



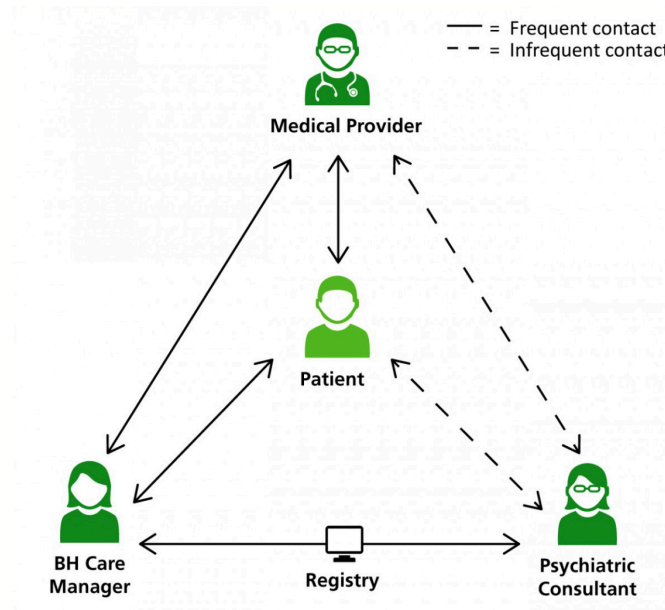
# **Collaborative Care Model Guidance for Commercial Health Plans**

## Collaborative Care Model (CoCM) Guidance for Commercial Health Plans

<b>Overview of Collaborative Care Model (CoCM)</b> .....	<b>3</b>
<b>Reimbursement of CoCM</b> .....	<b>4</b>
<b>Guidance for Health Plans</b> .....	<b>4</b>
Prior Authorization.....	5
Diagnosis Coding and Routing.....	5
Billing and Rendering Provider Requirements.....	5
Place of Service Requirements.....	6
Procedure Codes and Service Characteristics.....	6
Documentation Requirements.....	7
<b>CoCM and Inappropriate Billing</b> .....	<b>8</b>
Scenario (Appropriate Billing): Co-occurrence of Behavioral Health Care Services.....	8
Scenario (Inappropriate Billing): Duplicate Billing for CoCM.....	8
Scenario (Inappropriate Billing): Concurrent Billing for CoCM and General BHI Services.....	9
<b>Appendix A: Example CoCM Claims</b> .....	<b>10</b>
<b>Appendix B: Updated CMS BHI Services</b> .....	<b>12</b>
<b>Appendix C: Useful Resources</b> .....	<b>14</b>

## Overview of Collaborative Care Model (CoCM)

The Collaborative Care Model (CoCM) is a model for integrating behavioral health care into primary care, as three out of four appointments with a primary care provider typically include a mental or behavioral health concern. In the model, a team of providers works collaboratively to address common concerns such as depression, anxiety, or substance abuse.



Source: University of Washington Advancing Integrated Mental Health Solutions Center, "Collaborative Care: Team Structure."

A CoCM team consists of four members:<sup>1</sup>

- **Behavioral Health Care Manager:** A provider with formal education or specialized training in behavioral health, such as social work, nursing, or psychology, who works under the oversight and direction of the primary care provider.
- **Psychiatric Consultant:** A medical provider trained in psychiatry and qualified to prescribe medications, such as a psychiatrist.
- **Primary Care Provider:** A physician, physician assistant, or nurse practitioner who provides primary care and, in the CoCM model, acts as the treating (i.e., billing) provider.
- **Patient:** An active member of the care team.

<sup>1</sup> AIMS Center. (n.d.). *Collaborative Care*. University of Washington. <https://aims.uw.edu/collaborative-care/>

## Reimbursement of CoCM

CoCM has been covered by Medicare since 2017.<sup>2</sup> From a reimbursement standpoint, plans should understand that:

- CoCM services are a *medical* benefit even though treatment is focused on a behavioral or mental health condition, often associated with a chronic physical health condition.
- CoCM is a monthly, time-based care management service that involves:
  - Joint care planning
  - On-going care management support provided to the patient via face-to-face or virtual visits over an episode of care
  - Regular psychiatric interdisciplinary consultation
- CoCM services do not require prior authorization.
- CoCM services are delivered in a primary care setting.
- CoCM services are “incident to” (i.e., an integral part of) services delivered by the primary care provider and delivered by other members of the CoCM team:
  - Behavioral health case manager (BHCM) is identified as the rendering provider on a claim
  - Primary care provider (PCP) is identified as the billing provider
- CoCM services are billed using a specific set of CPT/HCPCS codes: 99492, 99493, 99494, G2214, G0512 (see below for details).

## Guidance for Health Plans

To ensure consistent, accurate, and timely adjudication, health plan should recognize that CoCM claims appropriately involve:

- No requirement for a behavioral health diagnosis
- No requirement for prior authorization
- Treatment of behavioral health conditions within a primary care setting
- PCP serving as the billing provider for care management services
- BHCM serving as the rendering provider under the PCP’s direction
- Place of service aligned with the PCP’s practice location
- Use of CoCM-specific, medical CPT/HCPCS codes
- Monthly, time-based documentation rather than individual, visit-based records

---

<sup>2</sup> Centers for Medicare & Medicaid Services. (2026). *Behavioral health integration services* (ICN MLN909432). <https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf>

When these elements are present, the claim should be processed and reimbursed under the medical benefit, assuming all other standard requirements have been met - including eligibility and financial responsibility.

Example claims for a patient receiving CoCM services during the first two months of an episode of care are included in [Appendix A](#) for reference.

### Prior Authorization

CoCM services do not inherently require prior authorization. Claims should not be held or denied due to the lack of authorization and standard prior authorization-related edits should be bypassed for CoCM CPT/HCPCS codes.

### Diagnosis Coding and Routing

CoCM is intended to enable treatment of behavioral or mental health conditions under the medical benefits. Therefore, behavioral health diagnosis codes listed on a claim are appropriate and expected for CoCM services. Common diagnoses may include, but are not limited to, depression, anxiety, and substance abuse. However, the diagnosis listed is **not** required to be a behavioral health diagnosis.

Inclusion of a behavioral or mental health diagnosis should not trigger:

- Routing to behavioral health service administrator
- Application of mental health benefit limitations
- Denial due to lack of a “medical” diagnosis

Many commercial health plans maintain separate behavioral health benefit structures or service administration arrangements. CoCM claims are often incorrectly identified as “behavioral health” due to the presence of behavioral health diagnosis codes and routed to the behavioral health service administrator, which subsequently denies the claim because the billing provider (PCP not BH clinician) is out of network. Therefore it is critical that standard routing logic for behavioral health-related services be re-written in the case of CoCM services; for example, a claim with a behavioral health diagnosis and CoCM-specific procedure codes should continue to be adjudicated within the medical claims processing workflow, not routed to either an internal or third-party behavioral health service administrator.

### Billing and Rendering Provider Requirements

CoCM services are billed under the PCP, who is a physician (MD), physician assistant (PA), or nurse practitioner (NP) providing primary care to the patient. The PCP has overall responsibility

for the patient’s care and oversees all care management activities performed either by the BHCM or psychiatric consultant. While this model is particularly prevalent in PCP offices, the medical provider may work in family medicine, internal medicine, geriatrics, or specialty medicine. The presence of a behavioral health diagnosis on a CoCM-related claim involving a medical billing provider is consistent with the CoCM model and should not be interpreted as an error.

The rendering provider for CoCM services will be the BHCM working under the direction of the PCP. This is also consistent with the CoCM model and should not be interpreted as an error.

Claims should not be denied because:

- Billing provider’s specialty is not behavioral health related
- Rendering provider is a BHCM and not a medical provider
- Perceived “mismatch” between billing provider specialty and rendering provider type, i.e., primary care vs. behavioral health

### Place of Service Requirements

The place of service (POS) on CoCM claims should reflect the location of the PCP’s practice, not the physical location of the BHCM or other CoCM team members. The BHCM may not be physically located at the same location as the PCP since CoCM services are often delivered through a combination of in-person, telephonic, and care coordination activities. This does not impact the appropriate place of service designation.

Claims must not be denied or adjusted due to:

- Differences between the BHCM’s physical location and the reported place of service
- Assumptions that the service location must reflect where each team member is individually located

### Procedure Codes and Service Characteristics

CoCM services represent monthly, time-based care management activities, rather than discrete face-to-face encounters. Health plans should not apply standard evaluation and management (E/M) visit logic when adjudicating CoCM claims. For example, the absence of a same-day office visit or face-to-face service is not a valid reason for denial.

CoCM services are billed monthly using specific CPT/HCPCS codes:



- **99492:** Initial psychiatric collaborative care management, first 70 minutes in the first calendar month, involving a behavioral health care manager and psychiatric consultant. Requires 36–70 minutes in the first month.
- **99493:** Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month. Requires 31–60 minutes in each subsequent month.
- **99494:** Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month (used with 99492 or 99493). This code can be billed up to four times per patient per month<sup>3</sup>.
- **G2214:** Cannot be used in conjunction with 99492-99494 codes. This code is exclusively when the minute thresholds are not met meaning that the service was within the range of 16-31 minutes. *If the total time is 15 minutes or less, the encounter is not billable.*
- **G0512:** For use by Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs) only. Psychiatric collaborative care management, 60 minutes or more per calendar month, involving a behavioral health care manager and psychiatric consultant. *(Note: This code was retired as of January 2026. Plans should make updates accordingly.)*

### CoCM Code Comparison

Code	Usage	Month Used	Time	Minimum Billing Threshold	Add-On?
99492	Initial CoCM services	First month	First 70 minutes	36 minutes	N
99493	Ongoing care	Subsequent months	First 60 minutes	31 minutes	N
99494	Extra time	Any	Additional 30 minutes	16 minutes	Y
G2214	Partial service	Any	First 30 minutes	16 minutes	N

### Documentation Requirements

While health plans may request documentation to support CoCM claims for purposes of program integrity, such requests should be applied judiciously and in a manner consistent with the continued support of the CoCM model.

<sup>3</sup> <https://aims.uw.edu/wordpress/wp-content/uploads/2023/06/Finance-Office-Hours-FAQs.pdf>

CoCM services are monthly, time- and team-based, care management activities with documentation spanning multiple interactions and care coordination activities. Routine requests for full, encounter-level documentation for every claim can create significant administrative burden for primary care practices and may discourage participation in CoCM. Therefore, documentation requests should follow a targeted, risk-based, or sampling approach, rather than being applied universally. Appropriate strategies include:

- Pre-payment or post-payment review based on:
  - Outlier billing patterns
  - New or higher-risk providers
  - Data-driven flags or anomalies
- Periodic random sampling for audit purposes
- Focused review following identified compliance concerns

## CoCM and Inappropriate Billing

As CoCM services are intended to support management of behavioral health conditions within a primary care setting, there can be instances where a patient is also appropriately receiving specialty behavioral health services at the same time, including psychotherapy and psychiatric care. The co-occurrence of both CoCM and behavioral health care services during any given month by itself does **not** indicate duplicate or inappropriate billing. However, certain billing practices should be deemed inappropriate; for example, duplicate billing may occur when care management activities performed as part of CoCM are also billed as individual services, particularly by the BHCM. There are several scenarios that health plans should especially monitor to ensure that appropriate co-occurring behavioral health treatment is approved, while identifying inappropriate billing.

### Scenario (Appropriate Billing): Co-occurrence of Behavioral Health Care Services

In certain instances, it is appropriate for specialty behavioral health care to be billed alongside CoCM services. For example, a patient may be receiving CoCM services for anxiety from her PCP while also undergoing psychotherapy with a mental health professional for their mental health condition. The type of procedure code billed can serve as a primary indicator. Services such as psychotherapy (e.g., CPT codes 90832–90837), psychiatric diagnostic evaluation (90791, 90792), or evaluation and management (E/M) services for medication management represent separate, face-to-face clinical encounters distinct from and outside the scope of CoCM.

### Scenario (Inappropriate Billing): Duplicate Billing for CoCM

Payment for CoCM is bundled as it is a type of monthly, time-based care management service. Therefore, minutes should not be “double counted,” i.e., care management activities performed

as part of CoCM are also billed as individual services. For example, a BHCM should not bill for three separate 20 minute telephone assessments using CPT 98697 if CoCM services (CPT 99492 or 99493) are also billed for in a given month. Submission of claims for both CoCM and comparable services for the same patient from the same provider organization (e.g., same TINs) in a given month would warrant further investigation.

Another example would be duplication of inter-disciplinary consultative services. A 10 minute case review with the BHCM and psychiatric consultant would count as 10 minutes total, not 10 minutes for the BHCM and 10 minutes for the psychiatric consultant.

### Scenario (Inappropriate Billing): Concurrent Billing for CoCM and General BHI Services

General behavioral health integration (BHI) is a different, less structured model for integrating behavioral health care into primary care. Like CoCM, BHI is a monthly, time-based service overseen by a PCP; however unlike CoCM, participation of a BHCM or psychiatric consultant is not required. A separate set of CPT/HCPCS codes must be used when billing for BHI (99484, G0323). Given the overlap between the two models, BHI and CoCM cannot be billed in the same month for the same patient.

In trying to determine the appropriateness of a claim, health plans decisions should not be based solely on a single factor, such as a patient's diagnosis or the identity, role, title, or specialty of the rendering provider. For example, BHCMS, psychiatrists, and other behavioral health specialists may appropriately perform multiple functions (including both CoCM-related activities and separate therapeutic services) or operate in hybrid roles. Instead health plans need to evaluate a multitude of factors, including specific services billed, nature of services billed (e.g., non-face-to-face, care management, etc.), time frames, billing organizations, contracting, and overall patterns of care.



## Appendix A: Example CoCM Claims

### Example 1: Claim for First Month of CoCM

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
PICA <input type="checkbox"/> PICA <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BY (LUNG) <input type="checkbox"/> OTHER <input type="checkbox"/>				1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>91234567A</b>							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DAVIS, ARIANA</b>				3. PATIENT'S BIRTH DATE (MM   DD   YY) SEX <b>04   12   00</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>DAVIS, ARIANA</b>			
5. PATIENT'S ADDRESS (No., Street) <b>1437 LAKE DRIVE</b>				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) <b>1437 LAKE DRIVE</b>			
CITY <b>TRUCKEE</b>			STATE <b>CA</b>			CITY <b>TRUCKEE</b>			STATE <b>CA</b>		
ZIP CODE <b>96160</b>		TELEPHONE (Include Area Code) <b>(530) 5827893</b>		ZIP CODE <b>96160</b>		TELEPHONE (Include Area Code) <b>(530) 5827893</b>		8. RESERVED FOR NUCC USE			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? (PLACE State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER <b>A13975</b>			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. INSURED'S DATE OF BIRTH (MM   DD   YY) SEX <b>04   12   00</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>				b. OTHER CLAIM ID (Designated by NUCC)			
b. RESERVED FOR NUCC USE				c. INSURANCE PLAN NAME OR PROGRAM NAME <b>COMMUNITY CARE HMO</b>				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO #if yes, complete items 9, 9a, and 9d			
c. RESERVED FOR NUCC USE				10d. CLAIM CODES (Designated by NUCC)				12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. <b>ARIANA DAVIS</b> DATE <b>03/31/2026</b>			
d. INSURANCE PLAN NAME OR PROGRAM NAME				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____				14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) (MM   DD   YY) QUAL <b>02   15   2026</b> QUAL			
15. OTHER DATE (MM   DD   YY) QUAL				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM   DD   YY TO MM   DD   YY)				17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a. NAME 17b. NPI)			
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM   DD   YY TO MM   DD   YY)				19. ADDITIONAL CLAIM INFORMATION (Designated)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A. <b>F33.1</b> B. <b>F41.1</b> C. ICD-10-PCS D. ICD-10-PCS E. ICD-10-PCS F. ICD-10-PCS G. ICD-10-PCS H. ICD-10-PCS I. ICD-10-PCS J. ICD-10-PCS				22. RESUBMISSION CODE ORIGINAL REF. NO.				23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE (From MM   DD   YY To MM   DD   YY)		B. PLACE OF SERVICE (EMG)		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (OPT-HCPCS MODIFIER)		E. DIAGNOSIS POINTER		F. \$ CHARGES		J. RENDERING PROVIDER ID #	
1 03   01   26   03   31   26   11		99492		Note: 99492 used to bill for CoCM services in first calendar month.		AB		141.26		1811519753	
2 03   01   26   03   31   26   11		99494				AB		57.88		1811519753	
3				Note: Dates of service are for start/end of month even though enrollment in CoCM began mid-month.						Note: NPI of rendering provider is for Lauren Brooks, Behavioral Health Care Manager.	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER <b>51-2144346</b>		26. PATIENT'S ACCOUNT NO. <b>PH37241908</b>		27. ACCEPT ASSIGNMENT? (For opt-out, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE <b>\$ 199.14</b>		29. AMOUNT PAID <b>\$ 0.00</b>		30. Remd. for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this claim and are made a part thereof) <b>EMILY CARTER</b> SIGNED _____ DATE <b>03/31/2026</b>		32. SERVICE FACILITY LOCATION INFORMATION <b>PACIFIC HEALTH NETWORK</b> 3719 NW 17TH ST. SOUTH LAKE TAHOE, CA 96157		33. BILLING PROVIDER INFO & PH# <b>EMILY CARTER, MD</b> 400 BALLPARK DR. WEST SACRAMENTO, CA 95691 Note: Billing provider is Ariana's PCP, Emily Carter.		34. a. <b>1932840347</b> b. <b>1235181497</b>		35. a. <b>1235181497</b> b. _____			
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMB-0938-1197 FORM 1500 (02-12)											



Example 2: Claim for Second Month of CoCM

HEALTH INSURANCE CLAIM FORM																			
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12																			
PICA <input type="checkbox"/> FICA <input type="checkbox"/>																			
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input checked="" type="checkbox"/> (ID#)	FECA BUYER (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		91234567A										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE (MM   DD   YY)		SEX (M   F   X)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
DAVIS, ARIANA				04   12   00		M   F   X		DAVIS, ARIANA											
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)													
1437 LAKE DRIVE				Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		1437 LAKE DRIVE													
CITY		STATE		8. RESERVED FOR NUCC USE						CITY		STATE							
TRUCKEE		CA								TRUCKEE		CA							
ZIP CODE		TELEPHONE (Include Area Code)								ZIP CODE		TELEPHONE (Include Area Code)							
96160		(530) 5827893								96160		(530) 5827893							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER											
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH (MM   DD   YY)											
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				04   12   00 M   F   X											
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)											
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME											
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				COMMUNITY CARE HMO											
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED: ARIANA DAVIS DATE: 04/30/2026										SIGNED:									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)				15. OTHER DATE				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION											
MM   DD   YY				QUAL				FROM MM   DD   YY TO MM   DD   YY											
02   15   2026																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES													
						FROM MM   DD   YY TO MM   DD   YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				17b. NPI		20. OUTSIDE LAB? \$ CHARGES													
						<input type="checkbox"/> YES <input type="checkbox"/> NO													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)										22. REMISSION CODE ORIGINAL REF. NO.									
A. F33.1 B. F41.1 C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM   DD   YY To MM   DD   YY										F. \$ CHARGES									
B. ICD-10 CODE										G. DAYS ON UNITS									
C. EMG										H. ICD-10 FAMILY No.									
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER										I. ID. QUAL.									
E. DIAGNOSIS POINTER										J. RENDERING PROVIDER ID. #									
1 04   01   26 04   30   26 11 99493 AB 112.14 1 NPI 1811519753																			
2 04   01   26 04   30   26 11 99494 AB 57.88 2 NPI 1811519753																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For dual claims, see 26d1)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rev'd for NUCC Use					
51-2144346				X		PH37241908		YES NO		\$ 227.90		\$ 0.00							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION									
EMILY CARTER										PACIFIC HEALTH NETWORK									
04/30/2026										3719 NW 17TH ST.									
DATE										SOUTH LAKE TAHOE, CA 96157									
SIGNED										33. BILLING PROVIDER INFO & PH# (530) 542-4637									
										EMILY CARTER, MD									
										400 BALLPARK DR.									
										WEST SACRAMENTO, CA 95691									
										a. 1235181497 b.									
NUCC Instruction Manual available at: www.nucc.org										PLEASE PRINT OR TYPE									
APPROVED CMB-0938-1197 FORM 1500 (02-12)																			

## Appendix B: Updated CMS BHI Services

Beginning January 2026, CMS introduced three new HCPCS codes to further support integrated behavioral health care. These codes (G0568, G0569, G0570) can be used when General BHI or CoCM services are provided in the same month as advanced primary care management (APCM) services. They are optional add-on codes that could be billed in conjunction with an APCM base code (G0556, G0557, or G0558) each month and do not have time-based requirements or require tracking of minutes, reducing administrative burden.<sup>4</sup> These codes are for Medicare; plans should evaluate adoption of the codes.

### **Base Codes: G0556, G0557, G0558 (Advanced Primary Care Management)**

These are the base HCPCS codes billed monthly for APCM. Providers choose the most appropriate one based on the patient's *medical complexity* and *financial status*.

- **G0556 (Level 1):** For patients with 0 or 1 chronic condition.
- **G0557 (Level 2):** For patients with 2 or more chronic conditions expected to last at least 12 months.
- **G0558 (Level 3):** For patients with 2 or more chronic conditions who are also Qualified Medicare Beneficiaries (QMB) (low-income patients who qualify for state assistance with Medicare costs).<sup>5</sup>

### **Add-on Codes: G0568, G0569, G0570 (Behavioral Health Integration)**

These new optional add-on codes allow providers to bill for General BHI or CoCM services *specifically* for patients already enrolled in APCM. They effectively replace the traditional 99492, 99493, 99484 codes for patients on an APCM plan.

- **G0568:** Used for the initial month of CoCM. It is the APCM equivalent of 99492.
- **G0569:** Used for subsequent months of CoCM. It is the APCM equivalent of 99493.
- **G0570:** Used for BHI. It is the APCM equivalent of 99484.

---

<sup>4</sup> Centers for Medicare & Medicaid Services. (2026). *Behavioral health integration services* (ICN MLN909432). <https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf>

<sup>5</sup> Centers for Medicare & Medicaid Services. (2025). *Advanced primary care management services*. <https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services>



**Use of APCM Base Codes with BHI Add-on Codes**

If patient is . . .	Use this Base Code	Add this for CoCM (Initial Month)	Add this for CoCM (Subsequent Months)	Add this for BHI Services (not part of CoCM)
Relatively healthy (0-1 conditions)	G0556	+ G0568	+ G0569	+G0570
Chronically ill (2+ conditions)	G0557	+ G0568	+ G0569	+G0570
Chronically ill + QMB	G0558	+ G0568	+ G0569	+G0570

**Important:** These new codes (G0556–G0570) are *not time-based*. Unlike G2214 or 99493, which require tracking exact minutes, these require you to meet *13 specific service elements* (like 24/7 access to care and systematic data sharing) to bill the monthly flat fee.

## Appendix C: Useful Resources

The California Quality Collaborative's BHI Payer Workgroup documents are available for other plans and partners to adapt and adopt, including:

- [BHI Health Plan Policy & FAQ](#) – provides health plans, and their managed behavioral health organization partners or internal behavioral health departments, with operational responsibilities to facilitate behavioral health integration in primary care, covering credentialing, billing and claims, medical/behavioral health collaboration, data analytics, enterprise strategy.
- [Behavioral Health Integration into Primary Care: Provider Implementation Guide](#) – a resource plans can share with providers to support implementation of BHI (either Collaborative Care or Primary Care Behavioral Health).
- [BHI Data Request](#) – template to analyze claims data to understand Collaborative Care codes in network.

Additionally, Blue Shield of California published a white paper [Advancing Behavioral Health Integration: Collaborative Strategies for Sustainable Change](#) on strategies for broader adoption of behavioral health integration in primary care settings through stakeholder collaboration, better reimbursement policies, and policy alignment.