

Medicaid Collaborative Care Program Billing Guidance for Article 28 Outpatient Clinic Claims

Article 28 outpatient clinics that have been certified as participants of the NYS Medicaid Collaborative Care Program are eligible to receive supplemental Medicaid payments for Collaborative Care services provided to Medicaid fee-for-service (FFS) and Medicaid managed care recipients. Note: Collaborative Care is “carved-out” of managed care; claims for managed care individuals must be submitted directly to FFS Medicaid). This billing guidance outlines the necessary steps required to ensure that the maximum reimbursement for delivering these services is received. Questions regarding this program may be sent to nyscollaborativecare@omh.ny.gov.

Collaborative Care provided in an Article 28 outpatient clinic program is reimbursed by Medicaid on a monthly case payment basis. Claims will be submitted using the 837i (institutional) claim form as this form allows for use of rate codes. In the header of the 837i Medicaid claim the biller will include the appropriate rate code as a value code. This is done in the value code field by first typing in “24” and following that immediately with the appropriate four digit rate code.

The NPI of the clinician providing the service will be entered on the claim as the attending provider. If the attending provider *is not* enrolled with Medicaid, the NPI of an enrolled referring professional must be added to the claim as well. If the attending provider *is* enrolled with Medicaid then the referring line may be left blank.

Additionally, the header of the claim **must** use the first day of the month of service as the “from date” and the last day of the month of service as the “through date”. For example, for January 2018, the biller would use January 1, 2018 as the “from date” and January 31, 2018 as the “through date”, regardless of the actual date(s) on which service was provided during January 2018. If service, defined as at least one qualifying contact, was not provided during the month, the provider may not bill for that month.

For rate codes 5246 and 5247 (see below), the individual claim lines **must** contain **every qualifying contact** for that month each coded with the actual date of service for that contact, using procedure code T2022, and the appropriate “U modifier code” (as explained below):

- U1- live phone contact with a non-licensed practitioner or paraprofessional
- U2- live phone contact with an appropriately licensed practitioner
- U3- face-to-face contact with a non-licensed practitioner or paraprofessional
- U4- face-to-face contact with an appropriately licensed practitioner
- U5- face-to-face contact in a group setting with an appropriately licensed practitioner

Additionally, to submit a collaborative care claim the client must have been seen by an appropriately licensed practitioner within the previous 90 days, meaning there must be at least one U4 or U5 as a qualifying contact for the month of the claim or one of the two months immediately prior. For example, to bill for January, there must have been a face-to-face contact in November, December or January. If the “three month” standard has not been met, the provider may not bill again until a U4 or U5 contact is provided (see example below).

For months where there was no face-to-face contact with a licensed professional (U4 or U5), there must be at least one contact (U1, U2, or U3) in order to bill the monthly case rate. In other words, there must be at least

one monthly contact at all times to maintain the monthly case rate payment. There must also be documentation of a completed PHQ-9 monthly in the patient's record to qualify for the monthly case payment.

Please note that it is acceptable to bill Collaborative Care for a patient also enrolled in a health home.

For the "Retainage" rate codes (5248 and 5249), the "from date" in the header of the claim must use the first day of the month you are submitting the claim. The actual services for which the Retainage is claimed will have already been billed under 5246 or 5247, but one line on the claim should be coded with T2022, using the "from date" in the header of the claim as the line-level date of service. The "through date" on the claim should be the same date as the "from date", although technically, from a billing systems perspective, this won't matter for these two rate codes.

Billing for face-to-face contacts with a psychiatrist/psychologist – Article 28 Clinic (Freestanding or Hospital)

In addition to the monthly Collaborative Care case payment, providers may also separately bill the appropriate APG rate code for face-to-face counseling, or other billable services, that are provided by a psychiatrist or licensed psychologist. This also applies to licensed social workers that provide a face-to-face service to a pregnant woman or a child enrolled in this program, except that those services are not billed under APGs, but rather to the special rate codes that have already been established for that purpose.

Billing for face-to-face contacts with a psychiatrist/psychologist/licensed social worker – Federally Qualified Health Center (FQHC)

In addition to the monthly collaborative care monthly case payment, FQHC providers may also separately bill their PPS rate for face-to-face counseling provided by a psychiatrist, licensed psychologist, or licensed social worker.

Billing for Medicare/Medicaid dually-eligible clients

On January 1, 2017, Medicare began reimbursing for Collaborative Care services provided by non-FQHCs. On January 1, 2018, Medicare expanded Collaborative Care service reimbursement to FQHCs. As the payer of last resort, a claim may only be submitted to Medicaid after the Collaborative Care provider submits the claim to Medicare, using the Medicare-assigned HCPCS / CPT codes. Currently the HCPCS / CPT codes used for Collaborative Care are not the same for Medicare and Medicaid. This difference will require that the provider change the codes on the claim before submitting to Medicaid. The provider will also need to indicate the amount received by Medicare on the Medicaid claim.

Medicaid Timely Filing Requirements

Medicaid regulations require that claims be initially submitted within 90 days of the date of service to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider. All such claims submitted after 90 days must be submitted within 30 days from the time submission came within the control of the provider. For more information regarding timely filing please see the link below: https://www.emedny.org/HIPAA/QuickRefDocs/FOD-7001_Sub_Claims_Over_90_days_Old.pdf

The use of delay reason code 3 – authorized delay for Collaborative Care claims requires the approval of the Office of Mental Health. To request approval for the use of this delay reason code for issues outside the control of the provider, please email nyscollaborativecare@omh.ny.gov.

Rate Code 5246 - Collaborative Care Monthly Case Payment, Year 1

To bill this rate code, the primary care provider and/or depression care manager must have a minimum of one clinical contact with the patient and completed the appropriate symptom scale (i.e. the PHQ-9 or GAD-7) every 30 days. This contact may include individual or group psychotherapy visits or telephonic engagement as long as treatment is delivered. In addition, there must be a minimum of one face-to-face contact with the patient

by an appropriately licensed person for a minimum of 15 minutes every three months. This rate code can be billed a maximum of 12 times per client. The payment will be \$112.50. Note that this amount is exclusive of a retainage that can be billed only after the first three months, then monthly for a maximum of twelve units, under rate code 5248. This will bring the effective monthly reimbursement to \$150.

Rate Code 5247 - Collaborative Care Monthly Case Payment, Year 2 (months 13-24 of treatment)

Although a patient is limited to 12 months of Collaborative Care treatment, **with prior approval from the Office of Mental Health's Medical Director**, or designee, an additional 12 months is permitted at two-thirds of the monthly rate of the initial 12 months if the treatment team demonstrates the need for ongoing depression care management. Sites must fill out the appropriate form for each case they want to be considered for additional months of treatment. The rules for billing this rate code are the same as those for rate code 5246. This rate code can be billed a maximum of 12 times per client. The payment will be \$75.00. Note that this amount is exclusive of a retainage that can be billed only after the first three months, then monthly for a maximum of twelve units under rate code 5249. This will bring the effective monthly reimbursement to \$100.

Please note that rate codes 5246 and 5247 cannot be billed in the same month.

Rate Code 5248 - Collaborative Care Retainage, Year 1

Twenty-five percent of the full monthly case payment will be withheld by the state. This retainage will be available only after completion of a patient's third month of enrollment if the provider has complied with the full terms of the Collaborative Care Program and has documented patient outcomes as specified by the program. Providers who have met the required criteria may begin billing for retainage after three months of service provision. Providers have flexibility in that they may bill retainage monthly (after the first three months), or they can bill in any increment up to the full twelve months of retainage. Before this rate code can be billed, rate code 5246 must have been billed for the months the provider is billing retainage for (e.g., the provider cannot bill for six units of retainage if the client has only been seen for five months of Collaborative Care). This rate code can be billed a maximum of twelve units per client. The payment will be \$37.50 per unit.

Rate Code 5249 - Collaborative Care Retainage, Year 2 (months 13-24 of treatment)

If a second year of Collaborative Care is approved, twenty-five percent of the full monthly case payment will again be withheld by the state. This retainage will be available only after completion of a patient's third month of enrollment if the provider has complied with the full terms of the Collaborative Care Program and has documented patient outcomes as specified by the program. Providers who have met the required criteria may begin billing for retainage after three months of service provision. Providers have flexibility in that they may bill retainage monthly (after the first three months), or they can bill in any increment up to the full twelve months of retainage. Before this rate code can be billed, rate code 5246 must have been billed for the months the provider is billing retainage for (e.g., the provider cannot bill for 6 units of retainage if the client has only been seen for 5 months of Collaborative Care). This rate code can be billed a maximum of twelve units per client. The payment will be \$25.00 per unit.

Please note that rate codes 5248 and 5249 cannot be billed in the same month.

Billing Example:

After a face-to-face assessment conducted by an appropriately licensed practitioner, with an accompanying baseline PHQ-9 score of ≥ 10 and confirmatory diagnosis of depression, a client is admitted to the Collaborative Care Depression Program on September 12, 2017. There are no other contacts for that month.

When billing for this client:

1. The header of the claim will show September 1, 2017 as the "from" date and September 30, 2017 will show as the "through" date;

2. The value code (rate code) will be 5246
3. Line level will include the actual date of service, CPT code T2022 and modifier U4 (to indicate the contact was face-to-face with a licensed practitioner)

Note: The use of the U4 or U5 modifier allows the provider to bill for February and March if at least one phone call and/or face-to-face contact with a non-licensed practitioner has occurred in each of those months but a face-to-face contact with a licensed practitioner has not. This pattern of contact requirements continues for the length of the client's program participation.

After three months the provider may bill an additional claim per month (for this example in December assuming all required contacts were made each month prior) using rate code 5248 for retainage so long as the provider has complied with all the requirements of the program.

Billing Case Study:

Jan – face-to-face assessment with licensed practitioner; PHQ-9 completed

Feb – face-to-face contact with licensed practitioner; PHQ-9 completed

Mar – phone contact; PHQ-9 completed

Apr – no contact; no PHQ-9

May – face-to-face contact with licensed practitioner; PHQ-9 completed

Jun – phone contact; PHQ-9 completed

Jul – face-to-face contact with licensed practitioner; PHQ-9 completed

Aug – phone contact; PHQ-9 completed

Sep – face-to-face contact with non-licensed practitioner; PHQ-9 completed

Oct – phone contact; PHQ-9 completed

Nov – phone contact; PHQ-9 completed

Dec – face-to-face contact with licensed practitioner; PHQ-9 completed

- The provider may not bill for April because there was no contact and no PHQ-9 completed
- The provider cannot bill for October because there has not been a face-to-face contact with a licensed practitioner in three months (the two months immediately prior and October).
- The provider cannot bill for November because there has not been a face-to-face contact with a licensed practitioner in three months (the two months immediately prior and November).
- The first retainage claim could be billed April 1st (after completing three billable months).
- The second retainage could not be billed until at least June 1st (after completing another billable month).