Certified Community Behavioral Health Clinic (CCBHC) Billing Webinar

September 12, 2024

HFS

Illinois Department of Healthcare and Family Services

Housekeeping

Phone lines are in listen only mode.

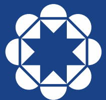
Submit questions via chat.

Slides and a recording will be posted to the HFS website.

AGENDA

1. Introductions and Purpose
2. CCBHC Reimbursement Overview
3. PPS Billable Services
4. Care Coordination and Targeted Case Management
5. Claim Requirements
6. Third Party Liability
7. Closing

Reimbursement Overview



Prospective Payment Systems

- The primary method of reimbursement for CCBHCs are prospective payment system (PPS) payments.
- PPS is a method of reimbursement in which payment for services is made based on a predetermined, fixed amount.
- Under the CCBHC Demonstration, states are required to pay CCBHCs for qualifying services using a CMS-approved PPS methodology.
- PPS rates are based upon facility cost reporting and must be updated/rebased on a regular basis.

CCBHC Demonstration Reimbursement

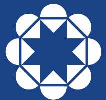
- Illinois is using the PPS-1 methodology, which is a daily, all-inclusive encounter payment.
- CCBHCs participating in Demonstration Year 1 must begin billing for CCBHC services using their PPS on October 1, 2024.
- Illinois has not elected to establish quality bonus payments for CCBHCs.

CCBHC Services

- CCBHCs must provide, directly or through a Designated Collaborating Organization (DCO), the services from the 9 required service categories.
- The following resources are available to assist providers in determining covered services:
  - SAMHSA CCBHC Certification Criteria
  - Illinois CCBHC Service Requirements
  - CCBHC Billing Code List (xlsx)

Note: HFS will be issuing an update to the CCBHC Billing Detail Code List prior to October 1.

PPS Billable Services



When Can I Bill Medicaid for a CCBHC Encounter?

CCBHCs should bill HFS or the applicable Managed Care Organization (MCO) for a CCBHC encounter when at least one **triggering service** has been delivered to a **Medicaid-enrolled customer** (regardless of age, residence, or geography) directly by the CCBHC or a DCO.

The CCBHC is responsible for submitting all claims for PPS-covered services delivered by a DCO to a CCBHC customer.

Eligibility Verification

- CCBHCs are responsible for verifying a customer's Medicaid eligibility prior to service delivery.
  - This includes determining whether the customer is enrolled with a Managed Care Organization (MCO) or in Medicaid fee-for-service.
- CCBHCs must also verify whether the customer has other health insurance (commercial or Medicare).
- Customer eligibility can be verified using any of the following:
  - Medical Electronic Data Interchange (MEDI)
  - Recipient Eligibility Verification (REV) System
  - Automated Voice Response System (AVRS) at 1-800-842-1461.

These protocols are the same as billing requirements prior to the CCBHC Demonstration.

What is a Triggering Service?

- For a CCBHC to bill, or “trigger”, the daily PPS, they must deliver at least one unit of service of one of the procedure codes listed on the CCBHC Billing Detail Code list.
- The triggering service should be billed on the date of service in which the service was initiated.
- Examples:
  - 1 hour (4 units) of Crisis Intervention (H2011) is provided from 11:30 PM – 12:30 AM. The CCBHC may bill a CCBHC Encounter for both days, with 2 units of H2011 detailed on each of the claims.
  - A Mobile Crisis Response event (S9484) is initiated on Monday at 11:55 PM and concludes at 12:30 AM on Tuesday. The CCBHC should bill one CCBHC Encounter for Monday with S9484 as the detail billing code.

Billable Unit of Service

- Each procedure code has a defined unit of service.
- For time-bound codes, unless otherwise specified in the code description, the CCBHC must minimally spend more than 50% of the unit time delivering the service to qualify for a PPS payment.
- Some codes are episode based rather than time-bound. Providers should follow the guidance in the CPT codebook or in the applicable HFS Provider Handbook to determine when service requirements for billing have been met.

Question to Consider: would I bill HFS under another provider type for a unit of this service?

Billable Unit Examples

Service Description	Procedure Code	Unit of Service	Min. Service Duration
IATP	H2000	15 mins.	8 mins.
Psychiatric diagnostic evaluation	90791	Event	N/A – refer to CPT codebook
Office/Other Outpt Visit, new patient, 15-29 mins	99202	Code Defined	15 mins.
SBIRT, 5-14 mins.	G2011	Code Defined	5 mins.

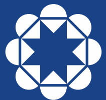
- Methadone is an optional service that can be provided by CCBHCs.
- CCBHCs electing to provide Methadone must be:
  - Appropriately credentialed to deliver methadone; and
  - Enrolled in IMPACT with the appropriate CCBHC subspecialty.

The dispensing and administration of methadone is billed using detail code H0020. H0020 represents a weekly episode of care and should only be billed once every 7 days for customers receiving methadone services.

Non-PPS Activities by a Partnering Entity

- Services and activities performed by a partnering entity are NOT eligible for PPS reimbursement if:
    1. The service is NOT covered by the formal agreement between the partnering entity (DCO) and CCBHC; and
    2. The customer is NOT a CCBHC customer.
- If the partnering entity provides a service or activity that is not covered under the agreement between the CCBHC and the DCO, the partnering entity is required to seek reimbursement from an alternative funding source (Medicaid fee-for-service, MCO, other).

Care Coordination and Targeted Case Management



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CCBHC Care Coordination

- CCBHCs must provide Care Coordination across a spectrum of health services, including physical health, behavioral health, social services, housing, educational systems, and employment opportunities.
- SAMHSA describes Care Coordination as activities that:
  - Promote clear and timely communication, deliberate coordination, and seamless transition; and,
  - Have the purpose of coordinating and managing the care and services furnished to each customer, regardless of whether it is provided directly by the CCBHC.

Examples of Care Coordination

- Organization and management of all aspects of a customer's care
- Resource management and advocacy
- Maintaining customer contact
- Referral tracking
- Information sharing between providers, the customer, authorized representative(s), and family
- Appointment making assistance, including coordinating transportation
- Use of case conferences
- Providing customer-centered education (e.g., diabetes education, nutrition)
- Use of care team huddles (short, daily meetings where the care team can discuss schedules, address care coordination needs, and problem solve)

Care Coordination Reimbursement

The SAMHSA CCBHC Criteria outlines that Care Coordination is:

- A mandatory function CCBHCs are required to provide to all customers that present to the CCBHC for service;
- Not a CCBHC service; and,
- <u>Not eligible for PPS reimbursement</u>.

Care Coordination and PPS Rates

- Staff Costs for performing Care Coordination are captured in the CCBHC PPS rate structure and reimbursed in part with every PPS payment.

Targeted Case Management (TCM)

- Assists customers in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports.
- Provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC.
- **TCM under CCBHCs is not the same as the Medicaid Targeted Case Management authority CMHCs currently bill under today.**

SAMHSA 2023 Criteria, 4.h.1

When is TCM Allowed?

- TCM services are distinguished from standard CCBHC Care Coordination by the population of focus and intensity of support provided.
- To be considered TCM, the activities must meet all the following:
  - Be documented on the customer's plan of care;
  - Be delivered under the CCBHC's TCM Program;
  - Provided to a customer meeting one of the allowable target populations; and
  - Delivered with greater intentionality and intensity than Care Coordination.

HFS Approved TCM Target Populations

- Customers at high risk of suicide or overdose;
- Customers participating in Assertive Community Treatment (ACT), Community Support Team (CST), Violence Prevention – CST (VP-CST) programs;
- Customers needing employment and housing supports;
- Customers transitioning from an incarcerated setting;
- Customers transitioning to the community from an institutional setting (e.g., hospital, nursing facility, residential treatment), jail, or prison; and
- Additional CCBHC proposed populations with written approval from HFS.

TCM Program Plan

CCBHCs will be required to create and submit a TCM Program Plan to HFS by: **January 31, 2025**.

The CCBHC TCM Program Plan must:

- Identify targeted populations;
- Detail protocols for managing customer participation;
- Propose a TCM service episode and means of managing utilization; and
- Detail protocols to prevent duplication of service delivery across programs and care providers.

CCBHC TCM Billing – DY1

- All TCM services for customers meeting the target population will be billed using the procedure code T1016.
    - To streamline TCM billing, HFS will be updating the CCBHC Detail Code list to remove the procedure code H0006.
- CCBHCs may bill TCM services for any customer determined to qualify under an Approved TCM Target Population and for whom medical necessity is documented on the plan of care.
- Customers receiving intensive case management from another program (e.g., Pathways to Success) may not receive CCBHC TCM services.

Claim Requirements

General Claims Submission Guidance

- For Medicaid customers, CCBHC claims are to be billed to HFS or the appropriate MCO using the 837P format.
- Information regarding electronic claims submission to HFS can be found in the HFS Provider Handbooks:
  - Topic 112 of the Chapter 100 General Policies and Procedures Handbook
  - Chapter 300, Professional (837P) Standard Companion Guide.
- MCOs generally align to HFS billing guidance; however, providers must work with each MCO to identify any nuanced differences in claims preparation and submission processes.

Timely Filing

- Claims are to be submitted after services have been rendered.
- All claims, including claims that have been corrected and resubmitted, must be received within 180 days of the date of:
  1. The service provision; or
  2. TPL adjudication
- HFS must receive a claim after disposition by Medicare no later than 24 months from the date of service.

Service Coding

CCBHC Encounter Code – T1040

- T1040 **MUST** be listed on the first service line, or the claim will not adjudicate appropriately.
- The CCBHC's site-specific PPS encounter rate should be listed in provider charges.
- No modifiers should be included on the T1040 service line.
- Always use the place of service code 99 (Other).
- The unit of service for the T1040 is 1.

Service Coding (cont.)

Detail Billing Codes

- On additional service lines, list the appropriate procedure code(s), modifiers when applicable, place of service code, and units of service.
- Only modifiers indicating DCO service delivery (XP) and telehealth (GT or 93) should be included on additional service line coding – no other modifiers are required (e.g., to note staffing level) at this time.
- Service lines with the same procedure code must be "rolled up." Note: this is different from traditional community mental health billing.
- Procedure codes for all PPS-covered services delivered to the customer on that date of service must be included.

Provider Detail Segments

Billing Provider

The CCBHC's NPI **MUST** always be reported in loop 2010AA, Billing Provider. Any other NPI reported will result in appropriate adjudication of the claim. Note: this is different from traditional community mental health claiming guidelines.

Rendering Provider

The Rendering Provider loop 2310B should be left blank for the duration of DY1 billing. HFS anticipates providing updated guidance in future years to record DCO's using the rendering provider loop.

Ordering/Referring Provider

Ordering and referring provider information is not required for CCBHC claims. Loops 2420E and 2310A should be left blank.

Other Claim Elements

Provider Taxonomy Code

CCBHC claims are to use taxonomy code 261QC1500X.

Diagnosis Code

Claims must include an ICD-10 diagnosis code. There are no limitations on diagnosis codes allowed for inclusion on a CCBHC claim.

Place of Service (POS)

All CCBHC claims should be submitted, using POS 99:

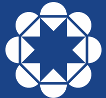
- At the claim level; and
- On service line 1 – T1040

Each detail service code line must specify the true location from which that service was rendered by reporting the appropriate 2-digit POS code.

Allowable Place of Service Codes

- 02 – Telehealth provided other than in patient's home
- 03 – School
- 04 – Homeless shelter
- 10 – Telehealth provided in patient's home
- 11 – Office
- 12 – Home
- 13 – Assisted living facility
- 14 – Group home
- 15 – Mobile unit
- 20 – Urgent care facility
- 21 – Inpatient Hospital
- 22 – On-campus outpatient hospital
- 23 – Emergency room – hospital
- 26 – Military treatment facility
- 27 – Outreach site/street
- 31 – Skilled nursing facility
- 32 – Nursing facility
- 33 – Specialized mental health rehabilitation facility
- 34 – Hospice
- 51 – Inpatient psychiatric facility
- 52 – Psychiatric facility – partial hospitalization
- 53 – Community Mental Health Center
- 54 – Intermediate care facility/individuals with intellectual disabilities
- 55 – Substance use disorder residential
- 56 – Psychiatric residential treatment facility
- 57 – Substance use disorder treatment site
- 71 – Public health clinic
- 99 – Other place of service

Third Party Liability (TPL)



TPL Responsibilities

- TPL is the obligation of another funder (e.g., private insurance, Medicare) to pay for all or part of the cost of rendered services.
- It is the responsibility of providers to determine if TPL is available for a customer.
- If a Medicaid customer has primary TPL, the CCBHC is required to first bill TPL to receive any possible payment for services.
- Claims submitted to TPL should use the billing codes that would normally be billed for the services rendered.
    - This may mean the CCBHC has to translate the service coding into a potentially acceptable format for any prospective payer.

Submitting Claims for Customers with Private Insurance as Primary

- For claims where the customer has private insurance in addition to Medicaid, CCBHCs must report the three-digit HFS TPL resource code, followed by the two-digit TPL status code utilizing Loop 2330B, REF02.
- If the CCBHC is reimbursed for services from TPL, the reimbursed amount must be included as a credit on the claim. TPL payment will be subtracted from the PPS reimbursement rate.
- The complete list of TPL resource and status codes can be found in on the HFS Provider Handbook landing page, under the section “Additional Resources for Providers.”

Do I have to submit a claim to TPL if I know the service is not covered?

- It is understood that some PPS-covered services are not reimbursable by private insurance.
- HFS is providing CCBHCs with flexibility in how they address their TPL responsibilities for non-covered services to reduce administrative burden and costs. CCBHCs may do either of the following:
  - Bill each claim to TPL and receive a denial or rejection for each claim; or,
  - Obtain documentation from each unique TPL payer once each fiscal year that attests the service is not covered.

Documentation Requirements for TPL Attestation of Non-Covered Services

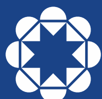
The Attestation of TPL Non-Covered Services must include all the following:

- The specific TPL payer
- Sufficient supporting documentation in the form of:
    1. Written Notice. CCBHCs may receive a written notice from the TPL payer(s) indicating that certain billable detail codes and practitioner combinations are not covered; or
    2. Demonstrated Effort. CCBHCs may retain documentation in the form of a claim rejection and EOB for each specific service and practitioner combination.

Providers choosing this option are responsible for maintaining documentation in line with HFS policy for audit purposes.

Claiming for Dual Medicare-Medicaid Customers in DY1

- For customers with Medicare as primary, **<u>do not</u>** submit a CCBHC encounter claim to Medicare.
  - Instead, **<u>always</u>** report the appropriate TPL resource code for Medicare and the TPL status code of 06 – services not covered utilizing Loop 2330B, REF02.
  - HFS is evaluating and seeking CMS guidance on issues with Medicare crossover claims.
- For customers enrolled in the Medicare-Medicaid Alignment Initiative (MMAI), a CCBHC claim is submitted to the customer's MCO for adjudication – no additional steps need to be taken.



Other Medicaid Reimbursement

- CCBHCs may add additional Subspecialities to their IMPACT enrollment, making them eligible to be reimbursed for non-PPS services (e.g., Pathways to Success, ABS services).
- PPS and non-PPS services must be billed on separate claims.
  - CCBHCs must NOT include Pathways to Success Services or ABS Services as Detail Codes under a T1040 Service Line 1.
  - Pathways to Success (Pathways) Services are found within the Community Based Behavioral Health Services (CBS) fee schedule.
  - ABS services are found on the ABS fee schedule.

Helpful Links

- SAMHSA 2023 CCBHC Certification Criteria
- HFS CCBHC Web Page
- HFS Provider Handbooks and Additional Resources
- HFS Fee Schedules

Questions?

Policy/Operational Questions
HFS.CCBHC@illinois.gov

IMPACT Enrollment Support
OMI.IMPACT@uillinois.edu

HFS Billing Consultant
Call 877-782-5565, option sequence 1, 2, 4, then 8