NATIONAL ASSOCIATION OF Community Health Centers®

PAYMENT

Reimbursement Tips:

FQHC Requirements for Medicare Psychiatric Collaborative Care Model (CoCM)

The Psychiatric Collaborative Care Model (CoCM) is a model of behavioral health integration designed to support patients with more complex mental, behavioral, or psychiatric conditions, including substance use disorders.

Program Requirements

The Psychiatric Collaborative Care Model (CoCM) includes two additional service components beyond those in general Behavioral Health: a care manager and psychiatric consultant. This expanded team collaborates to integrate behavioral health treatment with primary care services.

While CMS added HCPCS G2214, effective January 1, 2021, to capture a shorter amount of time spent by the behavioral health manager in patient care activities such as coordinating services for specialized care or hospitalization, FQHCs are not eligible to bill for G2214.

Patient Eligibility & Consent

Patients may be eligible for CoCM services as determined by their primary care provider (i.e., MD, DO, NP, PA, CNM, or CNS). Before CoCM services can begin, a separately billable initiating visiting with a FQHC primary care provider is required. Documentation must show that the patient was informed about available care management services and gave the billing provider permission to consult with relevant specialists, including a psychiatric consultant. The billing provider must also inform the beneficiary that cost sharing applies and that s/he will be responsible for co-insurance. Patient consent may be written or verbal and must be documented in the medical record.

Timeframe & Services

An initiating visit by the billing provider (separately billable) is required for new patients or those not seen within one year prior to the start of CoCM services.

Initial 70 minutes of Psychiatric CoCM services in the first month.

Subsequent

- At least 60 minutes of Psychiatric CoCM services in subsequent calendar months. These services include the primary care team's weekly reviews of a beneficiary's treatment plan and status with the psychiatric consultant.
- 30 additional minutes of Psychiatric CoCM services in any month (use an add-on code).

Each month, FQHCs should report CoCM services for each participating patient only if the documented services meet the minimum required time thresholds. Transcription time, translation services, and other administrative activities do not count toward the minimum minutes required to bill for CoCM services.

Initiating Visit

Prior to the start of CoCM services, a comprehensive initiating visit is required for new patients or patients not seen within one year. Initiating visits can include: Initial Preventive Physical Examination (IPPE), Annual Wellness Visit (AWV), or Evaluation and Management service (E/M) visits. The initiating visit is not part of CoCM services and is billed separately. CoCM services do not have to be discussed during the initiating visit, but this visit must occur during the year (12 months) prior to the start of CoCM.

At FQHCs under **Medicare**, a new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service. Dental service would not count as dental is not covered by Medicare. This definition differs from the traditional CPT definition of a new patient. FQHCs are encouraged to educate staff of the variance and may choose to use a single definition.

Authorized Provider/Staff

Only one practitioner/facility can furnish and be paid for CoCM during a calendar month. Different from general Behavioral Health Integration (BHI) services, the Psychiatric CoCM model requires the hiring of, or contracting with, a behavioral health care manager and a psychiatric consultant.

Services not provided personally by the billing practitioner are provided by other authorized staff under the direct supervision of the billing practitioner (i.e., "incident to" or "within shouting distance" oversight by the billing provider). Other services by the care management team are permitted under general supervision (the billing practitioner provides overall direction and control, but their direct physical presence is not required during provision of services). All services and supervision requirements (regardless of CMS/Medicare policy) are subject to applicable State law, licensure, and scope of practice definitions.

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Treating (Billing) Provider					Behavioral Health Care Manager*	Psychiatric Consultant*
Physicians (MD or DO)	Non-Physician Practictioners				x	x
	NP	PA	CNM	CNS		
x	x	x	x	x		

Medical Doctor (MD) or Doctor Osteopathy (DO) | Non-Physician Practitioners include: Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), and Clinical Nurse Specialist (CNS). | Behavioral Health Care Manager: Designated individual with formal/specialized training in behavioral health (i.e., social work, nursing, psychology) and at least a bachelor's degree, working under the oversight and direction of the billing practitioner; provides face-to-face and non-face-to-face services. | Psychiatric Consultant: Medical professional trained in psychiatry and qualified to prescribe the full range of medications.

Documentation

Psychiatric CoCM services are time-based and reported as the total monthly time spent. FQHCs billing G0512 to CMS/Medicare must follow documentation parameters outlined in the CPT requirements for the corresponding CPT codes listed below.

Behavioral health care manager documentation requirements:

- Assessment and care management services, including the administration of validated rating scales.
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revisions for patients who are not progressing or whose status changes.
- Brief psychosocial interventions.
- Collaboration with the FQHC practitioner.
- Maintaining a registry that tracks patient follow-up and progress.
- Consultation with the psychiatric consultant.
- Face-to-face services with the beneficiary.
- Maintaining a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team.

Psychiatric consultant documentation requirements:

CMS/Medicare requires a Psychiatric Consultant to perform and document the following items, including time spent on each:

- Regular reviews of the clinical status of patients receiving CoCM services.
- Advising the FQHC practitioner on diagnosis and options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment
- Making adjustments to behavioral health treatment for beneficiaries who are not progressing.
- Managing any negative interactions between beneficiaries' behavioral health and medical treatments.
- Facilitating referrals for the direct provision of psychiatric care when clinically indicated.

Coding & Billing

A comprehensive initiating visit (e.g., IPPE, AWV, or E/M) within the past 12 months is required before the start of CoCM services. In addition to IPPE, AWV, or E/M visits, the face-to-face visit included in Transitional Care Management (TCM) services (CPT codes 99495 and 99496) qualifies as a comprehensive CoCM service initiation visit.

For Medicare, FQHCs **bill CoCM using HCPCS code G0512** which, for non-Medicare payers is the equivalent of CPT codes 99492, 99493, or +99494. It is recommended that **providers select CPT code 99492, 99493, or +99494 for CoCM and that the revenue cycle management team crosswalk this CPT code with G0512**. Payment should be the average of these CPT codes shown in the table that follows. An FQHC can expect the payment to be slightly higher or lower depending on the geographic adjustment.

CoCM can be billed during the same month as CCM and TCM services, provided that all requirements to report each service are met and time and effort are not counted more than once (i.e., time/effort for CCM or TCM may not be additionally counted as CoCM time). Also, the patient consent must be individually obtained for each unique care management service. A single conversation or patient encounter could encompass consent for more than one care management service but consent to each much be documented.

See coding table on following page.

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Coding Table

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/Medicare 2021 Fees*
99492	***Initial Visit (70 mins)*** Initial psychiatric collaborative care management, first 70 minutes in the initial calendar month of behavioral health care manager activities, in consultation with the psychiatric consultant, and directed by the treating physician or other qualified health care professional. The following elements are required: • Outreach to a patient to engage in treatment 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. • Enter patient in a registry and track patient follow-up in the registry, with appropriate documentation. • Participate in weekly caseload consultation with the psychiatric consultant. • Provide brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	G0512	$154.23
	Same as 99492 but for 30 minutes of initial or subsequent behavioral health care managers activities.	G2214; FQHCs are not eligible to bill for this service.	
99493	***Subsequent months (60 mins)*** 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. The following elements are required: • Track patient follow-up and progress using the registry, with appropriate documentation. • Participate 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. • Provide brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies. • Monitor patient outcomes using validated rating scales. • Plan relapse prevention with patients as they achieve remission of symptoms and/or other treatment goals to assist them in preparing for discharge from active treatment.	G0512	$154.23
+99494	***Each additional 30 mins*** • Add-on code for additional 30-minutes but only in subsequent months.	G2214; FQHCs are not eligible to bill for this service.	

Notes: Rates here are based on the 2021 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.

References

- American Medical Association, CPT® 2021 Professional Edition
- CMS. Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), Frequently Asked Questions, December 2019. Accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf
- CMS. Medicare Learning Network. Behavioral Health Integration Services. May 2019. Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
- CMS. Medicare Learning Network. Evaluation and Management Services. August 2017. Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
- CMS. Medicare Benefit Policy Manual. Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services. Accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
- Initiating Visit requirements can be found through the following link: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
- CMS 2021 PFS Final Rule (pages https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf)