PRISM

Billable Activities Guide

Collaborative Care (CoCM) services are billed on a per-member, per-month basis to the primary care provider. The CoCM treatment team must furnish services for a minimum amount of time within the calendar month to bill for CoCM. Only activities delivered and documented by the behavioral health care manager (BHCM) will be counted toward the time requirement.

Billable Activities

Documented on the Day Services Delivered:

- Providing assessment and care management services
    - Any form of patient contact
    - Structured diagnostic assessments
    - Self-management planning
    - Relapse prevention planning
- Administering validated rating scales (e.g., PHQ-9, GAD-7, AUDIT-C, MoCA)
- Using brief therapeutic interventions, including but not limited to:
    - Motivational interviewing, behavioral activation, problem-solving therapy
- Conducting panel review with the psychiatric consultant to evaluate treatment progress of individual patients
- Documenting within the EHR
    - Does not include strictly administrative or clerical duties
- Maintaining the patient registry
- Liaising with the PCP or any other clinical staff (e.g., community-based providers)

Documented Once Per Calendar Month:

- "Running" the panel with the psychiatric consultant (i.e., conducting systematic, population-level review of participating patients). The following smart phrase may be used:
    - *"This patient has been included in weekly structured caseload review to identify those patients in need of focused individual case review/consultation by psychiatric consultant."*

Requirements for CoCM Billing

- A separate, billable initiating visit is required within the past year (e.g., Annual Wellness Visit (AWV), Evaluation/Management visit (E/M), or Initial Preventative Physical Exam (IPPE))
- Documentation of consent in the medical record is required
- A patient registry is required, allowing for systematic review of the caseload
- Services can be billed alone or with a claim for another billable visit
- 99492, 99493, 99494, and G0512 cannot be billed in the same calendar month as 99484 (i.e., General Behavioral Health Integration)

CoCM Billing Codes for Medicare Patients

Provider Location	Codes		Timeframe	Time Requirements
FQHC/RHC	G code	G0512	Initial Month	70 minutes
			Subsequent Months	60 minutes
		99484	Initial/Subsequent Month (General Behavioral Health Integration)	20 minutes
		G2214*	FQHC/RHC need to verify eligibility of this code	
Non-FQHC/RHC	CPT Codes	99492	Initial Month	36–70 minutes
		99493	Subsequent Months	31–60 minutes
		99494	Add-on (initial or subsequent)	16–30 additional minutes
		G2214	Any Month (recommended only for subsequent months	16-30 minutes
		99484	Initial/Subsequent Month (General Behavioral Health Integration)	11–20 minutes

CoCM Billing Codes for Medicaid Patients

Provider Location	Codes		Timeframe	Time Requirements
FQHC/RHC	G code	G0512	Initial Month	70 minutes
			Subsequent Months	60 minutes
		99484	Initial/Subsequent Month (General Behavioral Health Integration)	20 minutes
		G2214*	FQHC/RHC need to verify eligibility of this code	
Non-FQHC/RHC	CPT Codes	99492	Initial Month	36–70 minutes
		99493	Subsequent Months	31–60 minutes
		99494	Add-on (initial or subsequent)	16–30 additional minutes
		G2214	Subsequent Months	16–30 minutes
		99484	Initial/Subsequent Month (General Behavioral Health Integration)	11-20 minutes

CoCM Billing Codes for Commercial Patients

Provider Location	Codes		Timeframe	Time Requirements
Any location	CPT Codes	99492	Initial Month	36–70 minutes
		99493	Subsequent Months	31–60 minutes
		99494	Add-on (initial or subsequent)	16–30 additional minutes
		G2214	Subsequent Months	16–30 minutes
		99484	Initial/Subsequent Month (General Behavioral Health Integration)	11-20 minutes

Billing per Time Threshold

Codes	Timeframe	Time Spent	Billing Codes
G codes	Initial Month	<20 minutes	Not billable
		20–69 minutes	99484
		≥70 minutes	G0512
	Subsequent Month	<20 minutes	Not billable
		20–59 minutes	99484
		≥60 minutes	G0512
CPT codes	Initial Month	≤10 minutes	Not billable
		11–35 minutes	99484
		36–85 minutes	99492
		86–115 minutes	99492 + 99494
		116–130 minutes	99492 + 99494 + 99494
		>130 minutes	99492 + 99494 + 99494
	Subsequent Month(s)	≤10 minutes	Not billable
		11–15 minutes	99484
		16–30 minutes	G2214
		31–75 minutes	99493
		76–105 minutes	99493 + 99494
		105–135 minutes	99493 + 99494 + 99494

References

Centers for Medicare & Medicaid Services. (2018). *Medicare Benefit Policy Manual.* U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

https://www.michigan.gov/documents/mdhhs/MSA_20-38-CoCM_695453_7.pdf

APA FAQs: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/APA-CoCM-and-Gen-BHI-FAQs.pdf

Disclaimer:

*This material represents PRISM's 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