PCP-based behavioral health, teams expand; DMHT stalls

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Behavioral health

In two sections of the PFS, CMS adds to its ongoing fusion of primary care and behavioral care codes and expands behavioral health integration (BHI), psychiatric collaborative care model (CoCM), community health integration (CHI) and principal illness navigation (PIN), but fails to add to its digital behavioral health offerings.

Advanced primary care management (APCM) services, with codes **G0556**, **G0557** and **G0558** related to Levels 1, 2 and 3, were introduced in 2025 (*PBN 11/18/24*). They are intended to be provided by clinical staff under the direction of a physician or other qualified health care professional.

In this year's proposed rule, CMS announced psych add-on codes to be used with APCM, with the placeholders **GPCM1**, **GPCM2** and **GPCM3** (PBN 7/28/25). In the Enhanced Care Management section of the final rule, these codes have been finalized as **G0568** (Initial psychiatric collaborative care management, in the first calendar month of behavioral health care manager activities), **G0569** (Subsequent psychiatric collaborative care management, in a subsequent month of behavioral health care manager activities) and **G0570** (Care management services for behavioral health conditions, directed by a physician or other qualified health care professional, per calendar month).

These codes mirror, respectively, the CPT codes **99492** (Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities), **99493** (Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities) and **99484** (Care management services for behavioral health conditions, at least 20 minutes of clinical staff time).

The first two codes are related to BHI and the third to CoCM. Other codes related to these services are time-based, but CMS wants to allow providers performing APCM "to provide BHI services and CoCM without needing to document their time spent performing the service, because this would help facilitate a more holistic, team-based approach to care coordination and reduce burden," as well as make documentation easier, the agency says. Therefore, the add-ons' definitions are based on auxiliary provider activities (e.g., "tracking patient follow-up and progress using the registry, with appropriate documentation") rather than time.

The new add-on codes also help Medicare Shared Savings Program (MSSP) ACOs increase beneficiary assignment because patients billed with the new add-ons count as primary care recipients.

In the "Policies to Improve Care for Chronic Illness and Behavioral Health Needs" section of the rule, CMS similarly expands coding and billing opportunity for providers performing CHI and PIN for behavioral health patients.

CMS included CHI in the PFS in 2024 to reimburse "community health workers or other auxiliary personnel" doing groundwork that helps remove "health-related social barriers that are interfering with the practitioner's ability to execute a medically necessary plan of care" (PBN 9/21/23). The codes are **G0019** (CHI services, 60 minutes per calendar month) and **G0022** (... ; each additional 30 minutes per calendar month).

Previously, E/M visits were the only initiating provider services that allowed CHI codes to be billed. But in the final rule, CMS allows **90791** (Psychiatric diagnostic evaluation) or the health behavior assessment and intervention (HBAI) services **96156**, **96158**, **96159**, **96164**, **96165**, **96167**, and **96168** ("and any subsequent HBAI codes") to also serve that purpose, effective Jan. 1.

Also, CMS will now allow both CHI and PIN services to be performed by marriage and family therapists (MFT) and mental health counselors (MHC), because they have "a similar statutory benefit category as CSWs [clinical social workers]," who are currently authorized to provide these services.

DMHT stands pat

The digital mental health treatment (DMHT), aka "digital CBT" (cognitive behavioral therapy) services introduced in 2025 have hit a snag (*PBN 11/18/24*). Though CMS said it had examined some potential new applications for DMHT, including one for attention deficit hyperactivity disorder (ADHD), it has declined to advance them. Also, the agency reveals that claims data for these codes "have remained low in volume since we established these codes in the CY 2025 PFS final rule."

Going forward?

The overall aim of these changes, says David Halpert, chief of client team at Roji Health Intelligence in Chicago, is to improve outcomes for patients with behavioral health as well as other chronic conditions, a longstanding CMS goal (PBN 6/5/18).

Halpert suggests the change in administration may also have something to do with the continued emphasis on this integration. “The Trump administration has been critical of perceived ‘over-medication’” of people with behavioral issues, Halpert says, as seen in HHS Secretary Robert F. Kennedy’s skepticism toward antidepressants. It may be that CMS has made space for these codes “in the hope that behavioral health is addressed without pharmaceutical intervention in the primary care setting.”

But Martie Ross, office managing principal for the PYA consultancy in Kansas City and director of the PYA Center for Rural Health Advancement, believes adoption may be hampered by economic factors.

“CMS has established reimbursement for behavioral health integration, but physician practices are challenged to build the capacity to provide integrated care,” Ross says. “Medicare reimbursement is calculated on the cost of an operational program, meaning practices have to absorb the start-up costs for any new program—e.g., having to pay for staff while the program is gearing up. That’s likely the most significant obstacle to the adoption of these services by primary care services.”

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