NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | Department of Health

Medicaid Collaborative Care Program
Billing Guidance

Updated June 2025

Overview

Physical health providers/practices that have been certified as participants of the NYS Medicaid Collaborative Care Program are eligible to receive reimbursement for Collaborative Care services provided to Medicaid fee-for-service (FFS) and Medicaid managed care recipients. This billing guidance outlines the necessary steps required to ensure that the maximum reimbursement for delivering these services in institutional and professional settings is received. Questions regarding this program may be sent to nyscollaborativecare@omh.ny.gov.

Collaborative Care (CoCM) is an evidence-based model of behavioral health integration in primary care. CoCM enhances usual primary care by adding care management support for patients receiving behavioral health treatment and regular psychiatric consultation with a prescribing psychiatric provider. In addition to the treating (billing) primary care/specialty physician, the CoCM care team includes a Behavioral Health Care Manager, with formal education or specialized training in behavioral health, working under the direction of the billing provider to actively provide evidence-based behavioral health services. The billing physician and BHCM are supported by a Psychiatric Consultant, who consults on the caseload and provider treatment recommendations for those who are not improving. Payment for CoCM services will only be made for patients that meet diagnostic criteria for BH conditions listed in Appendix 1.

Note: **Collaborative Care is "carved-out" of Medicaid managed care,** meaning the Collaborative Care Model (CoCM) reimbursement is not paid to plans through the premium and is not covered under managed care contracts. **CoCM claims for any Medicaid recipients, including managed care individuals, must be submitted directly to FFS Medicaid**. Collaborative Care services are reimbursed by Medicaid on a monthly case payment basis.

NEW, EFFECTIVE September 1, 2025: **NYS Medicaid has adopted the CoCM add-on code billing structure**. 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. Only one add-on code unit will be reimbursable per month.

Procedure codes for monthly case payment claims are described below:

> **99492 –** Used for the first 70 minutes in the **first** calendar month for behavioral health care manager services, in consultation with a psychiatric consultant and directed by the treating provider.
>
> **99493 –** Used for the first 60 minutes in all **subsequent** months for behavioral health care manager activities.

99494 – If there is at least an additional 30 minutes of service than the requirements for 99492 or 99493, an additional 30 minutes may be claimed using this procedure code. NYS Medicaid will pay a maximum of one add on code per patient per month.

T2022 – 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. If T2022 is claimed, 99494 may not be submitted.

There must be at least one clinical contact and administration of the validated symptom monitoring tool per month to bill the monthly case rate procedure codes. The dates of service cover the entire month. To align with Medicare and Commercial plans, we recommend using the last day of the month. Providers will use the appropriate procedure code (T2022, 99492, 99493 or 99494) as determined by the cumulative time spent through the month. Please note that it is acceptable to bill Collaborative Care for a patient also enrolled in a health home.

NEW, EFFECTIVE September 1, 2025: Patients are eligible to receive Collaborative Care services for a maximum of 24 months, which are not required to be consecutive. After six months without a service, the 24-month service limit will reset. The Year 2 rate and approval procedure 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.

Institutional Claims

Institutional claims will be submitted via an 837i file if submitted electronically or, if submitting on paper, using a UB-04 form.

In the header of the 837i file or field 39 on the UB-04, the biller should include value code “24” and following that immediately with the appropriate four-digit rate code. For example, if rate code 5246 (Collaborative Care Monthly Case Payment) is used, the full coding should be “**24**5246.”

The header will also use the same date, ideally the last day of the calendar month, for both the “from” and “through” dates. If an individual’s eligibility is discontinued prior to the end of the month, the final date of eligibility should be used for the “from” and “through” dates.

The following rate codes shall be used for distinct CoCM services:

Rate Code 5246 - Collaborative Care Monthly Case Payment: To bill this rate code, the primary care provider and/or behavioral health care manager must have a minimum of one clinical contact each calendar month. This contact may include individual or group psychotherapy visits or telephonic engagement if treatment is delivered. The administration of a validated symptom monitoring tool should be documented in the registry.

Effective September 1, 2025, this rate code may be billed a maximum of 24 times per client, per episode of care.

NEW, EFFECTIVE September 1, 2025: Rate Code 5261 – Collaborative Care Case Payment Add-on: To bill this rate code, the primary care provider and/or behavioral health care manager must have provided at least 90 minutes of CoCM services. When

the requirements are met to bill this rate code, it must be submitted as a second, separate claim **with 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.

Retainage

EFFECTIVE SEPTEMBER 1, 2025: Retainage claims will be discontinued and there will no longer be different rate codes for Years 1 and 2. All submitted claims using rate code 5246 will be paid at the full rate starting from the first month. **Rate codes 5247, 5248 and 5249 will no longer be eligible for payment.**

Federally Qualified Health Center (FQHC)

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

Professional claims will use the 837p file or CMS-1500 form. Since the 837p does not allow for the input of rate codes, providers must include procedure codes for monthly case payment claims.

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.

For non-Article 28 sites (i.e., group practices or private practitioners) to bill for Collaborative Care, the billing (and, if applicable, referring) provider must have specialty code '333' on their provider file. **OMH updates provider files manually during the Provider Certification application process.** To indicate the provider is approved, Service Authorization Exception Code '7' (Special Handling) must be entered on the claim form (Box 25D on the EMEDNY-150003 form).

Billing for services provided by a psychiatrist/psychologist/licensed social worker – Article 28 Clinic (Freestanding or Hospital) and private practitioners/group practices

In addition to the monthly Collaborative Care case payment, providers may also separately bill for face-to-face counseling, or other billable services, that are provided by a psychiatrist or licensed psychologist.

Article 28 outpatient providers will submit a separate claim using the appropriate APG rate code. 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 special rate codes that have already been established for that purpose (listed below).

Rate Code	Description
4222	Individ LMHC/LMFT Services 20-30 min w/patient
4223	Individ LMHC/LMFT Services 45-50 min w/patient
4224	Family Srvcs LMHC/LMFT with or w/o p/t present

Private practitioners may also bill separately for services provided within their scope of practice by submitting a separate professional (non-APG, non-rate coded) claim.

In all instances, the time spent and billed for counseling or other billable services cannot be counted toward time for the CoCM codes.

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 contact nyscollaborativecare@omh.ny.gov for the Delay Request form.

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 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

Billing for Medicare/Medicaid Dually Eligible Clients

As the payer of last resort, a claim may only be submitted to Medicaid for dually eligible clients 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 Medicare-required number of minutes (depending on month of activity); however, this code is not valid for Medicare or commercial payers. When T2022 is used on a claim for 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.

Appendix 1: Eligible Diagnosis Code List

Appendix 2: Billing 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.

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**.

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.

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

1. Two claims will be submitted.
2. Claim one:
    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**.
3. Claim two:
    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.