SESSION SYNTHESIS · PCP BRIEF · 27 AUGUST 2026

CoCM is a primary-care product. The psychiatrist advises. The PCP treats — and bills.

Primary care physicians do not interact with Collaborative Care, or with its codes, the way a psychiatric consultant does. The treating PCP (or treating NP/PA) is the captain of the team, the prescriber, and the only lawful billing NPI for 99492 / 99493 / 99494 / G2214. The consultant reviews a registry. The behavioral health care manager produces the minutes. That inversion is the whole model.

What to do this week

Name the BHCM and the psychiatric consultant. Turn on PHQ-9 / GAD-7 at rooming. Offer CoCM to five patients with PHQ-9 ≥ 10 or GAD-7 ≥ 10. Close every consultant rec in about 72 hours. Do not sit the Tuesday huddle. Do not bill the psychiatrist's NPI.

Locked this session

Decisions from the 26–27 August 2026 thread (PCP engine, AIMS, value-based playbook, professional PDF). Operational locks for Nuestra Esperanza HEALTH — not payer contracts.

#	Lock	Why it matters to a PCP
1	Treating PCP/NP/PA bills CoCM	Consultant review is required. Consultant NPI is a hard block.
2	PCP E/M minutes are a separate clock	99213/99214 same month is allowed. Those minutes do not make 99493.
3	Closed loop ≤72 hours is the PCP job	An unsigned huddle rec is not medical direction.
4	AIMS five principles define "well-run"	If any principle is missing, AIMS says effective CoCM is not being practiced.

#	Lock	Why it matters to a PCP
5	Cite-or-refuse unsourced allowables	WI PFS computed amounts below are labeled. Commercial/Medicaid dollars refused without a schedule.
6	99484 is not a CoCM fallback	General BHI is a different product.
7	Value-based upside needs contract text	Shared-savings percents are not facts. Upside-only before two-sided risk.
8	Graduation is fidelity	Stable, low-minute patients leave the book.

TABLE 1. Locked decisions — this session.

SESSION ARC · AUDIENCE

This brief is written for the treating primary-care clinician first.

The psychiatric consultant’s view of CoCM is caseload science: who is stuck, who is unsafe, what to recommend. The PCP’s view is different. You already have the patient. You already prescribe. You already own the inbox. CoCM is not a referral out. It is a team that lets you treat depression and anxiety inside the medical home without becoming a psychiatrist and without abandoning the patient to a nine-month wait.

This session built a live PCP utilization engine (enroll, scripts, Tuesday huddle, time budget, 30-day launch, treating-clinician quiz) and an AIMS / value-based chapter. Skills routed: *skill-orchestrator* → *neh-session-synthesis-pdf* → *professional-pdf-design*, with *value-based-cocm-shared-savings-playbook* and the on-disk CoCM documentation pack. Planned names (autonomous RCM, digital twin) were not called.

How a PCP’s interaction with the system differs from the consultant’s

Surface	What the PCP does	What the consultant does
Relationship	Longitudinal treating clinician. Patient stays yours.	Usually never meets the patient. Advises you.
Who bills CoCM	Your NPI on 99492 / 99493 / G2214 ± 99494.	Does not bill CoCM. Face-to-face eval is a different service only if actually performed.
Minutes that count	Your E/M minutes do not count. Same-month visit is a separate clock.	Review time counts toward the CoCM month. Still not the billing NPI.
Weekly huddle	Not in the room the whole hour. You receive a rec list.	Runs systematic caseload review with the BHCM.
After huddle	Accept / modify / defer-with-date / step up. Chart it in ~72h. Prescribe.	Does not implement the meds. Does not take the claim.
Prescribing	You own the prescription pad.	Does not normally prescribe in CoCM (AIMS).

Surface	What the PCP does	What the consultant does
Failure mode	Silent inbox. Padding visit minutes. Calling it a psych referral.	Billing CoCM. Skipping non-improvers. Turning review into a shadow clinic.

TABLE 2. Role split. Sources: AIMS Center team structure (UW) — PCP directs team-based care including medication and does not usually work directly with the consultant; psychiatric consultant does not normally see the patient or prescribe; ~2–3 hours of consultant time per full-time BHCM per week. CMS psychiatric CoCM construct as used in this product.

DEFINITION

Collaborative Care is integrated psychiatric treatment delivered through primary care.

The AIMS Center at the University of Washington is the reference implementation of the Collaborative Care Model (CoCM). Trained primary-care clinicians work with an embedded behavioral health care manager. A psychiatric consultant reviews the caseload and recommends treatment. Patients are treated in primary care, not referred away as the default. The model is built on chronic-illness care: a defined population, a registry, and measurement-based treatment to target.

The founding evidence is the IMPACT trial (Unützer et al., *JAMA* 2002). At 12 months, 45% of older adults in Collaborative Care had a 50% or greater reduction in depressive symptoms, versus 19% in usual primary care. A Cochrane review (Archer et al., 2012, CD006525) included 79 randomized trials and 24,308 participants. Short-term depression outcomes favored collaborative care (SMD –0.34, 95% CI –0.41 to –0.27; RR 1.32, 95% CI 1.22 to 1.43) versus usual care. Those are clinical benefits. They are not a fee schedule.

What CoCM is not

- It is not a psychiatry clinic that happens to sit in the same building.
- It is not the PCP doing 70 minutes of counseling and billing a CoCM code.
- It is not general behavioral health integration (99484) with a psychiatrist’s name on the chart.
- It is not “the psychiatrist took the patient.” Accepting a rec to increase sertraline is not a referral.
- It is not crisis care. Mania, psychosis, and active suicide plans are step-ups.

The PCP remains the doctor

AIMS is explicit: the PCP directs team-based care and oversees the treatment plan, including medication. Treatment recommendations from the psychiatric consultant are communicated via the BHCM or the EHR. If the patient leaves your panel, you are no longer doing CoCM — you have made a referral.

Clinical benefits that accrue to primary care

- Treat common depression and anxiety where the patient already is — without a specialty wait list as the default.
- Non-response is visible at week 8–12 instead of at a no-show six months later.
- The consultant extends diagnostic and medication range without taking the relationship.
- BHCM outreach is the between-visit work PCPs do not have hours to do. Same-month chronic-care visits continue.

AIMS CENTER · UNIVERSITY OF WASHINGTON

Five principles define a well-run Collaborative Care program.

Developed in 2011 with national experts (Hartford, RWJF, AHRQ, California HealthCare Foundation). Source: aims.uw.edu/principles-of-collaborative-care.

AIMS test

If any one of these five principles is missing, effective Collaborative Care is not being practiced.

#	Principle	What it requires of the PCP's clinic
1	Patient-centered team	One shared plan including the patient's goals. Care in a familiar place. Not a handoff.
2	Population-based	Defined group in a registry. Reach non-improvers. Caseload-focused consultation, not only ad-hoc advice.
3	Measurement-based treatment to target	Named goals and outcomes (PHQ-9 and kin). Change treatment until the target is hit. Also called stepped care.
4	Evidence-based treatments	PST, behavioral activation, CBT, medications with a research base in primary care.
5	Accountable	Reimbursed for quality and outcomes, not only volume. Hinge to value-based payment.

TABLE 3. AIMS five principles — operational reading for primary care.

If a clinic only has a warm BHCM and bills 99493, it is running a counselor with a code attached — not CoCM.

AIMS CHECKLIST · CORE COMPONENTS AND TASKS (2014)

A well-run program is a checklist, not a poster.

AIMS “Patient-Centered Integrated Behavioral Health Care Principles & Tasks” (23 Dec 2014). Original tool scores each task none / some / most. Mapped here to the PCP’s job.

Group	PCP job	Tasks
1. Identification & diagnosis	You screen and diagnose. Do not wait for psychiatry to “confirm” depression.	Valid screens (PHQ-9/GAD-7) · diagnose related conditions · document baseline severity.
2. Engagement	You introduce the team. Consent lives on your visit. A PHQ-9 is not consent.	Introduce CoCM + self-management · start registry tracking.
3. Evidence-based treatment	You prescribe. BHCM delivers brief psychosocial treatment. Consultant recommends; you decide.	Biopsychosocial plan · education · MI/BA · PST/CBT/IPT when indicated · meds · change if not at target.
4. Follow-up, adjustment, relapse	You do not personally call every no-show. You act when the registry says “stuck.”	Registry follow-all · outreach to no-shows · measure each contact · side effects · flag non-improvers · relapse plan.
5. Communication	Closed loop ≤72h is how a rec becomes your order.	Provider communication · family when appropriate · track specialty/social referrals.
6. Psychiatric case review	You are usually not in the huddle. You receive recs. You remain the treating clinician.	Weekly caseload review · further diagnostic recs · in-person/tele eval only when the model steps up.
7. Oversight & QI	Clinic leadership owns QI. Outcomes are the product.	Admin + clinical supervision · examine outcomes and use them to improve.

TABLE 4. Full AIMS 2014 core-component task list, compressed. Use the live AIMS chapter for the unrolled checklist.

Component	Owner	Done when
Treating PCP/NP/PA	PCP	Named clinician who will prescribe and close loops.
BHCM	BHCM	One person: outreach, brief interventions, registry, time log.

Component	Owner	Done when
Psychiatric consultant	Psych	Weekly SCR. Recs to PCP. AIMS: ~2–3 h/week per BHCM FTE.
Registry	BHCM	Can list stuck / safety / new this week.
MBC	MA + BHCM	PHQ-9/GAD-7 every 2–4 weeks until target.
Step-up	PCP + psych	Change treatment if not ≥50% improved after 10–12 weeks on a given plan (AIMS).
Closed loop ≤72h	PCP	Accept / modify / defer-with-date / step up.
Time log	BHCM	Date, duration, activity, staff. Huddle ≠ threshold.
Graduation	Team	Sustained response → exit. Usual E/M continues.
Treating NPI	Biller	99492/93/G2214 ± 99494. Never consultant NPI.

TABLE 5. Owners. Caseload ~50–80 active per BHCM FTE is a staffing heuristic, not a CMS schedule.

CODES AND MONEY · PCP VIEW

The PCP bills the month. The PCP does not manufacture the minutes.

Psychiatric CoCM codes describe a calendar month of team activity directed by the treating physician or QHP, in consultation with a psychiatric consultant, of BHCM activities. Default in this product: do not count the treating clinician's E/M toward the CoCM total.

Code	What it is	Typical floor	PCP rule
99492	Initial psychiatric CoCM month	~70 min	First calendar month. Consent + initiating visit + treating relationship.
99493	Subsequent month	~60 min	Same fidelity stack. Huddle alone does not meet the floor.
99494	Add-on +30 min	+30 each	Never a base code. Stack only when minutes support each extra 30.
G2214	Short month	~30 min	Honest code when the full-month floor is not met.
99213/14	Same-month E/M	Visit clock	Allowed. Separate documentation. Do not dump into the CoCM ledger.
99484	General BHI — not CoCM	Different product	No psychiatric consultant required. Not a CoCM fallback.

TABLE 6. PCP code map. Verify MAC and Medicaid manuals. AAFP/CMS: directed by the treating physician or QHP.

Wisconsin Medicare computed alloweds in this product — carrier 06302, locality 00, nonfacility, non-QP, as of 30 July 2026. Full allowed amounts, not receipts, not commercial or Medicaid schedules.

Code	Physician computed allowed	Independently billing NP (85%)
99492	$153.19	$130.21
99493	$138.71	$117.90
99494	$58.72	$49.91
G2214	$58.01	$49.31

TABLE 7. WI PFS computed alloweds. Not a receipt.

Worked illustration — not a forecast

20 subsequent 99493 months × $138.71 = $2,774.20 computed physician allowed. Mix is never 100% subsequent. Collections are not alloweds. BHCM and consultant labor are costs.

Where clinics lose the money: consultant NPI; under-threshold 99493; double-counted psychotherapy minutes; silent inbox; never graduating; invented commercial alloweds in a board deck.

VALUE-BASED CARE

AIMS principle 5 is already a value-based statement. Payment can catch up.

Collaborative Care was designed as accountable care: the team is responsible for outcomes, not only encounters. Fee-for-service 99492–99494 pay for a month of that work. Value-based arrangements pay for the outcomes the registry is already measuring. The clinic does not need a new data factory. It needs the AIMS stack to be real, and a contract that names metrics already in the workflow.

Phase	What it is	PCP implication
FFS CoCM	99492/93/94/G2214 on the treating NPI when minutes and fidelity are real.	This is the floor. Do not skip it to chase a bonus.
Accountable (AIMS 5)	The team is already measuring PHQ-9/GAD-7, retention, and review fidelity.	Your 72-hour loop is a quality metric, not extra charting.
Upside-only shared savings	Pilot with 1–2 willing payers on a small cohort. User supplies the corridor.	Do not sign two-sided risk on a 12-patient book.
Two-sided risk	Only on a mature panel with stable MBC and written downside protection.	Counsel reviews the amendment. Not this brief.

TABLE 8. Value-based sequence from the on-disk shared-savings playbook. Refuse invented corridors.

Metric	Working definition	Data source
PHQ-9 response	≥50% drop at a defined interval	MBC already in CoCM
PHQ-9 remission	Score below an agreed threshold	Contract defines the cut
GAD-7 response	Parallel construction for anxiety	MBC already in CoCM
Retention	≥3 months continuous CoCM (or payer definition)	Registry
Closed-loop fidelity	% of recs with a dated PCP decision in ~72h	PCP utilization metric

Metric	Working definition	Data source
Psych review completion	% of active patients considered in SCR (product target ≥90%)	Huddle log

TABLE 9. Metric dictionary — not a signed contract.

Do not

Do not forecast shared-savings dollars without a contract. Do not call a Planned digital twin. Do not convert IMPACT's 45% vs 19% into a revenue model. Do not treat FFS CoCM and value-based upside as the same pile of money.

OPEN · REJECTED · PROVENANCE

What this session did not decide.

Open item	Owner	Note
Commercial / Medicaid fee schedules	User / contracting	Refused until pasted. WI PFS is not a proxy.
G2214 on WI Medicaid	Payer written policy	Treated as $0 in this product until confirmation.
Shared-savings corridor	Payer amendment + counsel	Upside-only first. Not a national percent.
Which two payers to pilot VBC	Practice leadership	Playbook suggests a willing Medicaid or regional ACO — not a selection.
BHCM FTE and consultant FMV	Operations + counsel	AIMS 2–3 h/week consultant per BHCM FTE is a heuristic.

TABLE 10. Open items. Not blocked work — unfinished inputs.

Rejected this session

- Billing CoCM on the psychiatric consultant NPI; counting PCP visit minutes toward 99492/99493.
- Using 99484 as a CoCM fallback; inventing commercial allowables or 30–50% shared savings as facts.
- Calling Planned products (autonomous RCM, digital twin, command center) as if Implemented.
- Treating IMPACT’s 45% vs 19% as a revenue model.

Cite-or-refuse

- Refused: commercial and Wisconsin Medicaid dollar amounts without a pasted schedule.
- Refused: national “30–50% shared savings” as a fact. User contract wins.
- Labeled: WI PFS computed alloweds in TABLE 7.
- Open: G2214 on WI Medicaid is $0 in this product until written confirmation.

Provenance

- Transcript: 26–27 August 2026 PCP engine + AIMS / value-based request.

- AIMS Center (UW): overview; five principles (2011); team structure; systematic caseload review; 2014 checklist.
- Unützer J et al. IMPACT. JAMA. 2002. Archer J et al. Cochrane Database Syst Rev. 2012;10:CD006525.
- CMS / AAFP: 99492, 99493, 99494, G2214 directed by the treating physician or QHP.
- This product: WI PFS computed alloweds, carrier 06302 / locality 00, as of 30 July 2026.
- Skills: skill-orchestrator · neh-session-synthesis-pdf · professional-pdf-design · value-based-cocm-shared-savings-playbook · cocm-documentation-templates-pack · cocm-revenue-optimization-engine.
- Connected search 27 Aug 2026: Google Drive title search empty. Notion/SharePoint: CoCM architecture syllabus note (Jul 2026) and insurance-reimbursement aggregator (Jun 2026). No contract text retrieved — none invented.