Practice Innovation Program
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

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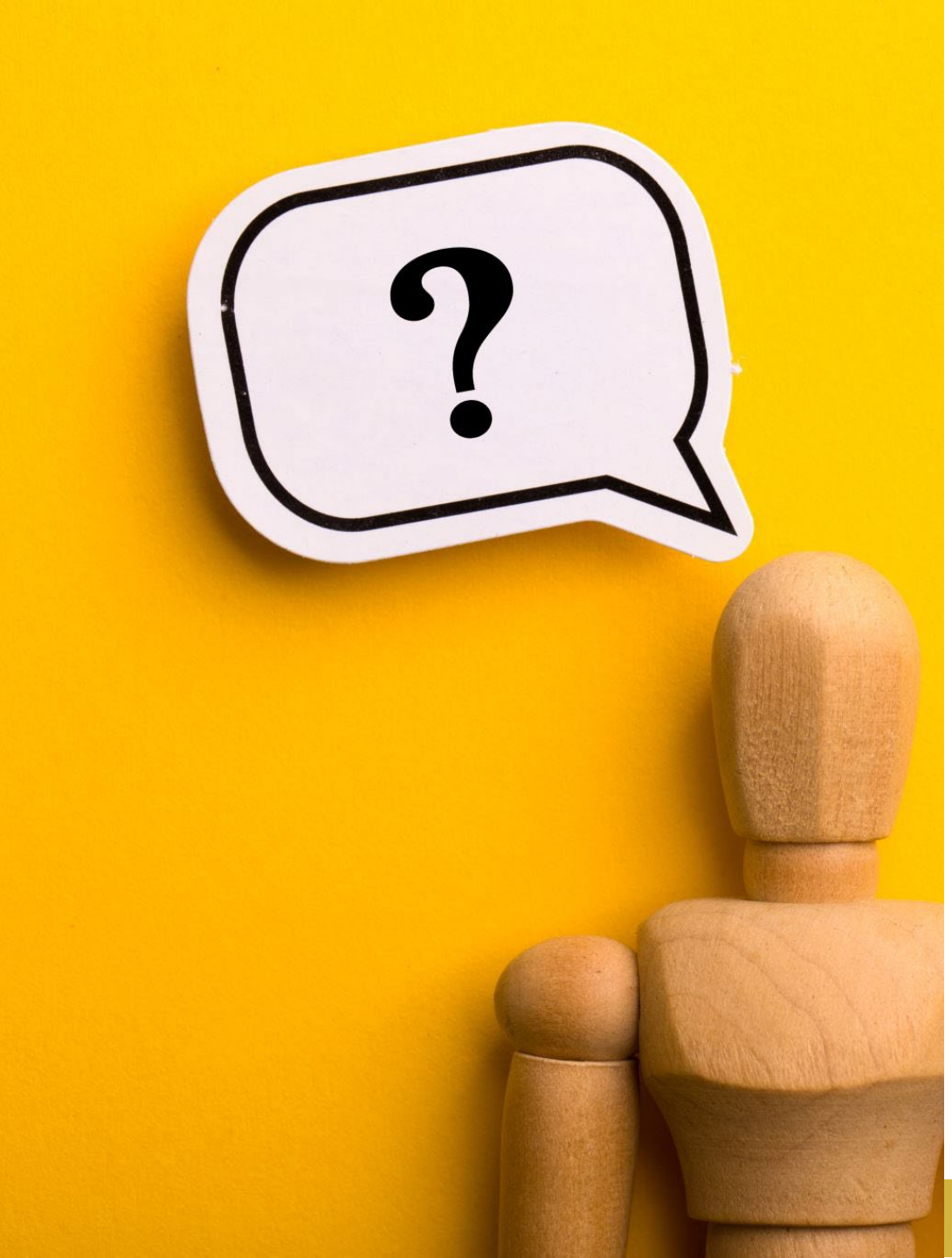
COLORADO
Department of Health Care Policy & Financing

1302 Practice Learning Community Coding and Billing for Collaborative Care Model

Pam Ballou-Nelson, HealthCare Consulting, Inc.

August 8, 2024

Department of Family Medicine



Welcome!

Please put your name, pronouns, practice name, and role in the chat.

You can ask questions via the chat we will monitor it as we go along. We will also pause for questions periodically.

These slides and the recording will be made available on the Practice Innovation Program website.

https://medschool.cuanschutz.edu/practice-innovation-program/current-initiatives/1302-behavioral-health-integration/for-practices

Today’s Agenda

- Affinity Group Reminders
- Upcoming Practice Learning Community Events
- Coding and Billing for Collaborative Care Model

Affinity Group 1 - Processes and Workflows to Support Integrated Care

- 4th Wednesday 12-1 pm MT
- Facilitators: Diane Cardwell and Cynthia Molina
- Zoom Link to register: https://us06web.zoom.us/meeting/register/tZctdOGuqzoqG9DWven3n_-gDT_OBv93UFFt

Affinity Group 2 - Behavioral Health Integration in Pediatrics

- 4th Wednesday 12–1 pm MT
- Facilitators: Mindy Craig and Danielle Peters
- Zoom Link to register: https://us06web.zoom.us/meeting/register/tZEpduGqqjorGddGk0Y_q9365ygalx5HbkqO

Affinity Group 3 - Integrating Primary Care in Behavioral Health Organizations

- 2nd Tuesday: 12- 1 pm MT
- Facilitators: Katie Ebinger and Angie Schindler-Berg
- Zoom link to register: https://us06web.zoom.us/meeting/register/tZYrcu6hqzsqGdOgZ5xZVOLyyFjzzdLPfAz_

Subscribe to the CHES newsletter for updates, including all Learning Community opportunities, https://bit.ly/chessignup

Scan to complete evaluation

https://practiceinnovationco.co1.qualtrics.com/jfe/form/SV_57mYL5eGKnm3qJM

1302 Practices
Lessons Learned

August 8th, 2024, 12-1PM

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Agenda

- Introduction
- CoCM - Collaborative Care
- BH Commercial Contracts
- Denials

"The underlying principle of behavioral health integration is that physical, behavioral, and social health are ***inextricably intertwined***.

If the practice is going to be successful with integrated BH then they must *at some point* embed the services and understand the connection".

From AMA Integrating PC /BH : How to assemble the best team to integrate mental health care | American Medical Association (ama-assn.org)



Collaborative Care Model CoCM

Behavioral Health

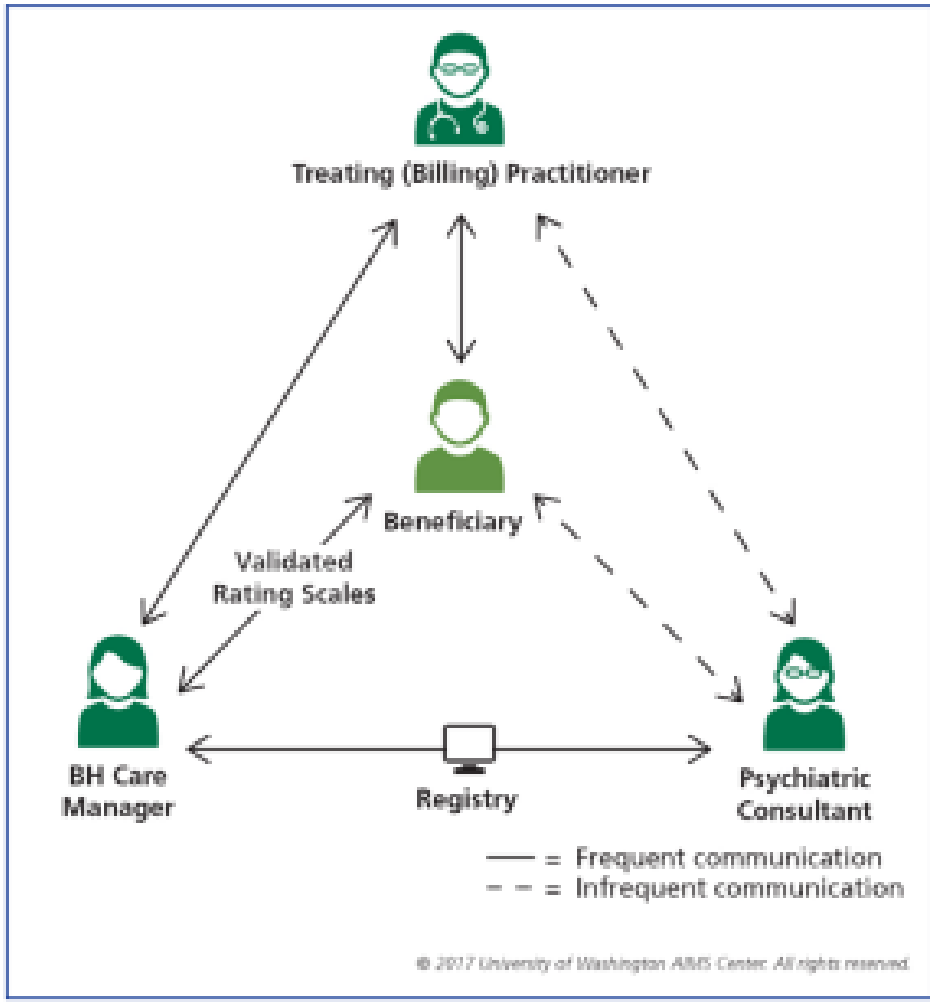


Figure 1: Illustration of a CoCM mode

Collaborative Care Model -CoCM

What is CoCM? Enhances usual primary care by adding 2 key services to the primary care team, particularly patients whose medical conditions aren't improving because of BH issues:

- Behavioral Health Care Manager
- Psychiatric Consultant – can be virtual not face to face with patient
- Treating (Billing) Practitioner

Collaborative Care Model – CoCM Facts

- ONLY for Medicare Patients & Commercial insurance patients. Medicaid Not participate yet.
- Do NOT need a BH commercial contract, these codes are **billed incident to the primary provider the patient is seeing.**
- The BH worker LCSW CSW LCPC LPC student does NOT need to be credentialed with the payer.
- Advance Consent Before starting BHI services, the patient must give the billing practitioner permission to consult with relevant specialists, which includes talking with a psychiatric consultant. The billing practitioner must inform the patient that cost sharing applies for both face-to-face and non-face-to-face services even if supplemental insurers cover cost sharing. We don’t require written consent. ● You may get verbal consent from the patient ● You must document it in the medical record

Collaborative Care Model Facts

- CoCM is delivered monthly for an episode of care that ends when targeted treatment goals are met or there is failure to meet targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).
- BHI and/or CoCM can be billed in the same month as chronic care management or transitional care management services. However, the time and activities used to meet the criteria for another service cannot be counted toward BHI or CoCM.
- BHI and CoCM cannot be billed together in the same month for the same patient.

Collaborative Care team for CoCM

- Treating (Billing) Practitioner – A physician or non-physician practitioner (physician assistant or nurse practitioner); typically, primary care, but may be of another specialty (for example, cardiology, oncology/Gyn, Pediatrics)
- Behavioral Health Care Manager – A designated provider with formal education or specialized training in behavioral health (including social work, Psych nursing, or psychology), working under the oversight and direction of the billing practitioner
- Psychiatric Consultant – A medical provider trained in psychiatry and qualified to prescribe the full range of medications
- Patient – The patient is a member of the care team

Collaborative Care Model –Services

- The primary care team performs the initial assessment and are responsible for the administering the validated rating scales.
- The primary care team's joint care planning with the patient, with care plan revision for patients whose condition isn't improving adequately. Treatment may include pharmacotherapy, psychotherapy, or other recommended treatments.
- Behavioral health care manager following up proactively and systematically using validated rating scales and a registry.
- Assesses treatment adherence, tolerability, and clinical response using validated rating scales • Delivers brief, evidence-based psychosocial interventions such as behavioral activation or motivational interviewing

Collaborative Care Model –Services

• 70 minutes of behavioral health care manager time the first month • 60 minutes following months • Add-on code for 30 more minutes any month

• Regular case load review by the behavioral health care manager and the psychiatric consultant:

• The behavioral health care manager and the psychiatric consultant review weekly the patient's treatment plan and status, and if the patient is not improving, discuss the patient's treatment plan for potential revision with the psychiatric consultant

• The primary care team continues or adjusts treatment, including referral to behavioral health specialty care, as needed

Example

September 5th

A 53-year-old man, Mr. A, presents to his PCP with a chief complaint of “not sleeping enough, having headaches, and feeling run down.” For the last 4 months, he has been waking up too early in the morning and cannot get back to sleep. During the day he is exhausted and is having trouble focusing when he’s at work. His chronic back pain has increased, so he has been staying at home and has stopped exercising. He has tried everything he can think of to “break out of this rut,” but feels like it is pointless and is ready to give up. The PCP administers a PHQ-9 (Mr. A scored 18) and then asks Mr. A about suicidality. After discussing the symptoms on the PHQ-9, Mr. A says that he never thought of himself as depressed before. The primary care provider expresses confidence to Mr. A that he will be able to improve and introduced Mr. A to the behavioral health care manager (BHCM) for further evaluation and treatment and consents him to engage in the clinic CoCM program

Example Billing

Date	Case Details	Minutes and Other Relevant Billing Codes	Billable BHCM Provider - Psychotherapy and/or CoCM CPT codes	NO Billable BHCM Provider - CoCM CPT codes ONLY
Sept 5	Initial presenting visit with PCP	Always bill E&M code as appropriate for PCP visits	Not Billable	Not Billable

The BH clinical provider sees Mr. A for a warm handoff visit to engage Mr. A and schedule time for a full intake in the future. Enters patient into the registry (done at the end of each encounter between the patient and BHCM) keeping track of your hours spent.

Date	Case Details	Minutes and Other Relevant Billing Codes	Billable BHCM Provider - Psychotherapy and/or CoCM CPT codes	NO Billable BHCM Provider - CoCM CPT codes ONLY
Sept 5	Initial presenting visit with PCP	Always bill E&M code as appropriate for PCP visits	Not Billable	Not Billable
Sept 5	15-minute visit 5 minutes registry	The BHCM records 20 minutes towards CoCM	The BHCM records 20 minutes towards CoCM	The BHCM records 20 minutes towards CoCM

Example

September 8th Patient returns to see BH provider

The BH conducts a comprehensive assessment of Mr. A and learns that he has been more irritable at home with his wife and children for the past six months. He has also stopped going out with friends. In the last two weeks he has been late to work four times because he can't get himself to get started in the morning. As part of the initial comprehensive assessment, the BHCM administers screening instruments for PTSD (PCL-C), and bipolar disorder (CIDI-3), both of which were negative. The BHCM screens for alcohol use disorder with the AUDIT-C and other substance use disorders with appropriate questionnaires. All are negative, but Mr. A report that he has started smoking cigarettes again. The BHCM and Mr. A discuss the provisional diagnosis of major depression and its treatment, as well as the connections between depression and chronic pain

Date	Case Details	Minutes and Other Relevant Billing Codes	Billable BHCM Provider - Psychotherapy and/or CoCM CPT codes	NO Billable BHCM Provider - CoCM CPT codes ONLY
Sept 8	Initial assessment with BH care manager	45-minute visit 5 minutes registry	The BHCM bills for an initial assessment with 90791 + 5 min CoCM OR The BHCM records 50 minutes towards CoCM	The BHCM records 50 minutes towards CoCM

Billing Example

Example Pysch Consult

SEPT 9:

The next day the BH and Psychiatric Consultant (PC) discuss Mr. A's presentation during weekly case review. The PCP had asked whether fluoxetine could be appropriate for Mr. A. The PC suggests considering bupropion as an initial antidepressant given its efficacy for both treating depression and in supporting smoking cessation. A titration schedule is provided to escalate the dose to the therapeutic range and monitor response with a PHQ-9 over four to six weeks. The PC completes the recommendation in the EMR and alerts the PCP to it via electronic messaging. No PC time is counted towards CoCM since this is not the work of the BHCM. SEPT 16: The BHCM meets Mr. A for another session and Problem Solving Treatment (PST) is started. This is to target Mr. A's goal of re-engaging in work and social activities. After the session, which was productive, Mr. A agreed to meet via phone in two weeks

Date	Case Details	Minutes and Other Relevant Billing Codes	Billable BHCM Provider - Psychotherapy and/or CoCM CPT codes	NO Billable BHCM Provider - CoCM CPT codes ONLY
Sept 9	The next day the BHCM and Psychiatric Consultant (PC) discuss Mr. A's presentation during weekly case review. ***No PC time is counted towards CoCM since this is not the work of the BHCM.***	5 minutes BHCM prep time 10-minute consult 5 minutes registry	Not billable with psychotherapy codes **OR** The BHCM records 20 minutes towards CoCM	The BHCM records 20 minutes towards CoCM
Sept 16	The BHCM meets Mr. A for another session and Problem Solving Treatment (PST) is started.	30-minute visit 5 minutes registry	The BHCM bills for a 30 minute psychotherapy session with code 90832 + 5min CoCM **OR** The BHCM records 35 minutes towards CoCM	The BHCM records 35 minutes towards CoCM

Example

Example

SEPT 17:

The BH organizes a discussion with the PCP to review the PC's recommendations for antidepressant medication and to discuss the recent initiation of PST. Additionally, the BHCM asks the PCP to follow-up with Mr. A on PST progress at their visit the following week.

SEPT 25:

The PCP sees Mr. A for a follow up visit and prescribes bupropion SR 150mg daily. The PCP reinforced the role of the BHCM in coordinating care and the value of PST for depression.

SEPT 27: The BHCM calls for a scheduled phone visit. The BHCM administers the PHQ-9 over the phone and records the score as 16. The BHCM checks in with Mr. A both about starting medications and reinforcing PST skills.

Example Billing

Sept 17	The BHCM organizes a discussion with the PCP to review recommendations. Asks the PCP to follow-up with Mr. A the following week.	5 minutes Care coordination 5 minutes registry	Not billable with psychotherapy codes OR The BHCM records 10 minutes towards CoCM	The BHCM records 10 minutes towards CoCM
Sept 25	The PCP sees Mr. A for a follow up visit and prescribes bupropion SR 150mg daily and reinforced the role of the BHCM.	Always bill E&M code as appropriate for a face-to-face visit with the PCP	Not billable	Not billable
Sept 27	The BHCM calls for a scheduled phone visit.	10-minute phone call 5 minutes registry	Not billable with psychotherapy codes OR The BHCM records 15 minutes towards CoCM	The BHCM records 15 minutes towards CoCM

SUMMARY OF MONTH 1 OF TREATMENT

AMERICAN PSYCHIATRIC ASSOCIATION

Date	Case Details	Minutes and Other Relevant Billing Codes	Billable BHCM Provider - Psychotherapy and/or CoCM CPT codes	NO Billable BHCM Provider - CoCM CPT codes ONLY
Summary of Month 1 of Treatment	Mr. A has been engaged in care, diagnosis has been established and treatment has been started. On the last day of the month the BHCM totals the time spent of the care of Mr. A.	2 E&M visits 45 minute visit 30 minute visit 75 minutes BHCM activities	2 PCP visits with E&M codes Bill 90791 x 1 (50 minutes) and 90832 x 1 (30 minutes). **AND** CoCM code 99492 (70 minutes) for first month of CoCM treatment **OR** 90791 and 99492 + 99494 x 1 **OR** 90832 and 99492+ 99494 x 2	2 PCP visits with E&M codes CoCM Code 99492 for first month (70 minutes) AND 99494 x 2 (2 x 30 minutes) 20 min unbillable

Commercial Contracts for BH

Understand your current contracts

Contact your IPA

Commercial Insurance Contracts

Need to consider review in the BH contract :

- Covered services
- Billing requirements
- Client financial responsibility
- Eligible providers
- Need to credential your BH providers with the commercial contracts

Commercial Insurance Contracts

Go to this link to see Colorado's resources For BH providers.

Commercial Insurance Resources for Behavioral Health Providers in Colorado | DORA Division of Insurance

Behavioral health providers can submit information related to complaints or issues with carriers by emailing the Division of Insurance at dora_bh_provider_issues@state.co.us.

Also note this: on Pre-Licensure, Provisional, and Delegated Credentialing Practices: Plan/Filing Year 2023 Insurance Company Response Summary

The DOI issued Bulletin B-4.131(opens in new window) directing Colorado insurance companies to adopt credentialing standards that clarify policies, expedite the process and reduce unnecessary administrative burdens for behavioral health providers. Companies were also strongly encouraged to allow pre-license, provisional, and delegated behavioral health provider candidates to bill for patient care, an approach that can increase the number of available, in-network providers and improve Coloradans' access to behavioral health care. In addition, the DOI requested information from insurance companies about their credentialing and billing policies for behavioral health providers. Below is a summary of the insurance companies' responses.

Summary of Responses

•11 out 18 companies **allow for billing and reimbursement of a pre-licensed* behavioral health provider candidate** under the supervision of a licensed behavioral health provider

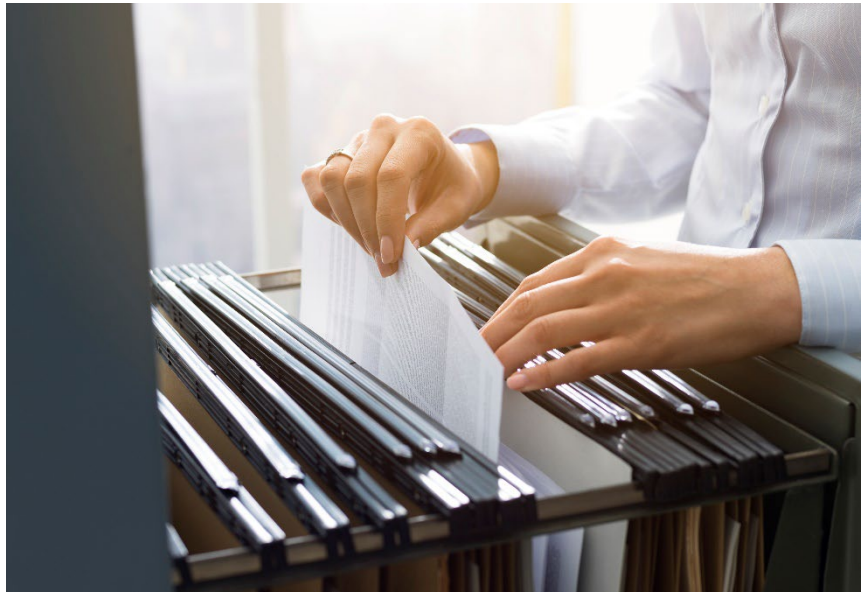
•2 out 18 of companies **allow for provisional billing** and reimbursement of a licensed behavioral health provider**

•14 out of 18 companies **allow for delegated credentialing*** of behavioral health providers**

**Pre-Licensure Billing*: *allowable billing and reimbursement for services provided by doctorate or masters level clinical mental health, behavioral health, and substance use providers who is under the supervision of a fully licensed contracted provider.*

***Provisional Credentialing**: *granting of provisional in-network status to mental health, behavioral health, and substance use providers to provide care to members while the entire credentialing process is completed.*

***Delegated Credentialing**: *occurs when a carrier grants a provider entity the authority to credential its mental health, behavioral health, and substance use practitioners.*



Navigating Denials

Navigating Denials

Top Reasons for Denials

- **Missing or incorrect patient information insurance card not on file**
- **Care covered by another payer patient has other insurance**
- **Services not covered by the payer** not part of your contract, like BH services
- **Coding errors:** This is why accurate medical billing and coding is so important in healthcare.
- Codes services that are part of a bundle or global period
- **Missing the payer's deadline:** Untimely filing,
- **Duplicate claims:** Claims for multiple instances of services or procedures can be interpreted as duplicate claims, especially if an appropriate code modifier isn't used to indicate the claim is not a duplicate.
- **Missing authorization:** . If prior authorization was not obtained, the payer is likely to deny the claim for the non-authorized procedure.
- **Dual coverage issues:** When two forms of health insurance coverage apply, as in an injured patient who has both primary insurance and Workers' Compensation, the claims process can be complicated, especially if there is a dispute with one or both insurers.
- **Provider is not credentialed with the payer.**
- **Providers and group are not contracted with the RAE**

Navigating Denials

Run the denial report Is the first step of this denial management process, the manager , biller/coder identifies the reason for the claim denial.

Claim adjustment reason codes (CARC) are usually given by the payer in the accompanying explanation of payment, but they can be confusing.

Review Practice management billing reports for denials with reasons for denial.

Take steps that could include retraining staff, adjusting workflows or revisiting your processes.

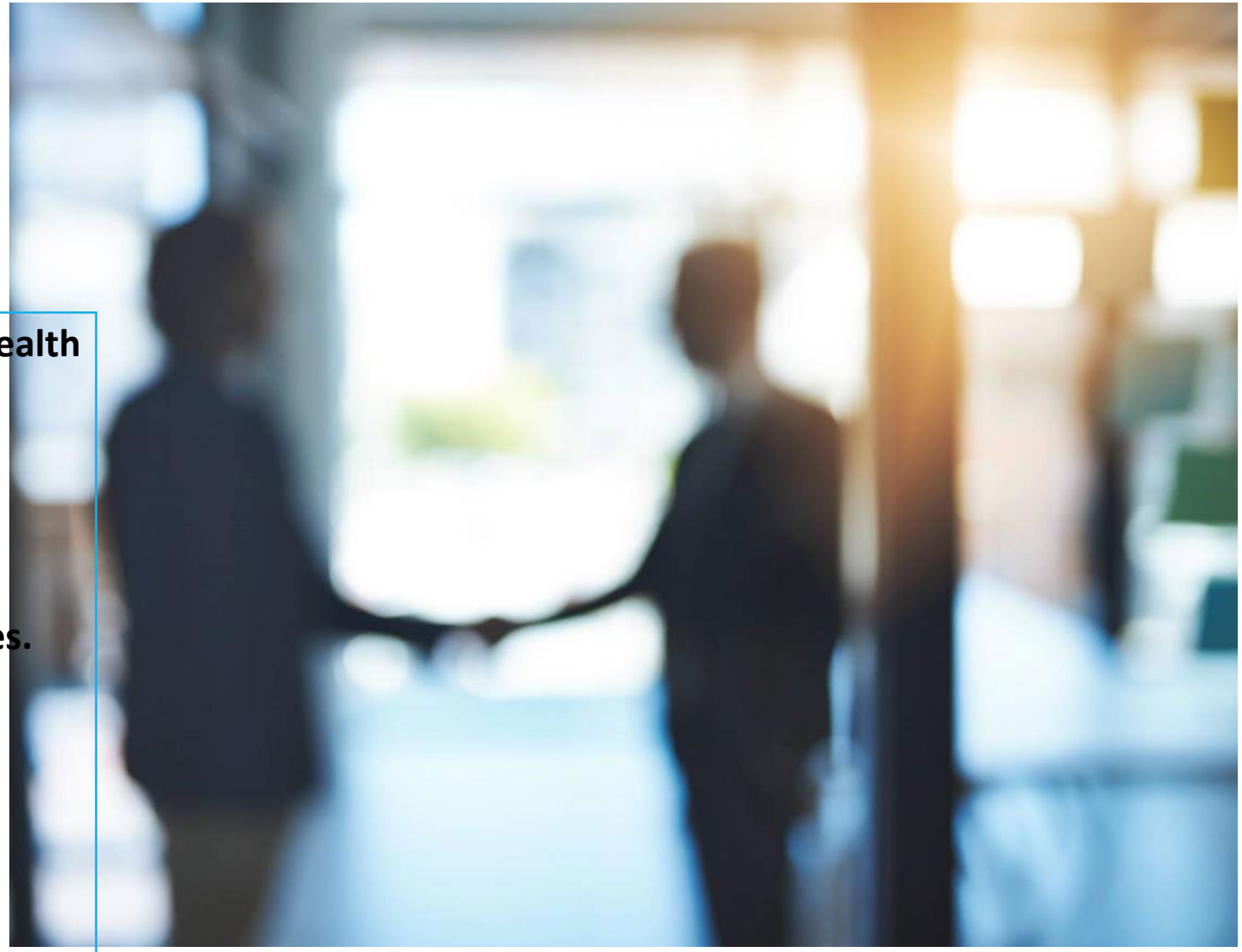
1. Identify
2. Manage
3. Monitor
4. Prevent
5. **Be Proactive, Not Reactive:**

Thank you

Business Operations Support for Behavioral Health Integration Practices

Please share with your practices information about how to take advantage of business operations supports available to the 1302 Behavioral Health Integration grantee practices.

LINK QR CODE to fill out 1302 practice request for assistance



Resources

Billing Codes behavioral health providers can bill for integrated care

- **90791 –** This code is designated for psychiatric diagnostic evaluation involving the collection of history, mental status, and professional recommendation. This code is designated for evaluations ONLY and is not to be applied to the delivery of therapeutic services.
- **90832,90834,90837 –** These three social work CPT codes are designated for the delivery of individual psychotherapy services. The differentiations reflect the time of the visit, and code 90832 reflects 16-37 minutes, code 90834 is 38-52 minutes, and code 90837 is 53 minutes or more.
- **90785 –** This code is an add-on CPT code that reflects interactive complexity in a visit. It should only be used in tandem with the previous four codes along with code 90853, never on its own.
- **90839-90840 –** These social work CPT codes reflect crisis psychotherapy or the delivery of urgent assessments involving the client's mental state, an examination of their mental status, and their disposition. These are meant to be used in matter or urgency only, with code ending in 39 used for the first 60 minutes and code ending in 40 for each additional 30 minutes.
- **90845 –** This is designated for psychoanalysis services.
- **90846 –** If a provider renders psychotherapy services to the family without the patient present, this code should be used. 50 minutes.
- **90847 –** Family psychotherapy session WITH patient present. 50 minutes.
- **90853 –** Group therapy sessions.

Collaborative Care Model – Codes

BHI Codes	Behavioral Health Care Manager or Clinical Staff Threshold Time	Assumed Billing Practitioner Time
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M) †	N/A	Usual work for the visit code
Care management services for behavioral health conditions (HCPCS code G0323)	At least 20 minutes of clinical psychologist or clinical social worker time, per calendar month	15 Minutes
CoCM First Month (CPT code 99492)	70 minutes per calendar month	30 minutes
CoCM Subsequent Months** (CPT code 99493)	60 minutes per calendar month	26 minutes
Add-On CoCM (Any month) (CPT code 99494)	Each additional 30 minutes per calendar month	13 minutes
General BHI (CPT code 99484)	At least 20 minutes per calendar month	15 minutes
Initial or subsequent psychiatric collaborative care management (HCPCS code G2214)	30 minutes of behavioral health care manager time per calendar month	Usual work for the visit code

*CoCM is delivered monthly for an episode of care that ends when targeted treatment goals are met or there is failure to meet targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).
†Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management services (TCM).

Side-by-side comparison of coding requirements for CoCM vs. general BHI services

Collaborative Care Management (CPT codes 99492, 99493, 99494, HCPCS code G2214) Requirements:	**General BHI (CPT code 99484) Shares common required service elements with CoCM, but has fewer requirements:**
Outreach to and engagement in treatment of a patient as directed by the treating physician or other qualified health care professional	Initial assessment or follow-up monitoring, including use of validated rating scale(s)
Initial assessment by primary care team and administration of validated rating scale(s)	Behavioral health care planning, including revisions for patients not progressing or whose status changes
Joint care planning with the primary care team, with revisions for patients whose condition is not improving adequately	Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, or psychiatric consultation

Side-by-side comparison of coding requirements for CoCM vs. general BHI services

Collaborative Care Management (CPT codes 99492, 99493, 99494, HCPCS code G2214) Requirements:	**General BHI (CPT code 99484) Shares common required service elements with CoCM, but has fewer requirements**
Review by the psychiatric consultant, with modifications to plan, if recommended	Continuity of care with a designated member of the care team
Proactive, systematic follow-up by behavioral health care manager using validated rating scale(s) and a registry	Patient consent (verbal or written) documented in the medical record
Regular (at least weekly) case load review with psychiatric consultant	
Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies	
Patient consent (verbal or written) documented in the medical record	

Scan to complete evaluation

https://practiceinnovationco.co1.qualtrics.com/jfe/form/SV_57mYL5eGKnm3qJM

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THANK YOU!