Certified Community Behavioral Health Clinic (CCBHC) Billing Guide

Definitions

Allowed Services: A service which can be included as an allowable activity in a CCBHC's cost report but does not on its own trigger PPS payment.

CCBHC Primary Location: The main facility site offering CCBHC services and used to register for their CCBHC National Provider Identifier (NPI).

CCBHC Provider Type: A provider type assigned to certified CCBHCs for billing purposes under the CCBHC Demonstration. The Iowa Medicaid CCBHC Provider Type is 88.

Designated Collaborating Organization or DCO: A provider that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers contracted services under the same requirements as the CCBHC. Services are billed by the CCBHC who reimburses the DCO a negotiated rate.

Excluded Services: A service which cannot be included as an allowable activity in a CCBHC cost report, nor can it be billed under the PPS model.

Satellite Location: A facility that was established by the CCBHC, operated under the governance and financial control of the CCBHC, and provides the following services: crisis services; screening, diagnosis, and risk assessment; person and family centered treatment planning; and outpatient mental health and substance use services as specified in CCBHC certification criteria Program Requirement 4. No payment shall be made to a satellite facility of a CCBHC established after April 1, 2014, under this demonstration. This definition does not limit the provision of services in non-clinic settings such as shelters and schools or at other locations managed by the CCBHC that do not meet the definition of a satellite facility.

Shadow Claim: Detailed data about individual services, reported in a manner like that on a standard claim form.

Threshold Services: A service which triggers payment of the Certified Community Behavioral Health Clinic (CCBHC) clinic-specific Prospective Payment System (PPS) rate.

Instructions

CCBHCs must follow standard billing procedures as mandated by Iowa Medicaid except where otherwise specified in this billing guide. Standard procedures include but are not limited to use of service code modifiers and prior authorizations.

To bill the Prospective Payment System (PPS) rate, the CCBHC must provide a threshold service on that day to an eligible Medicaid recipient. Threshold services are defined on the "Threshold Tab" of this workbook. The CCBHC will only be reimbursed once per day.

The CCBHC must also shadow claim all Medicaid reimbursable services provided to that member that day, including both threshold and allowed services. CCBHCs are prohibited from billing the PPS rate for any excluded services. CCBHC claims will automatically deny if they include any code(s) other than the T1040 encounter code and the threshold and allowed service codes in this billing guide.

The PPS is only billable when services are rendered to an active, Medicaid-enrolled individual (regardless of age, residence, or geography).

For individuals not enrolled in Medicaid, the CCBHC should bill the primary payer (i.e., Medicare, Commercial) as they would normally. In the event an individual is enrolled in Medicaid and has other primary insurance, see section on Coordination of Benefits regarding Third Party Liability.

Medicaid Plans & CCBHC PPS Eligibility

Medicaid Plans	Eligible for PPS
Traditional Medicaid	Yes
Iowa Health and Wellness Plan (IHAWP)	Yes
Healthy and Well Kids in Iowa (Hawki)	No
Family Planning Program (FPP)	No
Medicare Savings Program (MSP) – Qualified Medicare Beneficiary (QMB)	Yes
Medicare Savings Program (MSP) – Specified Low-Income Medicare Beneficiary (SLMB)	No

General Billing Guidance

CCBHCs should use the CMS-1500 claim form with the CCBHC-specific NPI as the billing provider.
Minimum requirements to trigger payment of the clinic-specific daily PPS Rate for CCBHC services include:

- Billing Provider = **CCBHC Provider Type 88**
- Primary diagnosis code = Behavioral Health Diagnosis Code
- First claim line item = HCPCS code **T1040** (Medicaid CCBHC Services, Per Diem)
- Second claim line item = Valid HCPCS code for a **threshold service** (see Appendix # for qualifying HCPCS codes)

CCBHCs are required to report all threshold and other allowable services rendered during the encounter. Service codes are reported as "informational only" and billed at $0.00.

Additional requirements for CCBHC claims include:

- Modifier slot 1 = Designated CCBHC service site **modifier** with service codes provided by a **DCO** or **CCBHC satellite location** (see below for details)
- Additional Claim Information – Claims with the DCO modifier – the **DCO entity NPI** in the required format (see below for details)

Coordination of Benefits (COB)

Billing for Clients with Medicare and Medicaid Benefits (Dual-Eligible Beneficiaries)

For members with Medicare and Medicaid insurance coverage, claims submitted to Medicare Plan under the CCBHC NPI need to include the procedure code T1040 so that it is present when the claim crosses over to Medicaid. The MCOs will coordinate these claims, by paying any difference between the payment of Medicare of the threshold services, up to the providers CCBHC PPS rate (applying lesser of methodology identify via Informational Letter [IL] 2157). Please see the example below:

Medicare Explanation of Benefits (EOB)

Claim Number:							Adjustment Date:				
Member Name:							Member ID:				
Provider Name:					Provider NPI:			Provider IRS:			
Carrier Name:	Medicare						GRP CDI:				
Carrier Address:						State: IA					
Alt Policy Number:				Amt D: 11778			Amt EAF: 0				
	Rev Code	CPT Code	Allow	Coins	Paid	Copay	Deduct	Other	Other	Other	Other
1		T1040									
2		99213	4778		4778			27392 CO 45			
		90834	9000	2000	7000						

Medicare will not cover the code T1040 however, T1040 needs to be included on the first line of the claim to Medicare even though it will be denied as not covered (or similar denial). In the example above, Medicare denied T1040 but paid on the lines with 99213 and 90834 totaling $117.78.

CCBHC PPS reimbursement/coordination will not occur if excluded services are included on the crossover claim.

Medicaid Explanation of Payment (EOP):

Service Line	YMDEFF	YMDEND	Procedure Code	MODIFIER	Number of Units	Billed Charges	Allowed Amount	Payment by Primary Insurance	Deductible	Copay	Coinsurance	Payment Amount
1	20250701	20250701	T1040		1	450.00	321.7	117.78	0	0	20.00	20.00
2	20250701	20250701	99213	HO	1	0	0	0	0	0	0	0
3	20250701	20250701	90834	HO	1	0	0	0	0	0	0	0

When submitting the claim to Medicaid, attach the Explanation of Benefits (EOB) to the claim*. The claims system will identify that the claim is for CCBHC by the T1040 present on the first line. On the Medicaid EOP you will see 99213 and 90834 as global to the encounter code (T1040) with the PPS rate as the allowed amount on the T1040 claim line. The full Medicare insurance payment will be applied on that line. If PPS rate is $321.70 and the other insurance payment is $117.78 with a $20 coinsurance, the system will pay the lessor of the Medicaid PPS rate – the Medicare payment or the coinsurance, whichever is less. In the case of this example the payment would be for $20 because it is the lessor of those two calculations.

**Most Medicare claims will automatically crossover to the MCOs via the Coordination of Benefits Agreement (COBA) process, as indicated via IL1619. In those instances, no further action would be required by the CCBHC provider, if the overarching claim submission guidance is followed (i.e. T1040 on the first line).*

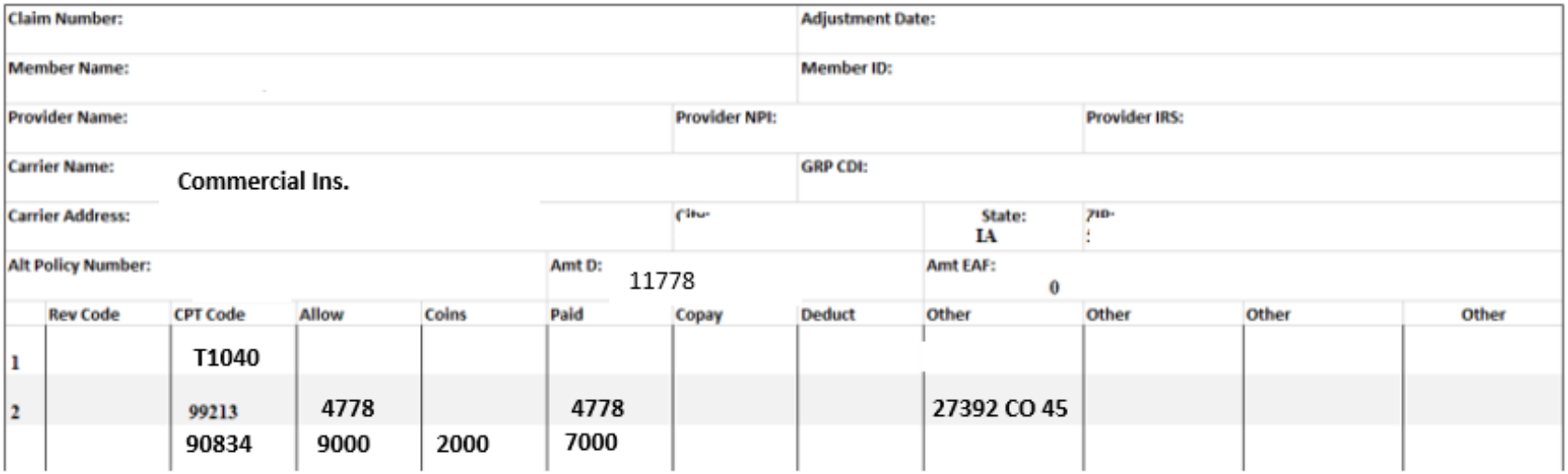
Billing for Clients with Commercial and Medicaid Benefits

For individuals with both commercial and Medicaid benefits, providers should bill the primary commercial insurance under their CCBHC provider NPI and using billing codes (threshold services and the CCBHC Encounter Code, T1040) they would typically bill for any services rendered to the beneficiary.

Upon determination and processing by the commercial payer, the CCBHC shall submit a claim for the difference (if any) in what was reimbursed by the commercial payer and their Medicaid CCBHC PPS rate. The claim submitted to Medicaid must include the CCBHC Provider NPI, PPS Code T1040, shadow claim detail and commercial payment remittance statement to support the claim amount.

The MCOs would coordinate this claim, paying any difference between the payment of the commercial insurer up to the providers Iowa Medicaid CCBHC PPS rate.

Commercial EOB



Claim Number:							Adjustment Date:					
Member Name:							Member ID:					
Provider Name:					Provider NPI:				Provider IRS:			
Carrier Name:	Commercial Ins.						GRP CDI:					
Carrier Address:					City:			State: LA	Zip:			
Alt Policy Number:					Amt D: 11778			Amt EAF: 0				
	Rev Code	CPT Code	Allow	Coins	Paid	Copay	Deduct	Other	Other	Other	Other	
1		T1040										
2		99213	4778		4778			27392 CO 45				
		90834	9000	2000	7000							

Commercial Insurance will not typically cover the code T1040 however, T1040 needs to be included on the first line of the claim to commercial insurance even though it will be denied as not covered (or similar denial). In the example above, the commercial payer denied T1040 but paid on the lines with 99213 and 90834 totaling $117.78

CCBHC PPS reimbursement/coordination will not occur if excluded services are included on the claim

Medicaid EOP:

Service Line	YMDEFF	YMDEND	Procedure Code	MODIFIER	Number of Units	Billed Charges	Allowed Amount	Payment by Primary Insurance	Deductible	Copay	Coinsurance	Payment Amount
1	20250701	20250701	T1040		1	450.00	321.7	117.78	0	0	20.00	203.92
2	20250701	20250701	99213	HO	1	0	0	0	0	0	0	0
3	20250701	20250701	90834	HO	1	0	0	0	0	0	0	0

When submitting the claim to Medicaid, attach the Explanation of Benefits (EOB) to the claim. The claims system will identify that the claim is for CCBHC by the T1040 present on the first line. On the Medicaid EOP you will see 99213 and 90834 as global to the encounter code (T1040) with the PPS rate as the allowed amount on the T1040 claim line. The full commercial insurance payment will be applied on that line. If PPS rate is $321.70 and the other insurance payment is $117.78 then the total paid should be $203.92.

Billing for Services Provided by a DCO Provider or Services Provided Outside the Primary CCBHC Location

CCBHCs are responsible for regularly ensuring that the DCOs providing services on their behalf are Medicaid enrolled providers in good standing. DCOs are prohibited from directly billing Medicaid for services provided on behalf of a CCBHC.

Append the designated modifier to service codes when provided by a DCO or a CCBHC satellite location.

Each line item of threshold services provided by a DCO or a CCBHC satellite location must append the appropriate modifier in the **first slot**, followed by other required service modifiers when applicable.

The CCBHC modifiers are intended to distinguish the CCBHC entity type providing the service. Place of service codes should reflect the physical location of service regardless of the rendering entity (see below).

The first line item with procedure code **T1040** must not have a modifier.

If the claim includes the DCO modifier, providers must report the DCO **entity** NPI (type 2):

Field 19 – Additional Claim Information. Enter qualifier "NTE", followed by "ADDDCONPI", then the DCO Entity National Provider Identifier (NPI) (e.g., NTEADDDCONPI0987654321). **Billing claims submitted with a DCO modifier but without Field 19 completed will be denied**.

Threshold Service Location	Modifier	Field 19 – Additional Claim Information
CCBHC Primary Location	No Modifier	Blank
CCBHC Satellite or Other Service Location	Q2	Blank
DCO Provider Location	HH	"NTE" + "ADD" + "DCO" + "NPI" + DCO NPI number e.g., NTEADDDCONPI0987654321

*CCBHC claims are subject to the same billing guidance as non-CCBHC claims for service codes that require informational modifiers (e.g., provider type/ licensure modifiers).

Additional Billing Guidance

Place of Service (03140) indicates where the service was rendered. This data element contains valid values accepted on medical claims (CMS 1500.) Place of Service Code Set | CMS

Please Note: **POS code 11 (Office)** should be used with the **T1040** encounter code on the first line of service. If the POS is left blank or contains a different number, the claim will be denied.

Rendering Provider ID typically indicates the individual provider performing the service. For CCBHC billing, enter the CCBHC billing provider NPI enrolled as Provider Type 88 for all service line items.

Allowed services are services CCBHCs are permitted to include in their cost report as allowable activities but are not considered threshold services on their own and will not trigger PPS reimbursement.

Please Note: Care management services are not permitted (according to Federal rule) to be considered threshold services for drawing down the CCBHC PPS rate. Care management services are included in this billing guide as allowed services.

Excluded services are services that are explicitly carved out from the CCBHC program. Any service not listed as threshold or allowed are excluded and will result in the PPS rate being denied when billed by a CCBHC using their CCBHC NPI number.

Integrated Health Home (IHH)

CCBHC Demonstration providers cannot receive a CCBHC PPS payment for services rendered to Medicaid members enrolled in any service tier with any IHH program. The only exception to this is a mobile crisis service*. CCBHCs can bill PPS for mobile crisis for individuals enrolled in an IHH program. All other services for IHH enrollees should be billed by the rendering provider in accordance with established, non-CCBHC billing practices. CCBHC services to members anticipated to continue as IHH-enrollees beyond July 1, 2025, should not be included in the CCBHC provider's cost projections. Additional information is included in CCBHC cost reporting guidance.

**Example scenario 4 in Appendix C.*

Assertive Community Treatment (ACT)

See Appendix A for ACT billing guidelines under CCBHC.

Regarding Excluded and Allowed Services

Some services will continue to be rendered and reimbursed by Medicaid outside the CCBHC Demonstration (i.e., IHH, Home and Community Based Services (HCBS) Habilitation and Waiver services, and residential services.) Please be aware of what services are in scope for this demonstration versus other Iowa waivers and programs. Services on the allowed list that have been included in the CCBHC's cost report cannot be billed outside of the PPS. For individuals enrolled in an IHH see above guidance regarding IHH.

Only CCBHC claims with a supporting threshold service will be reimbursed at the PPS rate. If a CCBHC claim includes only allowed services (without a threshold service) or includes excluded services, the CCBHC claim will be denied.

The Medicaid Program and Medicaid Managed Care Organizations (MCOs) will pay a daily PPS rate in full to eligible CCBHCs who provide a threshold visit to an eligible Medicaid member on the date billed.

CCBHCs should follow all applicable timeframes and billing requirements for Medicaid claim submissions.

CCBHCs with billing or payment disputes should follow the normal grievance and appeals process with supporting information and detail.

Mobile Crisis Guidance for Cost Reporting and Billing under CCBHC Demonstration

For mobile crisis being contracted through a DCO, reimbursement can be set according to the way mobile crisis is provided by the DCO. The fee structure established by the CCBHC and DCO should be set to mirror the service the DCO is providing to the CCBHC. (i.e., fees can be set up monthly to reimburse for "firehouse" response models or call center or can be set on a per service basis). If DCO mobile crisis costs are built into the CCBHC cost report and therefore reimbursed according to the CCBHC/DCO agreement, the DCO would not bill the Iowa Department of Health and Human Services (Iowa HHS) for any duplicative costs now covered by the CCBHC. Any costs not funded through the CCBHC (i.e., services that are outside scope of the defined CCBHC crisis service) may continue to be billed according to their contract with the Behavioral Health – Administrative Service Organization (BH-ASO).

If a CCBHC is providing mobile crisis costs directly, their cost report should include all the direct costs for standing up services compliant with CCBHC mobile crisis service criteria.

As a reminder, the PPS rate is a loaded, daily, cost-based rate, which will include these crisis costs and will be billed each time a Medicaid eligible member is served for a threshold CCBHC service, regardless of whether it is a mobile crisis encounter. Mobile crisis is a threshold event, but it is not the only threshold event where these costs will be paid according to the CCBHC PPS methodology.

For CCBHC billing purposes, please see the following guidance with respect to how to bill in the event of a threshold mobile crisis service:

1. CCBHCs will bill for mobile crisis when they (or their DCO) provide services to a confirmed, active CCBHC client.
    a. A confirmed, active CCBHC client can be verified directly by the client or their family/guardian/support system at the time of the mobile crisis event
    b. A confirmed, active CCBHC client can also be verified at the next outpatient BH visit following the client's crisis event

**** Please note: CCBHCs will bill for mobile crisis on behalf of their DCO partners and then pay DCO partners according to the terms of their DCO agreement. DCOs may not bill the PPS rate directly.**

2. If the mobile crisis visit is to a person who is not yet a client of the CCBHC, the crisis event can be a triggering event for referring and connecting that individual to the CCBHC in their service area. The mobile crisis team will assess and triage. With the individual's consent, the team will notify the CCBHC of the encounter to provide follow-up. CCBHCs are responsible for follow-up care either by providing an evaluation within the timeline determined by the assessment (urgent or routine) and per CCBHC criteria standards, or if the individual is hospitalized, following up with the individual to assist with discharge and connection to appropriate community services (CCBHC case management). CCBHCs can bill for the mobile crisis encounter whether provided directly or through their DCO on their behalf once follow up efforts have occurred. Follow up efforts include specific documentation of phone calls, text messages, and in-person visits.

3. If the confirmed and active CCBHC client is a Medicaid beneficiary, the CCBHC should bill Medicaid the PPS rate for the mobile crisis encounter (for themselves or on behalf of the DCO). If the client is dual eligible, the CCBHC should follow the process for billing dual eligible clients.

4. If the confirmed and active CCBHC client is not a Medicaid beneficiary (uninsured, commercial, Medicare, etc.), the CCBHC, if providing mobile crisis directly should bill Iowa HHS for the mobile crisis encounter, pursuant to their current contractual agreement with the BH-ASO.

5. CCBHCs and their DCOs who are state sanctioned mobile crisis providers are responsible for billing Iowa HHS directly for non-Medicaid enrolled individuals.

6. Crisis services outside the CCBHC model (which include residential-based crisis services) should be billed according to existing, allowable reimbursement methodologies, including billing through the Iowa HHS, Medicaid, or other insurance.

7. Mobile crisis providers who operate as a DCO for a CCBHC may draw down funding pursuant to a contractual agreement with the BH-ASO, however, they must not seek funding for any mobile crisis encounters for Medicaid members for whom they receive reimbursement from a CCBHC per their DCO relationship and agreement.

Questions can be directed to the CCBHC mailbox: IowaCCBHC@hhs.iowa.gov.

Threshold Services			
CCBHC Service Category	**Code**	**Modifier**	**Definition -**
Criteria 4.C. Crisis Behavioral Health Services	G0017		Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis service applies, other than the office setting); first 60 minutes
Criteria 4.C. Crisis Behavioral Health Services,	G0018		Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis service applies, other than the office setting); each additional 30 minutes – list separately in addition to code for primary service
Criteria 4.C. Crisis Behavioral Health Services	H0007		Alcohol/drug crisis intervention/outpatient
Criteria 4.C. Crisis Behavioral Health Services	H0014		Alcohol and/or drug services; ambulatory detoxification
Criteria 4.C. Crisis Behavioral Health Services	H2011	U3	Crisis intervention service - mobile crisis response. Use modifier U3 when billing PPS.
Criteria 4.C. Crisis Behavioral Health Services	S9484	TF	Crisis intervention mental health services, per hour. Use modifier TF for community. No residential may be billed under PPS.
Criteria 4.C. Crisis Behavioral Health Services	S9485	TF	Crisis intervention mental health services, per diem. Use modifier TF for community. No residential may be billed under PPS.
Criteria 4.C. Crisis Behavioral Health Services	90839		Psychotherapy for crisis; first 60 minutes
Criteria 4.C. Crisis Behavioral Health Services,	90882		Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
Criteria 4D: Screening, Assessment and Diagnosis	90785		Interactive complexity (List separately in addition to the code for primary procedure)
Criteria 4D: Screening, Assessment and Diagnosis	90791		Psychiatric diagnostic evaluation
Criteria 4D: Screening, Assessment and Diagnosis	90792		Psychiatric diagnostic evaluation with medical services
Criteria 4D: Screening, Assessment and Diagnosis	90887		Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient

Criteria 4D: Screening, Assessment and Diagnosis	96100		Psychological testing w/interpretation and report
Criteria 4D: Screening, Assessment and Diagnosis	96102		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
Criteria 4D: Screening, Assessment and Diagnosis	96103		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI), administered by a computer, with qualified health care professional interpretation and report
Criteria 4D: Screening, Assessment and Diagnosis	96127		Brief emotional behavioral assessment-Comm MH
Criteria 4D: Screening, Assessment and Diagnosis	96130		Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
Criteria 4D: Screening, Assessment and Diagnosis	96131		Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
Criteria 4D: Screening, Assessment and Diagnosis	96136		Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes

Criteria 4D: Screening, Assessment and Diagnosis	96137		Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
Criteria 4D: Screening, Assessment and Diagnosis	96138		Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
Criteria 4D: Screening, Assessment and Diagnosis	96139		Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
Criteria 4D: Screening, Assessment and Diagnosis	96146		Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
Criteria 4D: Screening, Assessment and Diagnosis	96156		HLTH BHV ASSMT/REASSESSMENT
Criteria 4D: Screening, Assessment and Diagnosis	99408		Alcohol/sub abuse screen & intervention 15-30 minutes
Criteria 4D: Screening, Assessment and Diagnosis	99409		AUDIT/DAST OVER 30 MINUTES
Criteria 4D: Screening, Assessment and Diagnosis	G0396		Alcohol &/or sub misuse assessment 15-30 minutes
Criteria 4D: Screening, Assessment and Diagnosis	G0397		Alcohol %/or sub misuse assessment >30 minutes
Criteria 4D: Screening, Assessment and Diagnosis	G0442		Annual alcohol screen 15 minutes
Criteria 4D: Screening, Assessment and Diagnosis	G0444		Depression screen annual
Criteria 4D: Screening, Assessment and Diagnosis	H0001		Alcohol and/or drug assessment
Criteria 4D: Screening, Assessment and Diagnosis	H0003		ALCOHOL/DRUG SCREENING
Criteria 4D: Screening, Assessment and Diagnosis	H0031		Mental health assessment, by nonphysician
Criteria 4D: Screening, Assessment and Diagnosis	H0049		Alcohol and/or drug screening

Criteria 4E: Person-Centered and Family-Centered Treatment Planning	H0032		Mental health service plan development by nonphysician
Criteria 4F: Outpatient Mental Health and Substance Use Services	90832		Psychotherapy, 30 minutes with patient
Criteria 4F: Outpatient Mental Health and Substance Use Services	90833		Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
Criteria 4F: Outpatient Mental Health and Substance Use Services	90834		Psychotherapy, 45 minutes with patient
Criteria 4F: Outpatient Mental Health and Substance Use Services	90836		Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
Criteria 4F: Outpatient Mental Health and Substance Use Services	90837		Psychotherapy, 60 minutes with patient
Criteria 4F: Outpatient Mental Health and Substance Use Services	90838		Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
Criteria 4F: Outpatient Mental Health and Substance Use Services	90840		Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
Criteria 4F: Outpatient Mental Health and Substance Use Services	90846		Family psychotherapy (without the patient present), 50 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	90847		Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	90849		Multiple-family group psychotherapy
Criteria 4F: Outpatient Mental Health and Substance Use Services	90853		Group psychotherapy (other than of a multiple-family group)
Criteria 4F: Outpatient Mental Health and Substance Use Services	90863		Pharmacologic management with psychotherapy
Criteria 4F: Outpatient Mental Health and Substance Use Services	90875		Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes

Criteria 4F: Outpatient Mental Health and Substance Use Services	90876		Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	90899		Unlisted psychiatric service or procedure
Criteria 4F: Outpatient Mental Health and Substance Use Services	96116		Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
Criteria 4F: Outpatient Mental Health and Substance Use Services	96118		Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
Criteria 4F: Outpatient Mental Health and Substance Use Services	96119		Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
Criteria 4F: Outpatient Mental Health and Substance Use Services	96120		Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report
Criteria 4F: Outpatient Mental Health and Substance Use Services	96121		Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)

Criteria 4F: Outpatient Mental Health and Substance Use Services	96132		Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
Criteria 4F: Outpatient Mental Health and Substance Use Services	96133		Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
Criteria 4F: Outpatient Mental Health and Substance Use Services	99201		Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99202		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99203		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

Criteria 4F: Outpatient Mental Health and Substance Use Services	99204		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99205		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99211		Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional
Criteria 4F: Outpatient Mental Health and Substance Use Services	99212		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99213		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99214		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

Criteria 4F: Outpatient Mental Health and Substance Use Services	99215		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
Criteria 4F: Outpatient Mental Health and Substance Use Services	99354		Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215])
Criteria 4F: Outpatient Mental Health and Substance Use Services	99417		Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)
Criteria 4F: Outpatient Mental Health and Substance Use Services	99441		Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion
Criteria 4F: Outpatient Mental Health and Substance Use Services	99442		Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11-20 minutes of medical discussion
Criteria 4F: Outpatient Mental Health and Substance Use Services	99499		Unlisted evaluation and management service

Criteria 4F: Outpatient Mental Health and Substance Use Services	99510		Home visit for individual, family, or marriage counseling
Criteria 4F: Outpatient Mental Health and Substance Use Services	G0443		Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	G0445		Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior
Criteria 4F: Outpatient Mental Health and Substance Use Services	G0446		Intensive behavioral therapy 15 min: Annual, face to face intensive behavioral health therapy for cardiovascular disease, individual
Criteria 4F: Outpatient Mental Health and Substance Use Services	G0447		Face to face behavioral counseling for Obesity, 15 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	G0473		Face to face behavioral counseling for Obesity, group (2-10), 30 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2068		Medication assisted treatment, **buprenorphine** (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2069		Medication assisted treatment, **buprenorphine** (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2070		Medication Assisted Treatment, Buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2071		Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)

Criteria 4F: Outpatient Mental Health and Substance Use Services	G2072		Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2073		Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2074		Medication assisted treatment, weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy and toxicology testing
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2075		Medication Assisted Treatment, Medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare enrolled opioid treatment program)
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2079		Take home supply of buprenorphine (oral); up to 7 additional day supply (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
Criteria 4F: Outpatient Mental Health and Substance Use Services	G2080		Each additional 30 minutes of counseling in a week of medication assisted treatment, (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
Criteria 4F: Outpatient Mental Health and Substance Use Services	H0004		Behavioral health counseling and therapy, 15 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	H0015		Alcohol and/or drug services, intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
Criteria 4F: Outpatient Mental Health and Substance Use Services	H0040		Assertive Community Treatment

Criteria 4F: Outpatient Mental Health and Substance Use Services	H0046		Mental health services, not otherwise specified
Criteria 4F: Outpatient Mental Health and Substance Use Services	H0050		Alcohol and/or drug services, brief intervention, per 15 minutes
Criteria 4F: Outpatient Mental Health and Substance Use Services	H2035		Alcohol and/or other drug treatment program, per hour
Criteria 4F: Outpatient Mental Health and Substance Use Services	J0570		Buprenorphine implant, 74.2 mg
Criteria 4F: Outpatient Mental Health and Substance Use Services	J0571		Buprenorphine, oral, 1 mg
Criteria 4F: Outpatient Mental Health and Substance Use Services	J0572		Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine
Criteria 4F: Outpatient Mental Health and Substance Use Services	J0573		Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine
Criteria 4F: Outpatient Mental Health and Substance Use Services	J0574		Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine
Criteria 4F: Outpatient Mental Health and Substance Use Services	J0575		Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine
Criteria 4F: Outpatient Mental Health and Substance Use Services	J0577		Injection, buprenorphine extended-release (Brixadi), less than or equal to 7 days of therapy
Criteria 4F: Outpatient Mental Health and Substance Use Services	J0578		Injection, buprenorphine extended-release (Brixadi), greater than 7 days and up to 28 days of therapy
Criteria 4F: Outpatient Mental Health and Substance Use Services	J0592		Injection, buprenorphine HCl, 0.1 mg
Criteria 4F: Outpatient Mental Health and Substance Use Services	J2315		Injection, naltrexone, depot form, 1 mg
Criteria 4F: Outpatient Mental Health and Substance Use Services	Q9991		Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg
Criteria 4F: Outpatient Mental Health and Substance Use Services	Q9992		Injection, buprenorphine extended-release (Sublocade), greater than 100 mg
Criteria 4G: Outpatient Clinic Primary Care Screening and Monitoring	99401		Preventative Medicine counseling/risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
Criteria 4G: Outpatient Clinic Primary Care Screening and Monitoring	99402		Preventative Medicine counseling/risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes

Criteria 4G: Outpatient Clinic Primary Care Screening and Monitoring	99403		Preventative Medicine Counseling/risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
Criteria 4G: Outpatient Clinic Primary Care Screening and Monitoring	99404		Preventative Medicine Counseling/risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
Criteria 4G: Outpatient Clinic Primary Care Screening and Monitoring	G2077		Periodic assessment: assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment/provision of the services by a Medicare-enrolled opioid treatment program; list separately in addition to code for primary procedure
Criteria 4I. Psychiatric Rehabilitative Services	90846	HK	Functional Family Therapy-family therapy without youth present, use HK modifier, provider types HP, HO, AF, SA
Criteria 4I. Psychiatric Rehabilitative Services	90847	HK	Functional Family Therapy-family therapy with youth present, use HK modifier, provider types HP, HO, AF, SA
Criteria 4I. Psychiatric Rehabilitative Services	90882		Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
Criteria 4I. Psychiatric Rehabilitative Services	H0034		Medication training and support, per 15 minutes
Criteria 4I. Psychiatric Rehabilitative Services	H2012		Behavioral health day treatment, per hour
Criteria 4I. Psychiatric Rehabilitative Services	H2033		Multisystemic therapy, per 15 minutes
Criteria 4I. Psychiatric Rehabilitative Services	S9480		Intensive outpatient psychiatric services, per diem
Criteria 4J. Peer Supports, Peer Counseling and Family/Caregiver Supports	H0038		Self-help/peer services, per 15 minutes
Criteria 4J. Peer Supports, Peer Counseling and Family/Caregiver Supports	T1027		FAMILY TRAINING & COUNSELING/PER 15 MINUTES

Allowed Services	
Code	**Definition**
90782	THER. INJ. OF MEDICATION (SPECIFY);SUBQ
96001	MOTION TEST W/FT PRESS MEAS
96105	Assessment of aphasia
96110	Developmental screening
96112	development test
96113	development test
96125	cognitive test by hc pro
96158	HLTH BHV IVNTJ INDIV 1ST 30
96164	HLTH BHV IVNTJ GRP 1ST 30
96165	HLTH BHV IVNTJ GRP EA ADDL
96167	HLTH BHV IVNTJ FAM 1ST 30
96168	HLTH BHV IVNTJ FAM EA ADDL
96170	HLTH BHV IVNTJ FAM WO PT 1ST
96171	HLTH BHV IVNTJ FAM W/O PT EA
96372	THER/PROPH/DIAG INJ SC/IM
96967	TELEPHONE A/M SERVICE, 11-20MIN OF DISC
98966	HC PRO PHONE CALL 5-10 MIN
98967	HC PRO PHONE CALL 11-20 MIN
98968	HC PRO PHONE CALL 21-30 MIN
99483	Assmt & care pln pt cog imp
99484	CARE MGMT SVC BHVL HLTH COND
99492	1ST PSYC COLLAB CARE MGMT
99493	SBSQ Psych collab care mgmt
99494	1st/SBSQ psych collab care
G0136	Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 min
G0449	Annual face-to-face obesity screening
G0450	Screen for sexually transmitted infection
G0451	DEVELOPMENT TESTING, WITH I & R
G0480	Drug test(s); utilizing drug identification
G0659	Drug test(s); utilizing drug identification
G2212	Prolong outpatient/office visit
G2214	Initial or subsequent psychiatric collab
G9012	OTHER SPECIFIED CASE MANAGEMENT SERVICE
H0033	Oral medication administration (psychotropic)

H2010	Comprehensive Medication Services/15 min
Q3014	Telehealth facility fee
T1013	Sign language or oral interpretation services
T1013	Telephonic interpretive services
T1016	Case management, each 15 minutes
T2023	Targeted case management; per month

Appendix A: Assertive Community Treatment (ACT) Billing Guidelines

Assertive Community Treatment (ACT) is a comprehensive, community-based mental health care model designed to support individuals with severe mental illnesses. Here are some key aspects of ACT:

- Holistic Approach: ACT provides multidisciplinary care, including psychiatry, nursing, case management, substance use treatment, and peer support.
- Community Integration: The goal is to help individuals live independently and integrate into their communities, reducing the need for hospitalization.
- 24/7 Support: ACT teams offer round-the-clock services, ensuring continuous support for those in need.
- Personalized Care: Services are tailored to meet the unique needs of an individual, focusing on improving their overall quality of life.

It is the expectation that an individual will receive the appropriate level and type of service interventions based on their clinical needs.

Historically, ACT has been reimbursed using a daily rate based on a meeting of the ACT Team Monday through Friday. Clinics designated as a Certified Community Behavioral Health Center (CCBHC) by Iowa HHS will provide and bill ACT services under a PPS rate. A PPS payment may be billed on a day a service is provided if that day counts as a visit. Starting on July 1, 2025, the ACT services that constitute a billable visit delivered by CCBHC must have a face-to-face component with the delivery of a threshold service. For complete coverage and definitions refer to Iowa Administrative code 441—78.45 (249A) Assertive community treatment. Billable services will be billed using code H0040.

Face-to-face to visits are defined as: a visit where the client or a member of the client's family/extended family, or support system is present and receives a threshold service during the interaction and include:

- Face-to-face contact in person with the individual receiving a threshold service.
- Face-to-face visits with the guardians of individuals, with the parents/foster parents/ guardian of children under 18 years of age.
- Face-to-face visits with other family members, including spouses and other major supports (teachers, care givers) receiving a threshold service.

Care coordination is hallmark and essential component for ACT. CCBHCs can include care coordination and case management costs in their cost report. However, care coordination and/or case management is not considered a threshold service under CCBHC and does not trigger PPS reimbursement. Care coordination includes:

- Direct contact by phone with the individual served.
- Direct contact in person or phone with families, staff within your agency or other agencies on behalf of the person served, other than stated above.

- Documentation time is not considered part of the service intervention unless completed collaboratively with the individual served during the face-to-face service session.
- Case management including phone calls, referrals, client monitoring.

ACT Threshold Services*		
CCBHC Service Category (H0040)	**Service**	**Eligible for PPS Payment**
Crisis Services	Crisis Response	Y
Outpatient Mental Health and Substance Use Services	Evaluation and Medication Management	Y
	Initial assessment and treatment planning	Y
	Integrated therapy and counseling for mental health and substance abuse	Y
	Skill teaching	Y
	Community Support	Y
	Education, support and consultation to family members and other major supports of the individual	Y
	Work related services	Y
Care Coordination	Case Management	N
	Team meetings	N
	Treatment plan development/review	N
	Care coordination meetings without client or supports	N
	Phone calls	N
	Scheduling appointments	N
Peer and Family Support	Peer Support	Y
Primary Care Screening and Monitoring	Preventative Medicine counseling/risk reduction interventions	Y
	Prevention Medicine vaccinations following USPSTF guidelines	Y
	Preventative Medicine Routing laboratory screening	Y
***For complete list of covered threshold codes refer to the Threshold Services section of the CCBHC billing guide.**		

Appendix B: CCBHC Claims Submission Instructions

The instructions below provide guidance specific to submitting a CMS-1500 claim form for CCBHC services. With the exception of the fields and guidance mentioned below, providers should follow the same billing guidance provided by Iowa Medicaid on their webpage for non-CCBHC claims, including completion of all required fields when submitting claims for CCBHC services.

Field No.	Field Name/ Description	Required or Conditional	Instructions
19	Additional Claim Information (Designated by NUCC)	**Conditional**	▪ If Field 24D includes modifier **HH** indicating the service was provided by a DCO. ▪ Enter **NTEADDDCONPI** plus the DCO NPI # (e.g., NTEADDDCONPI0987654321) ▪ Claims submitted with modifier **HH** and without Field 19 completed will be denied.
24B	Place of Service	**Required**	▪ Use POS code **11** (Office) on Line 1 for use with **T1040** encounter code. Billing claim will be denied if POS is blank or a code other than 11 is entered with the T1040 encounter code. ▪ Lines 2+ should include the POS number that corresponds to where the specific service was rendered.
24D – Lower Part	Procedures, Services or Supplies	**Required**	▪ Line 1 enter: Encounter code **T1040 (No modifier)** ▪ Line 2 enter: Threshold service code ▪ Lines 3+ enter: Threshold or other allowed services provided during the encounter. ▪ Modifiers should only be entered on lines 2+ (informational only) for threshold and allowed services. • If service is rendered by a CCBHC satellite or other service location enter: **Q2** in first modifier slot • If service is rendered by a DCO enter: **HH** in first modifier slot • When applicable, show HCPCS code modifiers with the HCPCS code for threshold and allowed services. ▪ Specific procedure code(s) on lines 2+ should indicate a $0.00 charge as 'informational only.' ▪ Claims submitted without 'informational only' procedure codes will be denied. Providers are required to include all CCBHC services provided on the service date.
24J – Lower Part	NPI	**Required**	▪ All Lines Enter: CCBHC Provider Type 88 NPI
33a	NPI	**Required**	▪ Enter: CCBHC Provider Type 88 NPI

Appendix C: Claims Submission Examples

All examples assume required fields are completed

Field 19. Enter: "**NTEADDDCONPI" + DCO NPI** *(if Field 24.D includes*

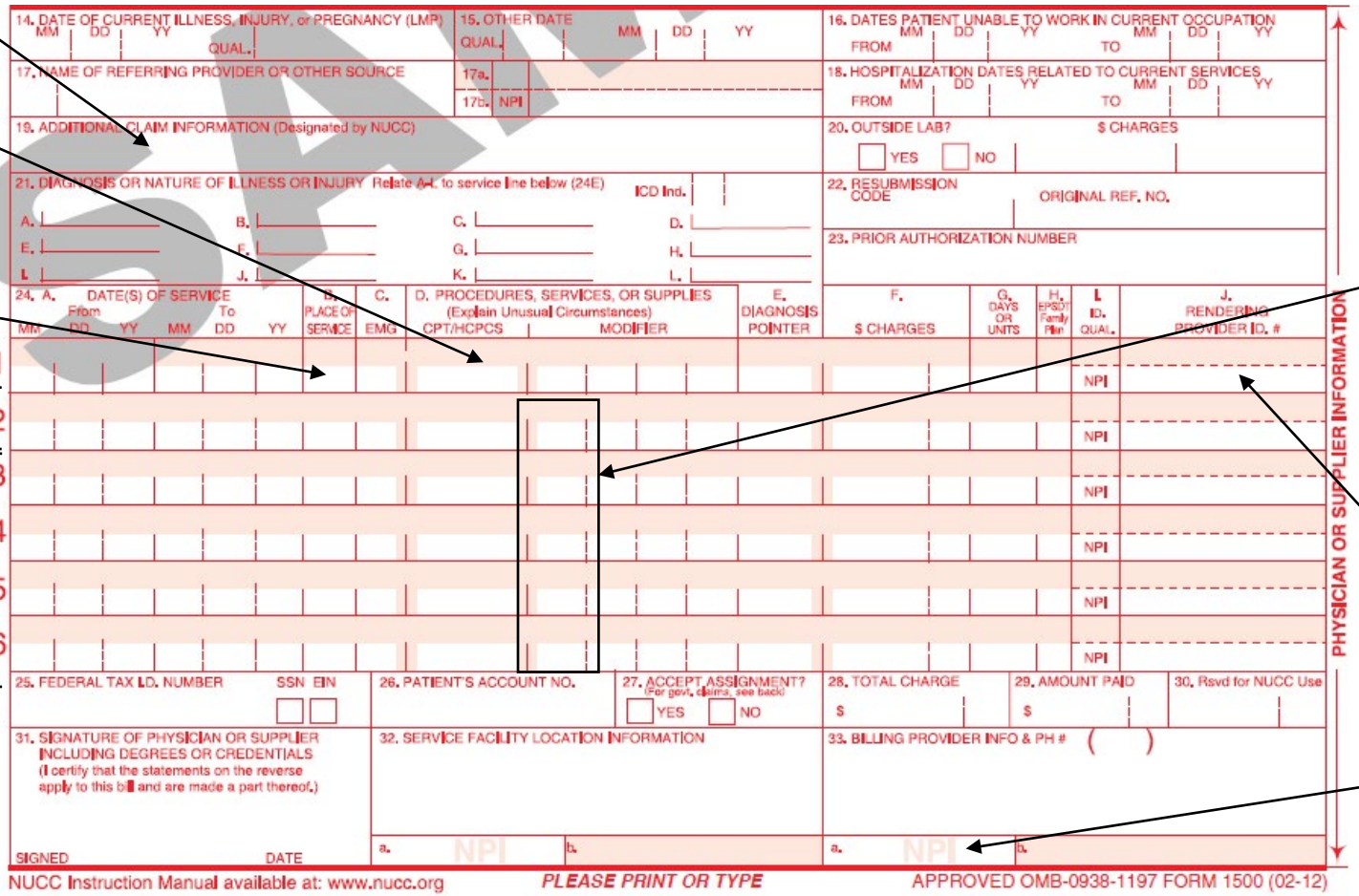
Field 24D – Line 1
CPT/ HCPCS
Enter: **T1040**
(No Modifier)

Field 24B – Line 1
Place of Service Enter: **11 with T1040 encounter code**

24B – Lines 2+ POS
Enter: # where specific service was rendered

Field 24D – Line 2
CPT/ HCPCS
Enter: **Threshold service** code

Field 24D – Line 3+
CPT/ HCPCS
Enter: Threshold or other allowed service code(s) provided during the encounter



Field 24D – Line 2+
Modifier Slot 1

If rendered by CCBHC primary location,
Enter: **blank or other service modifier**

If rendered by CCBHC satellite location or other service location,
Enter: **Q2**

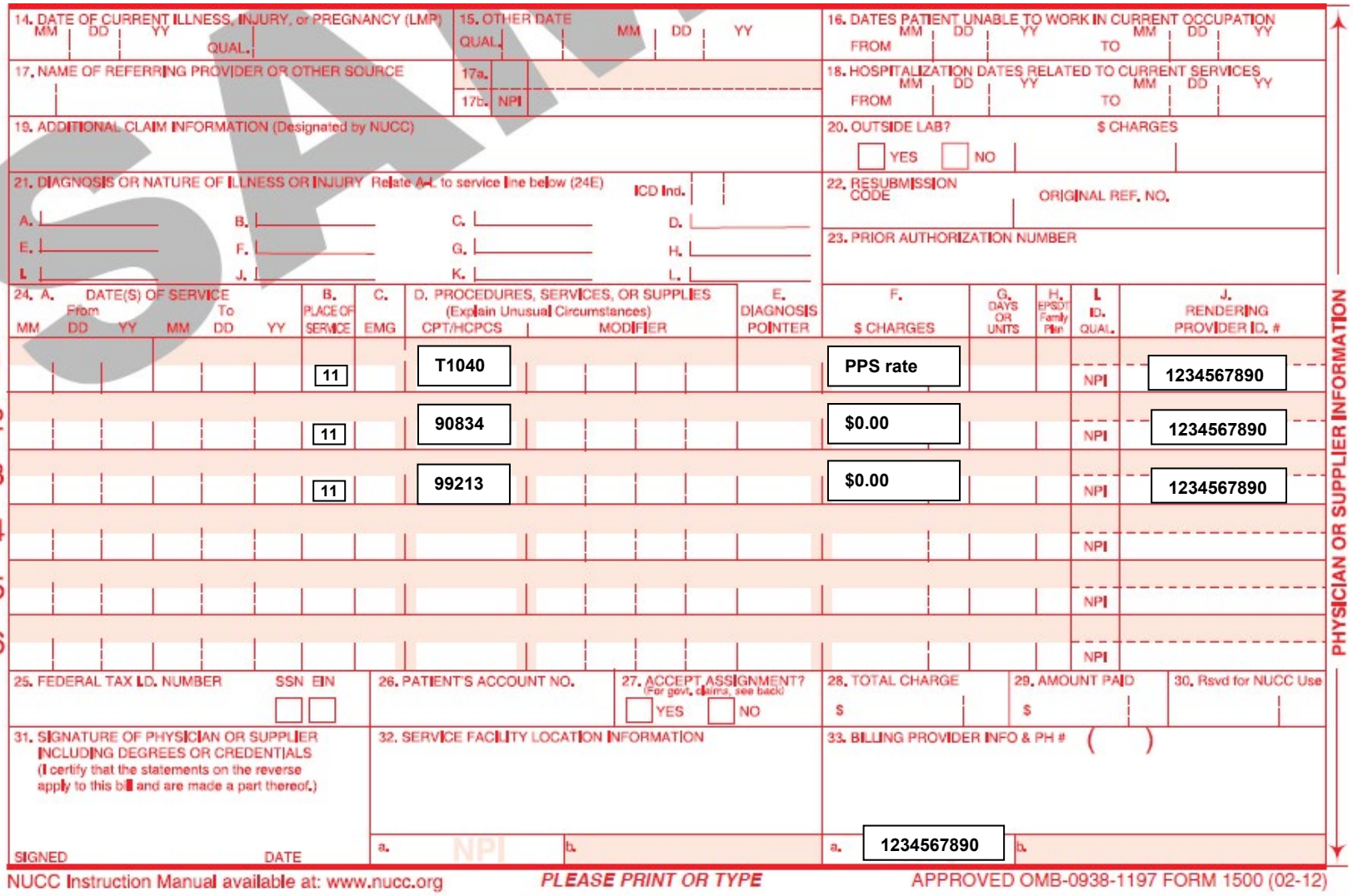
If rendered by DCO,
Enter: **HH**

Field 24D – Line 2+
Modifier Slot 2 – 4
If rendered by CCBHC satellite site or DCO:
Enter: **Other required modifiers for threshold service**

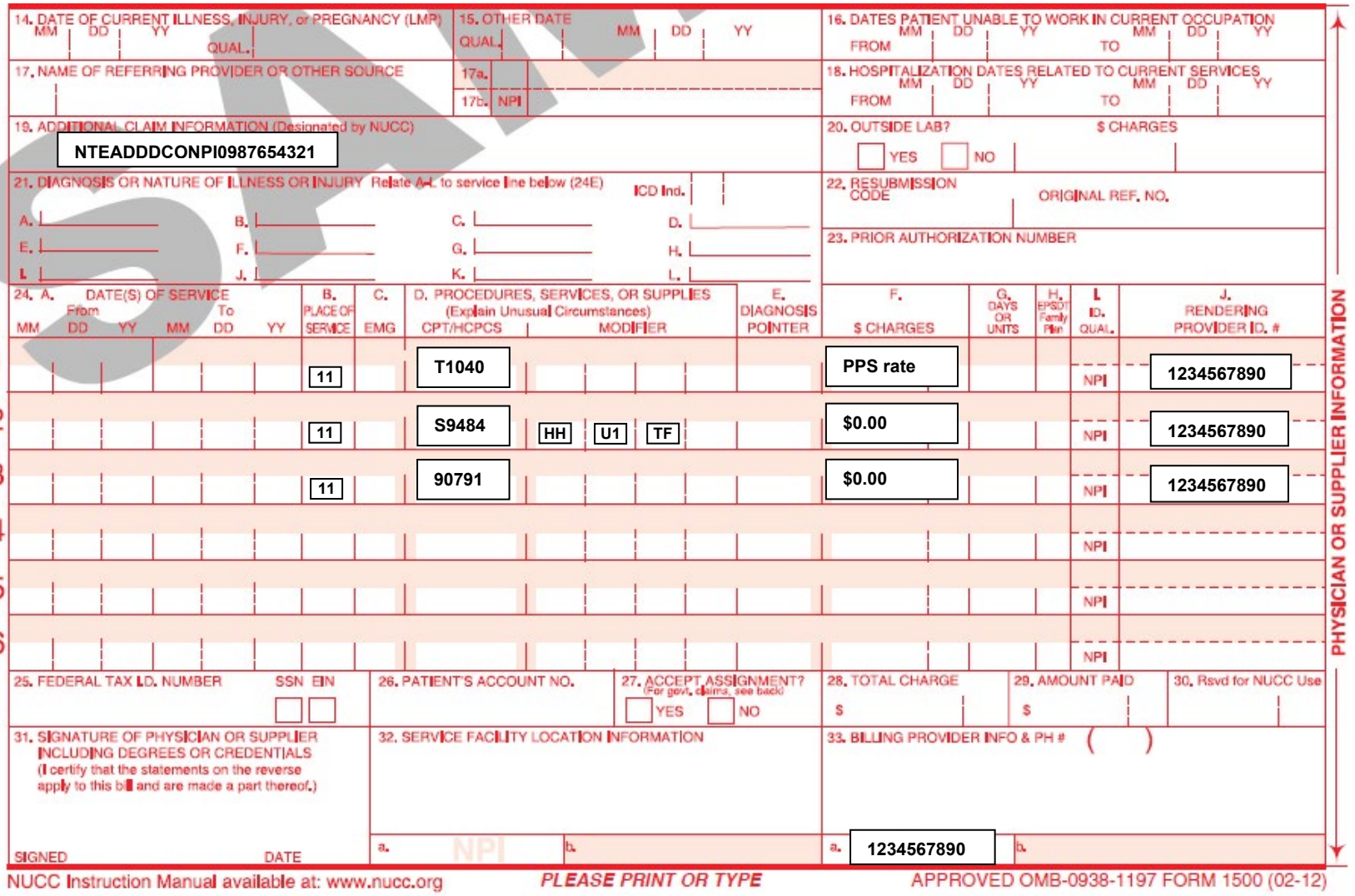
Field 24J – All Lines
Enter: **CCBHC Provider Type 88 NPI**

Field 33A
Enter: **CCBHC Provider Type 88 NPI**

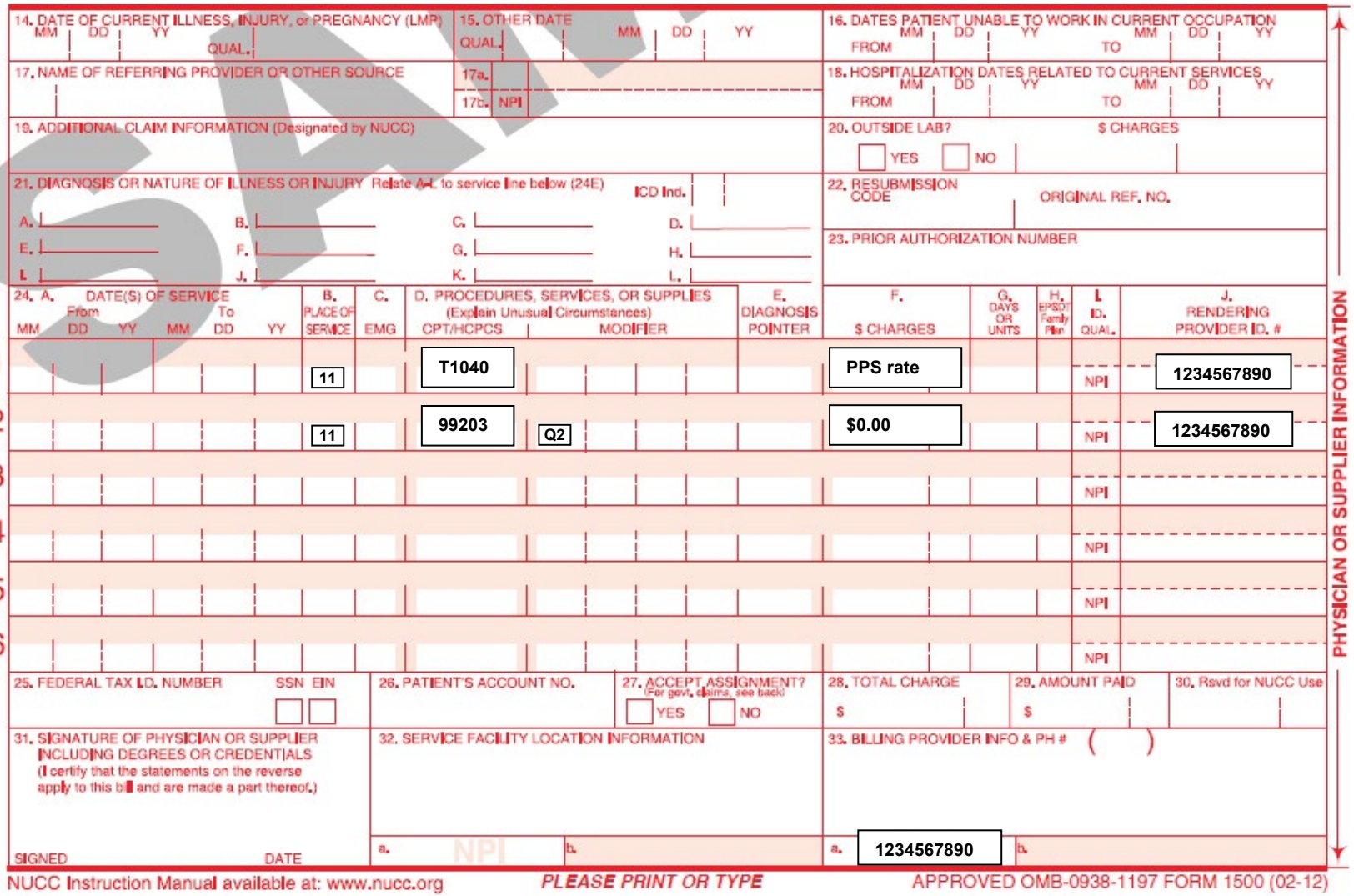
Scenario 1: Client A receives psychotherapy and another service during the CCBHC encounter. All services are provided at the CCBHC's primary location enrolled as provider type 88 with NPI 1234567890



Scenario 2: Client A receives crisis stabilization services by a DCO with NPI 0987654321 and is referred to the CCBHC primary location for psychiatric diagnostic evaluation.



Scenario 3: Client A receives evaluation and management services from a CCBHC satellite location.



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11		T1040			PPS rate			NPI	1234567890
2	11		99203	Q2		$0.00			NPI	1234567890
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.
33. BILLING PROVIDER INFO & PH # ( ) a. 1234567890 b.

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Scenario 4: Client A receives mobile crisis response in their home. Mobile crisis is provided by the DCO with NPI 0987654321 who provides the assessment and provides a warm handoff to the CCBHC for follow-up services per the client's request.