Office of Mental Health | Office of Addiction Services and Supports

New York State (NYS)

Certified Community Behavioral Health Clinic (CCBHC)

Billing Guidance

October 30, 2024

Background:

This CCBHC Billing Guidance is provided to assist CCBHCs to understand the Medicaid billing requirements for services provided in the CCBHC program and to develop CCBHC billing systems. This information **is applicable only** to those CCBHCs that have been approved by NYS to be part of the federal CCBHC Demonstration. This information **is not applicable** to a program that has received a CCBHC Expansion Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) that has not been approved to participate in the CCBHC Demonstration by NYS.

Claim Forms:

- CCBHC Medicaid claims submitted electronically must use the HIPAA Institutional 837I claim form.
- Paper claims submitted by CCBHCs should use the UB-04 claim form.
- General information on claims submission to eMedNY can be found in the NYS Medicaid General Billing Guidelines.
- Technical questions concerning the completion of the claim form to bill CCBHC services should be directed to GDIT at 1-800-343-9000.

Rate Code:

All CCBHC Medicaid Claims are billed using the unique rate code (1147). The Medicaid service will be reimbursed the CCBHC specific Prospective Provider System (PPS) rate calculated for each specific program.

Medicaid Managed Care Carve-Out:

- CCBHC Medicaid billing is currently “carved-out” of Medicaid Managed Care. All CCBHC services are billed directly to Medicaid using the claim form and rate code as described above, with other guidance as follows.
- No billing under Ambulatory Patient Groups (APGs) for any services required by the CCBHC, including outpatient mental health or substance abuse services, shall occur for locations that are part of the CCBHC after the state-designated start of the CCBHC program unless specifically approved, except for:

    1. The administration of medication by an Opioid Treatment Program (OTP) that is part of the CCBHC. Further information related to OTP billing is provided in the Billing Requirements and Restrictions Section below.

2. Lab services: Any facility that performs lab testing, even waived testing, is considered a laboratory for regulatory purposes and must be certified by the NYS Department of Health. Certification to perform testing is site specific, and therefore every address where testing occurs must have its own certification (e.g., Clinical Laboratory Improvement Amendments (CLIA) certificate, permit, registration). In such cases, billing would be done under the appropriate billing codes. If the CCBHC is simply collecting and sending out for results you would not require a CLIA certificate and would not be billing for the lab services.

Procedure Codes, E&M Codes and Modifiers:

The following Healthcare Common Procedure Codes (HCPC) must be present on **all** CCBHC Medicaid claims:

HCPC	Long Description	Short Description
T1040	Medicaid Certified Community Behavioral Health Clinic Services, per diem	Comm BH Clinic Svc Per Diem
Q2	Demonstration procedure/service	Demo procedure, service

In addition to the above, all individual CCBHC services provided during a specific day must be identified as discrete procedure codes on the Medicaid claim for the identified CCBHC rate code, using CPT codes currently used in Article 31 mental health clinics or Article 32 OASAS clinics, as applicable. A list allowable procedure codes for CCBHC can be found on the OMH CCBHC webpage at: https://omh.ny.gov/omhweb/bho/ccbhc.html. This list provides guidance for services that are part of the CCBHC that may not currently be billed in the existing clinics.

Location Requirements

CCBHC providers must only bill the PPS rate at NYS approved CCBHC sites, using the proper ZIP+4 location code pertaining to the location where the service was provided. The provider must not use an alternate CCBHC site ZIP+4 on the claim and/or submit all claims through the main CCBHC site if services are being provided at an additional site. It is expected that service volume reported by sites in CCBHC Cost Reports aligns with CCBHC billing.

Billing modifiers are required to be used but will not result in an adjustment to the CCBHC daily visit rate. The appropriate following modifiers are to be used with CCBHC Medicaid billings to indicate provider and location of each service provided:

- U1 - Service provided by CCBHC provider at CCBHC location.
- U2 - Service provided by CCBHC provider at other than a CCBHC location.
- U3 - Service provided by Designed Collaborating Organization (DCO) at CCBHC location.

- U4 - Service provided by DCO at other than a CCBHC location.

Other Codes Required on the Claim:

- **Revenue codes:** The following revenue codes should be used on each claim, as applicable:
  - **240 –** All-Inclusive Ancillary – General
  - **513 –** Clinic – Psychiatric Clinic
  - **520 –** Freestanding Clinic – General
  - **900 –** Behavioral Health Treatment/Services – General
  - **906 –** Behavioral Health Treatment/Services – Chemical Dependency
  - **911 –** Behavioral Health Treatment/Services – Rehabilitation
  - **914 –** Behavioral Health Treatment/Services – Individual Therapy
  - **915 –** Behavioral Health Treatment/Services – Group Therapy
  - **916 –** Behavioral Health Treatment/Services – Family Therapy
  - **918 –** Behavioral Health Treatment/Services – Testing
  - **944 –** Other Therapeutic Services – Drug Rehabilitation
  - **945 –** Other Therapeutic Services – Alcohol Rehabilitation

- **Diagnoses:** A primary diagnosis should be selected for individuals receiving CCBHC services on the same day who may have multiple diagnoses. For those individuals served with co-occurring substance use disorder (SUD) and mental health (MH) diagnoses, the secondary co-occurring diagnosis should be selected as well.
- **Provider:** A primary provider (practitioner) should be selected if the individual receives CCBHC services from more than one provider (practitioner) on the same day.

Billing Requirements and Restrictions:

- In any case where Medicaid is the secondary or tertiary payer, the other primary payers **must** be billed first. The Medicaid claim must display the payments received from the other payers appropriately, so that they are properly credited in the calculation of the Medicaid payment. This is often completed manually after the remittance information is received from the other payer(s).
- Medicare claims for Medicare-eligible CCBHC services for Dual Eligible Special Needs Plan (D-SNP) members would first be submitted to the member's D-SNP. After the remittance information is received from the D-SNP, a claim may be submitted to Medicaid using the PPS rate, with the D-SNP payment identified in the claim so that proper calculation of any remaining balance due could be calculated.
- At least one CCBHC billable service must be provided on a date of service before a claim can be submitted to Medicaid.
- If an Opioid Treatment Program (OTP Program) is part of the CCBHC, billing for the medication and administration of the medication would be done outside of the CCBHC PPS rate, using the same billing protocols as are currently in place. The counseling provided, as required by the program, could be part of the CCBHC and billed at the PPS rate. Only the costs and daily visits associated with the counseling would the reported in the CCBHC Cost Report.

- Pending the above stipulations, services rendered by the CCBHC program, at locations authorized by NYS or provided off-site from authorized locations, are billable under the PPS rate. This includes individuals newly referred and existing enrollees of CCBHC services.

- The following practices are **not** permitted:
    - Billing Medicaid for more than one CCBHC daily visit, per individual served, per specific date of service.
    - Billing Medicaid when no CCBHC service was provided (based on procedure code).
    - Billing Medicaid for activities furnished through modalities or in locations that do not meet the billable "visit" definition (based on procedure code or place of service code).
    - Billing Medicaid Managed Care Plans for services that have also been billed to eMedNY using the CCBHC rate code.
    - Billing Clinic APGs for any locations that are part of the CCBHC (unless specifically approved).
    - Contracting with DCOs at a cost that is other than fair market value.

- Coordination of benefits is required, as applicable, as previously described.

- Care Coordination is an allowable service in the CCBHC. However, billing the PPS for Care Coordination is not permissible. The cost of providing Care Coordination is included in the cost report, and therefore recognized in the PPS rate calculation. No daily visits are attributed to this service in the Cost Report.

- It is the provider's responsibility to ensure that all services are provided by staff within the Scope of Practice, level of competence, and under supervision, which is commensurate with their training, experience, and skills.

- Co-enrollment in CCBHC and other OMH or OASAS programs may be prohibited. For more information, please see the *New York State Medicaid Managed Care Behavioral Health Billing and Coding Manual* Section VIII. Service Combinations at: https://omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf, OR program specific guidance to determine if co-enrollment is allowed.[1]

The CCBHC Demonstration Billing Scenarios table below provides additional details to help understand when a service may be attributed to the CCBHC demonstration, and therefore billable under the PPS Medicaid rate for Medicaid enrolled individuals. Unless otherwise specified, the scenarios in the right column shall trigger the following: (1) application of the criteria, (2) application of the PPS, and (3) quality measure collection and reporting. In this table, the term "behavioral health clinic" shall mean those Article 31 and Article 32 MH and SUD Clinic Programs, respectively, which have been identified by the provider to be part of their CCBHC under the NYS Demonstration Program.

[1] Some service combinations and co-enrollment restrictions are found in specific program guidance. For example, CFTSS guidance outlines co-enrollment restrictions for CCBHC programs: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf

Services rendered by the CCBHC program, at locations authorized by NYS or provided off-site from authorized locations, are billable under the PPS rate. This includes individuals newly referred to CCBHC services or existing individuals enrolled in CCBHC programming. However, services provided at locations that are not authorized as part of the CCBHC, including those otherwise authorized under Part 599 and/or Part 822, are not billable under the PPS.

CCBHC Demonstration Billing Scenarios

Scenario	When is the Service Covered by the Demonstration
An individual receives non-crisis demonstration services from the CCBHC	If a **non-established/new individual/consumer** receives non-crisis demonstration services for the first time from a CCBHC, the service **IS** covered for the first time upon preliminary screening and risk assessment (core services provided directly by the CCBHC) to determine acuity of needs, with identifying and payment information gathered. If an **established/existing individual/consumer** of a behavioral health clinic receives any demonstration service from a CCBHC, the service is covered upon receipt of the first service at the CCBHC once the behavioral health clinic is designated by NYS to have met the certification requirements to be a CCBHC.
An individual receives crisis demonstration services from a CCBHC	If a **non-established/new individual/consumer** of the CCBHC receives a crisis demonstration service provided directly by the CCBHC, rather than by a state-sanctioned crisis service acting as a DCO, the crisis service is a CCBHC-covered service upon crisis assessment (which will include a screening and risk assessment). If a **non-established/new individual/consumer** of the CCBHC receives crisis demonstration services provided by a state-sanctioned crisis service acting as a DCO, the crisis service is covered upon receipt of: • Crisis assessment (which will include a screening and risk assessment) **AND** • Another of the nine services that fall within the scope of the CCBHC services delivered by the CCBHC within 10 business days of receiving the crisis services. If an **established/existing individual/consumer** of the CCBHC receives crisis services from the CCBHC it is designated by NYS to have met the certification requirements to be a CCBHC.

Scenario	When is the Service Covered by the Demonstration
An individual receives a demonstration service from the CCBHC via telehealth or mobile in-home services (as allowable within the NYS Medicaid program, as applicable, and NYS law)	If a **non-established/new individual/consumer** of the CCBHC receives demonstration services via telehealth or mobile in-home services, the service **IS** covered upon preliminary screening and risk assessment to determine acuity of needs, with identifying and payment information gathered. If an **established/existing induvial/consumer** of the CCBHC, the service **IS** covered upon receipt of the first telehealth or mobile in-home service once the behavioral health clinic is designated by NYS to have met the certification requirements to be a CCBHC.
An individual receives CCBHC demonstration services delivered by the CCBHC in other services locations, including schools and homeless shelters.	If a **non-established/new individual/consumer** of the CCBHC receives services delivered by the CCBHC in other service locations, the service **IS** covered upon preliminary screening and risk assessment to determine acuity of needs, and identifying and payment information is gathered. If an **established/existing individual/consumer** of the CCBHC receives services delivered by the CCBHC in other service locations, the service is covered upon receipt of the first such service once the behavioral health clinic providing the service is designated by NYS to have met the certification requirements to be a CCBHC.
An individual receives non-crisis demonstration services from a DCO.	If a **non-established/new individual/consumer** receives non-crisis demonstration services from a DCO the service **IS** covered only upon preliminary screening and risk assessment to determine acuity of needs, with identifying and payment information gathered by the CCBHC (not the DCO). *Without receiving a preliminary screening and risk assessment by the CCBHC, none of the criteria, PPS, and quality measurement, apply.* If an **established/existing consumer** receives services that fall within the scope of CCBHC services from a DCO (after the BHC becomes a CCBHC, but before receiving any service directly from the CCBHC itself) the service **IS** covered upon receipt of the first such service only if the DCO service is authorized by and coordinated with the CCBHC once the behavioral health clinic is designated by NYS to have met the certification requirements to be a CCBHC.

Scenario	When is the Service Covered by the Demonstration
An individual referred from a hospital or emergency department	If a **non-established/new consumer** is referred from a hospital or emergency department, the service **IS** covered upon preliminary screening and risk assessment to determine acuity of needs, with identifying and payment information gathered. once the behavioral health clinic is designated by NYS to have met the certification requirements to be a CCBHC.