CCBHO Provider EDI Billing Guide

Department of Mental Health
Division of Behavioral Health

Version 2.5
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Revision History

Version #	Version Date	Summary of Changes	Revised By	Job Title
1.0	11/21/2016	Initial document	Michael Marcus	Business Analyst
1.1	12/09/2016	Minor corrections	Michael Marcus	Business Analyst
1.2	1/17/2017	Changes from group review	Michael Marcus	Business Analyst
2.0	5/4/2017	General update	Michael Marcus	Business Analyst
2.1	8/30/2017	General update	Michael Marcus	Business Analyst
2.2	1/8/2018	Clarified what type of billing is sent through the Pass-Through (page 8); added SMT reporting specs under Claim Header Level detail (page 15); clarified Service Facility Location reporting (page 15).	Michael Marcus	Business Analyst
2.3	4/1/2018	Clarified how Rendering Provider is reported under different situations (page 16).	Michael Marcus	Business Analyst
2.4	8/2/2019	General updates prior to Provider review before project restart	Michael Marcus	Business Analyst
2.5	7/20/2021	Clarification of the Pass-Though system and Medicare billing.	Michael Marcus	Business Analyst

Contents

What you need to know

Providers Affected

The following Billing Guidelines are intended for Certified Community Behavioral Health Clinics (CCBHC) that are participating in the Department of Mental Health's Section 223 Demonstration Program which started on July 1, 2017, and in the new Certified Community Behavioral Health Organization (CCBHO) Program.

Background

In October, 2015, Missouri was one of 24 states that received a Planning Grant from the federal Substance Abuse Mental Health Services Administration (SAMHSA) to prepare for implementing a federal demonstration project designed to improve the availability, accessibility, and quality of community behavioral health care resulting from implementation of a Medicaid prospective payment system (PPS) for community behavioral health services provided by organizations meeting new national standards for community behavioral healthcare. Missouri utilized the Planning Grant to assist in the process of certifying organizations against the new national standards, and to begin designing and developing the prospective payment system.

In October 2016, Missouri was one of only eight (8) states selected by SAMHSA and the Centers for Medicare/Medicare Services (CMS) to actually participate in the two-year Demonstration Project.

During the planning process, the Division of Behavioral Health (DBH) determined that 15 community behavioral healthcare organizations, serving 19 of the state's 27 behavioral health service areas, were in substantial compliance with the new federal standards for "Certified Community Behavioral Health Clinics" (CCBHCs), and were eligible to participate in the Demonstration Project. CCBHCs are required to provide:

- Crisis Mental Health Services
- Screening, Assessment and Diagnosis
- Patient-centered Treatment Planning
- Outpatient Mental Health and Substance Use Disorder Treatment Services
- Screening and Monitoring of Health Risks and Status
- Targeted Case Management
- Psychiatric Rehabilitation
- Peer and Family Support Services

The populations of focus for the Demonstration Project in Missouri include:

- Adults with serious mental illness
- Children and adolescents with serious emotional disorders
- Children, adolescents, and adults with moderate to severe substance use disorders
- Children and adolescents in state custody who have behavioral health issues
- Young adults with mental illness or substance use disorders identified as in need of treatment by the courts, law enforcement, or hospital emergency rooms.
- CCBHCs are required to provide services to members of the armed forces and veterans consistent with guidelines set forth by the Veterans Administration.

The Medicaid State Plan Amendment: CCBHCs Become CCBHOs

The Department of Mental Health, with support from the MO HealthNet Division and CMS, has decided to continue the CCBHO program after the demonstration period. Convinced of the new healthcare standard's merits, and the value of the prospective reimbursement methodology, DMH-DBH in collaboration with MHD and CMS, amended Missouri's Medicaid State Plan to formalize the CCBHO program in Missouri. The amendment allows Missouri to continue to reimburse organizations that meet the national CCBHC standards using the PPS payment model. A State Plan Amendment (SPA) was formally approved by CMS on June 21, 2019. The SPA was originally intended to go into effect on July 1, 2019, but has been postponed as a result of CMS extending the demonstration period beyond the original end date of June 30, 2019. A new effective date will be communicated to all stakeholders by DMH. As part of the SPA agreement, CMS requested that Missouri change the name of organizations that participate in this new program from Certified Community Behavioral Health Clinics (CCBHCs) to Certified Community Behavioral Health Organizations (CCBHOs) – changing the last word from clinics to organizations

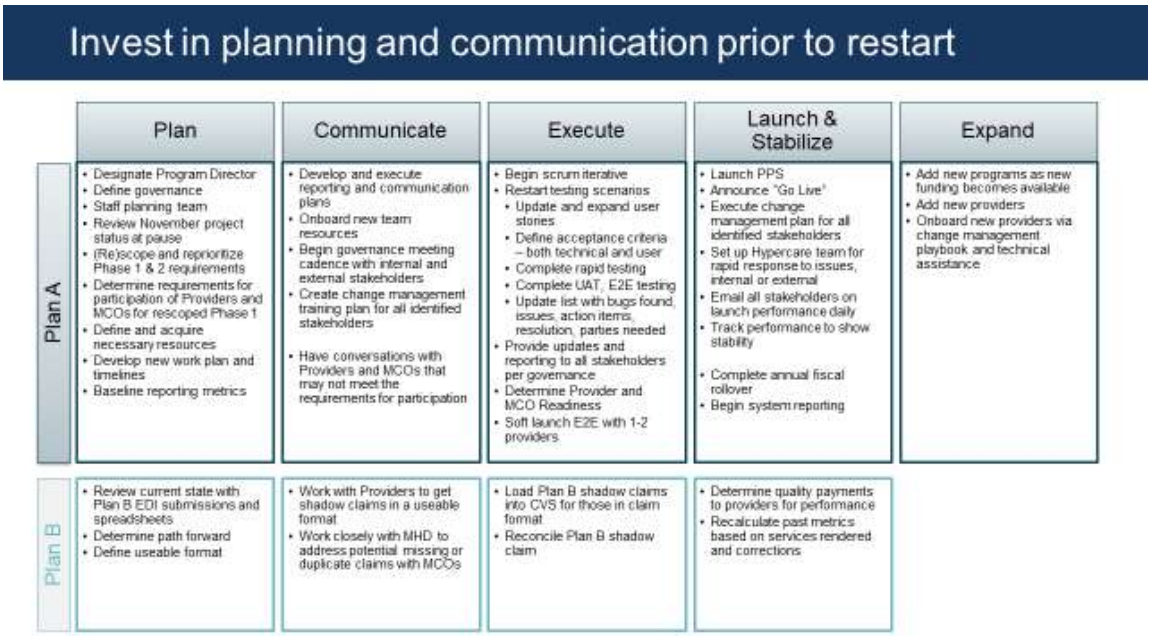
For the remainder of this document, the acronym CCBHO is used, except when referring to the original CCBHC Grant or CCBHC Demonstration Project.

Developing the New PPS Claims Processing System: Pause and Restart

Design, development, and implementation of the new prospective payment system was a considerable challenge and could not be completed in time for the Demonstration phase; which started on July 1, 2017. As a result, an alternate "Plan B" was implemented to manage PPS claims and payments during the interim, until the original CVS solution was ready (Plan A). Development and implementation

of Plan B necessarily took time and resources away from the continued development and implementation of the new PPS claims processing system (Plan A). Plan A system development and implementation was also hampered by significant changes in requirements, expectations, and workarounds to accommodate provider and payer system idiosyncrasies. As a result, the go-live date was deferred several times, requiring the stop-gap Plan B to be used beyond initial expectations.

In November 2018 the decision was made to pause further work on development of the new PPS claims processing system. Firefly Consulting was asked to assess the best options for proceeding to meet the need for a PPS solution. Based on a review of work to date, extensive interviews with all stakeholders, and analysis of PPS requirements, Firefly Consulting recommended continuation of the development and implementation of the new PPS claims processing system, but also recommend that the following investment and communication be made prior to restarting the project:



As recommended by Firefly, a Program Director was appointed by the DMH Director, and a new Steering Committee was established to oversee the final development and implementation of the new system. Upon completion of the review of the November project status at pause, and re-scoping and reprioritizing requirements, the Cabinet Information Technology Governing Council is expected to formally approve the restart of system development and testing in July, 2019.

Missouri's Prospective Payment System

For the CCBHC Demonstration Project, Missouri chose to implement the Prospective Payment System (PPS) using a daily rate methodology. Under the

daily rate model, CCBHOs receive a single cost-based payment for services rendered to a consumer in a single day. PPS payment may be issued from Missouri Medicaid, the three Managed Care Organizations that cover Missouri, or the Missouri Department of Mental Health, depending on the CCBHO services and the beneficiary's eligibility and health plan enrollment. PPS rates are reevaluated annually by the State and adjusted for inflation as needed.

The PPS rate is based on the model of a daily CCBHO Visit and is not adjusted based on the number, or type, of services rendered to the beneficiary. The PPS rate is also not adjusted for practitioners seen or the number of doctor appointments or services that occur on a single day. A daily CCBHO Visit is payable to a CCBHO when a Medicaid beneficiary receives at least one CCBHO covered service at a CCBHO site.

The PPS payment may be reduced if some, or all, of the rendered CCBHO services are paid in full or partially paid by other primary payers, such commercial insurance or Medicare. When other payer payments total above the CCBHO's PPS rate, the PPS reimbursement will be paid zero dollars. PPS payment may be issued from either Medicaid, the three Managed Care Organizations that cover Missouri, or the Department of Mental Health (DMH), depending on the CCBHO services and the beneficiary's eligibility and health plan enrollment.

Service Data

In addition to submitting a PPS claim for payment, CCBHOs are required to submit the individual CCBHO services (encounter data, sometimes referred to as "shadow data" or "shadow services) that were provided during a CCBHO Visit. In most cases, CCBHO's will report encounter data using standard 837 Professional claims; with individual services billed at the providers standard billing rate. CCBHOs can report all the Visit services individually, using multiple claims if needed, or they can bundle all the Visit related services onto one claim, or any combination in-between. The PPS can be bundled with the Visit service claims or submitted separately. CCBHO encounter data may also be reported on an 837 Institutional Outpatient claim in cases where a consumer is dual-eligible (Medicare and Medicaid) and the services rendered are covered under both the CCBHO and the Medicare Federally Qualified Health Clinic (FQHC) PPS programs.

In addition, Managed Care Organizations are required by Medicaid to report all paid services to MO HealthNet Division (MHD) using encounter claims. CCBHO services billed through Missouri's CCBHO Program, but covered and paid by Missouri MCOs, must be sent to MHD. MHD and DMH use the Visit encounter data to monitor the cost and utilization of services provided by CCBHOs.

Pass-Through/Claim Validation System

DMH in partnership with the MHD, developed a PPS implementation model that satisfies both the accurate payment of a PPS and the capturing of all associated encounter data. The inclusion of Clinic services to the scope of covered behavioral health services under the program, added considerable complexity to the overall project. Challenges included the accurate payment of a PPS in multi-payer billing scenarios and the accurate non-duplicative reporting of encounter data across multiple claim sources, including Medicare Crossovers, FQHC PPS Medicare claims, and Managed Care claims.

Missouri adopted a claim Pass-Through model for the demonstration program after evaluating several different approaches. The claim Pass-Through operates much like a claims clearinghouse with the CCBHO sending PPS and CCBHO service claims through the Pass-Through; which routes claims to the intended payer. Additional CCBHO specific information, added to CCBHO claims in support of the CCBHO data reporting requirements, are removed from claims before being forwarded on to the payer. Payer responses, such as electronic Claim Confirmations and Remittance Advices, are sent back through the Pass-Through and routed back to the originating CCBHO. The Pass-Through captures CCBHO Visit services and payment data and feeds it to a new billing engine called Claim Validation System (CVS).

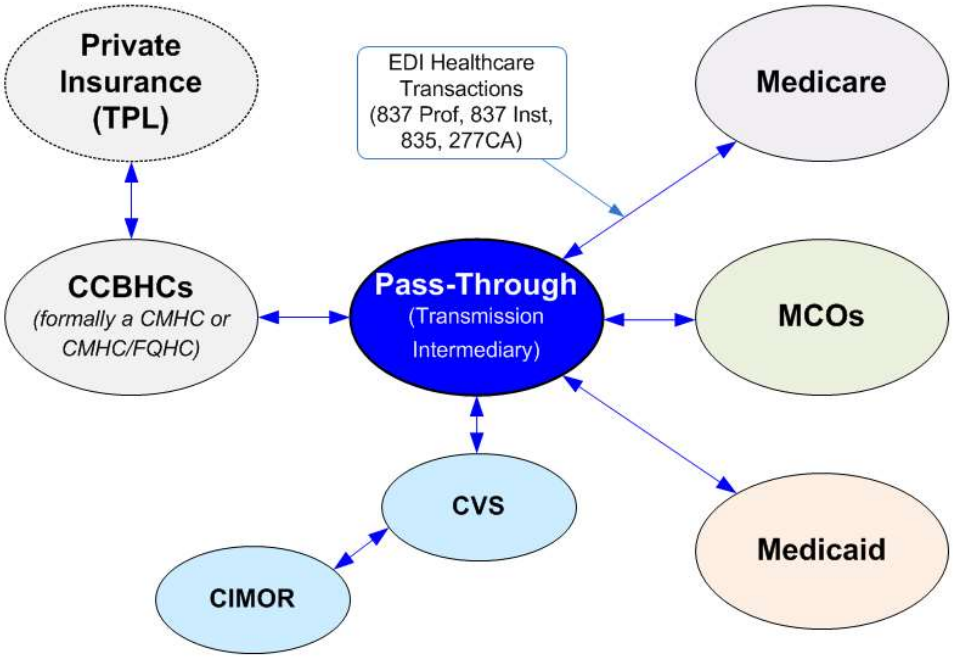


Figure 1: Pass-Through/Claim Validation System

The CVS billing engine is fed by claims and services captured by the Pass-Through. CVS interprets the EDI claim and service data, verifies the data by testing the

service data against both DMH and Medicaid system edits, and aggregates the services data into CCBHO Visits. The CVS handles:

- the accurate billing of a PPS to Medicaid, applying all third party liability payments;
- the bundling and billing of health plan covered services and PPS to Missouri Managed Care payers;
- the automatic routing of claims to the appropriate payer based on Visit services;
- the un-duplicative reporting of CCBHO services to Medicaid for encounter data reporting;
- the PPS payment back to the CCBHO provider;
- the apportioning of multiple funding sources across the services provided during a CCBHO Visit;
- and any Visit related claim/service/RA corrective actions received from CCBHOs or payers – including unsolicited payer initiated changes.

The CSV and the Pass-Through, are not part of DMH's CIMOR System, but a standalone modular solution that uses CIMOR data for various edit checks and program management.

CVS is a batch-only system
The Pass-Through/CVS solution is a batch-only system. There are no online claim data entry or editing features. To make corrections to services already batched, the provider must submit batch Void or Replacement claims referencing an ICN found on CVS generated Claim Confirmations or Remittance Advices. Providers can, however, use any claim editing functionality offered by the payer to make some changes. CVS detects payer-end claim/services data alterations by comparing the 835 Remittance Advices with original claim data captured in by the Pass-Through. CCBHO Visits will be updated with any changes and acted upon, if required.

Corrective billing limitations
When sending in a correction claim or editing online using a Medicare or Managed Care Organization system, CCBHO providers should not replace or change the date-of-service or the consumer identifier on a claim. Changes to consumer identifiers or date-of-service should only be done through the Voiding process. CVS denies PPS payment on claims that do not follow this policy.

TPL - Third Party Payers (Commercial Insurance, Supplemental, and Medicare)
CCBHOs are responsible for reporting all third-party payments made on CCBHO services that make up a Visit. The CVS system uses Medicaid's TPL rules and database to determine if "other payer paid" liability applies to services, and rejects services if upstream payers are indicated, but not reflected on the services from the provider.

CCBHO Services captured in the CVS CCBHO Visit

There are three primary categories of CCBHO Services:

1. **Qualifying Services** – services that qualify as a billable CCBHO Visit and were factored into the CCBHO cost;

2. **Non-Qualifying Services** – services that do not qualify as a billable Visit but were factored into the CCBHO cost;

3. **PPS Payment Code T1040 Q2** – a single payment code used to bill Medicaid for the PPS. CCBHO providers are required to submit this service to CVS to trigger a PPS payment.

All three categories of CCBHO Services and the CCBHO PPS need to be billed with a **Q2** modifier to distinguish the services from a normal FFS service.

A fourth category of services, captured in a CCBHO Visit, are Primary Care (PC) services that are provided with Behavioral Health (BH) services during a Visit at an FQHC, which is also a CCBHO. These services are part of a Medicare FQHC PPS visit that coincides with a CCBHO Visit, and are used in CVS to adjust the Medicaid PPS for any Behavioral Health component paid in the Medicare PPS payment. FQHC Payment codes (G0466, G0467, G0468, G0469, and G0470) are also recorded in this situation and may be considered during the processing of the PPS.

Mixing CCBHO services with non-CCBHO services
Non-CCBHO services cannot be combined with CCBHO services on a CCBHO claim (unless it is an FQHC Medicare PPS Institutional Claim). Non-CCBHO services must be submitted separately, outside of CVS, under the CCBHO's FFS billing NPI. CCBHO claims that contain only non-CCBHO services will be rejected by CVS. CVS will send back a Claim Confirmation with a reason for the denial.

CVS pays on the Visit
CVS pays a PPS for each valid qualifying CCBHO Visit. CVS builds and manages CCBHO Visits from shadow claim data sent in by the provider. Visits can consist of a single service, or multiple services from different DMH programs. As long as the Visit contains at least one valid qualifying service, a PPS will be paid. Only the **CVS** system pays on the Visit. Other payer systems, such as, Medicaid and Missouri MCOs, view CCBHO services individually, and process them under their own Fee-for-Service (FFS) models.

Pass-Through: Claim Submission and Pass-Through Payers

The Pass-Through system is an EDI document routing network that sits in front of the CVS system. CCBHO providers submit claims to CVS via the Pass-Through; dropping EDI claim files into their assigned inbound folders. Pass-Through checks the submitted EDI documents for ANSI X12 EDI compliance. If an inbound claim file fails the Pass-Through EDI compliance check, an EDI 999 is sent back to the provider, noting the error and error location within the file.

The payer's Electronic Transmission Identification Number, or ETIN, reported in the EDI claim Receiver Primary Identifier field, is used to determine how claims are routed in Pass-Through. The Receiver Primary Identifier is located in the 837 1000B Receiver Loop, segment field NM109. If the Receiver Primary Identifier is not recognized by the Pass-Through routing network, the file is placed on hold and the provider is notified. Files that are placed on hold or fail EDI compliance, will have to be corrected and resubmitted by the CCBHO.

Pass-Through routes claims to the following DMH systems:

- **CVS**
- **CIMOR**

CVS claims must contain CCBHO services, provided at CCBHO certified sites, and billed under PPS associated NPIs. All CVS claims must be compliant with the billing specification outlined in this document. Providers can also bill CIMOR via the Pass-Through by dropping CIMOR bound claims into the same CVS inbound folder. CIMOR claims submitted via the Pass-Through must also be compliant with the billing specification outlined in this document.

In addition to CVS and CIMOR, Pass-Through can route provider claims to the following payers (this is optional):

- Medicare – WPS 837 Professional Claim Format
- Medicare – NGS FQHC PPS 837 Institutional Claim Format
- Medicaid
- Medicaid contracted Managed Care Organizations
    - United Health Care
    - Home State
    - Anthem – Healthy Blue

Billing CCBHO services to **Medicare** via the Pass-Through is offered as a way to simplify the billing of CCBHO Clinic services when consumers have Medicare – such as, dual-eligibles, or when a consumer has Medicare and not Medicaid, but is State payable. The advantages of billing Medicare via the Pass-Through is the automation of TPL reporting, and a decrease in time-to-payment. Billing Medicare via the Pass-Through is optional, as Medicare and Medicaid Crossover payments can be reported as TPL on CVS inbound claims – but this will require additional work by the provider.

When using the Pass-Through for billing Medicare, the Pass-Through forwards the claim to the specified Medicare payer, as well as CVS. CVS processes the claim like normal, creating a Visit from the CCBHO services found on the claim; services with a Q2 modifier. To complete a Visit, the provider bills any remaining Visit services that were not billed to Medicare, and submits the required T1040. The Medicare 835 is passed on to CVS, either directly from the provider, or indirectly from the provider's clearinghouse or billing service. CVS does the rest.

After receiving the Medicare 835s, CVS applies any Medicare payments to the Visit services. Payment apportioning between medical and behavioral health services, which can happen under Medicare FQHC PPS, are automatically calculated and applied by CVS. Any related Medicaid Crossover payments are applied to the appropriate Visit services. CVS receives Medicaid Crossover payment data directly from Medicaid. After all reported TPL has been aggregated, apportioned, and applied for a Visit, the T1040 billed amount is reduced accordingly, and the PPS claim is submitted to Medicaid for payment. Or, in the case of non-Medicaid consumers Visits, CVS subtracts the total TPL from the State payment amount and pays accordingly.

Billing non-CCBHO services to Medicaid and/or Missouri's MCOs via the Pass-Through is also optional – and is offered as a one stop shop for sending claims to Medicaid and the MCOs. This option is referred to as **Pure-Pass-Through**. This option works for both behavioral health and medical service claims, allowing providers to drop their claim files in one location. As of this writing, no providers have indicated an interest in using the Pure-Pass-Through option.

Payer ID is important – claims should be addressed properly
Although claims are being submitted to DMH via the Pass-Through; if it's a Medicare or MCO client, the intended payer is still Medicare or MCO and not DMH or Medicaid. Payers not listed should be billed directly by the CCBHO and NOT through CVS.

Medicare Part B and FQHC PPS
CCBHO's must add consumer **MBI/HICN** to **CIMOR** prior to billing Medicare Part B and/or FQHC PPS through CVS. CVS scans Medicare claims for CCBHO services and creates new billable Visits when consumers and qualifying services are identified.

TPL is the CCBHO's responsibility
Billing and reporting payment from third party payers is the responsibility of the CCBHO. Claims should be billed to all TPL parties prior to billing CVS.

Provider Billing Requirements

A new Electronic Data Interchange (EDI) Claim Specification has been developed to support the new billing and data reporting requirements of the CCBHO Program. CCBHOs must use the new EDI Claim Specification for sending CCBHO Service and PPS Claims to CVS. CCBHOs also have the option of sending non-CCBHO FFS Claims to CIMOR through CVS Pass-Through using the new EDI specification – as indicated in the previous section.

New data elements that are specific to the CCBHO project, and are not required by the intended payer, will be removed prior to transmission by the Pass-Through. The Pass-Through will map and reformat specific data elements prior to submission to a payer, as indicated in the payer's EDI Billing Companion Guide. For example, if a CCBHO elects to bill Medicare via the Pass-Through, data elements required by CVS, such as Service Category and DMH Contract, will be removed from the EDI that is forwarded on to Medicare.

Due to the overlap in covered CCBHO services with the Medicare FQHC PPS program, CCBHOs that are also classified as FQHCs, will need to modify the FQHC PPS Outpatient 837 Institutional claims to include CCBHO specific data elements. These CCBHO program specific data elements will be removed by the Pass-Through prior to being sent on to Medicare.

To support CCBHOs that plan on submitting multiple services on a single claim, this new specification moves Service Category and DMH Contract reporting, from the claim level, to the service line level. Relocating the reporting of these required data elements allows CCBHOs the option of submitting any number of services per claim, regardless of the service mix – as long as the services are part of the same CCBHO Visit. Moreover, relocating Service Category and DMH Contract Number to the service level, eliminates data field conflicts when reporting TPL.

Registering of Clinic Consumers

Clinic Consumers must be registered in the Department of Mental Health's CIMOR System. Before billing CCBHO Service Claims or Medicare Claims (for dual eligible consumers) that contain CCBHO Services, a Clinic Consumer in CIMOR must have:

- a DMH ID;
- a validated Social Security Number (SSN);
- have an active Episode of Care (EOC);
- and an "Open" Clinic Program Assignment (in CIMOR, program options are "**CPS CCBHC Clinic Services**" or "**ADA CCBHC Clinic Services**").

Note: No program levels are required for Clinic program assignments.

PPS Payment Code Service

In support of this project, a new CCBHO PPS payment code and modifier was released in the November 2016 Billing Code update. The new PPS payment code is **T1040**; with a description of "*Medicaid certified community behavioral health clinic services, per Diem*". The T1040 code is part of the Healthcare Common Procedure Coding System (HCPCS) code set, and is not specific to the 223 Demonstration Program and must be accepted by all payers. The effective date for T1040 is January 1, 2017.

Please note, the T1040 payment code does not have to be the first line on a CCBHO Claim; the CVS billing engine will sort and process the services as needed.

Reporting CCBHO Services on CCBHO Claims

In support of the 223 Demonstration Program, a new procedure modifier was created to facilitate the identification and documentation of CCBHO Services reported on CCBHO claims. Released in the November 2016 Billing Code Update, the new modifier, "**Q2**", must be appended to all CCBHO Services including PPS Payment Code Services (**T1040**) reported on CCBHO Claims. The "Q2" modifier must be the last reported modifier (last populated position). Note: Providers do have the option of reporting the "Q2" modifier in the first modifier location, when billing MCOs via CVS. The rationale for this option is discussed later in this document.

Pass-Through: submitting and receiving EDI files

CCBHO providers must use the new EDI Claim Specification for billing both PPS and CCBHO Service claims to CVS.

Uploading claims - The provider must use secure File-Transfer-Protocol (sFTP) to upload EDI claim files into their assigned **inbound** folder; as they currently do when batching claims to legacy CIMOR. There is no difference.

For inbound EDI Claim Files, the following applies:

- The **Submitter ID** (1000A Loop) on the EDI file should be the CCBHO's ID.
- The **Receiver ID** (1000B Loop) on the EDI file should be the ID of the intended payer.

  The **Pass-Through** system uses **Receiver ID** to route claims to the intended payer. To distinguish between the CIMOR and CVS systems, two new Receiver IDs are provided. The new Receiver IDs replace the DMH ETIN (65102008) currently used on DMH bound claims. The CCBHO Claims sent

to CVS will be sent to the appropriate CCBHO payer: Medicaid, MCOs, or DMH.

When billing CVS or CIMOR via the Pass-Through, the inbound claim Receiver ID must be set to:

- **11111** – for the **CVS** system
- **22222** – for the **CIMOR** system

When billing Medicare claims that contain CCBHO Services through the Pass-Through, the Receiver ID should be set for the appropriate Medicare payer.

When billing Medicaid claims through the Pass-Through, the Receiver ID should be set to 431754897.

When billing non-CCBHO claims and services through the Pass-Through, the Receiver ID should be set to the appropriate payer.

The Pass-Through will route claim files based on the following Receiver IDs.

Payer	Receiver ID
CVS	11111
CIMOR	22222
WPS(Professional) (Medicare Pass Thru)	05302
NGS FQHC (Institutional) (Medicare Pass Thru)	12M29
MCAID (Pure Pass thru)	431754897
WPS (Institutional) (Pure Pass Thru)	05301
HomeState (MCO) (Pure Pass Thru)	68068
United Health Care (MCO) (Pure Pass Thru)	86050
Anthem (MCO) (Pure Pass Thru)	00541

- The Payer (2010BB Loop) on the claim should be the intended payer; however, CVS will ultimately determine the appropriate payer for the T1040 based on the Visit's service mix and results from Medicaid edits.

Downloading Payer responses – Separate folders for each payer will be added in the provider's folder. Under each payer folder, there will be three sub-folders: **Acknowledgements**, **Claim Confirmations**, and **835 Remittance Advices**. The provider must use secure File-Transfer-Protocol (sFTP) to download payer response files from these sub-folders.

The **Acknowledgements** folder may contain:

- Pass-Through 999 Functional Acknowledgement

The **Claim Confirmations** folder may contain:

- CVS Claim Confirmations (proprietary format)
- Medicare 277CA Claim Acknowledgement
- Managed Care Organization 277CA Claim Acknowledgement

The **835 Remittance Advice** folder may contain:

- CVS 835 Remittance Advice
- Medicare 835 Remittance Advice

The CCBHO provider will receive a 999 Acknowledgement each time a 5010 X12 EDI837P or 837I file is submitted to DMH.

Claim Receiver ID – CVS and CIMOR
When billing the **CVS** or **CIMOR** systems, the Claim **Receiver ID** must be set to: "**11111**" for **CVS**; or "**22222**" for **CIMOR**. Receiver IDs not recognized by the **Pass-Through** will require manual intervention by DMH and may result in a delay in payment.

Professional Claim Specification

The following applies only to CCBHO providers. CCBHOs must use the new claim specification for billing both CCBHO Services and PPS (T1040 Q2) claims. When billing CCBHO services and PPS claims, the CCBHO must use the **new CCBHO NPI** that is associated with a Medicaid assigned 88 Provider Type ID. CVS will reject services if the Billing Provider NPI is wrong for the type of services billed on a claim.

Non-CCBHOs will continue to use the CIMOR Companion Guide
Non-CCBHOs will continue to use the current billing guidance as outlined in the **Missouri Department of Mental Health HIPAA Transaction X12N 837 Professional Companion Guide for CIMOR**.

TPL reporting compliance
Reporting of other payer information and other payer payments should be done in accordance with Missouri Medicaid practices.

Changes from the existing legacy CIMOR Professional Claims Specification

- **CIMOR Service Category** is no longer reported under the 2000B Subscriber HL Loop – **Subscriber Information (SBR) Segment** – Reference Identification (SBR03) field. The Reference Identification (SBR03) field can be used as originally intended.

- **DMH Contract Number** is no longer reported under the 2300 Claim Loop – **Contract Information (CN1) Segment** – Reference Identification (CN104) field. The Reference Identification (CN104) field can be used as originally intended.

New specifications for CCBHO Claims

Transaction Level

- **Receiver ID** – Receiver ID (**1000B Loop - NM109 Receiver Primary Identifier)** must be set to the value of:

    - **11111** - when billing the DMH **CVS** system

    - **22222** - when billing the DMH **CIMOR** system

Billing Provider Level

- **Billing Provider NPI** (Billing Provider Loop 2010AA – NM109 Identification Code) must be the correct number for the intended payer.

  When billing Medicaid or Managed Care Organizations for the CCBHO Services, or for a CCBHO PPS, the Billing Provider NPI must be the **new CCBHO NPI** that is associated with a Medicaid assigned 88 Provider Type Number.

  When billing Medicare, the CCBHO provider should bill the Billing Provider NPI recognized by Medicare; this should NOT be your CCBHO NPI associated with you 88 legacy provider type number. Services on Medicare claims will be recognized as CCBHO Services by the Q2 modifier.

- **Billing Provider Taxonomy** Code – Taxonomy Code within the Billing Provider Hierarchical Level (2000A) Loop PRV Segment is required when billing Managed Care Organizations (MCO) and maybe required when billing DMH/Medicaid.

Subscriber Information Level

- **Subscriber Primary Identifier** (Subscriber Hierarchical Level 2000B - NM1 Subscriber Name segment, NM109 Subscriber Primary Identifier field) must be either the **DMH ID** or Medicaid **DCN** for when billing DMH, Medicaid, or MCOs, or the Medicare **HICN** or **MBI** when billing Medicare for dual eligible consumers. CVS uses consumer identifiers in CIMOR to determine if a person is part of the CCBHO Program. Therefore, it is vitally important that all applicable consumer identifiers be entered in to CIMOR prior to billing.

Claim Level (Header Level)

- CCBHOs should note that transactions are unbundled during processing, and **Claim Number** (i.e., Patient Control Number) should be used for batch matching. Claim Number is echoed back to the submitter on the CVS Claim Confirmation and CVS 835. This enables the matching of claims to payment information returned on 835s. It is **strongly recommended** that all providers use a unique Claim Number for each individual claim.

- **Place of Service** (POS) (Claim Information Loop 2300 – Facility Type Code CLM05-1) on the Services Claim and the PPS Claim should be set to whatever value is appropriate for the services rendered during the Visit. The submitted POS value on the PPS Service (**T1040 Q2**) will not be used in validation.

  Please note: It may be necessary to report Place of Service at the Service Level as well (Detail Level) (Professional Service Loop 2400 – Facility Type Code **SV105**) - on Service Claims with multiple CCBHO Services. This is required when the value for the service is different than the value indicated in Claim Information Loop 2300 – Facility Type Code **CLM05-1**.

- **Diagnoses** on the Services Claim and PPS Claim must be on the Consumer's Episode of Care (EOC) Diagnosis List in CIMOR - except for CCBHO Clinic Services.

- **Standard Means Test (SMT) Reporting** – CCBHO providers must report **SMT** applied to services claimed on the claim. **SMT** must be indicated in the Claim Information Loop 2300 – Patient Amount Paid AMT*F5 – **AMT02** field.

- **Rendering Provider Loop** – The rendering provider loop is required. Additional information can be found in Appendix A.

  - For CCBHO services covered under the TCM (15), ADA (86), and CPR (87) programs, the 2310B Rendering Provider Loop must report the agency name and program NPI. In the Rendering Provider Name segment (**NM1**), the Entity Type Qualifier (field **NM102**) must be set to the value of **2**, for **Non-Person Entity**.

- ✓ **Taxonomy** code is required when the reported NPI covers multiple Medicaid programs. Taxonomy is reported under the 2310B Rendering Provider Loop, **PRV** (Rendering Provider Specialty Information) segment.

- ✓ Extended Day Treatment Services (T1002, T1003) no longer require the reporting of the actual staff member.

- For CCBHO Services covered under the "Clinic Option" (50), FQHC (50/C8), and CMHC (56) programs, the rendering provider loop must report the staff member's name and NPI. In the Rendering Provider Name segment (NM1), the Entity Type Qualifier (field **NM102**) must be set to the value of **1**, for **Person**.

  - ✓ **Taxonomy** should be reported if it is required by Managed Care or Medicaid.

The Rendering Provider data are required but will not be validated in the CVS system. Reported names, NPI, and Taxonomy, will be sent from CVS to Medicaid and the Managed Care organizations without modification.

Please note: The Rendering Provider reported at the Claim level (Rendering Provider Loop 2310B) applies to the entire claim unless overridden on a service line by the presence of Loop 2420A.

- **Service Facility Location** - The Service Facility Site Location number must be attached to a CCBHO Site in CIMOR. Additional information can be found in Appendix A.

  Please note: Service Facility Location reported at the Claim Level (Service Facility Location Loop 2310C) applies to the entire claim unless overridden on a service line by the presence of Loop 2420C.

  Facility Site Location NPI reporting:

  - For **Clinic CCBHO services**, the Service Facility Location NPI (Service Facility Location Loop 2310C - NM109 Identification Code) must be set to the NPI Site Number currently used and recognized by Medicaid.

    For **non-Clinic CCBHO services**, the Service Facility Location NPI (Service Facility Location Loop 2310C - NM109 Identification Code) must be set to the appropriate number based on services provided.

  In addition to the site NPI number, DMH also requires that the **CIMOR Site Number** (a three to four-digit number) be reported in the Service Facility Location Secondary Identification, **REF*LU** Segment, in the REF02 Reference

Identification field. CVS uses the DMH site number to determine if a site is a certified CCBHO site.

The Service Facility Location loop should not be reported at the claim or service level on the **PPS only Claim** (a claim that ONLY contains the T1040 service). Billing Provider loop (2010AA) information is sufficient for the PPS Claim. The PPS Claim does not require the CIMOR Site Number.

Bundle Claims, i.e., claims that contain both CCBHO services and a T1040, require Service Facility Locations to be reported for all CCBHO services. Service Facility Location is not required for the T1040 service.

If the Place of Service = 12 (for Home), the Service Facility Location reported must be the location of the rendering practitioner.

Service Level (Detail Level)

- All CCBHO Services, including the PPS, must have a Q2 modifier. If not, the service will fail CVS Validation rules and the entire claim will be rejected. Please note: In the case of Medicare FQHC claims, services that are not part of the CCBHO Program, such as medical services, will be ignored by CVS edits, and the claim will not be rejected.

- The Q2 modifier must be the last reported modifier (there is an exception to this rule noted below). If there are no modifiers associated with a procedure code, such as H0038, the Q2 modifier must be reported in the first modifier position. If there are two modifiers associated with a procedure code, such as H0004 HH TG, the Q2 must be reported in the third modifier position. Multiple Q2s per procedure code will result in a service edit rejection, and the entire claim will be rejected.

  The Q2 modifier exception. Under Plan B, CCBHOs were required to report the Q2 in the first modifier position when billing the MCOs directly. To accommodate providers, CVS (Plan A) has been configured to allow providers to continue to report the Q2 in the first modifier position – when billing the MCOs CCBHO services via CVS.

- The T1040 payment code does not have to be the first line on a CCBHO Claim; the CVS billing engine will sort and process the services accordingly.

- For the T1040 service, the service line billed amount, Service Line Loop 2400 – Professional Service (SV1), SV102 - **Line Item Charged Amount**, should be set to the provider's PPS rate minus any patient SMT payment. A T1040 billed amount exceeding the provider's annual PPS rate will be reduced in CVS to the actual PPS rate. Do not reduce PPS (T1040 Q2) Line Item Charged Amount by TPL reported on the claim or spenddown. CVS will

automatically reduce the PPS payment amount by the total of all reported TPL for a Visit.

- For CCBHO Services (excluding the T1040) the service line billed amount, Service Line Loop 2400 – Professional Service (SV1), SV102 - **Line Item Charged Amount**, should be the provider's Standard Rate. CVS will use the reported service line item charge amounts in apportionment calculations. Any "other payer payments" (TPL) must be reported in the Loop 2430 Line Adjudication Information segments.

- **Service Line Item Control Number** (REF*6R) is required. It is strongly recommended that the provider sends a unique line item control number for each service line - to facilitate researching rejections and linking payment to original claims.

- **CIMOR Service Category** and **DMH Contract Number** must be reported in the Service Line Loop 2400 – **Line Note** (NTE), NTE02 Description field.

  Since two data elements are being reported in one field, reporting order and item delimitation are critical. The reporting order is as follows – Service Category first, followed by a single blank space, followed by the DMH Contract Number.

Examples of a Services Line Note Segment (* and @ are EDI delimiters). **The yellow area denotes a space between the two data elements.**
NTE*ADD*ADACSTARGENENH ADA-ER20160101@
NTE*ADD* CPSCCBHCPPS CPS-ER19814AP@

- **Rendering Practitioner** - When required (see Claim Level for details) Rendering Practitioner is reported in the Rendering Provider Loop 2420A. Service Level reporting may be required when multiple practitioners provide multiple CCBHO Services to a consumer on the same day and the services are reported on the same claim. The Rendering Provider Program NPI must correspond with the Service Category being billed when reporting an organization.

Rendering Provider for ADA/CPS/TCM/ACT/SUD services
The Rendering Provider Program NPI must correspond with the Service Category being billed.

- **Service Facility Location** – When required (see Claim Level for details) Service Facility is reported in the Service Facility Location Loop 2420C. Service Level reporting may be required when a consumer receives multiple services at different CCBHO Sites on the same day and the services are reported on the same claim.

  CIMOR Site Number - Facility Site Location Secondary Identification

  In addition to the site NPI number, DMH also requires that the CIMOR Site Number (a three or four-digit number) be reported in the Service Facility Location Secondary Identification – REF Segment – field REF02 Reference Identification. This REF Segment is under the Service Facility Location Loop 2420C.

Institutional Claim Specification

The following only applies to CCBHOs that are also **Federally Qualified Health Centers (FQHC)** and bill Medicare FQHC PPS Claims, and Medicare Part C Crossover claims billed to Medicaid.

Institutional Claims - Outpatient
Only **CCBHO Clinic Services** are impacted.

Information removed by CVS on FQHC PPS Claims
CCBHOs should continue to use the current billing guidance as defined by Medicare for FQHC PPS billing. Any additional content required in this specification will be removed by the Pass-Through System prior to submission to Medicare for payment.

Claim Level (Header Level)

- **CIMOR Service Category** and **DMH Contract Number** must be reported in the Claim Information Loop 2300 – Billing Note (NTE), NTE02 Description field. The Note Reference Code, NTE01, must be set to "ADD".

  Since two data elements are being reported in one field, reporting order and item delimitation is critical. The reporting order is as follows – Service Category first, followed by a single blank space, followed by DMH Contract

Number. For Clinic Services, the contract number will be the CPS Contract Number for each CCBHO.

Example of a Service Line Note Segment (* and @ are EDI delimiters). **The yellow area denotes a space between the two data elements.**
NTE*ADD*CPSCCBHCCLINIC CPS-ER19814AP@

The Service Category and DMH Contract Number will be removed from the Service Line Note fields prior to sending claims on to Medicare.

- **Rendering Practitioner** at the Claim level (Rendering Provider Loop 2310D) applies to the entire claim unless overridden on a service line by the presence of Loop 2420C.

  The Rendering Provider NPI must be a valid NPI for licensed practitioners.

Service Level (Detail Level)

- Service level reporting of the Rendering Provider (Rendering Provider Loop 2420C) is required when multiple practitioners provide multiple CCBHO Services to a consumer on the same day and the services are reported on the same claim – which is the case for FQHC PPS claims.

  The Rendering Provider NPI must be a valid NPI for licensed practitioners.

Managed Care Claims

Unlike Medicare, where Pass-Through forwards the Medicare claims on to Medicare, MCO bound claims are routed directly to CVS, where a CCBHO Visit is assembled from the reported services. Individual services that make-up the CCBHO Visit will be checked against Medicaid edits, and all services covered by the "Health Plan" will be identified. If any Visit services are determined to be MCO payable, the entire Visit is billed to the MCO, regardless of service mix. As with billing Medicaid or DMH, the provider must send in a T1040 to request a PPS for an MCO billable Visit.

CVS bundles the MCO covered services and the PPS on to a single claim (referred to as a "**MCO Bundled PPS Claim**") and bills said claim to the appropriate MCO for payment. Additional information supplied in the provider's Service Claims will

be added as needed to the MCO Bundled PPS Claim. Services not covered by the Health Plan will be pending in CVS until the MCO adjudicates and reports back claim payment status. CVS may change payers, depending on final MCO payment status.

Providers will receive direct payment and electronic remittance advices (835) from the MCOs for processed MCO Bundled PPS Claims. The MCO will also send a copy of the electronic remittance advice (835) back to CVS. CVS will report the MCO payment on the RA sent back by CVS for the provider's original PPS Claim. The CCBHO's PPS Claim will reflect the MCO's response.

For paid Visits, the Service Claims will be paid, but adjusted to pay zero dollars. An adjustment code of CO-97 will be used for zero pay services (CO-97 stands for – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated").

Claim Corrections

CVS allows providers to void and replace individual CCBHO Services/Claims from billable Visits, before payment (in-cycle corrections) and after payment (post-cycle corrections). Corrections can only be made with Void and Replacement batch claims; there are no online facilities for manually initiating corrections. The CCBHO provider must submit Void or Replacement claims with the Internal Control Number (ICN) found on the CVS Visit & Service Screen, or the 835 sent from CVS. CVS automatically sends service and PPS corrections to the PPS payer if paid, and Visit services are removed or adjusted accordingly.

Any fund apportioning changes as a result of a void, correction, or Payer initiated payment change, will trigger new 835 RA(s) back to the provider from CVS. This may result in one or multiple 835s, depending on the Visit payer, claim, and/or service mix.

NOTES:

- CVS requires at least one verified visit-qualifying CCBHO Service before a PPS Claim can be sent to a PPS payer.
- Void or Replacement claims received, after the PPS Claim has been submitted to a PPS payer, will be queued (saved) for later processing
- A CCBHO provider can void an entire CCBHO Visit by simply voiding the T1040 Claim.
- CCBHO services that are submitted late (after the PPS Claim has been submitted to Medicaid) are queued.

Limits to what can be Corrected
Consumer identification such as Consumer DCN or SSN, and Date of Service (DOS) cannot be replaced using a Replacement claim. This restriction is due to the Visit model design and CVS processing capability. If a Consumer identifier, or the DOS, needs to be corrected, the CCBHO must void out the incorrect Visit and rebuild a new Visit with corrected claims.

Unsolicited 835 Remittance Advice
CVS may initiate PPS Claim Voids and Replacements when Medicare, Managed Care or Medicaid makes changes to a paid claim and resends a Remittance Advice to notify the CCBHO. In this case, the Pass-Through captures the unsolicited 835 Remittance Advice from the payer and CVS initiates appropriate corrective action based on the payment data. In some cases, payer's subsequent actions may result in the CVS automatically voiding a paid PPS Claim.

Voiding a CCBHO Visit

A CCBHO provider can void an entire CCBHO Visit by simply voiding the **PPS Payment Code Service Claim**; a convenient short cut for providers billing either piecemeal or bundled. By voiding the payment code service, T1040 Q2, the provider is indicating the desire to void the entire Visit.

To void a PPS, the CCBHO provider resubmits the claim with PPS service on it; sets the **Claim Frequency Code** to **8** and returns the paid claims Internal Control Number (ICN) in the Claim Information Loop 2300 – REF Segment F8 field. The PPS will be voided and the services on the Visit will be voided. Any fund apportioning changes will trigger new 835s back to the provider.

Voiding a CCBHO Service Claim

A CCBHO provider can void individual Service Claims that make up a CCBHO Visit. If the provider voids the claim with the PPS, the entire Visit will be voided. Voiding individual CCBHO Service Claims works best for providers that plan on billing piecemeal followed with a separate PPS Claim.

To void a CCBHO Service Claim, the CCBHO provider resubmits the claim they want to void; sets the **Claim Frequency Code** to **8** and returns the paid claims ICN in the Claim Information Loop 2300 – REF Segment F8 field. The services on the CCBHO claim will be voided and any adjustment to PPS payment or funding

apportioning will take place automatically. If a CCBHO provider voids the only qualifying service in a visit, the visit is non-billable. If the visit is already paid, the prior payment is recouped during the next financial cycle. Any fund apportioning changes will trigger new 835s back to the provider.

Replacing a CCBHO Service Claim

A CCBHO provider can replace individual Service Claims that make up a CCBHO Visit. In the case of the bundled claim, the services will be replaced but the PPS will be ignored. Replacing individual CCBHO Service Claims works best for providers that plan on billing piecemeal followed with a separate PPS Claim.

To replace a CCBHO Service Claim, the CCBHO provider resubmits the claim; sets the **Claim Frequency Code** to **7** and returns the paid claims ICN in the Claim Information Loop 2300 – REF Segment F8 field. The Visit services on the CCBHO claim will be replaced and any impact to PPS payment or funding apportioning will take place automatically in CVS. Any fund apportioning changes will trigger new 835s back to the provider.

Feedback to CCBHOs

Pass-Through/CVS Validations

CCBHOs Services Claims pass through three levels of validation in the Pass-Through/CVS system.

- **Level 1 Validation** – File level checking: Validates the structural integrity of EDI file and syntax of the data. When errors are found the entire EDI file is rejected. Errors are reported back on the 999 to the provider.

- **Level 2 Validation** – Claim level checking: Validates claim and service level data against DMH data edits and business rules, such as checking if a consumer is in an open episode of care on a service date. When errors are found the claim is rejected. Errors are reported back on the **CVS Enhanced Claim Confirmation**.

  Note: For CCBHO Claims with multiple services lines, if any service on the claim fails Level 2 Validation, the entire claim is rejected. Rejecting the entire claim simplifies CVS processing and speeds up CCBHO claim corrections. The CCBHO provider simply fixes the problem and resubmits the claim (same day is possible) without the delay associated with waiting for the billing cycle to finish, receiving the RA, and sending a Replacement claim.

- **Level 3 Validation** – CCBHO Service level checking. Validates CCBHO Visit services against Medicaid's MMIS edits; for example, checking TPL reporting and Managed Care coverage. Errors are reported back on the 835 at the end of a CVS Financial Cycle.

CVS Enhanced Claim Confirmation

The Enhanced Claim Confirmation is only generated during Level 2 Validation processing in CVS and only reports if a claim or service(s) fails Level 2 edits. Successful claims are not reported back on the Enhanced Claim Confirmation. Claims that pass Level 2 Validations are appended to a Visit. CCBHO Management and Billers can use CVS online screens to review claims and services that make it to a Visit.

Only FAILED claims are reported back on CVS Claim Confirmations
Claims that pass Level 2 Validation and create a Visit are not reported back on CVS Claim Confirmations. A report in CVS identifies what claims that have passed Level 2.

CVS Remittance Advices

CCBHOs will receive 835 Remittance Advices (RA) for all accepted CCBHO Service Claims including the PPS T1040. The T1040 service will indicate the final payment, including any reductions due to applied TPL or spenddown. Rendered services (shadow services) will be paid, but adjusted to zero dollars. An adjustment code of CO-97 will be used for the zero pay services.

> CO-97 description is - "***The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated***".

The PPS paid amount is apportioned across all Qualifying Visit Services, when the payers are DMH or Medicaid, and the computed apportioned amounts are sent back in informational segments on the 835. Informational segment **Loop 2100 – AMT*T** is used to report the total paid claim amount; and informational segment **Loop 2110 – AMT*B6** is used to report the service level apportioned amount. Values in these segments are for informational purposes only and are not used in 835 balancing.

When a Visit is MCO billable, the MCO is billed a PPS by CVS, and the MCO pays the PPS minus any reductions. The MCO sends payment and an RA directly to the provider. Since CVS billed the MCO, the MCO also sends a copy of the RA back to CVS. CVS applies the MCO PPS payment to the Visit Services, and generates an RA back to the provider for each Visit Claim that the provider submitted.

The paid amounts on the CVS generated RAs reflect what the MCO paid, i.e., the T1040 is either paid or denied, and the MCO covered services are paid, but for zero dollars. Other non-covered Visit Services are paid for zero dollars. Since the MCO is fully responsible for an MCO billable Visit, the service amounts are not apportioned, and the informational segments at the service level are set to the original billed amount.

Please note: The CVS generated PPS 835 RA is always tied to the claim with the first reported T1040 service, unless said claim is voided. After the first T1040, duplicate T1040s are ignored by CVS. The only time an 835 references a new T1040 claim, is when the original T1040 claim is voided and a new T1040 is submitted for the Visit.

PPS Payment Apportioning

PPS payment is based on having a valid CCBHO Visit, and is not based on the number, type, or combination of services in the Visit. Only one service on a Visit needs to be accepted for the Visit to be payable, regardless of the status of the other services on the Visit. Payable Visits are paid the CCBHO's PPS rate; minus the sum of all third-party payments made for services on the Visit.

Micro apportioning is used to determine the funding split for each Visit service when Medicaid and/or DMH are the final payers. With Micro Apportioning, the total PPS payment is apportioned across all qualifying CCBHO services. A ratio is computed for each qualifying service by dividing the provider's standard billing rate by the total cost of all qualifying services on the Visit. This service to PPS ratio is then applied to the PPS payment amount for each qualifying service. The PPS payment is thus spread across all the qualifying services by an amount that is proportional with the FFS cost of the service. Based on the type of services billed, CVS applies the apportioned amount computed for each qualifying service; encumbering said amount from appropriate CVS funding streams. Non-Qualifying CCBHO services, such as, T1040 Q2 or GXXXX payment codes, and FQHC non-covered services (category 4) are not included in the Micro apportioning calculations. The apportioned amounts are reported back on 835 in informational segments, as noted in the last section.

Examples

The following three examples help illustrate how the Micro apportioning model works. In all three examples, the CCBHO T1040 Rate is **$200.00**.

DAY 1

					Micro Apportioning	
Service Type	**Code**	**Units**	**FFS Rate**	**FFS Total Amount**	**Micro Apportioned**	**Payment by Services based on PPS (Micro)**
Psychiatric Services	H0036	4	$ 24.94	$ 99.76	19.64%	$ 39.28
	H0037	1	$ 130.03	$ 130.03	25.60%	$ 51.19
	H2017	4	$ 3.00	$ 12.00	2.36%	$ 4.72
	H0004	2	$ 14.15	$ 28.30	5.57%	$ 11.14
	99205	0	$ 209.59	$ -	0.00%	$ -
SUD Service	H0004	2	$ 14.15	$ 28.30	5.57%	$ 11.14
Clinic Service	99205	1	$ 209.59	$ 209.59	41.26%	$ 82.52
				$ 507.98		**$ 200.00**

DAY 2

					Micro Apportioning	
Service Type	**Code**	**Units**	**FFS Rate**	**FFS Total Amount**	**Micro Apportioned**	**Payment by Services based on PPS (Micro)**
Psychiatric Service	H0036	8	$ 24.94	$ 199.52	100.00%	$ 200.00
SUD Service	none	0	$ -	$ -	0.00%	$ -
Clinic Service	none	0	$ -	$ -	0.00%	$ -
				$ 199.52		**$ 200.00**

DAY 3

					Micro Apportioning	
Service Type	**Code**	**Units**	**FFS Rate**	**FFS Total Amount**	**Micro Apportioned**	**Payment by Services based on PPS (Micro)**
Psychiatric Service	none	0	$ -	$ -	0.00%	$ -
SUD Services	H0004	2	$ 14.15	$ 28.30	15.90%	$ 31.81
	H2015	6	$ 24.94	$ 149.64	84.10%	$ 168.19
Clinic Service	none	0	$ -	$ -	0.00%	$ -
				$ 177.94		**$ 200.00**

Frequently Ask Questions

Q1. Will CCBHO's see all denials from Medicaid, Medicare, and MCO?

A1. Yes, DMH will pass through all denials received on the RA's.

Q2. If multiple services are sent as part of the visit and one service is denied by MHD, do CCBHOs have to send all services again or just the denied service?

A2. Only resend the denied service.

Q3. Some CPT codes are used both in FQHC Primary Care setting and the Behavioral Health setting. How will DMH know if this was a Primary Care or Behavioral Health service?

A3. This will be determined based on the rendering provider and diagnosis.

Q4. If Medicare pays the full PPS on a crossover client, will CCBHOs receive a remittance from Medicaid that states MHD paid $0.00?

A4. Yes!

Q5. What service category and DMH contract should be listed for clinic services in the 837 submitted to DMH?

A5. **CPSCCBHCCLINIC** CCBHOs should use their existing DMH contract and list it on the 837.

Q6. What service category should be listed for CCBHOs with no CSTAR contracts when SUD services are provided?

A6. **CPSCCBHCSUD**

Q7. What happens if my CCBHO does not successfully complete testing by the deadline?

A7. The CCBHO will hold billing pending successful completion of testing with DMH.

Q8. How will I know if apportioning changes due to either an unsolicited RA or a void/replacement from my CCBHO?

A8. An unsolicited RA or report will be sent back to the CCBHO from CVS.

Appendix A

CCBHC Project: Rendering Provider and Service Facility Location reporting clarification

1) DMH is changing how the legacy provider number on Shadow Claims for **ADA/CPS/TCM/ACT/SUD** services is determined in CVS. Instead of using the NPI reported under the Rendering Provider Loop, CVS will now use the reported Service Category, CIMOR Site Number, and Contract Number to determine the legacy provider number.

2) Providers who have NPIs that cover multiple clinic provider types (50/56) must report the legacy provider number (50 or 56 number) in the **REF*G2** segment under the **Service Facility Location** loops – at the claim level, and if applicable, at the service level (see yellow highlighted sections). For impacted providers, both REF*G2 and REF*LU segments are required under the Service Facility Loop.

Provider claims	**PPS Claim**	**Shadow Claim**	
Services	**T1040**	**ADA/CPS/TCM/ACT/SUD** services	**Clinic 50/56** services
Billing Level	Report: • 88 NPI • Taxonomy if provider has one		
Claim Level Rendering Provider **2310B loop**	Not required	Report: • Entity Type Qualifier set to 2 • Agency/Program name • NPI of 86/87/15 Agency/Program • Taxonomy for specialty	Report: • Entity Type Qualifier set to 1 • Staff person's name • NPI of staff person • Taxonomy for staff specialty
Claim Level Service Facility Location **2310C Loop**	Not required	Report: • Agency/Program name • CIMOR Site # (REF*LU segment)	Report: • Site name • NPI of Site • CIMOR Site # (REF*LU segment) • **50/56** Legacy # (**REF*G2** segment) – this is required for providers that have the same NPI # for multiple legacy #s.
Service Level Rendering Provider **2420A Loop**	Not required	Report Rendering Provider at the service level if different than what was reported at the claim level. Report: • Entity Type Qualifier set to 2 • Agency/Program name • NPI of 86/87/15 Agency/Program • Taxonomy for specialty	Report Rendering Provider at the service level if different than what was reported at the claim level. Report: • Entity Type Qualifier set to 1 • Staff person name • NPI of staff person • Taxonomy for staff specialty
Service Level Service Facility Location **2420C Loop**	Not required	Report Service Facility Location at the service level if different than what was reported at the claim level. Report: • Agency/Program name • CIMOR Site # (REF*LU segment)	Report Service Facility Location at the service level if different than what was reported at the claim level. Report: • Site name • NPI of Site • CIMOR Site # (REF*LU segment) • **50/56** Legacy # (**REF*G2** segment) – this is required for providers that have the same NPI # for multiple legacy #.