FIVE STEPS TO COLLABORATIVE CARE BILLING SUCCESS

Northwestern Medicine

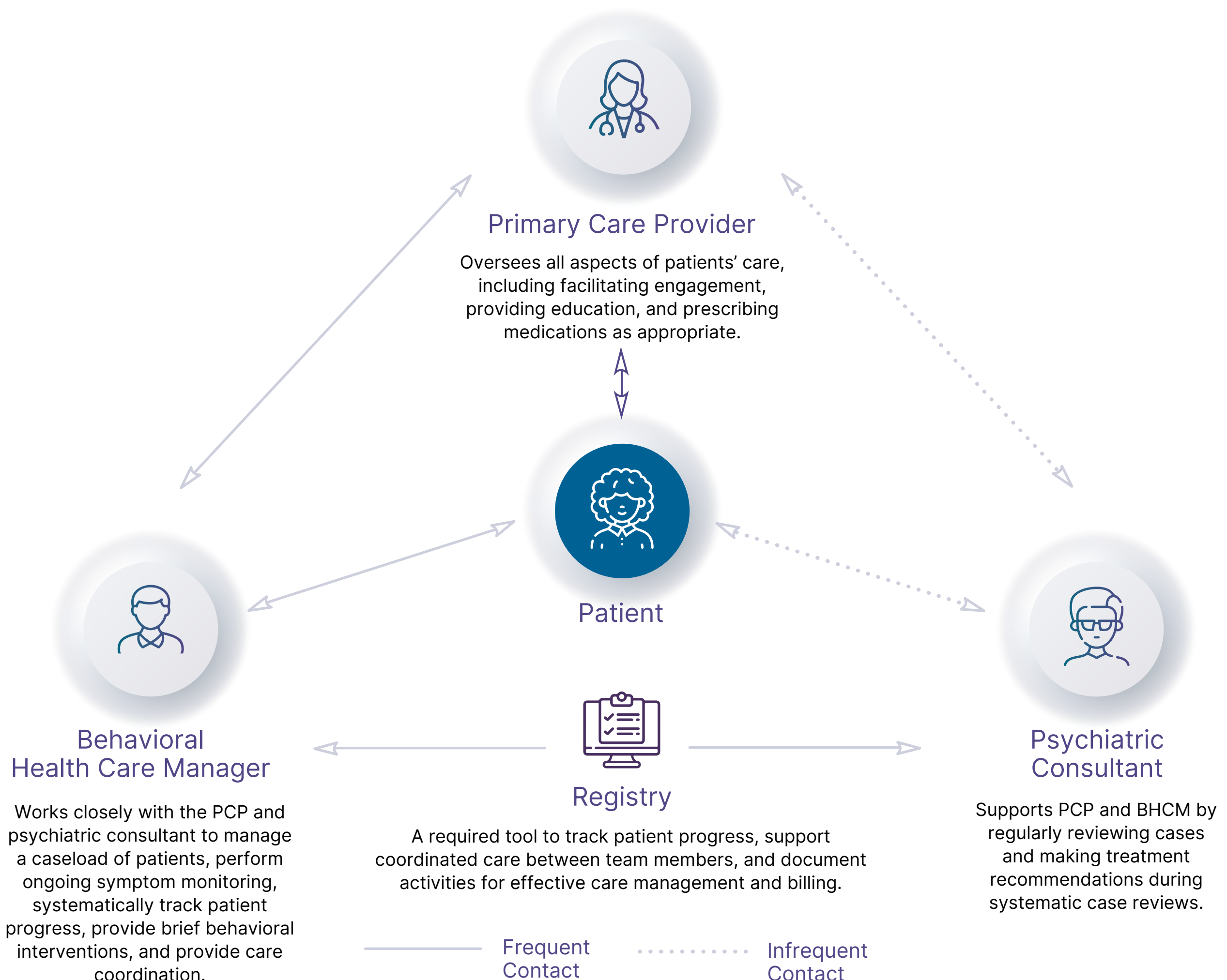
Meadows Mental Health Policy Institute

westhealth institute

The Collaborative Care Model

The Collaborative Care Model (CoCM), developed by the University of Washington's AIMS Center, is an evidence-based approach to mental healthcare that integrates behavioral health services into primary care settings. By providing behavioral health services where patients are already receiving care, CoCM reduces stigma, leverages existing patient-provider relationships, and promotes holistic care plans.

CoCM brings together an interdisciplinary team including a primary care provider (PCP) or specialty medical provider (e.g., OBGYN, oncologist, etc.), a behavioral health care manager (BHCM), and a psychiatric consultant to deliver high-quality, patient-centered, mental health care. The team collaborates to identify mental health conditions, provide evidence-based treatments, and systematically monitor patients' progress toward treatment goals using a patient registry, adjusting care as needed.



Source: Meadows Mental Health Policy Institute. (2024). Collaborative Care Model Technical Assistance Tools. https://mmhpi.org/cocm/

History of CoCM Financing

2017 The Centers for Medicare & Medicaid Services (CMS) began reimbursing for CoCM and general behavioral health integration services using the Healthcare Common Procedure Coding System (HCPCS) codes G0502, G0503, and G0507.

2018 CMS replaces the HCPCS codes with the Current Procedural Terminology (CPT®) codes 99492, 99493, and 99494 for CoCM, and 99484 for general behavioral health integration.

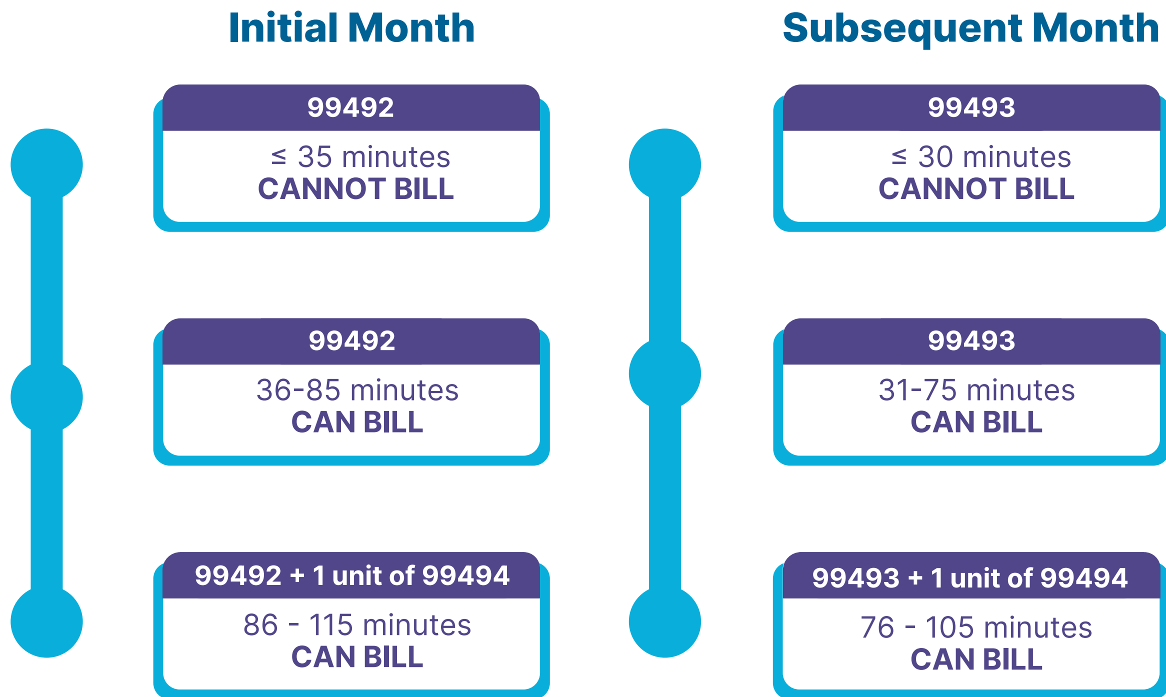
2021 CMS introduces the new CoCM HCPCS code G2214.

2026 CMS introduces new CoCM and general behavioral health integration add-on HCPCS codes G0568, G0569, and G0570 when billed in conjunction with an Advanced Primary Care Management (APCM) service. CMS unbundles G0512 for Federally Qualified Health Centers and Rural Health Clinics allowing the use of CPT® codes 99492, 99493, and 99494.

CoCM Billing Codes	
99492	Covers the first **70 minutes** of CoCM services provided during the **initial** calendar month.
99493	Covers the first **60 minutes** of CoCM services provided during any **subsequent** calendar month.
99494	An add-on code that works like prolonged services and covers each **additional 30 minutes** of CoCM services in **any** calendar month, once the time for the primary code has been met. As an add-on code, 99494 cannot be billed on its own and must be used with either 99492 or 99493. The maximum number of 99494 units allowed per month varies by payer.
G2214	Covers **30 minutes** of CoCM services provided in **any** calendar month. This is a standalone code and cannot be billed with 99492, 99493, or 99494.
G0568	**CoCM** provided in the **first** calendar month, **when billed with APCM code G0556, G0557, or G0558.** (Based on CPT® code 99492). This code is service-based rather than time-based, therefore tracking minutes is not required.
G0569	**CoCM** provided in a **subsequent** calendar month, **when billed with APCM code G0556, G0557, or G0558.** (Based on CPT® code 99493). This code is service-based rather than time-based, therefore tracking minutes is not required.

Billing and Time Tracking

The CPT® time rule, also known as the midpoint rule, allows time range CPT® codes to be billed once you reach at least 50% of the required time plus one additional minute. This means you don't have to meet the full time requirement, just cross the halfway point plus one minute. Always check with payors to see if they follow the CPT® defined time limits for billing.



Billable vs. Non-Billable Activities

CoCM billing codes 99492-99494 are time-based and reported as the total amount of time the BHCM spends engaging in clinical activities over the course of a calendar month. Services are billed monthly once the minimum time threshold has been met.

Billable	Non-Billable
Examples of clinical activities that count toward CoCM minutes include: • Preparing for and engaging in clinical work • Initial assessment and ongoing monthly symptom monitoring • Patient warm connection after consent is obtained by PCP • Outreach and communcation via electronic health record, phone calls, or secure text messaging • Care coordination with the CoCM team and other providers • Systematic case review meetings with the psychiatric consultant • Registry management and updates	Examples of non-clinical activities that do **not** count toward CoCM time include: • Scheduling appointments and appointment reminders • Staff trainings and meetings • Travel time

Five Steps to CoCM Billing Success

S

Set patient responsibility
Prior to CoCM services starting, the referring provider must obtain consent and inform the patient that cost-sharing may apply. CoCM billing codes are paid under the medical benefits and not the behavioral health carve-out.

T

Track time
CoCM billing codes are time-based and reported as the total amount of time the BHCM spends engaging in clinical activities over the course of a calendar month. Services are billed monthly once the minimum time threshold has been met.

E

Enter charges and submit claims
All services delivered by the BHCM working in collaboration with the psychiatric consultant are billed by the referring provider, who takes on the role of the billing and treating provider.

P

Post payments
After claims are submitted, payers will process whem according to the organization's contractual agreement. CoCM services are reimbursed by Medicare, most state Medicaid agencies, and major commerical payers. Other separate and distinct evaluation and management (E/M) and psychotherapy services will be paid in addition to CoCM.

S

Settle outstanding balances
CoCM claims may require troubleshooting due to denials or processing errors, including the code not being added to the fee schedule or the claim being incorrectly forwarded to the behavioral health carve-out.

Use this companion as a reference and return to the asynchronous online training modules for the complete course:

https://cocmtraining.westhealth.org/