IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202675 MAY 14, 2026

IHCP announces clarifications to the policies and billing procedures for the CCBHC program

The Indiana Health Coverage Programs (IHCP) clarifies changes to Certified Community Behavioral Health Clinic (CCBHC) pilot program policies and billing procedures announced in *IHCP Bulletins* *BT2025136* and *BT2024193*. These updates are effective as of **Feb. 1, 2026**.

CMHC and CCBHC services

As previously stated in *BT2025136*, community mental health center (CMHC) and CCBHC providers are not authorized to bill the same procedure code for the same member on the same date of service (DOS). CMHC claim details will deny as follows, when the service billed is the same as one billed by a CCBHC for the same member on the same DOS:

- If the CMHC claim is submitted after the CCBHC claim for the same service, same member and same DOS has been paid, the CMHC claim detail for that service will be denied with explanation of benefits (EOB) code 6356 – *Service not allowed same DOS as CCBHC*.
- If the CMHC claim has already been paid prior to a CCBHC claim being submitted for the same service, same member and same DOS, the CMHC claim detail that was previously paid for that service will be recouped with EOB code 6357 – *Service not allowed same DOS as CCBHC recoup*.

Exceptions

In limited circumstances, it may be appropriate for services to be provided separately by both a CMHC and a CCBHC. Such circumstances are limited to the following:

- When a member receives CCBHC services on a particular day and has a crisis event in another location on the same day and receives crisis services at the CMHC in that location:
  - ⇨ The CCBHC service should be billed using the CCBHC National Provider Identifier (NPI).
  - ⇨ The crisis event services rendered at the CMHC location should be billed using the CMHC NPI (unless the CMHC is also enrolled as a CCBHC).
- When a member receives school-based CMHC services outside of the CCBHC's designated service area on the same day as services received at a CCBHC:
  - ⇨ The school-based services should be billed using the CMHC NPI.
  - ⇨ The CCBHC services should be billed using the CCBHC NPI.

In these circumstances, the CMHC may bill the services using the appropriate NPI for that service location. The CMHC must include the XE modifier on the claims to indicate that the service is a separate encounter that is distinct because the service meets the requirements as an ***exception*** and that the service occurred during a separate and distinct encounter. ***CMHCs should NOT use the XE modifier for any other reason than these exceptions.***

Assertive community treatment

As announced in *BT2025136*, effective for DOS on or after **Feb. 1, 2026**, CCBHC providers will bill for assertive community treatment (ACT) services using the V4 modifier, instead of the Q2 modifier, along with the appropriate procedure code for ***any*** service delivered by an ACT team member. Procedure code H0039 has been removed from the CCBHC valid encounter (triggerable) code list. CCBHC providers will still be able to bill H0039 (as nontriggerable) for any ACT service that does not have a code that accurately describes the ACT service delivered. However, for the claim to be reimbursable, it must include at least one code from the CCBHC valid encounter code list at myersandstauffer.com.

Services not authorized as audio-only telehealth

In *BT2025136*, the IHCP announced enforcement of face-to-face requirements for procedure codes T1007 – *Alcohol and/or substance abuse services, treatment plan development and/or modification* and T1016 – *Case Management.* The bulletin stated that, because these services are not allowable as audio-only telehealth, claims for T1007 or T1016 billed with modifier 93 – *Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system* will be denied with EOB code 4286 – *Treatment plan/case mgmt. not covered via telemed*.

However, because these two services (T12007 and T1016) are *nontriggerable*, additional claim-processing considerations apply for CCBHCs:

- CCBHC claims for T1016 or T1007 that do **not** also include a triggerable service from the CCBHC valid encounter code list will be denied, regardless of whether modifier 93 is used, because **no triggerable** code is present on the claim.
- CCBHC claims that include T1016 or T1007 **in addition to** a triggerable service from the CCBHC valid encounter code list, as well as the T1040 encounter code, will pay the prospective payment system (PPS) rate, and the T1016 or T1007 service details will be adjudicated as follows:
  - ⇨ If modifier 93 is included for T1016 or T1007, that service detail will be denied because those services **and are NOT allowed to be delivered via audio-only telehealth**.
  - ⇨ If modifier 93 is **not** included for T1016 or T1007 (because the service is delivered in person or using audio-video telehealth [modifier 95]), that service detail will not be denied, but will pay at zero dollars.

Modifiers HL and HE not used on CCBHC claims

When billing any CCBHC services that are rendered by interns or qualifying practitioners completing their clinical hours and billing under a supervisor's National Provider Identifier (NPI), **do not** include the HL or HE modifier on the claim. Make sure that the patient's chart is documented appropriately to indicate that the service was provided by either an intern or a qualifying practitioner under supervision.

Reminder on Emergency Services Only members

IHCP coverage under Package E – Emergency Services Only (ESO) is limited to treatment for medical emergency conditions only. The *Omnibus Budget Reconciliation Act of 1986* (OBRA) defines an emergency medical condition as follows: "A medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member's health in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any organ or part."

A related benefit plan, ESO with Pregnancy Coverage (also known as "Package B") is limited to the same coverage as Package E, plus prenatal and postpartum services.

CCBHCs are reminded that only emergency services may be billed for the Package E population, and only emergency or prenatal/postpartum services may be billed for the Package B population.

T2022 Q2 U1 encounters

For DOS prior to Feb. 1, 2026, CCBHC claims for T2022 Q2 U1 (Care Coordination) should be submitted without the T1040. If triggerable encounter services were provided on the same date as the T2022 Q2 U1, all encounter services and the T1040 may be billed. For DOS on or after Feb. 1, 2026, CCBHC claims for T2022 Q2 U1 can be billed with T1040.

Submitting other insurance information, including for Medicare or commercial TPL, on CCBHC claims

The following sections provide instructions for CCBHCs to follow when submitting claims for members who have other insurance, such as Medicare or private insurance, in addition to Medicaid.

Dually eligible members with Medicare and full Medicaid

For dually eligible members with full Medicaid coverage, the Medicare or Medicare Advantage Plan payment, coinsurance, deductible, and/or copayment information needs to be submitted on the T1040 detail of the CCBHC claim; Medicare payments should not be submitted on the valid encounter details for these members.

Table 1 outlines a claim billed by a CCBHC provider for a member with full Medicaid coverage and with Medicare or a Medicare Advantage Plan as the primary payer. This claim is billed with the T1040 encounter code along with a valid CCBHC encounter service code.

Table 1 - Claim details for a dually eligible member with full Medicaid

Claim Detail	From Date of Service	Through Date of Service	Procedure Code	Modifier	Billed $
1	4/1/2026	4/1/2026	T1040		$315.00
2	4/1/2026	4/1/2026	98000	Q2 95	$0.00

Coordination of benefits (COB) information must be submitted at the detail level, and the amounts must total to the header amounts submitted. Detail 1 in Table 1 represents the provider's rate plus the member's total cost share amount.

Table 2 – Detail-level COB information for a dually eligible member with full Medicaid

Detail Number	Payer #	Payer ID	Payer Name	Paid Amount	Paid Date	Medicare Deductible	Medicare Copayment	Medicare Coinsurance
1	1	XXXXX	Medicare	$25.00	4/2/2026	$0.00	$0.00	$0.00

The Medicaid claim depicted in Tables 1 and 2 would pay as follows:

CCBHC provider rate ($300.00) – Medicare payment ($25.00) = $275.00

Dually eligible members with Medicare and QMB-Only or SLMB-Only

When a CCBHC bills the IHCP for services provided to a member who does **not** have full Medicaid coverage, but instead has ***only*** Qualified Medicare Beneficiary coverage (QMB-Only) or ***only*** Specified Low-Income Medicare Beneficiary coverage (SLMB-Only), the T1040 encounter code should not be submitted on the claim. Table 3 outlines a claim billed by a CCBHC provider for a QMB-Only or SLMB-Only member.

Table 3 – Claim detail for QMB-Only or SLMB-Only member

Claim Detail	From Date of Service	Through Date of Service	Procedure Code	Modifier	Billed $
1	4/1/2026	4/1/2026	98000	Q2 95	$25.00

COB information must be submitted at the detail level, as shown in Table 4, and the amounts must total to the header amounts submitted.

Table 4 – Detail-level COB information for a QMB-Only or SLMB-Only member

Detail Number	Payer #	Payer ID	Payer Name	Paid Amount	Paid Date	Medicare Deductible	Medicare Copayment	Medicare Coinsurance
1	1	XXXXX	Medicare	$10.00	4/2/2026	$15.00	$0.00	$0.00

The Medicaid claim depicted in Tables 3 and 4 would pay as follows:

Medicare deductible ($15.00) + copayment ($0.00) + coinsurance ($0.00) = $15.00

Commercial TPL

When submitting claims to the IHCP for members with private insurance (also known as commercial TPL), CCBHC providers should include the T1040 on the claim, along with all encounter services provided, and should report TPL at each detail level and sum that information up to the claim header.

Table 5 outlines a claim billed by a CCBHC provider for a member that has commercial TPL. This claim is billed with the T1040 encounter code along with a valid CCBHC encounter service codes.

Table 5 - Claim detail for member with private insurance

Claim Detail	From Date of Service	Through Date of Service	Procedure Code	Modifier	Billed $
1	4/1/2026	4/1/2026	T1040		$300.00
2	4/1/2026	4/1/2026	98000	Q2 95	$0.00
3	4/1/2026	4/1/2026	90832	Q2	$0.00

COB information must be submitted at the detail level, and the amounts must total to the header amounts submitted.

Table 6 – Detail-level COB information for member with private insurance

Detail Number	Payer #	TPL Payer ID	TPL Payer Name	Paid Amount	Paid Date
1	1	XXXXX	My Insurance Co.	$0.00	4/2/2026
2	1	XXXXX	My Insurance Co.	$25.00	4/2/2026
3	1	XXXXX	My Insurance Co.	$25.00	4/2/2026

The Medicaid claim depicted in Tables 5 and 6 would pay as follows:

CCBHC provider rate ($300.00) – total TPL payment amount ($50.00) = $250.00

Clarifications on benefit start periods for MRO Level of Need (LON) 4

As stated in *IHCP Bulletin* BT2024210, CCBHC providers do not need to create Medicaid Rehabilitation Option (MRO) packages through the Division of Mental Health and Addiction (DMHA) Data Assessment Registry for Mental Health and Addiction (DARMHA) database. CCBHC providers only need to request prior authorization (PA) for units above and beyond the unit thresholds in the adult or child level-of-need (LON) 4 MRO service package.

MRO service unit thresholds are based on a 180-day benefit period. When a CCBHC submits a claim for a MRO service, the claim-processing system will look back through the 180 rolling calendar days prior to the current claim's date of service (DOS) to determine the number of units of that service the member had already exhausted. If adding the units billed in the current claim would cause the total to exceed the threshold for that service under the LON 4 MRO package, and PA for the additional units has not been attained, the claim will deny. In other words, the benefit window for an MRO service is 180 rolling calendar days, starting with the date of service. For any claim submitted for an MRO service, the "anchor date" for the benefit look-back period is always 180 days prior to the DOS on the claim.

Example: Claim paid for DOS Jan. 1, 2026. Then provider bills a claim for March 1, 2026. The start date of the 180-day window would be Jan. 1, 2026, until 180 days after. After 180 days (after June 29, 2026), the next anchor date would be March 1, 2026.

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