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CHCF Fact Sheet

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Psychiatric Collaborative Care Management Benefit in Medi-Cal

In January 2021, Medi-Cal approved psychiatric Collaborative Care Management — or CoCM — as a new benefit for its enrollees. CoCM is an evidence-based model for integrating physical and behavioral health services in a primary care setting, while maximizing the impact of a limited behavioral health workforce. This fact sheet summarizes the benefit, outlines the new billing codes, and provides an overview of how providers working in different settings can be reimbursed.

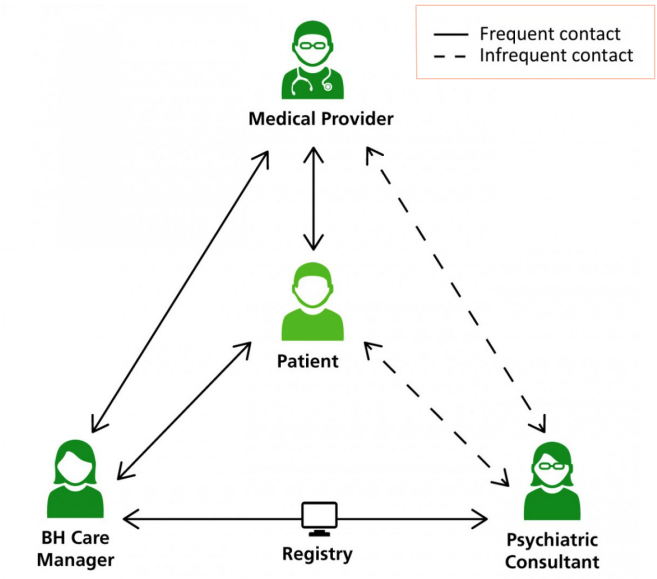
Collaborative care integrates two key team members into the primary care team: a behavioral health (BH) care manager and a psychiatric/addiction medicine consultant. These members expand the team's capability to identify and treat people with mental health and/or substance use disorders using a specific model of care, as illustrated in the diagram from the University of Washington's AIMS Center. The model includes the following components:

- Care management and evidence-based treatments, including psychotherapy and medications
- Regular/proactive monitoring and treatment to a targeted outcome using validated clinical rating scales
- Regular, systematic psychiatric caseload reviews

Dozens of randomized controlled trials have shown CoCM to be more effective and cost-effective than usual care for common behavioral health conditions like depression and substance use disorder, across diverse practice settings and patient populations.

Who benefits? Patients with behavioral health needs identified in primary care benefit from these services. People enrolled in either Medi-Cal managed care plans (MCPs) or Medi-Cal fee-for-service (FFS) are eligible for CoCM.

CoCM Team Structure



Source: University of Washington Advancing Integrated Mental Health Solutions Center, "Collaborative Care: Team Structure."

Who can be reimbursed for these services? Physicians and other qualified health professionals working in an outpatient setting, including but not limited to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Indian Health Service Memorandum of Agreement (IHS-MOA) clinics, can be reimbursed.

How does reimbursement work? There are three new Current Procedural Terminology (CPT) codes that treating physicians and other qualified health professionals must use to bill these services:

- 99492: First month of CoCM, first 70 minutes
- 99493: Subsequent month of CoCM, first 60 minutes

- 99494: Each additional 30 minutes, first or subsequent month of CoCM

In addition, DHCS has imposed the following frequency limits:

- One per calendar month: 99492 or 99493
- Two per calendar month: 99494

These CoCM CPT codes involve tracking the time of the team as well as delivering specific elements of the model. Here are the required activities needed to bill for 99492 (First month of CoCM):

- 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
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies

Further details on the definitions for episode of care, treating (billing) health care professional, behavioral health care manager, and psychiatric consultant can be found in the American Medical Association's CPT code books and in the Medi-Cal provider manual. Medi-Cal considers "psychiatric consultant" interchangeable with "addiction medicine consultant."

What is the CoCM reimbursement schedule in FFS Medi-Cal? FFS rates for these services as of May 2021 are as follows:

- 99492: First month of CoCM, first 70 minutes = $141.26
- 99493: Subsequent month of CoCM, first 60 minutes = $112.14
- 99494: First or subsequent month of CoCM, each additional 30 minutes = $57.88

How does CoCM reimbursement differ in an FQHC, RHC, or IHS-MOA clinic? Clinics may bill for CoCM services and receive their bundled rate when these services are delivered as a face-to-face encounter[1] by a billable provider. Providers do not need to count minutes. If the patient is not present, interactions between the team of practitioners are not separately billable. There are no limitations on monthly medically necessary CoCM services when appropriate billing code sets are used, but only one bundled rate payment will be provided per day.[2]

How does CoCM work in Medi-Cal managed care? All MCPs are required to cover medically necessary care. If medically necessary, CoCM may be approved by the MCP as part of the mild-to-moderate (or non-specialty) mental health benefit in accordance with its contractual agreements with its in-network providers. As a result, if capitated or delegated contracts do not include mild-to-moderate mental health services, arrangements will need to be adjusted to include this expanded scope of services.

Is CoCM reimbursed by other payers, such as Medicare? CoCM is covered by Medicare, and most commercial payers have followed suit. The American Psychiatric Association maintains a list of payers that include CoCM as a benefit.

Endnotes

1. Or equivalent under prevailing telehealth policy.
2. For specifics about bundled rates, billable providers, and billing code sets, please see the Medi-Cal provider manual Part 2 - Clinics and Hospitals (CAH).