All About Billing!

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PERINATAL COLLABORATIVE CARE COLLECTIVE

Billing basics

Medicare, some state Medicaids, and most commercial insurances will reimburse for collaborative care (CC)

Includes Federally Qualified Health Centers (FHQCs) and Rural Health Clinics (RHCs)

Although it is more common in primary care, there is growing familiarity of these billing practices in OB – but crucial to check with insurance companies ahead of time to make sure they will reimburse for these codes when dropped by OBs

All time spent that is NOT patient-facing (chart review, case review in meetings, case management phone calls, etc.) can be billed with CC codes

Patient-facing time can also be billed with CC codes, but depending on your practice you may also have an option of traditional psych codes

Overview of CC billing

Unique billing through the medical, not behavioral health, insurance

Patient must consent to these services – can be verbal but must be documented in chart by billing provider

Uses time-based bundled codes submitted by the OB, NOT the behavioral health team

- Codes capture all time spent by both behavioral care manager (BHCM) and psychiatric consultant
- An option for both patient-facing and non-patient-facing
- Bill is dropped by the OB
- Billed as initial month and then subsequent months, no time limit

What is required to use CC codes?

Any behavioral health condition qualifies
Must use validated rating scales (measurement-based care) to track progress
Must have a registry, used as the basis of weekly case review
Interdisciplinary team must include an OB billing clinician (so physician or APP), the BHCM, and a psychiatric consultant
Must document time spent and have evidence of care delivered (notes)
Care must include evidence-based brief interventions such as behavioral activation, motivational interviewing, and other focused treatment strategies

How do I keep track of the time?

Different practices do this differently, some just keep track of time per patient on a spreadsheet or notepad

If you use EPIC, it is possible to built a time tracker into EPIC; this allows you to indicate the number of minutes spent on an activity each time, and EPIC then adds it up

For example, if you do a documentation encounter to document case discussion in a meeting or a care management phone call, the tracker will allow you to enter the number of minutes spent on each activity

Additional time that did not result in encounter notes can be captured in a monthly summary note

What are the core CPT codes to use?

***Remember, you can only bill if you use at least 50% + 1 minute of the time increment (i.e., 36 minutes for 99492 etc.)**

Code	Meaning
96160	Screening
99492	Initial month psychiatric care management, first 70 minutes
99493	Subsequent month psychiatric care management, first 60 minutes
99494	Additional 30 minutes for either initial or subsequent care management
G0512	Was used in place of 99492 and 99493 in FHQCs and RHCs; PHASED OUT AS OF JANUARY 1, 2026
99484	General care management for patients with behavioral health conditions, does not have to meet all elements of collaborative care, used for at least 20 mins of staff time
G0511	Was used in place of 99484 in FHQCs and RHCs; PHASED OUT AS OF JANUARY 1, 2026
96127	Brief emotional/behavioral assessment, can be billed for screening EPDS or PHQ-9
G0444	Depression screen for Medicare

Important Differences for FQHCs

FQHCs use the G codes instead of the numbered codes

They may be more restrictive in general

You HAVE to use the entire 70 mins or 60 mins or you cannot bill; the number codes allow you to bill if you spend at least 50% + 1 minute

There are no added increments, so you can't get reimbursed for more than 70 mins – so any patient-facing time should be billed with regular psych codes

What are the qualifications required for the non-billing providers?

BHCM

A designated member of the team with specialized training in behavioral health, but there is no specific educational requirement

Psychiatric Consultant

Must be a medical professional trained in psychiatry and able to prescribe the full range of medications (so does not have to be a physician)

Psychiatric Consultant

Does NOT have to participate in Medicare, Medicaid, or other insurances to bill for those, only OB provider needs to participate

Do all team members need to be in the same practice?

BHCM Psychiatric Consultant

May be in the same practice as the billing provider, but it's not required

BHCM

Must be available to provide face-to-face service, though there is no requirement to actually provide that service

BHCM

Can be co-located with OB but not necessary (remote is fine)

What is the cost to the patient?

Depends on state and insurance provider

There is an almost infinite set of possibilities – some patients will have deductibles to meet, others will have co-pays or co-insurance

Even patients with the same insurance may have slightly different plans and costs

Unless you have time time to call all the insurances involved and get a breakdown of all plans, you will not be able to tell patients in advance what their cost will be

Important to communicate to patients that this service is NOT free, and is NOT part of bundled prenatal care, but is billed like any other medical service

Can I use traditional psych codes?

Depends on your practice and state

If your BHCMs are credentialed billing providers, you can use traditional psych codes to bill for patient-facing time

Whether this makes sense for you depends on whether your BHCMs are enrolled with all insurances and you have negotiated rates with them

You may be better off financially if you stick with CC codes, as reimbursement may be better

If your psychiatric consultant occasionally sees patients 1:1, those visits can and should be billed with traditional psych billing codes

What traditional psych codes can the BHCM use for patient-facing time?

Code	Meaning
90791	Psychiatric evaluation without medical services
90832	16-37 minutes of psychotherapy
90834	38-52 minutes of psychotherapy
90837	53+ minutes of psychotherapy
90846	50 minutes of family therapy (without patient)
90847	50 minutes of family therapy (with patient)
90785	Psychotherapy Complex Interactive
90853	Group Therapy

What traditional psych codes can psych consultant use for patient-facing time?

Code	Meaning
90792	Psychiatric evaluation with medical services
99201-99205	EM codes for initial visit, with medical services
99211-99215	EM codes for subsequent visits, with medical services
90833	16-37 minutes of psychotherapy, added to EM code
90836	38-52 minutes of psychotherapy, added to EM code
90838	53+ minutes of psychotherapy, added to EM code
90785	Psychotherapy Complex Interactive, added to EM code

Can I use BOTH CC and traditional psych codes?

Yes!

You can mix and match in the same month for the same patient

Be careful, though – if you bill a psych code for a patient encounter, you must be sure not to include those minutes when adding up how much time to bill for the CC code

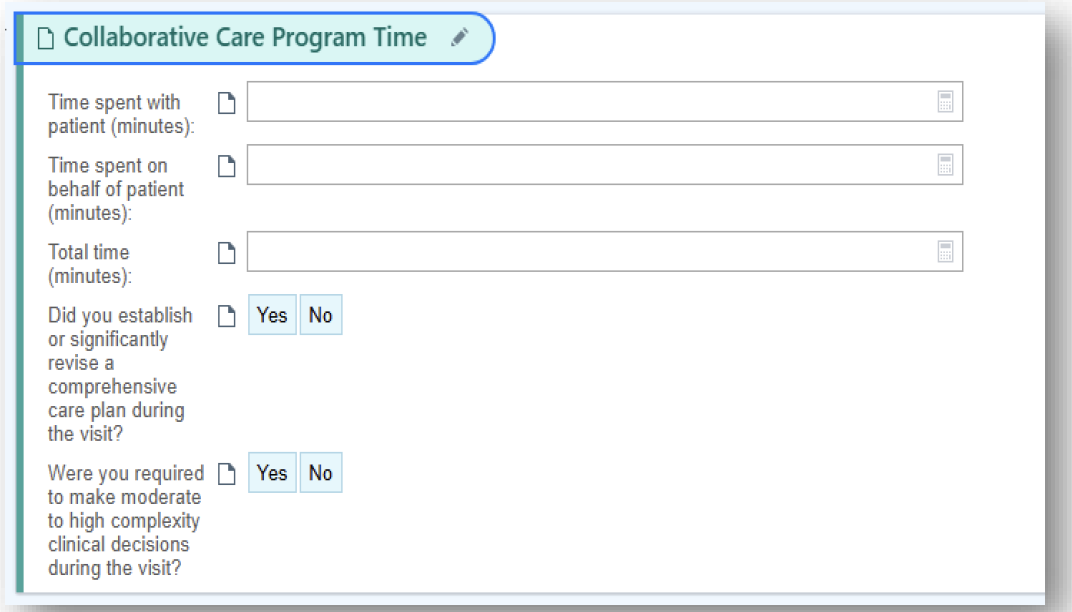
Let’s Walk Through a Case

On March 1, Mary presents to her OB’s office and screens positive for referral to collaborative care

This particular program has a clinician screening call as the first step, so Jennifer (a care manager) calls Mary on March 3

They spent 20 minutes on the phone, and Jennifer keeps track of that time in a SmartForm in her electronic health record

Jennifer also spends 5 minutes entering the patient in the registry

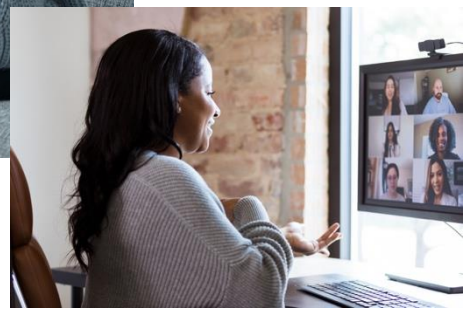


Case Continued

Jennifer decides that the patient needs a thorough intake, and in that visit (on March 9) she spends 50 minutes, which she again records in her smart form (so now we are up to 70 minutes)

Jennifer presents the case in systematic case review on March 12, and the psychiatrist makes recommendations and records 10 minutes on the smart form; Jennifer also spends 5 minutes on the registry

They decide that the patient needs regular therapy, but in addition the MDQ was positive and the psychiatrist needs to evaluate for bipolar disorder



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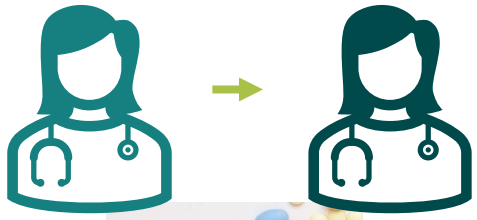

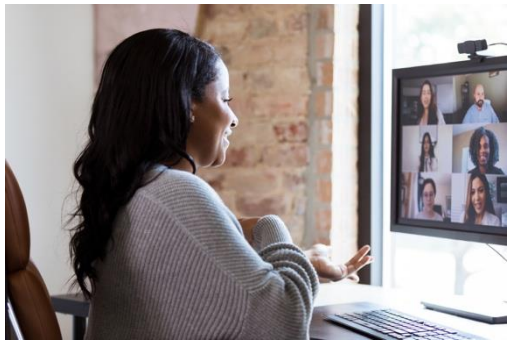

Jennifer begins biweekly therapy on March 15 and completes two 50-minute sessions, on March 15 and March 29

Jennifer also does two 8-minute check-in calls with the patient, on March 12 and March 22; she forgets to fill out the smart form, but writes down the time, and spends 5 additional mins on the registry on March 22

The psychiatrist does a 30-minute targeted evaluation for diagnostic clarification on March 17 and makes medication recommendations to the OB

On March 26, Jennifer again brings the case to systematic case review to discuss any needed changes to the med regiment; the psychiatrist records 10 minutes. After the meeting, Jennifer spends 5 minutes on the registry.

CASE TOTAL

Date	Service	Code
3/1	screening	96160
3/3	20 mins phone	99492
3/3	5 mins registry	99492
3/9	50 mins intake	99492 (up to 70) + 99494 (up to 5) OR 90791 OR 90834
3/12	10 mins review	99494 (1st increment, up to 15) OR 99492 (now up to 35 mins)
3/12	8 mins phone	99494 (1st, up to 23 mins) OR 99492 (now up to 43 mins)
3/12	5 mins registry	99494 (1st, up to 28) OR 99492 (up to 48)
3/15	50 mins therapy	99494 (1st, up to 30, + 2nd, up to 30, 3rd, up to 13) OR 90834
3/16	30 mins dx	99494 (3rd, up to 30, 4th up to 13) OR 99204 + 90833
3/22	8 mins phone	99494 (4th, up to 21) OR 99492 (now up to 56 mins)
3/22	5 mins registry	99494 (4th, up to 26) OR 99492 (now up to 61 mins)
3/26	10 mins review	99494 (4th, up to 30, 5th up to 6) OR 99492 (now up to 70 mins) + 99494 (1st, up to 1 min)
3/26	5 mins registry	99494 (5th, up to 11) OR 99494 (1st, up to 6, can't bill)
3/29	50 mins therapy	99494 (5th, up to 30; 6th, up to 30; 7th, up to 1 (can't bill) OR 90834
TOTAL		99492 + (6 x 99494) OR 99492 + 90791 + (2 x 90834) + 99204 +90833

What are Typical Reimbursement Rates?

Code	Description	2026 Medicare Rate	Sample 2025 Commercial Rates
99492	CoCM – first 70 mins, first month	$160.32	$383.11, $467.87, $541.55
99493	CoCM – first 60 mins, subsequent months	$144.96	$306.62, $371.72, $430.97
99494	CoCM – additional 30 mins in any month	$61.46	$154.79, $192.20, $222.23
G0512	CoCM in FQHCs	NO LONGER EXISTS	

*adapted from the AMA, see last slide

Important Caveats

Some insurance companies will restrict the number of add-ons you can use

The only way to know is to research this with insurance companies ahead of time; it will differ by plan and by state

You MUST have careful documentation of the time spent, evidence of measurement-based care, and a registry – you risk not being reimbursed if you don't have these

You may need to use a telehealth modifier (95) if doing remote visits, but that will depend how your system tracks telehealth

Where can I learn more?

- The American Psychiatric Association has a range of resources, including a tutorial
  - https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid
- The AIMS Center at the University of Washington has helpful information
  - https://aims.uw.edu/billing-and-financing/
  - https://aims.uw.edu/wordpress/wp-content/uploads/2023/11/CMS_FinalRule_FQHCs-RHCs_CheatSheet.pdf
- The CMS website lists requirements for Medicare providers
  - https://www.cms.gov/medicare/payment/fee-schedules/physician/care-management
- The Meadows Mental Health Policy Institute has a listing of state Medicaid reimbursement
  - https://mmhpi.org/wp-content/uploads/2025/04/Medicaid-Coverage_Collaborative-Care-Management-Codes.pdf
- The American Medical Association has a useful general webinar (aimed at primary care providers)
  - https://www.ama-assn.org/system/files/practical-billing-strategies-webinar-slides.pdf
- You can find a list of acceptable outcome measures at the Kennedy Forum
  - https://www.thekennedyforum.org/app/uploads/2017/06/MBC_supplement.pdf

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