



**Office of
Mental Health**

Updates to Collaborative Care Medicaid Billing

Office of Strategic Finance & Managed Care

July 2025

Summary of Changes

Summary of Modifications

The following changes have been submitted to CMS (pending SPA 24-0030) and the NYS Division of the Budget (DOB) for the NYS Collaborative Care (“CoCM”) program, effective 9/1/25:

- Year 2 rate reductions and approval requirements will be dropped
- New and discontinued rate codes
- New Rate Code 5261 – Collaborative Care Case Payment Add-On
- New Procedure Code 99494 – Additional Psych. (30 min)
- Rate Increases

24 Month Reimbursement Limit

- Providers will be reimbursed by Medicaid for patients receiving Collaborative Care services for a maximum of 24 months without the need for OMH approval after 12 months. The 24 months are not required to be consecutive.
- After six months without a service, the 24-month service limit will reset.
- The Year 2 rate code and rate reduction will be discontinued.
- CoCM is generally a short-term intervention, with most patients improving and being discharged in 9 months or less.
- The majority of patients will not require more than 12 months of care in a given episode.

Billing Time Requirements

- The following is a breakdown of time requirements for Medicaid and Medicare billing.

CPT Code	Type of Service	Total Duration
99492	Initial – 70 Minutes	36 – 85 minutes
99492 + 99494	Initial + Additional	86 – 115 minutes
99493	Subsequent	31 – 75 minutes
99493 + 99494	Subsequent + Additional	76 – 105 minutes

Source: American Medical Association CPT 2025 Professional Edition

Article 28 Outpatient Depts.

INSTITUTIONAL CLAIMING

New and Discontinued Rate Codes

- Currently CoCM has 4 rate codes:
 - 5246 – Year 1
 - 5247 – Year 2
 - 5248 – Retainage - Year 1 after 3 months of enrollment
 - 5249 – Retainage - Year 2 after 15 months of enrollment
- Effective Sept. 1, 2025:
 - Rate codes **5247**, **5248**, and **5249** will be discontinued
 - Rate code **5246** will be paid in full starting from the first month
 - Rate code **5261** will be added as a CoCM Payment Add-On

Rate Code	Description	Freestanding DTC	Art. 28
5246	CoCM Monthly Case Payment	\$172.97	\$184.21
5261	CoCM Case Payment Add-on	\$86.48	\$92.10

Rate Code 5261 – CoCM Payment Add-On

- To bill this rate code, the primary care provider and/or behavioral health care manager must have provided at least the initial 60-minute monthly requirement plus 30 additional minutes (90 minutes total) of CoCM services.
- When the requirements are met to bill this rate code, it must be submitted as a second, separate claim in addition to rate code 5246 with new procedure code **99494**.
- Only one claim per month for one unit may be submitted with this rate code for reimbursement, regardless of if monthly activities exceed the required additional 30 minutes.

Private Practitioners and Groups

PROFESSIONAL CLAIMING

Rate Changes

- Previously, Year 2 payment amounts were less than Year 1 payment amounts. The Year 2 rates will be discontinued.
- Procedure codes and payment rates related to CoCM have been updated to reflect a uniform payment amount for both Years 1 and 2.

Proc. Code	Description	New Rate
99492	Initial Psych. CoCM	\$172.97
99493	Subsequent Psych. CoCM	\$172.97
T2022	Case Management	\$172.97
99494	Additional Psych. CoCM (30 min)	\$86.48

Procedure Code 99494 – Additional Psych. (30 min)

- A second procedure code, 99494, may be submitted when there has been 30 additional minutes of time spent over the required 60 minutes or 70 minutes as a second, separate claim.
- Medicaid will pay an additional \$86.48 when this code is used.
- **Only one** add-on code unit will be reimbursable per month.

Example Scenarios

Scenario 1

- After a 50-minute, face-to-face assessment conducted by an appropriately licensed practitioner, with an accompanying baseline PHQ-9 score of greater than or equal to 10 and confirmatory diagnosis of depression, a client is admitted to the Collaborative Care Depression Program on January 10th.
- The BHCM then calls the patient to follow up on January 22nd and has a 15-minute phone call.
- The BHCM also records 5 minutes of documentation in the registry following each interaction with the patient for a total of 75 minutes for the month of January.

Scenario 1 – Billing Procedure

When billing Medicaid for services provided in an Article 28 for this client:

1. The date of service for this claim will be January 31st.
2. The value code will be **24** and the rate code will be **5246**.
3. Line level will include January 31st and CPT code **99492**.

For a non-Article 28 claim, the following should occur:

1. The date of service for this claim will be January 31st.
2. The CPT/HCPCS code **99492** will be used.
3. The billing provider will have specialty code **“333”** included.
4. Service Authorization Exemption code **“7”** will be used.

Scenario 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 BHCM only has a 15-minute phone call to follow up and administer the PHQ-9 in April.
- The BHCM 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 bill using procedure code **T2022**.

Scenario 2 – Billing Procedure

When billing Medicaid for services provided in an Article 28 for this client:

1. The date for this claim will be **April 30th**.
2. The value code will be **24** and the rate code will be **5246**.
3. Line level will include April 30th and CPT code **T2022**.

For a non-Article 28 claim, the following should occur:

1. The date of service for this claim will be **April 30th**.
2. The CPT/HCPCS code **T2022** will be used.
3. The billing provider will have specialty code **“333”** included.
4. Service Authorization Exemption code **“7”** will be used.

Scenario 3

- A patient was enrolled in CoCM in April, and the provider has successfully billed for both April and May.
- In June, the patient was seen on June 4 and June 15 for a total of 60 minutes. On June 29 there is an additional phone contact with the patient for 30 minutes.
- The total time spent with the patient is **90** minutes.
- The provider is entitled to receive the reimbursement add-on.

Scenario 3 – Billing Procedure

When billing Medicaid for services provided in an Article 28 for this client, **two claims will be submitted:**

1. Claim 1:

- a) The date for this claim will be **June 30th**.
- b) The value code will be **24** and the rate code will be **5246**.
- c) Line level will include June 30th and CPT code **99493**.

2. Claim 2:

- a) The date for this claim will be **June 30th**.
- b) The value code will be **24** and the rate code will be **5261**.
- c) Line level will include June 30th and CPT code **99494**.

For a non-Article 28 claim, the following should occur:

- 1. The date of service for this claim will be **June 30th**.
- 2. First line level will include **June 30th** and CPT code **99493**.
- 3. Second line level will include **June 30th** and CPT code **99494**.
- 4. The billing provider will have specialty code **“333”** included.
- 5. Service Authorization Exemption code **“7”** will be used.

Questions & Contact Information

Please contact:

Programmatic Questions: nyscollaborativecare@omh.ny.gov

Billing/Claims: medicaidffsbillinghelp@omh.ny.gov



Office of Mental Health