remote data (e.g., weight, blood pressure) and discusses lifestyle changes	First 10 minutes	\$27.76	Billing: Physicians, NPPs Rendering: Auxiliary Staff
99457	RPM treatment management services	Provider reviews remote data (e.g., weight, blood pressure) and discusses lifestyle changes	First 20 minutes	\$63.31	Billing: Physicians, NPPs Rendering: Auxiliary Staff

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99091	Collection and interpretation of physiological data	Physician or NPP collects and reviews physiological data (e.g., glucose monitor, blood pressure data)	30+ minutes per month	\$62.92	Billing: Physicians, NPPs Rendering: N/A

Multidisciplinary team

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99446-99449	Interprofessional telephone, internet, EHR consult; verbal discussion and written report	Used when a consulting provider (e.g., addiction specialist) spends at least five minutes discussing a patient's case with the treating provider (e.g., primary care provider)	5-31+ minutes (CPT code selection based on time)	\$25.11-\$85.00	Billing: Physicians, NPPs; Licensed MH Practitioners bill G0546-G0549 for Medicare Rendering: N/A
99451	Interprofessional consult with written report only (no verbal discussion)	Used when a consulting provider spends ≥ 5 minutes reviewing data and providing a written report to the treating provider	5+ minutes	\$40.08	Billing: Physicians, NPPs; Licensed MH Practitioners bill G0550 for Medicare Rendering: N/A
99452	Interprofessional referral service by the treating/ requesting provider	Used when treating provider (e.g., primary care provider) spends ≤ 30 minutes preparing for and participating in a consultation with a specialist	16-30 minutes	\$41.69	Billing: Physicians, NPPs; Licensed MH Practitioners bill G0551 for Medicare Rendering: N/A

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99211	Office visit for an established patient who may not require a physician (e.g., nurse visit)	Used for low-complexity services like vitals check, medication refill or patient education by a nurse or other qualified auxiliary staff	Typically 5-10 minutes; no strict time requirement	\$25.04	Billing: Physicians, NPPs Rendering: Auxiliary Staff
H0038 ³⁰	Certified peer specialist services	Provides coaching on medication management, diet and exercise plans as recommended by supervising provider; shares lived experience with skill-building	Typically 15-minute unit; varies by payer	N/A	Peer service typically billed under provider organization's National Provider Identifier (NPI)

Note: Assess local coverage policies to determine whether other auxiliary staff types may be billable in behavioral health settings, such as community health workers

Person-centered Self-management support

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
99497	Advance care planning	Discuss patient's health care wishes, medical treatment preferences and establish an end-of-life plan; includes psychiatric advance directives	First 16-30 minutes	\$96.69	Billing: Physicians, NPPs Rendering: N/A
+99498	Advance care planning, add-on code	Each additional 30 minutes of care planning, including psychiatric advance directives	Each additional 30 minutes	\$87.37	Billing: Physicians, NPPs Rendering: N/A

³⁰ Both billing code and time unit may vary by state. Medicare does not cover peer services as a standalone service, but peer specialists can bill G0140 and G0146 for PIN peer support.

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0023	PIN services	Patient navigation, care coordination, education and support for patients with serious or high-risk conditions; typically rendered by auxiliary staff	60 minutes per calendar month	\$92.48	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff ³¹
+G0024	PIN services, each additional 30 minutes	Used to continue care coordination for patients with serious conditions (e.g., chronic pain, cancer, substance use); typically rendered by auxiliary staff	30 minutes (add-on to G0023)	\$58.39	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff ³²
G0539 (primarily Medicare)	Caregiver training in behavior management (initial 30 minutes, without patient present)	Teaching caregivers stress management, de-escalation, signs of worsening symptoms	Initial 30 minutes	\$60.57	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: N/A
+G0540 (primarily Medicare)	Caregiver training in behavior management, add-on code	Add-on to G0539 for extended caregiver instruction	Each additional 15 minutes	\$30.26	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: N/A
G0543 (primarily Medicare)	Group caregiver training (without patient present)	Group sessions for multiple caregivers on direct care techniques (e.g., wound care, meal preparation, medication administration)	Varies by session	\$23.28	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: N/A

Note: Behavioral health providers may also have access to other billing codes that support person-centered self-management support, such as psychiatric rehabilitation (e.g., H2015-H2018). These billing codes, service definitions and payment rates vary widely by state.

³¹ Peer specialists can also provide PIN services under G0140.

³² Peer specialists can also provide additional PIN services under G0146.

Linkages with community and social services

Billing Code	Description	Typical Use for Integrated Care	Time (if Applicable)	Average 2026 Medicare Rate	Eligible Providers
G0019	CHI, first 60 minutes	Addressing barriers related to social needs (e.g., housing, food insecurity) via auxiliary staff under supervision	60 minutes per month	\$91.52	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff
+G0022	CHI services, each additional 30 minutes	Add-on to G0019 for extended CHI services	30 minutes (add-on)	\$58.07	Billing: Physicians, NPPs, Licensed MH Practitioners Rendering: Auxiliary Staff

Ongoing care coordination and care management

Behavioral health providers do not typically bill the ongoing care coordination and care management codes listed in Section 3.³³ However, they often have other billing codes available that can support ongoing care coordination and care management, such as Assertive Community Treatment (e.g., H0039) and Targeted Case Management (e.g., T1017). These billing codes, service definitions and payment rates vary widely by state. If CHI, PIN and/or PIN-PS services are covered, these provide another avenue to support ongoing care coordination and care management.

³³ Psychiatrists and psychiatric nurse practitioners or physician assistants may be eligible to bill these codes as part of managing related chronic conditions.

SECTION 5: ABBREVIATIONS AND RESOURCES

List of abbreviations

- **ACES: Adverse Childhood Experiences Survey.** Screens for exposure to childhood trauma (e.g., abuse, neglect, household dysfunction) to help assess risk for later physical and behavioral health concerns.
- **AHC-HRSN: Accountable Health Communities Health-Related Social Needs Screening Tool.** CMS-developed tool to screen for social and environmental factors that affect health, including housing instability, food insecurity, transportation and interpersonal safety.
- **APCM:** Advanced primary care management
- **AUDIT: Alcohol Use Disorders Identification Test.** The World Health Organization developed this 10-item screening tool for identifying risky or harmful alcohol use and potential alcohol use disorder.
- **BH:** Behavioral health
- **CCM:** Chronic care management
- **CHI:** Community health integration
- **CoCM:** Collaborative Care Model
- **CPT:** Current procedural terminology
- **CLIA:** Clinical Laboratory Improvement Amendments
- **DAST: Drug Abuse Screening Test.** Brief questionnaire to identify possible problematic drug use (excluding alcohol and tobacco). Versions range from DAST-10 to DAST-20.
- **DMHT:** Digital mental health treatment
- **EHR:** Electronic health record
- **E/M:** Evaluation and management
- **FDA:** Food and Drug Administration
- **FQHC:** Federally Qualified Health Center
- **GAD-7: Generalized Anxiety Disorder — 7 items.** Standardized screening tool to assess severity of generalized anxiety disorder symptoms over the past two weeks.
- **MH:** Mental health
- **NPP:** Nonphysician practitioner
- **PCM:** Principal care management
- **PHQ-2: Patient Health Questionnaire — 2 items.** Very brief depression screen that asks about frequency of depressed mood and anhedonia over the past two weeks; often used as a first step before PHQ-9.
- **PHQ-9: Patient Health Questionnaire — 9 items.** Widely used depression screening and monitoring tool that also assesses severity and impact on functioning.
- **PIN:** Principal illness navigation
- **PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences.** Standardized tool for assessing social and environmental factors that affect health (housing, food, utilities, safety, stress, etc.).
- **RHC:** Rural Health Clinic

- **RPM:** Remove patient monitoring
- **SBIRT: Screening, Brief Intervention and Referral to Treatment.** Approach for screening and early intervention for risky alcohol or drug use, often paired with AUDIT or DAST.
- **SUD:** Substance use disorder

General resources

- Centers for Medicare and Medicaid Services. (2024, November 25). *Medicare physician fee schedule final rule summary: CY 2025*. <https://www.cms.gov/files/document/mm13887-medicare-physician-fee-schedule-final-rule-summary-cy-2025.pdf>
- Centers for Medicare and Medicaid Services. (2026, January). *Behavioral health integration services*. <https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf>
- Centers for Medicare and Medicaid Services. (2025). *Medicare program; CY 2026 payment policies under the physician fee schedule and other changes to Part B payment and coverage policies (CMS-1832-F)*. U.S. Department of Health and Human Services. <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notice/cms-1832-f>
- National Council for Mental Wellbeing. (n.d.). Center of Excellence for Integrated Health Solutions. Retrieved March 24, 2026. <https://www.thenationalcouncil.org/program/center-of-excellence/>
- Substance Abuse and Mental Health Services Administration. (2023). *FY 2025 promoting integration of primary and behavioral health care: States — Notice of funding opportunity*. <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-2024-pipbhc-states-sm-24-003.pdf>

Resources related to CoCM billing

- Meadows Mental Health Policy Institute. (2024). *Collaborative care model billing basics*. https://mmhpi.org/wp-content/uploads/2025/05/CoCM_Billing_Basics-v2.pdf
- Meadows Mental Health Policy Institute. (2025, May). *State Medicaid coverage for Collaborative Care Management codes*. <https://mmhpi.org/wp-content/uploads/2025/05/State-Wide-Project-2025.pdf>
- National Council for Mental Wellbeing. *Financing the future of integrated care: Decision Support Tool*. Accessed March 24, 2026. <https://www.thenationalcouncil.org/resources/financing-the-future-of-integrated-care/>
- University of Washington AIMS Center. (n.d.). *Office hours*. Accessed September 17, 2025. <https://aims.uw.edu/office-hours/>
- American Psychiatric Association. (n.d.). *Getting paid in the Collaborative Care Model*. Accessed March 25, 2026. <https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid>