COLORADO
Department of Health Care Policy & Financing

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Collaborative Care Management

July 1, 2025

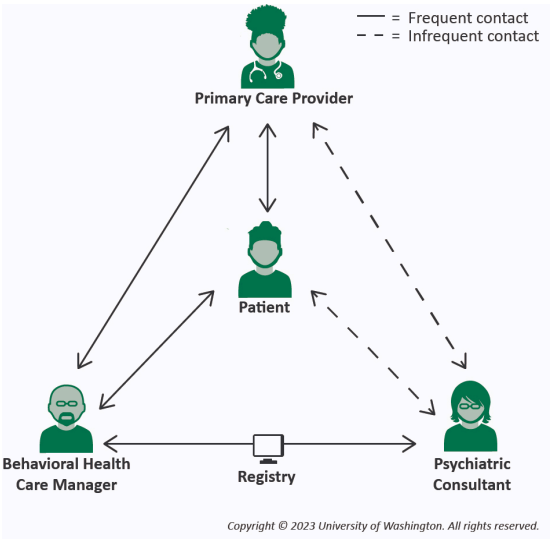
Overview

Starting July 1, 2025, the Colorado Department of Health Care Policy and Financing (HCPF) established the Integrated Care Sustainability Policy to both increase access to integrated care services for members, and build a sustainable reimbursement model for primary care providers who are incorporating behavioral health services into their practices. HCPF envisions increasing access to integrated care will improve member health.

A component of the Integrated Care Sustainability Policy includes allowance of Primary Care Medical Providers (PCMPs) to bill Collaborative Care Management (CoCM) codes and be reimbursed Fee-For-Service (FFS) or through a Managed Care Organization (MCO).

Collaborative Care Management (CoCM) Codes

CoCM codes provide psychiatric care in a primary care setting.



Billing

Practices must be contracted with a Regional Accountable Entity (RAE) or MCO as a PCMP to bill CoCM codes. PCMPs should use the most appropriate diagnosis when billing CoCM codes, however, a behavioral health diagnosis is not required.

Reimbursement

CoCM services are provided through the use of three collaborators:

1. PCMP;
2. Behavioral health care manager; and
3. Psychiatric consultant.

The PCMP provides initial assessment and is responsible for administering validated rating scales. The behavioral health care manager follows up proactively and systematically using validated rating scales and a registry. Finally, a regular case load review is conducted by the behavioral health care manager and the psychiatric consultant.

The behavioral health care manager and the psychiatric consultant review the member's treatment plan and status weekly. If the member is not improving, the behavioral health care manager discusses the member's treatment plan for potential revision with the psychiatric consultant. Collaborators, including the psychiatric consultant and behavioral health care manager, are required to be embedded in the practice either in person and/or virtually as a regular part of the integrated care team. These providers must be employed or contracted by the PCMP. The behavioral health care manager may be any designated member of the care team with formal education or specialized training in behavioral health, who is available to provide services on a face-to-face basis.

Practices may submit claims for reimbursement of CoCM codes for FFS reimbursement if they are contracted with a RAE or MCO as a PCMP. The billing provider on the claim must be the PCMP billing as one of the following primary care provider types:

- 05 - Physician
- 16 - Clinic (primary care)
- 25 - Non-physician practitioner group
- 26 - Osteopath
- 32 - Federally Qualified Health Center (FQHC)
- 41 - Family/Pediatric Nurse Practitioner
- 45 - Rural Health Clinic (RHC)
- 51 - School Health Services

The rendering provider on the claim must be Medicaid-enrolled and oversee treatment. The rendering provider must be enrolled as one of the following types:

- 37 - Licensed Psychologist (PhD, PsyD, EdD)
- 38 - Licensed Behavioral Health Clinician

Billing and rendering providers who behavioral health clinicians must be licensed as well as credentialed.

Requirements

Practices billing these codes must meet the standards of the evidence-based Collaborative Care Model, which will be validated by the RAE through the HCPF Practice Assessment Tool a minimum of every three years. Minimum standards to bill CoCM codes, outlined in Section 8.5 of the HCPF Practice Assessment Tool, include the following three components:

1. Availability of a psychiatric consultant who collaborates with the primary care clinician or care team on medication management;
2. Availability of a care manager actively responsible for identifying and coordinating behavioral health needs for patients; and
3. A maintained care registry for patients with behavioral health needs that is utilized to monitor symptoms and identify and address gaps in care. The registry must be reviewed and signed off on by the psychiatric consultant.

Please note that practices that are designated "Highly Integrated" through the HCPF Practice Assessment Tool are not necessarily able to bill CoCM codes. Practices must meet the specific requirements outlined in Section 8.5 of the HCPF Practice Assessment Tool, and meet minimum Medicare standards, to bill these codes.

Restrictions

A CoCM code and a Health Behavior Assessment and Intervention (HBAI) code cannot be billed together for the same member in the same calendar month.

Collaborative Care Model (CoCM) Codes

Code	Service & Description	Time	Provider Types
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and that the treating physician or other qualified health care professional directs, with the following required elements: 1. Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional 2.Initial assessment of the patient, including administering validated rating scales, with the development of an individualized treatment plan 3. Review by the psychiatric consultant with modifications of the plan, if recommended 4. Entering patient in a registry and tracking patient follow-up and progress using the registry, with proper documentation, and participation in weekly caseload consultation with the psychiatric consultant	Min. 70 minutes per calendar month	**Billing Providers:** 05, 16, 25, 26, 32, 41, 45, 51 **Service Providers:** Psychiatric Consultant, Behavioral Health Care Manager, PCMP **Common Notes:** These visits will not require a diagnosis covered by the capitated behavioral health benefit. PCMPs should use the

	5. Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies		most appropriate diagnosis that supports medical necessity.
99493	Follow up psychiatric collaborative care management, first 60 minutes in a following calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: 1. Tracking patient follow-up and progress using the registry, with proper documentation 2. Participation in weekly caseload consultation with the psychiatric consultant 3. Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers 4. Other review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations supplied by the psychiatric consultant 5. Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies 6. Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms, other treatment goals and prepare for discharge from active treatment	Min. 60 minutes per calendar month	
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and that the treating physician or other qualified health care professional directs (list separately from the code for the primary procedure). Notes: Must be used alongside 99492 or 99493 to bill for additional 30-minute increments of care management time.	Min. 16 minutes, max. 37 minutes; billed maximum of two times per calendar month	
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional: 1. Tracking patient follow-up and progress using the registry, with proper documentation; participation in weekly caseload consultation with the psychiatric consultant 2. Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified	Min. 30 minutes per calendar month	

	health care professional and any other treating mental health providers 3. Other review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations supplied by the psychiatric consultant Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies 4. Monitoring of patient outcomes using validated rating scales 5. Relapse prevention planning with patients as they achieve remission of symptoms, or other treatment goals and prepare for discharge from active treatment		

For more information contact:

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