

Strategies for Implementing and Enhancing Integrated Behavioral Health



March 3, 2026



Discussion Outline

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- Who are our qualified RHC mental health providers?
 - CMS
 - Oregon
- What limitations do we have when it comes to providing these services?
 - What is primary care?
 - What is behavioral/mental health?
 - How are these services defined?
 - Limitations in service lines?
- Care Management and IOP
- What codes are used to report behavioral health service?



Who are Qualified Mental Health Professionals in an RHC?

Medicare Mental Health Providers



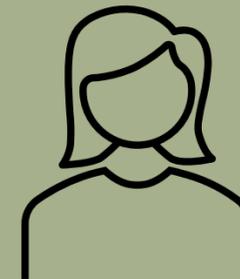
Psychiatrist

MD-PSYCHIATRY
DO-PSYCHIATRY
SPECIALTY



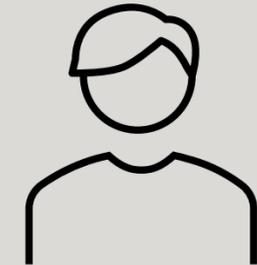
Advance Practice Provider

PMHNP
PSYCHIATRIC PA



LCSW

LICENSED CLINICAL
SOCIAL WORKER



Mental Health Professional

PROFESSIONAL
COUNSELOR
MARRIAGE &
FAMILY
THERAPIST

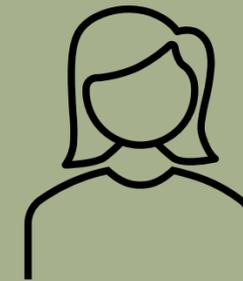
Medicaid Mental Health Providers



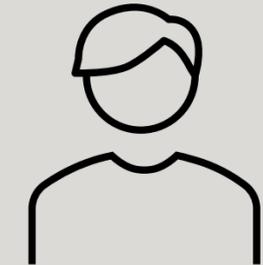
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Oregon Medicaid recognizes the following providers to bill these services: LMP, LPC, LMFT, LCSW, Psychologist, QMHP

410-147-0120 Division Encounter and Recognized Practitioners

(11) The following practitioners are recognized by the Division:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed Physician Associates;

(c) Dentists;

(d) Dental Hygienists who hold a Limited Access Permit (LAP) – may provide dental hygiene services without the supervision of a dentist in certain settings. For more information, refer to the section on Limited Access Permits, ORS 680.200 and the appropriate Oregon Board of Dentistry OARs;

(e) Pharmacists;

(f) Nurse Practitioners;

(g) Nurse Midwives;

(h) Other specialized nurse practitioners;

(i) Registered nurses – may accept and implement orders within the scope of their license for client care and treatment under the supervision of a licensed health care professional recognized by the Division in this section and who is authorized to independently diagnose and treat according to appropriate State of Oregon’s Board of Nursing OARs;

(j) Psychiatrists;

(k) Licensed Clinical Social Workers;

(L) Clinical psychologists;

(m) Acupuncturists – Refer to OAR chapter 410, division 130 for service coverage and limitations;

(n) Licensed professional counselor;

(o) Licensed marriage and family therapist; or

410-147-0120

Division Encounter and Recognized Practitioners

(p) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:

(A) Their individual provider's certification or license; or

(B) A clinic's mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH) (see OAR 410-147-0320).



What Services are available in an RHC?

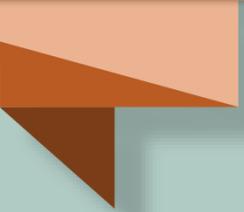
RHC Suite of Behavioral Health Services



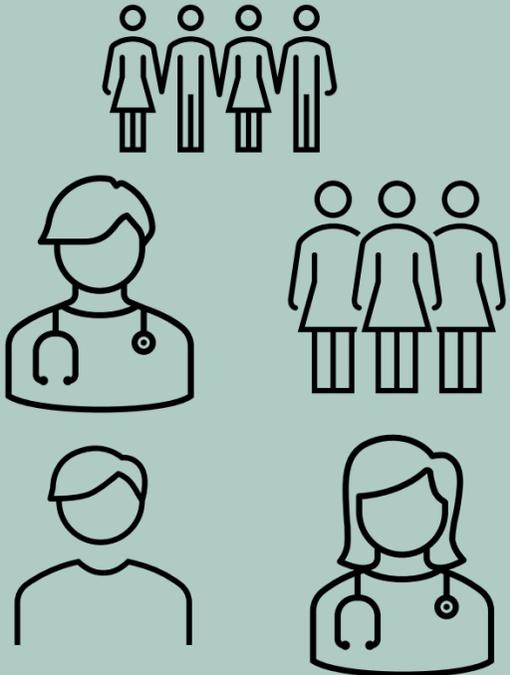
RHC Medical Encounter



RHC Mental Health Encounter



Care Management BHI and CoCM



Intensive Outpatient Services (IOP)





**What are our
challenges and
limitation?**

Challenge # 1: Not everyone has the same definition

- Is it just different providers within the same RHC?
- Is it care coordination?
- Is it an expanded medical home concept?
- Is it making outside referrals?

What is Integrated Behavioral Health?

Behavioral health is an umbrella term that includes mental health and substance abuse conditions, life stressors and crises, stress-related physical symptoms, and health behaviors. Behavioral health conditions often affect medical illnesses.

Integrated behavioral health care blends care in one setting for medical conditions and related behavioral health factors that affect health and well-being. Integrated behavioral health care, a part of “whole-person care,” is a rapidly emerging shift in the practice of high-quality health care. It is a core function of the “advanced patient-centered medical home.”

Integrated behavioral health care is sometimes called “behavioral health integration,” “integrated care,” “collaborative care,” or “primary care behavioral health.” No matter what one calls it, the goal is the same: better care and health for the whole person.

Providers practicing integrated behavioral health care recognize that both medical and behavioral health factors are important parts of a person’s overall health. Medical and behavioral health clinicians work together as a team to address a patient’s concerns. Care is delivered by these integrated teams in the primary care setting unless patients request or require specialty services. The advantage is better coordination and communication, while working toward one set of overall health goals.

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What Is Behavioral Health Integration?

Behavioral health integration (BHI) is integrating behavioral health care with other care, including primary care. It's an effective strategy to improve mental, behavioral, or psychiatric health for many patients.

Your patients may be eligible for BHI services if they have an identified mental, behavioral, or psychiatric health condition, including substance use disorder, and require:

- A behavioral health care assessment
- Behavioral health care planning
- Provision of interventions

These conditions may be pre-existing, or the billing practitioner may diagnose and refine the condition over time. Patients may also have comorbid, chronic, or other medical conditions the billing practitioner manages, but these aren't eligibility requirements.

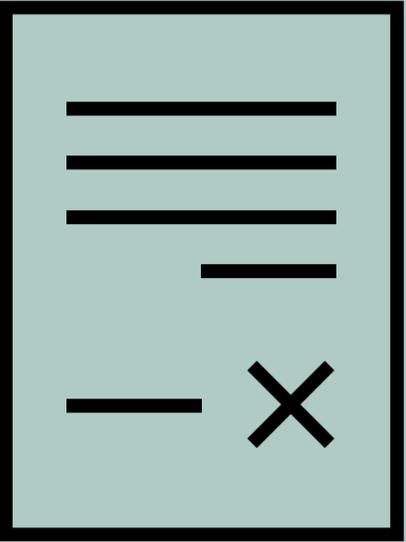
American Psychiatric Association

Examples of Integrated Care Services

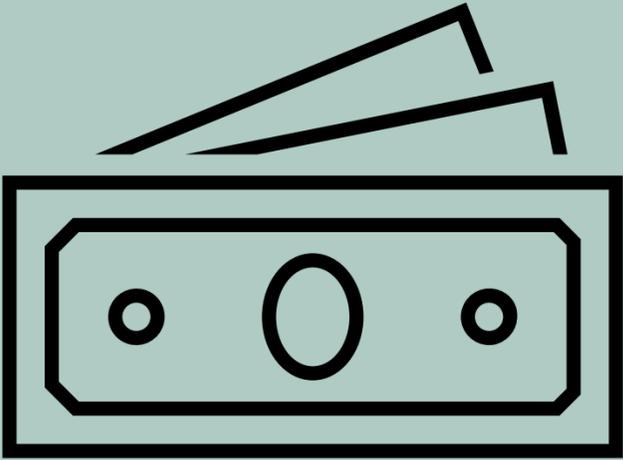
Here are examples of services that you might find in an integrated setting that are less common in other primary care sites:

- Routine screening for mental health conditions that are often associated with worse medical outcomes.
- Several visits with a therapist to get over a fear of social settings or going on an airplane or a fear of needles.
- Cognitive behavioral therapy for depression, anxiety and other conditions.
- Specific therapies for sleep issues or chronic pain.
- Programs that track your mood through frequent contact via phone or virtually and offer changes in treatment until it is clear you are getting better.
- A clear diagnostic interview to identify medical and psychiatric issues that may be present in your life.
- Help to start and stabilize on antidepressants or medications for other conditions.
- Assistance in identifying social challenges that may make it hard to follow your planned treatment (such as problems with insurance, transportation, housing or food insecurity, etc.)
- Targeted referrals to the right types of mental health assistance in your community.

Challenge # 2: Policy and Payment don't currently align



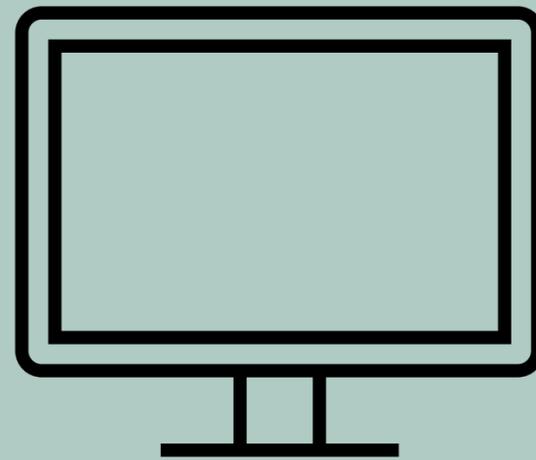
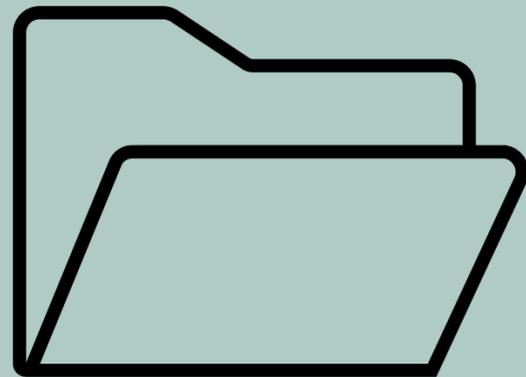
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Policy versus Payment

- Limit on one medical and one mental health visit regardless of the number of providers seen.
- Limit on the CPT®/HCPCS® codes which can be mapped as mental health services.
- Challenges in provider enrollment and claims submission configurations which may limit the ability to report certain services.
- Payer guidelines which fail to conform to either Medicare or Medicaid regulations or guidance.
- Siloed providers
- Care Management services are carved-out services although they are approved for RHCs.
- Can't perform some services on the same day.

Challenge # 3: EHR and Medical Record Limitations



EHR and Medical Record Limitations

- Not able to create more than one encounter per patient on the same day.
- Not being able to create two different template notes for the same patient on the same day.
- Inability to split charges to different claim formats if there is one encounter with multiple providers.
- Note and template creation to fit the provider and the service.
- Accessing care management notes or indexing them in a way that makes it easy for providers to see an overall picture of the patient's care.
- Added expense to have any changes made to the EHR.

EHR and Medical Record Limitations

- Additional privacy and confidentiality required for mental health notes.
- What is a therapy note? What is a “medical” note?
- What about care management records?
- Configuring roles and permissions for “need to know.”
- What about AI for mental health visits?
- What about Health Information Exchanges?
- What about “breaking the glass”?

Care Management Services and IOP for Behavioral Health

NEW CODES

Deleted Code: G0511 for BHI

This was the RHC-specific code for chronic care management and BHI that was created in 2015. G0511 later became the “umbrella code” used for care management, remote patient monitoring and remote therapeutic monitoring services. The code reimbursed a consolidated fee schedule amount (average) based on the current year’s MPFS.

Code Description: Rural Health Clinic or Federally Qualified Health Center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month.

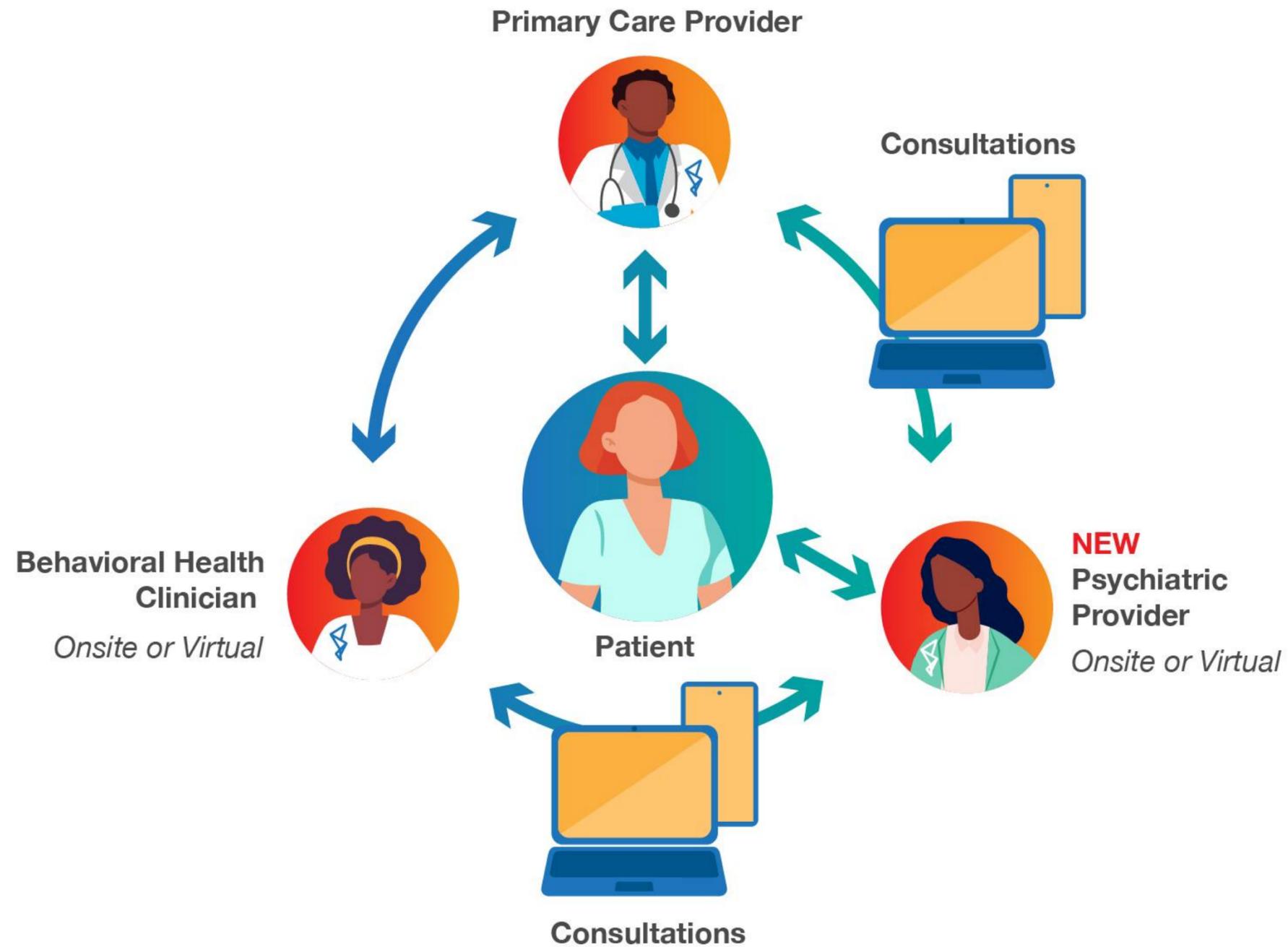
Use of the G0511: Optional use through September 2025. CMS instructed RHC to stop using this code as of 10/01/25. Most MACs had problems processing the “regular” codes. This was a nationwide problem that should be resolved. G0511 is now deleted from the code set for dates of service beginning 01/01/2026. See list of qualified codes for RHCs.

Behavioral Health Integration

99484

Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.

Psychiatric Collaborative Care Model Example



Graphic Credit:
<https://www.premisehealth.com/resources/news/premise-health-introduces-the-next-evolution-of-behavioral-health/>

Deleted Code: G0512 for CoCM

This was the RHC-specific code for that was created in 2015 for the Psychiatric Collaborative Care model. This CoCM model had specific requirements for both time and care team composition.

Code Description: Rural Health Clinic or Federally Qualified Health Center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month

Use of the G0512: This code is now deleted from the code set and cannot be used as of 01/01/26. RHCs are now instructed to report the appropriate CPT® based on the service performed. Codes may include 99492, 99493, and 99494.

Psychiatric Collaborative Care Management 99492

Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

Psychiatric Collaborative Care Management 99493

Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

Psychiatric Collaborative Care Management 99494

Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)

2026 APCM Add-on codes for Behavioral Health Integration

GPCM1 will mirror CPT 99492
GPCM2 will mirror CPT 99493
GPCM3 will mirror CPT 99484

RHC Intensive Outpatient Program



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MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

**Billing Requirements for Intensive Outpatient Program
Services for Federally Qualified Health Centers & Rural
Health Clinics**

Related CR Release Date: January 16, 2024 MLN Matters Number: MM13264

Effective Date: January 1, 2024 Related Change Request (CR) Number: [CR 13264](#)

Implementation Date: January 2, 2024 Related CR Transmittal Number: R12460OTN

Related CR Title: Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with Revenue Code 0905 for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

<https://www.cms.gov/files/document/mm13264-billing-requirements-intensive-outpatient-program-services-federally-qualified-health.pdf>

RHC Intensive Outpatient Program

IOP Scope of Benefits

Items and services available under the IOP benefit includes:

- Individual and group therapy with physicians or psychologists or other mental health professionals to the extent authorized under state law
- Occupational therapy by a qualified occupational therapist or under appropriate supervision of a qualified occupational therapist by an occupational therapy assistant
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients
- Drugs and biologicals provided for therapeutic purposes, which can't be self-administered
- Individualized activity therapies that aren't primarily recreational or diversionary
- Family counseling, the primary purpose of which is treatment of the patient's condition
- Patient training and education to the extent that training and educational activities are closely and clearly related to the patient's care and treatment
- Diagnostic services

RHC Intensive Outpatient Program

IOP Certification and Plan of Care Requirements

You must provide IOP services as part of an individualized, written plan of treatment established and periodically reviewed by a physician in consultation with appropriate staff participating in such program, which includes:

- The physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan
- Physician certification that an individual needs IOP services for a minimum of 9 hours per week of therapeutic services as written in their plan of care
- Review done no less than every other month

RHC Intensive Outpatient Program

Multiple Visits

Currently, encounters with more than 1 health professional and multiple encounters with the same health professional that take place on the same day and a single location constitute a single visit, except when a patient has:

- A medical visit and a mental health visit on the same day
- An initial preventive physical exam and a separate medical or mental health visit on the same day

When you provide IOP services on the same day as a mental health visit or on the same day as a medical visit, all services are covered under Medicare Part B.

- If you provide IOP services on the same day as a mental health visit, we'll make 1 payment at the IOP rate. We include payment for the mental health visit under the IOP rate.
- If you provide IOP services as a medical visit, we'll make 1 payment for the medical visit under the FQHC PPS and 1 payment for IOP services at the IOP rate.

Note: Continue to report mental health services with revenue code 0900. Don't report IOP services with revenue code 0900.

Cannot double dip mental health RHC encounters and IOP

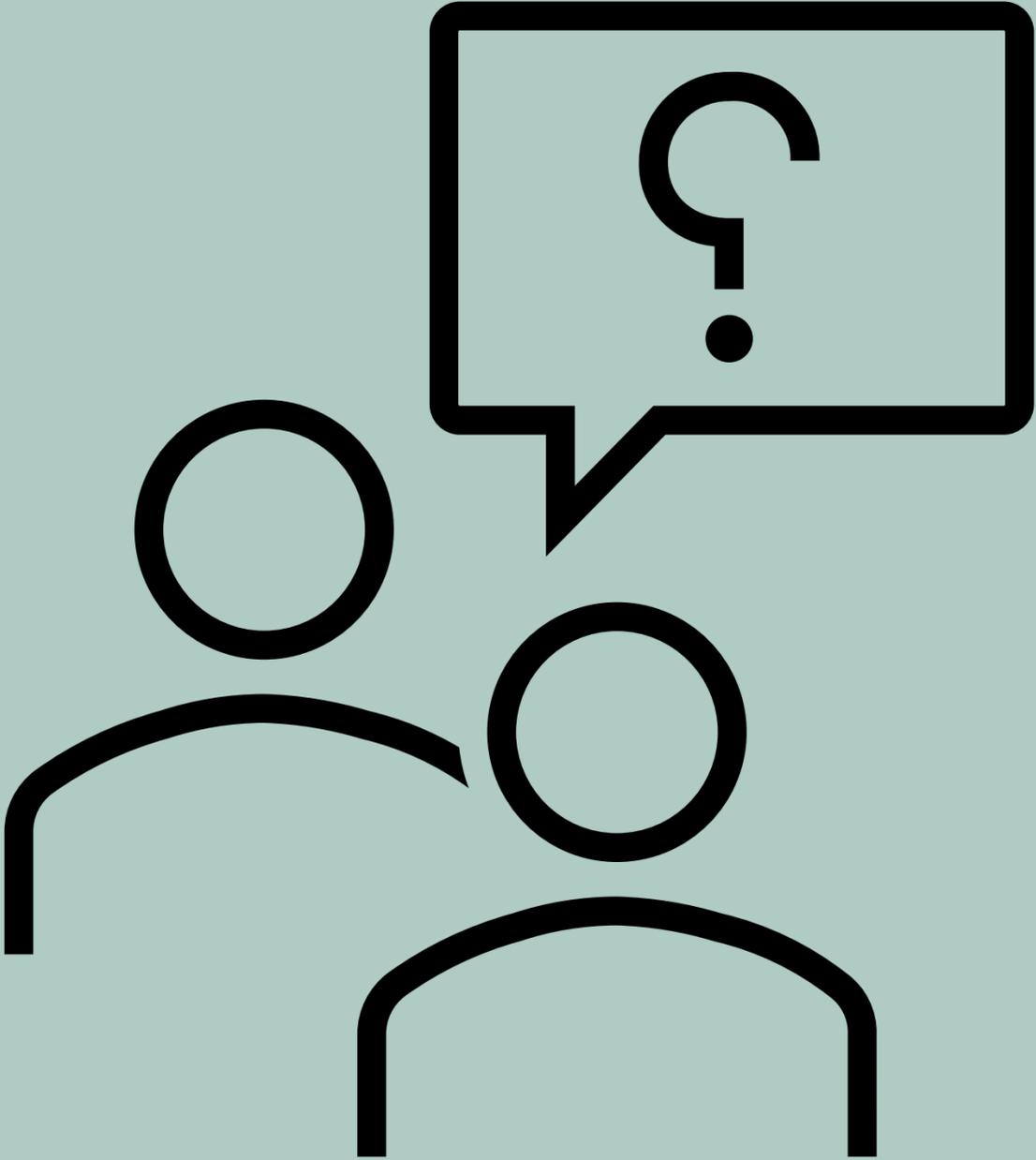


Implementation Strategies

Basic Steps to Implementation

- Assess population needs. (Payer mix, age, level of care)
- Determine RHC capacity to add new services.
 - Provider Availability
 - Space
 - Required Changes to Workflow
 - Required Operational Changes
 - Required System Changes
- Growing the new services organically.
- Evaluating implementation/Tweaking Processes
- Expanding services to meet need and capacity.

Comments?



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