

Subject:	CCBHC Provider Billing Guidance – QHP (UB-04 Billing)		
Policy Number:	PO-RE-177v1		
Effective Date:	07/01/2025	Last Approval Date:	09/21/2026

I. Policy Description

This reimbursement policy describes Healthfirst's reimbursement requirements for Certified Community Behavioral Health Clinic (CCBHC) services provided to eligible members enrolled in Healthfirst Qualified Health Plan (QHP) product.

Healthfirst covers and reimburses Certified Community Behavioral Health Clinic (CCBHC) services when billed in accordance with applicable billing requirements. Reimbursement is based on the submission of HCPCS procedure code T1040, the appropriate rate code, and the required U modifier.

This policy is intended to promote accurate claims submission, facilitate timely claims adjudication, ensure consistent reimbursement, and support compliance with applicable CMS guidance, New York State Department of Health (NYSDOH) requirements, Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS) guidance, and Healthfirst reimbursement policies.

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:

- Qualified Health Plan (QHP)

Billing Guidelines

For members enrolled in Healthfirst Qualified Health Plan (QHP), Healthfirst covers and reimburses services billed with HCPCS T1040 when submitted with the required billing elements.

Providers should submit CCBHC claims using the UB-04 (837I) institutional claim format.

Required Billing Elements

Claims should include:

Billing Element	Requirement
Claim Form	UB-04 (837I)
Procedure Code	T1040
Rate Code	Applicable Healthfirst-approved rate code
Modifier	One required U modifier (U1, U2, U3, or U4)
Revenue Code	As applicable
Diagnosis	Appropriate ICD-10-CM diagnosis code(s)

Modifier Requirements

One of the following modifiers must be reported with 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

The appropriate U modifier is required for accurate claims processing and reimbursement.

Encounter Procedure 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 the services furnished during the visit.

Examples include:

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

Encounter procedure codes identify the services rendered and support claims processing. The procedure code T1040 is the reimbursable billing code when submitted with the applicable rate code and required modifier.

Telehealth Billing Requirements

Healthfirst covers and reimburses eligible telehealth services for Qualified Health Plan (QHP) members when billed in accordance with applicable Healthfirst reimbursement policies, member benefits, and New York State telehealth billing requirements.

The required U modifier must be appended to HCPCS T1040 to identify the CCBHC service location.

Telehealth modifiers must be appended to the applicable CPT®/HCPCS encounter procedure code and not to HCPCS 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)	93 and/or FQ, as applicable
DCO at CCBHC location	U3	As applicable
DCO at non-CCBHC location	U4	As applicable

Reimbursement

Healthfirst reimburses HCPCS T1040 for eligible Qualified Health Plan (QHP) members when:

- The members have active Healthfirst QHP coverage.
- The provider is participating with Healthfirst.
- The claim is submitted on UB-04 (837I).
- The claim includes the applicable rate code.
- HCPCS T1040 is billed with the appropriate U modifier.
- Services are covered under the members' benefit plan.
- All applicable coding, billing, and reimbursement requirements are met.

Claims submitted without the required procedure code, rate code, modifier, or other required billing elements may be denied, rejected, or pending for correction before reimbursement.

Key Billing Reminders

- Submit all claims using the UB-04 (837I) institutional claim form.
- Include HCPCS T1040 with the applicable rate code.
- Report one required U modifier (U1, U2, U3, or U4) on the T1040 line.
- Report applicable CPT®/HCPCS encounter procedure codes on separate claim lines.
- Append telehealth modifiers to the encounter procedure code, not to HCPCS T1040.
- Healthfirst reimburses eligible T1040 claims for Qualified Health Plan (QHP) members in accordance with the member's benefit plan and the provider's participation agreement.

- Claims are subject to standard claims editing, medical necessity review, timely filing requirements, and applicable Healthfirst reimbursement policies.

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, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

For any questions or further clarification regarding this policy, providers are encouraged to reach out to their designated contact within our organization

II. Applicable Codes

Code	Description	Comment
90791	Psychiatric diagnostic evaluation	
90834	Psychotherapy, 45 minutes with patient	
90837	Psychotherapy, 60 minutes with patient	
90853	Group psychotherapy (other than of a multiple-family group)	
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

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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

VI. Revision History

Revision Date	Summary of Changes

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.