Answers to Frequently Asked Questions about Financing Collaborative Care (CoCM)

Please note that the answers below are based on Medicare rules for billing CoCM and other payers may have variations in the rules they apply.

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Common Abbreviations

APA = American Psychiatric Association

BHCM = Behavioral Health Care Manager

BHI = Behavioral Health Integration

CMS = Center for Medicare & Medicaid Services

CoCM = Collaborative Care Model

EMR = Electronic Medical Record

FQHC = Federally Qualified Health Center

RHC = Rural Health Clinic (RHC)

Ask the Experts

AIMS Center faculty and implementation experts host monthly office hours to answer questions about Collaborative Care billing, financial sustainment, as well as the Financial Modeling Workbook.

Clinics across the nation join and will often consult each other and share experiences in the process.

https://aims.uw.edu/office-hours/

The AIMS Center provides information about billing for integrated behavioral health based on our understanding of the rules and regulations from CMS and AMA CPT coding manuals. However, the AIMS Center does not employ Certified Professional Coders and we do not provide direct patient services. Final decisions about billing fall to the compliance department of each practice, which bears full responsibility for use of the codes. The AIMS Center shall not be responsible or liable for any claim or damages arising from use of the information provided.

Billing & Reimbursement

Can you bill for psychotherapy and Collaborative Care codes in the same month for the same patient?
A BHCM can bill psychotherapy codes in addition to CoCM codes for the same patient in the same month if they are licensed to do so in their state. Psychiatric providers may also bill for direct patient visits and CoCM consultation services. Time spent on activities for services reported separately may not be included in the services reported using time applied to CoCM codes.
Is there a list of payers who currently reimburse Collaborative Care codes?
The APA periodically updates its list of private payers and state Medicaid plans known to cover the CoCM codes. This list can be found, along with other helpful resources, at https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid.
Is there a list of pay rates for the Collaborative Care codes by each payer?
There is no list showing what each different payer and plan reimburses for CoCM codes. Medicare publishes a new Physician Fee Schedule each year, which includes RVUs and the conversion factor that results in the reimbursement amount. Each payer can establish their own payments for any CPT code, which may also vary by plan. The AIMS Center recommends that you compile a list of the most common payers for your clinical site and what they are reimbursing to use as a guideline.
How can I advocate with private payers to reimburse for the Collaborative Care codes?
The APA offers resources for psychiatrists advocating for Medicaid payment for the Collaborative Care Model. This includes some talking points when speaking with payers that may be helpful to look at: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid/medicaid-payment-and-collaborative-care-model
Is there a limit to the number of psychotherapy codes billed in a month?
Different payers may have different rules about how frequently psychotherapy codes can be billed. These rules are often about annual limits on services, rather than limits on monthly services. Again, this varies by payer, and it is the responsibility of the patient and provider to find out what, if any, limitations are imposed on these services.
Can the Collaborative Care codes be billed for patients under 18?
The CoCM billing codes do not specify any age limits. The evidence base for the Collaborative Care Model is largely related to its effectiveness with adults, but there is increasing evidence of the model being used effectively with adolescents. Given that the PHQ9 and GAD7 symptom scales are not validated for use with children under 12, practices may choose to focus the use of this model on ages 12 and up. Pediatric practices may use a BHCM and a Psychiatric Consultant with their patients, but their measurement-based care tools and brief behavioral interventions may differ significantly.

Can travel to meet with a patient in the community count in the minutes for billing CoCM?
No. The codes indicate that the minutes of the BHCM can be counted towards billing only if they are clinical in nature, not clerical or administrative. The AMA specifically excluded travel time from "countable" time for evaluation and management services in their March 2021 revisions to the E/M guideline changes effective January 1, 2021.
When billing Collaborative Care codes, is there a maximum amount that is billable? For example, is it reimbursable if a patient is more complex and requires 6 hours of Collaborative Care treatment each month for a few months to show improvement?
For billing the 99492-99494 codes, most payers honor the CMS "Medically Unlikely Edits" (MUE) rules that limit the add-on code of 99494 to being billed twice, for up to a total of 120 minutes. The practice would likely be denied additional add-on codes but may appeal and could be reimbursed for additional codes if their documentation clearly supports the additional billing. Some practices bill the maximum number of CoCM codes and then bill psychotherapy codes for any additional BHCM visits with the patient, if the activities and documentation support the use of psychotherapy codes and the BHCM is licensed to bill them. FQHC and RHC practices that bill the G0512 code can only receive reimbursement for that one code each month, regardless of additional time being spent with the patient.
Are both Collaborative Care codes (the base and the add-on) billed together at the end of each month?
Yes. Payers will not honor an add-on code billed separately from the base code, so the best practice is to submit all relevant codes together at the end of the month.

CoCM Team Specific

Which care team member's time can be billed using the Collaborative Care codes?
Only BHCM minutes count toward the time threshold and are billed under the Treating (Billing) Practitioner.
Does the Psychiatric Consultant need to be in-network to successfully bill the Collaborative Care codes?
It does not matter what network the Psychiatric Consultant is in since the bill does not go out under their name. All billing happens under the Treating (Billing) Practitioner monthly, so typically that medical provider needs to be credentialed with the plan that is billed. The only requirement for the Psychiatric Consultant is to have a continuous relationship and communicate regularly with the Treating (Billing) Practitioner and BHCM.
Does communication about a CoCM patient between the BHCM and the Treating (Billing) Practitioner count towards the monthly time requirement?
Yes, the time the BHCM spends with other team members communicating about a particular patient counts towards the monthly time requirement.
How does it affect billing if the patient receives counseling services outside of the Collaborative Care team?
Receiving counseling from a therapist outside of the CoCM team has no impact on billing the CoCM codes, but that time cannot be counted towards the billing minutes. The time that counts towards billing is only that of the BHCM for their clinical activities providing or coordinating care for a patient, which may include coordinating care with an external counseling service. This could include keeping the external therapist informed and/or involved in the treatment plan if the patient agrees to this coordination per HIPAA guidelines. https://aims.uw.edu/team-structure/
Are there requirements about the location of the BHCM delivering care?
Yes, CMS requires that the BHCM must be available to see the patient in person if needed, but they do not have to work in the physical location of the clinic, nor are they required to see the patient in person over the course of any individual CoCM episode.
Does the BHCM need to discuss every patient on their caseload during the Systematic Caseload Review with the Psychiatric Consultant each week?
No. The BHCM and Psychiatric Consultant should look at the status of patients on the registry and identify those to discuss during the weekly Systematic Caseload Review. During a conversation with CMS in 2019 we confirmed that not all patients need to be discussed weekly/monthly. CMS verbally approved the following language to use when submitting the monthly CoCM code(s): "***The patient has been included in the caseload review activities and consulted on as needed."***
Do you need to include the Treating (Billing) Practitioner in the weekly Systematic Caseload Review with the Psychiatric Consultant?
No.

General BHI Code (99484 or G0511)

Can you discuss the general BHI code (99484) and when to use it? What does the service for CPT code 99484 look like?
CMS created a code to describe general behavioral health integration services for patients with DSM5 conditions, which requires a consent, an assessment of needs, and the use of validated rating scales. The service can be billed for at least 20 minutes of either billing provider or clinical staff time once a month. The service is described thoroughly in the CPT code book and in our Quick Guide. https://aims.uw.edu/resource/quick-guide-on-bundled-payments-for-behavioral-health-integration-services/ For FQHCs and RHCs the general behavioral health integration code is G0511, and the description above would also apply to this code. https://aims.uw.edu/resource/quick-guide-on-payments-for-behavioral-health-integration-services-in-federally-qualified-health-centers-and-rural-health-clinics/
Can the General BHI code be billed for the same patient in the same month as the CoCM codes?
No, two different BHI-related Care Management codes may not be billed for the same patient in the same month. It may occasionally be appropriate for a single practitioner to report either the general BHI code or the CoCM codes for the same beneficiary in different months over the course of the episode of care depending on services provided. For example, if a patient has been receiving CoCM services, but is now being referred for specialty care and some care coordination is needed during the month to facilitate that, the General BHI code would be the best choice of code to bill. However, since the January 2021 introduction of the G2214 30-minute CoCM code, it may be more appropriate to bill that code if other CoCM services were also provided during the month.
I understand that a CoCM episode ranges roughly 6-12 months until the patient significantly improves or needs a higher level of service. Can the General BHI code 99484 be used as more of a long-term care management service, like a stepdown from higher level of 99493 care management?
The General BHI code could be appropriate for that use, when the level of service is not expected to reach the threshold for billing CoCM codes, and support can be provided in a much shorter time each month, or intermittently as needed, and without the need for regular psychiatric consultation. The General BHI code can be used to support a patient with any BH diagnosis in any month if all the requirements are met.
How do I know whether to use the general BHI code or the CoCM code when I bill each month?
The general BHI codes incorporate some, but not all, the activities associated with CoCM. For example, it does not require the full team of a BHCM and Psychiatric Consultant. It also does not require the use of a registry to track patient outcomes. It can be provided by the treating provider themselves or delegated to other clinical staff that have a continuous relationship with the patient. Billing the General BHI code requires the same consent conversation with the patient to describe the service and the possibility of cost-sharing.

What is the difference between 99484 and the new General BHI code G0323?
99484 is billed under the Treating (Billing) Practitioner for general behavioral health integration services provided to patients and G0323 is a new code for services performed by a clinical psychologist or clinical social worker. This can be performed independently from a Treating (Billing) Practitioner. A psychiatric diagnostic evaluation (90791) can serve as the initiating visit for the G0323 code.
Can the new BHI Code G0323 billed under Clinical Psychologists (CP) and Clinical Social Workers CSW) be billed in an FQHC or RHC?
No, these codes are not available for CPs and CSWs in an FQHC or RHC. Any services would need to be billed under the medical provider using G0511.

Patient Cost

What are the out-of-pocket costs for patients when billing using the Collaborative Care codes?
For Medicare, the 20% cost share will apply. For Medicare Advantage plans and other insurers, as with any service the out-of-pocket costs will vary depending on the frequency the service is provided and the patient's insurance coverage benefits. In general, the more time the BHCM spends with the patient or coordinating care on their behalf, the more out-of-pocket expense the patient is responsible for, just as if the patient saw a provider who billed for each visit using traditional psychotherapy codes. Given these variations it is not possible to predict exactly what the cost-sharing will be for an individual patient but, as with other services, the patient should be encouraged to contact their insurance provider to find out if this service is covered, and what the expected cost-share percentage or co-pay would be. With that information, the patient can work with the BHCM to adjust services to match their budget. In an FQHC or RHC practice the patient will have a predictable cost-share because the revenue for those practices is fixed and does not vary if the services are greater than the time required to bill the G0512 code. If the time requirement is not met in a month of service, the practice cannot bill for the service thus the patient would have no cost-sharing. Over time a practice will gain experience about which of their common payers consistently cover these services and what the average cost, or range, of out-of-pocket expenses is, and may be able to provide more accurate information to patients considering participating.

Does cost sharing affect whether patients participate in Collaborative Care?
It can, which is why consent is required and includes informing the patient that cost-sharing may be required. As with any service, the patient may be concerned that the cost will outweigh the benefit. Although there is no guarantee that an individual patient will realize significant benefits, in general, patients who get help treating behavioral health problems experience positive benefits to their physical and mental health, as well as their engagement in and enjoyment of life. Providers should encourage patients to engage with CoCM, just as they would with any other recommended treatment that has the potential to improve their health. As with any health care treatment, it is always their decision whether to do so. Some practices have also found it helpful for patients to compare the costs of CoCM to the costs, and the difficulty of finding, specialty behavioral health services.
Are CoCM services included in the patient's insurance deductible? Do they count as out-of-pocket expenses towards the annual maximum?
In general, until the annual deductible is met the patient will pay the full cost for any services they receive, including CoCM services. Out-of-pocket expenses will count towards any out-of-pocket maximum that applies to their insurance coverage, in the same way as other health care expenses do. Patients with a high-deductible health care plan may find that paying the full cost of CoCM care is a financial hardship, just as it would be with any health care costs incurred before meeting their high deductible. A few insurance plans designate CoCM services as "preventive" and exempt them from the annual deductible.

Registry Options

What are the options, costs, and requirements for a Collaborative Care registry?
A registry does not have to be purchased. Depending on the size of your practice a spreadsheet can function just fine. In fact, many clinics start their integrated care programs using a spreadsheet as a registry. However, managing large caseloads or multiple BHCMs on a spreadsheet can be challenging, and storing the data may be a HIPAA challenge. The AIMS Center provides information on choosing a CoCM registry option in our Collaborative Care Implementation Guide under Identify a Behavioral Health Patient Tracking System (pg. 10). https://aims.uw.edu/resource/collaborative-care-implementation-guide/ It is important to keep the functionality requirements of the registry in mind as you choose a tool. At a high level the registry has to be able to do these three things: track clinical outcomes and progress at both the individual patient level and overall caseload level for the target population, prompt treatment-to-target by summarizing patient's improvement and challenges in an easily understandable and actionable way, and facilitate efficient psychiatric consultation and case review, allowing providers to easily prioritize patients who need to be evaluated for changes in treatment. https://aims.uw.edu/registries-for-collaborative-care/
Does the AIMS Caseload Tracker automatically track the minutes a BHCM uses the registry?
No, the AIMS Caseload Tracker does not record the minutes the BHCM spends populating or reviewing it. The very brief minutes of registry management (1-3 minutes) are added each time the BHCM records contacts with patients, psychiatric consultation sessions about the patient, or other valid BHCM activities to be counted towards the minute threshold for billing CoCM.

Telehealth

Can CoCM services include telehealth as a method of patient care?
Yes. Telephone contacts and video conferencing calls have always been encouraged methods for the BHCM to connect with patients. Minutes doing telehealth visits count towards the minutes for billing each month, in the same way as in-person visits or care team communication count. Many practices had to pivot to telephone and video conferencing in March of 2020 in response to the COVID-19 pandemic. Many found that, with some preparation and training for the BHCM, these methods proved helpful for both patients and CoCM providers, and many practices will likely continue these methods even after social distancing protocols are no longer needed.

Do you always need a video component for telehealth psychotherapy?
Rules vary depending on the payer and codes billed for psychotherapy service, and the rules are different during the Public Health Emergency for COVID-19. When using the CoCM billing codes, telehealth services with the patient are allowed with or without a video component. Depending on the patient and type of psychotherapy being provided it may be clinically indicated to use a video component, but it is not required for billing CoCM codes.
Why are CoCM codes not included on the CMS list of services eligible for telehealth?
CoCM services have always been deliverable either in person or via telehealth and/or telephone, so they are not included because they are not considered essentially in-person services.

Time Tracking, Minutes & Eligible Activities

What is the minimum and maximum number of minutes you can bill the Collaborative Care codes in one month?
The CPT code book has a useful table showing the minimum and maximum number of minutes for billing each of the G2214 and 99492-99494 codes. Always check with your payers if they follow the CPT code book's outlined minimum and maximum number of minutes. FQHCs and RHCs billing using G0512 must meet the full minimum of 70 minutes in the initial month and 60 minutes in subsequent months and are not allowed any add-on billing for time that exceeds the minimum.
What activities are allowable to be counted towards billing Collaborative Care codes?
The time the BHCM spends on clinical care with the patient, with other CoCM team members, or coordinating with outside providers, as well as the time reaching out to the patient (even if it does not result in direct contact) and the time spent documenting in the registry/EHR to track patient's engagement and progress all count towards billing the CoCM codes. Clerical or administrative tasks such as scheduling an appointment, translation services, appointment reminders, or transcribing an encounter note do not count towards billing CoCM codes. For a summary of activities included in CoCM codes, refer to our Quick Guides on this page: https://aims.uw.edu/billing-and-financing/
Can Collaborative Care minutes be billed for patient groups?
Yes. You may capture the group minutes for CoCM billing or bill the group psychotherapy codes (if your BHCM meets psychotherapy billing requirements). You cannot capture time for both types of billing. If you bill these minutes under CoCM, you will want to divide the total minutes spent in a group by the number of participants to allocate the total provider time of the service for each participant.

Is it appropriate to include Biopsychosocial Assessment/ Intervention codes in minutes that count towards your time threshold? These are codes ranging from 96156 to 96171.
These codes are Health and Behavior Assessment and Intervention (HBAI) codes. HBAI codes apply to services that address psychological, behavioral, emotional, cognitive, and interpersonal factors in the treatment/management of patients diagnosed with physical health problems. The use of HBAI codes requires a physical health diagnosis (ICD-10) as the primary diagnosis. CoCM billing requires a behavioral health diagnosis, including substance use diagnoses, so the services you provide with HBAI codes cannot be counted towards CoCM codes. You may provide these services separately and bill them using different ICD-10 and CPT codes, but none of the time can count towards both.
If a Treating (Billing) Practitioner reviews the registry on their own, would that time not be counted separately?
The time the Treating (Billing) Practitioner spends in activities related to CoCM cannot be counted towards billing CoCM codes unless the BHCM is present and involved. It is ONLY the clinical time the BHCM spends with the patient, with other CoCM team members, or coordinating with outside providers, as well as the time doing outreach to the patient, and the time spent entering data into a registry tool to track the patient's engagement and progress, that can count towards billing the CoCM codes.

Miscellaneous

Where can I find information from CMS about Collaborative Care codes?
The most recent publication from CMS includes the new G2214 code added in 2021. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909432
Where can I find the APA billing toolkit?
The APA Practice and Billing Toolkit is a compilation of sample tools and resources from practices that have implemented CoCM and now bill for services delivered in the model. https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/implement

Will implementing Collaborative Care help our organization save money from decreased ER and hospital utilization?
Numerous trials and studies have demonstrated that CoCM and other proven integration strategies are cost effective and can lead to significant savings in healthcare costs. https://aims.uw.edu/building-the-business-case-for-team-based-integrated-care/ The analysis in the Milliman report strengthens the evidence base for integrated care by projecting the potential healthcare cost savings of successful, effective integrated medical and behavioral healthcare programs. https://integrationacademy.ahrq.gov/news-and-events/news/milliman-updates-projections-economic-impact-integrated-care
What is the best way to educate patients about Collaborative Care and help them understand the team, the symptom scales, and the cost to them?
The Treating (Billing) Practitioner is responsible for obtaining the patient's consent for services. This consists of a short conversation describing the team, how they work with the Treating (Billing) Practitioner, and the patient's potential cost-sharing. https://aims.uw.edu/resource/guidance-on-verbal-patient-consent-and-cocm/ The AIMS Center has a couple of examples of patient education materials on our website in English and Spanish that you can use to help explain to patients more about how the team works. A handout like this may be used to supplement the documented consent conversation. https://aims.uw.edu/resource/introducing-your-care-team/
Is there a sample contract to use between the behavioral health team and the primary care team?
The AIMS Center has an example of a contract between a primary care organization and a behavioral health organization that can provide some ideas for you. https://aims.uw.edu/resource/example-psychiatric-consultant-services-contract/
How is liability insurance factored into Collaborative Care?
This resource document provides background information on medical malpractice cases, defines the doctor-patient relationship, distinguishes the different forms of consultation offered to primary prescribers, describes the duty of the psychiatrist across the spectrum of roles on a patient care team, and makes recommendations to reduce the risk of malpractice issues. https://aims.uw.edu/resource/resource-document-on-risk-management-and-liability-issues-in-integrated-care-models/

What are the differences in billing workflow between billing psychotherapy codes and billing Collaborative Care codes?
Psychotherapy codes are billed for each session – in-person or telehealth – that the provider has with the patient. When the visit concludes the encounter is coded and submitted for payment. CoCM billing is billed on a calendar month basis under the Treating (Billing) Practitioner and includes all the minutes the BH Care Manager (BHCM) spends on clinical services during that calendar month (see section on care team member time below for more details). The best practice is to submit the code(s) once for the full month of activities since add-on codes must accompany the appropriate base code (99492 or 99493). Most EHRs and CoCM registries have tools that can help keep track of all the eligible minutes over a month for easier billing.
What does "specialized behavioral health training" entail?
The billing guidance for what constitutes "specialized training" is intentionally open-ended. Many different providers may serve in this role, including licensed BH providers and those working towards licensure. There are also many ways an RN or bachelor-level individual can acquire specialized training in behavioral health to qualify for the BHCM role. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909432 The AIMS Center provides online training modules for the BHCM role, but the AIMS Center training does not purport to fulfill requirements for education and training from CMS or any other insurance payer. https://aims.uw.edu/behavioral-health-care-managers/
How does CoCM relate to ACO REACH?
CoCM has no direct relationship with the CMS ACO REACH quality program, but providing CoCM services may help you reach the quality goals for depression that may be a part of reaching ACO REACH quality metrics.