

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 G2214 cannot be billed in the same calendar month as 99484 (i.e., General Behavioral Health Integration)

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 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 Billing Codes for Medicare and Michigan Medicaid Members, by location

Provider Location	Codes	Timeframe	Time Requirements
Non- FQHC/RHC	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
FQHC/RHC	99492	Initial Month	70 minutes
	99493	Subsequent Months	60 minutes
	99494	Add-on (initial or subsequent)	30 additional minutes
	99484	Initial/Subsequent Month (General Behavioral Health Integration)	20 minutes

* CPT time rule does not apply for Michigan Medicaid/Medicare/Medicare Advantage.

CoCM Billing Codes for Commercial Patients

Provider Location	Codes	Timeframe	Time Requirements
Any location	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

*FQHC/RHCs should check with each payor to see if G2214 is covered

References:

- [MLN909432 - 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](#)
- <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/2025-Bulletins/Final-Bulletin-MMP-26-03-Code-Update.pdf?rev=96160048d47443b29bef2c8b2746aaa6&hash=4D6DEFB562E3686578329FE704D11845>
- [Blue Cross Blue Shield of Michigan Value Partnerships Update April 2020](#)
- [National Association of Community Health Centers Reimbursement Tips: FQHC Psychiatric Collaborative Care Model](#)
- <https://www.mpca.net/wp-content/uploads/2024/06/MDHHS-Telemedicine-Qualifying-Visits-Comparison-02.2024-1.pdf>
- [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](#)
- <https://www.medusind.com/resources/blog/2026-medicare-physician-fee-schedule-final-rule-what-you-need-to-know-and-how-to-prepare>
- <https://www.narhc.org/News/31788/Summary-of-CY26-CMS-Final-Rules-for-RHCs#:~:text=We%20encourage%20you%20to%20review,progress%2C%20coordinating%20treatment%2C%20etc.>
- <https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services>

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