CCBHC Frequently Asked Questions

Payment

Q: Are MCO’s ready to accept these new and expanded codes? Or will there be a delay in billing/paying these?

A: As far as we know, all of the MCOs are ready to accept claims with Q2 modifiers as of 7/1/17. There is only one new code for CCBHCs – H0014 Withdrawal Management Level 2 – and MCOs will not cover that code. All billing for that code will be processed by the state’s MMIS fee-for-service system.

Q: Will authorization thresholds be bypassed for the new and expanded codes?

A: MMIS fee-for-service will bypass current authorization thresholds for H0032-Q2 Integrated Treatment Plan Development, and for 90791/90792-Q2 Initial and Comprehensive CCBHC Evaluation as long as the claim is submitted after July 17, 2017 for service dates on or after July 1, 2017. Most MCOs will do likewise, but check with your MCO regarding specific claims submission and authorization requirements.

Q: If an outside vendor provides a service that cannot be paid on the same day as another service that we provide a service, who will get paid? I.e. Children’s Individual Therapy and In-home Family Therapy provided on the same day.

A: CCBHC status does not affect this issue. CCBHCs will continue to be treated like all other providers.

Q: Can a CCBHC case manager bill for MH-TCM and Functional Assessment (H0031) in the same month?

A: No, the MH-TCM monthly rate already includes completion of a functional assessment.

Mental Health Services Policy

Q: Last year we were told in a Q and A document that Clinical Care Consultation (90899) could be billed for consultation between two agency staff serving completely different needs. (Not including clinical supervision of staff). Example: The psychiatry team consulting with a TCM could bill 90899, but the TCM could not bill for Clinical Care Consultation (90899). Can you please confirm if this is accurate?

A: After further research was completed about the current requirements of Clinical Care Consultation, it was clarified that it is not allowable to bill for consultation between two employees of the same organization.

Q: Electronic signature options for treatment plans for CTSS. Obtaining parent signatures after verbal approval continues to be frustrating and extremely time consuming. Could we please find a solution for this challenge?

A: Statute 256B.0943 already provides that the requirement for signature of the parent or legal guardian on the ITP or treatment plan review may be met either “by secure electronic signature or by documented oral approval that is later verified by written signature” [256B.0943, Subdivision
6(b)(2)(vi)]. “Secure electronic signature” means verification by secure electronic e-mail as well as an electronically captured signature in an electronic medical record. This already is more liberal than what is allowed in other mental health services, which require signature by the parent or legal guardian and make no provisions for alternative means of gaining consent. Verbal approval alone is not sufficient and using simple e-mail is not allowable under HIPAA as it is not a secure means of transmitting information.

Assessment

Q: Please confirm if the PHQ-9 and suicide risk screening measures are required or not for TCM encounters?

A: PHQ-9 and suicide risk screening measures are not required for TCM encounters.

Q: For CCBHC clients who are “assessment only”, do we use the initial evaluation/comprehensive evaluation forms or can the CCBHC use the old DA forms for those clients?

A: CCBHC clients who completed a preliminary screening and risk assessment should also have initial evaluation/comprehensive evaluations completed according to CCBHC standards. Diagnostic assessments according to current MN standards are allowable CCBHC encounters.

Q: For children receiving TCM in the CCBHC, how long is a comprehensive evaluation good for?

A: For all CCBHC clients, the comprehensive evaluation must be completed within 60 days of first contact and annually thereafter.

Q: For current clients receiving TCM, what are the timelines for the integrated treatment plan? Example: if the IFCSP is due to expire on 7/20/17, when would the integrated treatment plan need to be completed?

A: The CCBHC will complete the Integrated Treatment Plan in lieu of the individual community support plan (ICSP) and individual family community support plan (ICFSP). The CCBHC must collaboratively complete a person-centered or family-centered Integrated Treatment Plan within 90 days of delivering an eligible CCBHC service for existing recipients. The due date for the Integrated Treatment Plan is 90 days from delivery of the first, eligible CCBHC service and is not dependent upon existing IFSCP expiration date(s).

For new CCBHC recipients, the Integrated Treatment Plan is completed within 60 days of the delivery of an eligible CCBHC service.