OHCA Coverage Guideline

Medical Procedure Class:	**Psychiatric Collaborative Care and Behavioral Health Integration Services**
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* This document is not a contract, and these guidelines do not reflect or represent every conceived situation. Although all items contained in these guidelines may be met, this does not reflect, or imply any responsibility of this agency or department to change the plan provision to include the stated service as an eligible benefit.

☒ New Coverage ☐ Revision of Existing Coverage

Summary

Purpose:	To provide guidelines to assure medical necessity and consistency in the coverage of Psychiatric Collaborative Care and Behavioral Health Integration Services

Definitions

Collaborative care is a specific type of integrated care where medical providers and behavioral health providers work together to address behavioral health conditions, including mental health conditions and substance use disorders. When behavioral health problems are not effectively treated, this can impair self-care and adherence to treatments, and as a result are associated with poor health outcomes and increased mortality.

Episode of Care: An episode of care begins with the referral from the treating physician, physician assistant, or nurse practitioner to the behavioral health care manager in their practice and ends with the attainment of treatment goals, failure to attain treatment goals culminating in a referral to a psychiatric care provider, or a lack of continued engagement with no psychiatric collaborative care management services provided over six consecutive months. A new episode may begin after a break in episode of six or more consecutive months.

Health Care Professional: Refers to the treating physician, physician assistant, or nurse practitioner who manages the beneficiary's care and directs the behavioral health care manager.

Behavioral Health Care Manager: Masters or doctoral-level prepared clinical staff member, licensed staff member with behavioral health training (e.g., Licensed Clinical Mental Health Counselor/Professional Counselor, Licensed Marriage and Family Therapist, Licensed Social Worker, Registered Nurse, Nurse Practitioner, Licensed Psychologist, Masters-level licensure candidate/trainee (e.g., LCSW-A) or other designated and appropriately trained member of the care team who provides care management services and assessment of beneficiary needs. The Behavioral Health Care Manager consults with the psychiatric consultant and administers validated rating scales, develops care plans, provides brief interventions, collaborates with other members of the treatment team, and maintains a beneficiary registry. Services are provided face-to-face and non-face-to-face and psychiatric consultation is provided minimally on a regular and appropriate basis.

Psychiatric Consultant: Refers to the consulting physician or nurse practitioner who is trained in psychiatry or behavioral health with full prescribing authority. The consultant advises and makes recommendations and referrals as needed for psychiatric and medical care. These recommendations

and referrals are communicated to the treating provider through the behavioral health care manager. The psychiatric consultant typically does not see the beneficiary or prescribe medications.

Description

Psychiatric Collaborative Care Model (CoCM)

The Collaborative Care Model (CoCM) is a model of behavioral health integration that enhances "usual" primary care by adding two key services: care management support for clients receiving behavioral health treatment, and regular psychiatric consultation with the primary care team, particularly regarding clients whose conditions are not improving.

Collaborative care is provided monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals, culminating in referral to behavioral health specialty care, or there is a break in episode (no collaborative care services for six consecutive months).

Eligible behavioral health conditions include, but are not limited to, alcohol use disorder, anxiety, attention deficit hyperactivity disorder (ADHD), depression, and opioid use disorder that are being treated by the billing provider and, in the clinical judgment of the provider, warrant enrollment in CoCM services.

There are five core principles to CoCM developed in 2011 in consultation with a group of national experts in integrated behavioral health care with support from The John A. Hartford Foundation, The Robert Wood Johnson Foundation, the Agency for Healthcare Research and Quality, and the California HealthCare Foundation.

Core Principles

Patient-Centered Team Care Primary care and behavioral health providers collaborate with shared care plans that incorporate patient goals. The ability to get both physical and behavioral health care at a familiar location is comfortable to patients and reduces duplicate assessments. Increased patient engagement oftentimes results in a better health care experience and improved patient outcomes.

The treating medical provider leads the care. The treating medical provider prescribes all medications, including those recommended by the psychiatric consultant. The team structure in CoCM includes the following team members. These team members are required to be part of the care to be reimbursed for CoCM.

- **Treating (Billing) Medical Provider:** A physician and/or non-physician practitioner (MD, DO, ARNP, PA); typically, primary care, but may be of another specialty (e.g., cardiology, oncology). This provider leads the care and prescribes all medications, including those recommended by the psychiatric consultant.
- **Behavioral Health Care Manager:** A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the treating medical provider.
- **Psychiatric Consultant**: A medical professional trained in psychiatry and qualified to prescribe the full range of psychotropic medications.
- **Beneficiary:** The beneficiary is the patient who is a member of the care team.

Measurement-Based Treatment to Target A client's treatment plan must clearly articulate personal goals and target clinical outcomes that are routinely measured by using a validated clinical rating scale like the PHQ-9 depression scale. Treatment adjustments are made for clients not improving as

expected under their current treatment plan. Treatment adjustments are made until clients achieve treatment goals or care is discontinued due to referral or clients not participating.

Population-Based Care
The data-driven workflow to support CoCM requires the care team to use a registry to track clients on a CoCM caseload and monitor individual client's clinical outcomes over time.

Evidence-Based Treatment
Clients are offered evidence-based treatments to help meet treatment goals. These include medications and brief psychotherapy interventions such as behavioral activation, problem solving treatment, and motivational interviewing.

Accountable Care Providers are accountable for the treatment of all clients referred to the program, including quality of care and clinical outcomes for the clients managed under CoCM.

Behavioral Health Integration (BHI) Services

Used to bill monthly services delivered by using BHI models of care other than psychiatric collaborative care management (CoCM) that similarly include service elements such as systematic assessment and monitoring, care plan revision for patients whose condition is not improving adequately, and a continuous relationship with a designated care team member.

Also used to report models of care that do not involve a psychiatric consultant, or a designated behavioral health care manager, although these personnel may deliver general BHI services.

Care Team Members

- Treating (Billing) Practitioner – A physician and/or non-physician practitioner (PA or NP) typically primary care, but may be of another specialty (for example, cardiology, oncology, psychiatry).
- Beneficiary – The beneficiary is a member of the care team.
- Potential Clinical Staff – the billing practitioner delivers the service in full or uses qualified staff to deliver services using a team-based approach. Clinical staff includes contractors who meet the qualification for the CoCM behavioral health care manager or psychiatric consultant.

CPT and HCPCS Codes (see manual for code descriptions)

99484, 99492, 99493, 99494, G2214, G0512

General Considerations

Behavioral Health Integration (BHI) Services

99484

Care management services for behavioral health conditions, *20 minutes or more per calendar month* of clinical staff time directed by health care professional

With the following requirement elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scale(s)
- Systematic assessment and monitoring, using applicable validated rating scale(s)
- Behavioral health care planning by the primary care team jointly with the beneficiary, with care plan revision for patients whose condition is not improving
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, and/or psychiatric consultation
- Continuity of care with a designated member of the care team.

Documentation must include:

- A validated clinical rating scale
- Clients progress towards goals
- Include a plan of care
- Identify outcome goals of the treatments
- Time spent on reportable activities to meet time requirement

Billing:

- Only billed once per month when 20 minutes or more time spent for care management services for behavioral health conditions

Psychiatric Collaborative Care Management

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 client directed by the treating physician or other qualified health care professional (physician assistant or nurse practitioner)
- Initial assessment of the client, 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 client in a registry and tracking client follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies

Documentation must include:

- Use of validated clinical rating scale(s)
- Include a plan of care
- Identify outcome goals of the treatments
- Time spent on reportable activities to meet time requirement of code

Billing:

- 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 provider (physician assistant or nurse practitioner)
- Billable by the treating physician or other qualified health care provider who is leading the care
- Time used to meet requirements of the code should not include time or services used to meet criteria for a separately reported service
- 99492 is used only for the initial month of an episode of care.
- An episode of care starts the first calendar month of behavior health care manager activities
- A new episode of care must be initiated after 6 months lapse in services

99493

Subsequent psychiatric collaborative care management, *first 60 minutes in the 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 client 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 client outcomes using validated rating scales and relapse prevention planning with clients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
- Clients must have one face-to-face visit at least every three months.

Documentation must include:

- Clients progress towards goals
- Updated results of the validated clinical rating scales being utilized
- Modifications to treatment as appropriate
- Time spent on reportable activities to meet time requirement of code

Billing:

- First 60 minutes in the subsequent calendar months following the initial 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 (physician assistant or nurse practitioner)
- Billable by the treating physician or other qualified health care provider who is leading the care
- Time used to meet requirements of the code should not include time or services used to meet criteria for a separately reported service
- Bill only once per month
- Billed for subsequent calendar months following the initiation of an episode of CoCM services
- Clients must have a minimum of one face-to-face visit every three months with the directing treating physician or other qualified health care professional
- Prior authorization is required after 12 months following initiation of episode
- A new episode of care must be initiated after six-month lapse in services and include an initial assessment and a treatment plan.

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.

Documentation must include:

- Clients progress towards goals
- Updated results of the validated clinical rating scales being utilized
- Modifications to treatment as appropriate
- Time spent on reportable activities to meet time requirement of code

Billing:

- Additional 30 minutes of behavioral health care manager activities in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional (physician assistant or nurse practitioner)

- Use for additional 30 minutes of behavioral health care manager activities
- Time used to meet requirements of the code should not include time or services used to meet criteria for a separately reported service
- 99494 to be used with 99492 or 99493
- Limit of two units per month

G2214

Initial or subsequent psychiatric collaborative care management, *first 30 minutes in a 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 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 supplied 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
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment)

Documentation must include:

- A validated clinical rating scale
- Clients progress towards goals
- Include a plan of care
- Identify outcome goals of the treatments
- Time spent on reportable activities to meet time requirement

Billing:

- Code is allowed when CoCM services are provided but do not meet the qualifying times for 99492 or 99493 in a month
- May be billed in the initial month or subsequent months
- Code cannot be billed with other collaborative care codes
- At least 16 minutes must be provided to use this code

FQHC and RHC

G0512

Psychiatric collaborative care model services: *minimum of 60 minutes per 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 provided in an RHC or FQHC setting

With the following requirement elements:

- Outreach and engagement of clients
- Initial assessment, including administration of validated scales and resulting in a treatment plan
- A minimum of one face-to-face visit every three months with the directing treating physician or other qualified health care professional

- Entering clients into a registry for tracking client 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 client follow-up and progress using validated rating scales
- Ongoing collaboration and coordination with treating FQHC and RHC providers
- Relapse prevention planning and preparation for discharge from active treatment

Documentation must include:

- A validated clinical rating scale
- Clients progress towards goals
- Include a plan of care
- Identify outcome goals of the treatments
- Time spent on reportable activities to meet time requirement

Billing:

- A minimum of 60 minutes in any month of behavioral health care management activities in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional.
- FQHC or RHC only
- Code does not qualify for an encounter
- Only billed once per month
- PA is required after 12 months following initiation of episode
- A new episode of care must be initiated after six-month lapse in services and include an initial assessment and development of a treatment plan.

NOTE: A psychiatric consultant working in the CoCM model may also provide traditional services directly to the client in the same month but may not bill for the same time using multiple codes. The time spent on these activities for services reported separately may not be included in the services reported using time applied to 99492, 99493, 99494, G2214, or G0512.