CBHC Billing Questions

As of 12/20/2022

(replaces 12/9/2022 version)

1. Will there be a new taxonomy code for CBHC Providers?
   A: Optum will not require a new taxonomy code unless the Commonwealth of MA requires.

2. Will there be a new provider type and provider specialty?
   A: A new Attested Area of Expertise (AOE) has been created and will be a searchable option within the Provider Directory. The MA Designated CBHCs will be added to this Attested AOE.

3. Will there be a new NPI for CBHC Providers?
   A: Optum will not require a new NPI unless the Commonwealth of MA requires.

4. What Place of Service (POS) codes would we use for CBHC claims for the component services?
   A: Bill POS code based on where the service took place. Exception: This list of CBHC services must be billed with POS 15:
   S9485 + U1
   S9485 + HA & U1
   H2011 + HN & HB
   H2011 + HN & HA
   H2011 + HO & HB
   H2011 + HO & HA

5. What POS would be used for the PPS bundled service?
   A: Use POS that would normally be used for the services being provided under Encounter Bundle Services (T1040-HA and T1040-HB).

6. If there are two component services with different POS, what POS would the bundled service have?
   A: Standard billing and coding rules apply.

7. Will CBHC services that are rendered telephonically during the COVID Pandemic require a different POS?
   A: Use standard telephonic POS codes.

8. Are there any required documents/forms that must accompany the claims?
   A: No.

9. Do services have to be in a certain order?
   A: When encounter bundle services billed, the bundled service must come before the component codes.

10. What are the Bundle Billing Specifications?
    A: Based on the state's guidance, bill T code with the component codes to show the services provided within the bundle. Please see detailed instructions for CBHC Bundle Billing Specifications below.

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11. Is there going to be an opportunity for testing for bundle payments before go-live?
    A: Selected provider testing will be completed; timeline to be determined.

12. Will a rendering provider be required on the bundled daily payment rate charge?
    A: Yes.

13. If you are requiring a rendering provider on the bundled daily payment, what happens when there are two component services, and they have different rendering providers? Who will be listed as the rendering provider for the bundled service?
    A: List the primary rendering provider.

14. For the component services, do you want to see the usual and customary (gross) charge on the claim?
    A: Optum asks that the component services be billed with a zero charge on the claim.

15. Can you please clarify when the service code S9485 with the HB modifier should be billed?
    A: S9485 + HN, HB = Crisis Intervention service, per 15 mins. (Adult Mobile Crisis Intervention provided at CBHC site by a paraprofessional or bachelor's level staff. Follow-up interventions provided up to the third day following initial evaluation).

16. When there is denial, will you be expecting a voided claim or replacement claim?
    A: Standard Claims processing rules apply. Here are some examples of when a voided or replacement claim are utilized.
    - A claim is denied (example reasons: Primary carrier EOB, Auth not on file, Provider not covered or credentialed. Provider can either send the information and indicate the claim number it's in reference to or can submit a corrected (Frequency 7) claim with requested information.
    - A claim is paid but the provider realizes updates are needed (examples: didn't bill enough units or billed incorrect CPT code). Provider must submit a corrected claim.
    - A claim is paid but provider realizes they billed the date of service in error. Provider must submit a void (Frequency 8) claims to recoup the claim.

17. When there's a rebill scenario, do you have to rebill the entire claim?
    A: If Optum paid the claim and the provider is adding units or changing charged amount, etc., they should submit a corrected claim as the entire claim.

18. What is the outcome if a service that should have been billed as part of the bundle is billed separately in error?
    A: If the component CPT code is billed on a claim separate from the bundle code, the CPT code will deny.

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19. What if there are late component service(s) or component services with incorrect service information?
    a. Scenario 1: Claim is already paid and there is a late component service, but the late component service does not impact the payment on the bundled service.
       A: Provider must submit a corrected claim.
    b. Scenario 2: Claim is already paid and there is a late component service and the late component services affects the payment on the bundled service.
       A: Provider must submit a corrected claim.

CBHC Bundle Billing Specifications

CBHC Encounter Bundle Services

A. Encounter services rates, codes and modifiers:

Service Code	Modifier 1	Service Description
T1040	HB	Medicaid Certified Community Behavioral Health Clinic Services, per Diem (Adult Services)
T1040	HA	Medicaid Certified Community Behavioral Health Clinic Services, per Diem (Child/Adolescent Services)

Only one unit of T1040 (encounter rate) will be paid on the same date of service for the same CBHC provider and member. Additional units will be denied (whether included on the same claim, or on a separate claim).

Bill the adult encounter for services provided to members aged 21 and over using the code T1040 with modifier HB. Age based on member's date of birth on the date of service. Claim will deny if the adult code billed for services provided to members under age 21.

Bill the youth encounter for services provided to members under age 21 using the code T1040 with modifier HA. Age based on member's date of birth on the date of service. Claim will deny if the youth code billed for services provided to members aged 21 and over.

In addition to the encounter code (T1040) and the applicable modifier (HB or HA), the CBHC must include at least one of the Service Codes in the table below to indicate the specific component service provided. On any given date of service, multiple component services may be provided to a member. All applicable service codes should be included on the claim. The component service codes will "zero pay" when submitted with the encounter code. At least one component service code must be billed with a T1040 encounter code (+ HA or HB modifier), or the claim will deny.

Service Code	Service description
90791	Psychiatric diagnostic evaluation
90791-HA	Psychiatric diagnostic evaluation performed with a CANS (Children and Adolescent Needs and Strengths)

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90792	Psychiatric Diagnostic Evaluation with Medical Services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure). (Use this add-on code with an appropriate evaluation and management service code when medication management is also provided.)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure) (Use this add-on code with an appropriate evaluation and management service code when medication management is also provided.)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure). (Use this add-on code with an appropriate evaluation and management service code when medication management is also provided.)
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (List separately in addition to the code for primary procedure) (Add-on code).
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy with patient 50 minutes
90849	Multiple-family group psychotherapy (per person session not to exceed 10 clients)
90853	Group psychotherapy (other than multiple-family group) (per person per session not to exceed 12 clients)
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions (case consultation)
90887	Interpretation or explanation of results of psychiatric, or other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (per one-half hour)
96164	Health behavior group intervention, 30 minutes
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (list separately in addition to code for primary service) (add-on code).
96372	Therapeutic prophylactic or diagnostic injection (specify substance use or drug); subcutaneous or intramuscular
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 or the encounter.
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 straightforward medical decision making. When using time for code selection, 30-44 minutes of total time spent on the date of the encounter.
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 straightforward medical decision making. When using time for code selection, 45-59 minutes of total time spent on the date of the encounter
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 straightforward

	medical decision making. When using time for code selection, 60-74 minutes of total time spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal.
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 spent on the date of the encounter.
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 straightforward medical decision making. When using time for code selection, 20-29 minutes of total time spent on the date of the encounter.
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 straightforward medical decision making. When using time for code selection, 30-39 minutes of total time spent on the date of the encounter.
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 straightforward medical decision making. When using time for code selection, 40-54 minutes of total time spent on the date of the encounter.
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure), 60 minutes
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure)
H0004	Behavioral health counseling and therapy, per 15 minutes (individual counseling) (four units maximum) (per session)
H0005	Alcohol and/or drug services group counseling by a clinician (per 45-minute unit) (two units maximum)
H0033	Oral medication administration, direct observation (substance use disorder programs only)
T1006	Alcohol and/or substance abuse services; family/couple counseling (per 30 minutes, one unit maximum per day)

B. Services which CANNOT be billed on the same date as the encounter bundle Code T1040, by the same provider, for the same member:

- Code H0015 with TF modifier: Enhanced Structured Outpatient Addiction Program
- Code S9480: Intensive Outpatient Program
- Code H0015: Structured Outpatient Addiction Program

If any of these codes are billed on the same date of service as the T1040 code by the same provider and for the same member, the claim submitted first will be processed for payment. Any other claims on this list that are submitted for the same day will deny.

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CBHC Non-Encounter Bundle Services

Non-Encounter Bundle Services are services provided by the CBHC which are billed separately from the outpatient encounter bundle (T1040 + HA or HB) and which MAY be provided and paid on the same date of service as the encounter bundle services.

A. ***Crisis Intervention mental health services, per diem***

The payment rate of the per diem crisis intervention codes are controlled by the modifiers and place of service which are used to indicate whether the service is an adult or youth service, as well as the type or location of the crisis intervention service (i.e., adult community crisis stabilization, versus adult mobile crisis intervention at CBHC site, versus adult mobile crisis intervention in a community based location), as described in the table below.

- Only one unit of S9485 may be payable on the same date of service for the same member by the same provider, except for S9485-ET and S9485-HA ET. If a claim with multiple units, or two claim lines with the same code and same date of service, is submitted by the same provider, the plan must pay the first processed claim and must deny the second claim, except for S9485-ET and S9485-HA ET. The code S9485 and relevant modifiers may only be billed by different providers on consecutive days, except for S9485-ET and S9485-HA ET.

- The codes S9485 (except S9485-ET or S9485-HA ET) and H2011 may not be billed on the same date of service by the same provider. If both codes are billed on the same claim, the claim will deny. If the codes are billed on separate claims, the first claim to be processed will pay; the second claim to be processed will deny. S9485 with the modifier ET or HA ET (which represents community crisis stabilization) may be billed on the same day as H2011.

Service Code / Modifier	**Service Description**
S9485 – ET	Crisis intervention mental health services, per diem. (**Adult Community Crisis Stabilization** per day rate.)
S9485 – HA, ET	Crisis intervention mental health services, per diem. (**Youth Community Crisis Stabilization** Per day rate)
S9485 – HE	Crisis intervention mental health services, per diem. (**Adult Mobile Crisis Intervention provided at CBHC site**. Inclusive of initial evaluation and first day crisis interventions.)
S9485 – HA, HE	Crisis intervention mental health services, per diem. (**Youth Mobile Crisis Intervention provided at CBHC site**. Inclusive of initial evaluation and first day crisis interventions.)
S9485 – U1	Crisis intervention mental health services, per diem. (**Adult Mobile Crisis Intervention provided at community-based sites of service**. Inclusive of initial evaluation and first day crisis interventions. Use Place of Service 15.)

S9485 – HA, U1	Crisis intervention mental health services, per diem. (**Youth Mobile Crisis Intervention provided at community-based sites of service**. Inclusive of initial evaluation and first day crisis interventions Use Place of Service code 15.)

B. ***Crisis Intervention Service, per 15 minutes***

The payment rate of the 15-minute codes is controlled by the modifiers, which indicate adult or youth service, location of service, and staffing level of rendering provider. See details in table below.

- H2011 code (with any modifier or POS combination) will not pay on the same date of service as S9485 (with any modifier, except ET or HA ET or POS combination) for the same member and by the same provider.

- Multiple units of H2011 codes may be billed in one day, as each unit represents 15 minutes of service. Claim with multiple lines, including one line with H2011 HN modifier and one line with H2011 HO modifier will pay.

Service Code / Modifier	**Service Description**
H2011 – HN, HB	Crisis intervention service, per 15 minutes. (**Adult Mobile Crisis Intervention provided at CBHC site by a Paraprofessional or Bachelor's level staff**. Follow-up interventions provided up to the third day following initial evaluation.)
H2011 – HN, HA	Crisis intervention service, per 15 minutes. (**Youth Mobile Crisis Intervention provided at CBHC site by a Paraprofessional or Bachelor's level staff**. Follow-up interventions provided up to the seventh day following initial evaluation.)
H2011– HO, HB	Crisis intervention service, per 15 minutes. (**Adult Mobile Crisis Intervention provided at CBHC site by a Master's level Clinician**. Follow-up interventions provided up to the third day following initial evaluation.)
H2011 – HO, HA	Crisis intervention service, per 15 minutes. (**Youth Mobile Crisis Intervention provided at CBHC site by a Master's level clinician**. Follow-up interventions provided up to the seventh day following initial evaluation.)

H2011 – HN, HB	Crisis intervention service, per 15 minutes. (**Adult Mobile Crisis Intervention provided at a community-based site of service by a Paraprofessional or Bachelor's level staff**. Follow-up interventions provided up to the third day following initial evaluation. Use Place of Service code 15)
H2011 – HN, HA	Crisis intervention service, per 15 minutes. (**Youth Mobile Crisis Intervention at a community-based site of service by a Paraprofessional or Bachelor's level staff**. Follow-up interventions provided up to the seventh day following initial evaluation. Use Place of Service code 15)
H2011 – HO, HB	Crisis intervention service, per 15 minutes. (**Adult Mobile Crisis Intervention provided at a community-based site of service by a Master's level clinician**. Follow-up interventions provided up to the third day following initial evaluation. Use Place of Service code 15)
H2011 – HO, HA	Crisis intervention service, per 15 minutes. (**Youth Mobile Crisis Intervention provided at a community-based site of service by a Master's level clinician**. Follow-up interventions provided up to the seventh day following initial evaluation. Use Place of Service code 15)