

NETWORK Notification

Notice Date:January 1, 2024To:Indiana Medicaid ProvidersFrom:CareSourceSubject:Collaborative Care Model Services ReimbursementEffective Date:January 1, 2024

Summary

Beginning Jan. 1, 2024, CareSource will provide reimbursement for a model of integrated behavioral health care known as the **Collaborative Care Model (CoCM)**. The Collaborative Care Model (CoCM) is a specific type of integrated care developed by the University of Washington to treat common health conditions in medical settings like primary care. Behavioral health conditions such as depression, anxiety, post-traumatic stress disorder (PTSD), alcohol, or substances use disorders are among the most common and disabling health conditions worldwide. Based on *principles of effective chronic illness care*, CoCM focuses on defined patient populations who are tracked in a registry to monitor treatment progression. The treatment plan focuses on *measurement-based treatment to target* and ensure the patient's goals and clinical outcomes are met.

About the Model

The CoCM is driven by a collaborative care team, led by a primary medical provider (PMP) in coordination with behavioral health care managers, psychiatrists, and other mental health professionals. The team initiates a measurement-guided care plan using evidence-based practice guidelines and focuses attention primarily on patients not meeting their clinical goals.

The Elements of CoCM

- Patient-centered care team
- Population-based care
- Measurement-based treatment to target
- Evidence-based care

Members of the CoCM Team

- **Treating/Billing Practitioner** Primary medical provider or non-physician practitioner (physician assistant or nurse practitioner)
- Behavioral Health Care Manager Provider with formal education or special training in behavioral health which may include social work, nursing or psychology, working under the oversight and direction of the treating practitioner
- Psychiatric Consultant Medical provider trained in psychiatry and qualified to prescribe medications
- Patient The patient is a member of the care team

Importance of the Model

The CoCM model has been shown to:

- Improve medication adherence
- Decrease hypertension
- Improve hemoglobin A1c
- Increase the number of depression-free days

Patients treated in the CoCM model report:

- Greater satisfaction
- Improved quality of life
- Improved physical functioning more than usual care

There are multiple benefits of the CoCM, including:

- Improved quality of care leading to improved health outcomes
- Increased access to care, improving convenience for patients
- Reduced cost due to data sharing between providers
- Reduced waste and redundant spending

Implementing the Model

Coding for Psychiatric Collaborative Care

- 99492 Initial psychiatric collaborative care management, first 70 minutes in the first calendar month; this is a code in which minutes are cumulative over the month and represent minutes from the BH care manager, psychiatrist, and PMP
- 99493 Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities
- 99494 Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month
- G2214 Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified healthcare professional

Note: CoCM should be billed on an HCFA 1500 and not combined with non-CoCM codes.

Resources

To learn more about the CoCM, please visit the <u>University of Washington Advancing Integrated Mental</u> <u>Health Solutions (AIMS) Center Collaborative Care</u> website.

Questions?

For questions, please contact CareSource Provider Services at: **1-844-607-2831** Monday through Friday, 8 a.m. to 8 p.m. Eastern Time. Providers can also email questions directly to the Behavioral Health clinical inbox at Indiana BH@caresource.com.

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