

Billing opportunities and Collaborative Care



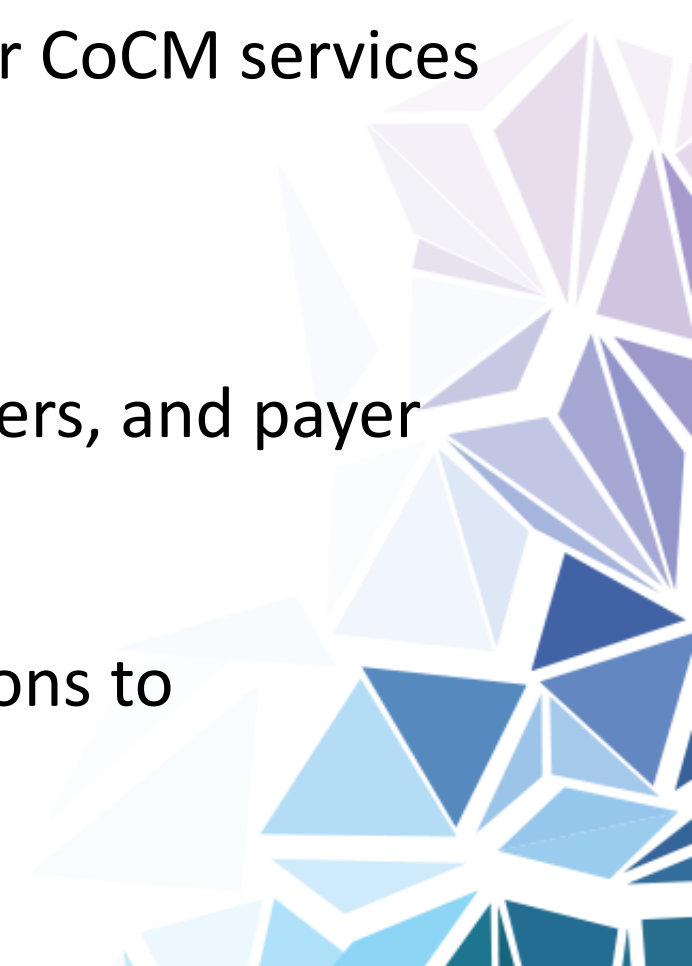
Learning Objectives

- Describe how Collaborative Care billing codes differ from other types of billing codes
- Identify aspects of team-based care in the Collaborative Care Model



Disclaimer

- This material represents our understanding of the Centers for Medicare & Medicaid Services (CMS) requirements for CoCM services
- Guidelines may vary by payer
- Verify guidance with your billing and compliance officers, and payer representatives
- Send Blue Cross Blue Shield of Michigan billing questions to valuepartnerships@bcbsm.com



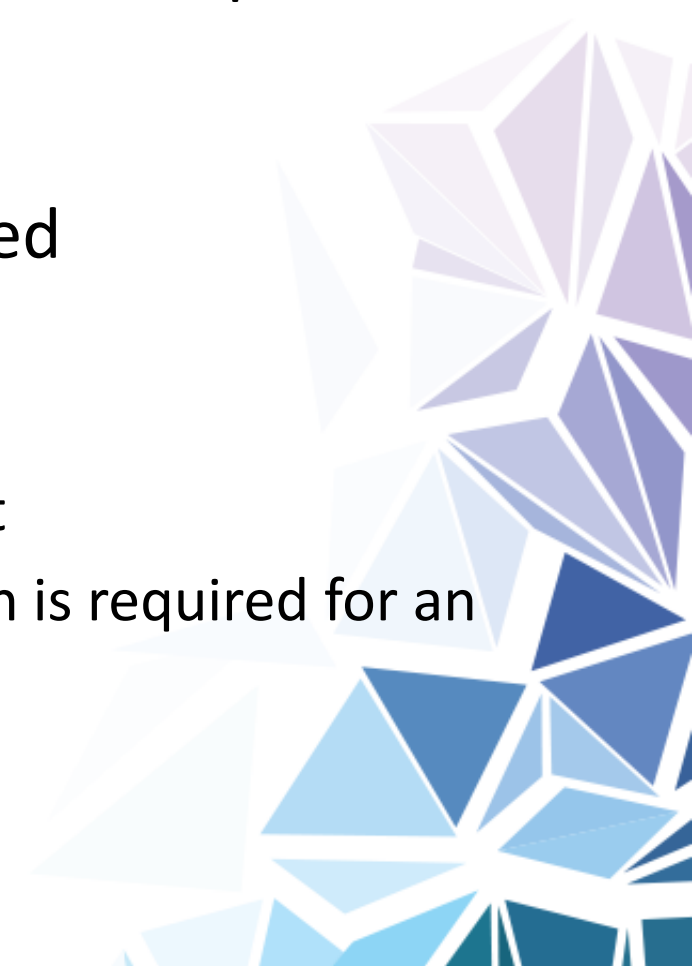
Collaborative Care billing basics (1 of 2)

- CoCM codes are medical codes, not behavioral health codes
- For BCBSM, Claims are submitted under the rendering physician's National Provider Identifier (NPI)
- Billing codes are based on the cumulative number of minutes of care provided by the BHCM
- CoCM codes are billed once per calendar month



Collaborative Care billing basics (2 of 2)

- An initiating billable visit with the primary care provider is required for patients not seen within one year
- Cost sharing, if applicable, is applied to each code billed
- Michigan Medicaid:
 - Initial assessment must have a visual and audio component
 - After the initial 12 months of treatment, prior authorization is required for an additional 12 months of treatment



CoCM billable activities (1 of 3)

Direct service provision

Systematic Case Review (SCR) related activities

Coordination of care

- Patient contact
- Intake and structured behavioral health assessments
- Using brief therapeutic interventions
- Self-management planning and relapse prevention planning
- Administering validated outcome measures

CoCM billable activities (2 of 3)

Direct service provision

Systematic Case Review (SCR) related activities

Coordination of care

- Preparing for systematic case review
- Conducting systematic case review with the psychiatric consultant
- Discussing a patient at the systematic case review meeting
- Maintaining and reviewing a systematic case review tool for patient tracking and follow-up

CoCM billable activities (3 of 3)

Direct service provision

Systematic Case Review (SCR) related activities

Coordination of care

- Linking patient with resources
- Collaboration and coordination with:
 - PCP
 - Other qualified health care professionals
 - Other mental health professionals
 - Community based service providers
 - Patient support persons

CoCM billing codes: commercial members, any location

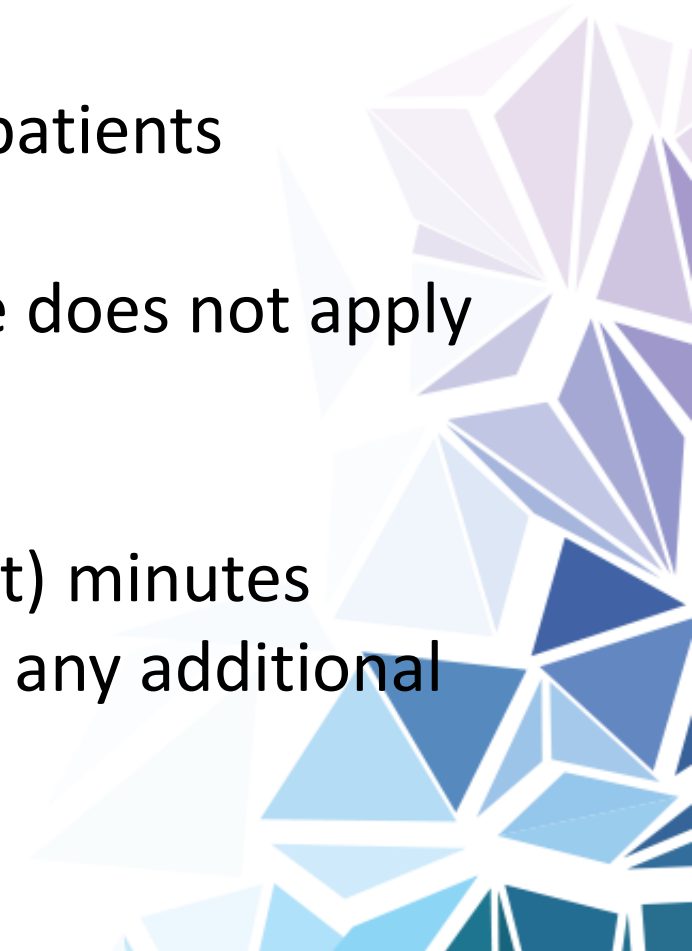
| Provider Location | Service | Code | Month | Time Threshold |
|-------------------|---------------------------------------|-------|--------------------------------|----------------|
| Any location | General Behavioral Health Integration | 99484 | Any month | 11-20 minutes |
| | Collaborative Care Management | 99492 | Initial month | 36-70 minutes |
| | | G2214 | Initial or subsequent month(s) | 16-30 minutes |
| | | 99493 | Subsequent month(s) | 31-60 minutes |
| | | 99494 | Add-on code | 16-30 minutes |

CoCM billing codes: Medicare and Michigan Medicaid members, by location

| Provider Location | Service | Code | Month | Time Threshold |
|-------------------|--|-------|--------------------------------|----------------|
| Non-FQHC/RHC | General Behavioral Health Integration | 99484 | Any month | 11-20 minutes |
| | Collaborative Care Management | 99492 | Initial month | 36-70 minutes |
| | | G2214 | Initial or subsequent month(s) | 16-30 minutes |
| | | 99493 | Subsequent month(s) | 31-60 minutes |
| | | 99494 | Add-on code | 16-30 minutes |
| FQHC/RHC | Chronic Care Management/ General Behavioral Health Integration | G0511 | Any month | 20 minutes |
| | Collaborative Care Management | G0512 | Initial month | 70 minutes |
| | | | Subsequent month(s) | 60 minutes |

Billing takeaways for FQHCs and RHCs

- FQHCs and RHCs are unable to bill G2214 regardless of insurance type
- FQHCs and RHCs may only bill 99494 for commercial patients
- CPT time rule and the add-on code for additional time does not apply for Medicaid/Medicare/Medicare Advantage.
- You must provide the full 70 (initial) or 60 (subsequent) minutes before billing for the service and sites are not paid for any additional time.



Required elements to bill 99492 (initial month)

- Patient outreach and engagement
- Initial assessment including validated scales
- Treatment plan development
- Review and plan modification by psychiatric consultant
- Patient added to registry/systematic case review tool
- Patient progress is tracked using that tool
- Weekly caseload review with psychiatric consultant is conducted and documented
- Provision of brief, evidence-based interventions



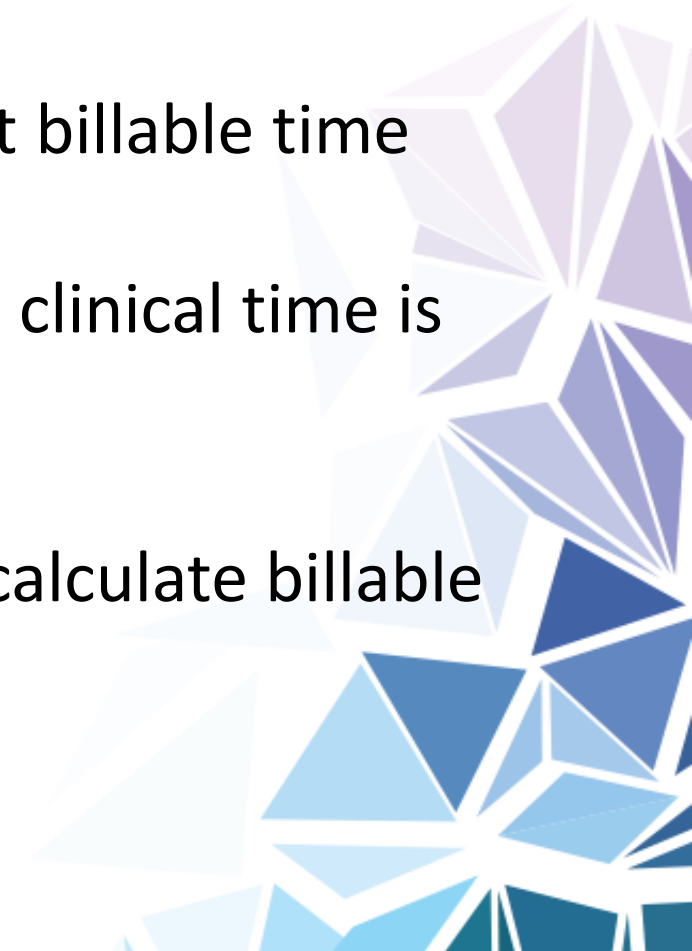
CoCM code billing dos and don'ts

| CoCM Codes | Can do | Can not do |
|---|---|---|
| 99492 99493 99494 G0512 G2214 | <ul style="list-style-type: none"> ✓ CoCM can be billed alone or with a claim for another billable visit ✓ Can bill CoCM services with provider-delivered care management claims if appropriate | <ul style="list-style-type: none"> ✗ Can't bill in the same month as a general behavioral health integration code (99484, G0511) ✗ Can't "double dip" minutes |

Example: initial month, commercial patient

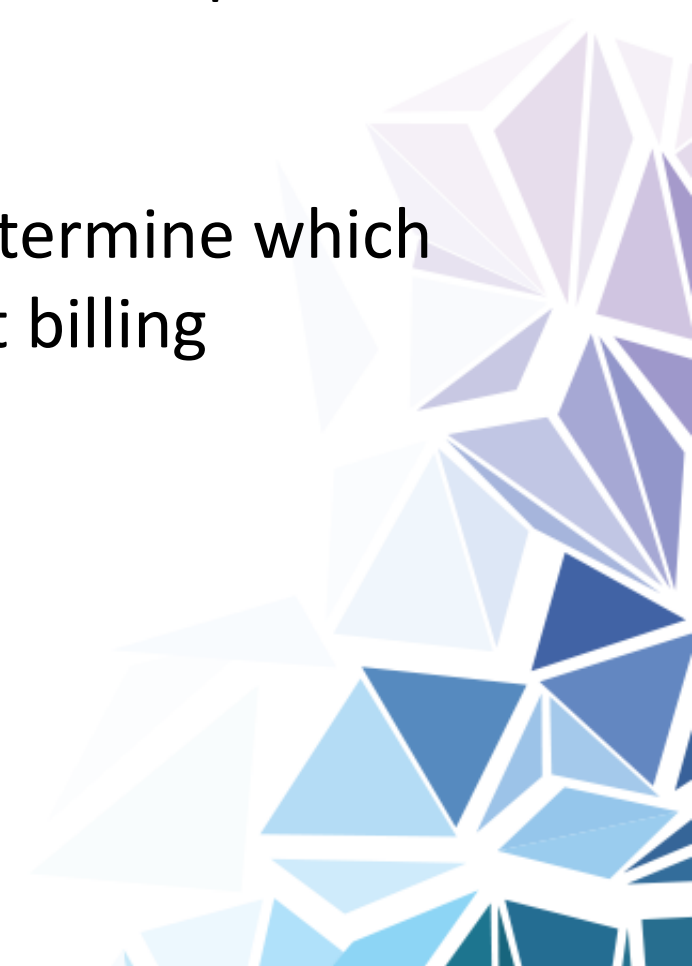
| Date | Activity | Minutes |
|---------|--|-----------|
| 2/2/23 | Patient enrolled in CoCM services; BHCM conducted initial assessment; BHCM administered PHQ-9/GAD-7; BHCM updated SCR tool | 45 |
| 2/7/23 | BHCM discussed patient with psychiatric consultant during SCR; BHCM followed-up with PCP; BHCM updated SCR tool | 15 |
| 2/8/23 | BHCM followed-up with patient by phone | 5 |
| 2/22/23 | BHCM followed-up with patient; BHCM delivered Behavioral Activation | 20 |
| No date | BHCM/psychiatric consultant 'ran' the systematic case review | 5 |
| | Total: Bill 99492 + 99494 | 90 |

Best practice: capture and document billable time

- Consider periodic BHCM **time studies** to create a general rubric
 - Create a **smart phrase** to prompt BHCMS to document billable time
 - Create a **documentation checklist** to ensure all BHCM clinical time is calculated
 - Create **EHR workflows** and processes to capture and calculate billable minutes
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Best practice: consistent review of billable minutes

- Review a report of documented billable minutes per patient per calendar month
- Review this report halfway through each month to determine which patients would need additional time to reach the next billing threshold
- Assess distribution of time across the entire caseload



Evaluating time delivered by minutes

| Patient | Mar | Apr | May | Jun | Jul | Aug |
|---------|-----|-----|--------|-----|-------|-----|
| A | 20 | 35 | 0 | 35 | 30 | 0 |
| B | 65 | 35 | 20 | 25 | 15 | 0 |
| C | 20 | 25 | 20 | 10 | 0 | 0 |
| D | 70 | 50 | 40 | 10 | 5 | 20 |
| E | 75 | 55 | 15 | 25 | 55 | 35 |
| F | 80 | 35 | 20 | 35 | 85* | 40 |
| G | | 70 | 45 | 35 | 0 | 40 |
| H | | 95* | 45 | 80* | 110** | 65 |
| I | | 70 | 20 | 30 | 0 | 35 |
| J | | | 60 | 60 | 30 | 30 |
| K | | | 145*** | 60 | 0 | 65 |

| Month | Minutes Spent | CPT Codes |
|---------------|---------------|--|
| Initial month | ≤10 | Not billable |
| | 11-35 | 99484 |
| | 36-85 | 99492 |
| | 86-115 | 99492 + 99494 |
| | 116-130 | 99492 + 99494, quantity 2 units |
| Sub. months | ≤10 | Not billable |
| | 11-30 | 99484 |
| | 31-75 | 99493 |
| | 76-105 | 99493 + 99494 |
| | 106-135 | 99493 + 99494, quantity 2 units |

Best practice: optimize billable clinical time

- Is your clinical time being optimized for your caseload size?
- Conduct a clinical caseload supervision
- Assess opportunities to keep the caseload “fluid” (i.e., who could benefit from a different level of care?)



Evaluating time delivered by code: 99492

| Patient | Mar | Apr | May | Jun | Jul | Aug |
|---------|-----------|-----------|------------|-----|-----|-----|
| A | 20 | 35 | 0 | 35 | 30 | 0 |
| B | 65 | 35 | 20 | 25 | 15 | 0 |
| C | 20 | 25 | 20 | 10 | 0 | 0 |
| D | 70 | 50 | 40 | 10 | 5 | 20 |
| E | 75 | 55 | 15 | 25 | 55 | 35 |
| F | 80 | 35 | 20 | 35 | 85 | 40 |
| G | | 70 | 45 | 35 | 0 | 40 |
| H | | 95 | 45 | 80 | 110 | 65 |
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Billing resources (1 of 2)

- [Medicare Learning Network Behavioral Health Integration Services](#)
- [Medicare Learning Network FAQ about Billing Medicare for BHI Services](#)
- [MDHHS MSA Bulletin 20-38 Coverage of Psychiatric Collaborative Care Model Services](#)
- [Blue Cross Blue Shield of Michigan Value Partnerships Update April 2020](#)
- [Collaborative Care Model \(CoCM\) Billing Webinar Presented by Blue Cross Blue Shield of Michigan](#)
- Find BCBSM billing guidance on the PGIP collaboration site under care management services

Billing resources (2 of 2)

- [National Association of Community Health Centers Payment Reimbursement Tips: FQHC Requirements for Medicare Psychiatric Collaborative Care Model](#)
- [Michigan Department of Health and Human Services FQHC Reimbursement List October 2021](#)
- [Michigan Department of Health and Human Services Medicaid Provider Manual](#)
- [American Psychiatric Association FAQ for billing the Psychiatric Collaborative Care Management and General Behavioral Health Intervention Codes](#)



References

1. Carlo, A.D., Corage Baden, A., McCarty, R.L. *et al.* Early Health System Experiences with Collaborative Care (CoCM) Billing Codes: a Qualitative Study of Leadership and Support Staff. *J GEN INTERN MED* 34, 2150–2158 (2019). <https://doi.org/10.1007/s11606-019-05195-0>.

