Behavioral Health Integration: Billing and Payment Codes

California Quality Collaborative

About this document

This resource provides vital guidance for medical organizations, health care providers, and finance teams across California on the accurate and compliant use of Behavioral Health Integration (BHI) billing codes within primary care settings. Designed to support effective implementation of integrated behavioral health services, the guide offers a comprehensive overview of BHI care models and associated billing codes, strategic insights to optimize billing workflows, and reimbursement. It is aligned with both state and federal standards, including Medi-Cal and Medicare, and incorporates updates taking effect in 2025 (in green). The document includes code groupings relevant to:

How to use this document

- **Collaborate with Billing and Finance Teams:** Collaboratively review the guide with key stakeholders to identify CPT codes that accurately reflect the services provided. Reference the CMS 2025 Physician Fee Schedule to estimate reimbursement for CPT codes and assess fiscal viability. **Additional Resources for Federally Qualified Health Centers (FQHCS):** National Association of Community Health Centers (NACHC) Medicare Billing Lingo, NACHC Summary of Medicare Care Management Services, and NACHC Reimbursement Tips: Behavioral Health Integration (BHI).
- **Integrate into Educational & Training Materials:** Adapt content for internal use by providers, care teams, and billing staff which can include presentations, onboarding modules, workflow diagrams, and job aides that support consistent documentation, compliance, and appropriate billing.
- **Support Workflow Design & Optimization:** Use the guide to map billing codes to care team roles and patient touchpoints—this helps clarify who delivers what, when, and under whose supervision, reducing ambiguity and streamlining service documentation.

Disclaimer

- The guidance in this document provides a general overview specific to California; however, coverage and frequency limits vary by insurer.
- For accurate information on billing, reimbursement, and service limits, refer to each insurer's official resources. Please note that links may change or become inactive over time.
    - Medicare: CMS Behavioral Health Integration Services and Medicare & Mental Health Coverage
    - Medi-Cal (California): All Provider Manuals
    - For commercial health plans and managed behavioral health organizations, consult their specific billing guidelines and provider manuals.
- Patient consent requirements may differ by organization and insurer. Always reference your internal policies and the payer's regulations for details related to documentation and consent protocols.

I. Primary Care Behavioral Health (PCBH) Codes

- These codes are typically billed under the patient's Behavioral Health Benefit, which may involve cost-sharing depending on the payer.
- H&B codes used within the PCBH model must be paired with an appropriate Health and Behavior ICD-10 diagnosis - reflecting behavioral factors affecting physical health conditions. Primary Diagnosis Requirement: Physical health condition must be the principal reason for the visit. Psychotherapy codes used within the PCBH model must be paired with an appropriate ICD-10 diagnosis - reflecting developmental, emotional, or mental health conditions. Primary Diagnosis Requirement: DSM condition must be the principal reason for the visit.
- Code pairings and billing practices are based on standard healthcare billing protocols. For the most accurate guidance, refer to the:
  - AMA CPT Codebook
  - ICD-10-CM Official Guidelines published by the Centers for Medicare & Medicaid Services (CMS)
- This list is not exhaustive, but highlights commonly used codes for integrated care services delivered in primary care settings aligned with the PCBH model.
- Ensure SOAP notes are aligned with the diagnosis and highlight the functional limitations/justification for services.

Code & Service	Time	Service Description	Required Documentation	Billing Provider Types
Psychotherapy Billing Codes *Primary Diagnosis Requirement*: Mental health condition must be the principal reason for the visit.				
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 based on the diagnosis. Many Medicare and Medicaid plans allow billing 90791 once per patient, per provider, per year. Some plans permit it every six months.	Diagnoses, 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. Required documentation: • Start and stop times and date • Length of face-to-face minutes • Justification of treatment • Mental status • Formal and informal assessment	1. Independently Licensed 2. Insurer Enrollment/Credentialing Psychologist (PsyD, PhD) Social Worker (LCSW) Marriage and Family Therapist (LMFT) Clinical Counselor (LPCC)

Code & Service	Time	Service Description	Required Documentation	Billing Provider Types
90792 Diagnostic Psychiatric Evaluation w/Medical Services	60 – 90 minutes	A psychiatric diagnostic evaluation with medical services is a comprehensive assessment that includes both mental health and medical components. It is typically used for a new patient's initial intake session. Can generally be billed once per patient, per provider, per evaluation episode, but it is not strictly limited to once per year and can be billed more often if medically necessary.	• Identification of specific interventions (evidence based) and overall efficacy • Patient's response to treatment • Progress made toward mental health measurable goals/objectives • Clinical decision making • Functional status and current level of symptoms • Prognosis and adherence • Risk assessment • Plan and referrals • Consultations 90792 ONLY: Examination and Medical Services, assessment, plan, medical necessity - weave these into what you have ensure to add HPI 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 Psychiatrist (MD or DO) Psychiatric Nurse Practitioner (PMHNP) Psychiatric Physician Assistant (PA)

Code & Service	Time	Service Description	Required Documentation	Billing Provider Types
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.	1. Independently Licensed 2. Insurer Enrollment/Credentialing Psychologist (PsyD, PhD) Social Worker (LCSW) Marriage and Family Therapist (LMFT) Clinical Counselor (LPCC)
90834 Individual Psychotherapy	45 minutes (38-52 min)			
90837 Individual Psychotherapy	60 minutes (≥53 min)			
Health & Behavior Codes *Primary Diagnosis Requirement*: 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 Worker (LCSW) Marriage and Family Therapist (LMFT) Clinical Counselor (LPCC)
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.	

Code & Service	Time	Service Description	Required Documentation	Billing Provider Types
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				

II. Collaborative Care Model (CoCM) Codes

- These codes are typically billed by the Primary Care Treating Provider and encompass services delivered by the full Collaborative Care team.
- Billed under the patient's medical benefit, which may include cost-sharing depending on insurer policy.
- A standard episode of care spans approximately 3 to 9 months, depending on clinical need and patient progress.
- Successful billing requires participation from a Primary Medical Provider, a Behavioral Health Care Manager, and a Psychiatric Consultant—all working in a coordinated, team-based approach.
- Time spent on CoCM services is tracked cumulatively over the calendar month, and appropriate CPT codes are selected based on the total monthly time.
- Location-specific billing guidelines may apply. Always consult with your organization's billing specialists or payer representatives to confirm local policies and coverage.
- Resources for FQHC: NACHC Medicare Billing Lingo, NACHC Summary of Medicare Care Management Services, and NACHC Reimbursement Tips: Behavioral Health Integration (BHI).

Code & Service	Time	Description	Required Documentation	Billing Provider Types
CoCM Codes 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.	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.	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.

Code & Service	Time	Description	Required Documentation	Billing Provider Types
		Monthly billing of care episodes is determined by time spent by care team. Continuity of care with a designated member of the care team.	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.	Team of 3 (one from each category) **Treating/Billing Provider:** Physician (MD and DO) Nurse Practitioners (NP) Physician Assistant (PA) **Behavioral Health Care Manager** Mental Health Counselor (Masters-level, licensure candidate, or trainee) Marriage and Family Therapist (MFT, AMFT, LMFT) Social Worker (MSW, ACSW, LCSW) Registered Nurse RN (BSN recommended) Nurse Practitioner (NP with behavioral health experience) Psychologist (PhD or PsyD) Bachelor's-Level Provider (With relevant behavioral health training and supervision) **Psychiatric Consultant** Physician (MD and DO) Nurse Practitioner (NP) Physician Assistant (PA)
99493 FQ - G0512 Collaborative Care (CoCM) subsequent month	60 minutes (31-75 min) FQ – 60 min	Subsequent psychiatric collaborative care management. Continuity of care with members of the care team.	Track patients and progress using registry. Weekly case consultations with a psychiatric consultant. Provision of brief interventions. Monitoring patient outcomes.	
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, add on, up to 4 times per calendar month for Medicare, 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.	

Code & Service	Time	Description	Required Documentation	Billing Provider Types
*Codes specific to Federally Qualified Health Centers (FQHCs) are described with FQ. Text reflects changed in 2025.				

III. General Screening and Care Coordination Integration Codes

- These codes support Behavioral Health Integration (BHI) workflows and are not tied to any specific care model—making them flexible tools for various clinical settings.
- May be billed by a:
  - Primary Care Treating Provider
  - Licensed Clinical Behavioral Health Provider
  - Trained ancillary personnel, as permitted by payer policy
- In some cases, services may be delivered by a non-billable provider (e.g. CHQ or care coordinator) under the supervision of a billable provider.

Code & 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	Initial assessment/follow up of the patient, including administration of validated rating scales, coordination with care team.	Federally Qualified Health Centers (FQHC) requires: 1. Independently Licensed 2. Insurer Enrollment/ Credentialing Physician (MD and DO) Nurse Practitioner (NP) Physician Assistant (PA) Certified Nurse Midwife (CNM)

Code & Service	Time	Description	Required Documentation	Billing Provider Types
		member		
G0323 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 of care with a designated member of the care team. Continuous relationship with a designated member of the care team.	Administration of applicable validated rating scale(s): Systematic assessment and monitoring, using applicable validated clinical rating scales. 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.	1. Independently Licensed 2. Insurer Enrollment/ Credentialing Psychologist (PsyD, PhD) Social Workers (LCSW) Marriage and Family Therapist (LMFT) Clinical Counselor (LPCC)
Principal Illness Navigation (PIN) Codes Designed to support patients with serious, high-risk medical or behavioral health conditions expected to last at least three months.				
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 establishing an action plan • Providing tailored support as needed to accomplish the person-centered goals in	Certified or trained* auxiliary personnel under the direction of a physician or other provider, 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 and ethical conduct,
G0024 Principal Illness	30 minutes/ month	Add on monthly person-centered services performed to better understand and support		

Code & Service	Time	Description	Required Documentation	Billing Provider Types
Navigation services Add-on		individual context of the serious, high-risk condition.	the provider's treatment plan • Assist the patient in communicating with their providers, 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 needed to address SDOH need(s)	and developed an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness, or disease being addressed.
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.		
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.		
Administration of Patient-Focused Health Risk Assessment Instrument Evaluate a patient's overall health status and identify specific risk factors.				
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	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 Physician (MD, DO) Nurse Practitioner (NP) Physician Assistant (PA) Social Worker (LCSW) Psychologist (PsyD, PhD) Marriage and Family Therapist (LMFT) Clinical Counselor (LPCC) These professionals must ensure that

Code & Service	Time	Description	Required Documentation	Billing Provider Types
		interview is a comprehensive assessment tool that focuses on: • Home Environment • Education and Employment • Eating • Peer-related Activities • Drugs • Sexuality • Suicide/Depression Safety from Injury and Violence		the assessment is administered and scored using a standardized instrument, and the results are documented appropriately.
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.	
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	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.	1. Independently Licensed 2. Insurer Enrollment/Credentialing Physician (MD and DO) Nurse Practitioner (NP) Physician Assistant (PA)

Code & Service	Time	Description	Required Documentation	Billing Provider Types
		other behavioral health conditions.	Can be billed up to four times per patient per visit.	Certified Nurse Midwife (CNM) Psychologist (PsyD, PhD) Social Worker (LCSW) Marriage and Family Therapist (LMFT) Clinical 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-based	Ages 18 and up Medicare-specific code is for annual depression screenings conducted in adults. Typically used during the Annual Wellness Visit (AWV).	Reimbursable once per year for Medicare patients. Ensure proper documentation of the screening to comply with Medicare requirements.	Physician (MD and DO) Nurse Practitioner (NP) Physician Assistant (PA) Social Worker (LCSW) Psychologist (PsyD & PhD) 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.
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 Wellness Visit (AWV).	1. Independently Licensed 2. Insurer Enrollment/ Credentialing Physician (MD, DO) Nurse Practitioner (NP) Physician Assistant (PA)

Code & Service	Time	Description	Required Documentation	Billing Provider Types
G0443 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.	Social Worker (LCSW) Psychologist (PsyD, PhD) Marriage and Family Therapist (LMFT) Clinical Counselor (LPCC) Nurse Midwife (CNM) & Certified Nurse Specialist (CNS) - Accepted by Medicare Only and some Medicaid plans
Interprofessional Telephone/ Internet/ Electronics Health Record Consultations				
99446 Non–face-to-face for interprofessional consults	5-10 minutes	These services involve a treating provider (e.g., PCP, NP, PA) requesting input from a consulting provider (e.g., specialist, psychologist, psychiatrist) via: • Telephone • Internet (email, secure messaging) • Electronic Health Record (EHR) The consulting provider reviews the patient's case and provides clinical guidance, either verbally or in writing, without a face-to-face visit.	Key Billing Conditions: • Consultant must not have seen the patient in the past 14 days • No face-to-face visit planned within the next 14 days • Must provide both verbal and written reports to the requested provider • Patient consent must be obtained and documented • Only one code may be billed per patient per 7-day period Required documentation: • Consult Request • Consent • Time Tracking • Service Description • Non-face-to-face contact • No transfer of care Avoid duplicative billing: CoCM codes should	1. Independently Licensed 2. Insurer Enrollment/ Credentialing Physician (MD, DO) Nurse Practitioner (NP) Physician Assistant (PA) Clinical Psychologist (PsyD, PhD) Nurse Midwife (CNM) Certified Nurse Specialist (CNS)
99447 Non–face-to-face for interprofessional consults	11-20 minutes			
99448 Non–face-to-face for interprofessional consults	21-30 minutes			
99449 Non–face-to-face for	31+ minutes			

Code & Service	Time	Description	Required Documentation	Billing Provider Types
interprofessional consults			not be billed alongside overlapping services.	
99451 Non–face-to-face for interprofessional consults	≥5 minutes	The consulting provider reviews the patient's case and provides clinical guidance, in writing only, without a face-to-face visit.		
99452 Non–face-to-face for interprofessional consults	16-30 minutes	Treating provider referral preparation and communication.		
Digital Mental Health Treatment (DMHT) Devices				
G0552 Digital Mental Health Treatment (DMHT) Devices	Not Timed Tied to DMHT	The billing provider must incur the cost of furnishing the device and deliver it incident to their professional services within a recognized behavioral health treatment plan. DMHT services include: • Supplying a DMHT device (e.g., FDA-cleared therapeutic software or app) as part of incident-to care • Providing initial education and patient onboarding • Delivering the device per	Documentation: • Mental health diagnosis requiring DMHT intervention • Behavioral health plan of care that incorporates the device • Confirmation that the device is FDA-cleared or De Novo authorized under 21 CFR 882.5801 • Summary of initial education and onboarding provided to the patient • Evidence that the billing provider incurred the cost of furnishing the device	1. Independently Licensed 2. Insurer Enrollment/ Credentialing Physician (MD, DO) Nurse Practitioner (NP) Physician Assistant (PA) Social Worker (LCSW) Psychologist (PsyD, PhD) Marriage and Family Therapist (LMFT) Clinical Counselor (LPCC) Nurse Midwife (CNM) & Certified Nurse Specialist (CNS) - Accepted by Medicare Only and some Medicaid plans

Code & Service	Time	Description	Required Documentation	Billing Provider Types
		course of treatment, not per visit or month These services must be integrated into an ongoing plan of care for a diagnosed mental health condition, documented and supported by appropriate clinical and billing records.	Additionally, the service must be delivered incident to the provider's professional services, and patient consent for device use and any cost-sharing must be recorded. G0553 and G0554 must include: • Time Spent • Summary of clinical insights and adjustment to care plan • Details of interactive communication (e.g. phone, video, secure massaging) • Linkage to behavioral health goals Avoid duplicative billing: CoCM codes should not be billed alongside overlapping services.	
G0553 Digital Mental Health Treatment (DMHT) Devices Interaction	First 20 minutes	Directly related to the patient's therapeutic use of an FDA-cleared DMHT device. Includes: • Reviewing patient-generated data and observations • One interactive communication with the patient or caregiver		
G0554 Digital Mental Health Treatment (DMHT) Devices Interaction	Each additional 20-minute			
*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. Community Health Worker (CHW) Services Billing Codes

- Services delivered by Community Health Workers (CHWs) must be provided under the supervision of a licensed provider, hospital, or outpatient clinic, as defined by Title 42 CFR § 440.90.
- These billing codes were recently added to Medi-Cal, with an effective date of April 1, 2025.
- Commercial payer adoption is not yet universal—verify coverage with individual health plans.
- While not exclusive to Behavioral Health Integration (BHI) models, these codes can be effectively leveraged within BHI frameworks to support person-centered care.
- For complete billing and policy guidance, refer to the Department of Health Care Services (DHCS) Medi-Cal website and Provider Manual documentation.

Code & Service	Time	Description	Required Documentation	Provider Types
Self-Management Education and Training				
98960 Self-management education and training for individual patient	30 minutes	Education and training for patient self-management provided by a qualified, nonphysician health care professional. Services are delivered face-to-face using a standardized curriculum, and may include participation of caregivers or family members. Billed in 30-minute increments, with CPT codes varying based on the number of patients present: • 98960 – Individual session (1 patient) • 98961 – Group session (2–4 patients) • 98962 – Group session (5–8 patients)	Self-management education can be delivered by a billing provider directly or if a CHW delivers the service, CHW must be supervised by a licensed provider. Documentation must focus on face-to-face education include: • Date and duration of each service • Nature of the service • ICD-10 diagnosis code • Plan of care or treatment plan • Consent • Modifier U2 (Denotes services delivered by CHW) Documentation must be accessible to the supervising provider and maintained for audit purpose.	Eligible billing entities include: Licensed provider* Clinic, including FQHC Hospital Community-Based Organization (CBO) Local Health Jurisdiction (LHJ) Pharmacy CHW must be supervised by a qualified** licensed nonphysician provider*: Nurse Practitioner (NP) Physician Assistant (PA) Certified Nurse Midwife (CNM) Certified Nurse Specialist (CNS) Podiatrist Registered Nurse (RN) Social Worker (LCSW) Psychologist (PsyD, PhD) Marriage and Family Therapist (LMFT) Clinical Counselor (LPCC)
98961 Self-management education and training for 2-4 patients				
98962 Self-				

Code & Service	Time	Description	Required Documentation	Provider Types
management education and training for 5-8 patients				Dentist Pharmacist Vocational Nurse (LVN)
Community Health Integration (CHI) Service				
G0019 (Medicare) CHI Services	First 60 minutes per month	Delivered by trained auxiliary personnel (e.g., CHWs) under the supervision of a licensed provider to address social determinants of health (SDOH) that hinder diagnosis or treatment. Activities include: • Person-centered assessment: Understanding the patient's context, strengths, cultural factors, and unmet SDOH needs • Goal setting & tailored support: Assisting with action planning aligned to treatment goals • Care coordination: Connecting with healthcare, social service, and community providers; managing transitions across care settings • Access facilitation: Navigating essential community services (e.g., housing, food, utilities) • Health system navigation:	Must address documented social determinants of health (SDOH) that impact diagnosis or treatment includes: • Person-centered assessment and goal setting • Care coordination across health and social services • Health system navigation • Patient education and self-advocacy • Emotional and social support • Use of lived experience when applicable Documentation must be tied SDOH, initiating visits, and care plans and include: • Date and duration of each service • Barrier of care • ICD-10 diagnosis code • Plan of care or treatment plan • Consent • Modifier U2 (Denotes services delivered by CHW) Documentation must be accessible to the supervising provider and maintained for audit purpose.	Eligible billing entities include: Licensed provider* Clinic, including FQHC Hospital Community-Based Organization (CBO) Local Health Jurisdiction (LHJ) Pharmacy CHW must be supervised by a qualified** licensed provider*: Physician (MD, DO) Nurse Practitioner (NP) Physician Assistant (PA) Certified Nurse Midwife (CNM) Certified Nurse Specialist (CNS) Podiatrist Registered Nurse (RN) Social Worker (LCSW) Psychologist (PsyD, PhD) Marriage and Family Therapist (LMFT) Licensed Professional

Code & Service	Time	Description	Required Documentation	Provider Types
		Identifying appropriate providers and helping secure appointments • Health education: Personalizing clinical guidance to reflect patient needs, preferences, and SDOH context • Behavioral change support: Promoting motivation, participation, and goal attainment for diagnosis and treatment • Social & emotional support: Helping patients cope with health concerns and adjust routines to support recovery • Self-advocacy skills: Empowering patients to engage with care teams and community-based supports • Lived experience mentorship: When applicable, offering inspiration, validation, and guidance rooted in shared experience		
G0022 Medicare CHI Services	Each add 30 minutes beyond initial up to 3 times	CHI services, each additional 30 minutes per calendar month (list separately in addition to G0019)	Must be billed in with G0019	

Code & Service	Time	Description	Required Documentation	Provider Types
** Confirm which provider types are recognized as eligible supervisors for CHW-delivered services and other billable activities.				

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

- SBIRT codes may be billed by a:
  - Primary Care Treating Provider
  - Licensed Clinical Behavioral Health Provider (see below)
  - Trained ancillary personnel, as permitted by payer policy
- These codes are not exclusive to BHI models, but can be effectively integrated into BHI workflows to support early identification and intervention for substance use and behavioral health concerns.
- For comprehensive coding guidance and documentation standards, consult SBIRT-specific billing resources, including payer guidelines and professional association recommendations.
- The American Academy of Pediatrics (AAP) provides a curated list of behavioral health screening tools suitable for use in primary care settings here.

Code & 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 Physician (MD, DO) Nurse Practitioner (NP) Physician Assistant (PA) Social Worker (LCSW) Psychologist (PsyD, PhD) Marriage and Family Therapist (LMFT) Clinical Counselor (LPCC) Certified Nurse Midwife (CNM) & Certified Nurse Specialist (CNS) - Accepted by Medicare Only and some Medicaid plans
99409 (Commercial)	> 30 minutes	Appropriate for longer SBIRT interventions in primary care.	Ensure that the assessment is administered and scored using a standardized instrument,	

Code & Service	Time	Description	Required Documentation	Provider Types
G0397 (Medicare) Alcohol and/or substance abuse structured screening and brief intervention services			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	HCPCS code used to bill for brief substance use interventions. Limits on units per session or treatment cycle may apply. Not separately priced by Medicare Part B, but often reimbursed under Medicaid.	Clear linkage between diagnosis and service. Consent forms and group rosters (if applicable). Telehealth consent when services are remote.	

IV. Dyadic Services

- Dyadic services refer to a family- and caregiver-focused model of care that supports both the patient (e.g., a child) and their caregiver (e.g., a parent). Together, they form the "dyad."
- The California Department of Health Care Services (DHCS) added dyadic services as a covered benefit effective January 1, 2023. These services are available to Medi-Cal members through both fee-for-service (FFS) and managed care plans (MCPs), with a primary focus on child health and development.
- Good fit for organizations providing integrated care to pediatric populations, especially those serving children ages 0–5 and their caregivers.

Code & Service	Time	Description	Required Documentation	Provider Types
Medi-Cal Dyadic Services				
H1011 Dyadic Behavioral Health (DBH) Child Visit	Per visit (not timed)	Child must be present for behavioral health history, observation, mental status assessment, SDOH screening. *Must follow Bright Futures periodicity schedule.	For children under 21 and their parent(s)/caregiver(s)—regardless of Medi-Cal eligibility—dyadic services must conform to all existing requirements. Documentation in the medical record should include: • Date and duration of services • Specific dyadic services provided with associated CPT/HCPCS codes • Identified needs, issues, and follow-up recommendations • Justification of medical necessity • Applicable diagnosis(es) • Discussion or development of a dyad service plan, if relevant • Any additional information needed to support the services rendered	1. Independently Licensed 2. Insurer Enrollment/ Credentialing Physician (MD, DO) Nurse Practitioner (NP) Physician Assistant (PA) Social Worker (LCSW) Psychologist (PsyD, PhD) Marriage and Family Therapist (LMFT) Clinical Counselor (LPCC) Associate-level provider types may render dyadic services under the supervision of a licensed, enrolled Medi-Cal provider who submits claims on their behalf.
H2015 Dyadic Community Supports	Per 15 minutes	For care coordination, resource navigation, and service plan support. *Max 24 units/year and billed with U1 modifier.		
H2027 Dyadic Psychoeducational Services	Per 15 minutes	Structured interventions to prevent or address behavioral health issues. *Max 24 units/year and billed with U1 modifier.		
T1027 Dyadic Family Training &	Per 15 minutes	Brief counseling on parenting, child development, and caregiver-child interaction. *Max 24 units/year and billed		

Code & Service	Time	Description	Required Documentation	Provider Types
Counseling		with U1 modifier.		
*Refer to DHCS Dyadic Service Manual for billing guidelines.				

Appendix: California Health Plans and Behavioral Health Management

- Data current as of July 2025.
- Covers the different health insurance providers in California, including Medi-Cal and private insurers.
- Explores organizations that oversee mental health and substance use treatment services.
- Highlights how health plans and behavioral health entities collaborate to ensure comprehensive patient care.

California Managed Medi-Cal Plans* and MBHO			
Managed Care Plan (MCP)	**Managed Behavioral Health Organization (MBHO)**	**Managed Care Plan (MCP)**	**Managed Behavioral Health Organization (MBHO)**
Alameda Alliance for Health	In-House	Health Net Community Solutions	In-House
Anthem Blue Cross Partnership Plan	Carelon Behavioral Health	Health Plan of San Joaquin	Carelon Behavioral Health
Blue Shield of California Promise Health Plan	In-House	Health Plan of San Mateo	In-House
CalOptima	In-House	Inland Empire Health Plan	In-House
CalViva Health	MHN (Health Net)	Kaiser Permanente	In-House
Care 1st Partner Plan	In-House	Kern Family Health Care	In-House
CenCal Health	In-House	L.A. Care Health Plan	Carelon Behavioral Health
Central California Alliance for Health	Carelon Behavioral Health	Molina Healthcare of California Partner Plan	In-House
Community Health Group Partnership Plan	In-House	Mountain Valley Health Plan	In-House
Community Health Plan of Imperial Valley	MHN (Health Net)	Partnership Health Plan of California	Carelon Behavioral Health
Contra Costa Health Plan	In-House	San Francisco Health Plan	Carelon Behavioral Health
Gold Coast Health Plan	Carelon Behavioral Health	Santa Clara Family Health Plan	In-House

California Managed Medicare Plans and MBHO			
Managed Care Plan (MCP)	**Managed Behavioral Health Organization (MBHO)**	**Managed Care Plan (MCP)**	**Managed Behavioral Health Organization (MBHO)**
Anthem Blue Cross Partnership Plan	Carelon Behavioral Health	L.A. Care Medicare Advantage	Carelon Behavioral Health
Blue Shield of California	Carelon Behavioral Health	Molina Healthcare Medicare Complete Care Plus	Magellan
CalOptima (Orange County)	In-House	SCAN Health Plan Medicare Advantage	In-House
Kaiser Permanente Medi-Cal	In-House		

California Commercial Medicare Plans and MBHO			
Managed Care Plan (MCP)	**Managed Behavioral Health Organization (MBHO)**	**Managed Care Plan (MCP)**	**Managed Behavioral Health Organization (MBHO)**
Aetna	In-House	Kaiser Permanente (North & South)	In-House
Anthem/Elevance	Carelon Behavioral Health	Sharp Health Plan	Magellan Health
Blue Shield of California	Magellan Health	United Healthcare of California	Optum Health
Cigna	Evernorth (In-House)	Western Health Advantage	Optum Health
Health Net	In-House		