VALUEPartnerships
Better Care. Better Outcomes. Better Value.

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan Physician Group Incentive Program

Collaborative Care Model (CoCM) Designation Program

Frequently asked questions

2023-2024

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Process questions

1. What is Psychiatric Collaborative Care (CoCM)?

Psychiatric Consult Collaborative Care, (CoCM) is a delivery model that coordinates patient treatment is through a primary care practitioner or a specialists to ensure patients receive the necessary behavioral health care in a familiar setting.

The PCP or treating provider is ultimately responsible for the patient treatment plan and makes determinations about recommendations. However, the care team is expanded to include two new members.

- A behavioral health care manager (BHCM) who provides frequent contacts to discuss progress, treatment efficacy, side effects and general resolution of barriers with the overall goal of treating each patient to target according to individualized treatment plans.
- A consulting psychiatrist who provides treatment review and recommendations to the BHCM during frequent case reviews, known as systematic case reviews (SCRs).

2. Why do we need a "CoCM Designation Program?"

The Collaborative Care Designation Program recognizes a CoCM practice's commitment to creating an empowered care team, that delivers the evidence-based care to best meet a patient's behavioral health needs in a patient-centered medical home environment, which is both familiar to the patient, destigmatizes mental health treatment, and makes judicious use of scarce behavioral health specialists.

The CoCM Designation Program builds on the essential foundation of Blue Cross' longstanding PCMH program to create a culture of sustained attention to the "whole person" philosophy—a critical goal for organizations to thrive. This philosophy is especially important now, a time when the need for behavioral health services is rapidly increasing due to the pandemic and other factors and when access to scarce behavioral health care is stretched further than ever.

Blue Cross' first-to-market CoCM Designation Program is value-based and population-based. It rewards collaboration between practitioners in areas where inter-specialty communication traditionally has not been a part of usual care; this communication dramatically helps improve both access to critical services and ultimately, clinical outcomes.

3. *Isn't CoCM designation the same thing as PCMH designation?*

No. A PCP practice must be patient-centered medical home-designated to become CoCM designated. OB/GYN practices must meet PCMH requirements, even though they are not PCMH designated. The CoCM capabilities build on foundational PCMH capabilities, but the CoCM capabilities aren't duplicative. The CoCM capabilities are the "must elements" of what is needed to deliver CoCM well.

Blue Cross realizes that delivering CoCM takes a both a shift in office culture and a commitment to practice transformation. Based on CoCM work to date, and on the successes of other PGIP programs, the capabilities required for designation are those needed to effectively and efficiently deliver CoCM.

Each capability defines guidelines that will enable practices to succeed in CoCM delivery.

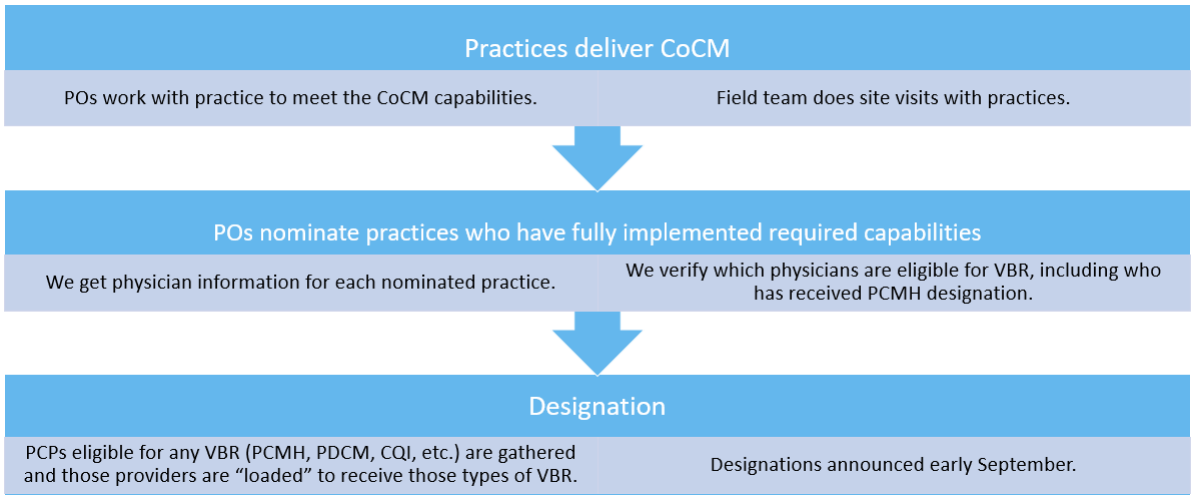
4. *What is the process for a practice to be designated?*

A practice must be PCMH-designated to receive CoCM designation.
Here are the steps to designation:

- The physician organization works with their practices throughout the year to ensure they have the CoCM capabilities fully in place.
- The PO reports on each practice's capabilities and nominates their eligible CoCM practices.
- Our field team will conduct site visits to validate that the capabilities are fully in place.

Nominations and reporting capabilities

Nomination and capability reporting will be done using the Self-Assessment Data tool on the PGIP Collaboration site. The nomination period will close at the lock-down date for the spring snapshot.



5. Who is responsible for reporting CoCM capabilities to Blue Cross?

Physician organizations will be responsible for reporting capabilities. Physician organizations will work with their practices to engage and educate them about effective use of the CoCM model. The POs will then report capabilities in place to Blue Cross.

It's not acceptable for a PO to request that practices simply report their capabilities. POs must validate that the capabilities are in place before reporting them.

6. May we report a capability in place as soon as the practice has the ability to use it?

No. Any capability reported to Blue Cross as "in place" must be fully in place *and in use by all appropriate members of the practice unit team on a routine and systematic basis*, and, where applicable, patients must be actively using the capability.

7. Do we have to implement the capabilities in order?

No. Although capabilities are not necessarily listed in sequential order and may be implemented in any sequence the PO and/or practice feels is most suitable to their practice transformation strategy.

8. Will my practice receive a site visit?

Perhaps. We will visit both employed-model practices and independent practices throughout the state..

Practices will be randomly selected for site visits. For any selected practice, the PO will be notified by email at least 30 days in advance.

Capability validation is a required component of the designation process. As with PCMH site visits, a random group of practices will be selected for site visits. Practices who received site visits in 2023 will not be selected for another in 2024. Practice will be selected from those that received designation in 2023. During the site visit the field team review the processes and procedures for each capability. As with PCMH site visits, much of the visit will focus on best practices that can be shared with, or have been shared by, other practices.

9. How should physician organizations prepare practices for a site visit?

Site visits are a vital component of Blue Cross' CoCM program.

POs should inform practices that they must demonstrate that the capabilities are in place. For example, if the practice is asked to show the field team their suicide protocol, the practice should demonstrate their workflow, how the screening tool is used, and then have the suicide policy available and patient examples identified ahead of time so that they are prepared to discuss them with the field team during the site visit.

All requested documentation must be available and provided prior to the site visit.

10. What happens during and after the site visit?

- During the site visit, the field team member leading the site visit will walk through the Validation Checklist with the practice and PO.
- The full field team, and any necessary PGIP decisionmakers, will evaluate the site visit to determine whether capabilities are fully in place. The field team member who led the site visit will communicate the results to the practice and PO within 10 days.

11. What if the field team notes that a capability or capabilities are not fully in place?

For any capabilities which aren't fully in place, the field team will discuss the necessary action steps and timelines with the practice and PO.

- If any capabilities aren't in place, the field team will schedule a follow up visit in approximately 90 days.
- Documentation of remediation activities for any of the capabilities that were marked "not fully in place," must be forwarded to the field team at least seven days prior to the scheduled site visit.
- If the remediation documentation isn't provided or if the remediation documentation doesn't fully address the missing capabilities, the site visit will be cancelled, and the practice will lose designation for the remainder of the designation cycle and loses six months of future CoCM VBR.
- For any of the capabilities that were marked "not fully in place," the practice and PO must demonstrate at the follow up visit that the missing capabilities are now fully in place.
- If capabilities aren't in place according to the above timeline, the practice loses designation for the remainder of the designation cycle and loses six months of future CoCM VBR.
- Value Partnerships reserves the right to terminate VBR.

12. If a practice loses designation, when would the practice be eligible for designation consideration

Designations are only awarded annually on Sept 1. POs will be allowed to nominate those practices who lost designation at the next designation cycle, which will be before the April snapshot to run Sept. 1 through Aug. 31. Nominations will be entered into the SAD tool.

13. If a practice loses VBR, when would the practice be eligible for CoCM VBR reconsideration?

If a practice loses their designation, they will also lose six months of VBR. Practices will be eligible to receive CoCM VBR either at the six-month cycle, nominated before the October snapshot to run from March 1st through August 31 or the full 12-month cycle, which runs Sept. 1 through Aug. 31, whichever comes first. Nominations will be entered into the SAD tool.

Example: If the practice cannot demonstrate that all the capabilities are fully in place by the April nomination date, the next VBR opportunity would be for the six-month October nomination which would begin March 1st of the following year. The next designation opportunity would be Sept. 1 of the following year.

14. What screening tools are used to diagnose and screen for depression and anxiety?

There are several validated, evidence-based screening tools widely available. See the PGIP Collaboration site for some screening tool descriptions. However, for the CoCM Designation Program, all CoCM patients must

receive the Patient Health Questionnaire-9 (PHQ-9 or PHQ-A) monthly. We also recommend the General Anxiety Disorder – 7 (GAD-7) to be used for anxiety. Other screeners may be used in addition to PHQ-9 and, if using, GAD-7 according to the needs of the PO and practice.

Blue Cross requires a written policy and/or procedure for screening frequency, interpreting, and tracking results.

Additionally, Blue Cross requires written protocol that outlines the process initiated when a patient presents with suicidality in person, virtually, or by phone.

15. How does a practice determine patients who may be a good fit for CoCM?

Typically, the PCP or treating provider will be the practitioner referring patients for CoCM and may use any of the following:

- Routine screening using either a PHQ-9 and/or GAD-7 of >10
- Review of the patient registry
- Patient has a new or a changed dose of psychotropic medication
- Patient not responding to psychiatric medication
- Self-reported depression/anxiety symptoms
- PCP familiarity and comfort level treating various behavioral health conditions

16. Should all patients with depression or anxiety be referred to CoCM?

No. It will vary by practice, but patients with the following will likely need a different level of care:

- Severe substance-use disorders
- Active psychosis
- Significant developmental disabilities
- Personality disorders requiring long-term specialty care
- Persons requiring community mental health-level services

Blue Cross requires a written policy and/or procedure for identifying patients who may be appropriate for treatment via the CoCM model, and a referral pathway to CoCM providers or other treatment.

17. What licensure does a primary care provider or treating provider need?

The primary care or treating provider can be a state-licensed physician or advanced practice provider who is able to prescribe medication.

18. Why have you added the term "treating provider"?

The term "treating provider" is used by Centers for Medicare & Medicaid services. We will include this term as we begin engaging specific specialties to adopt CoCM. In 2023, we began our training track for the perinatal population. This would include both family medicine practitioners and obstetric/gynecologists.

19. What is the primary care or treating provider's role?

The primary care or treating provider oversees the patient's treatment plan. Recommendations and feedback from the behavioral health care manager and consulting psychiatrist are considered and the PCP or treating provider ultimately determines the treatment plan and any treatment adjustments needed.

- The PCP or treating provider will introduce the CoCM model, why it might be helpful to the patient, how the care team works together, and letting them know who will be contacting them to talk about program enrollment. The PCP may obtain patient consent, or the BHCM can obtain consent at the initial patient outreach.
- Billing for all CoCM services must use the PCP or treating provider's NPI, regardless of which team member provided services.

Blue Cross requires that the practice has a written policy and/or procedure to show how the PCP or treating provider identifies CoCM candidates, the referral workflow and how the PCP or treating provider is alerted to activity gathered and documented by the BHCM and consulting psychiatrist.

20. What licensure does a BHCM need?

The BHCM is a designated individual with formal education or specialized training in behavioral health. The individual must be state licensed, in fields such as social work, nursing, or psychology.

21. What is the BHCM's role?

The BHCM will be the patient's primary contact during their CoCM enrollment. The BHCM performs the following functions:

- Gives initial and follow-up assessment
- Develops behavioral health care plans, including revisions for patients as their status changes
- Provides brief psychosocial intervention
- Works in ongoing collaboration with the PCP
- Consults with the psychiatric consultant
- Delivers the consulting psychiatrist recommendations to the PCP or treating physician
- Meets with patient to discuss treatment adjustments
- Maintains the registry and systematic case review tool

Blue Cross requires that the BHCM's schedule shows time dedicated to regular SCRs and that the BHCM workflow is documented in a written policy and/or procedure. This document should include the expectations for length of patient engagement in CoCM, reasons for ending participation, established transition plans, and individualized relapse prevention plans.

22. What licensure does a consulting psychiatrist need?

The consulting psychiatrist must be a state-licensed physician or a nurse practitioner working under the supervision of a psychiatrist. This consulting psychiatrist must be able to prescribe the whole range of medications.

23. Can a psychologist or other BH specialist fill the consulting psychiatrist role?

No. The consulting psychiatrist must be a medical professional trained in psychiatry and qualified to prescribe the full range of medications. Our recommendation, and the recommendation from others**,** is that this role is best filled by and M.D. or D.O., however we realize that may not be possible in all communities. A nurse practitioner who is working under the supervision of a psychiatrist may fill this role.

24. Will the consulting psychiatrist meet 1:1 with the patient?

Rarely. In CoCM, the consulting psychiatrist provides treatment recommendations for a caseload of patients to the BHCM and PCP. The consulting psychiatrist may see 5-8% of CoCM patients, typically for diagnostic clarification. This 1:1 visit is not a part of CoCM and must be billed according to the patient's behavioral health benefits.

25. How often do the BHCM and consulting psychiatrist conduct systematic caseload reviews?

The BHCM and consulting psychiatrist meet regularly, weekly is recommended, to discuss the caseload. The duration of this meeting will depend on the caseload size; typically, systematic case review will be conducted for 1 hour/week per 0.5 BHCM FTE. Each patient on the caseload won't need to be discussed in depth at each SCR.

26. How are the consulting psychiatrist's recommendations documented?

Preferably the consulting psychiatrist will enter discussion notes and treatment adjustments directly into either the systematic case tool, medical record, or registry. If this is not possible, the BHCM may capture the discussions and recommendations and review them with the consulting psychiatrist during the systematic case review. Blue Cross requires that all communication processes are documented in a written policy or procedure.

If the consulting psychiatrist does not have access to the EHR, Blue Cross requires a written process and/or procedure and an example of a consulting psychiatrist who reviewed a recommendation documented by a BHCM.

27. How are the consulting psychiatrist's recommendations presented to the PCP or treating physician?

Preferably the PCP or treating physician will review these recommendations from the BHCM and consulting psychiatrists at a scheduled time during the week and reply within the systematic case tool, medical record, or registry. We also encourage the PCP and BHCM to meet to discuss recommendations.

Blue Cross requires that all communication processes are documented in a written policy or procedure.

28. What is the process to talk to the patient about any treatment adjustments?

The BHCM will be in frequent contact with the patient, and when recommendations are made, the BHCM will discuss the benefits and risks of the treatment adjustment and patient desire and will document those decisions.

Blue Cross requires that all communication processes are documented in a written policy or procedure.

29. Are there specific requirements that are needed before a patient is enrolled into CoCM?

Yes. There must have been an initiating visit with the PCP or treating provider within the last year. The patient must give consent before beginning CoCM activities.

A written policy and/or procedure to documents the systematic process for obtaining consent is expected but will not be a part of the capability verification.

30. What is an initiating visit?

New patients or patients who have not been seen in the past 12 months must have an initial visit with the PCP or treating physician.

31. What is needed for patient consent?

There are two elements that must be included when asking a patient for consent:

- Patient must give the PCP or treating provider permission to consult with relevant specialists (consulting psychiatrist).
- Patient must be informed that there may be cost-sharing that may apply for both in-person or non-face-to- face services. Although Blue Cross removed the copayment for most groups, many employer groups chose benefits through an "Administrative Services Only" arrangement. These groups determine their own benefit designs and associated cost-sharing requirements. PGIP does not maintain a list of the ASO employer groups, so be sure to check the patient's benefits before rendering service.

The patient's consent may be verbal (written consent is not required) but must be documented in the medical record.

Billing questions

32. Are we required to bill claims for CoCM services?

We would like all practices to bill for these services. We know that some POs and practices may use other funding sources for CoCM, but we believe that billing is critical to sustainability of the model.

Additionally, we cannot identify CoCM services that are provided without billing, which means that reporting program/practice success or program/practice needs cannot be gathered using claim experience.

33. How do we bill for CoCM services?

Collaborative care codes are monthly, time-based codes, submitted under the PCP or treating provider's NPI, that reflect all the time spent on a patient's CoCM care in each month. The BHCM is typically the central point of contact, so counting the BHCM time may be the most accurate. Make sure to not duplicate shared time. For example, if a BHCM and consulting psychiatrist spend 10 minutes on a patient's case review, bill 10 minutes. Do not bill 10 minutes for BHCM and another 10 minutes for the consulting psychiatrist.

34. What are the CoCM codes and when would I use each code?

There are four codes for commercial members in any location, and one code for Federally Qualified Health Centers and Rural Health Clinics to use when treating Medicare, Medicare Advantage or Medicaid members. *See Charts 1 and 2 for details.*

Commercial patients, any location

- 99492 – Use for the initial month of services
- 99493 – Use for a subsequent month of services
- 99494 – Use as an add-on code for situations where more time than the upper time requirements for the initial or subsequent month requirements offer. It is possible to bill additional units of this code, if needed.
- G2214 – Use in place of 99492 or 99493 if less time than the time requirement for initial or subsequent month codes cannot be met. This code cannot be used in the same month as the above listed codes.

RQHC and RHC when treating Medicare, Medicare Advantage or Medicaid members

- G0512 – Use for either an initial month or a subsequent month.

35. Where would I find the reimbursement amounts associated with each of the CoCM codes?

To access the full fee schedule files:

- Sign into Availity
- Select *Payer Spaces*
- Select *BCBSM BCN*
- Go to *Resources*
- Select *Secure Provider Resources*
- Select *Fee Schedules*

36. May I use the CoCM codes for general behavioral health integration?

No. 99484 and G0511 are separate code for behavioral health integration that is billed monthly for services delivered using BHI models of care that do not meet CoCM requirements.

When providing general behavioral health integration or chronic care management to a Medicare, Medicare Advantage or Medicaid member, use G0511.

See Charts 1 and 2.

Chart 1:

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
	CoCM	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

Chart 2:

Codes for Medicare Advantage Members by Location (Rules differ for Federally Qualified Health Centers and Rural Health Clinics)

Provider Location	Service	Code	Month	Time Threshold
Non-FQHC/RHC	General Behavioral Health Integration	99484	Any month	11-20 minutes
	CoCM	99492	Initial month	36-70 minutes
		G2214*	Any month	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 *Cost share applies to this code related to state/federal rules	G0511	Any month	20 minutes
	CoCM	G0512	Initial month	70 minutes
			Subsequent month	60 minutes

37. How should I bill if a patient is enrolled toward month end and there isn't time to have an SCR?

There are a few was to handle this situation and you must determine which fits best with your practice guidelines.

- 99484 for onboarding activities in month 1 and then 99492 the next month.
- G2214 for onboarding activities in month 1, forgo billing the 99492 and instead bill 99493 + units of 99494 as appropriate to reflect the appropriate number of minutes the next month.
- Don't bill anything for onboarding activities in month 1 and then bill 99492 the next month.

38. Do I have to bill a CoCM code or have an SCR for every patient in every month?

No. As long the BHCM and consulting psychiatrist conduct a systematic review of caseload, even without specifically discussing the patient, one of the CoCM codes can be billed. This situation would be more likely to occur once the patient is stabilizing in their treatment progress. If this is not the case, it is possible to bill a general behavioral health integration code one month and then a CoCM code in another month.

39. Can I bill a CoCM code and a behavioral health integration code in the same month?

No, the practitioner must decide which code best fits the circumstance.

40. Can I bill a CoCM code and provider-delivered care management in the same month?

CoCM and general behavioral health integration are distinct, differing services even though there is some overlap in eligible patient populations. There may be circumstances in which it is reasonable and necessary to provide both services in a month. Billing and medical record documentation must reflect that distinct and differing services were provided.

41. Can I bill a CoCM code in the same month as I bill therapy or other counseling services?

CoCM and psychotherapy/counseling are distinct, differing services even though there is some overlap in eligible patient populations. There may be circumstances in which it is reasonable and necessary to provide both services in a month. Billing and medical record documentation must reflect that distinct and differing services were provided.

42. How do I earn VBR?

Based on practice nominations CoCM VBR is available to primary care practitioners and OB/GYNs who meet eligibility requirements. PCP practices will earn VBR as part of the PCMH PCP VBR cycle. Beginning in 2023 a second nomination cycle will take place in accordance with the October SAD Tool snapshot. These practices are eligible to earn six-months of CoCM VBR. These practices must nominate these practices prior to the October SAD snapshot and the six-month VBR cycle will run from March 1st through August 31st. Only PCMH-designated practices can receive CoCM designation. Other eligibility requirements, such as PCMH designation and meeting unconscious bias training requirements also apply.

OB/GYN practitioners earn VBR according to the specialist VBR cycle which runs each year from March 1st through the last day of February. OB/GYN practices who complete base training, perinatal training and begin implementation will be eligible for CoCM VBR consideration. Specialist CoCM designation will be announced in September along with the PCP CoCM designation.

43. Why do I need to submit patient-level outcomes data?

Patient-level outcomes data is the primary means to determining the CoCM results. With this data will be able to track quality, use and progress at a practice level, at the PO level and at the program level.

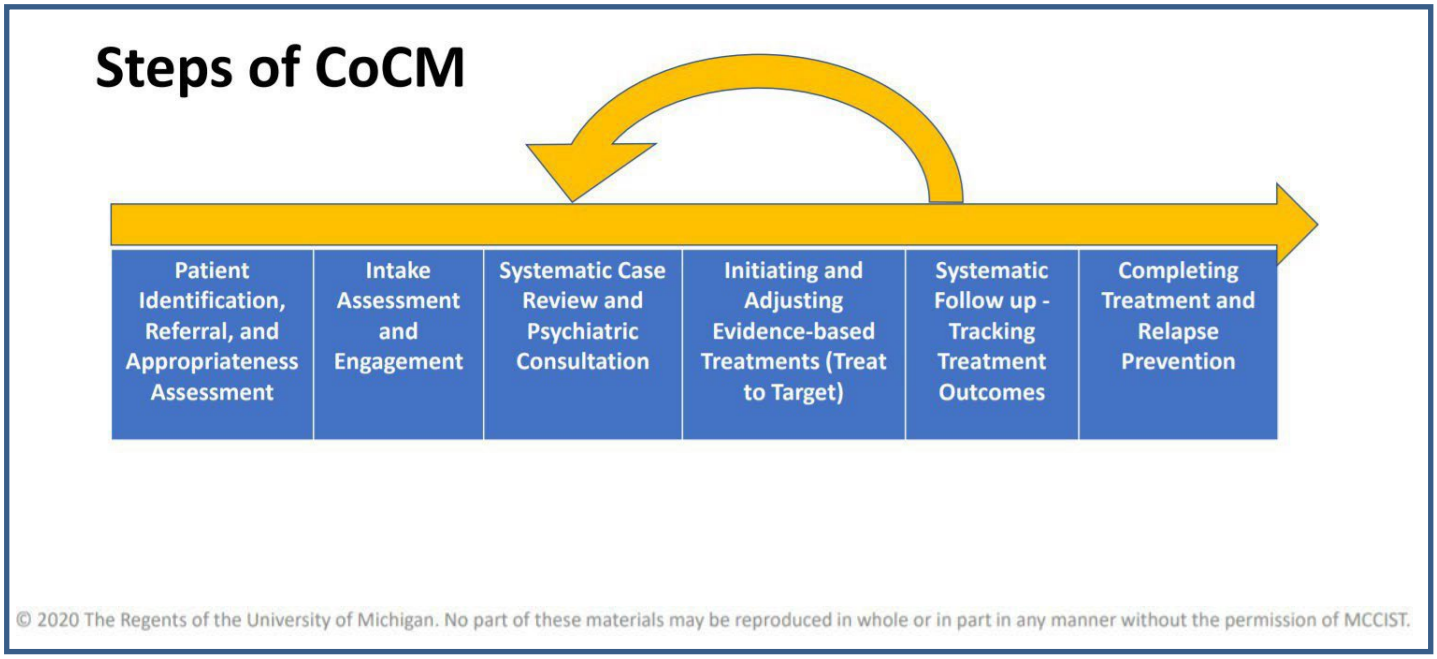
44. Are there cost-sharing requirement for patients?

Perhaps. Although Blue Cross and BCN's 2020 project removed cost-sharing requirements for most patients, there are some cases where patients have cost sharing requirements:

- When Blue Cross and BCN do not process benefits. These are typically groups like the Federal Employee program, or Flex-Link.
- "Administrative Services Only" employers determine all of their member benefits and associated cost share. Value Partnerships does not track these groups.
- Lastly, for members who belong to another Blue plan, such as Anthem, the member's Blue plan, known as the Home or Control plan, determines benefits and cost share. This is the policy set by the Blue Cross and Blue Shield Association. It is often easy to recognize these members by the plan name on their ID card.

It's always best to check the patient's benefits before providing services.

Resources:


Steps of CoCM
Patient Identification, Referral, and Appropriateness Assessment
Intake Assessment and Engagement
Systematic Case Review and Psychiatric Consultation
Initiating and Adjusting Evidence-based Treatments (Treat to Target)
Systematic Follow up - Tracking Treatment Outcomes
Completing Treatment and Relapse Prevention
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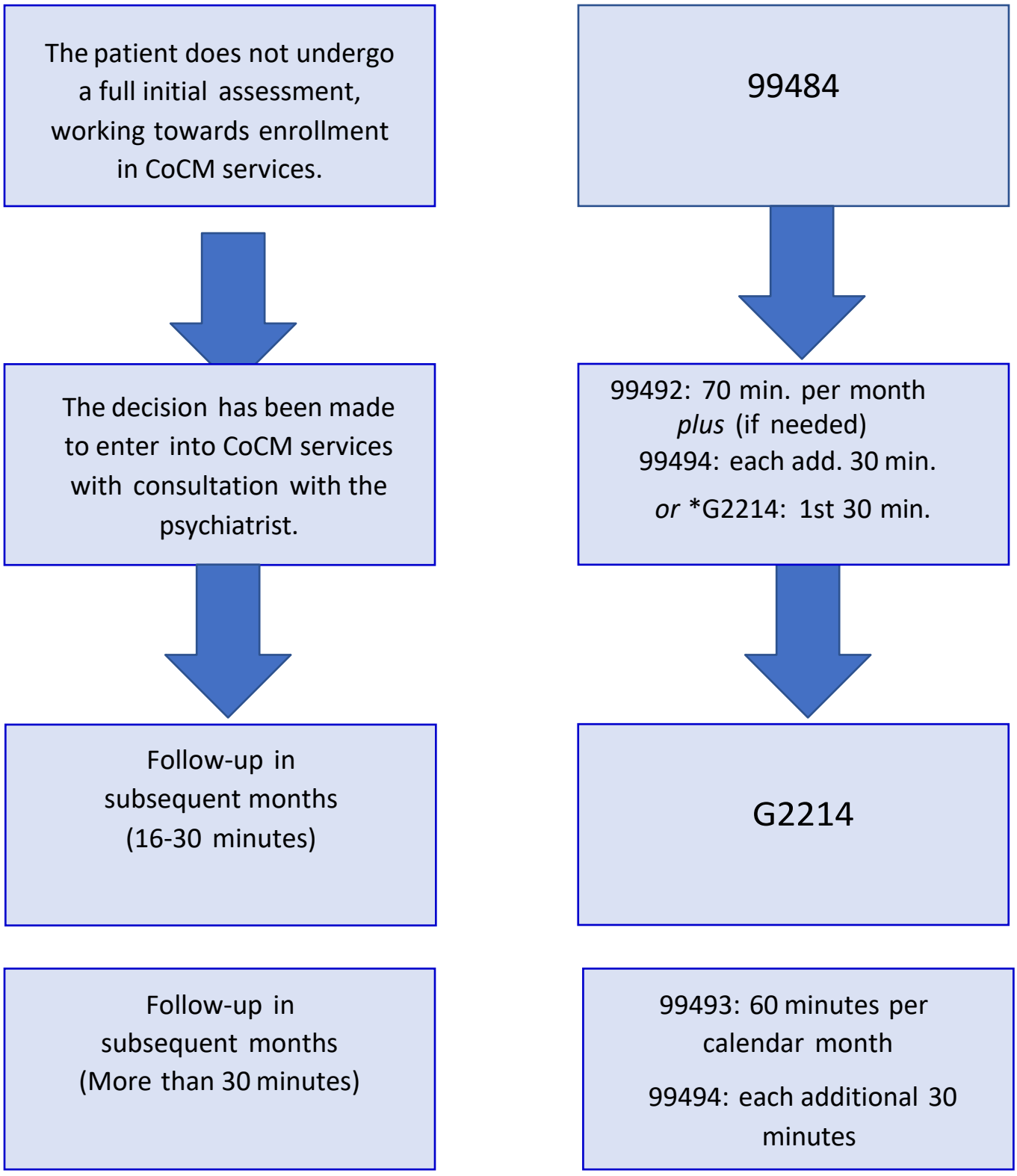
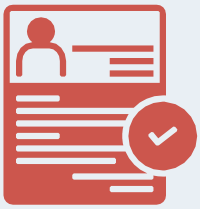
Collaborative Care: Handy Billing Flow



***** We do not routinely recommend using G2214 for the initial month of service, as it isn't adequate time for a full assessment and treatment planning. Try to meet the service time for 99492.

Collaborative Care: Handy Billing Flow



99484: Working towards enrollment in services

Initial Assessment

99492: 70 minutes

99492, 99494: 100 minutes

Follow-Up/Subsequent Visits

G2214: 16-30 minutes

99493: 60 minutes

99493, 99494: 90 minutes

Mi-CCSI Center for Clinical Systems Improvement

Michigan Collaborative Care IMPLEMENTATION SUPPORT TEAM

MICMT Michigan Institute for Care Management & Transformation

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CoCM Billing Tips - Avoiding "same date" denials

99492 and 99493 in the same month	You wouldn't bill an initial month (99492) and a subsequent month (99493) in the same month
99492 and G2214 in the same month	99492 is initial month, so you wouldn't combine with G2214, a code that could either be initial month or subsequent month. If you need to bill more minutes than 99492 provides, you'd bill 99492 and units of 99494. If you don't have enough minutes to bill 99492, you would bill G2214 alone.
99493 and G2214 in the same month	99493 is subsequent month, so you wouldn't combine with G2214, which is a code that could be either initial or subsequent month. If you need to bill more minutes than 99493 provides, you'd bill 99493 and units of 99494. If you don't have enough minutes to bill 99493, you would bill G2214 alone.
G2214 and 99494 in the same month	99494 is intended to be used as the add on to 99492 or 99493. The system isn't configured to allow G2214 to be billed with an add-on code.
99492 and 99492	You wouldn't bill two initial month codes in the same month.
99493 and 99493	You wouldn't bill two subsequent month codes in the same month.
G2214 and G2214	G2214 can be used for either an initial month or a subsequent month. However, it would only be used if there weren't enough minutes of activity to bill an either the initial month 99492 code or subsequent month 99493. To maximize reimbursement, whenever possible, use the 99xxx codes rather than G2214.
99494 and 99494	99494 is an add-on code and will not be payable unless it is combined with an initial month (99492) or subsequent month (99493) code. 99494 allows quantity units. If you are thinking of using 99494 twice, bill "99494 – Two units" instead.