healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Digital Mental Health Treatment (DMHT) Device		
Policy Number:	PO-RE-115v1		
Effective Date:	01/01/2025	**Last Approval Date:**	07/21/2025

I. Policy Description

A Digital Mental Health Treatment (DMHT) device is a device similar to a mobile device that allows billing practitioners to provide behavioral health services in conjunction with ongoing behavioral health care treatment. The purpose of this policy is to provide reimbursement guidelines for furnishing the DMHT device and services related to the patient's use of the device.

The information below applies to the following lines of business:

- Medicare Advantage
- Medicare PPO
- Medicaid Advantage Plus/MAP (CompleteCare)

Policy Scope

This policy applies to DMHT devices prescribed by licensed providers delivering DMHT services, including behavioral health practitioners and physician providing ongoing treatment of behavioral health services.

Key Definitions

- DMHT Devices: FDA-cleared or DeNova authorized devices used for digital mental health treatment, coded under HCPCS G0552 (device furnishing), G0553 (initial treatment management), and G0554 (subsequent treatment management).
- Privileging: The process by which providers are authorized to deliver DMHT services based on credentialing, training, and adherence to clinical guidelines.

Privileging Process

1. Providers Privileging Prior to Service Delivery:
   - Providers intending to deliver DMHT services must contact their assigned Healthfirst account manager.

- Complete the Privileging Protocol, including credential verification, clinical competency, and documentation review.
- Obtain approval before billing for DMHT services.

2. Special Provider Contract
   - Providers must initiate a separate provider contract specific to DMHT services.

Reimbursement Guidelines

1. The device must be part of an ongoing treatment plan.
2. The billing practitioner must diagnose the patient and prescribe or order the device.
3. Device coverage is authorized for up to ninety (90) days.
4. Continuation requires:
   - Physician order for ongoing services.
   - Supporting medical documentation and treatment plan.
5. Code G0552 should be billed for furnishing the device. This code may also be used for educating the patient on how to use the device.
6. Codes G0553 and G0554 are utilized for monthly treatment management services directly related to the patient's therapeutic use. These codes should not be billed when the patient discontinues use of the device.
7. PCP Scope of Services:
   - Primary Care Providers (PCPs) may incorporate DMHT services within their scope when appropriately privileged and aligned with their clinical expertise.
   - PCPs should coordinate with behavioral health specialists for complex cases requiring specialized intervention.
8. Device Cost and Reimbursement:
   - Providers who incur the cost of furnishing FDA-approved DMHT devices are eligible for reimbursement.
   - Reimbursement will be processed according to the Healthfirst standard fee schedule or the rates outlined in the provider's contract with Healthfirst.

Adjudication and Appeal Process

1. Claims submitted without prior privileging will be denied.
2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded in compliance with the correct coding and billing guidelines.
3. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

4. Reimbursement is subject to member eligibility, program coverage, and medical necessity at the time the service is provided.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

II. Applicable Codes

Code	Description	Comment
G0552	Supply of DMHT device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan	
G0553	**First** 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the DMHT device that augments a behavioral therapy plan, physician/other qualified healthcare professional time reviewing information related to the use of the DMHT device, including patient observations and patient-specific inputs in a calendar month, and requiring at least one interactive communication with the patient/caregiver during the calendar month	
G0554	Each **additional** 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the DMHT device that augments a behavioral therapy plan, physician/other qualified healthcare professional time reviewing information related to the use of the DMHT device, including patient observations and patient-specific inputs in a calendar month, and requiring at least one interactive communication with the patient/caregiver during the calendar month	

III. Definitions

Term	Meaning
DMHT	Digital Mental Health Treatment

HCPCS	Healthcare Common Procedure Coding System
PCP	Primary Care Providers

IV. Related Policies

Policy Number	Policy Description
MP-091	Digital Mental Health Treatment (DMHT) and Behavioral Health Remote Therapeutic Monitoring (RTM)

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

MM13887 - Medicare Physician Fee Schedule Final Rule Summary: CY 2025
Medicare Claims Processing

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amount that Healthfirst or the member owes the provider.