Review of the Billing Codes and Quantity Metrics

Billing Basics

- Billed per member per calendar month
- Only count BHCM time delivering CoCM services; payment accounts for time spent by all clinical team members but can't duplicate shared time
- Separate Initiating Billable Visit
  - Visit will include the treating provider establishing a relationship with the patient, assessing the patient prior to referral, and obtaining patient consent to consult with specialists
  - Required for patients not seen within one year

- Billed alone or with a claim for another billable visit
- Can bill CoCM services with PDCM claims
- Can't bill CoCM (99492, 99493, 99493, G0512) services in the same calendar month as chronic care management/general behavioral health integration (99484, G0511)

Additional Requirements

- Advance Consent
  - Verbal or written, must be documented in the EHR
  - Permission to consult with relevant specialists (i.e., psychiatric consultant)
  - Inform the patient of cost sharing

- **BCBSM has waived cost sharing (deductible, coinsurance and copayments) beginning July 1st**

"I have discussed [practice's] collaborative care program with the patient, including the roles of the behavioral health care manager and psychiatric consultant. I have informed the patient that they will be responsible for potential cost sharing expenses for both in-person and non-face-to-face services. The patient has agreed to participate in the collaborative care program and for consultations to be conducted with relevant specialists.

Face-to-face or telehealth visits with a behavioral health specialist are not associated with this model, even though they may be part of the patient's overall treatment plan. Services that are not a part of collaborative care can be provided and will be billed according to the patient's benefit package. These services would also be subject to the cost sharing expenses defined by that benefit plan."

Billing Codes: Commercial

Provider Location	Service	Code	Month	Time Threshold
Any Location	Chronic Care Management/ General Behavioral Health Integration	99484	Any month	11-20 minutes
	CoCM	99492	Initial month	36-70 minutes
		99493	Subsequent month(s)	31-60 minutes
		99494	Add-on code	16-30 minutes

Billing Codes: Medicare, MA, Medicaid

Provider Location	Service	Code	Month	Time Threshold
Non-FQHC/RHC	Chronic Care Management/ General Behavioral Health Integration	99484	Any month	11-20 minutes
	CoCM	99492	Initial month	36-70 minutes
		99493	Subsequent month(s)	31-60 minutes
		99494	Add-on code	16-30 minutes
FQHC/RHC	Chronic Care Management/General Behavioral Health Integration	G0511	Any month	20 minutes
	CoCM	G0512	Initial month	70 minutes
			Subsequent month	60 minutes

Medical Learning Network CMS

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

99493 Subsequent Psychiatric Collaborative CM

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

G2214 – New CoCM Code Federal Registry 2020-2021

- To accurately account for these resources costs, we are proposing to establish a G-code to describe 30 minutes of behavioral health care manager time. Since this code would describe one half of the time described by the existing code that describes subsequent months of CoCM services, we are proposing to price this code based on one half the work and direct PE inputs for CPT code 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 practitioners;
- 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……..

PCP VBR for PCPs: VBR Criteria - Continued

(revisions in red)

Cohort	VBR Effective Date	REVISED Criteria	Comments/Notes
Cohort 1	9/1/21-8/31/22	For practices with 1 PCP, between 10/15/20 and 3/31/21: * Must bill 99492 for ≥ 4 unique patients and * ≥ 2 codes 99493 or G2214 for these patients	Includes Blue Cross Commercial PPO and MAPPO patients (except for FQHCs and RHCs, which will be evaluated on Commercial PPO patients only)
		For practices with 2 PCPs, between 10/15/20 and 3/31/21: * Must bill 99492 for ≥8 unique patients and * Must bill codes 99493 or G2214 code for ≥4 of these patients	
		For practices with more than 3 PCPs, between 10/15/20 and 3/31/21: * Must bill 99492 code for ≥12 unique patients and * Must bill 99493 or G2214 code for ≥6 of these patients	

Note that there is a new CoCM code – G2214 – that is applicable to CoCM services provided for ≤30 minutes; additional information to follow

99494 Initial or Subsequent Psychiatric Collaborative CM

- 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)

99484 Care Management Services for Behavioral Health

Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales

- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes

- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation

- Continuity of care with a designated member of the care team

Billing by Time Threshold: CPT Codes*

Month	Time Spent	CPT Codes
Initial Month	≤10 minutes	Not billable
	11-35	99484 – Gen BHI
	36-85 minutes	99492
	86-115 minutes	99492 + 99494
	116-130 minutes	99492 + 99494, quantity 2 units
Subsequent Month(s)	≤10 minutes	Not billable
	11-30	99484
	31-75 minutes	99493
	76-105 minutes	99493 + 99494
	106-135 minutes	99493 + 99494, quantity 2 units

*https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Billing by Time Threshold: G Codes

Month	Time Spent	G Codes
Initial Month	<20 minutes	Not billable
	20-69 minutes	G0511
	≥70 minutes	G0512
Subsequent Month(s)	<20 minutes	Not billable
	20-59 minutes	G0511
	≥60 minutes	G0512

What Activities Can I Include?

- Providing assessment and care management services
  - Any form of patient contact
  - Structured behavioral health assessment
  - Self-management planning; relapse prevention planning
  - 99492 requires an initial assessment of the patient and development of individualized treatment plan
- Administering validated outcome measures (e.g., PHQ-9, GAD-7)
- Using brief therapeutic interventions (e.g., Motivational Interviewing, behavioral activation, problem solving therapy)
- Conducting systematic case review with the psychiatric consultant
- Maintaining systematic case review tool, disease registry, and/or EHR for patient tracking and follow-up
  - Does not include strictly administrative or clerical duties
- Collaboration and coordination with PCP or other qualified health care professionals
- “Running” the caseload with the psychiatric consultant (i.e., conducting a systematic review of caseload without specifically discussing the patient)
  - Approximately 5 billable minutes per calendar month
  - “the patient has been included in the caseload review activities and consulted on as needed”

Medicaid Guidelines

- Effective August 1, 2020

- Psychiatric consultant must have MD or DO licensure
- Initial visit must be face-to-face
- Monthly administration of outcome measures (e.g., PHQ-9, GAD-7)
- After the initial 6 months of treatment, prior authorization is required for an additional 6 months of treatment
- Can’t bill G0511
- Can’t bill CoCM patients receiving MI Care Team, Behavioral Health Home, or Opioid Health Home benefits

Best Practices

- Have you documented all billable time?
  - Create a smartphrase to prompt BHCMs to document billable time
  - Create a documentation checklist to ensure all BHCM clinical time is calculated
  - Add an EHR form to calculate billable time per calendar month
- Review a report of documented billable minutes per patient per calendar month
  - Review this report half-way through each month to determine which patients would need additional time to reach the next billing threshold
  - Assess distribution of time across the entire caseload
- Is your clinical time being optimized for your caseload size?
  - Conduct a clinical caseload supervision
  - Assess opportunities to keep the caseload “fluid” (i.e., who could benefit from a different level of care?)

Target Review

- Cohort 1 – First Measurement

Cohort 1 - Criteria for Continuing to Receive VBR

Date Span/ Measurement Period	10/15/2020 - 3/31/2021	
Period of VBR Award	9/1/2021 - 8/31/2022	
# of CoCM VBR Physicians in Practice	Code	Productivity
1 PCP	99492	4*
	99493 or G2214	2
2 PCP's	99492	8*
	99493 or G2214	4
3 or more PCP's	99492	12*
	99493 or G2214	6

Patient counts for the 99492 are based on commercial PPO and MAPPO members. –

* Based on a count of unique members

Note: Code 99493 is billed only for the members with a previously submitted 99492 code.

Date Span/ Measurement Period	1/1/21 - 2/28/22	
Period of VBR Award	9/1/2022 - 8/31/2023	
# of CoCM VBR Physicians in Practice	Code	Productivity
1 PCP	99492	28*
	99493 or G2214	21
2 PCP's	99492	56*
	99493 or G2214	42
3 or more PCP's	99492	74*
	99493 or G2214	56

* Unique Patients

As an alternative to the number of codes listed above, the practice can meet the VBR criteria by billing the 99494 code for 1% of their attributed commercial PPO and MAPPO members and the 99493 code for 0.5% of their attributed commercial PPO and MAPPO members.

<u>In addition to the productivity counts</u>, practices are also accountable for qualtiy metrics. They are as described:

50% of patients who have a baseline score greater than or equal to 10 and that have had CoCM codes billed on their behalf for 4-12 months, have improvement with one of the following:

- 5-point decline in their PHQ9 scores (and optional GAD7), OR
- 50% reduction in their PQH9 scores (and optional GAD7), OR
- Obtaining remission, meaning PHQ9 scores below 5 (and optional GAD7)

**–The GAD7 cannot be used without the PHQ9 score to count for the VBR criteria.

Status with Meeting Quantity Metrics

INPUT

CHALLENGES

Next Steps

- Brainstorming Ideas to meet expected metrics

Thank you

- Next clinical focus webinar topic
  - Pharmacology
  - Date to be determined – keep an eye out for an update