AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

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/what-we-do/aims-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 as well as 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 that are currently reimbursing Collaborative Care codes?
The APA periodically updates their list of private payers and state Medicaid plans that are known to be covering the CoCM codes. It 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 payer?
There is not a list showing what each different payer and plan reimburses for CoCM codes. Medicare publishes a new Physician Fee Schedule each year, which includes RVUs as well as the conversion factor that results in the reimbursement amount. Each payer can establish their own payments for any CPT code, and it may vary by plan as well. 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 will be 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 be counted in the minutes for billing CoCM?
The codes indicate that the minutes of the BHCM can be counted towards billing if they are clinical in nature, rather than clerical or administrative. Traveling to meet a patient in the community would most likely be considered an administrative activity but this is not specifically addressed in the guidance.
When billing Collaborative Care codes, is there a maximum amount that can be billed? For example, if a patient is more complex and requires 6 hours of Collaborative Care treatment each month for a few months for them to show improvement is that reimbursable?
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 using psychotherapy codes, if the BHCM is licensed to bill those codes. FQHC and RHC practices billing the G0512 code are limited to being reimbursed only with that one code each month, regardless of additional time being spent with the patient.
Are both Collaborative Care codes (the initial and the add-on) billed together at the end of each month?
Practices have a variety of workflows for billing CoCM codes. Some practices wait until the end of the month and bill all at once, and some bill as soon as a time threshold is met for the initial code, and then again for any add-on codes.

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 but are billed under the Treating Medical Provider. 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 doing outreach to the patient, even if it does not result in a direct contact, and the time spent entering data into a registry tool to track patient's engagement and progress all count towards billing the CoCM codes. Clerical tasks such as scheduling an appointment and writing chart notes do not count towards billing CoCM codes.
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, only that they have a continuous relationship and communicate regularly with the treating medical provider and BHCM. All billing happens under the treating medical provider monthly, so typically they will need to be in network with a plan billed.
Does communication about a CoCM patient between the BHCM and Treating Medical Provider 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 is getting other 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. 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/collaborative-care/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 are not required 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.

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 care management services for patients with behavioral health conditions, which incorporates some but not all of the CoCM principles. The service can be billed once you reach at least 20 minutes of clinical staff time and is only billed once a month. The service is described thoroughly in the CPT code book. https://aims.uw.edu/resource-library/cms-collaborative-care-payment-quick-guide 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-library/cms-behavioral-health-integration-payment-quick-guide-fqhcs-and-rhcs
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. G2214 is a 30 minute CoCM code introduced in January 2021. It can be billed for CoCM activities of 16-31 minutes in a month, so that is the best choice if the patient received CoCM services of a shorter duration than what is needed to bill 99492 or 99493.
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 for supporting 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 incorporates some but not all of the principles 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.

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, the out of pocket costs will vary depending on the frequency that the service is provided and the patient's insurance coverage benefits, as with any services. 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 will be responsible for, just as it would be if the patient was seeing 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 complete 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 services, 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 both their physical and mental health, as well as their engagement in and enjoyment of life. Patients should be encouraged to engage with CoCM, as they would be with any treatment that if recommended by their treating provider and 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 be able to compare the costs of CoCM to the costs, including 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, and this includes 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" services 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. https://aims.uw.edu/collaborative-care/implementation-guide/plan-clinical-practice-change/identify-behavioral-health It is important to keep in mind is the functionality requirements of the registry you choose. 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/resource-library/integrated-care-registry-requirements
Does the AIMS Caseload Tracker automatically track the minutes a BHCM spends using the registry?
No, the AIMS Caseload Tracker does not record the minutes that the BHCM spends populating it or reviewing it. The very brief minutes of registry management time (1-3 minutes) need to be included when 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 as well as 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 using both 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 will likely continue the practices even after social distancing protocols are no longer needed.
Do you always need a video component for telehealth psychotherapy?
Rules vary depending on payer and codes being 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.

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 very useful table that shows the minimum and maximum number of minutes for billing each of the 99492-99494 codes. 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?
For a summary of activities included in CoCM codes, look here: https://aims.uw.edu/resource-library/cms-collaborative-care-payment-quick-guide
Can Collaborative Care minutes be delivered in a group format?
Yes, absolutely. The time spent by the BHCM providing group services could be applied to patients who attend the group session.
Is it appropriate to include Biopsychosocial Assessment/ Intervention codes in counting minutes towards your time threshold? These are codes ranging from 96150 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. Use of HBAI codes requires a physical health diagnosis (ICD-10) to be 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 a different ICD-10 and CPT codes, but none of the time can count towards both.
Is the BHCM billing for time spent documenting a visit or just the time spent with the patient and staffing the case with the psychiatric consultant?
Typically documentation is not considered clinical care and would not be billable. However activities like manual entry into the registry and reviewing other team member notes for coordination of care may be justifiable clinical minutes.
If a Treating Medical Provider reviews the registry on their own, would that time not be counted separately?
Time that a Treating Medical Provider 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 patient's engagement and progress, that can be counted 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/Downloads/BehavioralHealthIntegration.pdf
Where can I find the APA billing toolkit?
The APA Practice and Billing Toolkit is a compilation of sample tools and resources from practices who have implemented CoCM and are billing 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/collaborative-care/building-business-case-cost-effectiveness-studies-collaborative-careAIMS 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 Medical Provider is responsible for assuring the patient's consent for services. This consists of a short conversation describing the team, how they work with the Treating Medical Provider, and the patient's potential cost sharing. https://aims.uw.edu/patient-consent-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-library/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-library/example-psychiatric-consultation-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, finally, makes recommendations to reduce the risk of malpractice issues. https://aims.uw.edu/resource-library/resource-document-risk-management-and-liability-issues-integrated-care-models; https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2014.1710501

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 medical treating provider 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). Some practices bill as soon as the minutes threshold is met for a code, and may bill again during the month if a subsequent threshold is met for an "add-on" code. Other practices submit their code(s) once for the full month of activities. Most EHRs and the 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. There are many different providers who 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 in order to qualify for serving in the BHCM role. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf The AIMS Center provides online training modules for the BHCM role but AIMS Center training does not purport to fulfill requirements for education and training from CMS or any other insurance payer. https://aims.uw.edu/online-bhcm-modules