Certified Community Behavioral Health Clinics

Use this billing guide as a supplement to the information available on the Certified Community Behavioral Health Clinics (CCBHC) web page (CCBHC Website).

Contents (last updated January 20, 2017)

Covered Services for OHP Members – CCBHC Demonstration

To receive your CCBHC's Prospective Payment System (PPS) rate for services delivered to OHP members, you must submit the claim with at least one of the procedure codes shown on the CCBHC Demonstration Services Crosswalk.

All other **non**-CCBHC services provided and billed will be reimbursed in accordance with the reimbursement method in place prior to the CCBHC Demonstration.

Client Eligibility and Enrollment

CCBHCs are responsible for verifying member eligibility before billing. Prior to billing, your CCBHC must also determine whether the member is enrolled in a Coordinate Care Organization/Managed Care Organization, or if they are fee-for-service (open card). Lastly, CCBHCs should verify if the member has other private health insurance, and bill the other insurance (including Medicare) prior to billing OHP. **These protocols are the same as billing requirements prior to the CCBHC Demonstration.**

The OHP eligibility verification page explains how to verify eligibility using the MMIS Provider Web Portal, Automated Voice Response (AVR), or electronic data interchange (EDI) 270/271 transaction. http://www.oregon.gov/oha/healthplan/Pages/verify.aspx

- Provider Web Portal
  - Real-time eligibility
  - Web based system
  - Get access – call Provider Services (800)336-6016
  - *https://www.or-medicaid.gov/*
- Automated Voice Response (AVR)
  - (866)692-3864
  - Telephone based system
- Electronic Data Interchange (EDI)

- Electronic information exchange
- HIPAA-compliant batch transactions and eligibility requests

Billing OHA Directly for CCBHC Services (open card members)

When an OHP member is eligible, but not enrolled in a CCO or managed care plan, they are considered to be *open card.* Similar to current billing operations, CCBHCs will bill OHA directly for services provided to open card members (rather than billing a CCO).

- **CCBHC Encounter Code – T1040:** Bill this CCBHC encounter procedure code on the top level of every CCBHC fee-for-service claim with your PPS encounter rate as the billed amount; **this code is not necessary on CCO/managed care claims**
- **CCBHC Crosswalk:** On additional lines of the claim, use the most appropriate procedure code(s) as shown on the CCBHC Demonstration Services Crosswalk. On all lines with procedure codes from the crosswalk, bill the usual and customary charge for the service
- MMIS will adjust paid amounts to your PPS rate for all CCBHC Demonstration Services provided to the OHP member on the date of service.
- **For information about electronic billing,** go to the Electronic Data Interchange page. http://www.oregon.gov/oha/healthplan/Pages/edi.aspx

Supplemental Wraparound Payments for CCBHC Services (CCO members)

OHA will supplement payments received by the CCBHC from CCO/managed care enrolled OHP members by issuing a supplemental wraparound payment. Bill the CCO or other payer as you normally would.

- On a quarterly basis, submit all CCBHC Demonstration Service encounters that were paid by the CCO/managed care plan to OHA by completing the *Supplemental Wraparound Data Submission Template* (attached to this document). Send the completed template to Eric Larson, Fiscal Analyst, at Eric.LARSON@dhsoha.state.or.us when encounters have been submitted to MMIS by your CCO/managed care plan.
- Report all payments received from CCOs, other managed care plans, Medicare, and other payers for CCBHC Demonstration Services delivered within the quarter
- Capitation payments, risk withholds, global payments, and other lump sums received for CCBHC Demonstration Services are to be **reported for the quarter in which they were received**

Prior Authorization - *See the* ***Behavioral Health Fee Schedule***

This protocol is the same as billing requirements prior to the CCBHC Demonstration. The *Management* column (column N) on the Behavioral Health Fee Schedule indicates which services require prior authorization.

For CCO members, follow prior authorization requirements by the specific CCO, as usual.