Certified Community Behavioral Health Clinic (CCBHC)

Overview

CCBHC is an integrated community behavioral health model of care that can improve service quality and accessibility. CCBHCs do the following:

• Provide integrated, evidence-based, trauma informed, recovery-oriented and person-and family-centered care
• Offer the full array of CCBHC-required mental health, substance-use disorder (SUD) and primary care screening services
• Have established collaborative relationships with other providers and health care systems to ensure coordination of care

Eligible Providers

Participating CCBHCs are enrolled MHCP service providers for all CCBHC services and have been certified as meeting the required federal criteria (PDF) and state standards as Certified Community Behavioral Health Clinics.

Certified providers are:

• Northwestern Mental Health Center
• Northern Pines Mental Health Center
• People Incorporated
• Ramsey County Mental Health Center
• Wilder Mental Health and Wellness
• Zumbro Valley Health Center

Eligible Recipients

All Minnesota Health Care Programs (MHCP) members are eligible for CCBHC services. "New" CCBHC clients, meaning they have not been served by the clinic in the six months prior to the current service, must meet one of the following to become a CCBHC client:

- Receive a preliminary screening and risk assessment and one CCBHC service, or
- Receive a crisis assessment

CCBHC Covered Services

Covered CCBHC services include the following existing and expanded services.

Existing MHCP services billed according to current MHCP requirements:

- Adult crisis response services
- Adult day treatment
- Adult rehabilitative mental health services (ARMHS)
- Alcohol and drug abuse services
- Certified peer specialist services
- Children's mental health crisis response services
- Children's therapeutic services and supports (CTSS)
- Diagnostic assessment
- Dialectical behavior therapy (DBT)
- Mental health family peer specialist
- Mental health provider travel time
- Neuropsychological services
- Psychiatric consultation to primary care providers
- Psychological testing
- Psychotherapy
- Psychotherapy for crisis

Expanded MHCP services only for CCBHC providers:

- Preliminary screening and risk assessment
- Initial evaluation
- Comprehensive evaluation
- Comprehensive evaluation update
- Integrated treatment plan
- Clinical care consultation
- Family psychoeducation

- Mental health targeted case management for adults (AMH-TCM)
- Mental health targeted case management for children (MH-TCM)
- Functional assessment and level-of-care determination
- Certified peer recovery specialist
- Comprehensive substance use disorder assessment
- Outpatient withdrawal management – level 2
- Care coordination

See the CCBHC rate schedule (PDF) for the CCBHC expanded service reimbursement rates.

ASAM 6 Dimensions

Providers must write the initial evaluation, comprehensive evaluation and the integrated treatment plan in the format of these ASAM 6 Dimensions:

- Dimension 1: Acute intoxication or withdrawal potential
- Dimension 2: Biomedical conditions and complications
- Dimension 3: Emotional, behavioral and cognitive
- Dimension 4: Readiness for change
- Dimension 5: Relapse, continued use and continued problem potential
- Dimension 6: Recovery environment

Initial Evaluation

The initial evaluation must:

- Include the reason the CCBHC recipient is presenting for assistance, a preliminary diagnosis, referrals to services within the CCBHC (specifically: outpatient SUD services, ARMHS, TCM, CTSS, peer services and psychotherapy) and medical necessity for those services
- Be administered to any new CCBHC recipient age 5 and older
- Include a face-to-face interview with the CCBHC recipient and a written evaluation completed by a mental health professional or practitioner working under a licensed professional as a clinical trainee

A licensed alcohol and drug abuse counselor (LADC) may assess an individual's substance use disorder diagnosis and determination of medical necessity for SUD treatment. Include SUD assessment results within the initial evaluation.

Required components of the initial evaluation

• Date of birth
• Gender
• Ethnicity
• Race
• Insurance status and type
• Primary language
• Current living situation
• A determination of whether the person presently is or ever has been a member of the U.S. Armed Services
• Referral source
• Reason for seeking care, as stated by the CCBHC recipient or other individuals who are significantly involved
• A drug profile including the person's prescriptions, over-the-counter medications, herbal remedies and other treatments or substances that could affect drug therapy, as well as information on drug allergies
• Assessment of recipient risk to self or to others, including suicide risk factors and other immediate health and safety concerns
• Assessment of need for medical care with referral and follow-up as required
• Screening for co-occurring mental health and substance use disorders using a tool approved by the commissioner
• Brief narrative within each of the 6 dimensions of the ASAM criteria addressing:
• All reasons for seeking care
• Strengths, cultural influences, life situations, learning differences and legal issues
• The narrative for Dimension 3 must include a brief diagnostic discussion including symptoms, duration, preliminary diagnoses and how symptoms impact the person's functioning
• Identification of the person's immediate clinical care needs for mental and substance use disorders related to the diagnoses and impact on functioning including:
• Recommendations for identified mental health and substance use disorder services (specifically: SUD services, ARMHS, TCM, CTSS, peer services and psychotherapy)
• Determination of medical necessity for those services. For substance use disorder services, utilization of the Minnesota Matrix (DHS-5204B) (PDF) to provide scores on the 6 Dimensions and the diagnosis of a substance use disorder is required only for those for whom substance use is identified
• Documentation of next steps for service initiation that may include recipient-defined initial goals, short-term objectives and suggested interventions, including need for further assessment

It is allowable for CCBHC providers to gather required initial evaluation information from internal staff, existing documentation, and other providers that the CCBHC has obtained a release of information from, if the documentation is less than one year old.

Comprehensive Evaluation

The comprehensive evaluation includes a review and synthesis of existing information obtained from external sources, internal staff, preliminary screening and risk assessment, crisis assessment, initial evaluation or other service received at the CCBHC.

The comprehensive evaluation must meet these requirements:

• It must include a face-to-face interview with the MHCP member and written evaluation done by a mental health professional or practitioner working under a licensed professional as a clinical trainee
• A new comprehensive evaluation or update is completed in accordance with timeframes established for completion of a new or updated diagnostic assessment within existing service standards (for example, annually for children receiving CTSS, every three years for an adult receiving TCM services)
• For existing CCBHC recipients, the comprehensive evaluation must be completed when the current diagnostic assessment expires

Required components of the comprehensive evaluation
The comprehensive evaluation must include the following components:

• Updates to all required components of the initial evaluation
• A psychosocial evaluation including housing, vocational and educational status, family or caregiver and social support, pregnancy and parenting status, legal issues and insurance status (a functional assessment (FA) completed within the previous 60 days satisfies this requirement)
• It is allowable, but not required to complete the WHODAS
• For children age 5-18 years old, complete the Strengths and Difficulties Questionnaire (SDQ) if not already completed within an FA
• Behavioral health (including mental health, chemical health and physical health) history (including trauma history and previous therapeutic interventions and hospitalizations)
• Assessment of imminent risk (including suicide risk, danger to self or others, substance withdrawal, urgent or critical medical conditions, other immediate risks including threats from another person)
• Depression screening tool
• Basic competency or cognitive impairment screening (including the person's ability to understand and participate in his or her own care)
• Developmental incidents and history

• A description of attitudes and behaviors, including cultural and environmental factors, that may affect the person's treatment plan
• The recipient's strengths, goals and other factors to be considered in recovery planning
• Depending on whether the CCBHC directly provides primary care screening and monitoring of key health indicators and health risk, either: (a) an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the person's primary care provider (with appropriate referral and follow-up), or (b) a basic physical assessment
• Brief narrative within each of the 6 dimensions of the ASAM criteria addressing:
• All reasons for seeking care
• Progress since last evaluation
• Remaining barriers that will lead to formation of the treatment plan
• Strengths, cultural influences, life situations, learning differences and legal issues
• The narrative for ASAM dimension 3 must include a mental status exam and a brief diagnostic discussion including symptoms, duration, preliminary diagnoses and how symptoms impact the person's functioning
• The narrative for ASAM dimension 4 must identify the stage of change for all reasons the recipient sought care
• Establish medical necessity for services and level of care (LOC) needs for recommended services (approved LOC tools: LOCUS for adults, CASII for children and adolescents, and ECSII for children up to five years old)
• Assessment of need and medical necessity for behavioral health services beyond what is already provided including:
• • For substance use disorder services, utilization of the Minnesota Matrix (DHS-5204B) (PDF) to provide scores on the 6 Dimensions and the diagnosis of a substance use disorder
• Assessment of the social service needs of the consumer with necessary referrals made to social services and, for pediatric consumers, to child welfare agencies as appropriate

Comprehensive evaluation for children under 5 years old must utilize the DC:0-5R diagnostic system for young children which may consist of up to three separate billable encounters which include:

• An initial session as a family psychotherapy session without the client present and may include providing treatment to the parent(s) or guardian(s) along with inquiring about the child. Bill the initial session as a family psychotherapy session (90846). If possible, defer billing until completion of assessment with encounter date as date of service.
• Three separate sessions follow the initial session; one session must include face-to-face contact with the child.
• Bill the three completed assessment sessions as an extended comprehensive evaluation (90791 TG Q2).
• The functional assessment and level of care tools must be incorporated into the comprehensive evaluation for it to be considered complete.

• The functional assessment and level of care tool is separately billable (H0031) provided it meets standards outlined in the Functional Assessment 0-5 section of this manual page.
• The extended comprehensive assessment and functional assessment must be completed prior to recommending additional CCBHC services.
• In the event patient or family participation stops before all sessions are completed, CCBHCs may bill for the sessions completed.

It is allowable for CCBHC providers to gather information for each required assessment component from internal staff, existing documentation or other providers from whom the CCBHC has obtained a release of information and if the documentation is less than one year old.

Comprehensive Evaluation Update
The comprehensive evaluation update is completed only with adults over 18 years old. It includes a review and synthesis of existing information obtained from external sources, internal staff, preliminary screening and risk assessment, crisis assessment, initial evaluation, previous comprehensive evaluations or other services the person receives at the CCBHC.

The comprehensive evaluation update must meet these requirements:

• Include a face-to-face interview with the MHCP member and written evaluation by a mental health professional or practitioner working under a licensed professional as a clinical trainee
• Be completed according to timeframes established for completion of a new or updated diagnostic assessment within existing service standards
• Be completed with adults only (age 18 and over)

Assessment Components

The comprehensive evaluation must include the following components:

• Review of all required components of the comprehensive evaluation and written updates, as needed
• Brief narrative within each of the 6 dimensions of the ASAM criteria addressing:
• All reasons for seeking care
• Progress since last evaluation
• Remaining barriers that will lead to formation of the treatment plan
• Strengths, cultural influences, life situations, learning differences and legal issues
• The narrative for ASAM Dimension 3 must include a mental status exam and a brief diagnostic discussion including symptoms, duration, preliminary diagnoses and how symptoms impact the person’s functioning

• The narrative for ASAM Dimension 4 must identify the stage of change for all reasons the recipient sought care
• Establish medical necessity for services and level of care (LOC) needs for recommended services
• Assessment of need and medical necessity for behavioral health services beyond what is already provided including:
• For substance use disorder services, use of the Minnesota Matrix to provide scores on the 6 Dimensions and the diagnosis of a substance use disorder
• Assessment of the social service needs of the consumer with necessary referrals made to social services

Integrated Treatment Plan

The integrated treatment plan (ITP) is the result of a person and family-centered planning process in which the member, any family or member-defined natural supports, CCBHC service providers, external service providers as appropriate, and care coordination staff are engaged in creation of the integrated treatment plan. ITP development should include the member and all interested parties; however, at minimum, the ITP must be completed in a face-to-face interaction with the member. It must be reviewed and signed by a qualified mental health professional or by a mental health practitioner working as a clinical trainee.

CCBHCs must complete the ITP within 60 days of first contact for new recipients.

Integrated treatment plan components
The components must be in the format of the 6 dimensions of the ASAM Criteria and must contain the following core elements:

• Member-defined vision
• Identified problems or functional barriers
• Measurable goals toward obtaining the recipient-defined vision
• Measurable objectives toward reaching the goals
• Interventions
• Strengths and resources that inform the objectives
• Cultural considerations
• Timeline (frequency and duration)
• Signatures of the mental health professional and the person with dates
• For a child, the signature of a parent or guardian or other adult authorized by law to provide consent for treatment
• A client's parent or guardian may approve the integrated treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature

• In instances where oral approval is verified by a later written signature, the effective date is the date of oral approval, which is documented in the integrated treatment plan

The integrated treatment plan incorporates information gathered about and by the member, including the initial evaluation, comprehensive evaluation and any progress made in all utilized services and:

• Documentation of member involvement in plan development
• Documentation of parental or guardian consent for those under 18 years old or under legal guardianship

Integrated Treatment Plan Update
Providers must update the ITP at least every 90 days and anytime there is significant change in the member's situation, functioning, service methods or at the request of the member or the member's legal guardian. ITP updates require the member be present and include engagement of any member-defined natural supports, CCBHC service providers, external service providers, as appropriate, and care coordination staff.

The ITP update must incorporate the following components:

• A review of the previous comprehensive evaluation, progress notes and information gathered since the last comprehensive evaluation
• A review of the previous integrated treatment plan, progress notes and information gathered since the last integrated treatment plan
• Brief summary of progress made and barriers that remain
• Diagnostic updates based on any changes, as needed
• Review of continuing need for all current behavioral health services and need for any additional services
• Treatment plan updates including goal achievement and identification of new goals and objectives
• Status updates:
• Whether member received some peer service as of date of update
• Whether member received some telemedicine service as of date of update
• Type of health insurance
• Housing or residential status

Clinical Care Consultation

Clinical care consultation is a covered CCBHC service for adult MHCP members (21 years old and over). Refer to the MHCP Provider Manual for Children's Mental Health Clinical Care Consultation for a definition of the covered service.

For all ages, a CCBHC can provide clinical care consultation via email or within an electronic health record that is not a face-to-face service.

Family Psychoeducation

Family psychoeducation is a covered CCBHC service for adult MHCP members (21 years old and over). Refer to the MHCP Provider Manual for Family Psychoeducation for a definition of the covered service.

Mental Health Targeted Case Management for Adults and Mental Health Targeted Case Management for Children

Mental health targeted case management (MH-TCM) for adults and children is a covered CCBHC service for MHCP members. Refer to the MHCP Provider Manual Mental Health Targeted Case Management section for a definition of the covered service.

For CCBHC providers only, in addition to current state eligibility criteria, MH-TCM supports and services may be provided to both children and adults who do not meet the current criteria who are deemed at high risk of suicide by a mental health professional, particularly during times of transitions from acute care and residential settings. The mental health professional can establish medical necessity for MH-TCM utilizing an evidence-based tool to determine risk of suicide or determine risk based on clinical judgment.

Functional Assessment and Level of Care Determination

Functional assessment and the level-of-care determination is a covered CCBHC service for all CCBHC members regardless of services rendered. Administer functional assessment and level–of-care determination instruments according to established service and instrument schedules.

Children up to 6 years old

Bill the level–of-care determination portion of the diagnostic process for young children as an additional encounter separate from the multi-session comprehensive evaluation. To be separately reimbursable, the level-of-care determination must:

• Utilize the Early Childhood Service Intensity Instrument (ECSII)
• Utilize the Child Behavior Checklist (CBCL)
• Be scored and interpreted by a mental health professional or practitioner working as a clinical trainee

Children 6 through 17 years old

Bill the level–of-care determination portion of the diagnostic process for children 6 through 17 years old as an additional encounter separate from the comprehensive evaluation. To be separately reimbursable, the level-of-care determination must:

• Utilize the Child and Adolescent Service Intensity Instrument (CASII)
• Utilize the Strengths and Difficulties Questionnaire (SDQ)
• Be completed, scored and interpreted by a mental health professional or practitioner working as a clinical trainee. Practitioner level staff may assist in the collection of information, but a mental health professional must perform the scoring and interpretation

Adults 18 years old and older

Bill for the functional assessment and level-of-care determination completed for any member age 18 years and older receiving CCBHC services. To be reimbursable as an encounter separate from other assessments, the functional assessment must:

• Include one of the following functional instruments:
• A narrative for each domain as described in the MHCP Provider Manual for Functional Assessments
• A DLA-20 and a functional summary. The functional summary is a personalized narrative that provides qualitative context to the quantitative information obtained from the DLA-20. The narrative describes how symptoms of mental illness impair functioning, informs the comprehensive evaluation and provides initial direction for the integrated treatment plan
• Be completed by a mental health practitioner, a mental health professional or practitioner working under a licensed professional as a clinical trainee

For those service lines that require the following, they are allowable in combination with the FA requirements:

• Level-of-Care Utilization System (LOCUS) assessment and a LOCUS Recording Form (DHS-6249)

• Interpretive Summary

Providers cannot bill FA and LOCUS assessments completed as part of targeted case management services as an independent encounter.

Certified Peer Services

Mental health certified peer specialist services are covered CCBHC services for adult MHCP members (18 years old and older) if determined medically necessary by a qualified mental health professional. CCBHC certified peer specialist services are subject to the same standards outlined in the Certified Peer Specialist Services section of the MHCP Provider Manual with the exception of limiting services to rehabilitation and crisis service recipients.

Mental health certified family peer specialist services are allowable within a CCBHC if determined medically necessary by a qualified mental health professional. CCBHC mental health certified family peer specialist services are subject to the same standards outlined in the Mental Health Certified Family Peer Specialist section of the MHCP Provider Manual.

Certified peer recovery specialist services are covered CCBHC services if determined medically necessary by a licensed professional. Certified peer recovery specialists who provide services must meet these guidelines:

• Have a minimum of one year in recovery from substance use disorder
• Hold a current credential from a certification body approved by the commissioner that demonstrates skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support
• Receive ongoing supervision in areas specific to the domains of the recovery peer's role by an alcohol and drug counselor or an individual with a certification approved by the commissioner

Certified peer recovery specialist services include:
• Education
• Advocacy
• Mentoring through self-disclosure of personal recovery experiences
• Attending recovery and other support groups with a client
• Accompanying the client to appointments that support recovery
• Assistance accessing resources to obtain housing, employment, education and advocacy services
• Nonclinical recovery support to assist the transition from treatment into the recovery community

Comprehensive Substance Use Disorder (SUD) Assessment

An alcohol and drug counselor must coordinate a comprehensive assessment of the client's substance use disorder within three sessions of outpatient SUD services. The counselor may rely on current information provided by a referring agency or other sources as a supplement when information is available. Information gathered more than 45 days before the date of admission is not current. The assessment must include sufficient information to complete the assessment summary. The comprehensive assessment must include information about the client's problems that relate to chemical use and personal strengths that support recovery, including:

• Age, sex, cultural background, sexual orientation, living situation, economic status and level of education
• Circumstances of service initiation
• Previous attempts at treatment for chemical use or dependency, compulsive gambling or mental illness
• Chemical use history including amounts and types of chemicals used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each chemical used within the previous 30 days, the information must include the date and time of the most recent use and any previous experience with withdrawal
• Specific problem behaviors exhibited by the client when under the influence of chemicals
• Current family status, family history, including history or presence of physical or sexual abuse, level of family support, and chemical use, abuse or dependency among family members and significant others
• Physical concerns or diagnoses, the severity of the concerns and whether the concerns are being addressed by a health care professional
• Mental health history and current psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability
• Arrests and legal interventions related to chemical use
• Ability to function appropriately in work and educational settings
• Ability to understand written treatment materials, including rules and client rights
• Risk-taking behavior, including behavior that puts the client at risk of exposure to blood borne or sexually transmitted diseases
• Social network in relation to expected support for recovery and leisure time activities that have been associated with chemical use
• Whether the client is pregnant and if so, the health of the unborn child and current involvement in prenatal care
• Whether the client recognizes problems related to substance use and is willing to follow treatment recommendations

An alcohol and drug counselor must prepare an assessment summary. The narrative summary of the comprehensive assessment results must meet the following requirements:

• A risk description according to Minnesota Rule, part 9530.6622, for the ASAM 6 dimensions
• Narrative supporting the risk descriptions
• A determination of whether the client meets the DSM criteria for a person with a substance use disorder
• Contain information relevant to treatment planning and recorded in the ASAM 6 dimensions

Outpatient (Ambulatory) Withdrawal Management

Outpatient Withdrawal Management (level 2-WM) is a time-limited service delivered in an office setting, an outpatient behavioral health clinic, or in a person's home by staff who provide medically supervised evaluation and detoxification services to achieve safe and comfortable withdrawal from substances and to facilitate the person's transition into ongoing treatment and recovery. It also includes trained observation of withdrawal symptoms and supportive services to encourage the person's recovery.

MHCP members experiencing acute intoxication or mild to moderate or persistent withdrawal symptoms who do not need residential or inpatient withdrawal management are eligible for outpatient withdrawal management.

Members of an interdisciplinary care team provide outpatient withdrawal management services. Members operate based on their own scope of practice and competency area to observe and monitor symptoms; provide assessment, planning, and supportive services; and bill according to their discipline, as follows:

• Withdrawal management assessment, withdrawal management plan and monitoring of symptoms:
• Psychiatrists
• Physicians
• Clinical nurse specialist-mental health (CNS-MH)
• Advanced practice registered nurse (APRN)
• Physician assistants (PA)
• Nurse practitioner (NP)
• Pharmacists
• Registered nurses (RN)
• Licensed practical nurses (LPN)

• Trained medication aides
• Medical assistants
• Community health workers
• Medication reconciliation and medication education services:
• Pharmacists
• Registered nurses (RN)
• Licensed practical nurses (LPN)
• Observation of symptoms, obtaining vitals and performing validated standardized withdrawal tools, with proper training and according to their scope of practice, and supportive services:
• Mental health professionals
• Licensed alcohol and drug counselors
• Mental health practitioners
• Alcohol and drug counselors
• Mental health rehabilitation workers
• Certified peer specialists
• Certified recovery peers
• Care coordinators
• SUD treatment coordinators
• Physicians, pharmacists and other providers who are eligible to bill for services ancillary to outpatient withdrawal management may bill H0014 or bill the following codes, but not both:
• Billed through an Evaluation and Management code:
• Medical examination
• Medication prescribing according to established medical protocols
• Medication management
• Billed through a Medication Therapy Management Services (MTMS) code: medication reconciliation provided by a pharmacist

Billable Outpatient Withdrawal Management Services

The following services are billable as Outpatient (Ambulatory) Withdrawal Management – level 2:

• A withdrawal management assessment including:
• Information incorporated from previous evaluations, such as:
• History of withdrawal and detoxification
• Substance use and medication history
• Potential medical and psychiatric complications
• Assessment of behavioral and physical symptoms of withdrawal
• Clinical Institute Withdrawal Assessment (CIWA), Clinical Opiate Withdrawal Scale (COWS), Fagerstrom (Tobacco withdrawal) or other validated standardized withdrawal tool that indicates a need for withdrawal management services

• Medication reconciliation
• A withdrawal management plan including:
• A withdrawal management monitoring schedule
• A safety plan that addresses the following, at a minimum:
• Patient health
• Emergency procedures or contacts
• Safe transportation for those requiring immediate care
• Procedure for overdose
• Linkages with residential withdrawal management services or emergency rooms
• Supportive services or engagement strategies to support ongoing recovery
• Support services including:
• Medication education
• Substance use and misuse education
• Counseling
• Coaching and skill development
• Family and significant other involvement
• Coordination of care with and referrals to other treatment services
• Monitoring of ongoing symptoms of withdrawal
• Observation of withdrawal symptoms by non-medical staff
• Obtaining vitals and performing validated standardized withdrawal tools appropriate for the person's needs, such as Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS), by medical staff or trained non-medical staff
• Reporting results of observations, vitals and assessment tools to medical staff
• Decision-making by medical staff

Noncovered Services for 2-WM

• Lab work, urine screens
• CCBHC staff, while providing other services, could observe withdrawal symptoms

Additional Services Required

Participating CCBHCs must provide additional services to receive the supplemental wrap payment. These services are not directly reimbursable through MHCP fee-for-service (FFS) billing, but are required and factored into the wrap payment.

Preliminary Screening and Risk Assessment
CCBHC providers must complete a preliminary screening and risk assessment for all new CCBHC recipients:

• New recipients have not received a service at a CCBHC within the last six months

• Preliminary screening and risk assessments are required of CCBHC providers but not a billable service
• Preliminary screening and risk assessment determine acuity of recipient need:
• If crisis need, referred to crisis or detox services
• If urgent need, an initial evaluation is scheduled within one business day of the preliminary screening and risk assessment followed by a comprehensive evaluation within 60 days of the preliminary screening and risk assessment
• If routine need, an initial evaluation is scheduled within 10 days of the preliminary screening and risk assessment followed by a comprehensive evaluation within 60 days of the preliminary screening and risk assessment

Care Coordination
CCBHC providers must provide required care coordination tasks (PDF), which include:

• Developing a person or family-centered plan of care
• Assisting with obtaining appointments and confirming the appointments were kept
• Creating a crisis plan
• Tracking recipient's medications
• Establishing a health IT system that contains the required elements in the CCBHC criteria (PDF)
• Implementing care coordination agreements according to required standards in the CCBHC criteria (PDF)

Authorization Requirements

For SUD services:

No authorization is required in or out of network.

For mental health services, CCBHCs:

Authorization is required for certain services out of network.

Billing Expanded CCBHC Services

Follow the billing guidelines in the following tables.

General Billing Guidelines

• CCBHC billing is subject to the same standards outlined in the IMCare Billing Policy manual page.

• Bill all mental health CCBHC services as a professional claim in the 837P electronic claim format. • Bill outpatient chemical dependency service claims as an institutional (837I electronic format) or a professional claim (837P electronic claim format). • Submit any non-CCBHC services delivered by CCBHC providers separately from CCBHC service claims.

Code	Modifier	Description	Unit
90791	Q2 52	Initial evaluation	1 session
90791	Q2 52 HN	Initial evaluation completed by a clinical trainee	1 session
90792	Q2 52	Initial evaluation with medical services	1 session

Comprehensive Evaluation

Code	Modifier	Description	Unit
90791	Q2	Comprehensive evaluation	1 session
90792	Q2	Comprehensive evaluation completed with medical services	1 session
90791	Q2 HN	Comprehensive evaluation completed by a clinical trainee	1 session
90791	Q2 TG	Extended comprehensive evaluation	1 session
90791	Q2 TG HN	Extended comprehensive evaluation completed by a clinical trainee	1 session
90792	Q2 TG	Extended comprehensive evaluation with medical services	1 session
90791	Q2 TS	Comprehensive evaluation update	1 session
90792	Q2 TS	Comprehensive evaluation update completed with medical services	1 session
90791	Q2 TS HN	Comprehensive evaluation update completed by a clinical trainee	1 session
• Utilize the DC:0-5R diagnostic system for assessment of children up to 5 years old and bill as an extended comprehensive evaluation. • When billing an extended comprehensive evaluation, follow current guidance for extended diagnostic assessment.			

Integrated Treatment Plan

Code	Mod	Brief Description	Units
H0032	Q2	Service plan development by non-physician	Per session
H0032	Q2 TS	Service plan development by non-physician update	Per session

CCBHC cannot bill for service plan development using (H0032) for an individual or family community support plan (ICSP or ICFSP) completed by a CCBHC targeted case manager. This does not preclude billing for an integrated treatment plan (service plan development or service plan update) by qualified CCBHC staff. This assumes that qualified staff are not duplicating the targeted case manager's work but coordinating with the targeted case manager and approaching development of the integrated treatment plan from an integrated perspective, incorporating other service lines and care coordination.

Clinical Care Consultation for Recipients 21 Years Old or Older

Procedure Code	Modifier	Brief Description	Unit
90899	Q2 U8	Clinical care consultation, face-to-face	5 to 10 minutes
90899	Q2 U9	Clinical care consultation, face-to-face	11 to 20 minutes
90899	Q2 UB	Clinical care consultation, face-to-face	21 to 30 minutes
90899	Q2 UC	Clinical care consultation, face-to-face	31 minutes and above

• Submit one claim line per day for each service. (Add up all the minutes of service provided for face-to-face or non-face-to-face services for each client for that day and submit a single claim regardless of the number of consultations.) Use modifier U4 for non-face-to-face service.
• For members under 21 years of age, use the billing codes outlined in the MHCP Provider Manual page for **Children's MH Clinical Care Consultation**.

Family Psychoeducation Benefits for Adults 21 Years Old and Older

Proc Code	Modifier	Brief Description	Unit

H2027	Q2	Family psychoeducation individual (with a single recipient)	15 minutes
	Q2 HQ	Family psychoeducation recipient group (with multiple recipients)	
	Q2 HR	Family psychoeducation recipient and family (with a single recipient and his or her family)	
	Q2 HS	Family psychoeducation family (with a single-family individual not present)	
	Q2 HQ HR	Family psychoeducation family group (with multiple families with individuals present)	
	Q2 HQ HS	Family psychoeducation family group (with multiple family's individuals not present)	

• Submit claims only for the member who is the primary subject of the family psychoeducation sessions, regardless of the number of other family or group members in the session.
• When more than one family member is an MHCP member (such as two or three siblings, each receiving treatment within a specific timeframe), bill only for the time spent conducting family psychoeducation with each member.
• When two professionals render group family psychoeducation, submit only one claim for each member. Professionals must determine which member they will bill for or one professional may claim for all members and reimburse the other professional.
• Enter the treating provider NPI number on each claim line.
• Use HN modifier for services performed by a clinical trainee.
• For members under 21 years of age, use the billing codes outlined in the Family Psychoeducation for Children and Youth section of the MHCP Provider Manual.

Functional Assessment

Code	Mod	Brief Description	Units
H0031		Mental health assessment, by non-physician	Per session
H0031	TS	Mental health assessment, by non-physician, follow-up service (review or update)	Per session
H0031	UA	Administering and reporting standardized measures	Per session

• CCBHC cannot bill for functional assessment (H0031) completed by the CCBHC's targeted case manager.

CCBHC Peer Specialist Services

Code	Mod	Brief Description	Units
H0038		MH peer services by level I certified peer specialist	15 minutes
	U5	MH peer services by level II certified peer specialist	
	HQ	MH peer services in a group setting	
H0038	Q2	Certified peer recovery specialist	15 minutes
H0038	HA	Certified family peer specialist services	15 minutes
H0038	HA HQ	Certified family peer specialist services in a group setting	

Comprehensive Substance Use Disorder Assessment

Code	Mod	Brief Description	Units
H0001		Comprehensive substance use disorder assessment	Per session
• If billing as an institutional claim, use revenue codes: 0944 (Drug), 0945 (Alcohol) or 0953 (Drug and Alcohol).			
Code	**Mod**	**Brief Description**	**Units**
H0014		Outpatient Withdrawal Management - Level 2	Per Diem
• Outpatient withdrawal management claims, whether the person has MA fee-for-service or is enrolled in an MCO, should be submitted and processed through the State of MN MA FFS process. Do not submit H0014 claims to MCOs.			

Additional CCBHC Billing and Payment Provisions

CCBHCs are eligible to receive up to four kinds of MA payment for CCBHC services:

• As enrolled providers of statewide covered services, such as outpatient MH and SUD services, MH-TCM, ARMHS, CTSS and other services, CCBHCs receive payment at the same

rates and within the same claims processing methodology and restrictions as other similarly enrolled providers. If the member is in managed care, the managed care organization (MCO) continues to pay these claims.
• CCBHCs can receive payment for new and expanded services described previously (see notes on Scope of Services table and MHCP Provider Manual sections pertaining to each of these services). If the member is in managed care, these claims are paid by the MCO, with the exception of H0014. Withdrawal Management Level 2, which is paid through FFS for all MA members. See CCBHC rate schedule (PDF).
• Based on the claims paid in the first two methods in this section, including managed care, IMCare makes a monthly supplemental wrap payment.
• CCBHCs are eligible to receive quality bonus payments averaging up to 5 percent of the other payments previously described. DHS (not the MCO) will make quality bonus payments based on each CCBHC's performance on outcome measures.

Supplemental Wrap Payments
CCBHCs receive a cost-based prospective payment system (PPS) rate for each clinic. The rate is based on a cost report from each clinic, using federal cost reporting rules. The cost report includes anticipated changes in costs, which are necessary costs to comply with CCBHC criteria. The report also includes historical and projected numbers of qualifying encounters or visits. DHS and a contracted accounting firm have reviewed all cost reports and determined rates for each CCBHC. Total approved costs for a year divided by total anticipated encounters arrive at a PPS rate per encounter. The rate represents an average cost per encounter for all clients receiving CCBHC services from a particular CCBHC. The rate includes the cost of providing services listed in the Scope of Services table (PDF).

A qualifying encounter is the first billable unit for a CCBHC service on a given service date, for dates of service on or after July 1, 2017. Billable unit is defined by billing policies that apply to each procedure code. Since MH-TCM is currently paid in monthly units, only one service date per month counts as a qualifying CCBHC encounter. Likewise, other services (such as extended diagnostic assessments) that may involve more than one day of actual service, but only one billing unit, are counted as one encounter for purposes of the wrap payment. Staff travel (H0046) is included only if it is required to provide a CCBHC service.

CCBHCs do not submit a separate claim for the wrap payment. DHS and a contractor calculate the monthly wrap payment by analyzing all claims processed for a CCBHC during the preceding month for CCBHC procedure codes. DHS determines the wrap payment by the following formula:

• The full PPS rate is assigned to each qualifying encounter (that is, one service date per client)

• The PPS rate is offset by all payments for all CCBHC services on that date of service for that client, including MMIS-FFS, MCO payments, Medicare, spenddown, family deductibles, third party liability, etc.
• The difference between the PPS rate and the payments is the wrap payment per person per date of service
• The amounts in the third bullet may be positive or negative. All of these amounts are added together for each CCBHC for a given month. Since the PPS rates are, on average, about double the current payment levels, we expect the total wrap payment per CCBHC will always be positive
• Wrap payment amounts will be continually adjusted back to July 1, 2017 for services provided between July 1, 2017 and June 30, 2019 and back to July 1, 2019 for services provided after July 1, 2019, if previously processed claims are replaced or changed in any way that affects the wrap calculation.

Legal References

Minnesota Rule 245.735, Excellence in Mental Health Demonstration Project
Public Law 113-93