HFS
Illinois Department of
Healthcare and Family Services

# Psychiatric Collaborative Care Model Guidelines

## 1. Purpose

Pursuant to Public Act 101-0574, the Department of Healthcare and Family Services (HFS) is implementing coverage of Psychiatric Collaborative Care Model (CoCM) services in both the fee-for-service and managed care service delivery systems effective for dates of service on and after July 1, 2022. The goal of these services is to extend the capabilities of primary care practices to identify and treat customers with low to moderate behavioral health needs.

## 2. Psychiatric Collaborative Care Model Overview

CoCM is an evidence-based model for integrating behavioral health into primary care settings using a person-centered, team-based approach. The CoCM team is led by a primary care provider (PCP) and includes a behavioral health care manager (BHCM) and a psychiatric consultant. The team develops, implements, and regularly monitors a person-centered care plan, making referrals to specialized services when necessary. The model requires the use of validated screening tools and a patient registry, typically maintained by the BHCM, that is accessible to the PCP and psychiatric consultant. Five core principles define collaborative care and are necessary for an effective implementation of the model:

- **Person-centered care**: the customer is part of the treatment team and makes the ultimate decision regarding their treatment.
- **Measurement based treatment-to-target strategy**: validated tools are used for the measurement of customer symptoms and needs.
- **Population-based care**: the use of a patient registry to allow the team to monitor the customer's outcomes over time.
- **Evidence-based treatment**: treatments offered to customers are evidence-based (e.g., medications, brief interventions).
- **Accountable care**: the team is accountable for the customer's care, including the quality of care and clinical outcomes.

## 3. Coverage of CoCM

CoCM is a covered service for customers whose diagnosed behavioral health disorder requires systematic management, regular monitoring, and the provision of brief interventions to ameliorate their behavioral health symptoms. CoCM services must be recommended by the customer's PCP or treating physician and must be delivered consistent with the person-centered goals established on the customer's care plan.

CoCM is intended for customers with common behavioral health conditions that require systematic follow-up due to their persistent nature, including but not limited

to mild to moderate depression, anxiety, post-traumatic stress disorder (PTSD), and substance use disorders (SUD). Customers who need help engaging in treatment, have not responded to care delivered in a traditional primary care setting, or who require further assessment and engagement prior to consideration of a referral to more specialized behavioral health services may particularly benefit from CoCM services. These services are not intended to manage complex, severe, and/or persistent conditions which may require more specialized care from a Community Mental Health Center (CMHC), Behavioral Health Clinic (BHC), or licensed SUD provider.

**4. Service Components**

- An initial assessment conducted by the primary care team, inclusive of the administration of at least one validated measurement tool (e.g., PHQ-9 or GAD-7);
- Person-centered care planning done the primary care team jointly with the customer, with revisions as needed;
- Proactive, systematic follow-up conducted by the BHCM documented in a patient registry that includes an assessment of treatment adherence and clinical progress and the monthly administration of the validated measurement tool(s);
- Provision of brief evidence-based psychosocial interventions;
- Regular case load review with the psychiatric consultant; and,
- Referrals to specialty services and social services as needed.

CoCM services may be delivered face-to-face, by video, or phone; however, at least one face-to-face meeting is required every 90 days (a PCP visit can fulfill this requirement).

**5. CoCM Team Roles and Qualifications**

- **PCP**: a licensed physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) who is enrolled as a provider in the HFS Medical Programs. The PCP serves as the team lead and is responsible for:
  - Directing and supervising the BHCM;
  - Providing and directing the customer's behavioral and physical healthcare;
  - Prescribing and managing medications based on psychiatric consultant recommendations; and
  - Making referrals to specialty care as needed.

- **BHCM**: an individual who meets any of the following qualifications:
  - A bachelor's or master's degree in counseling and guidance, rehabilitation counseling, social work, education, vocational counseling, psychology, pastoral counseling, family therapy, or related human service field**;**
  - A bachelor's degree in any field with two years of documented, supervised clinical experience in a behavioral health setting; or
  - Registered Nurse (RN).

The BHCM must work under the direction and supervision of the PCP and is responsible for:

- Providing care management services;
- Customer engagement and education;
- Assessing customer needs;
- Developing, reviewing, and updating person-centered care plans;
- Administering validated screening tools (e.g., PHQ-9 or GAD-7) for each customer at least monthly;
- Delivering evidence-based brief interventions;
- Collaborating with team members, including facilitating communication between the PCP and the psychiatric consultant;
- Maintaining the patient registry;
- Consulting weekly with the psychiatric consultant; and,
- Facilitation of referrals to social services.

- **Psychiatric Consultant**: A licensed psychiatrist, an APN with a current certification in Psychiatric and Mental Health Nursing, or a licensed clinical psychologist (LCP) with the authority to prescribe medication pursuant to the Clinical Psychologist Licensing Act (225 ILCS 15). The psychiatric consultant is responsible for:
  - Consulting weekly with the BHCM on complex cases and customers who aren't improving as expected;
  - Recommending treatment strategies and medications, including changes based on the customer's status;
  - Recommending referral to specialty services when needed; and
  - Be available to consult with and advise the PCP as needed.

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.

## 6. Provider Enrollment Requirements

CoCM services are reimbursable to teams organized by a physician, advanced practice nurse, Federally Qualified Health Center (FQHCs), Rural Health Clinic (RHCs), Encounter Rate Clinic (ERC), local health department, and School-Based Health Clinic enrolled in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system as one of the Provider Type/Specialty/Subspecialty Combinations listed in Table 1 below.

**Table 1. CoCM IMPACT Provider Enrollment Guide**

| Enrollment Type | Provider Type | Legacy PT Code | Specialty | Subspecialty | Legacy COS | CoCM Billing Codes |
|---|---|---|---|---|---|---|
| Individual Sole Proprietor | Physician | 010 | Behavioral Health Integration | Collaborative Care | 001 | • 99492<br>• 99493<br>• 99494 |
| | Advanced Practice Nurse | 016 | APN Behavioral Health Integration | Collaborative Care | 001 | • 99492<br>• 99493<br>• 99494 |
| Rendering/ Servicing Provider | Physician Assistant | 089 | Physician Assistants | Collaborative Care | 001 | • 99492<br>• 99493<br>• 99494 |
| Facility, Agency, Organization (FAO) | Public Health Department | 052 | Certified Health Departments | Collaborative Care | 001 | • 99492<br>• 99493<br>• 99494 |
| | Clinic | 056 | School Based/Linked Health Clinic | Collaborative Care | 104 | • 99492<br>• 99493<br>• 99494 |
| | | 040 | Federally Qualified Health Center | Collaborative Care | 104 | • G0512 |
| | | 048 | Rural Health Clinic | Collaborative Care | 104 | • G0512 |
| | | 043 | Encounter Rate Clinic | Collaborative Care | 104 | • G0512 |

Providers must attest to providing CoCM services consistent with the core principles and the specific service delivery requirements outlined in this HFS Collaborative Care Model Guidelines document by completing and submitting the Attestation for Collaborative Care Model form. The attestation is required initially as part of the CoCM provider enrollment process and annually thereafter by October 1 of each calendar year.

## 7. Reimbursement

CoCM services are reimbursed as a bundled monthly payment based on the care management activities rendered by team members during a calendar month. Providers are expected to continue delivering medically necessary CoCM services during a given month, even after the time threshold to bill CoCM is met. However, after completion of the minimum staff time required to bill, providers may submit the claim and need not hold the claim until the end of the month.

CoCM services are billed under the National Provider Identifier (NPI) number of the PCP serving as team lead or of the entity employing the PCP serving as team lead. The PCP is responsible for reimbursing team members, who can be employees or contracted staff.

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, 99494, and G0512.

**Table 2. CoCM Covered Codes and Reimbursement Rates**

| CPT | Description | Unit Rate | Max Qty. |
|---|---|---|---|
| 99492 | First month of collaborative care, 70 minutes | $69.45 | 1 |
| 99493 | Subsequent months of collaborative care, 60 minutes | $76.30 | 1 |
| 99494 | Each additional 30 minutes of collaborative care | $31.10 | 2 |
| G0512* | Single monthly (inclusive of all time frames) rate for 60 minutes or more of collaborative care in Federally Qualified Health Clinic/Rural Health Clinic settings | $98.07 | 1 |

**CoCM services provided by a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Encounter Rate Clinic (ERC) do not qualify as an encounter. CoCM services, however, will be reimbursed outside of the Prospective Payment System. FQHCs, RHCs, and ERCs must use HCPCS code G0512 to report CoCM services.*

To avoid duplication of services, CoCM services should not be provided to:

- Customers receiving regular case management services as a component of a treatment plan from another provider;
- Customers enrolled in the Department's Pathways to Success program; or
- Customers receiving Assertive Community Treatment (ACT) services.

## 8. Resources

Additional information regarding the evidence-base behind CoCM and implementation resources for providers can be found on the AIMS Center Collaborative Care website through the University of Washington.