Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin Number: MMP 22-30

Distribution: Federally Qualified Health Centers, Medicaid Health Plans, Local Health Departments, Practitioners, Rural Health Clinics, Tribal Health Centers, Prepaid Inpatient Health Plans, Community Mental Health Services Programs

Issued: September 30, 2022

Subject: Updates to Coverage of Psychiatric Collaborative Care Model (CoCM) Services Policy

Effective: November 1, 2022

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

The purpose of this policy is to update the coverage parameters of CoCM services effective for dates of service on and after November 1, 2022. CoCM services were initially described in Bulletin MSA 20-38.

CoCM is a model of integrated behavioral health service which is typically provided within the primary care setting. Eligible conditions include, but are not limited to, mild to moderate depression, anxiety, bipolar disorder, attention deficit disorder (ADD), and substance use disorder (SUD). CoCM is also available to individuals who may not be deemed eligible for specialty services through Community Mental Health Services Programs.

Coverage of CoCM Services – Initial Assessment and Prior Authorization

CoCM must include an initial assessment. The Medicaid program will now allow the initial face-to-face CoCM visit to be provided via dual audio-visual telemedicine, as most clinically appropriate for patient-centered care, consistent with the current Medicaid telemedicine policy (refer to the Practitioner chapter of the MDHHS Medicaid Provider Manual, Telemedicine section, for additional information).

The Medicaid program will extend the CoCM prior authorization requirement from 6 months to 12 months. After the initial 12 months of care, prior authorization is required for 12 additional calendar months if the beneficiary shows improvement and there is a need for continued care. If no improvement occurs after the initial 12 months or their condition worsens, the beneficiary is to be referred to specialty services.

Collaborative Care Team Criteria – Psychiatric Consultant

The CoCM team includes the primary care provider or treating physician, a behavioral health care manager, a psychiatric consultant and the Medicaid Fee-for-Service (FFS) or Medicaid Health Plan (MHP) beneficiary. This policy updates the collaborative care team criteria for the psychiatric consultant. Specifically, the psychiatric consultant role has been expanded to include licensed, qualified mental health nurse practitioners (MHNPs).

Psychiatric consultant: A medical professional (MD or DO) or (MHNP) who is trained in psychiatry or behavioral health and qualified to prescribe the full range of medications. The psychiatric consultant will:

- Recommend treatment strategies,
- Recommend medication and changes in medication based on beneficiary status,
- Recommend referral to specialty services when needed,
- Consult weekly with the behavioral health care manager, and
- Consult with and advise the primary care provider or treating physician as clinically indicated.

Indian Health Center Reimbursement

CoCM services provided by a Tribal Health Center (THC) or Tribal Federally Qualified Health Center (FQHC) provider (e.g., MD/DO, Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Physician Assistant [PA]) do not qualify as an encounter. It may, however, be reimbursed outside of the All-Inclusive Rate (AIR). THCs and Tribal FQHCs should use Healthcare Common Procedure Coding System (HCPCS) code G0512 to report CoCM services.

Manual Maintenance

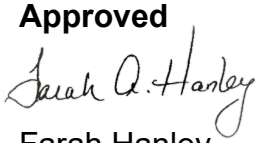
Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved



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