Collaborative Care (CoCM/BHI) Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A collaborative care note is the registry-backed monthly record behind the psychiatric Collaborative Care Model: contacts, validated scores, psychiatric consultant recommendations, and the clinical minutes that support the month's claim under 99492, 99493, 99494, or 99484.

Team and month header the three-member model on paper
Do: name the billing practitioner, care manager with credentials, and psychiatric consultant, plus the calendar month.
Pitfall: an unnamed consultant makes the team unverifiable and the claim unsupportable.

Consent and initiating visit one line, documented once
Do: anchor the verbal consent (date, cost sharing explained) and the initiating visit type and date.
Pitfall: consent that lives in memory; auditors read absence as never obtained.

Contact and activity log the spine of the note
Do: write one dated entry per contact with mode, clinical content, and minutes; registry time counts.
Pitfall: a bare end-of-month total; time nobody can reconstruct is time nobody credits.

Validated measure tracking trajectory at a glance
Do: put this month's score beside baseline and priors; CMS names no specific tool.
Pitfall: a filed score with no response; flat numbers over a static plan.

Psychiatric consultant review fingerprints in the chart
Do: record the review date, the recommendations, and who entered them; the care manager may.
Pitfall: a weekly meeting that never reaches this patient's record.

Treatment-to-target response what changed because of the numbers
Do: relay medication recommendations, deliver the brief intervention, step the referral.
Pitfall: "supportive contact" with no link to the tracked target.

Monthly time summary and code the audit spine
Do: total the clinical minutes and name the code they support; the month is the unit.
Pitfall: rolling minutes forward, or counting clerical, travel, or solo review time.

Next month and exit plan episodes end somewhere
Do: set the re-administration date and plan relapse prevention as scores approach remission.
Pitfall: registries full of indefinite maintenance patients; reviewers notice.

Before you sign

- [ ] Three team roles named with credentials
- [ ] Consent documented once, with its date
- [ ] Every entry pairs minutes with activity
- [ ] Scores tracked and responded to
- [ ] Consultant review dated inside the month
- [ ] Total clears the code, nothing rolled
- [ ] No 99484 in a CoCM month, no double count

Drafting with AI

Capture 30 seconds of bullets after each contact: mode, what happened, minutes, score if taken, recommendation if relayed.

"Draft this month's collaborative care note from these entries, month 3, PHQ-9 11 to 8, sertraline increased per consultant, 92 minutes: …"

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

75 to 250 words	3 to 8 min per entry	Every calendar month	Team · payers · auditors
per registry entry	clinical team estimate	of a CoCM episode	who reads it

Full guide and sample note:
bastiongpt.com/template/collaborative-care-note

Collaborative Care Monthly Note Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Patient (initials): | Month/Year: | Dx code: | Episode month:

Billing practitioner: | Care manager / credentials: | Psychiatric consultant:

Consent and initiating visit
Date obtained, verbal noted, cost sharing explained; initiating visit type and date

Contact and activity log
One line per contact: date, mode, clinical activity, minutes; registry time counts, clerical does not

Validated measures
Scale, baseline, prior, and this month's score with dates

Psychiatric consultant review
Caseload review date; recommendations; recorded by; relayed to the prescriber with action

Treatment-to-target response
What changed because of the scores; interventions delivered

Month total and codes
Total clinical minutes and the code supported; clerical and travel excluded; no 99484 with CoCM

Plan for next month / relapse prevention
Re-administration date; relapse prevention and exit as scores approach remission

Signature / credentials: | Date: