Certified Community Behavioral Health Centers (CCBHC) Billing Guidance Webinar 6/12/25

Questions & Answers

General Billing

Question: Is timely filing for CCBHC 90 days?

- **Answer:** Yes, timely filing for CCBHC claims submission is 90 days from date of service.

Q: Targeted Case Management (TCM) & Psychiatric Rehabilitation Services (PSR) are generally not covered by commercial insurance. Is a denial from commercial plans required for every claim to submitted to Medicaid?

- **A:** Yes, for individuals with both commercial insurance and Medicaid, you must bill claims first to the primary payors even if you expect a denial.

Q: Does the U modifier go before a telehealth modifier on the service line?

- **A:** The order of modifiers does not change the claim. The U modifier can come before or after any applicable modifiers on a service line.

Q: Which MMIS number should we use on CCBHC claims?

- **A:** The MMIS number you submitted on your application is the number you will use for CCBHC claims. The CCBHC reimbursement page on the OMH website also includes each CCBHC MMIS number along with their PPS rate: https://omh.ny.gov/omhweb/medicaid_reimbursement/excel/ccbhc.xlsx

Q: How is Care Coordination billed by a CCBHC?

- **A:** 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. Therefore, it is recognized in the PPS rate calculation. No daily visits are attributed to this service in the Cost Report, so it has the impact of raising the PPS rate.
- **Q:** Is there any guidance on the staff credential requirements for each service (CPT code)?

- **A:** Please follow the AMA CPT 2025 and HCPCS Level II 2025 manuals for staff credentialing requirements.

Q: Can you clarify billing Child Health Plus (CHP) and Essential Plans – can we bill the Article 31/32 Medicaid rate code on a claim to these payers to get paid the APG rate?

- **A:** Correct, this is how a CCBHC provider is expected to bill these plans. The Essential Plan and CHP are not Medicaid plans; thus, this does not go against the rule that CCBHCs cannot bill APGs to Medicaid.

Q: When billing the T1040 to Medicaid, should the other CPT codes on the claim have a $0 rate or $.01 rate?

- **A:** This is up to the provider, as it will not impact the PPS reimbursement rate.

Q: If we bill the APG rate to commercial insurance, how do we balance bill the claim to NYS Medicaid for patient responsibility? Do we need to include all CCBHC CPT codes even if they are not reimbursable, or do we zero-fill for those CPT codes?

- **A:** Providers will include all CCBHC CPT codes on both the commercial and crossover claims.

Q: Can you provide more information on billing the T1040/Q2 to a primary payer?

- **A:** NYS only requires that T1040 and Q2 are submitted on claims billed to Medicaid. Providers must use the codes required by the commercial insurers when submitting claims to those plans.

Q: Can a CCBHC bill the PPS rate for a School Based Mental Health MHOTRS (SBMH) client that comes in for a service not available at the SBMH MHOTRS site?

- **A:** In the case where a School Based Mental Health MHOTRS satellite that is not designated as a CCBHC refers a patient for services that are not available at the SMBH site but are available at the main site that is a CCBHC, and the services are qualifying CCBHC services, the CCBHC may bill the PPS rate.

Q: Are school-based clients with limited access to psychiatric services that prefer in-person psychiatric services to telehealth eligible for the PPS rate?

- **A:** CCBHC and School Based Mental Health MHOTRS programs are required to offer in-person psychiatric services if the patient requests them. If an individual that is enrolled at the SBMH satellite is seen in-person at the main site that is designated as a CCBHC, the CCBHC would bill the PPS rate.

Q: Would it be appropriate to claim services for those individuals seen at the CCBHC main site that are enrolled with the SBMH program as off-site “in community” under the client’s primary outpatient clinic (APG)?

- **A:** No. The CCBHC will bill their PPS rate. Please note that the use of an off-site rate code is intended to identify and provide a higher reimbursement for services provided in home and community settings outside of a licensed location. They are not intended for services provided at other OMH/OASAS licensed locations.

Rates and Payments

Q: Will commercial pay no less than the Medicaid rate for fully insured only?

- **A:** Yes, commercial payors are required to pay no less than the Medicaid rate for non-self-funded, fully insured clients only.

Q: If CCBHC rates are not approved and loaded prior to July 1, 2025 for cohort 3 providers, are claims held until it is active?

- **A:** Yes, please hold claims until the PPS rate is loaded. The effective date of the rate will be July 1, 2025, and claims that are held will receive the PPS rate once billed.

Q: How does an agency receive a waiver to bill APG from a CCBHC location?

- **A:** We do not have a waiver for the ability to bill APG rates to Medicaid FFS for CCBHC locations.

Q: Can you clarify if the AGP rate cannot be billed from a CCBHC location?

- **A:** APG rates cannot be billed to Medicaid FFS from a CCBHC location. Payors other than Medicaid may be required to reimburse at the APG rate, which is allowable.

Q: Are commercial payors required to pay the CCBHC rates for the demo sites?

- **A:** Commercial payors are required to pay no less than the Medicaid rate effective prior to April 1st established prior to October 1st of the preceding calendar year.

  This means the PPS rate will be used beginning 1/1/2025 for Cohort 1 providers, 1/1/2026 for Cohort 2 providers, and 1/1/2027 for Cohort 3 providers.

  Commercial payors are expected to pay at the APG rate for CCBHC providers until the PPS rate minimum goes into effect.

Q: When will new CCBHC demo providers receive notification that our PPS rate has been added to our Medicaid provider enrollment (with our approved locations with zip+4)?

- **A:** Providers will receive a system generated notice from eMedNY to the contact listed in the system stating the PPS rate has been loaded. This notice will include a list of locations where that rate is loaded including the zip+4.

Co-Enrollment

Q: Can a non-CCBHC patient, that is linked at another outpatient clinic or agency, come to the CCBHC for a one-time service?

- **A:** Yes, a non-CCBHC client may be seen at a CCBHC for services not provided by the program they are enrolled in. This will be billed by the CCBHC at the PPS rate. Please note, it is the provider's responsibility to ensure services are not duplicative.

Q: If a client enrolled in a SBMH MHOTRS program gets a service at a CCBHC location, is the PPS rate billable?

A: If the individual was seen in person at the CCBHC site for a service not available at the SBMH, the CCBHC can bill the PPS rate. When the SBMH clinic is not available (e.g. summer session), then the CCBHC may provide any approved CCBHC services, including services provided via telehealth, and bill at the PPS rate.
Q: What is the difference between a co-enrolled client, enrolled in a CCBHC versus a 1-2 time visit that seems to be allowed?

- **A:** Co-enrollment occurs when a client is regularly seen at a CCBHC while being enrolled in a program that offers similar services. If a CCBHC provides a one-time service that is not available at the program in which they are enrolled, that does not constitute co-enrollment.

Q: For high-risk patients requiring on-site psychiatric care who are not enrolled in a CCBHC location, can they receive services at a CCBHC location within the provider network without transferring to the CCBHC. The patient does not wish to transfer all services to CCBHC location and/or may not be in clinical need of all services available through the CCBHC.

- **A:** This would not be eligible to bill at the PPS rate due to co-enrollment disallowance between CCBHCs and MHTORS clinics. The client would have to disenroll from the other clinic to receive CCBHC services.

Reporting

Q: Where will we report the variety of the nine core CCBHC services being provided? Will this data point be pulled from claims?

- **A:** This information will be pulled from claims. All services must be listed on the claims for tracking purposes.

Q: Should CCBHC Demo programs be reported by site (zip+4) or consolidated under one column in the Consolidated Financial Report (CFR)?

- **A:** Please report CCBHC Demo programs by site (zip+4) on the CFR.