FAQs for billing the Psychiatric Collaborative Care Management (CoCM) codes (99492, 99493, 99494, and G0512 in FQHCs/RHCs) and General Behavioral Health Intervention (BHI) code (99484, and G0511 in FQHCs/RHCs)

Starting in January of 2017, the Centers for Medicare and Medicaid Services (CMS) approved payment for services provided to patients with behavioral health disorders who are participating in psychiatric collaborative care programs or are receiving behavioral health integration services.[1] CMS has classified this group of services as "Behavioral Health Integration" (BHI) services and it includes three codes describing Psychiatric Collaborative Care Management services (CoCM) (99492, 99493,99494) and General BHI service (99484). Coverage for these services includes patients with a behavioral health or substance use disorder who receive coverage through a traditional Medicare plan or Medicare advantage plan. These services can be billed in both non-facility and facility settings. These services are also covered in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) settings. APA encourages all private payers to adopt these codes as well.

What is collaborative care management (CoCM)?

Psychiatric CoCM typically is provided by a primary care team consisting of a primary care physician and a care manager who work in collaboration with a psychiatric consultant, such as a psychiatrist. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations. [Final Rule, 80230]

What are the new billing codes for Psychiatric Collaborative Care Management services?

The following CPT® codes are used to bill for CoCM in all settings except FQHCs and RHCs. CMS has adopted the coding language[2] approved by the CPT Editorial Panel in 2017.

99492 - Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and.

[1]See http://www.nejm.org/doi/pdf/10.1056/NEJMp1614134 for CMS' viewpoint on Medicare payment for behavioral health care management services.

[2] https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf pg 80227

- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

99493 - Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

99494 - Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure). (Use 99494 in conjunction with 99492, 99493).

Calculation of time and the CPT "Time Rule"
The billing of these codes is based on the amount of time the behavioral health care manager spends doing clinical work (face-to-face and non face-to-face) with the patient. The CPT "Time Rule" applies to these services which means that the service can be billed when the mid-point of the stated time has been passed. Payer policies vary. Services in an FQHC and RHC differ, see the section below on billing in those settings. The table below for more information on the time increments.

Type of Service	**Total Duration of Collaborative Care Management Over Calendar Month**	**Bill Code(s)**
Initial - 70 minutes	Less than 36 minutes 36-85 minutes (36 minutes - 1 hr. 25 minutes)	Not reported separately 99492
Initial plus each additional increment up to 30 minutes	86-115 minutes (1 hr. 26 minutes - 1 hr. 55 minutes)	99492 X 1 AND 99494 X 1
Subsequent - 60 minutes	Less than 31 minutes 31-75 minutes (31 minutes - 1 hr. 15 minutes)	Not reported separately 99493

Subsequent plus each additional increment up to 30 minutes	76-105 minutes (1 hr. 16 minutes - 1 hr. 45 minutes)	99493 X 1 AND 99494 X 1

I understand CMS has approved a general care management code (99484). What is that code and the associated service?

CMS created a code to describe general care management services for patients with behavioral health conditions, which incorporates some but not all of the principles associated with collaborative care. The service can be billed once you reach at least 20 minutes of clinical staff time

99484 - Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

How do I bill for services in an FQHC or RHC?

CMS has incorporated the payment for FQHCs and RHCs in to two HCPCS codes. When billing for the general care management service - care management for behavioral health conditions - use G0511. When billing for Collaborative care services use G0512. FQHCs and RHCs do not recognize the CPT time rule nor the add-on code for additional time. You must provide the full 70 (initial) or 60 (subsequent) minutes before billing for the service and sites are not paid for any additional time. It is important that you review the specific requirements associated with billing in these settings. For more information see the following CMS documents:

- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf

- Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

G0511 – General Care Management Services: Minimum of 20 minutes per calendar month. G0511 may only be billed once per month per beneficiary and may not be billed if other care management services such as transitional care management or home health care supervision are billed for the same time period.

Service elements must include:

- Initial assessment or follow-up monitoring, including use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

G0512 – Psychiatric Collaborative Care Model services: Minimum of 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months. Minutes counted towards the time threshold are those of the behavioral health care manager only. The valuation of the codes includes the time of the psychiatric consultant and treating medical provider, who bill usual codes for any E/M or evaluation services.

G0512 may only be billed once per month per beneficiary and may not be billed at the same time as G0511.

Service elements must include:

- Outreach and engagement of patients;
- Initial assessment, including administration of validated scales and resulting in a treatment plan;
- Entering patients into a registry for tracking patient follow-up and progress;
- Participation in weekly caseload review with psychiatric consultant and modifications to treatment, if recommended;
- Provision of brief interventions using evidence-based treatments such as behavioral activation, problem-solving treatment, and other focused treatment activities;
- Tracking patient follow-up and progress using validated rating scales;
- Ongoing collaboration and coordination with treating FQHC and RHC providers; and
- Relapse prevention planning and preparation for discharge from active treatment.

Who bills for these services?

The treating physician/Primary Care Provider (PCP) submits the claims for these services. The consulting psychiatrist and the care manager are then paid by the PCP though a contract, employment, or other arrangement.

What are the requirements for billing the codes?

All of the bulleted items must be performed and documented and the time thresholds met.

For patients with multiple chronic conditions, including behavioral health conditions, how should one decide when to bill chronic care management (CCM) services versus BHI services? (CMS question 1)

As noted in the CY 2017 PFS final rule (81 FR 80233, 80247), CCM and BHI are distinct services, although there is some overlap in eligible patient populations. There are substantial differences in the potential number and nature of conditions, types of individuals providing the services, and time spent providing services. CCM involves care planning for all health issues and includes systems to ensure receipt of all recommended preventive services, whereas BHI care planning focuses on individuals with behavioral health issues, systematic care management using validated rating scales, and does not focus on preventive services. CCM requires use of certified electronic health information technology, whereas BHI does not. In most cases, we believe it would not be difficult to determine which set of codes (BHI or CCM) more accurately describe the patient and the services provided. As CMS states in the final rule, the code(s) that most specifically describe the services being furnished

should be used. If a BHI service code more specifically describes the service furnished (service time and other relevant aspects of the service being equal), then it is more appropriate to report the BHI code(s) than the CCM code(s).

Can the BHI codes be billed in the same month as CCM? What about other non-face-to-face care management services? (CMS question 2)

As discussed above (see #1), CCM and BHI are distinct, differing services even though there is some overlap in eligible patient populations. There may be some circumstances in which it is reasonable and necessary to provide both services in a given month. The BHI codes can be billed for the same patient in the same month as CCM if advance consent for both services and all other requirements to report BHI and to report CCM are met and time and effort are not counted more than once. Billing practitioners should keep in mind that cost sharing and advance consent apply to each service independently and there can only be one reporting practitioner for CCM each month. If all requirements to report each service are met, both may be billed.

Can the General BHI code (99484) be billed for the same patient in the same month as the CoCM codes (99492, 99493,99494)? (CMS question 3)

No, as noted in the CY 2017 PFS final rule, (81 FR 80242), a single practitioner must choose whether to report the General BHI code or the CoCM codes in a given month (service period) for a given beneficiary. However, in many cases, it may be appropriate for a single practitioner to report the General BHI code or the CoCM codes for the same beneficiary over the course of several months.

For CoCM, must the psychiatric consultant and the billing practitioner be in the same practice? What about the behavioral health care manager and the billing practitioner? (CMS question 4)

The psychiatric consultant and behavioral health care manager may, but are not required to be, employees in the same practice as the billing practitioner. As noted in the CY 2017 final rule (81 FR 80235), these other care team members are either employees or working under contract to the billing practitioner whom Medicare directly pays for BHI. However, the behavioral health care manager must be available to provide services on a face-to-face basis (though face-to-face services do not necessarily have to be provided). Under the current CoCM model of care, the psychiatric consultant is commonly (but not required to be) remotely located.

What qualifications are required for the behavioral health care manager role? (CMS question 5)

As noted in the CY 2017 PFS final rule, (81 FR 80231), the behavioral health care manager is a designated member of the care team with formal education or specialized training in behavioral health (which would include a range of disciplines, for example, social work, nursing, and psychology), but Medicare did not specify a minimum education requirement. They may or may not be a professional who meets all the requirements to independently furnish and report services to Medicare. The behavioral health care manager must be available to provide services face-to-face with the beneficiary, have a continuous relationship with the beneficiary, and have a collaborative, integrated relationship with the rest of the care team. He or she must also be able to engage the beneficiary outside of regular clinic hours as needed.

If a General BHI model of care includes provision of services by a behavioral health care manager or similar qualifying clinical staff (other than the billing practitioner), do these other staff have to be available to provide their services on a face-to-face basis? (CMS question 6)

No, General BHI does not require face-to-face provision of services by clinical staff nor availability of clinical staff for face-to-face services.

Can the behavioral health care manager bill for psychotherapy and other similar codes separate from BHI? (CMS question 7)

Yes. As noted in the CY 2017 PFS Final Rule, (81 FR 80231-80232) if the behavioral health care manager is eligible to independently furnish and report services to Medicare, then that individual could report separate services furnished to a beneficiary receiving BHI services in the same calendar month, such as psychiatric evaluation, psychotherapy, and alcohol or substance abuse intervention services. Time spent by the behavioral health care manager on activities for services reported separately could not be included in the time applied to any BHI service code (in other words, time and effort cannot be counted more than once).

All providers (including the PCP and psychiatric consultant) can bill separately for face-to-face services they provide in conjunction with collaborative care services so long as this time is not included in the calculation of the time spent in providing psychiatric collaborative care services.

Can a psychiatrist that is non-participating with Medicare serve as the psychiatric consultant? (CMS question 8)

Yes, since Medicare makes payment to the billing practitioner for the service, the third-party practitioner they contract with does not necessarily have to be participating with Medicare.

What are the qualifications for the psychiatric consultant?

The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of medications. [CMS Final Rule 80232]

What is the primary role of a psychiatric consultant?
The psychiatric consultant advises and makes recommendations as needed for psychiatric and other medical care, including:

- psychiatric and other medical diagnoses,
- treatment strategies including appropriate therapies,
- medication management,
- medical management of complications associated with treatment of psychiatric disorders, and
- referral for specialty services

The recommendations are communicated to the treating physician or other qualified health care professional, typically through the behavioral health care manager. They would not typically see the patient or prescribe medications, except in rare circumstances, but could and should facilitate a referral to a psychiatric care provider when clinically indicated. The psychiatric consultant may provide services in the calendar month described by other codes, such as evaluation and management (E/M) services and psychiatric evaluation (90792). These services may be reported separately by the psychiatric consultant. Activities for services reported separately are not included in the services or time reported using 99492, 99493,99494).

How do I get paid as a psychiatric consultant?

Psychiatric consultants are paid by the billing practitioner, either by contract, or employment or other financial arrangement, for services provided as part of CoCM.

What are the liability issues as a psychiatric consultant?

Anyone interested in serving as a psychiatric consultant should contact their individual liability insurance carrier regarding coverage. APA has a document *Resource Document on Risk Management and Liability Issues in Integrated Care Models* that may be helpful in the process.

Are the BHI codes limited to Medicare beneficiaries with certain behavioral health conditions/diagnoses? (CMS question 9)

No, as provided in the CY 2017 PFS Final Rule (81 FR 80232), the BHI codes may be used to treat patients with any mental, behavioral health, or psychiatric condition that is being treated by the billing practitioner, including substance use disorders. CMS did not limit billing and payment for the BHI codes to a specified set of behavioral health conditions. The services require that there must be a presenting mental, psychiatric, or behavioral health condition(s) that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time.

What date of service (DOS) should be used on the professional claim, and when should the claim be submitted? (CMS question 10)

The BHI service period is one calendar month. The Centers for Medicare and Medicaid Services (CMS) expects the billing practitioner to continue furnishing services during a given month, if medically necessary, even after the time threshold to bill BHI is met. However, after completion of the minimum clinical staff service time required to bill, the practitioner may submit the claim and need not hold the claim until the end of the month.

What place of service (POS) should be reported on the professional claim? (CMS question 11)

The BHI codes are priced in both facility and non-facility settings. The billing practitioner should report the POS for the location where he or she would ordinarily provide face-to-face care to the beneficiary.

Can BHI be billed if it is provided to a beneficiary who spends part or all of the month in a facility stay or institutional setting? (CMS question 12)

Yes, the BHI codes are priced in both facility and non-facility settings. The POS on the claim should be the location where the billing practitioner would ordinarily provide face-to-face care to the beneficiary.

Which specialties can report BHI services (99492, 99493,99494, and 99484) **? Can BHI codes be billed by specialists other than "traditional" primary care specialties? (CMS question 13)**

The BHI codes (99492, 99493,99494, and 99484) can be billed (directly reported) by physicians and non-physician practitioners whose scope of practice includes evaluation & management (E/M) services and who have a statutory benefit for independently reporting services to Medicare. This includes physicians of any specialty, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives. Generally, we would not expect psychiatrists to bill the psychiatric CoCM codes (99492, 99493,99494), because psychiatric work is defined as a sub-component of the psychiatric CoCM codes. However, General BHI (99484) could be billed by a psychiatrist who furnished the services described by the General BHI code (99484) and met all requirements to bill it.

Who can provide BHI services? (CMS question 14)

For all BHI codes, the billing practitioner performs aspects of the service him or herself. For CoCM (99492, 99493,99494), other specified individuals (namely the behavioral health care manager and the psychiatric

consultant) provide parts of the service under very specific roles and qualifications. CoCM is, by definition, provided by a team of three individuals rather than a single individual. In contrast, services included in the General BHI code (99484) may be provided solely by the billing practitioner. Alternatively, the practitioner billing General BHI may (but is not required to) use other qualified individuals termed ''clinical staff" to provide certain aspects of the service in a team-based approach to care. The term "clinical staff" is defined by CPT (see the Introduction to the CPT manual) as an individual who performs services "incident to" (as an integral part of) services of the billing practitioner, subject to applicable state law, licensure, scope of practice, and supervision. The clinical staff may, but are not required to, include individuals who meet the qualifications for the CoCM behavioral health care manager or psychiatric consultant. For example, for General BHI, a behavioral health consultant who is not authorized to prescribe medication, such as a psychologist, could participate in the care team. Clinical staff may be employees of the billing practitioner or may be a contracted "third party." Refer to the CMS BHI Fact Sheet and governing regulations for a complete description of BHI staffing requirements.

In every month in which one bills BHI, does one also need to bill at least one E&M visit? (CMS question 15)

No, the only required visit is the initiating visit, which is only required for new patients or patients not seen within a year of commencement of BHI services and could be furnished the preceding calendar month. For CoCM, the behavioral health care manager must be available to provide his or her services face-to-face service with the beneficiary as needed, but there is no other requirement for in-person care.

Is written consent required? (CMS question 16)

Prior beneficiary consent is required for all of the BHI codes, recognizing that any applicable rules continue to apply regarding privacy. The consent will include permission to consult with relevant specialists, including a psychiatric consultant, and inform the beneficiary that cost sharing will apply to in-person and non-face-to-face services provided. Consent may be verbal (written consent is not required) but must be documented in the medical record.

Is a new patient consent form required each calendar month or annually? (CMS question 17)

No, a new consent is only required if the patient changes billing practitioners, in which case a new consent must be obtained and documented by the new billing practitioner prior to furnishing the service.

What are the requirements for initiating the service?

There must be an initiating visit for new patients or beneficiaries not seen within one year prior to the start of BHI services. This visit establishes the beneficiary's relationship with the billing practitioner and insures the billing practitioner assesses the beneficiary prior to initiating BHC services.

The patient must be informed about the program and provide general consent, which must be documented in the medical record. This includes giving permission to consult with relevant specialists (including the psychiatric consultant) and the acknowledgement that there is beneficiary cost-sharing/co-payment for both non-face-to-face and face-to face services. Consent may be verbal (written consent is not required) but must be documented in the medical record.[3]

What services qualify as a BHI initiating visit? (CMS question 18)

[3] CMS Fact Sheet https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf (pg 4)

For new patients or patients not seen within a year prior to the commencement of BHI services, BHI must be initiated by the billing practitioner during a "comprehensive" Evaluation & Management (E/M) visit, annual wellness visit (AWV), or initial preventive physical exam (IPPE). This face-to-face visit is not part of the BHI service and can be separately billed under the PFS, but is required before BHI services can be provided. The billing practitioner must discuss BHI with the patient at this visit. While informed patient consent does not have to be obtained during this visit, it is an opportunity to obtain the required consent. The face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) qualifies as a "comprehensive" visit for BHI initiation. Levels 2 through 5 E/M visits (CPT codes 99202-99205 and 99212-99215) also qualify; CMS is not requiring the practice to initiate BHI during a level 4 or 5 E/M visit. However, CPT codes that do not involve a face-to-face visit by the billing practitioner or are not separately payable by Medicare (such as CPT code 99211, anticoagulant management, online services, telephone and other E/M services) do not meet the requirement for the visit that must occur before BHI services are furnished. If the practitioner furnishes a "comprehensive" E/M, AWV, or IPPE and does not discuss BHI with the patient at that visit, that visit cannot count as the initiating visit for BHI.

Will the patient have a co-pay/cost sharing?

Medicare patients will have a copay (cost sharing) due to statutory requirements, although supplemental policy coverage may apply. It is unclear right now if commercial payers will also require a copay.

Why is there cost sharing for BHI? Does CMS have any mechanism for removing the cost sharing to encourage patient engagement? (CMS question 19)

Part B cost sharing applies to the services described by the BHI codes, consistent with statutory requirements.

Will Medicaid cover the beneficiary cost sharing for BHI for dually eligible beneficiaries? (CMS question 21)

CMS wishes to ensure that Medicare-Medicaid dually eligible beneficiaries have access to BHI services. The majority of dually eligible beneficiaries (approximately 64%, or 7 million of the 11.4 million dually eligible beneficiaries) are Qualified Medicare Beneficiaries who will not be responsible for BHI cost sharing. For Qualified Medicare Beneficiaries, Medicaid is responsible for deductibles/co-insurance for Medicare services, including these services, even if the services are not covered in the State Plan. However, as permitted by federal statute, most states limit payment of Medicare cost-sharing to the "lesser-of" Medicaid or Medicare rates. If the service is not covered in the State plan, States can set other reasonable payment limits, approved by CMS, for the service. In states where there would be coverage of some or all of the beneficiary cost-sharing, providers need to be enrolled as Medicaid providers to be paid for the Medicare-cost-sharing.

Do the BHI codes allow for BHI furnished via telehealth? (CMS question 22)

The BHI codes allow for remote provision of certain services by the psychiatric consultant and other members of the care team. For CoCM, the behavioral health care manager must be available to provide face-to-face services in person, but provision of face-to-face services is not required. The BHI codes do not describe services that are subject to the rules for Medicare telehealth services in the narrow meaning of the term (under section 1834(m) of the Social Security Act).

Does there have to be an ICD 10 diagnosis of a mental health condition to bill for the BHI services or can a referral be made based on identified risk factors to rule out a mental health condition? (CMS question 23)

The BHI services require that there must be a presenting psychiatric or behavioral health condition that, in the clinical judgment of the treating physician or other qualified health professional, warrants "referral" to the

behavioral health care manager for further assessment and treatment through provision of psychiatric CoCM services or General BHI.

Where can I find more guidance on BHI payment provisions? (CMS question 23)

A Fact Sheet and other materials on BHI will be available on the CMS website on the Physician Fee Schedule (PFS) page under the "Care Management" hyperlink. The governing regulation for BHI is the CY 2017 PFS final rule, which is also available on the CMS Physician Fee Schedule web page.

Can addiction specialists serve as the consulting physician in furnishing CoCM?

In cases where a substance use disorder is being treated, medical professionals who specialize in addiction medicine and are qualified to prescribe the full range of medications may function in the consultant role, for purposes of meeting the billing requirements for the CoCM services.

Where can I find more guidance [from CMS] on BHI payment provisions? (CMS question 25)

A Fact Sheet and other materials on BHI will be available on the CMS website on the Physician Fee Schedule (PFS) page under the "Care Management" hyperlink at (https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeeSched/). The governing regulation for BHI is the CY 2017 PFS final rule, which is also available on the CMS Physician Fee Schedule web page.

One of the requirements in providing these services is the use of validated rating scales. Where can I find a list of these?

As noted in the Final Rule: "We are aware of a number of validated rating scales that are available for use for a number of conditions addressed by BHI models of care, such as those described by the Kennedy Forum *Issue Brief: A Core Set of Outcome Measures for Behavioral Health Across Service Settings*. We are requiring the use of such scales when applicable to the condition(s) that are being treated."

Where can I find additional resources on the Collaborative Care Model including training and implementation tools?

APA, in collaboration with the University of Washington's AIMS Center, has developed a range of resources for those interested in integrating care, including information and trainings on specific aspects of the collaborative care model. This effort is supported by a grant from the U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services. Visit www.psychiatry.org/SAN for more information.

[July 2018] There is a chart in the MLN Fact Sheet on CoCM that includes a column titled "Assumed Billing Practitioner time." Are these times that the billing practitioner has to meet before they can bill for collaborative care services (time in addition to the time of the behavioral health care manager)?

No, these times should be considered like the typical times for evaluation & management (E/M) office visits. They are assumed times, established through physician survey by the American Medical Association when the codes were created and valued, for how much time the billing practitioner spends himself or herself each month, but are not exact times. The billing practitioner's time could be spent in activities such as directing clinical staff; personally performing clinical staff activities; or performing medical decision making that is not billed separately. (Similar FAQ in FAQs for CCM services)

[July 2018] Can the clinical staff of the billing professional perform the informed consent prior to the initiation of the services and document that in the chart or MUST it be the billing practitioner themselves?

The CY 2017 PFS final rule stated, "We are not proposing a formal limit at this time, but we stress that BHI services can only be reported by a treating physician or other qualified health care professional when he or she has obtained the required beneficiary consent, directed the BHI services he or she reports for the duration of time reported, and has a qualifying relationship with individuals providing the reported services under his or her direction and control." (81 FR 80240)

On page 80239 (81 FR 80239) CMS discussed that the initiating visit is an opportunity to obtain consent: "The initiating visit would establish the beneficiary's relationship with the billing practitioner (most aspects of the BHI services would be furnished incident to the billing practitioner's professional services), ensure the billing practitioner assesses the beneficiary prior to initiating care management processes, and provide an opportunity to obtain beneficiary consent."

[July 2018] Can you count the time spent by the care manager providing care on the days the billing practitioner is not at physically at that site/in the office?

Yes, time spent by the behavioral health care manager when the billing practitioner is not at the site does count. CMS made an exception allowing for general supervision of these services: In the CY 2017 PFS final rule we stated, "For payment purposes, we are assigning general supervision to the psychiatric CoCM codes because we do not believe it is clinically necessary that the professionals on the team who provide services other than the treating practitioner (namely, the behavioral health care manager and the psychiatric consultant) must have the billing practitioner immediately available to them at all times, as would be required under a higher level of supervision. However, general supervision sets the minimum standard for supervision and does not, by itself, meet the requirements we are setting for billing new codes G0502, G0503 and G0504." (81 FR 80235) –This also applies for the general BHI code.

[May 2019] FAQ: The CPT coding descriptor notes that the care manager consults with the psychiatric consultant weekly, but we don't discuss all patients in the caseload; only those that are not improving. Our BHCM reviews their registry of patients to ensure all are progressing but may only address a handful pf patients in the discussion with the psychiatric consultant. Does that meet the requirement for regular case load review with psychiatric consultant?

From MLN: "Regular case load review with psychiatric consultant - The primary care team regularly (at least weekly) reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care as needed."

- The AIMS and APA teams clarified with CMS that it is not expected that every patient billed in a given month has had an individual case review/consultation with the psychiatric consultant during that month.
- However, CMS does expect that the psychiatric consultant has evaluated the status of all patients on their assigned case load as part of the case load review with the care manager. This is for the purpose of determining which patients need individual case review/consultation at the weekly meeting with the BH care manager.

- To provide evidence that they have evaluated every patient on their case load, the psychiatric consultant may include a statement in their summary documentation at the end of the month indicating that a patient was included in the weekly caseload review and identified for further psychiatric case review/consultation when needed.. That might be accomplished through a smart phrase or some similar mechanism.
- Caveat: This is our understanding through a preliminary conversation with CMS. We will all have to wait to see if CMS incorporates language to reflect this two-step process:

    1. Case load review: All patients in the registry/case load of a BH care manager evaluated and considered for possible case review on a weekly basis.

    2. Case review: Discussion of an individual patient or consultation with the BH care manager which results in specific recommendations/care plan for the team.

The case load review is an important component of the collaborative care (CoCM) service model, as it allows the psychiatric consultant to provide oversight on a panel of patients (a population) being managed by the behavioral health care manager (BHCM).