CCBHC Frequently Asked Questions
October 5, 2017

Federal Criteria & Oregon Standards

Question: *Does the HERC prioritized list criteria (regarding diagnoses) apply to the CCBHC population as well? In other words, if someone came in and is diagnosed with a condition that is below the line from a Medicaid standpoint, does that mean the same thing in terms of access for the uninsured/underinsured client?*

Answer: The Prioritized List of Health Services only applies to coverage for Oregon Health Plan members.

Question: *We currently have a sliding fee schedule in place for our uninsured/underinsured population. How should this practice change in light of the CCBHC? Should we set up the PPS rate on a sliding fee schedule or continue to set up the individual services (IT, CM, etc.) on sliding fees? Are we allowed to collect sliding fees from clients for CCBHC services?*

Answer: According to the federal guidance document, criteria 2.d.2 states that The CCBHC has a published SFS that includes all services the CCBHC proposes to offer pursuant to these criteria…" and criteria 2.d.4 states that "[t]he CCBHC has written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. Those polices are applied equally to all individuals seeking service." We recommend continuing to use the existing SFS (with the understanding it needs to align with federal CCBHC criteria) and that yes, the CCBHC is allowed to collect sliding fees.

If we look to FQHCs for guidance, the sliding fee scale must be **consistent with locally prevailing rates or charges and designed to cover the site's reasonable costs of operation**. In this case, it would not be permissible to have a separate fee schedule with much higher rates than the clinic would charge other payers for the same services, for this population.

Billing & Payment Methodology

Question: *What billing format will the CCBHC daily/monthly charge be billed on (837P/837I)?*

Answer: The format will not change and will remain the same as it is presently

Question: *What is the CPT code or Revenue Code that will be billed with the CCBHC daily/monthly charge service?*

Answer: T1040. The amount billed for this code should be the clinic's PPS rate

Question: *Are there any requirements for what Diagnosis Code should be billed if the individual rendered CCBHC services that have different diagnosis codes? This would occur if a Substance Abuse and Mental health service occurred on the same date.*

Answer: The requirements are the same as prior to the CCBHC demonstration.

Question: *Are there any requirements for the provider that should be billed if the individual rendered CCBHC services that have different rendering providers? This would occur if a Substance Abuse and Mental Health service occurred on the same date.*

Answer: The requirements are the same as prior to the CCBHC demonstration.

Question: *Does the state require the individual CCBHC services be (shadow) billed in conjunction with CCBHC daily or monthly rate? If so, what are the requirements for billing those individual services (i.e. can the daily/monthly be on the same 837 file as the individual services)? Should these individual services be billed with the agency's standard charge, or $0? Will the agency receive a remittance back on the individual services?*

Answer: Yes, T1040 encounter codes must be accompanied by the actual CCBHC Demonstration Service procedure code on additional detail lines of the claim. Individual services should be billed with the standard charge, and then the system will $0 pay. Billing $0 may cause the detail line to deny. Agencies will receive a remittance back on the individual services.

Question: *Will the agency need to report any money collected from primary payers? If so, how does the state expect this to occur?*

Answer: Yes. The requirements are the same as prior to the CCBHC demonstration.

Question: *Will the state reduce agency payments for money collected from primary payers? If so, how will this occur?*

Answer: Yes the process is the same as what occurred prior to the CCBHC demonstration.

Question: *Can we confirm we have to hold the OR Medicaid T code claim until after Medicare Processes the claim?*

Answer: No, CCBHCs may bill Oregon Medicaid using T1040 before or after Medicare processes the claim. When billing Oregon Medicaid using T1040, report on the claim that Medicare does not cover the T1040 code by inputting NC (on paper claims) or 96 as the adjustment reason code.

Question: *If an FQHC is currently contracted with a CCBHC to provide primary care services on their site ("reverse integration") and currently bills at their PPS rate, will they need to change to billing through the CCBHC?*

Answer: Yes, CCBHC demonstration services need to be billed through the CCBHC at their PPS rate; the FQHC would be reimbursed through the contract with the CCBHC and prevent duplication of billing.

Question: *Can we report more than one date of service on a claim? If we have multiple dates of service, can they be reported on the same claim and would the T1040 for each day be at the top of the claim or could it be reported with T1040 on top of services for each day? We are having trouble breaking by date*

of service. For example, if John Doe received therapy services on 4/01 and 4/02, would the data be reflected as:

Claim line 1 T1040 04/01/17
Claim line 2 90834 04/01/17
Claim line 3 T1040 04/02/17
Claim line 4 90834 04/02/17

OR

Claim line 1 T1040 04/01/17
Claim line 2 T1040 04/02/17
Claim line 3 90834 04/01/17
Claim line 4 90834 04/02/17

Answer: Multiple CCBHC encounters may be reported on a single claim, for multiple days. In this situation, bill the T1040 at the top detail line and then the actual CCBHC procedure code(s) for each day, in order. The first scenario listed in the question is correct.

Question: *Can you please provide clarification on what to bill to open card for CCBHC on the crosswalk? There are managed care codes that open card normally doesn't cover, H2011, H2021, H0023 but with CCBHC changes, can we now bill these with the T1040 code up to open card?*

Answer: Yes, all services on the CCBHC crosswalk are available for open card PPS reimbursement.

Question: *I have a FFS – open-card crossover claim I need to process. I've been inputting my FFS claims manually into MMIS. Medicare paid, and DMAP paid the rest on our last EOB. What are my steps to take in MMIS to get the remaining amount of our PPS payment?*

Answer: For dual-eligible (Medicare and Medicaid covered) individuals, submit an additional claim to Oregon Medicaid with only the T1040 code billed at your PPS rate. When billing Oregon Medicaid using T1040, report on the claim that Medicare does not cover the T1040 code by inputting NC (on paper claims) or 96 as the adjustment reason code.

Data Collection & Analysis

Question: *For existing behavioral health clients coming into the CCBHC, they wouldn't have a first contact date as they are already our clients. Would we still include these individuals in the denominator? Would they have a first contact date and an initial evaluation date?*

Answer: If the consumer has not been seen in the past 6 months they will be treated as a new client and this will be first contact for purposes of the measure. If the individual has been seen in

the past 6 months, they are considered an existing client and excluded from the denominator. You are free to treat the first contact with existing clients after the CCBHC goes live as an opportunity to perform an evaluation but should not include them in the denominator.

Question: *We have Mental Health Treatment Court clients open with us for coordination, but their primary therapist is a community provider. We feel like they should be exempt from some of the metrics since we are not their primary provider, but based on the CCBHC definitions, they would be considered a CCBHC consumer.*

Answer: The CCBHC concept envisions the CCBHC providing all core services (which includes therapy). The criteria, however, clearly do envision that referrals may be needed for specialty services and the principal of allowing consumers to select providers is also incorporated in the criteria. We understand that collecting data from external community partners may be difficult but, within the definition of consumer, these individuals are consumers and should be included in the denominator (and, as appropriate, the numerator) of measures. For state-lead measures, the state should have access to needed data. For CCBHC-lead measures, coordination with the outside therapist will be required. If it is impossible to obtain the needed data from these external community partners, we recommend you exclude them from measures affected by data access problems and clearly note the exclusions in the data reporting template for the pertinent measures. Because the measures are designed to capture accomplishments of certain activities rather than simply be an exercise in calculation, we believe this would be the most meaningful approach.