1

2

Disclosure

- Royalties: American Psychiatric Publishing for Integrated Care: Working at the Interface of Primary Care and Behavioral Health
- Integrated Care: A Guide for Effective Implementation

- No pharmaceutical or device manufacturing funding
- No off-label discussion of pharmaceuticals

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Learning Objectives

By the end of this training, learner will be able to:

1. **Successfully** bill the CoCM codes by examination of the CPT coding process
2. **Examine** at least one outcome and one process measure for your current state of implementation of COCM to determine efficacy of the program

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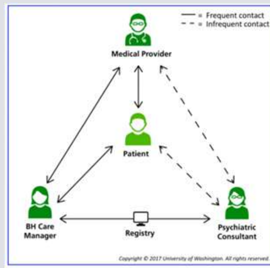
Collaborative Care Model Refresher



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CPT CODES FOR "PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT" (COCM)

- 99492 (Initial month, CoCM)
- 99493 (Subsequent month, CoCM)
- 99494 (Add'l 30 mins, CoCM)
- G2214 – 30 minutes CoCM billed separately from above codes
- ~~G0512 – 60 minutes, FQHC/RHC~~

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Who are the codes for?

- **Only** the work of the Behavioral Care Manager
  - Not the PCP
  - Not the psychiatric consultant
  - Could be shared care manager time if on the team
- Billed once a month **by the PCP** under their NPI number
- Financing is out of the “medical” bucket – Not behavioral health
- Part of the PCPs paneling/credentialling with the payers – not the BCM
- Patient needs to consent to treatment like any other medical procedure
- TIME BASED CODES
- TASK BASED CODES

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BILLING CODES FOR CoCM – 1st MONTH TASKS

HCPCS Code	Long Descriptor
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 · provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

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BILLING CODES FOR CoCM: SUBSEQUENT MONTHS TASKS

HCPCS Code	Long Descriptor
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.

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BILLING CODES FOR CoCM – 30 minutes of EXTRA TIME
Can bill 4/month but make sure you are doing COCM!

HCPCS Code	Long Descriptor
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).

Good for Crisis too

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Code G2214

Use when limited time to bill in a month such as admitted close to end of the month or getting better and not much to do THAT MONTH

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

Cannot bill with other COCM codes

At least 16 minutes

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G0512

FQHC/RHC

Rural health clinic or federally qualified health center (RHC or FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month

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"MAJORITY RULE" MEDICARE

MAJORITY = half the time + 1 minute

- 99492 - 70 minutes = 36
- 99493 - 60 minutes = 31
- 99494 - Add on = 16 minute minimum
- G2214 - 16 minute minimum

Add on code 99494 – up to 4

- Initial month 99492
  - 1st add on 99494 = 70 + 16 = **86**
  - 2nd add on 99494 = 70 + 30 + 16 = **116** And so on
- Subsequent month 99493
  - 1st add on 99494 = 60+16 = 76
  - additional 99494 = 60+30+16 = 96, and so on

Example:

- Alice is admitted to COCM and a total of 153 minutes spent that calendar month
- What CPT codes can you bill?

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Answer: 153 minutes first month COCM

- 99492 – first month 70 minutes
- Plus 99494 – 1st one 70 + 30 = 100 minutes
- Plus 99494 – 2nd one 70 + 30 + 30 = 130 minutes
- Plus 99494 – 3rd one 70 + 30 + 30 + 23 (at least 16) = 153 minutes
- Bill 99492 and 3 add on 99494s

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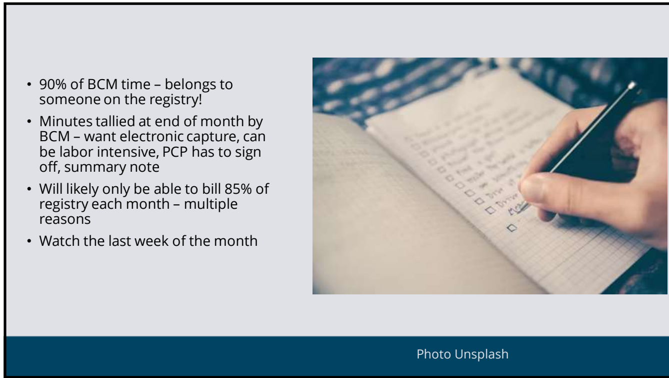

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"Broad" CONSENT

- Preferably by the PCP in the chart note from that day's visit
- However is considered "incident to" billing so could be clarified by BCM
- Does not have to be on paper/signed – just noted
- Includes 1) agrees to CoCM and 2) know there is cost sharing (just like any other mental health or physical heath care)
- PCPs sometimes resistant about discussing money ("call your insurance company if you want to know what your copay is")
- Develop "smart phrase" in your EMR for both consent and cost share for ease with PCPs

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Key take-aways

- Capturing minutes will get easier over time!
- Watch the end of the month
- Meet regularly with your revenue cycle team – understand reasons for "back-end denials"
- Bill according to location (FQHC or not?) and payer (MCD, MCR, Commercial, self?)
- Do the math: staff salary and overhead and reimbursement = registry size to be in the black

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Quality and Metrics for COCM

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Why are metrics important?

- Patient level – get better and reduce suffering
- Population "reach" – more people in need get effective care
- Reduced wait for psychiatry, PCPs get help and learning
- Value based payment (VBP)/performance bonuses
  - BCBS example – readmissions, PHQ
- When BH gets better, physical health gets better – less suffering and overall healthcare costs decrease
  - Diabetes and depression
  - Substance use and anxiety

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NC BCBS Medicaid Quality Measures

Healthy Blue Quality Measures Desktop Reference for Medicaid Providers 2022

Effectiveness of care	Measure	Source	Inclusion criteria	Occurrence	Description of measurement, screening, test, or treatment needed
Behavioral health	Screening for Depression and Follow-Up Plan	CMS	Ages 12 years and older	Per episode	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool and if positive, a follow up plan is documented on the date of the positive screen
Behavioral health	Antidepressant Medication Management **(AMM)***	HEDIS	Ages 18 and older	Per episode	The percentage of members who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported: • Effective acute phase treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). • Effective continuation phase treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

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Healthy Blue
Quality Measures Desktop Reference for Medicaid Providers

Effectiveness of care	Measure	Source	Inclusion criteria	Occurrence	Description of measurement, screening, test, or treatment needed
Behavioral health	Follow-Up Care for Children Prescribed ADHD Medication **(ADD)***	HEDIS	Ages 6 to 12	Varies by phase	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed — Two rates are reported: • **Initiation** Phase. The percentage of members six to 12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. • **Continuation and maintenance** (C&M) Phase. The percentage of members six to 12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.

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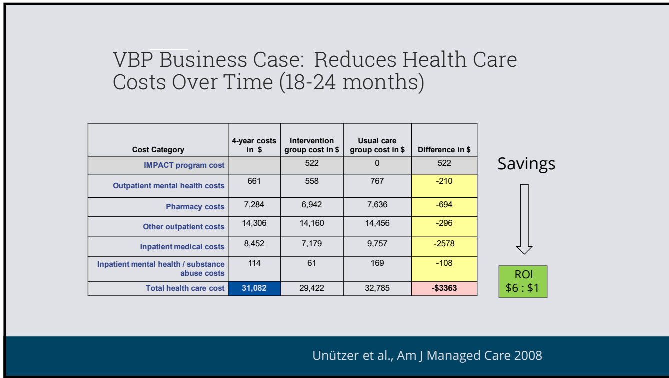

VBP Business Case: Reduces Health Care Costs Over Time (18-24 months)

Cost Category	4-year costs in $	Intervention group cost in $	Usual care group cost in $	Difference in $
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost	31,082	29,422	32,785	-$3363

Unützer et al., Am J Managed Care 2008

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USE VALIDATED TOOLS SCREENING & MEASUREMENT

Mood Disorders
- PHQ-9 Depression
- Altman Mania Scale
- CIDI: Bipolar Disorder
- EPDS: Postnatal Depression

Anxiety Disorders
- GAD-7: Anxiety
- PCL-5: PTSD
- SCARED
- Mini Social Phobia: Social Phobia

Substance Use Disorders
- CAGE-AID
- AUDIT-C
- Brief Addiction Monitor (BAM)
- CRAFFT
- Alcohol Screening and BI for Youth

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EFFECTIVE MEASUREMENT FOR METRICS GATHERING

- Systematic (define timing) administration of tools
- Frequently enough to capture timing of change
- Timely so can be used to adjust care

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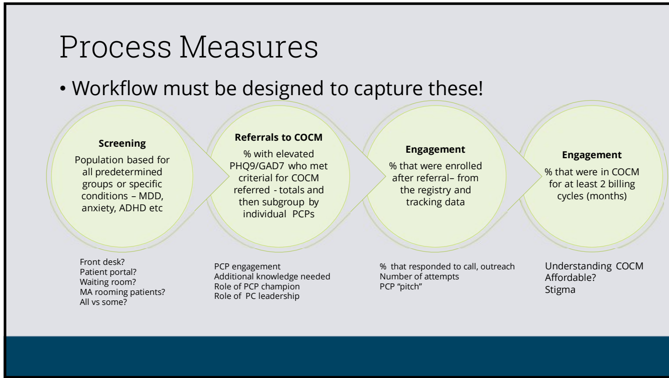

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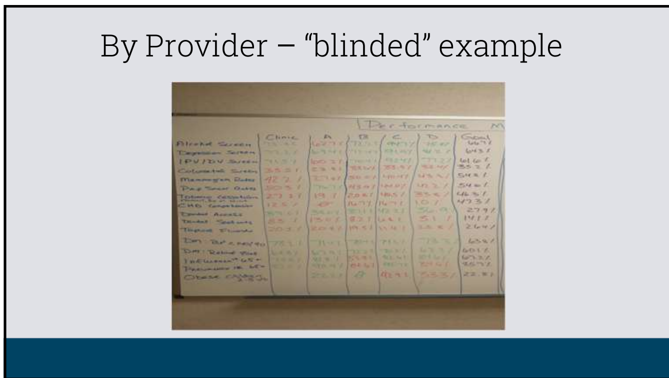

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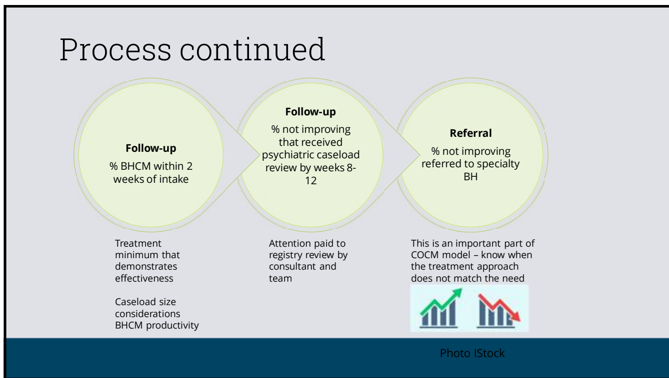

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PROCESS AND OUTCOME

			Behavioral Heatlh													
			Treatment Status					PHQ-9				GAD-7				
MRN	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Average # Contacts per month	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7
1234501	Active	Bryson Clay	2/28/2018	10/1/2018	9	30	1.20	21	9	-57.1%	10/1/2018	10	4	-60.0%	10/1/2018
1234502	Active	Kayla Ho	3/15/2018	9/30/2018	8	28	1.14	13	17	30.8%	9/30/2018	5	5	0.0%	9/30/2018
1234503	Active	Reed Snow	2/7/2018	9/3/2018	9	29	1.24	10	4	-60.0%	9/3/2018	18	14	-22.2%	9/3/2018
1234504	Active	Princess Hull	4/22/2018	9/17/2018	9	21	1.71	18	18	[illegible]	9/17/2018	19	18	-5.3%	9/17/2018
1234505	Active	Ignacio Tanner	4/17/2018	10/1/2018	9	23	1.57	14	[illegible]	-42.9%	10/1/2018	16	14	-12.5%	10/1/2018
1234506	Active	Jan Jacobson	2/20/2018	10/2/2018	8	32	1.00	11	4	-63.6%	10/2/2018	19	18	-5.3%	10/2/2018
1234507	Active	Eddie Wu	2/19/2018	9/17/2018	8	30	1.07	16	8	-50.0%	9/17/2018	10	18	80.0%	9/17/2018
1234508	Active	Ulises Rosales	7/30/2018	9/15/2018	4	6	2.67	17	16	-5.9%	9/15/2018	4	3	-25.0%	9/15/2018
1234509	Active	Freddy Keith	7/21/2018	10/15/2018	13	12	4.33	22	18	-18.2%	10/15/2018	5	3	-40.0%	10/15/2018
1234510	Active	Grayson Mcgee	12/19/2017	10/15/2018	7	42	0.67	14	4	-71.4%	10/15/2018	7	17	142.9%	10/15/2018

Minutes this month	Last Psych
42	9/1/2018
15	5/22/2018
69	6/18/2018
112	3/30/2018
0	8/2/2018

Two crucial data points:
50% reduction PHQ-9
Remission (PHQ 9 < 5)

Registry – Lori Raney

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Outcome Measures

- Percent with 5 point drop in PHQ9 or GAD7 – **Minimal** response
- Percent with 50% reduction PHQ-9/GAD-7 – **Clinically significan**t Response
  - NQF 1884 and 1885
- Percent reaching **remission** (PHQ-9/GAD-7 < 5)
  - NQF 710 and 711

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MEASURING CHANGE

			Behavioral Heatlh													
			Treatment Status					PHQ-9				GAD-7				
MRN	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Average # Contacts per month	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7
1234501	Active	Bryson Clay	2/28/2018	10/1/2018	9	30	1.20	21	9	-57.1%	10/1/2018	10	4	-60.0%	10/1/2018
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1234507	Active	Eddie Wu	2/19/2018	9/17/2018	8	30	1.07	16	8	-50.0%	9/17/2018	10	18	80.0%	9/17/2018
1234508	Active	Ulises Rosales	7/30/2018	9/15/2018	4	6	2.67	17	16	-5.9%	9/15/2018	4	3	-25.0%	9/15/2018
1234509	Active	Freddy Keith	7/21/2018	10/15/2018	13	12	4.33	22	18	-18.2%	10/15/2018	5	3	-40.0%	10/15/2018
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Two crucial data points:
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Remission (PHQ 9 < 5)

Registry – Lori Raney

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Measures for SUD

Retention: The fundamental measure for treating Substance Use Disorders

- Individual Goal
- Population Goal

Other Useful Metrics

- Illicit Substance Use
  - Urine, saliva drug and alcohol screens
- Dose of Buprenorphine (as indicated)
  - On average, individual and population dose should be ≥ 8mg of Buprenorphine daily (typical dose is 12-16mg a day)

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Performance metrics for Perinatal COCM

- Depression/Anxiety Response and Remission
- Preterm delivery
- Connection to care post delivery
- Low birth weight infants

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Financial measures

- Financial considerations too
  - % Back end denials by payer- and those resolved
    - Contract negotiations?
    - Billing staff understand the codes?
  - % of registry billed each month (85% national average)
  - Meeting monthly minutes goals?
  - Revenue compared to expenses
  - pro forma goals being met?
  - BHCM correct coding?
  - PCP sign off?

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Prepare for Billing

			Behavioral Heatlh												
			Treatment Status					PHQ-9				GAD-7			
MRN	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Average # Contacts per month	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7
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1234508	Active	Ulises Rosales	7/30/2018	9/15/2018	4	6	2.67	17	16	-5.9%	9/15/2018	4	3	-25.0%	9/15/2018
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Minutes this month	Last Psych Review
42	9/1/2018
15	5/22/2018
69	6/18/2018
112	3/30/2018
0	8/2/2018

Registry – Lori Raney

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Other measures

- Patient satisfaction with COCM
- PCP satisfaction with COCM
- BHCM satisfaction with COCM

- Functional – return to school/work, housed

- Cost – ED visit reduction, overall cost, reduced 30 day readmits
  - Longer term for outcomes – year or more!

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RESPONDING TO FINDINGS

- Improvement cycle
  - Ex: PDSA – Plan Do Study Act
  - Adjust workflow, message, provide supports, education

Plan
Do
Study
Act
Do it again

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Outcomes Need to be Shared

- Celebrate successes!!
- Share data with the teams!

Photo Istock

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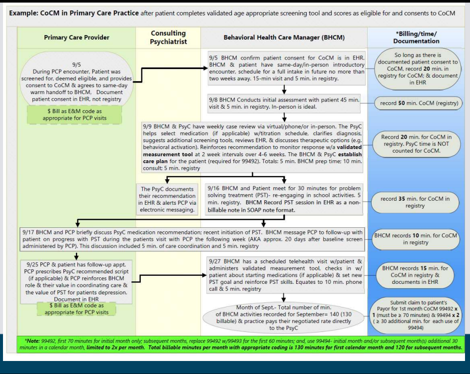
Workflow



AHEC Playbook

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MAHEC OUTCOMES 2023

METRIC	DEPRESSION OUTCOMES	ANXIETY OUTCOMES
50% Reduction PHQ9	47%	48%
Remission PHQ 9 < 5	30%	26%

Source: Lori Raney

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Conclusion

- Design a quality improvement plan to capture both process and outcome measures – SET GOALS BEFORE YOU BEGIN – THIS IS WHY YOU ARE DOING COCM IN THE FIRST PLACE!!
- Goals will be reached at different stages in your implementation and should be adjusted based on findings
- Make changes and measure again, set new goals
- Share share share the results!

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Time for Discussion

Name one process measure you have implemented and share your experience with us

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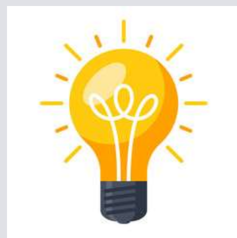
Time for Your Participation!

Name one clinical outcome measure you are working on or have achieved



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References

- Integrated Care: A Guide to Successful Implementation, L Raney, 2017. APA press
- Kinnan, Emerson et al. Waitlist Reduction Psychiatric Services in Advance 2019 (doi: 10.1176/appi.ps.201900222)
- Unutzer et al: The Business Case for COCM: Am J Managed Care 2009
- Katz et al: Time to remission COCM vs usual care: ABFM, 2016

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