healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	CCBHC Provider Billing Guidance (UB-04 Billing)		
Policy Number:	PO-RE-173v1		
Effective Date:	7/1/2025	**Last Approval Date:**	7/29/2026

I. Policy Description

This reimbursement policy describes Healthfirst's reimbursement requirements for Certified Community Behavioral Health Clinic (CCBHC) services provided to eligible Healthfirst members. The policy establishes claim submission, coding, modifier, billing, and reimbursement requirements for services reimbursed under the New York State Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS) and other applicable reimbursement methodologies.

This policy is intended to promote accurate claims submission, facilitate timely claims adjudication, ensure consistency in reimbursement, and support compliance with applicable federal and New York State regulations, including guidance issued by the Centers for Medicare & Medicaid Services (CMS), the New York State Department of Health (NYSDOH), the Office of Mental Health (OMH), and the Office of Addiction Services and Supports (OASAS).

Reimbursement is subject to member eligibility, covered benefits, provider participation status, applicable provider agreements, medical necessity, coordination of benefits, and all Healthfirst payment and reimbursement policies.

The information below applies to the following lines of business:

• Medicaid Managed Care (MMC)	• Integrated Benefit Dual Plan (IB-Dual)
• Medicare Advantage HMO	• Medicaid Advantage Plus/MAP (CompleteCare)
• Personal Wellness Plan (HARP)	

Policy Scope

This policy applies to participating Certified Community Behavioral Health Clinics (CCBHCs) billing Healthfirst for covered behavioral health services provided to members enrolled in applicable Healthfirst products, including:

- Medicaid
- Medicare Dual Eligible Special Needs Plans (D-SNP)
- Integrated Benefits (IB) Dual

- Other applicable Healthfirst Lines of Business, **as determined by the member's benefit plan**

Reimbursement Guidelines

CCBHC Medicaid services are carved out of Medicaid Managed Care. CCBHC PPS claims (HCPCS T1040 with the applicable rate code) are billed directly to New York State Medicaid Fee-for-Service (FFS) and are not reimbursable by Healthfirst Medicaid Managed Care plans**.**

Unless otherwise required by contract or regulatory guidance, providers should submit CCBHC claims using the UB-04 (837I) institutional claim format. Reimbursement under the CCBHC Prospective Payment System (PPS) is based on the submission of HCPCS code T1040 with the applicable CCBHC rate code and required modifier. Encounter procedure codes are reported to identify services rendered and support claims processing but do not determine the PPS payment.

Important: CCBHC PPS (HCPCS T1040) claims are carved out of Medicaid Managed Care and are billed directly to New York State Fee-for-Service Medicaid. Healthfirst does not reimburse the T1040 PPS line for Medicaid Managed Care or IB Dual.

Claims submitted without the required billing elements may be denied or placed on hold for review or require correction before reimbursement.

Billing Instructions

- Providers submitting claims for CCBHC services should adhere to the following billing requirements.

Institutional Claim Submission

- Submit CCBHC services using the UB-04 (837I) institutional claim form.
- This billing methodology applies to all applicable Healthfirst products unless otherwise specified.

CCBHC PPS Billing Requirements

For Medicaid CCBHC services reimbursed under the Prospective Payment System (PPS), claims should include:

- UB-04 (837I)
- Rate Code 1147
- HCPCS T1040 (CCBHC PPS Per Diem)
- Appropriate U modifier (U1, U2, U3, or U4)

The T1040 service line represents the CCBHC PPS daily payment. For applicable Medicaid claims, reimbursement is made by New York State Fee-for-Service Medicaid under the CCBHC PPS methodology. Healthfirst does not reimburse the T1040 line.

Reporting Encounter (Service) Codes

In addition to HCPCS T1040, providers should report all applicable OMH/OASAS-approved CPT or HCPCS encounter procedure codes on separate claim lines to identify services furnished during the visit.

Examples include:

- 90791 – Psychiatric Diagnostic Evaluation
- 90834 – Psychotherapy, 45 minutes
- 90837 – Psychotherapy, 60 minutes
- 90853 – Group Psychotherapy

Additional OMH/OASAS-approved procedure codes may be reported, as appropriate.

Encounter procedure codes identify services rendered for reporting and claims processing purposes. PPS reimbursement is based on HCPCS T1040 and is not determined by the encounter procedure code(s).

Providers should reference the current New York State OMH CCBHC Allowable CPT Code Crosswalk for the complete list of approved encounter codes.

Modifier Requirements

One of the following modifiers must be reported on HCPCS T1040.

Modifier	Description
U1	CCBHC provider furnishing services at a CCBHC location
U2	CCBHC provider furnishing services at a location other than a CCBHC location
U3	Designated Collaborating Organization (DCO) provider furnishing services at a CCBHC location
U4	DCO provider furnishing services at a location other than a CCBHC location

Note: U modifiers are required for reporting purposes but do not impact the CCBHC PPS daily payment rate.

Medicaid Billing Instructions

For Medicaid Managed Care members, CCBHC PPS claims (T1040 with Rate Code 1147) should be billed directly to New York State Fee-for-Service Medicaid, as these services are carved out of Medicaid Managed Care. Healthfirst does not reimburse the CCBHC PPS (T1040) line under Medicaid Managed Care.

Healthfirst does not reimburse the CCBHC PPS (T1040) line under Medicaid Managed Care. Providers should report all applicable encounter procedure codes in accordance with New York State billing guidance and submit PPS claims to Fee-for-Service Medicaid.

Medicare D-SNP Billing Instructions
For members enrolled in both **Medicare and Medicaid**:

Step 1 – Bill HF Medicare

Submit the claim to the member's Healthfirst Medicare D-SNP plan using a UB-04 (837I).

Step 2 – Medicare Processing

- Medicare-covered CCBHC services included in the approved crosswalk reimburse at the applicable Healthfirst Medicare contracted rate.
- Non-Medicare-covered services deny

Step 3 – Bill Fee-for-Service Medicaid

Following Medicare adjudication, bill FFS Medicaid, when applicable, using:

- UB-04 (837I)
- Rate Code 1147
- T1040
- Appropriate U modifier

When applicable, New York State Fee-for-Service Medicaid reimburses the difference between the Medicare payment and the CCBHC PPS payment in accordance with state and federal coordination-of-benefits requirements.

Integrated Benefits (IB) Dual Billing Instructions

For Healthfirst Integrated Benefits (IB) Dual members:

Submit claims using:

- UB-04 (837I)
- Rate Code 1147
- HCPCS T1040
- Appropriate U modifier

Healthfirst does not reimburse the CCBHC PPS (T1040) line for IB Dual. However, eligible Medicare-covered CCBHC service lines submitted on the claim may be reimbursed in accordance with the member's IB Dual benefits and applicable reimbursement policies. Providers should bill the CCBHC PPS claim to New York State Fee-for-Service Medicaid, as applicable.

Step-by -Step Billing Instructions for IB Dual members:

1. Submit the initial claim to Healthfirst Medicare (IB Dual).
   Bill Healthfirst Medicare (IB Dual) as the primary payer for all covered services.

2. Allow the claim to automatically cross over.
   After Healthfirst Medicare processes the claim, it will automatically cross over to Healthfirst Medicaid for secondary processing. No separate submission to Healthfirst Medicaid is required.

3. Review both remittance advices (ERAs).
   After secondary processing is complete, providers will receive:
   - One ERA from Healthfirst Medicare (primary payer), and
   - One ERA from Healthfirst Medicaid (secondary payer).

4. Review reimbursement for the crossover claim.
   After Healthfirst Medicare processes the claim, Healthfirst Medicaid adjudicates the crossover claim. Eligible Medicare-covered, non-CCBHC service lines included on the claim may be reimbursed according to the member's IB Dual benefits and applicable reimbursement policies. **The CCBHC Prospective Payment System (PPS) line billed with HCPCS T1040 is not reimbursed.** Providers should bill the CCBHC PPS payment to New York State Fee-for-Service Medicaid, as applicable once Healthfirst Medicaid process the claim.

5. Submit the CCBHC PPS claim to New York State Fee-for-Service (FFS) Medicaid.
   If applicable, bill **HCPCS T1040 with Rate Code 1147** directly to **New York State Fee-for-Service (FFS) Medicaid** in accordance with New York State Coordination of Benefits (COB) billing requirements to receive the CCBHC PPS payment.

Providers should submit the CCBHC PPS claim (HCPCS T1040 with Rate Code 1147) to New York State Fee-for-Service Medicaid, as applicable for Coordination of Benefits.

Telehealth Billing Instructions

The U modifier is appended to T1040.

Telehealth modifiers are appended to the applicable OMH/OASAS CPT/HCPCS encounter code, not to T1040.

Service Type	T1040 Modifier	Telehealth Modifier (Encounter Code)
In-person, CCBHC location	U1	N/A
In-person, non-CCBHC location	U2	N/A
Video telehealth	U2 (or applicable U modifier)	95 (preferred) or GT
Audio-only telehealth	U2 (or applicable U modifier)	FQ and/or 93
DCO at CCBHC location	U3	As applicable
DCO at non-CCBHC location	U4	As applicable

Do not use U1 for telehealth. For telehealth use **U2** when a CCBHC provider delivers services from a location other than the CCBHC site.

Sample Claim Structure

Claim Line	Code	Modifier(s)	Rate Code	Purpose
1	**T1040**	**U2**	**1147**	CCBHC PPS per diem payment
2	**90837**	**95**	—	Psychotherapy encounter (video telehealth)

Key Billing Reminders

- Submit all CCBHC claims using the UB-04 (837I) institutional claim form.

- Include Rate Code 1147 and HCPCS T1040 with the applicable U modifier on CCBHC PPS claims, when required.
- Report applicable OMH/OASAS CPT/HCPCS encounter procedure codes on separate claim lines.
- Append telehealth modifiers to the encounter procedure code, not to HCPCS T1040.
- CCBHC PPS (T1040) services are carved out of Medicaid Managed Care and are billed directly to New York State Fee-for-Service Medicaid.
- Healthfirst does not reimburse the CCBHC PPS (T1040) line for Medicaid Managed Care or Integrated Benefits (IB) Dual members.
- Eligible non-CCBHC service lines may be reimbursed for IB Dual members in accordance with applicable benefit coverage.
- Follow the appropriate billing pathway based on the member's line of business (Medicaid, Medicare D-SNP, or IB Dual).

Adjudication and Appeal Process

1. Reimbursement for CCBHC services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.

4. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

*For questions regarding CCBHC billing requirements or claims submission, please contact your **Healthfirst Provider Relations Representative** or **Healthfirst Provider Services**.*

II. Applicable Codes

Code	Description	Comment
T1040	Medicaid certified community behavioral health clinic services, per diem	

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

New York State OMH CCBHC Allowable CPT Code Crosswalk
Certified Community Behavioral Health Clinics (CCBHC)
New York State Certified Community Behavioral Health Clinic Billing Guidance

VI. Revision History

Revision Date	Summary of Changes

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Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.