FAQs

Coordination of Health Care Exchange of Information

For DBHDD-Certified Behavioral Health Providers

What is coordination of care? Is coordination of care a reimbursable service?
CareSource reimburses Department of Behavioral Health and Disabilities (DBHDD) certified behavioral health providers for appropriate coordination of care between behavioral health (BH) providers and the member's primary care provider (PCP) and/or specialist provider quarterly/four times per year. DBHDD-certified BH providers may bill CPT code G9001 for the coordination of care for all CareSource Medicaid members. The provider group can bill this code once a quarter per member for a $25 reimbursement.

Is consent needed to coordinate care?
Yes, BH providers must receive written consent from the member or the member's parent/guardian to coordinate care. This process can be a part of the already established consent paperwork during intake to BH services.

What if the member does not give consent?
It is important to share the importance of coordination of care, but if a member chooses to refuse consent and the provider continues with treatment and without coordination of care taking place, the coordinated care code cannot be billed.

Is it a HIPAA violation to send this information to the PCP and/or specialist?
To ensure HIPAA compliance, BH providers must receive written consent from the member or the member's parent/guardian to coordinate care. This process can be a part of the already established consent paperwork during intake to BH services.

What if the member does not have a traditional PCP?
In an effort to ensure coordination of care, if a member does not have a PCP, this is an opportunity for BH providers to facilitate helping the member identify a PCP. During the assessment phase, if the member identifies having a specialist as his or her PCP, coordination of care is encouraged to be completed with the specialist. Our case managers are available to assist with this process if necessary.

How does the provider show proof of coordinated care to bill G9001?
Providers are responsible for maintaining documentation within each member's health record as an attestation of coordination of care when utilizing this benefit. The method of documentation is at the discretion of the provider and may include something already accounted for via internal processes (i.e., notation in a progress note, proof of medical record transmission). CareSource may ask providers to demonstrate this documentation via submission of medical records for audit.

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Who can bill G9001?
Any provider within the provider group may document coordination of care, including those who do not have clinical credentials. As such, the G9001 code does not have a modifier when being billed.

How often can I bill G9001?
The code can be billed for all CareSource Georgia Families (Medicaid and Peachcare for Kids) members once per quarter, per provider group (e.g., if multiple therapists within the same group practice are seeing a member, the group practice can only bill once a quarter for coordinated care for that member).