KENTUCKY CABINET FOR
HEALTH AND FAMILY SERVICES

CCBHC – Q &A
Physicians & MCOs
11/10/2021

T1040 code

- T1040 is a valid HCPCS code for *Medicaid certified community behavioral health clinic services, per diem. Not payable by Medicare*
- T1040 ~~should~~ does NOT have to be the first service line on the claim
- One claim per member per day per billing provider
  - Claims / Encounters will fail if more than one claim per member for a date of service
  - Claims/Encounters will fail if T1040 not on the claim

T1040 - continued

- T1040 would not have modifier Q2
- Performing Modifier would NOT be appropriate/required on this service line
- Place of service should follow same instructions as other service codes
  - Allowed:
    - 02, 03, 04, 11, 12, 13, 14, 15, 16, 33, 49, 57
  - New code per CMS: 10 (see CMS Telehealth instructions)

T1040 Amount

Question from MCO: The spreadsheet says that T1040 is a $0 dollar code, triggering wrap, but DMS typically rejects any paid service line that doesn't have either (1) payment by MCO or (2) payment by primary insurer.

- Providers should submit T1040 with a billed amount greater than zero (0.00)
- MCOs may choose to adjudicate and report a zero dollar paid amount on this service line

Providers – Paper vs Electronic

- Billing Provider (required)
  - Electronic
    - CCBHC Billing name, address and NPI – Loop 2010AA
    - Taxonomy – Loop 2000A, PRV segment
  - Paper
    - CCBHC Billing, address, Zipcode, – Box 33
    - NPI – Box 33A
    - Taxonomy – Box 33B (Shaded area)
- Rendering Provider (claim level required)
  - Electronic
    - Name and NPI – Loop 2310B, NM1 segment
    - Taxonomy – Loop 2310B, PRV segment
  - Box 31 must be a person, not a group

Service Location

- CCBHC should report the Service Facility Location on the claim – Loop 2310C

- Service line detail – Service Location can be reported in Loop 2420C if different than claim level

Providers – Paper vs Electronic

- Rendering Provider (service line detail)
  - Electronic (send if different provider than claim level)
    - Name and NPI – Loop 2420A NM1 segment
    - Taxonomy – Loop 2420A PRV segment
  - Paper
    - NPI – Box 24J (NOTE: must be person)
    - Taxonomy – Box 24I (shaded area) ZZ, Box 24J (shaded area) taxonomy

Providers

- Every claim is expected to have a rendering provider that is registered with KY MPPA
  - See col. G – Required Rendering Provider Types
- Rendering provider is typically the provider who is supervising the service but can be the performing provider
  - Example:
    - Licensed Clinical Social Worker - Provider Type 82 - Rendering
    - Certified Social Worker – Modifier U4 - Performing
- Each service line can have a different Rendering provider

Provider Modifiers

- Provider modifiers are not required on the service line if the rendering provider is the performing provider
  - Example: APRN does not require modifier SA
- A Provider modifier is required on the service line if:
  - the “performing” provider is not registered with KY MPPA as a provider type

Modifiers

- Q2 is required on all services performed in a CCBHC except T1040
- Other Modifiers (column E) are included on the spreadsheet and should be reported as appropriate for the service billed
  - Example:
    - T2023 – report HE, HF, TG, UA to indicate population served
- Q2 or T1040 submitted on a CMHC Provider type 30 claim will reject/fail

Targeted Case Management – T2023

CCBHC covered service list was updated on 11/9/2021 for allowed and excluded provider modifiers

Allowed: U3, U4, U5, U6

Excluded: UC, U7, U2, TD, HN, HM, UD

The requirement for a case manager performing TCM services are listed bachelor of arts or science degrees in behavioral science.

Coverage questions

- COVID-19 Admin fees – continue to bill using CMHC provider type 30
- PE (professional equivalency) is not covered under CCBHC
- H0006 – KY MOMS code that should be billed out of CMHC provider type 30 claims
- H0020 – Must be billed out of the CMHC provider type 30 claims for narcotic treatment program
- DMS CCBHC covered list will not be a published fee scheduled since these service(s) are bundled into the PPS rate.

Coverage questions

- Procedure code 90785 added to CCBHC spreadsheet 11/9/2021
- U2 modifier from CMHC not listed for allowable. Was this an error? No, additional changes will be made for U2 modifier

Medicare Billing

- Per CMS, covered and non-covered services should be submitted to Medicare so CCBHC claims can correctly reflect both paid and non-paid line items
- Non-covered Medicare services should not be submitted without the Medicare denial adjustment code or CO-96

Two Same Day

- How do we bill services that are rendered on the same day but at two different locations?
  - CCBHC should report the Service Facility Location on the claim level – Loop 2310C
  - Electronic claims allow reporting a different service location at Loop 2420C
- How do we bill services that are rendered by two different rendering providers on the same day?
  - Electronic claims allow reporting one provider at the claim level, Loop 2310B and the other provider at the service line level, Loop 2420A

MCOs

- How will it be handled when an MCO gives a false denial and agrees it was incorrect (example no authorization is required)?
- How will it be handled when MCO pays incorrect rate?
- How does timely filing apply if MCO holds claim and doesn't pay right away and then goes to Medicaid late?
- How will appeals be handled if recoupment request is incorrect from the MCO?

Providers and MCOs should work together to address disputes as contracted.

MCOs

- What do MCOs require to bill primary care services of the CCBHC services allowed (non-E&M services)? *Providers need to work with MCO to understand billing requirements*
- What is the timeline that an MCO is required to submit an encounter to Medicaid? (so we can know to expect supplemental payment) *Once the claim is adjudicated, the MCO has 30 days to submit the encounter*

MCO

- What place of service do we use instead of 53 (CMHC), one MCO says we can't use this place of service? A CCBHC can not use a Place of Service 53
- Most MCOs are requiring a staff modifier in the performing provider box on the claim. We have been instructed by MCO's if the TCM does not have another credential… use U5. The staff member has to have the appropriate Behavioral Science bachelors degree according to the regulation. See updated code list for TCM

Supplemental payments

- Entire FFS claim will fail/reject if one service line is submitted incorrectly.
  - Providers should correct claim and resubmit
- Encounter will fail if one service line is submitted incorrectly.
  - MCO should work with provider to ensure corrected encounter is submitted
- Supplemental payment will be calculated on clean claim using per diem less Medicare payment, less Third Party payment and MCO payment

Reimbursement

- Will there be CCBHC and CMHC payments in the same payment? No, because payments issued by provider type
- What will the 835 look like?
- Will denials and zero pays in the same 835?
- When the PPS payment comes back will it include the internal claim number on the remittance?

Questions

- Whose modifier should we expect to see on the service line, and in what position? The performing provider modifier should follow the same rules as CMHC with the exception that the rendering provider modifier is not required if the rendering provider reported in 2310B or 2420A is also the performing provider.

Questions

- Will the CCBHC providers be allowed to continually add new rendering providers throughout the year? Does it matter if the Q2 modifier is the first or second modifier?

CCBHC Covered Services

- Updated spreadsheet will be posted to MCO and Provider SharePoint sites ASAP