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 state-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 at 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

qualify for PPS reimbursement, CCBHCs must meet the Medicaid standard for the service they are providing as defined by the CPT code.

To bill the Prospective Payment System (PPS) rate, the CCBHC must provide a threshold service on that day to an eligible Medicaid recipient. The CCBHC can only be reimbursed one PPS per day per eligible member.

The CCBHC must 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 posted on the Medicaid website.

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

CCBHCs may only bill PPS for qualifying threshold services provided to Medicaid-enrolled members in their CCBHC service area. CCBHCs are not able to bill fee-for-service (FFS) for CCBHC services provided in their CCBHC service area. However, they may bill FFS for services not included in the CCBHC spectrum of services (e.g., Community Support Services (CSS), Intensive Psychiatric Rehabilitation (IPR), Crisis Stabilization Residential (CSR), etc.) or any eligible services that occur outside of their CCBHC service area.

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. For individuals who are uninsured or underinsured, CCBHCs should follow **guidance** for determining eligibility and submitting claims to Iowa HHS through the Iowa Safety Net Management Information System (SNMIS). For questions related to SNMIS, please contact: **BHassistance@hhs.iowa.gov**.

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

***Non-medically exempt Iowa Health and Wellness Plan (IHAWP) enrollees** are not eligible for B3 services within CCBHC. CCBHCs are expected to work with Medicaid to obtain medical exemption for enrollees, if appropriate.

General Billing Guidance

CCBHCs should use the CMS-1500 claim form with the CCBHC-specific NPI as the billing provider unless otherwise specified.
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 (F-series*)
- 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)

***Z-series screening codes** can be used for H2011 mobile crisis response only.

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)

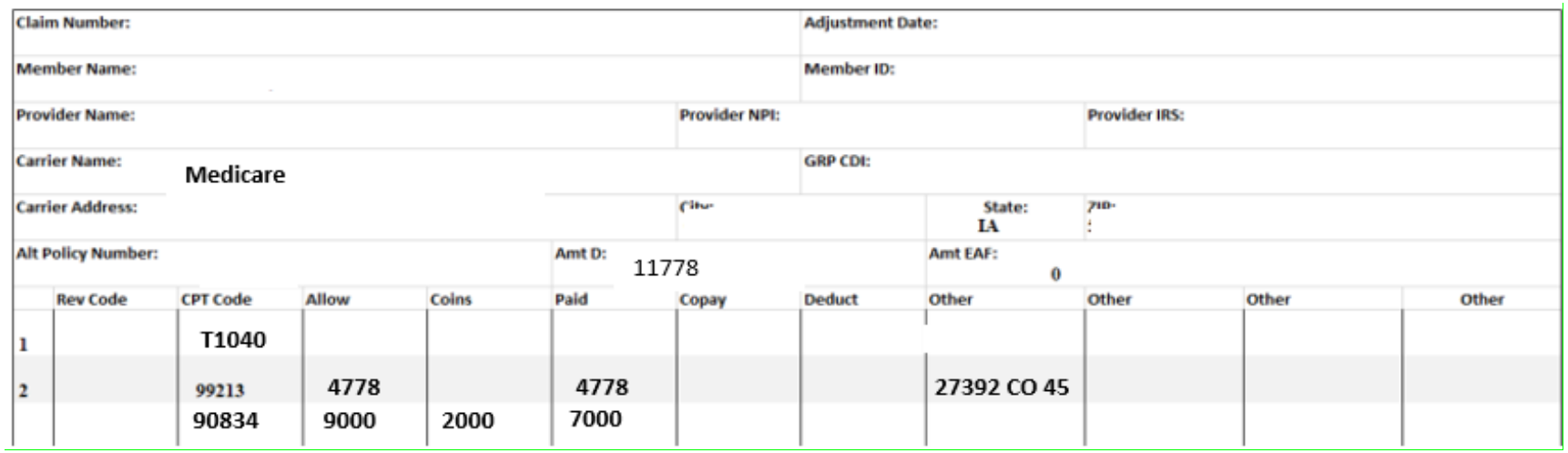
Coordination of Benefits (COB) – Original Guidance - Preferred Method*

**Please try using the preferred method first before moving on to the alternative guidance.*

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

For clients 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:				City:		State: IA	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						

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). Line two and below should be completed to reflect the services provided using general Medicare billing practices including adding any necessary modifiers, fees, and using the rendering provider NPI. 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 $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. Except for including the T1040 encounter code on the first line and the triggering threshold service on the second line, CCBHCs should follow standard claim guidance for submission of their claims to commercial insurers.

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. CCBHCs should follow CCBHC billing guidance in submission of secondary claims.

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:						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							

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.

Coordination of Benefits: Alternative Guidance if Preferred Method Doesn't Work

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

For members with Medicare and Medicaid insurance coverage, providers should bill claims as they would normally as a Community Mental Health Center (CMHC) or Behavioral Health Provider. Claims must be billed under the provider's CCBHC NPI but should be submitted without the T1040 encounter code line. When the claim crosses over to Medicaid or the MCOs it will be denied due to no payable service on the claim. This is due to there being no T1040 encounter code. CCBHCs must resubmit a corrected claim. The corrected claim must include the T1040 encounter code and line filled out reflecting the PPS and the CCBHC NPI as the rendering provider. The claim should also have the shadow line dollar amounts zeroed out ensuring that Line 2 is a threshold service, and that the rendering provider NPI billed on the original Medicare claim should be removed from the shadow lines. The corrected claim must be resubmitted to Medicaid or the MCOs with the Explanation of Benefits (EOB) showing what was paid. CCBHC PPS reimbursement/coordination will not occur if excluded services are included on the crossover claim.

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 detailed via Informational Letter [IL] 2157).

Billing for Clients with Commercial and Medicaid Benefits

For individuals with both commercial and Medicaid benefits, providers should bill the primary commercial insurance as they would normally under the NPI they have currently credentialed with the payer. Claims to the primary payer cannot include the T1040 encounter code or the PPS rate. When the claim returns to the provider showing payment or denial by the primary commercial payer, CCBHCs must submit a secondary claim to Medicaid or the MCO under their CCBHC NPI. The secondary claim must include the T1040 encounter code and line completed according to the CCBHC billing guidance with the PPS amount and the CCBHC NPI as the rendering provider. The claim must also include all shadow services at zero dollars ensuring that the service code on Line 2 is a threshold service to justify the PPS. The rendering provider NPIs from the original commercial claim should be removed from the shadow lines as well. CCBHC PPS reimbursement/coordination will not occur if excluded services are included in the claim. The secondary claim must be submitted to Medicaid or the MCOs along with the EOB(s) attached showing what the primary commercial insurance has paid.

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.

CCBHCs must document in their EHRs the reason for billing commercial insurance under one NPI and Medicaid/MCOs under their CCBHC NPI for the same member. This reason being that commercial payers wouldn't credential the provider's CCBHC NPI which was required for CCBHC billing and PPS reimbursement by Iowa Medicaid. This documentation is necessary if there is an audit.

Billing for Multiple Services in the Same Day by Different Providers for Dual-Eligible Beneficiaries

Providers must submit claims to primary payers (Medicaid or commercial) according to the above COB guidance for each respective health plan. Provider's current billing practice for Medicare and commercial claims require providers to submit a separate claim for each provider that provided a service on a specific day. CCBHCs must consolidate multiple claims into one corrected CCBHC claim when resubmitting their corrected claim (Medicare/Medicaid clients) or submitting their secondary claim (commercial/Medicaid) to Medicaid or the MCOs. These corrected or secondary claims must be submitted under the CCBHC NPI with the T1040 encounter code line completed including the place of service, PPS amount and the CCBHC NPI as the rendering provider. These claims must also include all shadow claim lines, ensuring that Line 2 is a threshold service thereby justifying the PPS reimbursement. Shadow claim lines should have their dollars zeroed out and the original individual rendering provider NPI removed from the claim form. When submitting to Medicaid and the MCOs the corrected or secondary claim MUST include all services provided on that date of service and must also have the EOB(s) attached showing what was paid.

Bypass Services

CCBHC's should follow the current Medicaid billing practice of submitting dual claims directly to Medicaid for specific services not covered by Medicaid or commercial payers. For CCBHC these "bypass" services include Assertive Community Treatment (ACT), Mobile Crisis Response, Crisis Stabilization Community Based (CSCBS), and Peer Services. Claims that include a Medicare or commercial covered service must be submitted to the primary insurance (Medicare or commercial) even if a "bypass" service is provided on the same day. CCBHCs cannot submit multiple claims for the same date of service to Medicaid/MCOs.

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.

CCBHCs must follow standard Medicaid billing practices with regards to completing the diagnosis portion of all CCBHC claims. The only exception is the inclusion of specific Z-series screening codes that have been approved for use during mobile crisis response encounters, when appropriate. The **approved list of Z-series screening codes** can be found on the Medicaid website.

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 coordination services are not permitted (according to Federal rule) to be considered threshold services for drawing down the CCBHC PPS rate. Care coordination 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.

Iowa Medicaid reviews the CCBHC codes on a regular basis to ensure they are still in compliance with the Centers for Medicare and Medicaid Services (CMS) and will make changes as appropriate. CCBHCs are responsible for reviewing these lists for these changes. **CCBHC threshold and allowed service codes** can be found on the Medicaid website at: **Fee Schedules | Health & Human Services**.

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 response 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.

**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., Home and Community Based Services (HCBS) Habilitation and Waiver services, and residential services, etc.) 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.

Cost Reporting for Mobile Crisis 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 response 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 the 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 provides mobile crisis response 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.

Billing for Mobile Crisis Response when Provided by a DCO

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

1. CCBHCs will bill for mobile crisis response 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 response 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. For an individual who is not an active CCBHC client, the crisis event can be a triggering event for referring and connecting that individual to the CCBHC in their service area, if the individual indicates that they are interested in pursuing services and would like follow-up from the CCBHC. The mobile crisis response team (MCRT) will assess and triage and with the individual's consent, the MCRT will notify the CCBHC of the encounter to provide follow-up. The expectation is that the CCBHC and DCO have agreed on the language the MCRT will use to inquire if they are interested in services and follow up with the CCBHC. Referrals are made for those who have expressed interest and signed the necessary forms that will allow the CCBHC to treat and bill for the encounter.

3. For those individuals who are active CCBHC clients or are interested in being referred to the CCBHC for services, CCBHCs are responsible for follow-up care. Follow-up includes establishing initial contact, typically through a phone call, to ensure the individual is stable, still interested in pursuing services and to set up a time for them to come in for an initial evaluation. The timeline for the evaluation is determined by the MCRT assessment (urgent or routine) and by CCBHC criteria standards. If the individual was hospitalized following the mobile crisis encounter, initial contact would include following up with the individual to assist with discharge and connection to appropriate community services.

4. If the CCBHC is not able to reach the individual and make initial contact, they are expected to make reasonable, varied, and documented attempts to follow up which may include phone calls, text messages and/or in-person visits. CCBHCs can bill for the mobile crisis service if documentation shows initial contact was made or that reasonable attempts were made to try and contact the individual but were unsuccessful.

5. DCOs need to make sure that they have the individual sign all necessary documentation (consent to treat/ consent to bill) prior to notifying the CCBHC regarding the follow-up. CCBHCs and DCOs can discuss best practice for when inquiries are made to the individual about interest in referrals to services. (Example: The MCRT asks if the individual is

interested in services/follow-up from the CCBHC and have them fill out the necessary consent to bill and consent to treat documentation for the CCBHC. The MCRT can then either 1) send it in to the CCBHC for immediate referral following the encounter or 2) wait and verify with the individual if they are still interested in the referral to the CCBHC for services/follow-up when they do their follow-up the next day.) This is a discussion between the CCBHC and DCO to determine what will work best for their process. The process should be documented in their contractual agreement to ensure that members receive the necessary follow-up and that billing is correct.

6. Use Appendix D: CCBHC Mobile Crisis Encounter Provided by a DCO Flow Chart to determine the appropriate provider to follow up and to bill for services.

7. Mobile crisis providers who operate as a DCO for a CCBHC must not bill Medicaid for any mobile crisis encounters for Medicaid members for whom they receive reimbursement from a CCBHC per their DCO relationship and agreement.

Billing for Mobile Crisis when the CCBHC is the State Sanctioned Mobile Crisis Response Provider

8. CCBHC MCRTs are required to meet Chapter 24 as well as CCBHC requirements for delivery of mobile crisis response services. CCBHCs are required to meet the timeframe requirements of 60 minutes noted in Iowa Administrative Code 441-24.36(2)b which are more prescriptive than CCBHC Criteria 4.c.1 Crisis Behavioral Health Services.

9. If the member has Medicaid primary, the CCBHC should bill Medicaid the PPS rate for the mobile crisis encounter, if provided within their CCBHC service area. If the client is dual eligible, mobile crisis response is considered a “bypass service” and can be sent directly to Medicaid without submitting to primary insurance providers.

10. CCBHCs who are state-sanctioned mobile crisis providers, are responsible for billing SNMIS directly for non-Medicaid enrolled individuals who meet eligibility.

11. 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.

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

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 solely under a PPS rate for Medicaid members within their CCBHC service area. 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. PPS reimbursement for ACT is capped at ten ACT threshold qualifying billings per month. This does not limit the amount of services that the member receives. Services are to be provided in compliance with Iowa Administrative code 441—78.45 (249A) and ACT fidelity requirements. To qualify for PPS reimbursement an ACT service must meet eligibility based on the chart below and be a minimum of 15 continuous minutes in length.

Face-to-face 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/ guardians 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
	Group work (support groups, peer-led groups)	N
	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
	Peer-led groups	N
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 modifier **HH**)*

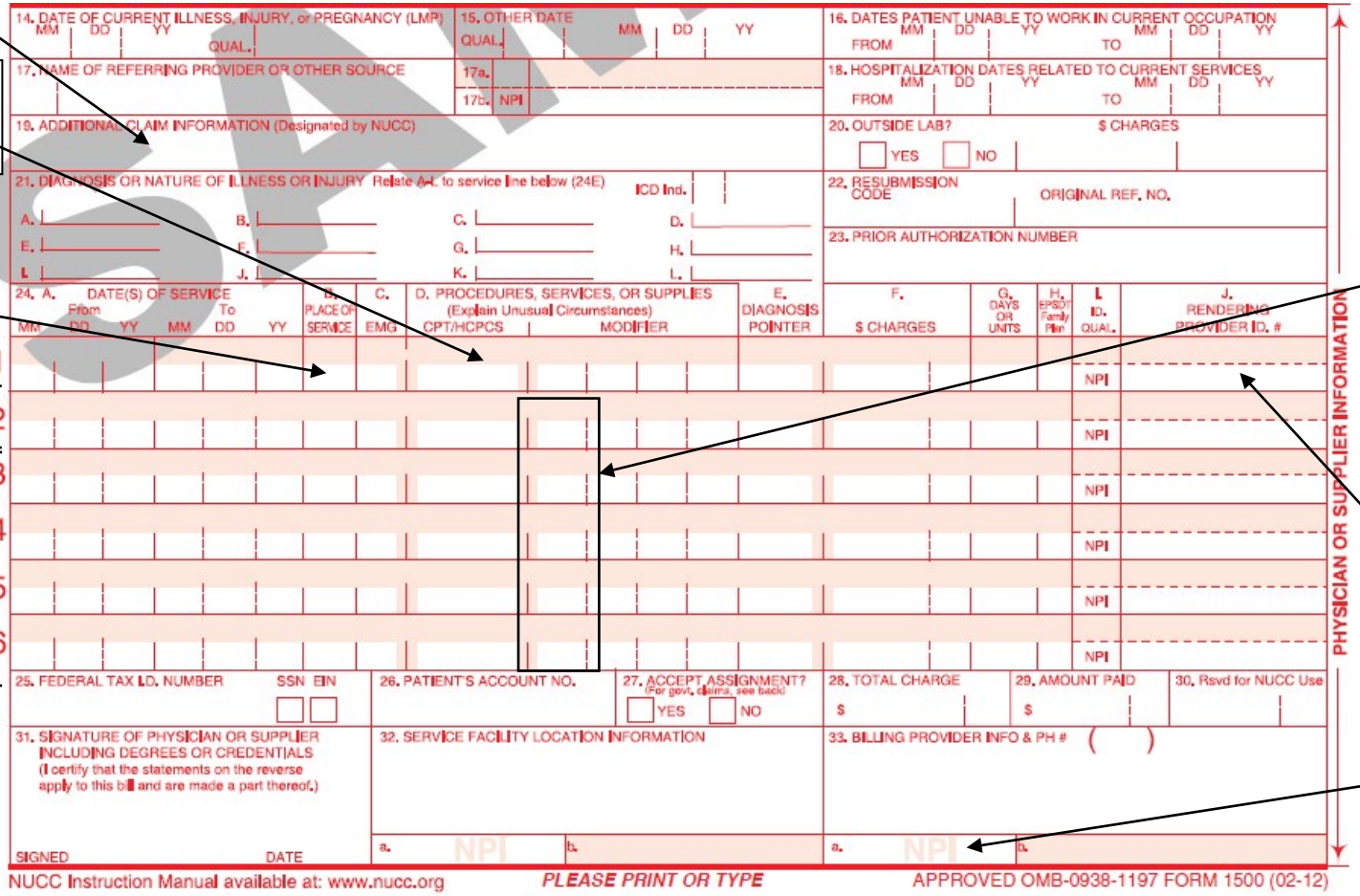
Field 24D – Line 1 CPT/ HCPCS
Enter: **T1040**
(No Modifier)

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

<u>If rendered by CCBHC primary location</u>,
Enter: **blank or other service modifier**

<u>If rendered by CCBHC satellite location or other service location</u>,
Enter: **Q2**

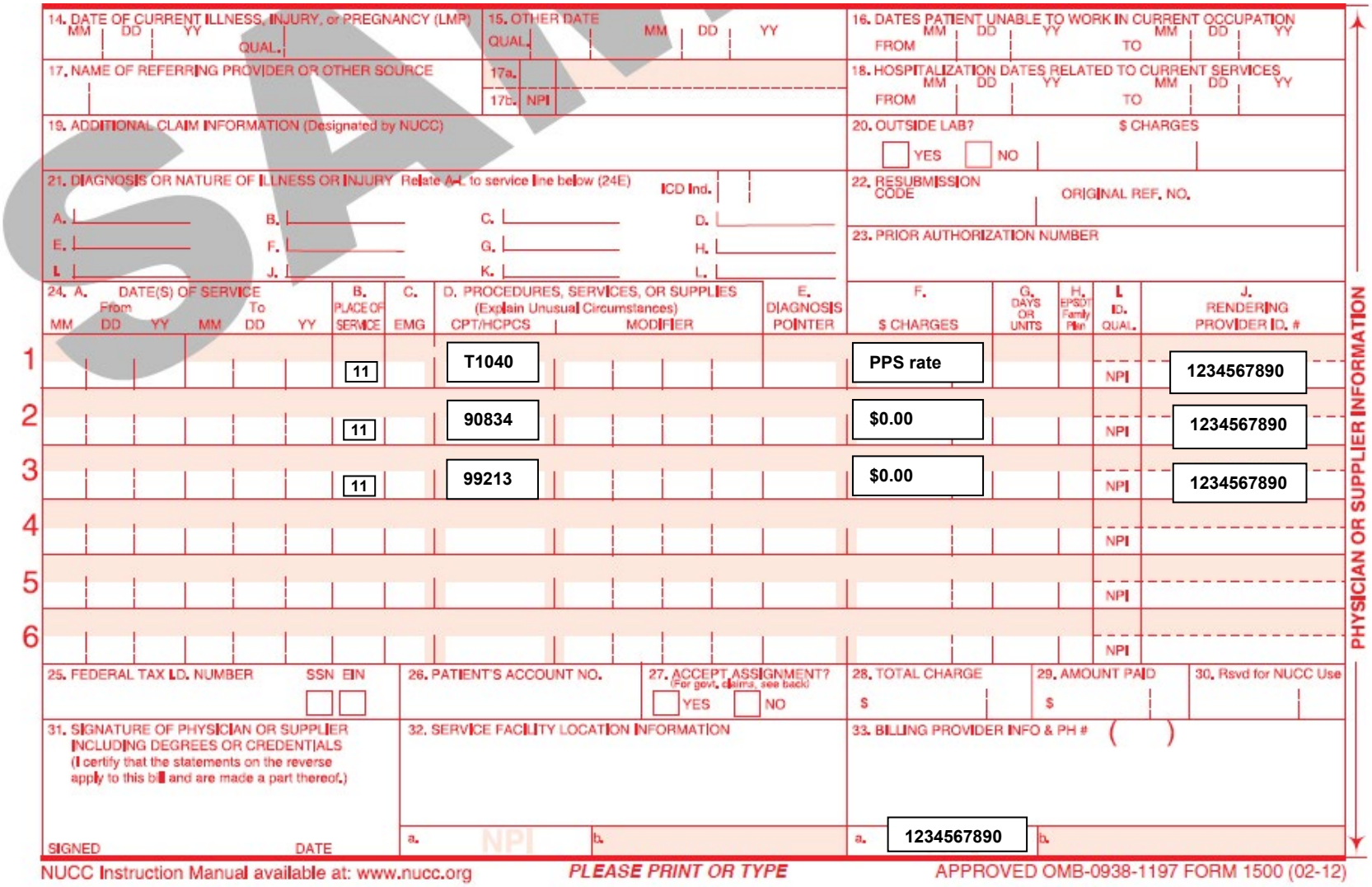
<u>If rendered by DCO</u>,
Enter: **HH**

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

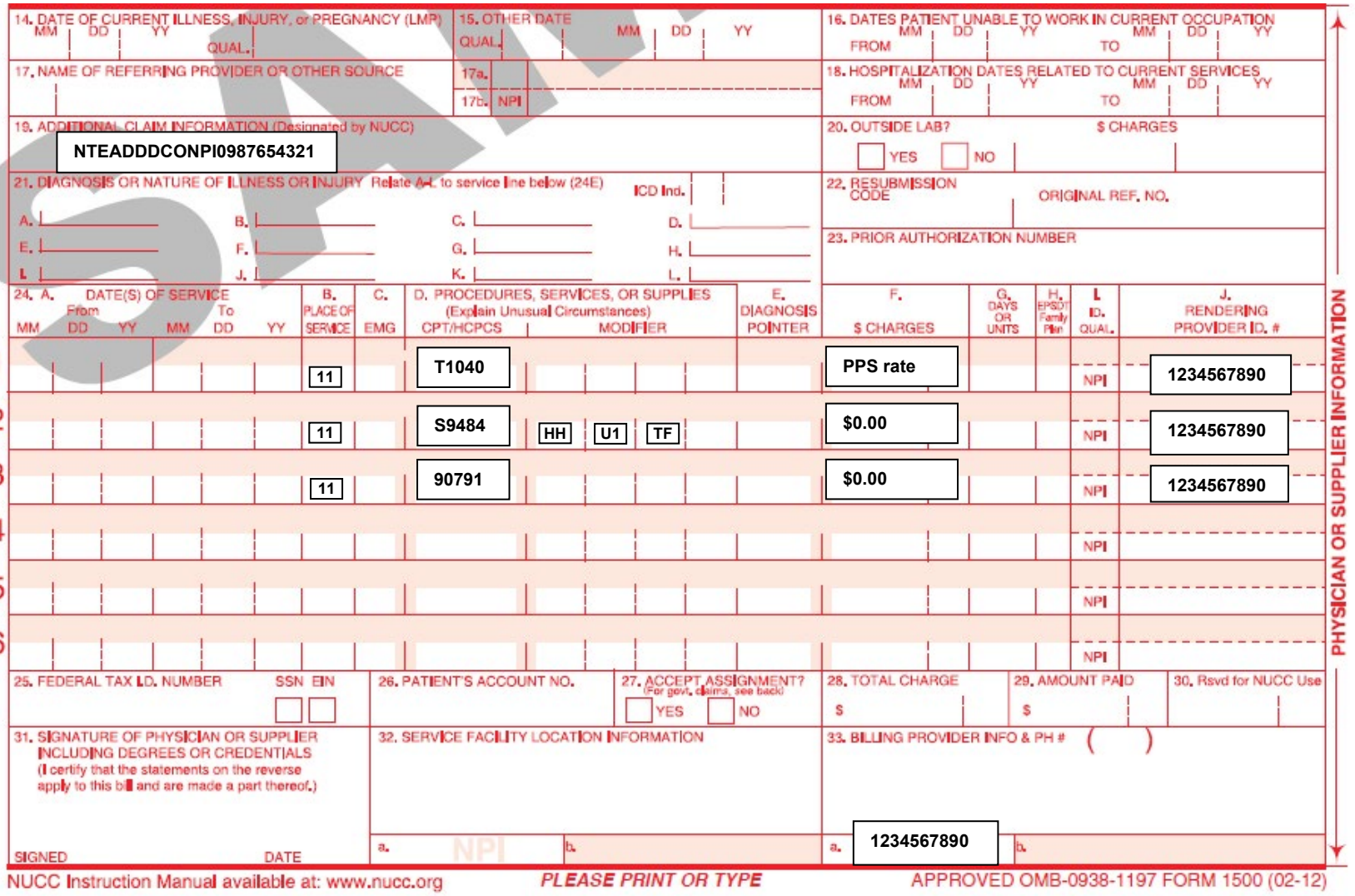
Field 24J – All Lines
Enter: **CCBHC Provider Type 88 NPI**

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

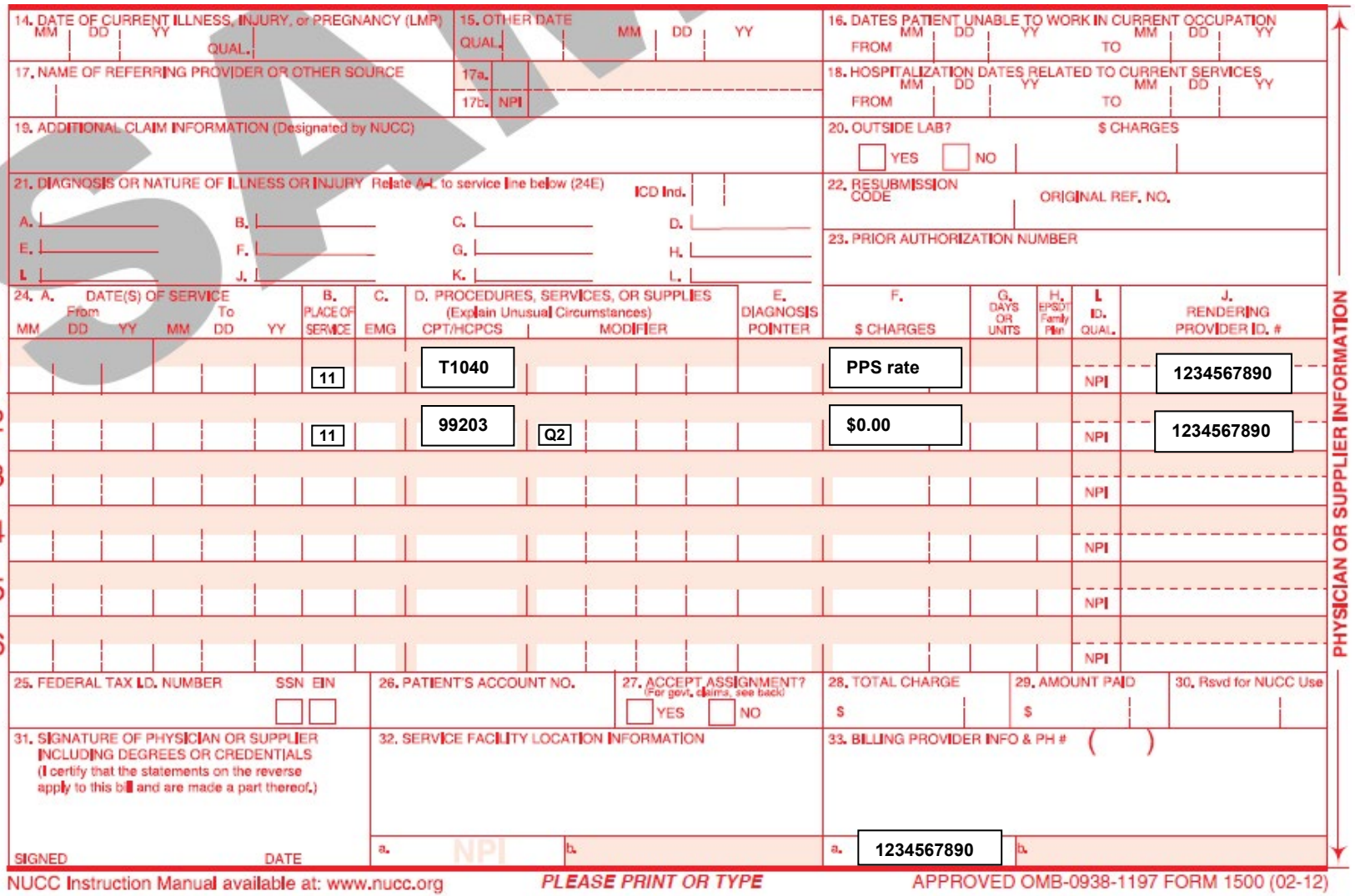
Scenario 1: Client A receives psychotherapy and another service during the CCBHC encounter. All services are provided at the CCBHC's primary location enrolled as provider type 88 with NPI 1234567890



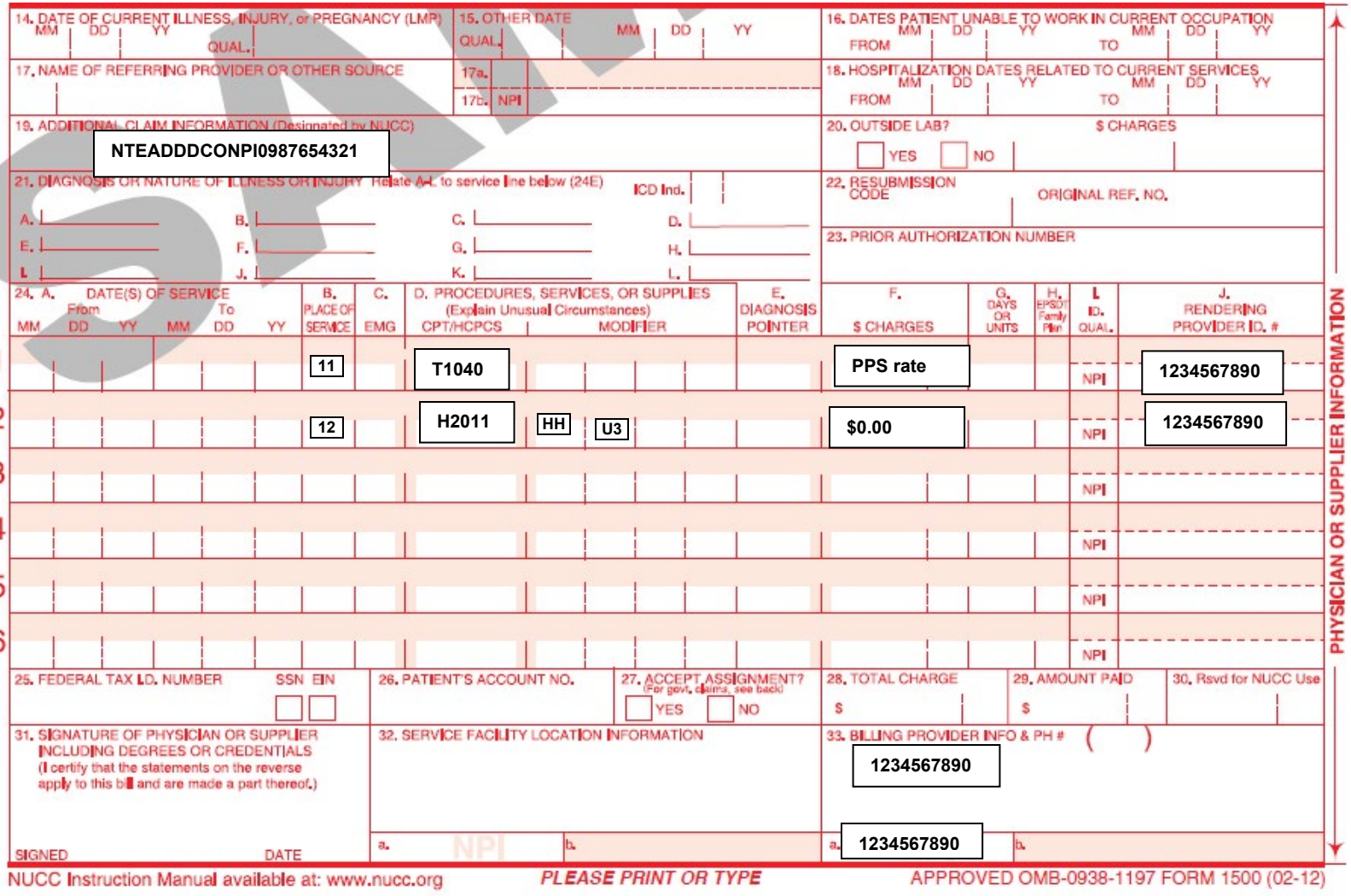
Scenario 2: Client A receives crisis stabilization services by a DCO with NPI 0987654321 and is referred to the CCBHC primary location for psychiatric diagnostic evaluation.



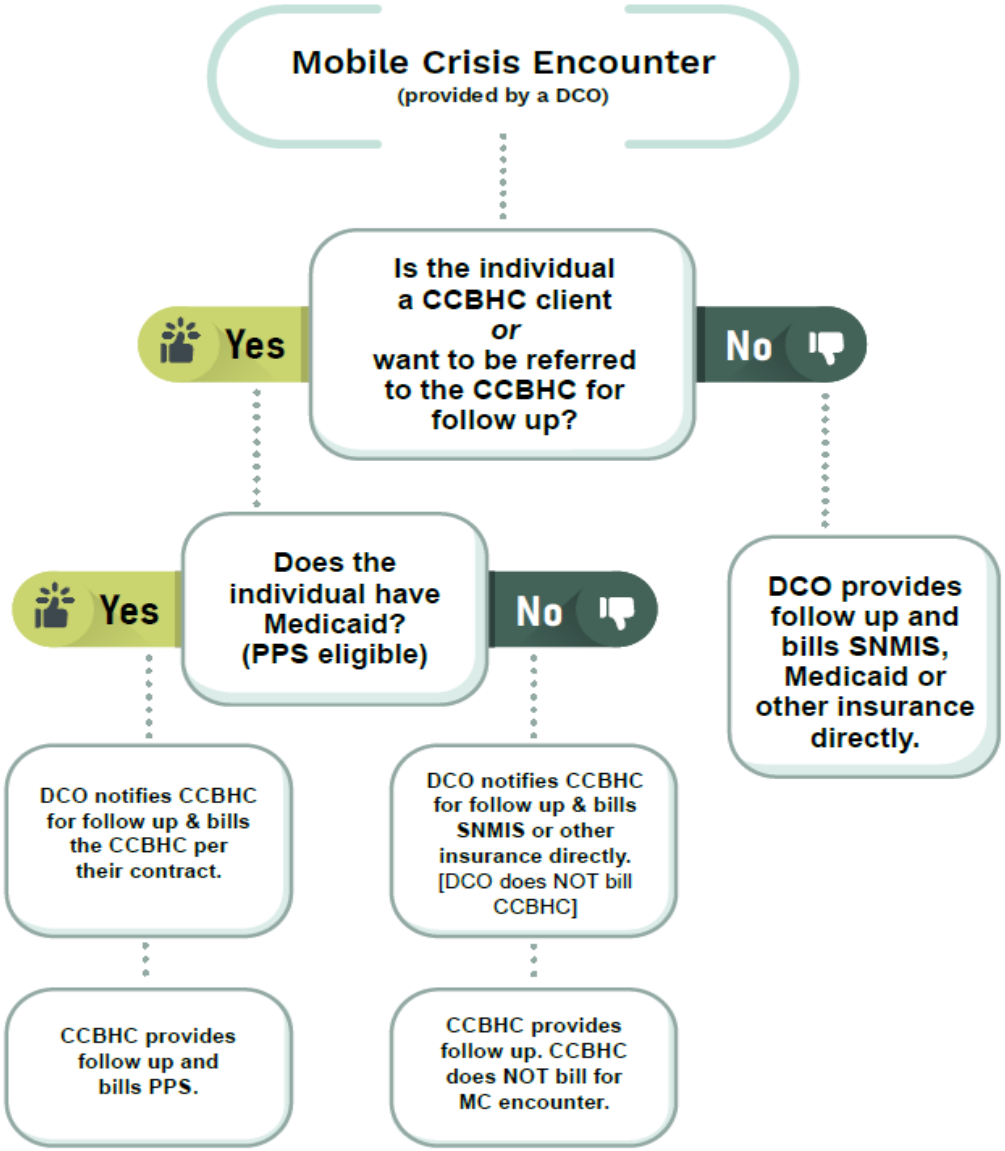
Scenario 3: Client A receives evaluation and management services from a CCBHC satellite location.



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.



Appendix D: CCBHC Mobile Crisis Encounter Provided by a DCO Flow Chart



Certified Community Behavioral Health Clinic (CCBHC) Billing Guide Summary of Changes

Effective date: September 23, 2025

Page #	Section/Topic	Summary of Changes
1-2	Instructions	• Clarification noting that CCBHCs must meet Medicaid standards for the service provided as defined by the CPT code. • Added links to threshold and allowed service codes which were removed from the billing guide and moved to the Medicaid website. • Added language noting that CCBHCs are not able to bill fee-for-service for CCBHC services provided within their CCBHC service area, and where/when FFS might be appropriate. • Added language and links on what CCBHCs should do regarding billing for uninsured or underinsured clients.
2	Medicaid Plans & CCBHC PPS Eligibility	• Added information to Iowa Health and Wellness Plan noting that non-medically exempt enrollees were not eligible for B3 services.
3	General Billing Guidance	• Added a note to Primary Diagnosis Code that it needs to be an F-series Behavioral Health Diagnosis code except for Z-series screening codes that can be used for H2011 – mobile crisis response only.
3	Coordination of Benefits (COB) – Original Guidance – Preferred Method	• Added language to state this was the preferred method for providers, and that they should try this method first before using the alternative guidance for COB claims.
4	Medicare Explanation of Benefits (EOB) Original Guidance	• Added language indicating claim lines two and below should be completed to reflect services provided using general Medicare billing practices including adding any necessary modifiers, fees, and the rendering provider's NPI.

Page #	Section/Topic	Summary of Changes
5	Billing for Clients with Commercial and Medicaid Benefits *Original Guidance*	• Added language indicating that CCBHCs should follow standard claim guidance for submission of their claims to commercial insurers except for including the T1040 encounter code on the first line and the triggering threshold service on the second. • Added language indicating that when submitting their secondary claims to Medicaid/MCOs that CCBHCs should follow CCBHC billing guidance.
6-7	Coordination of Benefits (COB) – Alternative Guidance	• Updated guidance on billing for Medicare/Medicaid dual eligible beneficiaries. • Updated guidance on billing for commercial/Medicaid dual eligible beneficiaries. • Guidance on billing for multiple services provided by different providers on the same day for individuals who are dual-eligible.
8	Bypass Services	• Added information on services that bypass primary third-party payers (Medicare or commercial insurance) and should be billed directly to Medicare.
9	Additional Billing Guidance	• Added information and a link for approved Z-series screening codes approved for mobile crisis services. • Added information noting that the Threshold and Approved Service Code lists for CCBHC were moved to the Medicaid website and included link to the Fee Schedule page where these lists are located and monitored by Medicaid.
9	Integrated Health Home (IHH)	• Removed information about cost reporting and IHH.
10	Cost Reporting for Mobile Crisis under CCBHC Demonstration	• Separated cost reporting from billing guidance for mobile crisis.
11-12	Billing for Mobile Crisis Response (MCR) when Provided by a DCO	• Separated billing guidance for MCR provided by a DCO into its own section. • Expanded and provided clarification on the roles and responsibilities of the CCBHC and DCO.
12	Billing for Mobile Crisis when the CCBHC is the State Sanctioned Mobile Crisis Response (MCR) Provider	• Separated billing guidance for MCR when the CCBHC is the state-sanctioned provider.

Page #	Section/Topic	Summary of Changes
13-14	Appendix A: Assertive Community Treatment (ACT) Billing Guidance	• Added language to clarify that CCBHCs are only allowed to bill PPS for ACT services for Medicaid members within their CCBHC service area. • Added language which indicates that PPS billing for ACT is capped at ten ACT threshold qualifying billings per month, but this cap doesn't limit the amount of service that the member receives. • Added link and reference to ACT in Iowa Administrative Code (IAC) and noted that providers are required to be in compliance with IAC as well as ACT fidelity. • Added language stipulating that to qualify for reimbursement that an ACT service must meet eligibility based on the chart in the appendix and be a minimum of 15 continuous minutes in length. • Added groups to the ACT Threshold Services list under Outpatient Mental Health and Substance Use Services and Peer and Family Support. Group work is not eligible for PPS payment under either section.
21	Appendix D: CCBHC Mobile Crisis Encounter Provided by a DCO Flow Chart	• Flow chart added as a resource to help determine who (CCBHC or DCO) provides follow up and/or billing based on the encounter.