This drafted Medicaid medical policy is open for a two-week public comment period. This box is not part of the drafted policy language itself and is intended for use only during the comment period to provide readers with a summary of the new policy.

As mandated by Senate Bill 672, 87th Legislature, Regular Session, 2021, HHSC is publishing a draft of the new Medicaid medical policy for the Collaborative Care Model for Medicaid recipients of all ages with a mental health and/or substance use condition.

The following is a summary of the scope for this policy review:

- Described Benefit
- Described Eligibility Requirements
- Described Prior Authorization and Documentation Requirements
- Described Reimbursement and Billing Guidelines
- Identified Exclusions

Collaborative Care Model

Statement of Benefits

Description of Collaborative Care Model

1. The Collaborative Care Model (CoCM) is a systematic approach to the treatment of behavioral health conditions (mental health and/or substance use) in primary care settings. The model integrates the services of behavioral health care managers (BHCMs) and consulting psychiatrists with primary care provider (PCP) oversight to proactively manage behavioral health conditions as chronic diseases, rather than treating acute symptoms.

2. CoCM services are benefits of Texas Medicaid for persons of all ages who have a mental health and/or substance use condition to include a pre-existing or suspected mental health or substance use condition, as determined by the PCP, i.e. physician, physician assistant or nurse practitioner.

3. CoCM services must be provided under the direction of the PCP and are benefits when provided in an office, outpatient hospital, inpatient hospital, skilled nursing facility or intermediate care facility, extended care facility or other locations.

4. An episode of care of CoCM services begins when the person receiving services is referred by the PCP to the BHCM for CoCM services, and ends after 12 calendar months (initial calendar month plus 11 subsequent calendar months) of services or earlier if treatment goals are met. A new episode of care must be initiated if/when:

4.1 The person receiving services is referred to a psychiatric provider for ongoing treatment of the behavioral health condition; or

4.2 There is a break in services, which is defined as no CoCM services provided for six consecutive calendar months.

5. CoCM services are individually delivered, time-based, monthly services that include outreach and engagement, completing an initial assessment, developing an individualized and person-centered plan of care, monitoring and tracking a person’s progress using a registry, providing brief interventions and other focused treatments, and conducting weekly caseload reviews with the psychiatric consultant.

5.1 Initial CoCM services (procedure code 99492) are those BHCM activities provided to the person receiving services in the first calendar month of services. Initial CoCM services, using procedure code 99492, must include the following elements and be documented in the electronic medical record (EMR) or electronic health record (EHR) for reimbursement:

5.1.1 Conducting outreach to and engagement of the person needing services, directed by the PCP;

5.1.2 Completion of an initial assessment to include administration of a validated rating scale;

5.1.3 Development of a person-centered plan of care that is reviewed and modified, as needed, by the psychiatric consultant;

5.1.4 Monitoring progress and updating the person-centered plan of care, as needed;

5.1.5 Entering information into the registry and tracking follow-up activities and progress via the registry with appropriate documentation;

5.1.6 Participating in weekly caseload consultation meetings with the psychiatric consultant; and

5.1.7 Providing evidenced-based brief interventions, such as motivational interviewing or other focused strategies.

5.2 Subsequent CoCM services (procedure code 99493) are those BHCM activities provided to the person receiving services in the months following the first calendar month of services.

5.3 Initial or subsequent CoCM services (procedure code G2214) are those BHCM activities provided to the person receiving services in the first or subsequent calendar month/s of services.

5.4 Procedure codes 99493 and G2214 must include the following elements and be documented in the EMR or EHR for reimbursement:

5.4.1 Tracking follow-up activities and progress of the person receiving services via the registry with appropriate documentation;

5.4.2 Participating in weekly caseload consultation meetings with the psychiatric consultant;

5.4.3 Ongoing collaboration and coordination with/of the person’s care/treatment with the PCP and/or other treating mental health providers;

5.4.4 Reviewing progress and recommendations from the psychiatric consultant for changes in treatment to include modifications to the medication regimen;

5.4.5 Providing evidenced-based brief interventions;

5.4.6 Monitoring clinical outcomes using a validated rating scale; and

5.4.7 Planning for relapse prevention as the person receiving services prepares for discharge from services.

CoCM Team Member Qualifications and Responsibilities

6. The PCP must be a physician, to include specialists, such as a cardiologist, oncologist, etc., physician assistant or nurse practitioner that has an established CoCM program. The PCP:

6.1 Directs the BHCM and other clinical staff;

6.2 Oversees the care of the person receiving services to include prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed; and

6.3 Remains actively involved in the care and treatment of the person receiving services via continuous oversight, management, collaboration and reassessment.

7. The BHCM must be credentialed as a Qualified Mental Health Professional-Community Services (QMHP-CS), as defined in Title 1 Texas Administrative Code (TAC) §353.1415. The BHCM works under the oversight and direction of the PCP and provides care management services, in consultation with the psychiatric consultant, to include:

7.1 Completion of an initial assessment;

7.2 Administration of a validated rating scale;

7.3 Development of a person-centered plan of care;

7.4 Provision of evidenced-based brief interventions;

7.5 Ongoing collaboration with the PCP; and

7.6 Maintenance of the registry.

8. The BHCM must:

8.1 Be available to provide CoCM services in person when needed;

8.2 Maintain a continuous relationship with the person receiving CoCM services; and

8.3 Be able to engage the person receiving CoCM services outside of regular office hours, as needed, to perform CoCM duties.

Note: *BHCM activities may be provided in person, face-to-face (synchronous audiovisual technology) or audio only, as clinically appropriate.*

9. The psychiatric consultant must be a physician who is trained in psychiatry and qualified to prescribe the full range of medications. The psychiatric consultant advises and makes recommendations, either directly to the PCP or via the BHCM, regarding psychiatric and other medical care to include:

9.1 Psychiatric and other medical diagnoses;

9.2 Treatment strategies to include appropriate therapies, medication management, and medical management of complications associated with treatment of psychiatric disorders; and

9.3 Referral for specialty services.

10. The psychiatric consultant typically does not meet with the person receiving services, or prescribe medications, but must be able to do so when needed. The psychiatric consultant must also facilitate referrals to a psychiatric care provider when clinically appropriate. Psychiatric consultation must occur at least weekly either in person, face-to-face (synchronous audiovisual technology) or audio only.

Prior Authorization/Authorization Requirements

Electronic Signature Language

11. Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. The electronic signature technology must meet all applicable federal and state statutes and administrative rules. Electronically-signed documents must have an electronic date on the same page as the signature, Electronic signatures that are generated through an electronic medical record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are acceptable. All electronically-signed transactions and electronically-signed documents must be kept in the client's medical record. Prescribing and dispensing providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules. Providers who submit a prior authorization request must also attest that electronic signatures included in the request are true and correct to the best of

their knowledge. A hard copy of electronic transactions and signed documents must be available upon request. Stamped signatures and images of wet signatures will not be accepted. Prescribing or ordering providers, dispensing providers, responsible adults of persons receiving services, and persons receiving services may sign prior authorization forms and supporting documentation using electronic or wet signatures.

12. To complete the prior authorization process by paper, the provider must fax or mail the completed prior authorization request form to the TMHP Prior Authorization Department and retain a copy of the signed and dated prior authorization form in the person's medical record.

13. To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated prior authorization form in the person's medical record.

14. To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity for the services requested. The physician must maintain documentation of medical necessity in the person's medical record.

15. The requesting provider may be asked for additional information to clarify or complete a request.

16. Retrospective review may be performed to ensure documentation supports the medical necessity of the requested services.

Prior Authorization Not Required

17. Prior authorization is not required for the first six calendar months (initial month and five subsequent months) of CoCM services.

Prior Authorization Required

18. Prior authorization is required for an additional six calendar months (beyond the first six calendar months) of CoCM services.

Note: *Prior authorization is a condition of reimbursement, not a guarantee of payment.*

19. Prior authorization requests are considered on a case-by-case basis with documentation supporting medical necessity for an additional six calendar months of CoCM services. Requests must be received prior to the last day of the sixth calendar month of services. The documentation must demonstrate

the person receiving services continues to meet eligibility criteria, as outlined in the Statement of Benefits section above, and include the following:

19.1 The current person-centered recovery plan and goals/objectives; and

19.2 Progress made relative to the goals and objectives outlined in the person-centered recovery plan.

20. Requests must be submitted by the PCP to the Special Medical Prior Authorization (SMPA) department using the Special Medical Prior Authorization (SMPA) Request Form. The form must be signed and dated within 30 calendar days prior to the start of an additional six calendar months of CoCM services, and must include the following information:

20.1 Identifying information for the person receiving services

20.2 Provider information

20.3 Service and procedure code information

20.4 Expected dates of service

20.5 Diagnosis or diagnoses

20.6 Medical necessity information

Note: *A nurse practitioner and physician assistant may sign all documentation related to the provision of CoCM services on behalf of the physician when the physician delegates this authority to the nurse practitioner or physician assistant.*

21. PCPs are required to adhere to prior authorization requirements.

Documentation Requirements

22. Prior to receiving CoCM services, the PCP must obtain verbal or written consent from the person being referred for CoCM services to consult with the psychiatric consultant and other relevant specialists. A new consent is not required for each subsequent calendar month of services or annually unless the person receiving services changes PCPs. If the person receiving services changes PCPs, then a new verbal or written consent must be obtained and documented by the new PCP prior to the provision of CoCM services. Informed consent must be documented in the EMR or EHR.

23. PCPs must use a registry, that is used jointly with the EMR or EHR of the practice, to track clinical outcomes.

24. All elements for the procedure code being billed (99492, 99493 or G2214), as described in the Statement of Benefits section, must be documented in the

registry for reimbursement. In addition, documentation must also include the following:

24.1 The initial assessment and any subsequent assessments;

24.2 The validated rating scale, or scales, used to include results; and

24.3 All versions of the individualized, person-centered plan of care. The person-centered plan of care must:

24.3.1 Identify the goals of treatment;

24.3.2 Indicate progress of the person receiving services towards their goals; and

24.3.3 Include any modifications to care and treatment.

25. All services outlined in this policy are subject to retrospective review to ensure that the documentation in the person's medical record supports the medical necessity of the service(s) provided.

Reimbursement/Billing Guidelines

26. CoCM services are time-based and reported as the total amount of time the BHCM spends engaging in clinical activities over the course of a calendar month.

27. Only the PCP may submit claims for CoCM services. The BHCM and psychiatric consultant are reimbursed by the PCP via a contract, employment or other arrangement.

28. To be reimbursed for CoCM services, the PCP must meet the following core components:

28.1 Provide active treatment and care management for an identified population;

28.2 Use a registry to monitor treatment and outcomes, and to conduct psychiatric caseload reviews.

29. The PCP must use procedure codes 99492, 99493, 99494*, or G2214 to bill for monthly CoCM services in all settings. The PCP must also use the place of service code for the location where services would normally be provided for in person care/treatment.

Note: *Add-on procedure codes indicated with asterisk must be billed with the appropriate primary procedure code.*

30. CoCM services begin after the referral is made by the PCP and the BHCM starts engaging in reimbursable clinical activities, as described in the Statement of Benefits section.

31. The PCP must use the appropriate evaluation and management (E/M) code for the initial presenting visit with the person.

32. All required elements of the procedure codes, as described in this policy, must be performed and documented, and time thresholds met, to be reimbursed for services.

33. The PCP must use procedure code 99492 for the first 70 minutes accrued during the initial calendar month of BHCM activities, in consultation with the psychiatric consultant.

34. The PCP must use procedure code 99493 for the first 60 minutes accrued during each subsequent month of BHCM activities, in consultation with the psychiatric consultant.

35. The PCP must use add-on procedure code 99494* for each additional 30 minutes accrued during the initial and/or subsequent month/s of BHCM activities, in consultation with the psychiatric consultant.

36. The PCP must use procedure code G2214 for the no more than 30 minutes accrued during an initial and/or subsequent month/s of BHCM activities, in consultation with the psychiatric consultant.

37. The PCP may not bill both G2214 and 99492 during the initial calendar month of services or G2214 and 99493 during any subsequent calendar month of services for the same person, same provider. See Table A below for information about time thresholds.

38. The BHCM may provide other outpatient mental health services, if eligible for reimbursement, in the same calendar month as CoCM services but those services are separate and distinct from CoCM services and do not count toward the time thresholds for CoCM services. Therefore, the BHCM must report separately those other mental health services that are delivered in the same calendar month as CoCM services.

39. The psychiatric consultant may provide evaluation and management (E/M) services and other outpatient mental health services, if eligible for reimbursement, in the same calendar month as CoCM consultation services but those services are separate and distinct from CoCM services and do not count toward the time thresholds for CoCM services. Therefore, the psychiatric consultant must report separately E/M or other mental health services that are delivered in the same calendar month as CoCM services.

Refer to: Section 4, "Outpatient Mental Health Services" of the ***Behavioral Health and Case Management Services Handbook*** (*Vol. 2, Provider Handbooks*), Subsection 9.2.56, "Physician Evaluation and Management (E/M) Services" of the ***Medical and Nursing Specialists, Physicians, and***

Physician Assistants Handbook (Vol. 2, Provider Handbooks), and Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (***Vol. 1, General Information***) for more information.

40. The following procedure codes may be reimbursed for CoCM services:

Table A: Procedure Codes Collaborative Care Model

Procedure Code	Procedure Description	Additional Information
1-99492	Initial month: First 70 minutes of services in the first calendar month of BHCM activities in consultation with the psychiatric consultant and directed by the PCP.	Billable at 36 minutes. Time threshold is 36 to 85 minutes. Administrative and/or clerical duties do not count towards the time threshold. May only be billed by the PCP during the initial calendar month of an episode of care. Code limited to one per initial calendar month, same person, same provider. May not be billed in subsequent months of services.
1-99493	Subsequent months: First 60 minutes of services in subsequent calendar months of BHCM activities in consultation with the psychiatric consultant and directed by the PCP.	Billable at 31 minutes. Time threshold is 31 to 75 minutes. Administrative and/or clerical duties do not count towards the time threshold. May only be billed by the PCP during subsequent calendar months of an episode of care. Code limited to one per subsequent calendar month, same person, same provider. May not be billed in the initial calendar month of services.

Procedure Code	Procedure Description	Additional Information
1-99494*	Additional 30 minutes of services: Initial or subsequent calendar months of BHCM activities in consultation with the psychiatric consultant and directed by the PCP.	Billable at 16 minutes, beyond total time, to 30 minutes. Administrative and/or clerical duties do not count towards the time threshold. May only be billed by the PCP during any calendar month (initial and/or subsequent) of an episode of care. Code limited to two per calendar month (initial and/or subsequent), same person, same provider. Add-on code must be billed with primary procedure code 99492 or 99493. May not be used with procedure code G2214.

Procedure Code	Procedure Description	Additional Information
1-G2214	Initial or subsequent months:30 minutes of BHCM activities in the first and/or subsequent calendar month/s in consultation with the psychiatric consultant and directed by the PCP.	Billable at 16 minutes. Time threshold is 16 to 30 minutes Administrative and/or clerical duties do not count towards the time threshold. May only be billed by the PCP during any calendar month (initial and/or subsequent) of an episode of care. Code limited to one per calendar month (initial and/or subsequent), same person, same provider. The PCP may not bill both G2214 and 99492 during the initial calendar month of services or G2214 and 99493 during any subsequent calendar month of services for the same person, same provider.

41. Procedure code 99492 is limited to one occurrence/unit in the initial calendar month of CoCM services, same person, same provider during an episode of care. Procedure code 99492 will be denied if billed during any subsequent month of CoCM services.

42. Procedure code 99493 is limited to one occurrence/unit per calendar month for all subsequent calendar months of CoCM services, same person, same provider during an episode of care. Procedure code 99493 will be denied if billed during the initial calendar month of CoCM services.

43. Procedure code 99494* is limited to two occurrences/units per calendar month (initial and/or subsequent) of CoCM services, same person, same provider during an episode of care. Procedure code 99494* will be denied if billed without primary procedure code 99492 or 99493 for the same person, same provider.

44. Procedure code G2214 is limited to one occurrence/unit per calendar month (initial and/or subsequent) of CoCM services, same person, same provider during an episode of care.

45. Procedure codes 99492, 99493, and G2214 will be denied if billed in the same calendar month of CoCM services, same person, same provider.

Exclusions

46. The following services are non-covered benefits of CoCM**:**

46.1 Administrative and/or clerical duties, except for entering information in the registry which is a required element of the procedure codes.