Mi-CCSI
Center for Clinical
Systems Improvement

Mi-CCSI

CoCM Training

Day One

Handouts

1. Why Practice Collaborative Care

Why Practice Collaborative Care?

Collaborative care (CoCM) is beneficial to primary care providers (PCPs) and their patients because it offers better medical care, access to psychiatry experts, helps with challenging patient cases, and team collaboration.

1. **Established Evidence Base**
CoCM has a robust evidence base of over 80 randomized controlled trials and has been shown to be the best approach to treating depression in many populations and settings.

CoCM has a strong and expanding evidence base for its use with diverse behavioral health diagnoses such as anxiety, posttraumatic stress disorder, chronic pain, and dementia.

2. **Better Medical Outcomes**
CoCM is linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis.

CoCM is recommended as a primary prevention strategy for cardiovascular events in patients without preexisting heart disease (*Psychosomatic Medicine*, 2014).

3. **Help with Challenging Patient Cases**
Many challenging cases likely have patients with untreated or undertreated behavioral health conditions. Behavioral health providers do the follow-up and intervention tasks that a busy PCP doesn't have time to do, but make a big difference for patients.

PCPs are generally more satisfied working within an integrated behavioral health care program than within usual care (*Family Community Health*, 2015).

4. **Faster Improvement**
A 2016 retrospective study at Mayo Clinic found that the time to depression remission was 86 days in a CoCM program while in usual care it was 614 days.

Analysis of a large CoCM implementation found that early, intense intervention by the behavioral health provider was key to early improvement in patients with depression symptoms (*Psychiatric Services*, 2015).

5. **It Takes a Team**
CoCM uses an enhanced care team to provide a population based, treat-to-target approach to care. Through shared care planning, the team makes proactive changes in treatment to make sure that no patients fall through the cracks.

Only 30-50% of patients have a full response to the first treatment. That means 50-70% of patients need at least one treatment adjustment. Additional experts can help.

2. CoCM Team Member Self-Assessment

Step 1: Team Member Self-Assessment

Conditions for which you plan to provide clinical care (select all that apply)
☐ Depression ☐ Substance Abuse
☐ Anxiety (e.g., PTSD) ☐ Other Mental Disorders

Name and role in the clinic? _____

Collaborative Care Tasks	Is This Your Role Now?		If Not, Whose Role?	Your Organization's Capacity with This Task?		Your Level of Comfort with This Task		Would You Like Training to Perform This Task?	
Identify and Engage Patients	Yes	No	Position title	High	Med/Low	High	Med/Low	Yes	No
Identify People Who May Need Help	☐	☐		☐	☐	☐	☐	☐	☐
Screen for Behavioral Health Problems Using Valid Measures	☐	☐		☐	☐	☐	☐	☐	☐
Diagnose Behavioral Health Disorders	☐	☐		☐	☐	☐	☐	☐	☐
Engage Patient in Collaborative Care Program and Introduce Care Team	☐	☐		☐	☐	☐	☐	☐	☐
Initiate and Provide Treatment	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Perform Behavioral Health Assessment	☐	☐		☐	☐	☐	☐	☐	☐
Develop & Update Behavioral Health Treatment Plan	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Symptoms & Treatment Options	☐	☐		☐	☐	☐	☐	☐	☐
Prescribe Psychotropic Medications	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Medications & Side Effects	☐	☐		☐	☐	☐	☐	☐	☐
Brief Counseling, Activity Scheduling, Behavioral Activation	☐	☐		☐	☐	☐	☐	☐	☐
Evidence-based Psychotherapy (e.g., PST, CBT, IPT)	☐	☐		☐	☐	☐	☐	☐	☐
Identify & Treat Coexisting Medical Conditions	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Referral to Specialty Care or Social Services	☐	☐		☐	☐	☐	☐	☐	☐
Create & Support Relapse Prevention Plan	☐	☐		☐	☐	☐	☐	☐	☐
Track Treatment Outcomes	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Track Treatment Engagement & Adherence using Registry	☐	☐		☐	☐	☐	☐	☐	☐
Reach out to Patients who are Non-adherent or Disengaged	☐	☐		☐	☐	☐	☐	☐	☐
Track Patients' Symptoms with Measurement Tool (e.g., PHQ-9)	☐	☐		☐	☐	☐	☐	☐	☐
Track Medication Side Effects & Concerns	☐	☐		☐	☐	☐	☐	☐	☐
Track Outcome of Referrals & Other Treatments	☐	☐		☐	☐	☐	☐	☐	☐
Proactively Adjust Treatment if Patients are Not Responding	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Assess Need for Changes in Treatment	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Changes in Treatment / Treatment Plan	☐	☐		☐	☐	☐	☐	☐	☐
Provide Caseload-Focused Psychiatric Consultation	☐	☐		☐	☐	☐	☐	☐	☐
Provide In-Person Psychiatric Assessment when Needed	☐	☐		☐	☐	☐	☐	☐	☐
Other Tasks Important for Our Program (add tasks as needed)	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Coordinate Communication Among Team Members / Providers	☐	☐		☐	☐	☐	☐	☐	☐
Administrative Support for Program (e.g., Scheduling, Resources)	☐	☐		☐	☐	☐	☐	☐	☐
Clinical Supervision for Program	☐	☐		☐	☐	☐	☐	☐	☐
Training of Team Members in Behavioral Health	☐	☐		☐	☐	☐	☐	☐	☐

3. PHQ-9

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

4. GAD-7

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

5. Introduction of CoCare to Patient Scripting

Introduction of CoCare to Patient following warm handover by PCP

Hello, Mrs Smith-what do you prefer I call you? (smile, eye contact, welcoming)
As Dr Wilson just explained, my name is Robin and I am a nurse. They call me a Behavioral Health Care Manager and I work right here in Dr Wilson's office. I am a member of Dr Wilson's team.

What is your understanding of why Dr Wilson referred you to me today?

Would it be ok if I took 10 or so to explain how this might work for you?

Dr Wilson is concerned about the depression you are experiencing and how it seems to be worsening. The best way he and our team can support you and help you feel better is with what we call CoCare. In CoCare, there is a whole treatment team working on your behalf--some directly and some indirectly. I would work closely with you to learn how depression is effecting you day to day. Together we can discover actions and skills that you can use that will help you feel better. We also have a psychiatrist working in the background to be a resource to Dr Wilson in considering treatment choices such as medication or other therapies. We will review your progress periodically and suggest adjustments to further progress. We can also bring in other team members such as the pharmacist or social worker or make referrals if needed. Dr Wilson is still your Primary Physician, he leads the team and you will still have office visits with him as usual.

You are the most important team member. You are the expert on your life so your participation is key. One way is that we will monitor your symptoms periodically asking you the depression questions like we did today. This helps us know what to focus on and what is working. Another way is that you and I will meet together by phone, video or in person to see if skills and actions you are trying out are working and problem solve together.

If you chose to participate in CoCare-our first visit will be around 1 hour long so that I can get to know you better. After that our contacts will be shorter-often weekly at first and then less frequently as your symptoms improve and you begin to feel better. Our work in between office visits with Dr Wilson helps you make progress more quickly. The goal of CoCare treatment is to get your depression into remission and this often takes 6-12 months.

I know this is a lot. What questions do you have? It is your choice to participate and you don't have decide now. You can think about it and I can call you in a few days if you'd like.

Thank you for taking the time to meet with me today.

6. Mi-CCSI Relapse Prevention Plan

Relapse Prevention Plan

A Relapse Prevention Plan focuses on stress reduction and self-monitoring and can help you to recognize depression early.

Patient Name: **Today's Date:**

Program activation date:

Contact/Appointment information

Primary Care Provider:_____

Next appointment: Date:_____Time:____

Care Manager:_____ Telephone number:_____

Next Appointment:_____ (circle one-6 mo/12mo follow up call)

**Use the depression-fighting strategies that have worked for you in the past, including taking your antidepressant medication regularly, increasing your pleasurable activities and maintaining a healthy lifestyle.

Maintenance Antidepressant Medications

Diagnosis:_____

1.

2.

You will need to stay on your medications to avoid relapse of depressive symptoms. If you feel you need to change or stops medications-please call your Primary Care Team. Your Physician can help you decide the safest options for medication changes.

Other Treatments

**Write down the problems that can trigger your depression and strategies that have helped you in the past.

• What are some of my everyday stressors?

• What coping strategies have worked for me in the past?

• Are these skills I can use every day or every week?

• How can I remind myself to use these skills daily?

**Watch for warning signs by regular self monitoring. You can check routinely for personal warning signs or telltale patterns of thought or behavior. You may want to ask a partner or friend to let you know if they notice any warning signs

**Use the PHQ test to check your depression score. If your score goes up over 10, it's time to get help again.

Triggers for my depression:

1.

Personal Warning Signs

1.

Coping strategies:

1.

Goals/Actions: How to minimize Stress from Depression

**Try to identify three or four specific actions that will help you. Be realistic about what you can and will do.

**Prepare yourself for high-risk situations.

• What are some problems or predictable stressors that might affect you in the future?

• Can you do anything to make a particular event less likely or less stressful?

• If you can't avoid a stressful situation: can you avoid negative reactions (like criticizing yourself) or react in a more positive way?

1.

2.

3.

4.

When we've made changes in our behavior, there's always a tendency to drift back towards old habits. How can you stop the backward drift?

****Put drift into perspective. We all make plans, but all of us drift away. The key is catching yourself and getting back on track.**

If symptoms return, contact:_____

Patient Signiture_____**Date**_____

Thank you very much for participating in the CoCM at _____!

7. AIMS Relapse Prevention Plan

Relapse Prevention Plan

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Date: _____

Purpose: Depression can occur multiple times during a person's lifetime. The purpose of a relapse prevention plan is to help you understand your own personal warning signs. These warning signs are specific to each person and can help you identify when depression may be starting to return so you can get help sooner – before the symptoms get bad. The other purpose of a relapse prevention plan is to help remind you what has worked for you to feel better. Both of these put YOU in charge!

Instructions: 1. Fill out this form with your care manager. 2. Put it where you'll come across it on a regular basis. 3. Use the PHQ-9 on the back to self-assess yourself. 4. If you see signs of returning depression, use your prevention plan.

Maintenance medications

1. _____; _____tablet(s) of _____mg _____Take at least until_____
2. _____; _____tablet(s) of _____mg _____Take at least until_____
3. _____; _____tablet(s) of _____mg _____Take at least until_____
4. _____; _____tablet(s) of _____mg _____Take at least until_____

Call your primary care provider or your care manager with any questions (see contact information below).

Other treatments

1. _____
2. _____
3. _____

Personal warning signs

1. _____
2. _____
3. _____
4. _____

Things that help me feel better

1. _____
2. _____
3. _____
4. _____

If symptoms return, contact: _____

Primary Care Provider: _____ Phone: _____ Email: _____
Care Manager: _____ Phone: _____ Email: _____

Next appointment: Date: _____ Time: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	add columns:		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)	**TOTAL:**			

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all** _____ **Somewhat difficult** _____ **Very difficult** _____ **Extremely difficult** _____

ZT242043

8. Suicide Policy-Protocol Template

TITLE: SUICIDAL OR POTENTIALLY SUICIDAL PATIENT CARE IN PHYSICIANS OFFICE PRACTICES

POLICY OWNER: Quality Improvement Committee Chair
APPROVAL: _____

President & Chief Medical Officer,
POLICY STATEMENT/SCOPE: Encounters with patients who have thoughts of suicide can occur within the physician office setting. It is the responsibility of the health care team to provide support and assistance for maintaining the safety of patients who experience suicidal thoughts or behaviors.
PURPOSE: To outline the process for maintaining the safety of patients who are exhibiting suicidal thoughts and behaviors during an ambulatory care setting encounter.

RESPONSIBILTY: Physicians, Advanced Practice Providers, Clinical staff, Practice Leaders with entire office staff to provide support and assistance.

PROCESS / PROCEDURE:
I. Patient shows signs or symptoms of suicidality
1. Business Office associate

a. Phone
i. Remain on the phone with the patient
ii. Alert another associate or instant message the patient physicians care team or designee
iii. When transferring the call, remain on the call until they are transferred to physician/designee clinical care team

b. In person
i. Remain with the patient
ii. Alert another associate or instant message the patient physicians care team or designee
iii. Handoff to clinical team member who takes over.

2. Physician/Clinical Care Team/Designee
a. Determine risk level (**imminent/acute, moderate to high, chronic/lower)**
 Have you thought about hurting yourself?
 Sometimes others in situations similar to yours think about hurting themselves. Have you ever thought that way?
 I'm concerned about you and wonder if you sometimes wish you were dead or have ever thought about killing yourself. That is, patient's **intent, plans, and means.**
Physician & Clinic Practices 2 AMB 10/300

i. **Imminent/Acute Risk -Intent with lethal plan - This level always requires immediate action.**
1) On the phone
a. Confirm the patient's current phone number and location.
b. Instant message to practice/clinical leader who will notify/consult immediately with physician/designee.
c. Ask patient if they are currently safe while you complete an assessment.
i. If patient is unsafe, call 9-1-1. Attempt to keep patient on the line until police arrive.
1. If patient's support person is known, it is appropriate to contact the support person with or without patient's consent.
ii. If currently safe
1. Identify a family or friend in order to further assess risk level/strength of support system.
2. If patient and support person states they are safe, arrange for an appointment or send to hospital Emergency Department.

2) Patient present in the office
a. Nurse or physician/designee stays in room with patient sending an instant message to practice/clinical leader, provider and fellow care team members who will:
b. **Off campus offices/clinics:** Activate 9-1-1 to bring patient to emergency room via ambulance.
c. **On campus offices/clinics:** Utilize office Social Worker, if available, or call Security if necessary to keep patient safe, then escort to the hospital Emergency Department.
d. Contact hospital Emergency Room, (**SM Express at 685-4800**) with pertinent Hand Off information and for further evaluation/disposition.

ii. **Moderate to High Risk - Current/acute thoughts with plan but no means or intent.** This risk level may not require immediate hospitalization but should be addressed clearly and specifically including statements such as: What keeps you from attempting to harm yourself? Substantiate that it is a good reason to live.
1) Patient makes threat on the phone
a. Notify/consult immediately with patient's physician/designee
b. If no access to lethal means, good social support, intact judgment; psychiatric symptoms have been addressed safe hand off to a mental health provider, significant other or family member who can assume follow up of the patient.
c. Offer the patient/support person information contact numbers and procedures if suicidal ideation worsens:
i. Suicide Hotline 1-800-273 TALK or 1-800-784.2433
ii. Proceed to hospital Emergency Department
2) Patient present in the office
a. Notify/consult immediately with patient's physician/designee
b. If no access to lethal means, good social support, intact judgment; psychiatric symptoms have been addressed safe hand off to a mental health provider, significant other or family member who can assume follow up of the patient.
c. Offer the patient information about contact numbers and procedures if suicidal ideation worsens:
i. Suicide Hotline 1-800-273 TALK or 1-800-784.2433
ii. Proceed to hospital Emergency Department
Physician & Clinic Practices 3 AMB 10/300

iii. **Chronic/Lower Risk -Chronic thoughts with no intent, plan, or means**
1) Patient makes threat on the phone
a. Discuss with designated provider within 24 hours;
b. Offer patient information about contact numbers and procedures if suicidal ideation returns or worsens
i. Suicide Hotline 1-800-273 TALK or 1-800-784.2433
ii. Proceed to ER
2) Patient Present in the office
a. Notify/consult with patient's physician/designee within 24 hours
i. Offer patient information about contact numbers and procedures if suicidal ideation returns or worsens
a) Suicide Hotline 1-800-273 TALK or 1-800-784.2433
b) Proceed to ER
iv. **Follow up and Documentation**
1) Following contact with the patient
a. Confirm all plans are in place and responsible parties have been notified
b. Determine next steps
i. Follow up with patient/family
ii. Follow up with facility/provider
iii. Provide any additional necessary information as necessary (medications, current plan of care, contact information, certification actions)
2) Documentation
a. Document in patient record
b. Documentation should include but is not limited to:
i. Assessment
ii. Screening tool (PHQ-9)
iii. Interventions and actions taken
iv. Follow up plan

REFERENCES: 2012 National Strategy for Suicide Prevention; Goals and Objectives for Action, Washington, DC: HHS, September 2012
Telephone Triage Protocols for Nurses, 4th Edition, Briggs, JK, Lippincott, Williams & Wilkins, 2012
CONCURRENT REVIEW:
Clinical Integration & Quality Improvement Date
Committee Chair
VP, Chief Nursing Officer, MHSM Date

9. Safety Plan Template

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

10. Self-Management Goals Menu

Goals Important to You

- ☐
- ☐
- ☐
- ☐

Healthy Lifestyle

- ☐ Exercise regularly
- ☐ Avoid addictive substances
- ☐ Make healthy food choices and eat at a regular time in a comfortable space
- ☐ Get regular sleep

Relationships

- ☐ Spend time with others
- ☐ Go to social events or get coffee with friends
- ☐ Build supportive relationships

Stick With Your Plan

- ☐ Take medications as directed
- ☐ Keep appointments
- ☐ Participate in groups/counseling
- ☐ Stay in touch with your care manager
- ☐ Work on your goals

Productivity

- ☐ Get involved in workplace projects or community events
- ☐ Start or keep working on a regular basis
- ☐ Get involved in personal or family activities

Self-Reward

- ☐ Plan weekly activities that are relaxing or that you have enjoyed in the past like reading or listening to music
- ☐ Take up an old hobby or attend a special event

Spiritual

- ☐ Connect with a spiritual community
- ☐ Look for ways to meet your spiritual needs such as quiet study, meditation, services/ceremonies

11. Initial Care Manager Note Example

Florence Nightingale is a 73 y.o. female, with a history of Depression and Anxiety who is referred to IBH Care Coordination for help in management of mood symptoms.

Primary symptoms of concern: Increased irritability

Current stressors: Physical health, increased difficulties with memory

The following patient reported outcomes were completed:

PHQ9 Score	11/2/2016	6/15/2020	7/13/2020
PHQ-9 Total Score (max 27)	1	6	11

GAD7 Score	6/15/2020	7/13/2020
GAD-7 Total Score (max 21)	5	5

Current psychiatric pharmacological interventions: nothing currently - Patient states she would prefer not to take psychotropic drugs, but states they also have not been offered. States her personal reason is history of seeing people "get really messed up".

Does have prescription for amitriptyline 10 mg for sleep, states does not taking regular. States has fear of falling when getting up in the night.
Current nonpharmacological interventions: Meditation, prayer, exercise (2-3 times a week)
Current psychotherapist: denies
Current psychiatric prescribing provider: denies

Suicidal Ideations: denies
Non-suicidal self-injury: denies
Homicidal ideations: denies
Access to firearms: denies

Sleep: Reports sleeps in 2 hour periods of time, notes getting up to go to the bathroom, occasional GI distress, reports this is fairly regular. No difficulty with falling asleep. Amitriptyline, does not take regular basis, states fear of falling when getting up. Does endorse slightly better sleep when using, NO CPAP, getting overnight oximetry test.

Pain interference: Some chronic abdominal pain following Whipple procedure in Oct 2019. Reports pain is most noticeable in the evening when lying down

PAST MEDICAL HISTORY

Medical History:
Patient Active Problem List
Diagnosis
- Hyperlipidemia
- Hypertension Essential Primary
- Diverticulitis Colon
- Breathing Related Sleep Disorder
- Personal History Of Other Malignant Neoplasm Of Skin
- Gastroesophageal Reflux Disease NOS
- Hypothyroidism Primary
- Implant Breast Status Post
- Insufficiency Venous

- Neuropathy Peripheral
- Osteopenia
- Tremor Essential
- Varicose Vein Lower Extremity With Pain Bilateral
- Other Specified Diseases Of Biliary Tract
- Cancer Breast Personal History
- Overgrowth Bacterial Small Bowel (HCC)
- Fever Of Unknown Origin
- Depression Major Recurrent Moderate (HCC)
- Anxiety
- Irritable Bowel Syndrome With Diarrhea

Lab Results

Component	Value	Date
TSH	7.6 (H)	07/10/2020

Mental Health History:
Reports onset of depression after Whipple procedure (Oct 2019), denies any other treatment for depression. Husband reports a different person since surgery. States she was very positive, happy, smiling, did a fair amount of volunteer work, and feels she has lost all of that

Past medication trials: denies
Mental Health Hospitalizations: Denies
Mental Health ED Visits: Denies

Past psychotherapists: Denies
Past psychiatric prescribing provider: Denies
Past ECT/TMS/Ketamine: Denies
Genomic testing: Denies

Past suicide attempts: Denies
Past non-suicidal self-injury: Denies
Past homicidal ideations: Denies

FAMILY HISTORY

Sister - Depression - unsure of treatment method

SOCIAL HISTORY

Born and raised in Iowa by Mom and Dad is oldest in a sib ship of 6. Reports overall good childhood and was raised by "good parents". Reports a good relationship with all of her siblings and has regular contact with all of her sisters and brothers. States between her and her husband they have 8 children, states 2 children that live close by and others are somewhat scattered and 6 grandchildren in Owatonna

History of trauma/abuse/neglect: denies
Learning: denies
Military history: denies
Legal history: denies

Current support: Husband, sisters, multiple friends

Patient reports the following leisure activities: Walking, reading, used to volunteer (not currently), puzzles, video games on computer

Social Determinants of Health:
No categories of concern noted by patient.

Substance abuse: denies
Nicotine use: denies
Supplement use: Women's multi vitamins
Caffeine use: Minimal caffeine
Physical activity: Walking 2-3 times a week

Past chemical dependency treatments: denies

ASSESSMENT / PLAN

The following program goals were identified:

Patient goals for care coordination:

1. Work on establishing a schedule for walking 15 minutes a day
2. .Would be open to listening to medication options
3. Identify strategies for maintaining mood despite and resilience

Referrals: No additional referrals needed at this time

Next contact: 1 week(s) by Phone Call.

12. Initial Psychiatry Note Example

Psychiatry note on Intake

PATIENT WAS NOT SEEN and information was gathered by the care coordinator, Danielle Boone, RN. See care coordinator notes for additional details. Care coordinator documentation associated with these recommendations can be accessed by clicking the hyperlink below.

ASSESSMENT:
Florence Nightingale is a 73 y.o. female, with a history of Depression and Anxiety who is referred to IBH Care Coordination for help in management of mood symptoms.

Primary symptoms of concern: Increased irritability

Current medications - amitriptyline PRN at 10 mg (worries about falls)
Past medication trials: denies - records show Ambien in the past
RECOMMENDATIONS:

1. She has recently had her thyroid medication increased (this month) and she has been describing sleep issues as primary with fears about falling from amitriptyline (given per records for bowel issues). No other trials. Will need a follow up TSH in the fall.
2. With memory concerns and worries about a fall, amitriptyline is not ideal. Could test out a low dose of mirtazapine to see if she sleeps better without any dizziness but she should still get up carefully.
3. She may be having some challenges related to medical issues and stress. Therapy could look at CBT for insomnia and resilience support.

PATIENT WAS NOT SEEN and information was gathered by the care coordinator. Recommendations are based on chart review and discussion with the care coordination team. The intention is for these recommendations to be seen as options/suggestions by the care coordination team. The application of these or other clinical recommendations are subject to PCP's discretion and clinical discussions with the patient.

13. Follow-up Care Manager Note Example

Care manager monthly note:

SUBJECTIVE

REASON FOR VISIT

Integrated Behavioral Health (IBH) Care Coordination Monthly Systematic Case Review (SCR)

ASSESSMENT

Florence Nightingale is a 73 y.o. female with a history of Depression who is referred to IBH Care Coordination for help in mood management

Date of enrollment: 7/14/20

PHQ-9 at enrollment: 11

The following patient reported outcomes were completed:

PHQ9 Score	6/15/2020	7/13/2020	8/5/2020
PHQ-9 Total Score (max 27)	6	11	0

GAD7 Score	6/15/2020	7/13/2020	8/5/2020
GAD-7 Total Score (max 21)	5	5	0

Goals unique to Florence Nightingale, RN:

1. Work on establishing a schedule for walking 15 minutes a day
2. Would be open to listening to medication options
3. Identify strategies for maintaining mood despite and resilience

Mental Health hospitalizations since last SCR: 0
Mental Health ED visits since last SCR 0

Current Psychotropic Medications (including date of last dose change:)
Mirtazapine 15 mg

Pharmacological interventions since enrollment (including failed medication trials):
Amitriptyline discontinued

Current Psychotherapy relationship:
N/A

Previous SCR recommendations:

1. She has recently had her thyroid medication increased (this month) and she has been describing sleep issues as primary with fears about falling from amitriptyline (given per records for bowel issues). No other trials. Will need a follow up TSH in the fall.
2. With memory concerns and worries about a fall, amitriptyline is not ideal. Could test out a low dose of mirtazapine to see if she sleeps better without any dizziness but she should still get up carefully.

3. She may be having some challenges related to medical issues and stress. Therapy could look at CBT for insomnia and resilience support.

Updates since last SCR (Medications, non-pharmacologic interventions, progress towards previous recommendations):
Doing well, just recently spent some time in northern Minnesota. Reports has also been spending time in the garden and this has been enjoyable. Continues to spend time talking with sister and friends and finds this helpful. Denies any specific difficulties with her mood. In terms of Mirtazapine, Florence does feel this has been an improvement from the Amitriptyline. I did ask if I could check in with her husband to get his perspective on overall improvement given history of some mild memory concerns, but he was unavailable and so I will check in with him later.

14. Follow-up Psychiatry Note Example

PSYCHIATRY MONTHLY NOTE

PATIENT WAS NOT SEEN and information was gathered by the care coordinator, Danielle Boone, RN. See care coordinator notes for additional details. Care coordinator documentation associated with these recommendations can be accessed by clicking the hyperlink below.

SUMMARY/UPDATES FROM LAST MONTH:

Date of enrollment: 7/14/20

PHQ-9 at enrollment: 11. Most recent PHQ-9 was 0 on 8/5/2020.

Per Danielle Boone:

Doing well, just recently spent some time in northern Minnesota. Reports has also been spending time in the garden and this has been enjoyable. Continues to spend time talking with sister and friends and finds this helpful. Denies any specific difficulties with her mood. In terms of Mirtazapine, Florence Nightingale does feel this has been an improvement from the Amitriptyline. I did ask if I could check in with her husband to get his perspective on overall improvement given history of some mild memory concerns, but he was unavailable and so I will check in with him later.

Current Psychotropic Medications (including date of last dose change:)
Mirtazapine 15 mg

Pharmacological interventions since enrollment (including failed medication trials):
Amitriptyline discontinued

RECOMMENDATIONS:

1. We will check with collateral and on her progress in regards to concerns about falls and memory. If doing well in all the areas, would consider moving towards discharge.

PATIENT WAS NOT SEEN and information was gathered by the care coordinator. Recommendations are based on chart review and discussion with the care coordination team. The intention is for these recommendations to be seen as options/suggestions by the care coordination team. The application of these or other clinical recommendations are subject to PCP's discretion and clinical discussions with the patient.

15. CMS MLN Behavioral Health Services

BEHAVIORAL HEALTH INTEGRATION SERVICES

TARGET AUDIENCE

Medicare Fee-For-Service Program Providers

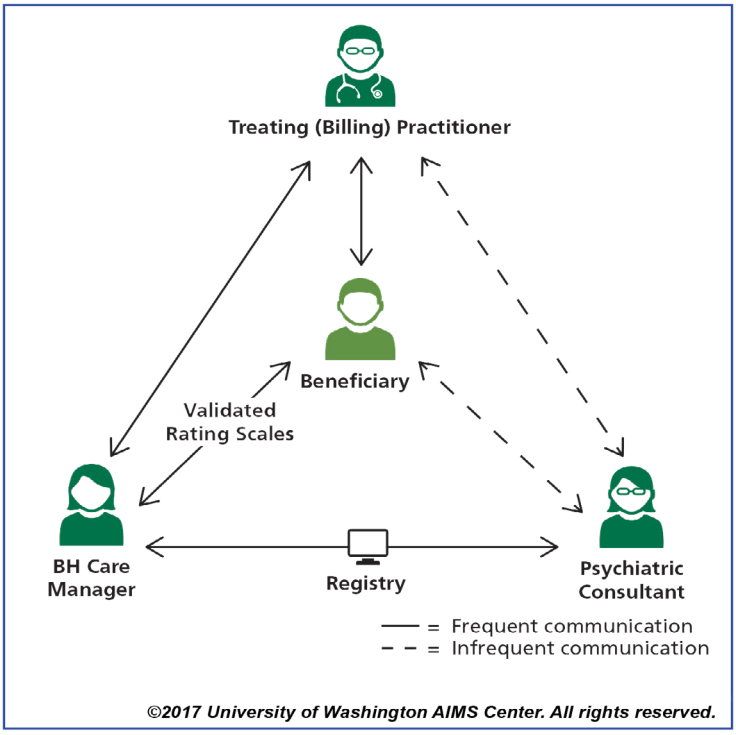
Integrating behavioral health care with primary care ("behavioral health integration" or "BHI") is an effective strategy for improving outcomes for the millions of Americans with mental or behavioral health conditions. As of January 1, 2017, Medicare makes separate payments to physicians and non-physician practitioners for BHI services they furnish to beneficiaries over a calendar month service period. As of January 1, 2018, these services will be reported using new CPT codes, listed below.

PSYCHIATRIC COLLABORATIVE CARE SERVICES (COCM)

CPT codes 99492, 99493, and 99494 are used to bill for monthly services furnished using the Psychiatric Collaborative Care Model (CoCM), an approach to BHI shown to improve outcomes in multiple studies.

What is CoCM? This figure is a model of behavioral health integration that enhances "usual" primary care by adding two key services to the primary care team, particularly regarding patients whose conditions are not improving:

- Care management support for patients receiving behavioral health treatment
- Regular psychiatric inter-specialty consultation
- A team of three individuals provide CoCM: the Behavioral Health Care Manager, the Psychiatric Consultant and the Treating (Billing) Practitioner

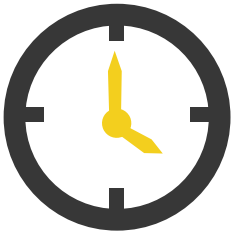


CARE TEAM MEMBERS

- **Treating (Billing) Practitioner** – A physician and/or non-physician practitioner (physician assistant or nurse practitioner); typically primary care, but may be of another specialty (for example, cardiology, oncology)
- **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 billing practitioner
- **Psychiatric Consultant** – A medical professional trained in psychiatry and qualified to prescribe the full range of medications
- **Beneficiary** – The beneficiary is a member of the care team

Service Components

- Initial assessment by the primary care team (billing practitioner and behavioral health care manager)
  - Initiating visit (if required, separately billed)
  - Administration of validated rating scale(s)
- Care planning by the primary care team, jointly with the beneficiary, with care plan revision for patients whose condition is not improving adequately. Treatment may include pharmacotherapy, psychotherapy, and/or other indicated treatments
- Behavioral health care manager performs proactive, systematic follow-up using validated rating scales and a registry



  - Assesses treatment adherence, tolerability, and clinical response using validated rating scales; may provide brief evidence-based psychosocial interventions such as behavioral activation or motivational interviewing
  - 70 minutes of behavioral health care manager time the first month
  - 60 minutes subsequent months
  - Add-on code for 30 additional minutes any month
- Regular case load review with psychiatric consultant:
  - The primary care team regularly (at least weekly) reviews the beneficiary's treatment plan and status with the psychiatric consultant
  - The primary care team maintains or adjusts treatment, including referral to behavioral health specialty care, as needed

GENERAL BHI

CPT code 99484 is used to bill monthly services furnished using BHI models of care other than CoCM that similarly include "core" 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.

CPT code 99484 may be used to report models of care that do not involve a psychiatric consultant, nor a designated behavioral health care manager (although such personnel may furnish General BHI services). CMS expects to refine this code over time, as more information becomes available regarding other BHI care models in use.

CARE TEAM MEMBERS

- **Treating (Billing) Practitioner** – A physician and/or non-physician practitioner (PA, NP, CNS, CNM); 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 service may be provided in full by the billing practitioner. The billing practitioner may also use qualified clinical staff to provide certain services using a team-based approach. The clinical staff may include staff or contractors who meet the qualifications for the CoCM behavioral health care manager or psychiatric consultant.

Service Components

- Initial assessment
  - Initiating visit (if required, separately billed)
  - Administration of applicable validated rating scale(s)
- Systematic assessment and monitoring, using applicable validated clinical rating scales
- Care planning by the primary care team jointly with the beneficiary, with care plan revision for patients whose condition is not improving
- Facilitation and coordination of behavioral health treatment
- Continuous relationship with a designated member of the care team

Note: The BHI Codes allow for remote provision of certain services by the psychiatric consultant and other members of the care team.

ELIGIBLE CONDITIONS

Eligible conditions are classified as any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time.

Beneficiaries may, but are not required to have, comorbid, chronic, or other medical condition(s) that are being managed by the billing practitioner.

RELATIONSHIPS AND ROLES OF CARE TEAM MEMBERS

The BHI codes provide a mechanism to identify and pay for services provided using models of care having well defined roles and relationships among the care team members. The following roles and relationships characterize all of the BHI services unless otherwise indicated.

"Incident To"
BHI services that are not provided personally by the billing practitioner are provided by the other members of the care team (other than the beneficiary), under the direction of the billing practitioner on an "incident to" basis (as an integral part of services provided by the billing practitioner), subject to applicable State law, licensure, and scope of practice. These other care team members are either employees or working under contract to the billing practitioner whom Medicare directly pays for BHI.

Initiating Visit
An initiating visit (separately billable) is required for new patients or beneficiaries not seen within one year prior to commencement of BHI services. This visit establishes the beneficiary's relationship with the billing practitioner, and ensures the billing practitioner assesses the beneficiary prior to initiating BHI services.

Treating (Billing) Practitioner

- Directs the behavioral health care manager or clinical staff
- Oversees the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed
- Remains involved through ongoing oversight, management, collaboration and reassessment
- May provide the General BHI service in its entirety

Behavioral Health Care Manager (required for CoCM; optional for General BHI)

- Provides assessment and care management services, including the administration of 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; provision of brief psychosocial interventions; ongoing collaboration with the billing practitioner; maintenance of the registry; all in consultation with the psychiatric consultant
- Available to provide services face-to-face with the beneficiary; has a continuous relationship with the beneficiary and a collaborative, integrated relationship with the rest of the care team
- Able to engage the beneficiary outside of regular clinic hours as necessary to perform the behavioral health care manager's duties
- May or may not be a professional who meets all the requirements to independently furnish and report services to Medicare
- Does not include administrative or clerical staff; time spent in strictly administrative or clerical duties is not counted towards the time threshold to bill the BHI codes

Psychiatric Consultant (required for CoCM; optional for General BHI)

- Participates in regular review of clinical status of patients receiving BHI services
- Advises the billing practitioner (and behavioral health care manager) regarding diagnosis; indicates options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; makes adjustments to behavioral health treatment for beneficiaries who are not progressing; manages any negative interactions between beneficiaries' behavioral health and medical treatments. Can (and typically will) be remotely located; is generally not expected to have direct contact with the beneficiary, nor prescribe medications or furnish other treatment to the beneficiary directly
- Can and should facilitate referral for direct provision of psychiatric care when clinically indicated

Clinical Staff (may be used in provision of General BHI)

- Continuous relationship with the beneficiary and a collaborative, integrated relationship with the rest of the care team
- May or may not be a professional who meets all the requirements to independently furnish and report services to Medicare
- Does not include administrative or clerical staff time
- May include (but not required to include) a behavioral health care manager or psychiatric consultant

Supervision
BHI services that are not personally performed by the billing practitioner are assigned general supervision under the Medicare Physician Fee Schedule (MPFS)*, although general supervision does not, by itself, comprise a qualifying relationship between the billing practitioner and the other members of the care team. General supervision is defined as the service being furnished under the overall direction and control of the billing practitioner, and his or her physical presence is not required during service provision.

Advance Consent
Prior to commencement of BHI services, the beneficiary must give the billing practitioner permission to consult with relevant specialists, which would include conferring with a psychiatric consultant. The billing practitioner must inform the beneficiary that cost sharing applies for both face-to-face and non-face-to-face services that are provided, although supplemental insurers may cover cost sharing. Consent may be verbal (written consent is not required) but must be documented in the medical record.

*Medicare Physician Fee Schedule (MPFS) payment is available under the MPFS regardless of whether the beneficiary spends part or all of the month in a facility stay or institutional setting. Report the place-of-service (POS) where the billing practitioner would ordinarily provide face-to-face care to the beneficiary. Separate Part B payment can be made to hospitals (including critical access hospitals) when the billing practitioner reports a hospital outpatient POS.

BHI CODING SUMMARY

BHI CODE	BEHAVIORAL HEALTH CARE MANAGER OR CLINICAL STAFF THRESHOLD TIME	ASSUMED BILLING PRACTITIONER TIME
CoCM First Month (99492)	70 minutes per calendar month	30 minutes
CoCM Subsequent Months** (99493)	60 minutes per calendar month	26 minutes
Add-On CoCM (Any month) (99494)	Each additional 30 minutes per calendar month	13 minutes
General BHI (99484)	At least 20 minutes per calendar month	15 minutes
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M)†	N/A	Usual work for the visit code

**CoCM is furnished 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 for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).
†Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management services (TCM).

Full Code Descriptors

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 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*

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)*

99484 *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*

RESOURCES

RESOURCES	WEB ADDRESS
BHI Frequently Asked Questions (FAQs)	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html
CY 2017 MPFS Final Rule pp.80230-80243	https://www.govinfo.gov/content/pkg/FR-2016-11-15/pdf/2016-26668.pdf
CY 2019 Medicare Physician Fee Schedule Final Rule	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html
New England Journal of Medicine - Medicare Payment for Behavioral Health Integration	http://www.nejm.org/doi/pdf/10.1056/NEJMp1614134
CoCM Implementation Resources	https://aims.uw.edu/collaborative-care/implementation-guide
The Kennedy Forum-A Core Set of Outcome Measures for Behavioral Health Across Service Settings [Content on Validated Rating Scales pg. 4]	http://thekennedyforum-dot-org.s3.amazonaws.com/documents/MBC_supplement.pdf
Agency for Healthcare Research and Quality-Develop a Shared Care Plan	https://integrationacademy.ahrq.gov/products/playbook/develop-shared-care-plan
NEJM Catalyst-Making the Comprehensive Shared Care Plan A Reality	https://catalyst.nejm.org/making-the-comprehensive-shared-care-plan-a-reality/

RESOURCES	WEB ADDRESS
Institute for Healthcare Improvement-My Shared Care Plan	http://www.ihi.org/resources/Pages/Tools/MySharedCarePlan.aspx

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16. MDHHS MSA Bulletin-Medicaid Coverage

MDHHS Michigan Department of Health & Human Services

Medical Services Administration
BULLETIN MSA

Bulletin Number: MSA 20-38

Distribution: Federally Qualified Health Centers, Medicaid Health Plans, Local Health Departments, Practitioners, Rural Health Clinics, Tribal Health Centers, Prepaid Inpatient Health Plans, Community Mental Health Services Programs

Issued: July 1, 2020

Subject: Coverage of Psychiatric Collaborative Care Model Services

Effective: August 1, 2020

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

The purpose of this policy is to establish Medicaid program coverage conditions and requirements for Psychiatric Collaborative Care Model (CoCM) Services effective for dates of service on and after August 1, 2020. The goal of these services is to improve access to effective care for mild to moderate behavioral health disorders within the primary care setting for Medicaid Fee-for-Service (FFS) and Medicaid Health Plan beneficiaries. Participation in CoCM services is voluntary and participation is not required prior to obtaining a referral to specialty behavioral health services.

I. General Information

CoCM is a model of integrated behavioral health service which is typically provided within the primary care setting. The evidence-based model includes a person-centered care team, weekly and/or monthly monitoring of person-centered goals, and referral to behavioral health support services if goals are unmet after an initial six-month episode of care. CoCM uses team-based collaborative and management services which are provided under the direction and supervision of a treating physician or other qualified healthcare professional and utilizes a measurement-based treatment-to-target approach. The CoCM team includes the primary care provider, a behavioral health care manager, a psychiatric consultant and the FFS or Medicaid Health Plan beneficiary. The model requires the use and maintenance of a patient registry, typically maintained by the behavioral health care manager, which is to be accessible by the primary care provider and psychiatric consultant. CoCM allows for behavioral health integration services to be delivered in a familiar setting that helps engage beneficiaries in care, adapts to their changing needs over time, and reduces the likelihood of duplication of services by addressing both physical and behavioral health care in one setting.

II. Target Population

CoCM is intended for beneficiaries who typically have behavioral signs and/or symptoms of a newly diagnosed behavioral health condition, need help engaging in treatment, have not responded to care delivered in a non-psychiatric setting or require further assessment, engagement and management prior to consideration of a referral to a psychiatric care setting.

These services are not intended to manage severe and/or persistent conditions which require specialty care. Eligible conditions include, but are not limited to, mild to moderate depression, anxiety, bipolar disorder, attention deficit disorder, substance use disorder (SUD), and individuals who may not be deemed eligible for specialty services through the Community Mental Health Services Program (CMHSP).

III. The Psychiatric Collaborative Care Model

Medicaid enrolled providers must be able to demonstrate they are following the evidence-based best practices of CoCM. The model is most effective when all five core principles are in place and incorporated into service delivery. These principles include:

- Person-centered care: the beneficiary is part of the team and makes the ultimate decisions regarding their treatment and based on their own goals.
- Measurement-based treatment-to-target strategy: the use of validated tools allows measurement of beneficiary signs and symptoms.
- Population-based care: the patient registry allows monitoring of beneficiary outcomes by the care team over time and can be utilized in conjunction with, or alongside, existing beneficiary health records.
- Evidence-based treatment: beneficiaries are offered evidence-based treatment that may include medications and brief therapeutic interventions.
- Accountable care: the CoCM team of providers is accountable for all beneficiary care, including quality and clinical outcomes for beneficiaries receiving CoCM support services.

A. Episode of Care

An episode of care begins when a beneficiary starts CoCM and an episode of care ends when a beneficiary either:

- Fulfills treatment goals and the beneficiary returns to usual primary care follow-up,
- Fails to attain treatment goals, fails to improve or their condition worsens and requires referral to specialty services, or
- A break in services for six consecutive months or more occurs, at which point a new episode of care begins.

B. Measurement-Based Treatment-to-Target Strategy

The model utilizes validated tools which allows for measurement of beneficiary signs and symptoms. At a minimum, the plan of care (POC) for each beneficiary should be adjusted every 10-12 weeks based on the goal of reducing measured symptoms. Outcome measures are tracked in a patient registry. For example, if a beneficiary is recommended to engage in evidence-based therapy and does not exhibit symptom measurement improvement after 10 weeks, the psychiatric consultant may recommend an adjustment to treatment in an effort to reach person-centered goals.

C. Required Documentation

CoCM is a data-driven service delivery model that requires the use of a patient registry and corresponding POC for each beneficiary. The registry can be part of, or maintained alongside, an already existing Electronic Health Record (EHR). Typically, the behavioral health care manager is responsible for maintaining these tools and ensuring all documentation is included. CoCM services are most effective when the psychiatric consultant has direct access. Documentation must support the services provided and follow Medicaid documentation requirements, including consent for treatment. Services must be provided within the confines of state and federal law. Behavioral health care managers are required to ensure all aspects of registry/POC are included in the documentation.

Documentation requirements, at a minimum:

- Beneficiary information,
- Assessment, treatment plan, including evidence-based treatment interventions,
- Monitoring of individual beneficiary progress,
- Referrals, and
- Medication management.

The patient registry, at a minimum, must include the following key components:

- Date of enrollment and date of most recent contact with care team,
- Initial and most recent validated outcome measure,
- Prompt treatment-to-target strategies for treatment adjustment according to changes in validated tool scores, such as a flagging/alert system or systematic weekly review of the patient registry, and
- Facilitation of efficient, systematic psychiatric caseload review.

IV. Collaborative Care Team Criteria

All team members must participate in the care and treatment of the beneficiary to be considered as a covered CoCM service. Services are reported by the primary care provider and include the services of the treating physician, behavioral health care manager and the psychiatric consultant who is contracted to provide consultative services to the primary care provider. Psychiatric consultants typically make recommendations to the behavioral health care manager who will then convey recommendations to the treating physician. The psychiatric consultant does not typically provide direct consultation to the treating physician or direct treatment to beneficiaries, but instead works through the behavioral health care manager.

- **Primary care provider or treating physician**: a licensed Medicaid-enrolled health care provider (e.g., MD/DO, Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Physician Assistant [PA]), who will:

  - Direct the behavioral health care manager,
  - Continue to provide and direct beneficiary behavioral health and physical care,
  - Prescribe and manage medications based on psychiatric consultant recommendations, and
  - Make referrals to specialty care as needed.

- **Behavioral health care manager**: a licensed master's or doctoral level clinician, or individual with specialized training in behavioral health (such as a licensed social worker, registered nurse, or licensed psychologist) working under the direction and supervision of the primary care provider, who will:

  - Provide care management services through face-to-face and non-face-to-face interactions,
  - Assess beneficiary needs,
  - Develop a POC,
  - Administer validated screening tools (PHQ-9 or GAD-7) at least monthly, or more frequently if clinically indicated,
  - Provide evidence-based interventions,
  - Engage in ongoing collaboration with the primary care provider,
  - Maintain the patient registry, and
  - Consult weekly with the psychiatric consultant (may be non-face-to-face).

- **Psychiatric consultant**: medical professional (MD or DO) who is trained in psychiatry or behavioral health and qualified to prescribe the full range of medications. The psychiatric consultant will:

  - Recommend treatment strategies,
  - Recommend medication and changes in medication based on beneficiary status,
  - Recommend referral to specialty services when needed,
  - Consult weekly with the behavioral health care manager,
  - Consult with and advise the treating primary care provider as clinically indicated,

  - Have infrequent contact with beneficiaries (see Reimbursement for details), and
  - On rare occasions, directly prescribe medications to a beneficiary.

- **The beneficiary:** the beneficiary is an active member of the care team and participation in care has proven to increase motivation, adherence to treatment plan, satisfaction with care and positive beneficiary outcomes.

V. Coverage of CoCM Services

CoCM is a covered service for beneficiaries who are diagnosed with a psychiatric disorder that requires behavioral health care assessment; establishing, implementing, revising, or monitoring a care plan; and brief interventions. For primary medical care practices that meet all CoCM team criteria, Medicaid will cover CoCM services provided by the care team and rendered by the primary care provider for six months of care. After the initial six months, prior authorization is required for six additional calendar months if the beneficiary shows improvement and there is a need for continued care. If no improvement occurs after the initial six months or their condition worsens, the beneficiary is to be referred to specialty services. An episode of care does not have to be six consecutive months. A beneficiary can be absent from services for five months and still return to their initial episode of care. After a six-month break in service, a new episode of care begins and prior authorization is not required.

CoCM services are based on reaching person-centered goals through the planning and management of the behavioral health care manager and primary care provider all in consultation with the psychiatric consultant.

CoCM services must include:

- **Initial assessment:** Face-to-face visit in which the beneficiary sets goals and is screened by a diagnosis-appropriate and consistent validated clinical rating scale, such as the PHQ-9 or GAD-7, which also must be done prior to subsequent CoCM services.

- **Continued monitoring:** Face-to-face or non-face-to-face weekly to monthly follow-up by the behavioral health care manager that must include monthly screening with validated rating scale, monitoring of goals and/or medication, and may include recommended evidence-based therapies.

- **Monthly monitoring:** Continues until goals are met, the beneficiary stops participating or the beneficiary is referred to specialty services.

VI. Non-covered Services

Psychiatric CoCM services do not include:

- Treatment related to severe and persistent behavioral health conditions that require specialty care beyond the intent of CoCM services.

- Direct interaction between the beneficiary and the psychiatric consultant, either in person or by telephone. CoCM services typically include the psychiatric consultant as recommending treatment to the behavioral health care manager and are ultimately directed by the primary care provider.
- SUD-related Medication Assisted Treatment (MAT) is not covered under CoCM services and should be reported separately.

VII. Prior Authorization

After an initial six-month episode of care, prior authorization is required for an additional six months. Prior authorization requests must include documentation showing progress toward beneficiary goals through validated screening tool scores and an explanation for the medical necessity of continued services. If a six-month lapse in CoCM occurs, a new episode of care can begin without prior authorization. (Refer to the Practitioner chapter of the Medicaid Provider Manual, Prior Authorization subsection for additional information. The Medicaid Provider Manual can be accessed on the Michigan Department of Health and Human Services website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.)

VIII. Reimbursement

CoCM is a bundled monthly payment that represents a model of care rendered by all team members. The primary care provider is the sole biller for CoCM and services are not to be billed by the psychiatric consultant. The primary care provider agency is expected to have its own contract with the psychiatric consultant and will pay for his or her services as part of the CoCM. Providers are expected to adhere to the American Medical Association's Current Procedural Terminology (CPT®) coding guidelines for Psychiatric Collaborative Care Management Services as reported by CPT codes 99492, 99493, and 99494.

Direct consultant services delivered to beneficiaries by the psychiatric consultant outside of CoCM, such as evaluation and management or therapeutic interventions, may be reported separately.

To avoid duplication of services, CoCM services should not be provided to beneficiaries receiving the following Medicaid program services:

- MI Care Team benefit,
- Behavioral Health Home benefit,
- Opioid Health Home benefit, or
- Other care management services that include mental health treatment.

Providers may check the beneficiary's assigned benefit plan information in the Community Health Automated Medicaid Processing System (CHAMPS).

IX. Federally Qualified Health Center and Rural Health Clinic Reimbursement

CoCM services provided by a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) provider (e.g., MD/DO, Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Physician Assistant [PA]) do not qualify as an encounter. It may, however, be reimbursed outside of the Prospective Payment System. FQHCs and RHCs should use Healthcare Common Procedure Coding System (HCPCS) code G0512 to report CoCM services.

X. Substance Use Disorder CoCM Reimbursement

For Medicaid Health Plan enrolled beneficiaries, CoCM services provided for a primary diagnosis of SUD are carved-out of the Medicaid Health Plans. Such services will be reimbursed by the Prepaid Inpatient Health Plans, or FFS as applicable, per Medicaid policy.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Kate Massey, Director
Medical Services Administration

17. CMS Medicare FAQ

April 17, 2018

Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services

This document answers frequently asked questions about billing behavioral health integration (BHI) services to the Physician Fee Schedule (PFS). Beginning January 1, 2017, four new Medicare Part B billing codes are available to report BHI services furnished to beneficiaries during a calendar month service period. As of January 1, 2017, Medicare makes separate payments to physicians and non-physician practitioners for BHI services they furnish to beneficiaries over a calendar month service period. Beginning January 1, 2018, these services will be reported using new CPT codes. CPT codes 99492, 99493, and 99494 will be used to bill for services furnished using the Psychiatric Collaborative Care Model (CoCM). CPT code 99484 (General BHI) will be used to bill services furnished using other BHI models of care.

1. **For patients with multiple chronic conditions, including behavioral health conditions, how should one decide when to bill chronic care management (CCM) services versus BHI services?**

   As noted in the CY 2017 PFS final rule (81 FR 80233, 80247), CCM and BHI are distinct services although there is some overlap in eligible patient populations. There are substantial differences in the potential number and nature of conditions, types of individuals providing the services, and time spent providing services. CCM involves care planning for all health issues and includes systems to ensure receipt of all recommended preventive services, whereas BHI care planning focuses on individuals with behavioral health issues, systematic care management using validated rating scales (when applicable), and does not focus on preventive services. CCM requires use of certified electronic health information technology, whereas BHI does not. In most cases, we believe it would not be difficult to determine which set of codes (BHI or CCM) more accurately describe the patient and the services provided. As we state in the final rule, the code(s) that most specifically describe the services being furnished should be used. If a BHI service code more specifically describes the service furnished (service time and other relevant aspects of the service being equal), then it is more appropriate to report the BHI code(s) than the CCM code(s).

2. **Can the BHI codes be billed in the same month as CCM? What about other non-face-to-face care management services?**

   As discussed above (see #1), CCM and BHI are distinct, differing services even though there is some overlap in eligible patient populations. There may be some circumstances in which it is reasonable and necessary to provide both services in a given month. The BHI codes can be billed for the same patient in the same month as CCM if advance consent for both services and all other requirements to report BHI and to report CCM are met and time and effort are not counted more than once. Billing practitioners should keep in mind that cost sharing and advance consent apply to each service independently and there can only be one reporting practitioner for CCM each month. If all requirements to report each service are met, both may be billed.

3. **Can the General BHI code be billed for the same patient in the same month as the CoCM codes?**

   No, as noted in the CY 2017 PFS final rule, (81 FR 80242), a single practitioner must choose whether to report the general BHI code or the CoCM codes in a given month (service period) for a given beneficiary. However, in many cases, it may be appropriate for a single practitioner to report the general BHI code or the CoCM codes for the same beneficiary over the course of several months.

4. **For CoCM, must the psychiatric consultant and the billing practitioner be in the same practice? What about the behavioral health care manager and the billing practitioner?**

   The psychiatric consultant and behavioral health care manager may, but are not required to be, employees in the same practice as the billing practitioner. As noted in the CY 2017 final rule (81 FR 80235), these other care team members are either employees or working under contract to the billing practitioner whom Medicare directly pays for BHI. However, the behavioral health care manager must be available to provide services on a face-to-face basis (though face-to-face services do not necessarily have to be provided). Under the current CoCM model of care, the psychiatric consultant is commonly (but not required to be) remotely located.

5. **What qualifications are required for the behavioral health care manager role?**

   As noted in the CY 2017 PFS final rule, (81 FR 80231), the behavioral health care manager is a designated member of the care team with formal education or specialized training in behavioral health (which would include a range of disciplines, for example, social work, nursing, and psychology), but Medicare did not specify a minimum education requirement. They may or may not be a professional who meets all the requirements to independently furnish and report services to Medicare. The behavioral health care manager must be available to provide services face-to-face with the beneficiary, have a continuous relationship with the beneficiary, and have a collaborative, integrated relationship with the rest of the care team. He or she must also be able to engage the beneficiary outside of regular clinic hours as needed.

6. **If a General BHI model of care includes provision of services by a behavioral health care manager or similar qualifying clinical staff other than the billing practitioner, do these other staff have to be available to provide their services on a face-to-face basis?**

   No, general BHI does not require face-to-face provision of services by clinical staff, nor availability of clinical staff for face-to-face services.

7. **Can the behavioral health care manager bill for psychotherapy and other similar codes separate from BHI?**

Yes. As noted in the CY 2017 PFS Final Rule, (81 FR 80231-80232) if the behavioral health care manager is eligible to independently furnish and report services to Medicare, then that individual could report separate services furnished to a beneficiary receiving BHI services in the same calendar month such as psychiatric evaluation, psychotherapy, and alcohol or substance abuse intervention services. Time spent by the behavioral health care manager on activities for services reported separately could not be included in the time applied to any BHI service code (in other words, time and effort cannot be counted more than once).

8. Can a psychiatrist that is non-participating with Medicare serve as the psychiatric consultant?

Yes, since Medicare makes payment to the billing practitioner for the service, the third party they contract with does not necessarily have to be participating with Medicare.

9. Are the BHI codes limited to Medicare beneficiaries with certain behavioral health conditions/diagnoses?

No, as provided in the CY 2017 PFS Final Rule (81 FR 80232), the BHI codes may be used to treat patients with any mental, behavioral health or psychiatric condition that is being treated by the billing practitioner, including substance use disorders. We did not limit billing and payment for the BHI codes to a specified set of behavioral health conditions. The services require that there must be a presenting mental, psychiatric or behavioral health condition(s) that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time.

10. What date of service (DOS) should be used on the professional claim and when should the claim be submitted?

The BHI service period is one calendar month. Centers for Medicare and Medicaid Services (CMS) expects the billing practitioner to continue furnishing services during a given month, if medically necessary, even after the time threshold to bill BHI is met. However, after completion of the minimum clinical staff service time required to bill, the practitioner may submit the claim and need not hold the claim until the end of the month.

11. What place of service (POS) should be reported on the professional claim?

The BHI codes are priced in both facility and non-facility settings. The billing practitioner should report the POS for the location where he or she would ordinarily provide face-to-face care to the beneficiary.

12. Can BHI be billed if it is provided to a beneficiary who spends part or all of the month in a facility stay or institutional setting?

Yes, the BHI codes are priced in both facility and non-facility settings. The POS on the claim should be the location where the billing practitioner would ordinarily provide face-to-face care to the beneficiary.

13. Which specialties can report BHI services? Can BHI be billed by specialists other than "traditional" primary care specialties?

The BHI codes can be billed (directly reported) by physicians and non-physician practitioners whose scope of practice includes evaluation & management (E/M) services and who have a statutory benefit for independently reporting services to Medicare. This includes physicians of any specialty, physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives. Generally, we would not expect psychiatrists to bill the psychiatric CoCM codes, because psychiatric work is defined as a sub-component of the psychiatric CoCM codes. However, General BHI could be billed by a psychiatrist who furnished the services described by the general BHI code and met all requirements to bill it.

14. Who can provide BHI services?

For all BHI codes, the billing practitioner performs aspects of the service him or herself. For CoCM, other specified individuals (namely the behavioral health care manager and the psychiatric consultant) provide parts of the service under very specific roles and qualifications. CoCM is by definition provided by a team of three individuals rather than a single individual.

In contrast, services included in the General BHI code may be provided solely by the billing practitioner. Alternatively, the practitioner billing General BHI may (but is not required to) use other qualified individuals termed ‘‘clinical staff" to provide certain aspects of the service in a team-based approach to care. The term "clinical staff" is defined by CPT (see the Introduction to the CPT manual) and also means an individual who is clinical (not strictly clerical or administrative) and performs their services "incident to" (as an integral part of) services of the billing practitioner, subject to applicable state law, licensure, scope of practice and supervision. The clinical staff may, but are not required to, include individuals who meet the qualifications for the CoCM behavioral health care manager or psychiatric consultant. For example, for General BHI, a behavioral health consultant who is not authorized to prescribe medication, such as a psychologist, could participate in the care team. Clinical staff may be employees of the billing practitioner or may be a contracted "third party." Refer to the BHI Fact Sheet and governing regulations for a complete description of BHI staffing requirements.

15. In every month in which one bills BHI, does one also need to bill at least one E&M visit?

No, the only required visit is the initiating visit, which is only required for new patients or patients not seen within a year of commencement of BHI services, and could be furnished

the preceding calendar month. For CoCM, the behavioral health care manager must be available to provide his or her services face-to-face service with the beneficiary as needed, but there is no other requirement for in-person care.

16. Is written consent required?

Prior beneficiary consent is required for all of the BHI codes, recognizing that any applicable rules continue to apply regarding privacy. The consent will include permission to consult with relevant specialists, including a psychiatric consultant, and inform the beneficiary that cost sharing will apply to in-person and non-face-to-face services provided. Consent may be verbal (written consent is not required) but must be documented in the medical record.

17. Is a new patient consent form required each calendar month or annually?

No, a new consent is only required if the patient changes billing practitioners, in which case a new consent must be obtained and documented by the new billing practitioner prior to furnishing the service.

18. What services qualify as a BHI initiating visit?

For new patients or patients not seen within a year prior to the commencement of BHI services, BHI must be initiated by the billing practitioner during a "comprehensive" Evaluation & Management (E/M) visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). This face-to-face visit is not part of the BHI service and can be separately billed under the PFS, but is required before BHI services can be provided. The billing practitioner must discuss BHI with the patient at this visit. While informed patient consent does not have to be obtained during this visit, it is an opportunity to obtain the required consent. The face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) qualifies as a "comprehensive" visit for BHI initiation. Levels 2 through 5 E/M visits (CPT codes 99202-99205 and 99212-99215) also qualify; CMS is not requiring the practice to initiate BHI during a level 4 or 5 E/M visit. However CPT codes that do not involve a face-to-face visit by the billing practitioner or are not separately payable by Medicare (such as CPT code 99211, anticoagulant management, online services, telephone and other E/M services) do not meet the requirement for the visit that must occur before BHI services are furnished. If the practitioner furnishes a "comprehensive" E/M, AWV, or IPPE and does not discuss BHI with the patient at that visit, that visit cannot count as the initiating visit for BHI.

19. Why is there cost sharing for BHI? Does CMS have any mechanism for removing the cost sharing to encourage patient engagement?

Part B cost sharing applies to the services described by the BHI codes, consistent with statutory requirements. .

20. **Will Medigap cover the beneficiary cost sharing for BHI?**

Yes. If services are covered under Medicare Part B, Medigap insurers do not have authority to deny the coinsurance, copayments or other benefits that are payable on behalf of the beneficiary under the provisions of the Medigap insurance contract. Private insurers providing standardized Medigap plans agree to accept a notice of Medicare payment as a claim for the payment of benefits under the Medigap plan, unless the Medigap policy itself has a deductible that has not yet been met (e.g., high deductible Plan F).

21. Will Medicaid cover the beneficiary cost sharing for BHI for dually eligible beneficiaries?

CMS wishes to ensure that Medicare-Medicaid dually eligible beneficiaries have access to BHI services. The majority of dually eligible beneficiaries (approximately 64%, or 7 of the 11.4 million dually eligible beneficiaries) are Qualified Medicare Beneficiaries who will not be responsible for BHI cost sharing. For Qualified Medicare Beneficiaries, Medicaid is responsible for deductibles/co-insurance for Medicare services, including these services, even if the services are not covered in the State Plan. However, as permitted by federal statute, most states limit payment of Medicare cost-sharing to the "lesser-of" Medicaid or Medicare rates. If the service is not covered in the State plan, States can set other reasonable payment limits, approved by CMS, for the service. In states where there would be coverage of some or all of the beneficiary cost-sharing, providers need to be enrolled as Medicaid providers to be paid for the Medicare-cost-sharing; however, Medicare automatically "crosses over" claims to states for dual eligible beneficiaries, so providers need not submit their own bill.

22. Do the BHI codes allow for BHI furnished via telehealth?

The BHI codes allow for remote provision of certain services by the psychiatric consultant and other members of the care team. For CoCM, the behavioral health care manager must be available to provide face-to-face services in person, but provision of face-to-face services is not required. The BHI codes do not describe services that are subject to the rules for Medicare telehealth services in the narrow meaning of the term (under section 1834(m) of the Social Security Act).

23. Does there have to be an ICD 10 diagnosis of a mental health condition to bill for the BHI services or can a referral be made based on identified risk factors to rule out a mental health condition?

The BHI services require that there must be a presenting psychiatric or behavioral health condition that, in the clinical judgment of the treating physician or other qualified health professional, warrants "referral" to the behavioral health care manager for further assessment and treatment through provision of psychiatric CoCM services or General BHI.

24. Can addiction specialists serve as the consulting physician in furnishing CoCM?

In cases where a substance use disorder is being treated, medical professionals who specialize in addiction medicine and are qualified to prescribe the full range of medications may function in the consultant role, for purposes of meeting the billing requirements for the CoCM services.

25. Where can I find more guidance on BHI payment provisions?

A Fact Sheet and other materials on BHI will be available on the CMS website on the Physician Fee Schedule (PFS) page under the "Care Management" hyperlink at (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/). The governing regulation for BHI is the CY 2017 PFS final rule, which is also available on the CMS Physician Fee Schedule web page.

18. AIMS Medicare Payments Cheat Sheet

Cheat Sheet on Medicare Payments for Behavioral Health Integration Services

Updated: April 4, 2019

Medicare pays for services provided to patients receiving collaborative care services (CoCM) or other behavioral health integration (BHI) services. The payment structure may be used for patients with any behavioral health condition being addressed by the treating provider, including substance use disorders.

The codes described below are not billable by Federally Qualified Health Centers or Rural Health Clinics. For information on BHI codes for FQHC and RHC practices; see http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs.

Useful online resources describing the CMS Medicare codes include the following:

- *Fact Sheet*: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
- *FAQ*: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf

The codes for the Collaborative Care Model (CoCM) are billed under the treating medical provider. Minutes counted towards the time threshold are those of the behavioral health care manager only. Valuation of the codes includes the time of the psychiatric consultant and treating medical provider who bill usual codes for any E/M or evaluation services.

99492– First 70 minutes in the first calendar month for behavioral health care manager activities. Must include:

- Outreach and engagement of patients;
- Initial assessment, including administration of validated scales and resulting in a treatment plan;
- Review by psychiatric consultant and modifications, if recommended;
- Entering patients into a registry and tracking patient follow-up and progress, and participation in weekly caseload review with psychiatric consultant; and
- Provision of brief interventions using evidence-based treatments such as behavioral activation, problem solving treatment, and other focused treatment activities.

99493– First 60 minutes in a subsequent month for behavioral health care manager activities. Must include:

- Tracking patient follow-up and progress;
- Participation in weekly caseload review with psychiatric consultant;
- Ongoing collaboration and coordination with treating providers;
- Ongoing review by psychiatric consultant and modifications based on recommendations;
- Provision of brief interventions using evidence based treatments;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning and preparation for discharge from active treatment.

99494– Each additional 30 minutes in a calendar month of behavioral health care manager activities listed above.

- Listed separately and used in conjunction with 99492 and 99493.
- MUE limit of 2 add-ons each month.

Payment for General Behavioral Health Integration Services
CMS provides a separate payment for behavioral health integration services that are delivered outside of the CoCM benefit. A behavioral health care manager with formal or specialized education is not required. CMS rules allow "clinical staff" to provide these services using the same definition as applied under the Chronic Care Management benefit.

99484– Care management services for behavioral health conditions - At least 20 minutes of clinical staff time per calendar month. Must include:

- Initial assessment or follow-up monitoring, including 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; and
- Continuity of care with a designated member of the care team.

Medicare CPT Payment Summary 2019*

CPT	Description	Payment/Pt (Non-Facilities) Primary Care Settings	Payment/Pt (Fac) Hospitals and Facilities
99492	Initial psych care mgmt, 70 min/month - CoCM	$162.18	$90.46
99493	Subsequent psych care mgmt, 60 min/month - CoCM	$129.38	$81.81
99494	Initial/subsequent psych care mgmt, additional 30 min CoCM	$67.03	$43.97
99484	Care mgmt. services, min 20 min – General BHI Services	$48.65	$32.80

**Please note actual payment rates may vary. Check with your billing/finance department.*

Initiating Visit, Consent, and Co-Payments
An initiating visit is required prior to billing for the 99492, 99493, 99494, and 99484 codes. This visit is required for new patients and for those who have not been seen within the year prior to commencement of integrated behavioral health services. This visit will include the treating provider establishing a relationship with the patient, assessing the patient prior to referral, and obtaining broad beneficiary consent to consult with specialists that can be verbally obtained but must be documented in the medical record. Medicare beneficiaries are responsible for any applicable Part B co-insurance for these billing codes.

Behavioral Health Care Manager Qualifications
The behavioral health care manager must have formal education or specialized training in behavioral health, which could include a range of disciplines including social work, nursing, and psychology, but need not be licensed to bill traditional psychotherapy codes.

Provision of Psychotherapy and Psychiatric Services in Addition to Psychiatric CoCM
Behavioral health care managers qualified to bill traditional psychiatric evaluation and therapy codes for Medicare recipients may bill for additional psychiatric services in the same month. However, time spent on these activities for services reported separately may not be included in the services reported using time applied to 99492, 99493, 99494, or 99484.

19. AIMS Creating a Clinical Workflow

Create a Clinical Workflow

It's important to know how your team will function the moment a patient walks through the door, including protocols for suicidal patients and patients in crisis. Planning and creating a clinical flow that shows the exact process of what happens when a patient comes to the clinic ensures that no patient falls through the cracks. Mapping a patient's care experience -- from identifying a behavioral health care need to initiating treatment to communicating treatment adjustments -- gives a framework for knowing the next step of care.

Implementation Resources

1. The Planning Team, led by the Implementation Leader [1], should systematically review the results from the Build Your Team [2] section in order to plan for implementation changes and to document these plans. Discussion should center on gaps, duplication, needed training, and/or re-assignments in the context of the “practical ideal” you are striving for to provide the most effective care for your patients.

2. Next, the Planning Team should fill out a Clinical Workflow Plan [3]. For each task—or set of tasks as shown in the worksheet—document who, how, when, and where the task will be completed as part of your implementation plan. This worksheet documents your current situation plus your plans for change and will help you:

- Document how each collaborative care task will be changed/accomplished, including plans for smooth hand-offs and communication methods.
- Document when a task is completed, in terms of patient flow (e.g., intake, initial assessment).
- Document where the task will be completed. At the clinic? At a partner agency? Through an external referral?
- Assess whether organizational-level changes ar necessary. Staff training needs? Staff hires? Other needs? Additional supervision?

3. Using the completed Clinical Workflow Plan, the Planning Team should now create a **clinical flowchart** showing the exact process of what happens when a patient comes to the clinic. Include a protocol for psychiatric emergencies [4] (e.g., suicidal), and pay particular attention to communication among team members (e.g., ensuring recommendations from psychiatric consultant are communicated to primary care provider, providing tools [5] to the primary care provider to ensure patients are referred to the correct team members). Every clinic's flowchart will be unique and there is no right way or wrong way to ensure Collaborative Care tasks get done.

Source URL: https://aims.uw.edu/collaborative-care/implementation-guide/plan-clinical-practice-change/create-clinical-workflow

Links
[1] http://aims.uw.edu/collaborative-care/implementation-guide/lay-foundation/identify-your-champions
[2] http://aims.uw.edu/collaborative-care/implementation-guide/plan-clinical-practice-change/build-your-team
[3] http://aims.uw.edu/resource-library/clinical-workflow-plan
[4] http://aims.uw.edu/resource-library/psychiatric-emergency-management-resources
[5] http://aims.uw.edu/resource-library/example-pocket-provider-tool

/

20. AIMS Team Building & Workflow Guide

STEP 3: TEAM BUILDING & WORKFLOW GUIDE Clinical Workflow Plan

IDENTIFY AND ENGAGE PATIENTS				
COLLABORATIVE CARE TASKS	WHO Name / Discipline	HOW Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	WHEN In terms of patient flow and time constraints	WHERE Clinic? Partner agency? Through an external referral?
Identify People Who May Need Help				
Screen for Behavioral Health Problems Using Valid Measures				
Diagnose Behavioral Health Disorders				
Engage Patient in Collaborative Care Program and Introduce Care Team				
Needed Organization-Level Changes ☐ Staff Hires ☐ Staff Training ☐ Clinical Supervision ☐ Administrative Supervision ☐ Other Resources needed	Notes:			

INITIATE AND PROVIDE TREATMENT				
COLLABORATIVE CARE TASKS	WHO Name / Discipline	HOW Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	WHEN In terms of patient flow and time constraints	WHERE Clinic? Partner agency? Through an external referral?
Perform Behavioral Health Assessment				
Develop & Update Behavioral Health Treatment Plan				
Patient Education about Symptoms & Treatment Options				
Prescribe Psychotropic Medications				
Patient Education about Medications & Side Effects				
Brief Counseling, Activity Scheduling, Behavioral Activation				
Evidence-based Psychotherapy (e.g., PST, CBT, IPT)				

INITIATE AND PROVIDE TREATMENT (CONTINUED)				
COLLABORATIVE CARE TASKS	WHO Name / Discipline	HOW Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	WHEN In terms of patient flow and time constraints	WHERE Clinic? Partner agency? Through an external referral?
Identify & Treat Coexisting Medical Conditions				
Facilitate Referral to Specialty Care or Social Services				
Create & Support Relapse Prevention Plan				
Needed Organization-Level Changes ☐ Staff Hires ☐ Staff Training ☐ Clinical Supervision ☐ Administrative Supervision ☐ Other Resources needed	Notes:			

TRACK TREATMENT OUTCOMES				
COLLABORATIVE CARE TASKS	WHO Name / Discipline	HOW Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	WHEN In terms of patient flow and time constraints	WHERE Clinic? Partner agency? Through an external referral?
Track Treatment Engagement & Adherence using Registry				
Reach out to Patients who are Non-adherent or Disengaged				
Track Patients' Symptoms with Measurement Tool (e.g., PHQ-9)				
Track Medication Side Effects & Concerns				
Track Outcome of Referrals & Other Treatments				
Needed Organization-Level Changes ☐ Staff Hires ☐ Staff Training ☐ Clinical Supervision ☐ Administrative Supervision ☐ Other Resources needed	Notes:			

PROACTIVELY ADJUST TREATMENT IF PATIENTS ARE NOT RESPONDING				
COLLABORATIVE CARE TASKS	WHO Name / Discipline	HOW Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	WHEN In terms of patient flow and time constraints	WHERE Clinic? Partner agency? Through an external referral?
Assess Need for Changes in Treatment				
Facilitate Changes in Treatment / Treatment Plan				
Provide Caseload-Focused Psychiatric Consultation				
Provide In-Person Psychiatric Assessment of Challenging Patients				
Needed Organization-Level Changes ☐ Staff Hires ☐ Staff Training ☐ Clinical Supervision ☐ Administrative Supervision ☐ Other Resources needed	Notes:			

OTHER TASKS IMPORTANT FOR OUR PROGRAM (ADD AS NEEDED)				
COLLABORATIVE CARE TASKS	WHO Name / Discipline	HOW Process (Including Hand-offs) & Communication Methods (e.g., telephone, mail)	WHEN In terms of patient flow and time constraints	WHERE Clinic? Partner agency? Through an external referral?
Coordinate Communication Among Team Members / Providers				
Administrative Support for Program (e.g., Scheduling, Resources)				
Clinical Supervision for Program				
Training of Team Members in Behavioral Health				
Needed Organization-Level Changes ☐ Staff Hires ☐ Staff Training ☐ Clinical Supervision ☐ Administrative Supervision ☐ Other Resources needed	Notes:			

21. EPIC Care Coordination Intake Template

@SUBJECTIVEBEGIN@

REASON FOR VISIT

Integrated Behavioral Health (IBH) Care Coordination **Enrollment**

HISTORY OF PRESENT ILLNESS

@PREFERREDNAME@ is a @age@ @sex@, with a history of *** who is referred to IBH Care Coordination for ***.

Primary symptoms of concern: ***

Current stressors: ***

The following patient reported outcomes were completed:

{IBH Reported Outcomes:71872}

Current psychiatric pharmacological interventions: ***
Current nonpharmacological interventions: ***
Current psychotherapist: ***
Current psychiatric prescribing provider: ***

Suicidal Ideations: ***
Non-suicidal self-injury: ***
Homicidal ideations: ***
Access to firearms: ***

Sleep: ***
Pain interference: ***

PAST MEDICAL HISTORY

Medical History: ***

@LASTTSH@

Mental Health History: ***

Past medication trials: ***
Mental Health Hospitalizations: ***
Mental Health ED Visits: ***

Past psychotherapists: ***
Past psychiatric prescribing provider: ***
Past ECT/TMS/Ketamine: ***
Genomic testing: ***

Past suicide attempts: ***
Past non-suicidal self-injury: ***

Past homicidal ideations: ***

FAMILY HISTORY

***

SOCIAL HISTORY

***
History of trauma/abuse/neglect: ***
Learning: ***
Military history: ***
Legal history: ***

Current support: ***
Patient reports the following leisure activities: ***
Patient reports the following stress reductions activities: ***

Social Determinants of Health:
{SDOH assessment:78746}

Substance abuse: ***
Nicotine use: ***
Supplement use: ***
Caffeine use: ***
Physical activity: ***

Past chemical dependency treatments: ***

@ASSESSMENTPLANBEGIN@

The following program goals were identified:

Patient goals for care coordination:

1. ***

Healthcare team goals for care coordination:

1. ***

Referrals: {IBH CC referrals:73568}

Next contact: {numbers 0-10:5044} {DAYS/WEEKS/MONTHS:21172} by {MC AMB HP NEXT CONTACT TYPE:39416}.

Discussion items for next contact include ***.

The following emergency resources were reviewed with the patient: {MC CARE COORD MH RESOURCES:43699}.

The {Persons; family members:60370} was instructed to contact the care coordinator with any questions or concerns and stated understanding of the information provided.

{Complete all 4 sections if encounter is over the phone (Optional):71765}

RECOMMENDATIONS

Please see associated supervising psychiatrist note for additional recommendations for consideration by the Primary Care Provider.

22. SBAR Care Review Tool

Mi-CCSI Center for Clinical Systems Improvement

SBAR Case Review Tool

Patient Name: Date: PCP:

Situation (brief, 2 sentences)

Age Race Care Management start:

Main Care concern(s) (behavioral/medical/physical:

Background

Tobacco/Substance use:
Diagnoses:
Living situation/support system:
Health Literacy:
Adherence barriers/concerns:
Key leverage point: (pt. values/strengths etc…)

PHQ(9) latest:
BP latest:
A1c latest:
LDL latest:
HF Classification/EF:
MMSE latest:
eGFR

PHQ(9) previous:
BP previous:
A1c previous:
LDL previous:

Other Provider specific information:

Medications:

Allergies and Medications tried:

Imaging:

Consultants:

Assessment

Successes: Challenges: Prioritize care issues:

Recommendations

Behavioral:

Medical:

23. Implementation Breakout Session Questions

Implementation Breakout

- Review the checklist and look for your areas of opportunity
- Where are you most nervous about implementation?
- What additional training and supports are needed to get started

**See AIMS Team Member Self-Assessment Form