



CENTER FOR
INTEGRATIVE NEUROSCIENCE

The CoCM Startup Brief

*Who does the work, who bills, what
Medicare requires.*

NATIONAL MODEL, MICHIGAN NOTES • 2026

01 DESIGNATION 02 STAFFING 03 BILLING 04 REGISTRY PRIMARY SOURCES

Written from the primary sources and the Behavioral Health Workforce
Observatory's records. CMS booklet MLN909432 and public payer
sources, checked August 2026. Free, ungated, and yours either way.

Would Collaborative Care fit this practice, and what would it require?

Collaborative Care sounds like a program a practice signs up for. It is not. It is a way of organizing work that a practice puts in place itself, and the payment follows the arrangement rather than the other way around. Seeing the arrangement first makes the rest of the decision much simpler.

This Brief is a plain-language introduction for medical practices considering whether to bring more mental health care inside the medical team. Every requirement here comes from published CMS material and public payer pages. Nothing rests on correspondence with an agency or a payer.

WHO THIS IS FOR

- A primary care or OB/GYN practice weighing whether to start.
- A practice manager asked to work out what it would cost and who would do it.
- A behavioral health clinician being asked to join a medical team.
- A physician organization fielding the same question from several practices.

YOU WILL LEAVE KNOWING

- What the model actually is, in three roles and one month.
- Who may serve as the behavioral health care manager, and what that turns on.
- Who bills, and what the codes represent.
- What the registry has to hold, and why it is not optional.
- What to calculate before assuming the model pays for itself.

HOW TO READ THIS DOCUMENT

Three kinds of line, and the difference is the whole method.

The key first, then what this particular document covers.

SOLID LINE

A cited public source establishes this.

The source is named where the claim is made, and dated. If you want to check it, you can.

DASHED LINE

This describes what happens today.

Current practice, or your own situation. True as a description, and not asserted as a rule.

DOTTED LINE, ENDING IN ?

The record does not tell us this yet.

Nobody has measured it. A question mark is printed rather than a confident-sounding phrase standing in for a number.

AND WHAT IT COVERS

THIS BRIEF CAN ANSWER

What the model requires, who bills, and what the codes represent.

Written from CMS booklet MLN909432 and published payer material.

THIS BRIEF CANNOT ANSWER

Whether your particular staffing arrangement qualifies.

That turns on the actual roles, scope, supervision, documentation, contracts, and the requirements of your own payers. Confirm it with them before you begin.

Three roles, one patient, and a month rather than a visit.

Collaborative Care is a defined model, not a label a practice applies to work it is already doing. Three roles have to exist, the patient stays with the medical practice, and the unit of service is the month rather than the appointment.

FIGURE 01

Who does what, around one patient.

The three roles are distinct. One person may not simply absorb another’s work and leave the model intact.

MEDICAL PRACTITIONER	BEHAVIORAL HEALTH CARE MANAGER	PSYCHIATRIC CONSULTANT
<i>Keeps the patient. Bills the service.</i>	<i>Does the month’s work.</i>	<i>Reviews the caseload. Advises the team.</i>
• Directs the care team. • Prescribes and adjusts treatment. • Remains the treating practitioner throughout.	• Follows patients between medical visits. • Measures symptoms with a validated tool. • Delivers brief interventions appropriate to the role. • Maintains the registry and the caseload review.	• Reviews patients who are not improving. • Makes treatment recommendations to the medical practitioner. • Does not usually see the patient directly.

The patient never leaves the medical practice. That is what separates this model from a referral.

CENTER FOR INTEGRATIVE NEUROSCIENCE • MODEL ROLES PER CMS BOOKLET MLN909432 • CHECKED AUGUST 2026 • INTEGRATIVE-NEUROSCIENCE.COM/GUIDES/INTEGRATION

What has to be in place before the first month

Patient consent for the arrangement, a way to record it, a named care manager, a psychiatric consultant under an arrangement the practice can evidence, a registry, a validated measurement tool, and a means of tracking the time the care manager spends. None of these is a formality. Each of them is something a payer may ask you to show.

02 • STAFFING

The care-manager question, answered carefully.

This is the question every practice asks first, usually as: can the clinician we already employ do this? The honest answer has two halves, and most of the trouble comes from hearing only one of them.

Under the model, the monthly service is billed by the treating medical practitioner rather than by the clinician furnishing the care-management work. So the question of who may serve as the behavioral health care manager is answered by the model requirements and the payer's own published rules, rather than by that clinician's independent billing status.

You may have more options than you thought.

A clinician's independent billing status does not by itself answer whether that clinician may perform the care-manager role. Practices that assumed the door was closed have a question worth asking rather than an answer.

That is the first half. The second half closes the door again for anyone who stops reading there: the clinician still has to actually perform the care-manager role, and the arrangement still has to satisfy the applicable scope, supervision, documentation, employment or contracting, and payer requirements. Recognizing a code is one question. Whether a particular staffing arrangement satisfies the model is another. Nothing here establishes that any particular clinician or arrangement qualifies.

**OPEN
QUESTION**

Whether qualifying care-manager work can count toward Michigan's required supervised experience remains unresolved. It is a question the state should answer, and this Brief does not answer it in either direction.

Two kinds of oversight, and they are not interchangeable

PSYCHIATRIC CONSULTANT

Part of the Collaborative Care model. Reviews the caseload and makes treatment recommendations to the medical team.

LICENSURE SUPERVISOR

Supervises a limited-license clinician's professional practice under state licensing requirements.

They solve different problems. One does not replace the other.

03 • BILLING

The codes describe time and role, not a session.

The most common misreading is to treat these as therapy codes with a different number. They are not. They describe care-management time within a calendar month, furnished under the model, and billed by the treating medical practitioner.

FIGURE 02

What each code represents.

Read the current CMS descriptors and your payer’s published rules for the time thresholds and the conditions that apply in the year you are billing.

CODE	WHAT IT REPRESENTS
99492	The first calendar month of care-management work under the model, at the time threshold the descriptor sets.
99493	A subsequent calendar month of the same work, at its own threshold.
99494	Additional care-management time within a month, reported alongside the month’s base code.
G2214	A shorter increment of Collaborative Care time within a month, for patients who need less.
99484	General behavioral health integration. A different arrangement from Collaborative Care, not a lighter version of it.

CENTER FOR INTEGRATIVE NEUROSCIENCE • CODE STRUCTURE PER CMS BOOKLET MLN909432 •
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Three things follow from that structure. The month is the unit, so the work has to be tracked as it happens rather than reconstructed. The billing practitioner is the medical practitioner, so the practice’s billing setup matters more than the care manager’s. And the general behavioral health integration code describes a different arrangement from Collaborative Care, so choosing between them is a description of what you actually do, not a preference.

A MICHIGAN NOTE • BCBSM AND BCN

BCBSM and BCN recognize the Collaborative Care and general behavioral health integration codes, and BCBSM follows the Collaborative Care model described in CMS booklet MLN909432. Separately, BCBSM supports Collaborative Care through its Physician Group Incentive Program, with practices working through their Physician Organization for participation and implementation guidance. BCBSM's publicly described Collaborative Care designation currently covers primary-care and OB/GYN practices.

Code recognition and program participation are separate facts. The designation is a program status a practice holds, not a billing permission, and neither one answers the other. A practice asks its own Physician Organization about participation requirements.

04 • REGISTRY

The registry is not paperwork. It is how the model works.

Collaborative Care works because somebody is watching a whole caseload rather than waiting for the next appointment. The registry is what makes that possible, and a practice that treats it as documentation to be caught up on later has quietly stopped doing the model.

What it has to hold

- Every enrolled patient, with the date the arrangement began and consent recorded.
- Each measurement, with its date, so a trend is visible rather than a single score.
- Contacts and care-management time within the month.
- Caseload review dates and the psychiatric consultant's recommendations.
- Treatment changes, and whether the patient responded to them.
- Patients who are not improving, surfaced rather than buried.

A spreadsheet can do this at small volume. Whether it should is a different question, and the answer usually changes at the point where nobody can say from memory which patients have not been contacted this month.

The economics, before anyone assumes

A practice hiring an entirely new care-management team has one cost structure. A practice that already employs a clinician who could appropriately fill the role may have another. The calculation involves more than comparing revenue lines: the clinician's available time, the work the role requires, psychiatric consultation, medical-practitioner participation, registry and administrative work, payer rates, and the number of enrolled patients.

This Brief shows what a practice needs to calculate. It does not promise the answer will be yes.

WORKSHEET

Before the first enrolled patient

Ten boxes, all of them from what this document has already told you.
Print it, or put it on the wall.

☐ A named behavioral health care manager, with the role written down.

☐ A psychiatric consultant under an arrangement you can evidence.

☐ The treating medical practitioner identified for each patient.

☐ Patient consent to the arrangement, and a place it is recorded.

☐ A validated measurement tool chosen, and everyone trained on it.

☐ A registry that holds the caseload, not a folder of notes.

☐ A way to track care-management time as it happens.

☐ A scheduled caseload review with the psychiatric consultant.

☐ Payer requirements confirmed with each payer you will bill.

☐ The economics run with your own numbers, not a national average.

If those boxes are checked, enroll your first patient.

BEFORE THE FIRST ENROLLED PATIENT · CENTER FOR INTEGRATIVE NEUROSCIENCE · SOURCES
CHECKED AUGUST 2026

THE OPEN QUESTION

Could Michigan’s mental health workforce help medical practices build more mental health capacity?

WHAT IS ESTABLISHED

The model, the roles, the billing structure, and the payer recognitions above are published, and this Brief cites them.

WHAT IS NOT MEASURED

What happens after a referral, how long psychiatric access actually takes, and what would make a medical and mental health partnership workable in practice.

- Patients referred out who are never seen ?
- Weeks to psychiatric access in your area ?
- Practices that tried this model and stopped ?

You may know one of the numbers nobody has.

If you referred a patient and never heard back, waited months for psychiatric access, tried to staff this model and could not, or built it and made it work, your experience belongs in the record above. No public dataset holds it.

Put your experience in the record.

About seven minutes. What happened in your practice becomes part of what the field can finally measure.

TELL THE OBSERVATORY WHAT HAPPENED →
integrative-neuroscience.com/research/integration

Findings return to respondents before broader publication.
Participation is optional. The Brief is yours whether you answer or not.

NEXT MOVE

You have the model. What comes next depends on why you are here.

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|---|--|--|
| → | We are deciding whether to start | Work the checklist against your own staffing, then ask your Physician Organization and your payers the two questions this Brief could not answer for you. |
| → | We have a clinician who might fill the role | The BHCM Pivot Playbook works through what would have to change for that role to function, and what it means for the person doing it. |
| → | Our clinicians are not enrolled yet | The Medicare Enrollment Cheat-Sheet covers the federal path, and the Credentialing Cheat-Sheet puts four Michigan payers side by side. |
| → | I want help getting this done
JOIN KEDGE EARLY ACCESS → | Understanding the model is not the same as standing it up. Kedge is building guided enrollment and implementation for practices and clinicians, with step-by-step help based on your role, state, payer, and practice structure. |

PRIMARY SOURCES

Everything above comes from these, and each carries a date.

Public sources only. No payer or agency correspondence appears in this document. Where a source is a landing page rather than a specific section, that is stated rather than hidden.

SOURCE	USED FOR	CHECKED
CMS booklet MLN909432	The model, the three roles, the monthly structure, and the billing practitioner	August 2026
CMS behavioral health integration code descriptors	What 99492, 99493, 99494, G2214, and 99484 represent	August 2026
BCBSM and BCN published payer pages	Michigan recognition of the Collaborative Care and integration codes	August 2026
Michigan Institute for Care Management and Transformation, Collaborative Care Model page micmt-cares.org/collaborative-care-model-cocm-1	That Physician Organizations implement Collaborative Care as part of BCBSM's Physician Group Incentive Program	August 2026
BCBSM Collaborative Care article, 30 September 2025	That BCBSM operates a Collaborative Care designation, and that the designated practices are primary-care and OB/GYN	August 2026
BCN Provider Manual, behavioral health integration section	That BCN lists the Collaborative Care codes and identifies the treating medical provider as the billing practitioner	August 2026

Requirements change. Confirm what applies to your practice with the relevant payer, your Physician Organization, and your compliance advisor before acting on anything here. Found something stale? Write to the correction address below. We will correct the record and date the correction.

COLOPHON

*Independent educational research
and practice guidance, grounded in
primary sources.*

Educational information, not medical, legal, billing, or licensure advice.

Payer and regulatory requirements change; confirm what applies to your practice with the relevant payer, agency, and compliance advisor. Each publication carries the date its sources were last checked. Do not send protected health information.

AUTHORSHIP

Co-authored by the co-founders of the Center for Integrative Neuroscience, from the primary sources and the Behavioral Health Workforce Observatory's records.

CORRECTIONS

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integrative-neuroscience.com/sources

FOUR NAMES, FOUR JOBS

Center for Integrative Neuroscience · what the public rules say

Kedge · guided enrollment, in build. A separate company

Behavioral Health Workforce Observatory · what the record cannot show. The Center's research arm

Integral Neuroscience Initiative · evidence carried into public-interest work. A separate nonprofit

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