

ALABAMA DEPARTMENT OF MENTAL HEALTH

Certified Community Behavioral Health Clinic (CCBHC) Contract Billing Manual

Effective November 17, 2025

Disclaimer: *The Certified Community Behavioral Health Clinic (CCBHC) Contract Billing Manual serves as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, or item is covered is not a determination that a provider will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis.*

Providers should utilize appropriate billing and submission guidelines, including industry standard, compliant codes on all claim submissions. Services should be billed with appropriate Current Procedural Terminology (CPT®) codes and Healthcare Common Procedure Coding System (HCPCS) codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the patient's medical record.

The billing manual may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in revisions to the billing manual. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the billing manual. In addition, we reserve the right to review and revise the billing manual when necessary. When there is an update, we will publish the most current billing manual to our website.

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Introduction and Purpose

This document is the Contract Billing Manual and is intended to define billable services, eligible staff (where appropriate), reporting codes and processes, restrictions (if any), and any other condition of billing a service under the Alabama CCBHC Demonstration. Although every effort is made to keep this Manual up to date, the information provided is subject to change.

The purpose of this manual is to:

- **Provide Standardized Guidance:** Establishing clear service delivery and billing protocols for Alabama CCBHCs that align with state and federal policies. This includes specific credentialing, coding, billing, and documentation requirements for services rendered.
- **Ensure Accurate Reimbursement:** Outline processes for obtaining reimbursement for covered services, promoting financial sustainability, and enabling the continuous delivery of high-quality care to Alabama communities.
- **Support Compliance with Regulations:** Ensure that Alabama CCBHCs meet state and federal regulatory requirements for billing and documentation. Compliance with these standards helps prevent fraud, waste, and abuse.

This Certified Community Behavioral Health (CCBHC) Contract Billing Manual is intended to support CCBHC billing in Alabama as a companion to the following:

- [Alabama Comprehensive Provider Manual for Certified Community Behavioral Health Clinics \(CCBHCs\)](#)
- Alabama's CCBHC Certification Process, which provides a comprehensive description of the programmatic and operational requirements of the CCBHC model. For more information, please see: <https://mh.alabama.gov/certified-community-behavioral-health-clinics/for-prospective-ccbhc/>
- The SAMHSA [Certified Community Behavioral Health Clinic \(CCBHC\) Certification Criteria](#), established set of uniform standards providers must meet to be a CCBHC.
- Alabama Licensing and Certification Requirements, including (but not limited to) Chapters 105, 106, and 112, as well as all relevant Alabama Administrative Code requirements.
- HIPAA, 42 CFR Part 2, and other applicable state or federal laws.

Questions or comments pertaining to the CCBHC Contract Billing Manual may be directed to ccbhc.dmh@mh.alabama.gov.

Version History

Version #	Date Published	Summary of Revisions
1	11/17/2025	Publication of the Alabama Certified Community Behavioral Health Clinic (CCBHC) Contract Billing Manual

PPS-1 Methodology for CCBHC Billing and Payment

CCBHCs in the Alabama Medicaid CCBHC Demonstration are paid using a Prospective Payment System (PPS)-1 daily rate.

Under the PPS-1 methodology, CCBHCs receive a single payment each day when at least one CCBHC triggering event service is provided to a Medicaid enrollee. A Triggering Event is an allowable service under the CCBHC program that when provided, will trigger the daily PPS-1 payment. For more details about Triggering Events, see below, as well as the “Triggering Events” spreadsheet linked here: <https://mh.alabama.gov/certified-community-behavioral-health-clinics/for-current-ccbhc/>.

For more on the CCBHC PPS structure, see: <https://www.medicaid.gov/medicaid/financial-management/downloads/updated-ccbhc-pps-guidance-02152024.pdf>

CCBHC Cost Reporting

Each clinic’s PPS rate is established via a clinic-specific Cost Report. Alabama uses the CMS CCBHC Cost Report (see the following link for Cost Report instructions: <https://www.medicaid.gov/media/173121>), which is approved by Alabama Medicaid and ADMH). The Cost Report includes the total cost of operating the CCBHC (triggering events plus allowable activities) along with the number of daily CCBHC visits (the number of days when a triggering event service was provided). Both costs and visits should be inclusive of those related to Medicaid and non-Medicaid enrollees. Together, these data inputs result in a clinic-specific PPS (daily) rate.

CCBHCs completing their Cost Reports for Demonstration Year 1 (to attain their first year’s PPS rate) should include both historical costs, as well as anticipated costs. Anticipated costs are expenses that are anticipated for the rate year, including personnel costs, facility costs, technology costs, supplies and materials costs, training and development costs not included in actual costs in the reporting period. Anticipated costs are allowed for demonstration year 1 only. CCBHC Cost Reports for demonstration year 2 (and beyond) must include only actual cost/visit data.

Billing Requirements

To be eligible for payment, CCBHCs must be certified by ADMH as an Alabama CCBHC Demonstration provider. CCBHCs must also have an approved provider agreement on file with ADMH. Through this agreement, the CCBHC assures that requirements are met and assures compliance with all applicable federal and State Medicaid law, including, but not limited to, state administrative rules, the Code of Federal regulations, and the State Medicaid Plan. These agreements are renewed annually with each provider.

If the CCBHC uses a Designated Collaborating Organization (DCO), payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. The lead CCBHC is responsible for billing Alabama Medicaid for all CCBHC services provided to Medicaid enrollees, including those provided by a DCO. The contractual agreement with a DCO must include, amongst other things:

- The DCO must adhere to the standards outlined within the SAMHSA CCBHC Certification Criteria,
- The DCO must align with the same service delivery requirements and expectations of the CCBHC,
- Payment mechanisms between the CCBHC and DCO (including how the DCO will report services delivered to the CCBHC and how the CCBHC will pay the DCO for these services for a

fair market rate). *This requirement does not apply if the DCO relationship is with state-sanctioned crisis providers,*

- Quality of care and data reporting mechanisms, and
- Outlined responsibilities for participation in the interdisciplinary team, which includes collaboration in treatment planning and treatment team meetings.

CCBHC Specific National Provider Identifier (NPI)

Participating CCBHC providers will be responsible for obtaining a unique, CCBHC-specific NPI upon certification, using the appropriate taxonomy. The taxonomy code is chosen by the provider when applying for an NPI. This 10-digit code describes the kind of specialty provider type the agency is. Providers should enroll as a Medicaid provider using that NPI. The NPI will represent the billing provider. The website to obtain your NPI: <https://nppes.cms.hhs.gov>

Medicaid ID

Participating CCBHC providers are required to obtain a Medicaid ID number for each CCBHC site, regardless of the site type (Full, Satellite, or Access). Following the issuance of the provider's CCBHC NPI, ADMH will provide the CCBHC Enrollment Application necessary to apply for their Medicaid ID.

Service Settings

ADMH and Alabama Medicaid are committed to supporting CCBHCs to deliver services outside of their clinic sites' four walls in locations that are convenient and accessible to individuals being served. This includes (in some instances) residential programs and/or congregate living facilities, at which the provision of CCBHC services would expand (and not duplicate) services already available through the residential/congregate program.

Settings Where CCBHC Services Cannot Be Provided

There are service settings where CCBHC services are not allowed to be billed. In each of these instances, services to meet the person's holistic needs are fully funded through the service setting where they are residing at that time. In other words, while an individual is residing in one of the service settings below, they cannot also receive services billed under the CCBHC Demonstration program:

- MI Crisis Residential Units (10 and 16 bed facilities)
- MI Forensic Crisis Residential Units
- Child and Adolescent (C&A) Residential Intensive
- Crisis Center (Extended Observation Beds)
- Inpatient Psychiatric Hospital
- Facilities that qualify as an Institution for Mental Diseases (IMD) – those that have more than 16 beds and that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services
- Carceral settings, including jails, detention centers, and prisons*

While CCBHCs cannot bill for CCBHC services while individuals are residing in the above service settings, it is critical that CCBHCs establish care coordination agreements with the above providers in their catchment area to support transition planning prior to discharge to ensure timely continuity of care.

**Based on CMS guidance,¹ CCBHCs cannot include the costs of, and visits associated with providing services to individuals in correctional settings as part of their CCBHC Cost Report. However, CCBHCs can and should use other funding sources (e.g., state and federal funding within the organization’s ADMH contract) to participate in collaborative transition planning that arranges expedient delivery of CCBHC services upon release from a correctional setting.*

Settings where Non-duplicative CCBHC Services Can Be Provided

In addition, there are a number of congregate care/residential service settings where CCBHCs are allowed to provide services to individuals residing in these settings, in order to support whole-person care. In some instances, there are limitations related to certain CCBHC services that would be duplicative of what is already offered by the congregate care/residential setting. These services are considered duplicative because similar services in the residential setting are being appropriately reimbursed through alternative payment sources. In these instances, CCBHCs are able to provide non-duplicative services to individuals residing in these settings (those that are not indicated in the table below as being restricted). Further, with the person receiving service consent, CCBHCs should coordinate with the congregate care/residential provider as part of the person’s Interdisciplinary Team.

Medicaid does not pay for services when an individual is residing in an Institution for Mental Disease (IMD). An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is “primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”² In some cases, the below service settings might qualify as an IMD, depending on how many beds they have (e.g., the ASAM Level 3 Facilities, Nursing Homes). With that in mind, CCBHCs should assess each service setting to determine whether or not it qualifies as an IMD, before delivering any services at that setting. If guidance on this is needed, please reach out to ADMH at ccbhc.dmh@mh.alabama.gov.

The following table outlines the list of settings where CCBHCs can deliver non-duplicative services. In addition to the services listed in this table, CCBHCs should work with each congregate care/residential provider to understand the services that they offer onsite (as some providers offer services above and beyond the basic contract expectations for the service setting). If a CCBHC is serving an individual living in one of the above settings, CCBHCs are responsible for:

- (1) assuring no duplication in services being offered by the CCBHC; and
- (2) (with the person receiving services consent) attempting to engage the congregate care/residential staff (as appropriate) in Interdisciplinary Team processes (i.e., meetings, information sharing, care coordination, etc.).

¹ [Reentry Services for Incarcerated Individuals | Medicaid](#)

² <https://www.congress.gov/crs-product/IF10222>

Congregate Care/Residential Setting	CCBHC Services that Cannot Be Provided to Individuals in this Setting <i>(due to duplication in what is already funded/provided by the Congregate/Residential Program)</i>	Other Considerations
Supportive Housing for People with Disabilities (Section 811)	- Targeted Case Management - Psychosocial Rehabilitation (e.g., Supported Employment, Basic Living Skills, Supports for Activities of Daily Living)	Engagement in services is not a requirement of living in this type of residence, so if an individual declines TCM and PSR at their Section 811 residence, they can receive these services from the CCBHC.
MI EBP Supportive Housing	- Targeted Case Management	
MI Foster Homes	- Basic Living Skills	Verify additionally approved services listed on ADMH approved Program Description to avoid duplication of services.
MI Meals Observation Medications (MOMs) - 20 bed/30 bed/Other	- Individual and group therapy (MI) - Family therapy - Medication administration and monitoring - Nursing Assessments and Other Nursing Services - Basic Living Skills - Mental Health Care Coordination/Case Consultation - Crisis intervention	Verify additionally approved services listed on ADMH approved Program Description to avoid duplication of services.
MI Basic Group Home – 3 bed/10 bed/16 bed	- Basic Living Skills	Verify additionally approved services listed on ADMH approved Program Description to avoid duplication of services.
MI Behavioral Group Home – 10 bed/16 bed	- Basic Living Skills	Verify additionally approved services listed on ADMH approved Program Description to avoid duplication of services.
MI Forensic Group Home – 16 beds	- Basic Living Skills	Verify additionally approved services listed on ADMH approved Program Description to avoid duplication of services.
MI Medical Group Home – 10 bed/16 bed	- Basic Living Skills - Medication administration and monitoring - Nursing Assessments and Other Nursing Services	Verify additionally approved services listed on ADMH approved Program Description to avoid duplication of services.
MI Deaf Specialty Group	- Basic Living Skills	Verify additionally approved services listed on

Congregate Care/Residential Setting	CCBHC Services that Cannot Be Provided to Individuals in this Setting <i>(due to duplication in what is already funded/provided by the Congregate/Residential Program)</i>	Other Considerations
Home	- N/A – individuals living in these residential settings can receive all non-duplicative CCBHC services; however, CCBHCs must engage with these residential providers to monitor what they are providing at the residential setting to assure no duplicative services are provided	ADMH approved Program Description to avoid duplication of services.
Child and Adolescent Residential - Moderate/Basic	- N/A – individuals living in these residential settings can receive all non-duplicative CCBHC services; however, CCBHCs must engage with these residential providers to monitor what they are providing at the residential setting to assure no duplicative services are provided	
SUD Level 3.01	- Individual and group therapy (SUD) - Psychoeducation - Certified Recovery Support Specialist - Targeted Case Management	Engagement in Case Management services is optional for individuals being served by Level 3.01 facilities, so if an individual declines CM at their residential program, they can receive this service from the CCBHC. Note: This level of care will be discontinued in 2027
SUD ASAM Level 3.1 Facilities	- Individual and group therapy (SUD) - Psychoeducation - Certified Recovery Support Specialist - Targeted Case Management	Because an individual may be in a phase of treatment where they are reintegrating into the community, the CCBHC may consider delivering MH services in the outpatient setting (or a hybrid model) with close coordination with the Level 3.1 provider.
SUD ASAM Level 3.3 Facilities	- Individual and group therapy (SUD) - Psychoeducation - Certified Recovery Support Specialist - Targeted Case Management	Because an individual's SUD is in an acute phase, services will likely be provided to the person in the residential treatment setting. Because individuals at a 3.3 level of care often have specific cognitive needs, this should be incorporated into the treatment plan.
SUD ASAM Level 3.5 Facilities General-Special Populations – Women/Adolescents	- Individual and group therapy (SUD) - Psychoeducation - Certified Recovery Support Specialist - Targeted Case Management	Because an individual's SUD is in an acute phase, services will likely be provided to the person in the residential treatment setting.

Congregate Care/Residential Setting	CCBHC Services that Cannot Be Provided to Individuals in this Setting <i>(due to duplication in what is already funded/provided by the Congregate/Residential Program)</i>	Other Considerations
SUD ASAM Level 3.7 Facilities - Adults/Adolescents	- Individual and group therapy (SUD) - Psychoeducation - Certified Recovery Support Specialist - Targeted Case Management	Because an individual's SUD (and potentially medical/psychiatric co morbidities) is in an acute phase, services will likely be provided to the person in the residential treatment provider.
SUD ASAM Level 3.7 Withdrawal Management Facilities –Adults/Adolescents	- SUD Medication Administration and Monitoring - Targeted Case Management - Certified Recovery Support Specialist	Because an individual's SUD (and potentially medical/psychiatric co morbidities) is in an acute phase, services will likely be provided to the person in the residential treatment provider.
Recovery Housing - Alabama Alliance of Christian Recovery Ministers (AACRM)/AARR/Oxford House Assisted Living Facilities	- N/A – individuals living in these residential settings can receive all CCBHC services	
Skilled Assisted Living Facilities	- N/A – individuals living in these residential settings can receive all CCBHC services - Primary Care Screening and Monitoring	

**Congregate
Care/Residential Setting**

**CCBHC Services that Cannot Be Provided to Individuals
in this Setting**

*(due to duplication in what is already funded/provided by the
Congregate/Residential Program)*

Other Considerations

Nursing Homes

- Primary Care Screening and Monitoring

Generally speaking, services provided in nursing facilities would be considered institutional services and are not allowed under the CCBHC Demonstration. However, CCBHCs in Alabama are allowed to provide services to a person as part of in-reach for the purpose of transitioning them out of nursing facility. In order for these services to be included in the Cost Report and coverable under the CCBHC Demonstration, they must:

- (1) be furnished pursuant to a written plan of care. CCBHCs must document the necessity of services, as well as coordination with the Nursing Facility on care planning and roles to ensure services are not duplicative. Services must be documented in both the Nursing Facility Care Plan and the CCBHC Plan of Care. Additionally, CCBHCs must document the person is not eligible for Preadmission Screening and Resident Review (PASRR) Specialized Services.
- (2) be services considered outside the scope of both Nursing Facility and specialized services. CCBHCs should document this non-duplication of services via a written Care Coordination agreement with the Nursing Facility prior to providing any services to individuals residing in that service setting.

**Congregate
Care/Residential Setting**

**CCBHC Services that Cannot Be Provided to Individuals
in this Setting**

*(due to duplication in what is already funded/provided by the
Congregate/Residential Program)*

Other Considerations

- (3) be for non-recurring set-up expenses for people transitioning from an institution.
- (4) and are provided on or after the start of the discharge planning process. CCBHCs must attain the client's Discharge Plan from the NF and include it in the client's health record.

Allowable services would include those in alignment with the nine required CCBHC demonstration services that are also necessary to enable a person to transition into their own household such as assessing needs after discharge, working to identify and set up behavioral health services the person will need after discharge, accessing community services, non-medical transportation, and education, employment, and housing related services and supports. Expenses for transitional services **cannot** constitute room and board, and do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

In addition, payments for transitional services provided to individuals under the CCBHC demonstration may only be paid after an individual is discharged from the Nursing Facility and cannot be duplicative of payments or services delivered to Medicaid beneficiaries under existing state Medicaid Waiver benefits.

Congregate Care/Residential Setting	CCBHC Services that Cannot Be Provided to Individuals in this Setting <i>(due to duplication in what is already funded/provided by the Congregate/Residential Program)</i>	Other Considerations
Emergency Shelters for Individuals who are Homeless	- N/A – individuals living in these residential settings can receive all CCBHC services; However, CCBHCs should engage with each individual shelter program to assure there are no duplicative services being offered within that service setting.	Because the length of stay in Emergency Department settings is by nature short/temporary, CCBHCs can provide any CCBHC service meant to engage the individual in ongoing services while the individual is at the ED setting. However, the CCBHC must work with the ED facility in order to confirm that no duplicative services (e.g., a psychiatric assessment) are provided on the same day.
General Medical Hospital Emergency Department	- Primary Care Screening and Monitoring - N/A – individuals receiving services at an ED can receive all CCBHC services	
Colleges/Universities	- N/A – individuals living in these residential settings can receive all CCBHC services; however, CCBHCs should work directly with the College/University to understand the services they offer and assure they are not duplicating services.	

Regardless of service setting, each CCBHC is responsible for assuring services provided are not duplicative to other services the individual is receiving. For example, individuals receiving basic living skills services and other supports for activities of daily living from their congregate care setting are not eligible to receive these services from the CCBHC.

Non-duplicative of CCBHC Services with Individuals receiving services via a Waiver Program

In addition to the above, Alabama operates several Waiver programs for individuals with Intellectual Disabilities and Older Adults. Because these individuals may also be served by a CCBHC, CCBHCs should check the Medicaid system to verify that the individual receiving services is not receiving duplicative services through a Waiver program. If a provider requires training on checking for an individual's Waiver enrollment, they are encouraged to contact a Gainwell representative for assistance.

Alabama Waiver Program	Target Population	CCBHC Services that Cannot Be Provided to Individuals Enrolled in that Waiver Program <i>(due to duplication in what is already funded/provided by the Waiver Program)</i>
Intellectual Disabilities Waiver	- Adults and children who are living with intellectual disabilities who would otherwise qualify for care in an intermediate care facility	- Targeted Case Management - Basic Living Skills - Employment and Housing Linkage Support Services
Elderly and Disabled Waiver	- Individuals who are elderly and/or disabled who would otherwise require care in a nursing facility	- Targeted Case Management - Basic Living Skills
Alabama Community Transitions Waiver	- Individuals with disabilities or long-term illnesses who currently live in a nursing facility and who desire to transition to home and community setting	- Targeted Case Management - Basic Living Skills - Employment Support Services
State of Alabama Independent Living (SAIL) Waiver	- Adults 18 years of age or older living with disabilities and specific medical diagnoses, who would otherwise qualify for care in a nursing care facility.	- Targeted Case Management - Basic Living Skills - Employment Support Services
Technology Assisted Waiver	- Individuals (over 21) who have had a tracheostomy or who are ventilator dependent and require skilled nursing services	- Targeted Case Management - Basic Living Skills - Employment Support Services
Community Waiver	- Individuals living with intellectual disabilities in Baldwin, Elmore, Houston, Jefferson, Limestone, Madison, Mobile, Montgomery, Morgan, Tuscaloosa, and Walker counties who fall into one of the following enrollment groups: - o Group 1: Children (ages 3-13) with intellectual disabilities who live with family or other natural supports - o Group 2: Transition-age youth with intellectual disabilities who (ages 14-21) live with family or other natural supports or who (ages 18-21) live independently - o Group 3: Working age or older adults (ages 22+) with intellectual disabilities	- Targeted Case Management - Basic Living Skills - Employment and Housing Linkage Support Services

**Alabama Waiver
Program**

Target Population

**CCBHC Services that Cannot Be Provided to
Individuals Enrolled in that Waiver Program**
*(due to duplication in what is already funded/provided by
the Waiver Program)*

	who live with family or other natural supports or who live independently ○ Group 4: Persons (ages 3+) with intellectual disabilities who are unable to live with family or other natural supports or to live independently ○ Group 5: Working-age or older adults (ages 22+) with intellectual disabilities, who don't qualify for the level of care offered in Group 3 but need home and community-based services to maintain community living and/or work in the community.	
Living at Home Waiver	- Adults and children 3 years or older who have a diagnosis of intellectual disabilities who would otherwise qualify for care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	- Targeted Case Management - Basic Living Skills - Employment and Housing Linkage Support Services

Claiming for CCBHC Services

All CCBHC Medicaid claims should be submitted using the **T1040** procedure code, which is tied to the CCBHC's PPS rate. In addition, CCBHCs are required to report all service activities (both triggering and non-triggering CCBHC services) provided on the visit day associated with each submitted T1040 claim. It is critical that CCBHCs document non-triggering, allowable services as the costs for these services are included in the PPS rate.

- **Triggering Events** – an allowable service under the CCBHC program that when provided, will trigger the daily PPS payment. PPS payment can be triggered only once each day, per individual served person receiving services by the CCBHC. For an up-to-date list of procedure codes included as Triggering Services, see the Resources section of the ADMH CCBHC webpage here: <https://mh.alabama.gov/certified-community-behavioral-health-clinics/>
- **Non-Triggering Support Services** – an allowable service or activity under the CCBHC program that does not trigger a daily PPS payment, such as care coordination. The expense of the non-triggering service/activity is an allowable cost in the CCBHC's Cost Report (e.g., the cost of staff time to deliver these services) and therefore the expense is built into the PPS rate for each clinic. However, these services, when delivered alone, do not qualify as a triggering event for the purpose of billing the PPS daily rate. This means the delivery of these services by themselves will not trigger a payment of the PPS rate.

ADMH and AMA will use service code details to monitor the cost and utilization of services provided by CCBHCs. Underlying encounters will also be used to validate services provided to CCBHC attributed populations and their assignment to the appropriate population category. These service level details are also critical to successful PPS rate setting and rebasing. CCBHCs that under-report service codes will risk substantive reductions in future PPS rates that may be tested and justified against these claims. Failure to submit adequate and appropriate information related to services provided may trigger a Medicaid Financial Audit or Corrective Action. If the CCBHC is using their own billing software, then their software vendor would need to configure their software to submit these types of transactions.

CCBHCs should submit claims in a timely manner. General timely filing rules apply.

Claims for non-Medicaid recipients must be maintained and readily accessible upon request. These records are subject to review during site visits and/or as part of the site certification process.

Allowable Modifier Codes for CCBHC Claiming:

Each CCBHC claim using the T1040 code must include the Q2 modifier to indicate that it is a claim being submitted under the Alabama CCBHC Demonstration.

In addition, CCBHCs should utilize the appropriate modifier to indicate that the service being provided is related to Substance Use (SU) or Mental Health (MH). These modifiers will be used by ADMH for tracking purposes (e.g., tracking the match funding source), and (as long as a modifier is included on the claim) the specific modifier will not be used to deny payment to a CCBHC.

Modifier

HE

HF

Modifier Use

Mental Health

Substance Use

Finally, CCBHCs must use the appropriate modifiers to indicate service modality, when appropriate. These modifiers align with Alabama Medicaid Billing rules, and include the following (as appropriate to each service provided):

Modifier	Modifier Use
Q2	Demonstration Service (CCBHC)
HQ	Group Services
GT	Telehealth Audio/Visual
FQ	Telehealth Audio Only
HA	Adolescent
HS	Parent/Guardian
U1	RN for T1001/T1002
U1	SMI Adults for Targeted Case Management (TCM)
U2	LPN for T1001/T1002
U3	SED Child for TCM
U9	SUD Adults and Adolescents for TCM

Triggering Event Services

The following services are included as triggering events for the Alabama CCBHC program. For clarity and consistency, they are presented in the same sequence as they appear in the officially approved list of [triggering events](#).

Intake Evaluation - 90791

Definition:

Initial clinical evaluation of the individual's request for assistance. Individuals receiving substance use services undergo standardized psychosocial assessment. The intake evaluation presents psychological and social functioning, individual's reported physical and medical condition, the need for additional evaluation and/or treatment, and the individual's fitness for rehabilitative services.

Key service functions include the following:

- A clinical interview with the individual receiving services and/or collateral
- Screening for needed medical, psychiatric, or neurological assessment, as well as other specialized evaluations
- A brief mental status evaluation
- Review of the individual's presenting problem, symptoms, functional deficits, and history
- Initial diagnostic formulation
- Development of an initial plan for subsequent treatment and/or evaluation
- Referral to other medical, professional, or community services as indicate

Evaluation may incorporate the use of play equipment, physical devices, language interpreter, or other aids to enhance therapeutic interaction.

Eligible Practitioners:

Rehabilitative Services Professional (all types)

Maximum Unit(s):

Unlimited (Mental Illness)

1 per year (Substance Use)

Billing Restrictions

May not be billed in combination with Treatment Plan Review (H0032), Individual Counseling (90832-HF, 90834-HF, 90837-HF), Group Counseling (90853-HF), Family Counseling (90846-HF, 90847-HF), Multi Family Group Psychotherapy (90849-HF)

Procedure Codes and Modifiers

Intake Evaluation	90791	HE	
Intake Evaluation	90791	HF	
Intake Evaluation	90791	HE	GT
Intake Evaluation	90791	HF	GT
Intake Evaluation	90791	HE	FQ
Intake Evaluation	90791	HF	FQ

Service Location:

Services can be delivered in any allowable setting for CCBHCs that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

Cannot be billed on the same day with H0031.

An intake evaluation must be performed for each person receiving services considered for initial entry into a treatment program. This requirement applies to any organized program or course of covered services that an individual enters or attends to receive scheduled or planned rehabilitative services. Individuals who are transferred between programs within an agency do not require a new intake at the time of transfer.

Individual Counseling – 90832, 90834, 90837**Definition:**

The utilization of professional skills by a qualified practitioner to assist an individual in a face-to-face (in person or via telemedicine), one-to-one psychotherapeutic encounter in achieving specific objectives of treatment or care for a mental health and/or a substance use disorder. Services are generally directed toward alleviating maladaptive functioning and emotional disturbances relative to a mental health and/or substance use disorder, and restoration of the individual to a level of functioning capable of supporting and sustaining recovery. Individual Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services.

Key service functions include the following:

- Interaction where interventions are tailored toward achieving specific goals and/or objectives of the individual's treatment plan
- On-going assessment of the individual's presenting condition and progress made in treatment.

Eligible Practitioners:

Rehabilitative Services Professional (all types)
QSAP II

Maximum Unit(s):

52 per year

Billing Restrictions:

May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child & Adolescent Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ), Intake (90791-HF), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification With Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014)

Procedure Codes and Modifiers

Individual Tx	90832	HE	
Individual Tx	90832	HF	
Individual Tx	90832	HE	GT
Individual Tx	90832	HF	GT
Individual Tx	90832	HE	FQ
Individual Tx	90832	HF	FQ
Individual Tx	90834	HE	
Individual Tx	90834	HF	
Individual Tx	90834	HE	GT
Individual Tx	90834	HF	GT
Individual Tx	90834	HE	FQ
Individual Tx	90834	HF	FQ
Individual Tx	90837	HE	
Individual Tx	90837	HF	
Individual Tx	90837	HE	GT
Individual Tx	90837	HF	GT
Individual Tx	90837	HE	FQ
Individual Tx	90837	HF	FQ

Service Location:

Services can be delivered in any allowable setting for CCBHCs that is acceptable for both the person receiving services and the staff member, that affords an adequate therapeutic

environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

Individual Therapy/Counseling for mental health shall include at a minimum:

- Face-to-face interaction where interventions are tailored toward achieving specific measurable goals and/or objectives of the individual's treatment plan.
- On-going assessment of the individual's preexisting condition and progress being made in treatment.
- Symptom management education and education about mental illness and medication effects.
- Psychological support, problem solving, and assistance in adapting to illness.
- **Code 90832** = therapy given for **16 to 37 minutes**
- **Code 90834** = therapy given for **38 to 52 minutes**
- **Code 90837** = therapy given for **53 minutes or greater**

Family Counseling – 90846, 90847, 90849

Definition:

A person receiving a focused intervention that may include the person receiving services, his/her family unit and/or significant others, and a qualified practitioner. This service is designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a substance use disorder (and any co-occurring mental health disorder) that interferes with the person receiving services' personal, familial, vocational, and/or community functioning.

Family Therapy shall include at a minimum:

- Face-to-face interaction with the individual receiving services, family, and/or significant others where interventions are tailored toward achieving specific measurable goals and/or objectives of the individual's treatment plan.
- On-going assessment of the individual's presenting condition and progress being made in treatment.

Eligible Practitioners:

Rehabilitative Services Professional (all types)
QSAP II

Maximum Unit(s):

104 per year

Billing Restrictions

May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040- HQ), Intake (90791-HF), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification with Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended Onsite Monitoring (I-D) (H0014)

Procedure Codes and Modifiers

Family Tx W/o Pt	90846	HE	
Family Tx W/o Pt	90846	HF	
Family Tx W/o Pt	90846	HE	GT
Family Tx W/o Pt	90846	HF	GT
Family Tx W/o Pt	90846	HE	FQ
Family Tx W/o Pt	90846	HF	FQ
Family Tx W/ Pt	90847	HE	
Family Tx W/ Pt	90847	HF	
Family Tx W/ Pt	90847	HE	GT
Family Tx W/ Pt	90847	HF	GT
Family Tx W/ Pt	90847	HE	FQ
Family Tx W/ Pt	90847	HF	FQ
Family Tx Multi-fam group	90849	HE	
Family Tx Multi-fam group	90849	HF	
Family Tx Multi-fam group	90849	HE	GT
Family Tx Multi-fam group	90849	HF	GT

Service Location:

Services can be delivered in any allowable setting for CCBHCs that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

Family Treatment Multi-Family Group (90849) shall include at a minimum:

- Length of Service – 60 minutes minimally
- Face to face interaction with a group of individuals (not to exceed sixteen (16) for groups with only adults and ten (10) for groups involving children and adolescents) where interventions use the interactions of individuals and group dynamics to achieve specific goals and/or objectives of the individual's treatment plan.
- On-going assessment of the individual's presenting condition and progress being made in treatment

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session.

When a family consists of a Medicaid eligible adult and child(ren) and the therapy is not directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is not eligible and the

family therapy is directed to the adult and not the child, the service may not be billed using the child's recipient ID number.

A family is not a group, and providers may not submit a claim for each eligible person attending the same family therapy session. All members of the family in attendance for the session will sign/mark the signature log or progress note to document their participation in the session (in addition to the therapist documenting their presence/participation).

Group Treatment - 90853

Definition:

The utilization of professional skills by a qualified practitioner to assist two or more individuals in a group setting in achieving specific objectives of treatment or care for mental health or substance use disorder. Services are generally directed toward alleviating maladaptive functioning and behavioral, psychological, and/or emotional disturbances, and utilization of the shared experiences of the group's members to assist in restoration of each participant to a level of functioning capable of supporting and sustaining recovery. Group Counseling may consist of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic service strategies.

Eligible Practitioners:

Rehabilitative Services Professional (all types)
QSAP II

Maximum Unit(s):

104 episodes per year

Billing Restrictions

May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child & Adolescent Day Treatment (H2012-HA), ACT (H0040), PACT (H0040-HQ), Intake (90791-HF), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification with Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification without Extended On-Site Monitoring (I-D) (H0014).

Procedure Codes and Modifiers

Group Tx	90853	HE	
Group Tx	90853	HF	
Group Tx	90853	HE	GT
Group Tx	90853	HF	GT

Service Location:

Services can be delivered in any allowable setting for CCBHCs that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

Group Counseling shall include at a minimum:

- Face to face interaction with a group of individuals (not to exceed sixteen (16) for adults and ten (10) for children and adolescents) where interventions utilize the interactions of individuals and group dynamics to achieve specific goals and/or objectives of the individual's treatment plan.
- On-going assessment of the individual's presenting condition and progress being made in treatment

Diagnostic Testing Administered by Physician – 96130, 96131, 96136, & 96137

Definition:

Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour in a face-to-face (in person or via telemedicine) interaction between the individual receiving services and the psychologist or psychiatrist and interpretation of the test results to assist with a definitive diagnosis. Once the diagnosis has been confirmed, this information is used to guide proper treatment by the development of an individualized, person-centered treatment plan.

Eligible Practitioners:

Psychiatrist or Psychologist licensed under Alabama Law.

Maximum Unit(s):

96130- 1 per year

96131- 7 per year

96136 - 1 per year

96137- 11 per year

Billing Restrictions

None

Procedure Codes and Modifiers

Diagnostic Testing -Psychologist/Extenders	96130	HE	
Diagnostic Testing - Psychologist/Extenders	96130	HF	
Diagnostic Testing -Psychologist/Extenders	96130	HE	GT
Diagnostic Testing - Psychologist/Extenders	96130	HF	GT
Diagnostic Testing -Psychologist/Extenders	96131	HE	
Diagnostic Testing - Psychologist/Extenders	96131	HF	
Diagnostic Testing -Psychologist/Extenders	96131	HE	GT
Diagnostic Testing - Psychologist/Extenders	96131	HF	GT
Diagnostic Testing -Psychologist/Extenders	96136	HE	

Diagnostic Testing - Psychologist/Extenders	96136	HF	
Diagnostic Testing -Psychologist/Extenders	96136	HE	GT
Diagnostic Testing - Psychologist/Extenders	96136	HF	GT
Diagnostic Testing -Psychologist/Extenders	96137	HE	
Diagnostic Testing - Psychologist/Extenders	96137	HF	
Diagnostic Testing -Psychologist/Extenders	96137	HE	GT
Diagnostic Testing - Psychologist/Extenders	96137	HF	GT

Service Location:

Services can be delivered in any allowable setting for CCBHCs that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

Evaluation services include interpretation of test results and clinical data, integration of patient data, clinical decision-making, treatment planning, report generation, and interactive feedback to the patient, family member(s) or caregiver(s). The first hour of psychological evaluation is billed using 96130 and each additional hour needed to complete the service is billed with the add-on code 96131.

Test administration and scoring services performed by the psychologist includes time spent to administer and score a minimum of two (2) psychological tests. The first 30 minutes of test administration and scoring is billed using 96136 and each additional 30-minute increment needed to complete the service is billed with code 96137.

Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

The time started and time ended of service delivery will not include time spent for scoring, interpretation and report writing (at this time). Billing should reflect the total time for face-to-face (in person or via telemedicine) administration, scoring, interpretation and report writing. The test(s) given on the date of service billed must be documented in the treatment note for post payment review purposes.

Intellectual Disability and Developmental Disability/Autism Spectrum diagnosis codes (ICD-10 F70-F89) are not covered for treatment services; however, Medicaid will cover diagnostic testing, status exam (96130/96131, 96136/96137), even if the resulting diagnosis is intellectual/developmental disability secondary to a primary mental health diagnosis.

Diagnostic Testing Administered by Technician – 96138 & 96139

Definition:

Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient,

family member(s) or caregiver(s), when performed; first hour in a face-to-face (in person or via telemedicine) interaction between the individual receiving services and the psychologist or psychiatrist and interpretation of the test results to assist with a definitive diagnosis. Once the diagnosis has been confirmed, this information is used to guide proper treatment by the development of an individualized, person-centered treatment plan.

Eligible Practitioners:

Rehabilitative Services Professional (operating within their scope of practice and consistent with the individual's training and experience)

An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other human service field areas and who meets at least one of the following qualifications:

- Has successfully completed a practicum as a part of the requirements for the degree
- Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of postgraduate clinical experience

Maximum Unit(s):

96138- 1 per year

96139- 11 per year

Billing Restrictions

None

Procedure Codes and Modifiers

Diagnostic Testing - Technician	96138	HE	
Diagnostic Testing - Technician	96138	HF	
Diagnostic Testing - Technician	96138	HE	GT
Diagnostic Testing - Technician	96138	HF	GT
Diagnostic Testing - Technician	96139	HE	
Diagnostic Testing - Technician	96139	HF	
Diagnostic Testing - Technician	96139	HE	GT
Diagnostic Testing - Technician	96139	HF	GT

Service Location:

Services can be delivered in any allowable setting for CCBHC services that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

The first 30 minutes are billed using 96138 and each additional 30-minute increment is billed with 96139.

Psychological Evaluation services include interpretation of test results and clinical data, integration of patient data, clinical decision-making, treatment planning, report generation, and

interactive feedback to the patient, family member(s) or caregiver(s).

Evaluation services must always be performed by the professional prior to test administration, and must be billed on the last date of service, but documented in the medical record the actual date(s) the service is performed

Test administration and scoring services performed by the Technician includes time spent to administer and score a minimum of two (2) psychological tests.

The first 30 minutes of test administration and scoring is billed using 96138 and each additional 30-minute increment needed to complete the service is billed with code 96139.

Diagnostic Testing Administered by Computer - 96146

Definition:

Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only.

Eligible Practitioners:

Diagnostic testing-procedure code 96146 must be administered by a computer and interpreted by a computer.

Maximum Units:

1 per year

Billing Restrictions

None

Procedure Codes and Modifiers

Diagnostic Testing - Computer	96146	HE	
Diagnostic Testing - Computer	96146	HF	
Diagnostic Testing - Computer	96146	HE	GT
Diagnostic Testing - Computer	96146	HF	GT

Service Location:

Services can be delivered in any allowable setting for CCBHC services that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

Automated interpretation of diagnostic testing is not billable. Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

Intellectual Disability and Developmental Disability/Autism Spectrum diagnosis codes (ICD-10 F70-F89) are not covered for treatment services; however, Medicaid will cover diagnostic testing,

status exam (96146), even if the resulting diagnosis is intellectual/developmental disability secondary to a primary mental health diagnosis.

Medication Administration – Injectable - 96372

Definition:

Administration of injectable medication under the direction of a physician, physician assistant or certified registered nurse practitioner.

Eligible Practitioners:

Physician
Physician Assistant
Certified Registered Nurse Practitioner (CRNP)
Registered Nurse (RN) (licensed under Alabama law)
Licensed Practical Nurse (LPN) (licensed under Alabama law under the direction of a physician)
A Certified Medical Assistant certified through the American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT)

Maximum Unit(s):

1095 per year

Billing Restrictions:

May not be billed in combination with Partial Hospitalization (H0035), ACT (H0040), PACT (H0040-HQ), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification with Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended Onsite Monitoring (I-D) (H0014), Vivitrol (J2315).

Procedure Codes and Modifiers

Med Admin - Injectable	96372	HE
Med Admin - Injectable	96372	HF

Service Location:

Services can be delivered in any allowable setting for CCBHCs that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

This service does not include the intravenous administration of medications. Utilization will be monitored through retrospective reviews.

For individuals receiving substance use services, this service cannot be billed if the MAS nurse has determined they are capable of self- administration.

For payment processing for 96372, only one claim can be processed per day, for a maximum unit of three (3).

Evaluation/Management, New Patient – 99202, 99203, 99204, and 99205

Definition:

Office or other outpatient visit for the evaluation and management of a new patient, which requires these key components:

- An expanded problem focused history, and/or examination
- Clinically appropriate medical decision making

A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who also works at the CCBHC, within the past three years.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Please note that the evaluation/management codes go beyond screening and monitoring (for which there are other more appropriate codes). When determining which evaluation/management code to utilize, providers should consider the following:

	99202 (15+ minutes; straightforward medical decision making; minor)	99203 (30+ minutes; low-level of medical decision making; routine)	99204 (45+ minutes; low-level of medical decision making; routine)	99205 (45+ minutes; moderate level of medical decision making; complex)
Number & Complexity of Problems Addressed at the Encounter	1 self-limited or minimal issue	2+ minor, or 1 chronic stable, or 1 acute stable, or 1 acute uncomplicated	2+ minor, or 1 chronic stable, or 1 acute stable, or 1 acute uncomplicated	2+ chronic stable, or 1 chronic/ worsened, or 1 acute complicated
Amount/ Complexity of Data to Be Reviewed and Analyzed	None	2 ordered tests/ assessment results or outside notes	2 ordered tests/ assessment results or outside notes	3 ordered tests/ assessment results or outside notes
Risk of Complication, Morbidity, or Mortality	Minimal concern regarding long- term functional impairment, diminished quality of life, or death	Low concern regarding long- term functional impairment, diminished quality of life, or death	Low concern regarding long- term functional impairment, diminished quality of life, or death	Moderate concern regarding long- term functional impairment, diminished quality of life, or death

Eligible Practitioners:

Physician who is appropriately authorized/licensed in accordance with Alabama Medicaid Chapter 28

Physician Assistants

Certified Registered Nurse Practitioners (CRNPs)

Maximum Units:

Annual office visit benefit limits (inclusive of all Chapter 28 Physician services) are 14 office visits per calendar year.

Billing Restrictions:

May not be billed in combination with any other Physician service listed in Chapter 28.

Procedure Codes and Modifiers

Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	99202	HE	
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	99202	HE	GT
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	99202	HF	
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	99202	HF	GT
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	99203	HE	
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	99203	HE	GT
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and	99203	HF	

low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.			
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	99203	HF	GT
Office or other outpatient visit for evaluation/management of a new patient, when using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	99204	HE	
Office or other outpatient visit for evaluation/management of a new patient, when using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	99204	HE	GT
Office or other outpatient visit for evaluation/management of a new patient, when using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	99204	HF	
Office or other outpatient visit for evaluation/management of a new patient, when using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	99204	HF	GT
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	99205	HE	
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	99205	HE	GT
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	99205	HF	
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and	99205	HF	GT

moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.			
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Service Location:

Services can be delivered in any allowable setting for CCBHC services that is acceptable for both the person receiving services and staff members, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality. Location should follow all applicable federal, state, and local codes.

Additional Information:

Best practice for providers documenting time-based E/M services is to note:

- The total time of the visit;
- The total time spent in counseling or coordination of care; and
- A synopsis of the discussion.

The note within the medical record should be a thorough account of the activity with the patient, the recommendations, and the patient's concerns. The clinician shouldn't limit the documentation to only the time and counseling information but should also include information gathered from the history and examination elements, as well as Medical Decision-Making concerns, ordered and reviewed tests, co-morbid conditions, etc., to further substantiate the level of service and the time spent counseling.

Evaluation/Management, Established Patient – 99211, 99212, 99213, 99214, and 99215

Definition:

Face-to-face office or other outpatient visit for the evaluation and management of an established patient, which requires these key components:

- An expanded problem focused history, and/or examination
- Clinically appropriate medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Please note that the evaluation/management codes go beyond screening and monitoring (for which there are other more appropriate codes). When determining which evaluation/management code to utilize, providers should consider the following:

	99211 (No minimum time; straightforward medical decision making; minor)	99212 (10+ minutes; straightforward medical decision making; minor)	99213 (20+ minutes; low-level of medical decision making; routine)	99214 (30+ minutes; moderate level of medical decision making; complex)	99214* (40+ minutes; high level of medical decision making; emergency)
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Number & Complexity of Problems Addressed at the Encounter	1 self-limited or minimal issue	1 self-limited or minimal issue	2+ minor, or 1 chronic stable, or 1 acute stable, or 1 acute uncomplicated	2+ chronic stable, or 1 chronic/worsened, or 1 acute complicated	1 chronic with severe exacerbation
Amount/ Complexity of Data to Be Reviewed and Analyzed	None	None	2 ordered tests/ assessment results or outside notes	3 ordered tests/ assessment results or outside notes	3 ordered tests/ assessment results or outside notes
Risk of Complication, Morbidity, or Mortality	Minimal concern regarding long-term functional impairment, diminished quality of life, or death	Minimal concern regarding long-term functional impairment, diminished quality of life, or death	Low concern regarding long-term functional impairment, diminished quality of life, or death	Moderate concern regarding long-term functional impairment, diminished quality of life, or death	High concern regarding long-term functional impairment, diminished quality of life, or death

Eligible Practitioners

Physician who is appropriately authorized/licensed in accordance with Alabama Medicaid Chapter 28

Physician Assistants

Certified Registered Nurse Practitioners (CRNPs)

Maximum Units

Annual office visit benefit limits are 14 office visits per calendar year.

Billing Restrictions

May not be billed in combination with any other Physician service listed in Chapter 28.

Procedure Codes and Modifiers

Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	99211	HE	
Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	99211	HE	GT
Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	99211	HF	
Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	99211	HF	GT
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.	99212	HE	

When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.			
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	99212	HE	GT
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	99212	HF	
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	99212	HF	GT
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	99213	HE	
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	99213	HE	GT
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	99213	HF	
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	99213	HF	GT
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	99214	HE	
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.	99214	HE	GT

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.			
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	99214	HF	
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	99214	HF	GT
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	99215	HE	
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	99215	HE	GT
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	99215	HF	
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	99215	HF	GT

Service Location:

Services can be delivered in any allowable setting for CCBHC services that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality. Location should follow all applicable federal, state, and local codes.

Additional Information:

Best practice for providers documenting time-based E/M services is to note:

- The total time of the visit;
- The total time spent in counseling or coordination of care; and
- A synopsis of the discussion.

The note within the medical record should be a thorough account of the activity with the patient, the recommendations, and the patient's concerns. The clinician shouldn't limit the documentation

to only the time and counseling information but should also include information gathered from the history and examination elements, as well as Medical Decision-Making concerns, ordered and reviewed tests, co-morbid conditions, etc., to further substantiate the level of service and the time spent counseling.

Behavioral Health Placement Screening – H0002

Definition:

A structured interview process conducted by a qualified professional for the purpose of identifying a person receiving services' presenting strengths and needs and establishing a corresponding recommendation for placement in an appropriate level of care. This process may incorporate determination of the appropriateness of admission/commitment to a state psychiatric hospital or a local inpatient psychiatric unit.

Key service functions include the following:

- A clinical assessment of the person receiving services' need for local or state psychiatric hospitalization
- An assessment of whether the person receiving services meets involuntary commitment criteria, if applicable
- Preparation of reports for the judicial system and/or testimony presented during the course of commitment hearing
- An assessment of whether other less restrictive treatment alternatives are appropriate and available
- Referral to other appropriate and available treatment alternatives

Eligible Practitioners:

Rehabilitative Services Professional (all types)

Licensed Registered Nurse

Maximum Units:

16 per year

Billing Restrictions

None

Procedure Codes and Modifiers

Behavioral Health Screening	H0002	HE	
Behavioral Health Screening	H0002	HE	GT

Service Location:

Services can be delivered in any allowable setting for CCBHC services that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality. Location should follow all applicable federal, state, and local codes.

Additional Information:

For CCBHCs, Z04.6 is covered for this service.

For CCBHCs, this service also covers children/adolescents' assessments for appropriate level of care and/or appropriate community-based services to divert from out-of-home placement.

Medical Assessment and Treatment – H0004

Definition:

Contact with an individual during which a qualified practitioner provides psychotherapy and/or medical management services. Services may include physical examinations, evaluation of co-morbid medical conditions, development or management of medication regimens, the provision of insight oriented, behavior modifying, supportive, or interactive psychotherapeutic services, or the provision of educational services related to management of a physical, mental health, or substance use disorder.

Key service functions include the following:

- Specialized medical/psychiatric assessment of physiological phenomena
- Psychiatric diagnostic evaluation
- Medical/psychiatric therapeutic services
- Assessment of the appropriateness of initiating or continuing the use of psychotropic or detoxification medication

Eligible Practitioners:

Physician (licensed under Alabama law to practice medicine or osteopathy)

Physician Assistant (licensed under Alabama law and practicing within the guidelines outlined by Alabama Board of Medical Examiners)

Certified Registered Nurse Practitioner (CRNP) (licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses)

Maximum Unit(s):

52 per year

Billing Restrictions

May not be billed in combination with Partial Hospitalization (H0035), ACT (H0040), PACT (H0040-HQ), Outpatient Detoxification – Ambulatory Detoxification with Extended On-Site Monitoring (IID) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended On-Site Monitoring (I-D) (H0014)

Procedure Codes and Modifiers

Medical Assessment & Treatment	H0004	HE	
Medical Assessment & Treatment	H0004	HF	
Medical Assessment & Treatment	H0004	HE	GT
Medical Assessment & Treatment	H0004	HF	GT

Medical Assessment & Treatment	H0004	HE	FQ
Medical Assessment & Treatment	H0004	HF	FQ

Service Location:

Services can be delivered in any allowable setting that is acceptable for CCBHCs for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

All services rendered by a physician, physician assistant, or nurse practitioner that meet the definition above should be billed under this code including those rendered via teleconference with a direct service or consultation recipient.

Mental Health and Substance Use Disorders Assessment Update – H0031

Definition:

A structured interview process that functions to evaluate a person receiving services' present level of functioning and/or presenting needs. The assessment is used to establish additional or modify existing diagnoses, establish new or additional rehabilitation service goals, assess progress toward goals, and/or to determine the need for continued care, transfer, or discharge.

The use of the ADMH Update Assessment tool is a required element.

Eligible Practitioners:

Rehabilitative Services Professional (all types)

Maximum Unit(s):

56 units per year

Billing Restrictions

May not be billed in combination with Intake Evaluation (90791)

Procedure Codes and Modifiers

Mental Health & Substance Use Disorders Update	H0031	HF
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Service Location:

Services can be delivered in any allowable setting for CCBHCs that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Medication Administration – Oral – H0033

Definition:

Administration of oral medication under the direction of a physician, physician assistant, or certified registered nurse practitioner.

Eligible Practitioners:

Registered Nurse (RN) (licensed under Alabama law)
Licensed Practical Nurse (LPN) (licensed under Alabama law under the direction of a physician)
A Certified Medical Assistant certified through the American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT).
MAC Worker
QSAP 1, II, and III
Qualified Paraprofessional (QPP) (must hold a current MAC certification)
Certified Recovery Support Specialist (must hold a current MAC certification)

Maximum Unit(s):

1095 per year

Billing Restrictions

May not be billed in combination with Partial Hospitalization (H0035), ACT (H0040), PACT (H0040-HQ), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification with Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification Without Extended Onsite Monitoring (I-D) (H0014), Vivitrol (J2315).

Procedure Codes and Modifiers

Med Admin – Oral	H0033	HE
Med Admin – Oral	H0033	HF

Service Location:

Services can be delivered in any allowable setting for CCBHCs that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

This service does not include the intravenous administration of medications, nor does it include the preparation of medication trays in a residential setting. Utilization will be monitored through retrospective reviews.

For individuals receiving substance use services, this service cannot be billed if the MAS nurse has determined they are capable of self-administration.

For payment processing H0033, only one claim can be processed per day (1-3) for a maximum unit of three (3).

Medication Monitoring – H0034

Definition:

Contact between the individual receiving services and an eligible provider, or child and adolescent services professional, monitoring compliance with dosage instructions; educating the individual and/or collateral of expected effects of medications; and identifying changes in

the medication regimen.

Eligible Practitioners:

Rehabilitative Services Professional (all types)

Qualified Mental Health Provider – Bachelor’s

QSAP II & III

Registered Nurse (RN) licensed under Alabama law

Licensed Practical Nurse (LPN) licensed under Alabama law

Pharmacist licensed under Alabama law

Certified Nursing Assistant

A Certified Medical Assistant certified through the American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT)

Maximum Unit(s):

52 per year

Billing Restrictions

May not be billed in combination with Partial Hospitalization (H0035), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040- HQ), Opioid Use Disorders Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification with Extended On-Site Monitoring (IID) (H0013), Outpatient Detoxification – Ambulatory Detoxification without Extended On-Site Monitoring (I-D) (H0014), or Vivitrol (J2315)

Procedure Codes and Modifiers

Med Monitoring	H0034	HE	
Med Monitoring	H0034	HF	
Med Monitoring	H0034	HE	GT
Med Monitoring	H0034	HF	GT
Med Monitoring	H0034	HE	FQ
Med Monitoring	H0034	HF	FQ

Service Location:

Services can be delivered in any allowable setting for CCBHCs that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services’ rights to privacy and confidentiality

Peer Support Services – H0038

The following information is applicable to all Peer Support Services (H0038) provided by a CCBHC:

Definition:

Peer Support Services (Adult/Child and Adolescent/Family/Recovery Support Specialist) provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Peer Specialists (Adult, Youth, Family Peer Specialists, Recovery Support Specialists).

Peer Support service actively engages and empowers an individual and his/her identified supports in leading and directing the design of the service plan and thereby ensures that the plan reflects the needs and preferences of the individual (and family when appropriate) with the goal of active participation in this process. Additionally, this service provides support and coaching interventions to individuals (and family when appropriate) to promote recovery, resiliency and healthy lifestyles and to reduce identifiable behavioral health and physical health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic health conditions.

Peer support provides effective techniques that focus on the individual's self-management and decision making about healthy choices, which ultimately extend the members' lifespan. Family peer specialists assist children, youth, and families to participate in the wraparound planning process, access services, and navigate complicated adult/child - serving agencies.

Maximum Unit(s):

2080 per year for Individual

2080 per year for Group

Service Location:

Services can be delivered in any allowable setting for CCBHCs that is acceptable for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

MI Youth Peer Services and/or MI Parent Peer Services can be billed during a Child and Family Care Team meeting when the Target 10 SED care plan is being developed or reviewed, if they are providing peer service that is documented on the treatment plan.

Peer Services should follow service delivery patterns taught in the ADMH approved Certified Peer Specialist training to maintain the consistency and fidelity of the model.

The following information specifically relates to different types of Peer Support Services – Adult, Youth, Parent – that are provided by a CCBHC:

Certified Peer Specialist – Adult**Eligible Practitioners:**

Certified Mental Health Peer Specialist – Adult*

Certified Recovery Support Specialist (CRSS)*

Procedure Codes and Modifiers

Certified Peer Specialist - Adult - Individual	H0038	HE		
Certified Peer Specialist - Adult - Individual	H0038	HF		
Certified Peer Specialist - Adult - Individual	H0038	HE	GT	
Certified Peer Specialist - Adult - Individual	H0038	HF	GT	
Certified Peer Specialist - Adult - Individual	H0038	HE	FQ	
Certified Peer Specialist - Adult - Individual	H0038	HF	FQ	
Certified Peer Specialist - Adult - Group	H0038	HE	HQ	
Certified Peer Specialist - Adult - Group	H0038	HF	HQ	
Certified Peer Specialist - Adult - Group	H0038	HE	HQ	GT
Certified Peer Specialist - Adult - Group	H0038	HF	HQ	GT

Billing Restrictions

Certified Peer Services – Adult may not be billed in combination with Therapeutic Mentoring (H2019), Certified Peer Services – Youth (H0038 HE:HA), and Adult In-Home Intervention (H2021) if one of the team members is a Certified Peer Specialist-Adult.

*Certified Peer Specialist – Youth***Eligible Practitioners:**

Certified Mental Health Peer Specialist – Youth*

Procedure Codes and Modifiers

Certified Peer Specialist - Youth - Individual	H0038	HE	HA	
Certified Peer Specialist - Youth - Individual	H0038	HE	HA	GT
Certified Peer Specialist - Youth - Individual	H0038	HE	HA	FQ
Certified Peer Specialist - Youth - Group	H0038	HE	HA	HQ
Certified Peer Specialist - Youth - Group	H0038	HE	HA	HQ

Billing Restrictions

Certified Peer Services – Youth may not be billed in combination with Therapeutic Mentoring (H2019), and Certified Peer Services – Adult (H0038 HE).

*Certified Peer Specialist – Parent***Eligible Practitioners:**

Certified Mental Health Peer Specialists – Parent*

Procedure Codes and Modifiers

Certified Peer Specialist - Parent - Individual	H0038	HE	HS	
Certified Peer Specialist - Parent - Individual	H0038	HE	HS	GT

Certified Peer Specialist - Parent - Individual	H0038	HE	HS	FQ
Certified Peer Specialist - Parent - Group	H0038	HE	HS	HQ

Billing Restrictions

Certified Peer Services – Parent cannot be billed in combination with C&A In-Home Intervention (H2022- HA) if one of the team members is a Certified Peer Specialist – Parent.

**All Certified Mental Health Peer Specialists – Youth, Adult, and Parent - and Certified Recovery Support Specialists must successfully complete an approved AMA Peer training program authorized by the appropriate state agency department within six (6) months of date of hire.*

Crisis Intervention – H2011

Definition:

Immediate emergency intervention with an individual, or the individual's collateral* (in person or by telephone) to ameliorate a maladaptive emotional/behavioral reaction by the individual. Service is designed to resolve crisis and develop symptomatic relief, increase knowledge of resources to assist in mitigating a future crisis, and facilitate return to pre-crisis routine functioning. Interventions include a brief, situational assessment; verbal interventions to de-escalate the crisis; assistance in immediate crisis resolution; mobilization of natural and formal support systems; and referral to alternate services at the appropriate level.

Key service functions include the following:

- Specifying factors that led to the person receiving services' crisis state, when known
- Identifying the maladaptive reactions exhibited by the person receiving services
- Evaluating the potential for rapid regression
- Resolving the crisis
- Referring the person receiving services for treatment at an alternative setting, when indicated

Eligible Practitioners:

Rehabilitative Services Professional (all types)

Registered Nurse (RN) licensed under Alabama law

Licensed Practical Nurse (LPN) licensed under Alabama law

Certified Nursing Assistant

A Certified Medical Assistant certified through the American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT)

Qualified Mental Health Provider – Bachelor's

Certified Mental Health Peer Specialist (Youth, Adult, and Parent)

QSAP II & III

Certified Recovery Support Specialist (CRSS)

Maximum Unit(s):

7,300 per year

Billing Restrictions:

May not be billed in combination with In-Home Intervention (H2021, H2022-HA), ACT(H0040), PACT (H0040-HQ), Opioid Use Disorder Treatment (H0020), Outpatient Detoxification – Ambulatory Detoxification with Extended On-Site Monitoring (II-D) (H0013), Outpatient Detoxification – Ambulatory Detoxification without Extended On-Site Monitoring (I-D) (H0014)

Procedure Codes and Modifiers

Crisis Intervention	H2011	HE	
Crisis Intervention	H2011	HF	
Crisis Intervention	H2011	HE	GT
Crisis Intervention	H2011	HF	GT
Crisis Intervention	H2011	HE	FQ
Crisis Intervention	H2011	HF	FQ

Service Location:

H2011 may be billed when services are provided outside of a crisis stabilization center setting. Services can be delivered in any allowable setting that is acceptable for CCBHCs for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

If the individual receiving services is unable to sign a receipt for service or if the service is rendered by phone, the documentation in the individual's record should so indicate.

Mobile Crisis Team (MCT) – S9485**Definition:**

Mobile Crisis Teams (MCT) are designed to specifically diffuse and mitigate a behavioral health crisis. MCT services offer community-based interventions to adults, youth, and their families experiencing a behavioral health crisis-whether in their homes, schools, or communities. The MCT provides crisis stabilization services to adults, youth and their families/caregivers, experiencing a behavioral health crisis. The Mobile Crisis Services (MCS) may be delivered in-person, in-home, and/or in community settings, and are available within a timely manner. Telemedicine and telephonic support may be provided until in-person response arrives and or as follow-up post crisis regarding coordination and referrals.

MCT Services *may* include:

- Intake Evaluation
- Crisis Intervention
- Behavioral Health Placement Assessment
- Psychoeducational Services
- Individual Counseling
- Family Counseling
- Mental Health Care Coordination
- Adult Peer Support Services

- Youth Peer Support Services

Response from MCTs is in teams of two; however, this may differ if the team is dispatched from a staffed facility or if, as in rural communities, telemedicine services are utilized. The two-person team is available 24 hours a day, 7 days per week and can travel throughout the state to respond on location. The stabilization service supports the individual's ability to manage daily activities and establishes clear connections to treatment services and community support to reduce the likelihood of ongoing behavioral health crises. Services may also include follow up interventions for a period of up to 72 hours after the initial response that may include, where appropriate, additional MCS and/or behavioral health crisis intervention services, de-escalation, and coordination with and referrals to health, social, emergency management, and other services and supports as needed to effect symptom reduction and harm reduction. If continued stabilization services are identified after 72 hours, a crisis stabilization plan must be developed as part of ongoing CCBHC services for coordination with referrals for continued stabilization services.

Eligible Practitioners:

MCT ("Team") must include a team of at least two of the following licensed and/or credentialed staff members, one of whom is in a supervisory role who has expertise and experience using evidence-based assessment tools with target populations:

- Rehabilitative Services Professional (Master's Level and Above)
- Qualified Mental Health Provider (Bachelor's Level)
- Mental Health Certified Adult Peer (CPS-A)
- Mental Health Certified Youth Peer (CPS-Y)
- Certified Recovery Support Specialist (CRSS)

The team must include, at a minimum, at least one individual who may conduct an assessment within their authorized scope of practice under state law and other professionals or paraprofessionals with appropriate expertise in behavioral health care.

Maximum Unit(s):

96 per year

Billing Restrictions

May not be billed in combination with Intake Evaluation (90791), Crisis Intervention (H2011), Individual Counseling (90832, 90834, 90837), Family Counseling (90846, 90847, 90849), Mental Health Care Coordination (H0046), Psychoeducational Services (H2027), Behavioral Health Placement Assessment (H0002), and Mental & Substance Use Disorders Assessment (H0031-HF). Also, CPS-Adult (H0038-HE) and CRSS (H2019) when the team member is a Certified Mental Health Peer Specialist – Adult or CRSS.

Procedure Codes and Modifiers

Mobile Crisis Team (MCT) - Adult	S9485	HE	
Mobile Crisis Team (MCT) - Adult	S9485	HF	
Mobile Crisis Team (MCT)- C&A	S9485	HE	HA
Mobile Crisis Team (MCT)- C&A	S9485	HF	HA

Service Location:

Services can be delivered in any allowable setting that is acceptable for CCBHCs for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

Utilization will be monitored through retrospective reviews.

Primary Care Screening and Monitoring of Key Indicators and Health Risks – 96156

Definition:

Screening and monitoring services that measure specific health indicators and need for a physical exam or further evaluation by appropriate health care professionals.

For children and adolescents, outpatient clinic primary care screening and monitoring of key health indicators and health risk services must include:

- Assessment of whether the individual is connected to a primary care provider
- Assessment of physical activity and diet
- If six years of age or older, Body Mass Index (BMI) measurement
- As indicated, preventive interventions, such as weight assessment and counseling for nutrition and physical activity.

For adults, these services must include:

- Assessment of whether the individual is connected to a primary care provider
- Body Mass Index (BMI) measurement
- Blood pressure measurement
- Diabetes risk assessment, with connection to further testing/labs as indicated
- Cholesterol risk assessment, with connection to further testing/labs as indicated
- HIV and Hepatitis B/C risk assessment, with connection to testing as indicated
- blood pressure
- Preventive interventions, such as those associated with healthy lifestyles and smoking cessation.

The provision of primary care services, outside of primary care screening and monitoring as defined in Section 4.g of the SAMHSA CCBHC Criteria³ is not within the scope of the nine required CCBHC services. While CCBHC organizations may provide primary care services outside the nine required services, but these primary care services cannot be reimbursed through the Section 223 CCBHC demonstration PPS. In other words, CCBHCs may not submit claims for primary care services under the Section 223 CCBHC Demonstration PPS beyond those defined within the Section 4.g of the SAMHSA CCBHC Criteria.

³ <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>

CCBHCs should coordinate with primary care providers to support integrated provision of primary and behavioral health care.

Eligible Practitioners:

Rehabilitative Services Professional (all types)

Physician

Physician Assistant

Certified Registered Nurse Practitioner (CRNP)

Registered Nurse (RN)

Licensed Practical Nurse (LPN)

Certified Nursing Assistant

A Certified Medical Assistant certified through the American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT)

In addition, the Primary Care Screenings can be completed by the following staff members:

- QSAP II and III
- Qualified Paraprofessionals (QPP)
- Qualified Mental Health Provider – Bachelor’s
- Qualified Mental Health Provider– Non-Degreed
- A Certified Mental Health Peer Specialist (Adult, Youth, Family)
- Certified Recovery Support Specialist

Maximum Unit(s):

365 per year

Procedure Codes and Modifiers

Primary care screening and monitoring of key health indicators and health risks.	96156	HE	
Primary care screening and monitoring of key health indicators and health risks.	96156	HF	
Primary care screening and monitoring of key health indicators and health risks.	96156	HE	GT
Primary care screening and monitoring of key health indicators and health risks.	96156	HF	GT
Primary care screening and monitoring of key health indicators and health risks.	96156	HE	FQ
Primary care screening and monitoring of key health indicators and health risks.	96156	HF	FQ

Service Location:

Services can be delivered in any allowable setting that is acceptable for CCBHC services for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services’ rights to privacy and confidentiality.

Additional Information:

Per CMS requirements,⁴ a clinic that both participates in the Medicaid program as a FQHC and is also a CCBHC demonstration provider should receive a separate Medicaid FQHC services payment for an encounter during which CCBHC services were provided only if it also furnished at least one distinct non-CCBHC FQHC service during that encounter.

When all of the services provided to a clinic patient during the same encounter/visit are both CCBHC demonstration services and state plan Medicaid FQHC services, the payment rate for these services under the demonstration should be the higher of the payment that would otherwise have been paid under the state plan for Medicaid FQHC services (either the FQHC PPS rate or the rate under an alternative payment methodology) or the CCBHC PPS rate.

Initial Referral, Screening to Determine the Appropriateness of Consideration of an Individual for Participation in a Specified Program, Project, or Treatment Protocol – T1023

Definition:

Assessing the need for and appropriateness of behavioral and health related services to ensure the needs of the person receiving services are met. These functions are essential for determining the appropriate level of care and ensuring that the person receives the services they need. The screening process should involve evaluating the person receiving services' psychological, social, and physiological signs and symptoms as well as identifying any coexisting conditions that may require additional professional assessment and services. *For CCBHCs, this code can be used to support the initial triage process to determine whether a client has routine, urgent, or crisis-level needs.*

Eligible Practitioners:

Rehabilitative Services Professional (all types)
Qualified Mental Health Provider – Bachelor's
QSAP II & III
Qualified Mental Health Provider– Non-Degreed
Qualified Paraprofessional (QPP)
Registered Nurse (RN) licensed under Alabama law
Licensed Practical Nurse (LPN) licensed under Alabama law
Certified Nursing Assistant
A Certified Medical Assistant certified through the American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT)
Certified Mental Health Peer Specialist (Youth, Adult, and Parent)
Certified Recovery Support Specialist (CRSS)

Maximum Billable Unit(s):

16 per year

⁴ <https://www.cms.gov/medicare/payment/prospective-payment-systems>

Billing Restrictions

May not be billed in combination with Intake Evaluation (90791)

Procedure Codes and Modifiers

Initial referral, screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.	T1023	HE	
Initial referral, screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.	T1023	HF	
Initial referral, screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.	T1023	HE	GT
Initial referral, screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.	T1023	HF	GT
Initial referral, screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.	T1023	HE	FQ
Initial referral, screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.	T1023	HF	FQ

Service Location:

Services can be delivered in any allowable setting that is acceptable for CCBHCs for both the person receiving services and staff member, that affords an adequate therapeutic environment, and that protects the person receiving services' rights to privacy and confidentiality.

Additional Information:

Utilization of this billing code will be monitored through retrospective reviews.

Carried Costs/Carved In Non-Triggering Services and Activities

In addition to the above Triggering Event services, CCBHCs are responsible for engaging in activities that support individuals served, but that will not trigger a PPS payment. The cost for delivering these activities *is* carved into the CCBHC's Cost Report, meaning it will be incorporated as part of the CCBHC's bundled rate.

However, delivery of the below activities without another triggering event service provided on the same day will not result in a PPS payment to the CCBHC. Accordingly, these services will not impact the visit day count of the CCBHC's Cost Report. Days when only these carved in services are provided to a Medicaid enrollee without another triggering event service will not be included in the CCBHC's visit day count for its Cost Report.

Additionally, because costs associated with these activities are included in the CCBHC's Cost Report, CCBHCs should not bill for the same service/activity via another reimbursement mechanism (e.g., billing TCM for Target Groups 1, 3, and 9 through fee for service Targeted Case Management/Chapter 106). CCBHCs should submit these service codes as part of their claiming processes to ADMH described above.

The list of activities that are carved in as 'carried costs' to the Alabama CCBHC model (those that do not trigger a PPS payment) can be found here: <https://mh.alabama.gov/certified-community-behavioral-health-clinics/for-current-ccbhc/>

Carved Out Services Not Included in Alabama's CCBHC

There are also services that Medicaid and ADMH have determined to be 'carved out' of the CCBHC. The cost of these services should not be included in the CCBHC's Cost Report, and CCBHCs will continue to bill for these services via traditional billing mechanisms (e.g., TCM for Target Group 10 through fee for service Targeted Case Management and Assertive Community Treatment (ACT) through the Rehabilitation Option).

The list of services that are carved out of the Alabama CCBHC model can be found here: <https://mh.alabama.gov/certified-community-behavioral-health-clinics/for-current-ccbhc/>

Service Code Process

In addition to billing the PPS rate code and modifier to Alabama Medicaid, ADMH requires CCBHCs to submit claims for the individual triggering and non-triggering events that were provided during a CCBHC visit.⁵ These detailed claims or encounter data are needed to track important performance measures. *Only triggering events should be submitted to Medicaid for payment. All information, including triggering and non-triggering service codes are sent to ADMH for state reporting only.*

Detailed claims or encounter data are critical to successful PPS rate setting and rebasing. CCBHCs that under report these service codes will risk substantive reductions in future PPS rates that may be tested and justified against these claims.

Providers are required to include all codes associated with services provided on the submitted claim. While it should be rare, if a provider identifies that there was a service that was missed, any corrections should be submitted using an electronic process. Within the electronic process an adjustment is called a replacement claim (replacing an original paid claim), and a recoupment is called a void.

The PPS rate code and modifier should be bundled with the corresponding triggering and non-triggering events provided to the attributed member for that month, including all relevant billing codes. Please note, providers must update date span to include dates of all services.

⁵ <https://mh.alabama.gov/certified-community-behavioral-health-clinics/for-current-ccbhc/>

Other Billing Considerations of Note

Eligibility and Enrollment

CCBHCs are responsible for verifying the eligibility of the person receiving services before billing.

CCBHCs are also expected to facilitate the health insurance application and enrollment process for eligible uninsured person receiving services.

Billing Format and Claim Forms

Alabama recognizes two standard claim forms (UB-04 and CMS-1500). This also includes HIPAA transactions 837 Professional and 837 Institutional. Providers should list the appropriate procedure code(s), modifiers when applicable, place of service code, and units of service. Procedure codes for all PPS-covered services delivered to the individual receiving services on that date of service must be included. Claims must include an ICD-10 diagnosis code.

CCBHC providers can electronically submit claims using the Provider Electronic Solutions (PES) software or by using software vendor, Gainwell⁶.

Timely Filing

AMA requires all claims to be filed within 365 days of the date of service.

Electronic Remittance Advice (ERA)

The 835 Health Care Payment/Advice, also known as the Electronic Remittance Advice (ERA), provides information for the payee regarding claims in their final status, including information about the payee, the payer, the payment amount, and any payment identifying information.

Using Grant Funds to Supplement Not Supplant CCBHC Services

Grant funds – including but not limited to SAMHSA CCBHC Planning, Development and Implementation (PDI) and Improvement and Advancement (IA) Grants - may be used to supplement existing activities that cannot be charged to the individual's insurance. Grant funds may not be used to supplant current funding of existing activities. "Supplant" is defined as replacing funding of an organization's existing program with funds from a federal grant (2 CFR Part 200, Appendix XI).

Line items that are contained within an agency's grant budget may not be included in the CCBHC's Cost Report, unless the agency makes a modification to the grant budget such that the line item becomes an "Actual Cost" (or Anticipated Cost in the case of a CCBHC completing its first Cost Report) to the CCBHC program operations. Line items should not be duplicated within a grant

⁶ Gainwell Technologies is a company that provides technology solutions and services for various state Medicaid programs, including Alabama Medicaid. Their role typically involves managing and processing claims, providing data analytics, and improving the overall efficiency and effectiveness of Medicaid services. Gainwell may also support the implementation of Medicaid policies, enhance the provider and member experience, and help with compliance and reporting requirements. Their technology solutions aim to streamline operations and ensure that beneficiaries receive the services they need.

budget and the CCBHC Cost Report.

Agencies who have questions specific to other grant funding and CCBHC operations should reach out to ADMH at ccbhc.dmh@mh.alabama.gov.

Evidence Based Practices (EBPs)

A CCBHC may demonstrate it meets the following requirements through the provision of training and/or credentialing/certification of staff members. Where an EBP requires credentialing/certification to be delivered, staff members who deliver treatment must be credentialed/certified or seeking credentialing/certification as demonstrated by enrollment in such a process. Any EBPs with a certification verification process should be verified to ensure the practitioner is qualified to provide the treatment modality. It is the responsibility of the CCBHC to review the requirements for each EBL implemented.

Enrollment and Credentialing of Staff

To ensure the safety and quality of services delivered in the CCBHC, all CCBHCs are required to follow AMA and ADMH credentialing guidelines to ensure services are delivered by staff with the appropriate training, licensure, and certification.

Items Needed for Credentialing

- Collect and verify detailed information about the provider's qualifications.
 - Official government-issued identification (Driver's License, Non-Driver's ID, and passport are the only acceptable forms of identification).
 - Personal details like contact information
 - Educational background
 - Work history
 - Professional licenses and certifications related to the job
 - Malpractice history and disciplinary actions ⁷(e.g., ethical violations)
 - Malpractice insurance coverage (maybe required if not provided by CCBHC)
- All staff's credentials and backgrounds must be reviewed post-offer and before interaction with CCBHC participants to ensure:
 - They are not excluded from providing services or through the Alabama Medicaid program⁸
 - They are not conflicted from providing services through Medicare, Medicaid, or other federal funding⁹
 - All staff must undergo a criminal background check and child maltreatment screenings post-offer and pass before interaction with people receiving CCBHC services.
 - Obtain and verify references (including program director, department chair)

⁷ To find out if a practitioner has a malpractice history, you can check their license status with your state's licensing board, which will usually include any disciplinary actions taken against them, including malpractice claims; you can also access the [National Practitioner Data Bank \(NPDB\)](#) which contains information about malpractice payments made by healthcare practitioners across the United States

⁸ [Alabama Medicaid](#)

⁹ [Search the Exclusions Database | Office of Inspector General](#)

Primary Source Verification (PSV)

All credentials must be verified through PSV. Secondary sources of information (e.g., a resume, application, verbal verification) might be inaccurate, unreliable, or biased to verify up-to-date licensure and malpractice history.

The following information must be verified only through PSV:

- Criminal background status and child abuse clearance
- Highest level of education reported (verification through school's Registrar (database, sealed letter from school's registrar's office))
- Where applicable, the practitioner's board certification status, licenses, certifications, DEA registration status, and malpractice history (see Appendix A for a list of Alabama licensing, malpractice history, databases by profession)
- Practitioner's work history
- Professional liability coverage

All PSV review records must be stored in a password-protected file or secure location for potential certifier/auditor review.

Assessment and Identification of Gaps or Discrepancies

After the verification process, the gathered data is thoroughly assessed for inconsistencies or gaps in the practitioner's history. Check for missing employment periods, unreported malpractice claims, or disciplinary actions not initially disclosed.

Any discrepancies or red flags must be investigated and resolved before proceeding. Credentialing staff rarely make decisions about credentialing. Rather, they provide the data and key insight for leaders in administrative roles or on committees to move the provider forward in the process.

Recredentialing

All CCBHC practitioners who furnish services directly, and any Designated Collaborating Organization (DCO) practitioners that furnish services under arrangement with the CCBHC, are legally authorized in accordance with federal, state, and local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations. This includes any applicable state Medicaid billing regulations or policies. Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers must assure their staff and contractors have and maintain all necessary state-required licenses, certifications, or other credentialing.

Minimum Qualifications for Staff Providing CCBHC Services

A Rehabilitative Services Professional is defined as the following:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- An associate licensed counselor under Alabama law
- An independent Clinical social worker licensed under Alabama law
- A licensed master social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A marriage and family therapist associate licensed under Alabama law

- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- A Masters Level Clinician is an individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other human service field areas and is under the supervision of a master's level or above clinician with two years of postgraduate clinical experience
- QSAP I (Substance Abuse): A Qualified Substance Abuse Professional I shall consist of: (i) An individual licensed in the State of Alabama as a: (I) Professional Counselor, Graduate Level Social Worker, Psychiatric Clinical Nurse Specialist, Psychiatric Nurse Practitioner, Marriage and Family Therapist, Clinical Psychologist, Physician's Assistant, Physician; or (ii) An individual who: (I) Has a master's Degree or above from a nationally or regionally accredited university or college in psychology, social work, counseling, psychiatric nursing, and * (II) Has successfully completed a clinical practicum or has six month's post master's clinical experience; and * (III) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of date of hire

Other staff members who are qualified to provide CCBHC services (within their scope of practice and in alignment with the "Eligible Practitioners" guidance above) include:

- A physician licensed under Alabama law
- A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners
- A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses or multistate licensure privilege
- A pharmacist licensed under Alabama state law may provide medication monitoring
- A Registered Nurse licensed under Alabama state law
- A Practical Nurse licensed under Alabama state law
- Qualified Mental Health Provider – Bachelor's – A person with a Bachelor's Degree in a human services field
- Qualified Mental Health Provider– Non-Degreed – A person with a high school diploma or GED supervised by a Rehabilitative Services Professional
- A Nursing Assistant certified pursuant to Alabama State Law.
- A Certified Medical Assistant certified through the American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT).
- Medication Assistant Certified (MAC) Worker – A person working under a Medication Assistance Supervising (MAS) nurse that meets the Alabama Board of Nursing requirements.
- A Certified Mental Health Youth Peer Specialist - Youth who has personal verified lived experience with children and adolescent's mental health, who is willing to share his/her personal experiences, who has at least a high school diploma or GED, and who has satisfactorily completed a Mental Health Youth Peer Specialist training program approved by the state within six (6) months of date of hire. Certified Mental Health Peer Specialist must be supervised by a Rehabilitative Services Professional.
- A Certified Mental Health Adult Peer Specialist who has personal verified lived experience with recovery from mental illness, who is willing to share his/her personal experiences, who has at

least a high school diploma or GED, and who has satisfactorily completed a Mental Health Peer Specialist training program approved by the state within six (6) months of date of hire. A Mental Health Certified Adult Peer Specialist must be supervised by a Rehabilitative Services Professional.

- A Mental Health Youth Parent Peer Support Specialist provider who is parenting or has parented a child experiencing mental, emotional or behavioral health disorders and can articulate the understanding of their lived experience with another parent or family member. This individual may be a birth parent, adoptive parent, family member standing in for an absent parent, or other person chosen by the family or youth to have the role of parent. This individual has at least a high school diploma or GED and has satisfactorily completed a Mental Health Youth Parent Peer Support Provider training program approved by state within six (6) months of date of hire. A Mental Health Youth Parent Peer Support Specialist must be supervised by a Rehabilitative Services Professional
- QSAP II shall consist of: An individual who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Is licensed in the State of Alabama as a Bachelor Level Social Worker; or (III) Has a Bachelor's Degree from a nationally or regionally accredited college or university in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (IV) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium.
- QSAP III shall consist of: An individual who: (I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community-rehabilitation, pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and (II) Participates in ongoing supervision by a certified or licensed QSAP I for a minimum of one (1) hour individual per week until attainment of a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, or Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of hire.
- Qualified Paraprofessionals (QPP) shall have the following minimum qualifications: (i) A high school diploma or equivalent, and (ii) One (1) year of work experience directly related to job responsibilities and (iii) Concurrent participation in clinical supervision by a licensed or certified QSAP I.
- Certified Recovery Support Specialist (CRSS) must meet the following minimum qualifications: (i) Certified by ADMH as a Certified Recovery Support Specialist (CRSS) within six (6) months of date of hire, (ii) and has 2 years verified lived experience and (iii) Concurrent participation in clinical supervision by a licensed or certified QSAP I.
- A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses
- A Pharmacist licensed under Alabama state law.
- A Registered Nurse licensed under Alabama state law or multistate licensure privilege.

- A Practical Nurse licensed under Alabama state law or multistate licensure privilege.
- Medication Assistant Certified (MAC) Worker – A person working under a Medication Assistance Supervising (MAS) nurse that meets the Alabama Board of Nursing requirements

Billing for Family Engagement

While it is recognized that involvement of family members may be necessary and appropriate to support the individual being served by a CCBHC, provision of services where the family is involved must be clearly directed towards meeting the identified individual's needs. Services provided to non-Medicaid eligible family members independent of meeting the identified person receiving services' needs are not covered by Medicaid.

CCBHC Service Monitoring and Reporting

To ensure that CCBHCs in Alabama provide effective, efficient, and coordinated care to individuals, this section outlines the requirements for monitoring and reporting services to payers, which have been determined to be paid in error. This process applies to all staff members, including clinical, administrative, and support staff within the CCBHC, as well as external partners and service providers involved in the delivery of behavioral health services.

Services paid in error including the following:

Action	Description
Duplication of Services	The provision of the same or similar behavioral health services to an individual by multiple provider agencies within an episode of care, leading to unnecessary costs and potential confusion in care delivery.
Upcoding	Upcoding refers to the practice of billing for a service at a higher complexity level than what was provided, often leading to increased reimbursement. Note: This includes billing for time-based procedure codes where the "8-minute rule" applies. The "8-minute rule" states, for any single timed CPT code on the same day, measured in 15-minute units, practitioners must bill a single 15-minute unit for treatment greater than or equal to 8 minutes through (and including) 22 minutes.
Unbundling	Unbundling involves separating related services into individual billable components instead of using a bundled code, which can also inflate costs. CCBHCs must use the PPS rate for persons served, unless the service provided is carved out of the PPS rate. While each CCBHC is expected to provide information about all services provided during the visit day, only one claim per Medicaid enrollee per visit day is to be submitted for reimbursement under the PPS rate.

Implementation of Auditing and Monitoring

The CCBHC will implement a system to monitor services provided to each person being served, including:

- Regular audits of the individual being served records to identify any overlapping CCBHC services across multiple providers.
- Utilization reviews to assess the appropriateness and necessity of services being delivered.
- Staff will be trained to recognize and report any instances of duplicate services.

The CCBHC will also maintain a reporting protocol to notify payers of any services paid in error. This may consist of:

- **Internal Audits.** Comprehensive reviews of clinical and administrative processes, focusing on billing practices, service delivery, and adherence to regulations.
- **Performance Audits.** Evaluating the effectiveness of programs and services offered by the CCBHC, including patient outcomes and satisfaction.
- **Compliance Audits.** Assessing adherence to federal and state regulations, including those set forth by AMA and other relevant bodies.

As a condition of payment, Medicare and Medicaid require that items and services be medically reasonable and necessary. Therefore, CCBHCs should ensure that any claims reviews and audits include a review of the medical necessity of the item or service by appropriately credentialed personnel. CCBHCs that do not include clinical review of medical necessity in their claim's audits may fail to identify important compliance concerns relating to medical necessity.

Compliance and Program Integrity

The CCBHC will provide timely reporting summarizing any claims where services were paid in error and did not result in a Medicaid denial or adjustment. Detailed documentation of the nature of the services, the practitioners involved, and the actions taken to resolve any errors and duplications should be retained. The CCBHC will engage in ongoing communication with ADMH and AMA to ensure transparency and compliance with reimbursement policies.

Overpayments

Overpayments occur when a CCBHC receives funds from AMA that exceed the amount owed for services rendered. Common causes of overpayments in a CCBHC setting may include:

- Billing for services not provided or not medically necessary.
- Errors in coding or billing practices.
- Duplicate claims submissions for the same service.
- Misinterpretation of service limits or eligibility criteria.

Upon identification of an overpayment, CCBHCs must take immediate corrective action such as:

Item	Description
Reporting Overpayments	CCBHCs are required to report overpayments to Alabama Medicaid no later than 60 days after the overpayment is identified. This reporting is crucial for maintaining compliance and avoiding potential penalties.
Correcting Overpayment	Once an overpayment is reported, CCBHCs must initiate a withhold process, which involves withholding future payments to correct the overpayment to the CCBHC
Documentation	CCBHCs must maintain thorough documentation of all overpayment investigations, corrective actions taken, and communications with Alabama Medicaid regarding the resolution of the issue.

If a CCBHC identifies billing mistakes or other non-compliance with program rules leading to an overpayment, the provider must repay the overpayments to Medicare and/or Medicaid to avoid False Claims Act liability.

Making Corrections to Submitted Claims - Adjustments

While it should be rare, if a CCBHC identifies that there was a mistake made in claiming, any corrections should be submitted using the Alabama Medicaid electronic process. Within the electronic process an adjustment is called a replacement claim (replacing an original paid claim) and a recoupment is called a void. Adjustments may be performed only on claims paid in error (for example, overpayments, underpayments, and payments for wrong procedure code, incorrect units, or other errors). The adjustment process allows the system to "take back" or cancel the incorrect payment and reprocess the claim as if it were a new claim. Providers must submit their adjustment requests electronically.

Preventing Fraud, Waste, and Abuse (FWA)

CCBHCs must implement robust policies and practices to prevent fraud, waste, and abuse, which is defined as:

Item	Description
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
Waste	As defined by CMS, "The overutilization of services or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather misuse of resources".
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes practices that result in unnecessary cost to the Medicaid program.

It is the policy of the state of Alabama for providers to have an FWA compliance program which reflect the regulations, recommendations, standards, and guidance set forth by the following agencies towards the detection, deterrence, and prevention of FWA in Medicaid-funded behavioral health care:

- U.S. Justice Department (DOJ)
- Office of Inspector General (OIG)
- Attorney General's Medicaid Fraud Control Section (MFCS)
- Medical Assistance/Medicaid program
- Bureau of Program Integrity (BPI)
- Office of Mental Health and Substance use Services (OMHSAS) of the Department of Human Services (DHS)
- Centers for Medicare and Medicaid Services (CMS)

CCBHCs should leverage tools and references that include, but are not limited to the following:
Code of Federal Regulations

- Medical Assistance Regulations and Bulletins
- Alabama Annotated Code
- Licensing regulations
- Fee schedules
- Provider manuals
- Provider alerts

Failure to address issues related to fraud, waste, and abuse can lead to severe consequences, including:

- **Negative Financial Impact.** CCBHCs may incur fines and/or withholds for identified overpayments or fraudulent activities.
- **Loss of Medicaid Enrollment.** Serious violations can result in the termination of the clinic's participation in the Alabama Medicaid program, severely impacting service delivery.
- **Legal Action.** Engaging in fraudulent practices can expose CCBHCs and their staff to criminal prosecution and civil liability.

Medicaid Financial Auditing, Corrective Action, and Decertification Standards and Processes

CCBHCs must undergo regular financial audits to ensure compliance with Medicaid billing regulations. The auditing process will include:

- **Frequency of Audits.** CCBHCs will be audited at least annually, with additional audits conducted as needed based on previous audit results or reports of non-compliance.
- **Scope of Audits.** Audits will review billing practices, clinical documentation, service delivery, and financial records to ensure adherence to Medicaid guidelines.
- **Audit Findings.** All findings must be documented, and CCBHCs will receive a written report detailing the results. Findings will be categorized as minor, moderate, or major based on the severity of the non-compliance.

Disclaimer: *The Certified Community Behavioral Health Clinic (CCBHC) Contract Billing Manual serves as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, or item is covered is not a determination that a provider will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis.*

Providers should utilize appropriate billing and submission guidelines, including industry standard, compliant codes on all claim submissions. Services should be billed with appropriate Current Procedural Terminology (CPT®) codes and Healthcare Common Procedure Coding System (HCPCS) codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the patient's medical record.

The billing manual may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in revisions to the billing manual. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the billing manual. In addition, we reserve the right to review and revise the billing manual when necessary. When there is an update, we will publish the most current billing manual to our website.