

## Medicaid Collaborative Care Program Billing Guidance

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](mailto:nyscollaborativecare@omh.ny.gov).

Physical health providers/practices 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**, meaning CoCM reimbursement is not reimbursed to plans through the Premium and is not covered under managed care contracts. **Claims for any CoCM Medicaid billing, including managed care individuals, must be submitted directly to FFS Medicaid.**

Collaborative Care provided is reimbursed by Medicaid on a monthly case payment basis.

The NPI of the primary care provider directing the service will be entered on the claim as the attending provider. If the attending provider **is not** enrolled with Medicaid, the NPI of a Medicaid 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.

The dates of service cover the entire month. To align with Medicare and Commercial plans, we recommend using the last day of the month. Provider will use the appropriate procedure code (T2022, 99492, or 99493) as determined by the cumulative time spent through the month (up to 60/70 minutes). A second claim line will only be used for indicating additional time spent over 60/70 minutes in increments of 30 minutes (99494). There will be no increase in payment for additional claim lines. All lines will use the same date of service.

Procedure codes for monthly case payment claims (rate codes 5246 and 5247 for institutional claims) are described below:

- **99492** – First 70 minutes in the first calendar month for behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating provider. Medicaid payment will be the same rate as it is currently: \$112.50 in the first year (Art. 28 rate code 5246), \$75 in year two (Art. 28 rate code 5247).
- **99493** – First 60 minutes in a subsequent month for behavioral health care manager activities. Medicaid payment will be the same rate as it is currently: \$112.50 in the first year (Art 28 rate code 5246), \$75 in year two (Art 28 rate code 5247).
- **99494** – Each additional 30 minutes in a calendar month of behavioral health care manager activities listed above. This code is listed separately and only used in addition to 99492 or 99493. Medicaid will pay \$0.00 for this code but it is required for informational purposes, as well as for Medicare/Medicaid dually eligible clients (see below)
- **T2022 – Case Management, per month.** This code will be used if the time spent on the delivery of Collaborative Care does not meet the time requirements for procedure codes 99492 or 99493 over the course of the month. Medicaid payment will be the same rate as it is currently: \$112.50 in the first year (Article 28 rate code 5246), \$75 in year two (Art. 28 rate code 5247).

Additionally, to submit a collaborative care claim the client must have had a face to face contact with an appropriately licensed practitioner within the previous 90 days. 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 an appropriately licensed face to face contact is provided (see example below).

For months where there was no face-to-face contact with a licensed professional (but there was within the previous 90 days), there must be at least one contact in order to bill the monthly case rate. In other words, there

must be at least one monthly contact (by phone, video or face-to-face) at all times to maintain the monthly case rate payment. There must also be documentation of a completed relevant monitoring tool (i.e., PHQ-9 or GAD-7) 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.

### **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. If claims are not submitted within the required 90 days, providers must seek prior approval from OMH to use "delay reason code 3 – authorized delay." To request approval for the use of this delay reason code for issues outside the control of the provider, please complete the Delay Request form and send to [nyscollaborativecare@omh.ny.gov](mailto:nyscollaborativecare@omh.ny.gov).

If approval is granted, delayed claims must be submitted within 30 days from the date of the approval letter. Only one delay letter may be issued per practice, per time period. Once the approval letter expires, another letter will NOT be issued. Providers should ensure that timely claims are being processed and paid correctly so claims are not encountering any other edits that would prevent the delayed claims from being processed.

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](https://www.emedny.org/HIPAA/QuickRefDocs/FOD-7001_Sub_Claims_Over_90_days_Old.pdf)

### **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, for dually eligible clients a claim may only be submitted to Medicaid after the Collaborative Care provider submits the claim to Medicare, using the HCPCS / CPT codes described above. The provider will also need to indicate the amount received by Medicare on the Medicaid claim.

Medicare requires a minimum of 70 minutes for the first month of activities provided to a client and 60 minutes for subsequent months (Non-FQHCs may apply the "half plus one rule" and bill Medicare/ Commercial plans for a minimum of either 36 or 31 minutes of CoCM, respectively); Medicaid does not require a time threshold for T2022. Providers may use procedure code T2022 when the service provided is under the required number of minutes (depending on month of activity); however, this code is not valid for Medicare or commercial payers. When T2022 is provided to a Medicare/Medicaid dually eligible client, the provider will be able to "zero-fill" the claim and submit directly to Medicaid as the Medicare requirements for payment have not been met.

### **Billing Example Scenarios:**

1. After a 50 minute, face-to-face assessment conducted by an appropriately licensed practitioner, with an accompanying baseline PHQ-9 score of  $\geq 10$  and confirmatory diagnosis of depression, a client is admitted to the Collaborative Care Depression Program on January 10th. The BH CM then call the patient to follow up on January 22<sup>nd</sup>, and has a 15 minute phone call. The BH CM also documents 5 minutes of documentation in the registry following each interaction with the patient for a total of 75 minutes for the month of January.

When billing Medicaid for this client:

1. The date of service for this claim will be January 31<sup>st</sup>.
  2. The value code (rate code) will be 5246 if in an Article 28 practice
  3. Line level will include January 31st and CPT code 99492.
2. After a few months of treatment, the frequency and duration of contacts with the patient decrease. After seeing the patient in person in February, and several phone contacts in March, the BH CM only has a 15

minute phone call to follow up and administer the PHQ-9 in April. The BH CM spends a few minutes documenting in the registry, but will not meet the criteria for the 994XX CPT codes for this month. In this scenario, they would be T2022.

When billing Medicaid for this client:

1. The date for this claims will be April 30<sup>th</sup>.
2. The value code (rate code) will be 5246 if in an Article 28 practice.
3. Line level will include April 30th and CPT code T2022.

### **CCMP 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).

### **For Article 28 Sites:**

- The first retainage claim *for an Article 28* could be billed April 1<sup>st</sup> (after completing three billable months).
- The second retainage claim *for an Article 28* could not be billed until at least June 1st (after completing another billable month).

### **Guidance Specific to Article 28 Clinics (those doing institutional billing)**

Claims will be submitted using the 837i (institutional) (UB04 paper) 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 header will also use the same date, ideally the end of the calendar month, for both the “from” and “through” dates.

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

To bill this rate code, the primary care provider and/or behavioral health 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) each calendar month. 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) -REQUIRES PRIOR APPROVAL FROM OMH**

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.

#### **Article 28 ONLY- Additional Quality Supplemental Retainage Payment**

For the "Retainage" rate codes (5248 and 5249), the "from date" in the header of the claim should be the same as the "through date" of the month you are **submitting the claim**. For consistency in billing, you may use the last day of the month, as with the other monthly claims. The actual services for which the Retainage is claimed will have already been billed under 5246 or 5247, but one line on the claim must be coded with T2022, using the "from date" in the header of the claim as the line-level date of service. You can only bill retainage for months that there is a 5246 or 5247 claim for that patient that 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 receiving billable Collaborative Care services if the provider has complied with the full terms of the Collaborative Care Program and has documented patient outcomes as specified by the program. In addition to being in full compliance with the terms of this program, the provider must document in the patient record that one of the following outcomes was achieved:

- Demonstrable clinical improvement, as defined by:
  1. A drop in the relevant symptom score to below 'positive' level; for PHQ-9 and GAD-7, this is below 10 (Note, If patient is being treated for both depression and anxiety, BOTH PHQ-9 and GAD-7 scores must decrease to meet this improvement criteria)
  2. Or a 50% decrease in the symptom score from the level of the original score
- In cases where there was no demonstrable clinical improvement within that billing period, there must be documentation in the medical record of one of the following:
  1. Psychiatric consultation (defined here as review of the case by the designated collaborative care psychiatrist with either the care manager or primary care provider) and a recommendation for treatment change by the psychiatric consultant
  2. Change in treatment (e.g., change in medication\*, change in psychotherapy type or frequency, or completed referral to more intensive specialty mental health treatment).

*\*Please note, change in dosage may constitute a change in medication only if the dose change does not represent a titration up to treatment dose, but a true modification of the patient's course. In order to capture this, we will limit the window for change in dose to between 6 weeks and 12 weeks after starting treatment.*

Providers who have met the required criteria may begin billing for retainage after three months of service billable Collaborative Care 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. Providers that do not use the CMTS registry are required to submit the OMH Retainage Attestation form for each month they bill retainage claims.

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

If an additional twelve months 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 5247 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). Reminder, this needs prior approval from OMH. 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 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. Time spent and billed for counseling services cannot be counted towards time for the CoCM codes.

**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. Time spent and billed for counseling services cannot be counted towards time for the CoCM codes.

**Guidance Specific to Non-Article 28 sites (those billing professional claims)**

In order to bill for Collaborative Care, the billing (and, if applicable, referring) provider must have specialty code '333' on their provider file. To indicate the provider is approved, on the professional claim form, Service Authorization Exception Code '7' (Special Handling) must be selected (Box 25D on the EMEDNY-150003 form).

Claims will be submitted using the 837p (professional) claim form.

Billing for 13+ months of Collaborative Care services requires prior approval from OMH.