BRANDING PAGE

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INTRODUCTION

CCBHC BILLING MANUAL OVERVIEW

The Vermont Department of Mental Health and the Division of Substance Use (DMH/DSU) has developed this guide to assist CCBHCs in billing and preparing for billing for services. This manual **only applies** to those CCBHCs that DMH/DSU has formally certified to participate in Vermont's federal CCBHC Demonstration. This billing manual **does not apply** to programs that have received a CCBHC Expansion Grant or other approvals from the Substance Abuse and Mental Health Services Administration (SAMHSA) but have not received an approved certification from DMH/DSU.

As Vermont participates in this federal demonstration project, aimed at testing the performance and outcomes of the CCBHC model, DMH/DSU expects the program to evolve. Consequently, updates and refinements to this manual will be necessary. Input from program participants, healthcare providers, community members, and clients will be crucial in guiding these updates. Additionally, revisions may be required in response to changes from state and federal authorities, such as the Centers for Medicare and Medicaid Services (CMS) and SAMHSA. Updates will be reflected in the table below as they occur.

VERSION HISTORY

Version Number	Date	Summary of Changes
1.0	April 1, 2025	Publication of Initial CCBHC Billing Manual

This manual serves as a resource for providers, ensuring compliance and consistency across Vermont's CCBHC program operations. This manual provides guidance on the CCBHC billing only. For additional guidance and documentation, please consult the Vermont CCBHC website.

Printed copies of this manual are considered uncontrolled. Providers are responsible for ensuring they are using the most up-to-date version, which can be found at: [**insert website**].

Links to other manuals provided in this document are for your convenience. However, please be aware that they may not reflect the most recent updates. Always refer to the Vermont Medicaid Portal (vtmedicaid.com) to access the most current versions of all relevant manuals.

To request changes or report broken links, please email: **[inbox]**.

PROGRAM OVERVIEW

WHAT SERVICES DO CCBHCS PROVIDE?

Certified Community-Based integrated Health Centers for Mental Health and Substance Use (CCBHCs)[1] in Vermont are required to provide nine core services as outlined in the SAMHSA CCBHC criteria. These services include:

- **Crisis Services:** Includes emergency crisis intervention services, 24-hour mobile crisis teams, and crisis receiving/stabilization services. These services must include suicide prevention and intervention, overdose risk assessment and prevention, and application of trauma-informed care.
- **Screening, Assessment, and Diagnosis:** Provide comprehensive screening, assessment, and diagnosis, including risk assessment for mental health and substance use disorder conditions, in a time frame responsive to the needs and preferences of the individual or family.
- **Person-Centered and Family-Centered Treatment Planning:** A collaborative process to identify and prioritize treatment goals and preferences for the individual or family receiving services, ensuring care is tailored to their needs.
- **Peer and Family/Caregiver Support Services:** These services connect individuals and families with peer specialists and recovery coaches—people who have lived experience with mental health and substance use challenges—to provide guidance, support, and help in accessing resources.
- **Targeted Case Management Services:** Assists individuals in accessing and receiving essential services, including medical, social, legal, educational, housing, vocational, and other community supports.
- **Outpatient Mental Health and Substance Use Services:** Offers therapy, medication management, and other mental health and substance use treatments to address challenges.
- **Psychiatric Rehabilitation Services:** Supports individuals in developing rehabilitative skills for independent living, such as securing housing, education, or employment.
- **Primary Care Screening and Monitoring:** Includes screenings and health assessments to identify and monitor any physical health conditions that may require coordination with a primary care provider or other health professionals.
- **Community Care for Uniformed Service Members and Veterans:** Provide community-based mental health and substance use disorder care consistent with the minimum clinical mental health guidelines of the Veterans Health Administration.

The complete range of outpatient mental health and substance use treatment services are outlined in the Vermont CCBHC Provider Manual/Certification Standards.

WHO IS ELIGIBLE?

CCBHC services are available to all Vermonters seeking help for a mental health or substance use condition, including individuals with serious mental illness (SMI), serious emotional disturbances (SED), mild or moderate mental health and substance use disorders, and co-occurring mental health and substance use disorders. These

[1] The State of Vermont has deliberately removed the term "behavioral" from discussions of mental illness and substance use, as it can carry negative connotations and contribute to stigma.

services are provided to all individuals, regardless of age, race, ethnicity, disability, sexual orientation, gender identity, developmental ability, justice system involvement, housing status, place of residence[2], or ability to pay.

CCBHCs are committed to serving everyone, regardless of where they live or their financial situation. For those who are uninsured or underinsured, CCBHC clinics offer sliding-scale payment options based on income, ensuring that financial status does not prevent access to care. Anyone can walk into a CCBHC clinic to be screened for service eligibility.

INTRODUCTION TO THE PPS-1 METHODOLOGY

CCBHC services will be reimbursed through the daily Prospective Payment System (PPS-1) model. Under this system, each clinic's unique reimbursement rate is determined by dividing its allowable costs by the number of qualifying daily encounters throughout the year. The PPS-1 payment model supports clinics in expanding services, increasing the number of clients they serve, and enhancing their flexibility to deliver client-centered care.

- **Daily PPS Payment:** CCBHCs receive a single payment each day a client receives a qualifying service. The rate is set at a level calculated to cover the clinic's anticipated costs of delivering care over the year.
- **Unique Rates:** Each CCBHC has an individualized payment rate based on its specific care delivery model and the population it serves.

This daily rate structure ensures that CCBHCs are reimbursed appropriately for the services provided while allowing for greater flexibility in meeting client needs.

QUALIFYING VS. SUPPORT SERVICES

There are two primary categories of CCBHC Services in billing:

- **Qualifying Services** – These are allowable services under the CCBHC program that trigger a daily PPS-1 payment when provided. The PPS-1 payment can be triggered only once per day, per member.
- **Support Services** – These are also allowable services under the CCBHC program but do not trigger a PPS-1 payment on their own. While the costs associated with delivering Support Services are factored into the overall PPS-1 rate through the cost report, they do not qualify as a "visit" for the purpose of daily billing unless paired with a Qualifying Service.

This distinction ensures that while all services contribute to the overall care and cost structure, only Qualifying Services directly initiate a PPS payment. However, support services play a critical role in enhancing access and care under the CCBHC model. Below are examples of support services and their rationale for not triggering a payment:

- **T1013, Interpreter Services:**
  The qualifying service for the daily rate would be the mental health or substance use service that required an interpreter. While interpreter services are essential for facilitating communication, they are considered an add-on to the primary mental health and substance use services and are not billed separately. The cost of providing interpreter services is factored into the PPS-1 rate through the cost template.
- **90833, Psychotherapy, 30 minutes with patient:**
  The qualifying service for the daily rate is 90832, while 90833 serves as an add-on for an additional 30 minutes with the patient. The costs associated with providing both services are incorporated into the PPS-1 rate through the cost template.

[2] Individuals who walk into a CCBHC, regardless of their place of residence, have the right to be assessed. However, after the assessment, they may be referred to a provider in their local area.

These examples demonstrate how support services are integrated into the overall payment structure, allowing CCBHCs to deliver comprehensive, holistic care. This payment model balances flexibility—by reducing the number of payment-triggering services and minimizing service-by-service accountability—with the traditional fee-for-service model, where each individual service triggers a payment and ensures accountability for every service provided.

For the complete list of Qualifying and Support codes and services, see page XXX.

BILLING REQUIREMENTS

ENROLLING AS A VERMONT MEDICAID PROVIDER WITH A CCBHC-SPECIFIC NATIONAL PROVIDER IDENTIFIER (NPI)

Introduction: In preparation for billing CCBHC services, DMH/DSU requires all CCBHC providers to complete the following steps to ensure compliance with state and federal regulations:

1. Secure a new NPI specific to your designation as a CCBHC.
2. Enroll as a Vermont Medicaid provider using this new CCBHC NPI.
3. Bill for all CCBHC services using this CCBHC NPI beginning on the date of service provided in your approval letter.

STEP 1: SECURING A NEW CCBHC NPI

Providers must obtain a new NPI through the National Plan and Provider Enumeration System (NPPES) website. This NPI will be specific to your CCBHC designation and should include the following taxonomy:

- **Taxonomy Code:** 251S00000X
- **Type:** Community/Behavioral Health
- **Classification:** Clinic/Center
- **Specialization:** Public Health, State or Local
- **Level:** Level III - Area of Specialization

For detailed application instructions, refer to the NPI Application Guide.

STEP 2: ENROLLING AS A VERMONT MEDICAID PROVIDER USING THE CCBHC NPI

Once the new NPI is obtained, CCBHC providers must enroll as Medicaid providers using this new NPI. Enrollment will be done via the Vermont Medicaid Portal.

At a minimum, the following documentation is required for enrollment:

- NPI and Taxonomy approval letter
- Current W-9 form
- CCBHC certification approval letter from DMH/DSU

BILLING PROCESS & CODES

The Centers for Medicare and Medicaid Services has established specific billing codes for CCBHCs participating in the federal demonstration project. On November 17, 2016, CMS published the 2017 Alpha Numeric Healthcare Common Procedure Coding System (HCPCS) file, which includes dedicated billing codes for CCBHC demonstration encounters, as well as a billing code modifier.

The "T" codes are used exclusively for billing services related to CCBHC demonstration encounters, while the Q2 modifier is applied to capture service-level data for each encounter. These codes are effective for dates of service beginning on or after January 1, 2017.

In Vermont, CCBHCs may begin demonstration billing starting on the date of service specified in their DMH/DSU certification letter and may continue billing until the end of the Vermont demonstration period[3], the certification end date, or three years from the date of certification approval, whichever occurs first. Please note that Vermont CCBHCs are only authorized to use demonstration billing codes while they maintain active certification by DMH/DSU.

BILLING CODES AND DESCRIPTIONS FOR DAILY RATES

The following HCPCS identifiers must be present on all CCBHC Medicaid claims:

HCPCS	Long Description	Short Description
T1040	Medicaid certified community behavioral health clinic services, per diem	Comm bh clinic svc per diem
Q2	Demonstration procedure/service	Demo procedure, service

These codes are essential for ensuring accurate billing and reporting for CCBHC demonstration services.

In addition to the above, all individual CCBHC services provided during a specific day must be identified as discrete procedure codes on the Medicaid claim. Please refer to the CCBHC code list for all procedure codes: XXXX.

MODIFIERS

CCBHC claims submitted to the Medicaid Management Information System (MMIS) require modifiers. Providers should refer to the most current Alpha Numeric HCPCS file posted by CMS for up-to-date modifier information. The modifiers listed below have been selected for use in Vermont's Medicaid and are defined by **OPTUM360**.

Billing modifiers are required to be used but will not result in an adjustment to the CCBHC daily visit rate.

[Insert Modifiers]

REVENUE CODES

The following revenue codes should be used on each claim, as applicable:

Revenue Code	
240	All-Inclusive Ancillary – General
513	Clinic – Psychiatric Clinic
520	Freestanding Clinic – General
900	Behavioral Health Treatment/Services – General
906	Behavioral Health Treatment/Services – Chemical Dependency
911	Behavioral Health Treatment/Services – Rehabilitation
914	Behavioral Health Treatment/Services – Individual Therapy
915	Behavioral Health Treatment/Services – Group Therapy

[3] Vermont is expected to decide on pursuing a State Plan Amendment at least one year before the demonstration ends, allowing ample time for thorough planning and a smooth transition after Vermont's demonstration ends.

916	Behavioral Health Treatment/Services – Family Therapy
918	Behavioral Health Treatment/Services – Testing
944	Other Therapeutic Services – Drug Rehabilitation
945	Other Therapeutic Services – Alcohol Rehabilitation

DIAGNOSES

A primary diagnosis should be selected on the Medicaid claim for individuals who may have multiple diagnoses receiving CCBHC services on the same day. For those individuals served with co-occurring substance use disorder (SUD) and mental health (MH) diagnoses, the secondary co-occurring diagnosis should be selected as well. All diagnoses should be on the claim.

PRIMARY PROVIDER

A primary provider (practitioner) should be selected on the Medicaid claim if the individual receives CCBHC services from more than one provider (practitioner) on the same day. The billing facility may not be entered as the attending provider for services.

BILLING GUIDELINES

BILLING EXCEPTIONS

The below **Exceptions** are billed outside of the CCBHC model. This may include, but is not limited to:

- School-based Services
- The Hub Payment Model services
- The Spoke Payment Model services covered under the Blueprint scope of work.
- Mental Health Urgent Care Centers
- Enhanced Mobile Crisis

BILLING RESTRICTIONS

Please note the following billing restrictions under Vermont's CCBHC program:

- **Correctional facilities** are a disallowed setting for Medicaid billing under federal ~~law.~~
- CCBHC services **cannot be reimbursed** if they are provided in a setting or as part of a service where mental health and/or substance use care is already included in a bundled payment
- CCBHC services **cannot be billed** (under the CCBHC provider number) if they are paid through a separate grant/contract or included in the expectations for an alternative fund source (such as Global Commitment Investments).[4]
- Service provision is limited to **discharge planning activities** in the following settings, as outlined in more detail below:
    - Nursing homes

[4] CCBHCs should review the specific reimbursement guidelines for services that are excluded from this model to ensure compliance with billing and coverage requirements.

- Inpatient hospitals
- Institutes of Mental Disease (IMDs)
- 24-hour intensive residential facilities (i.e., any placement that is not categorized as home-and-community-based settings)
- Psychiatric Residential Treatment Facilities (PRTFs)
- Crisis Beds
- Intermediate Care Facilities

BILLING GUIDANCE FOR NON-CARCERAL INSTITUTIONAL SETTINGS

If CCBHC staff provide services as part of care coordination to facilitate transitions from these non-carceral institutional settings, the activity may be billable under the following conditions:

1. The services must be furnished **pursuant to a written plan of care**.
2. The services must be considered **outside the scope of both the setting and the specialized services** provided by that setting.
3. The services must be **specific to discharge planning**.

Allowable services include those aligned with the nine required CCBHC demonstration services that are necessary for transitioning individuals into their own households. These may include:

- Assessing needs post-discharge,
- Identifying and setting up mental health and substance use services the person will require after discharge,
- Accessing community-based services,
- Non-medical transportation, and
- Other related services and supports necessary to ensure a successful transition.

These restrictions ensure that CCBHC services are appropriately reimbursed while maintaining compliance with federal and state regulations.

BILLING GUIDANCE FOR CONCURRENT BILLING WITH OTHER OUTPATIENT MENTAL HEALTH & SUBSTANCE USE SERVICES

The PPS-1 rate is not built on attribution of specific individuals.

This means that one individual accessing mental health and substance use disorder services may on occasion receive those services from more than one CCBHC and/or other mental health practitioner(s) based on individual choice and location of services best meeting the individual's needs.

TELEHEALTH AND TELEMEDICINE BILLING

For the latest telehealth and telemedicine policy, please ensure you are using the most current information available here: Telehealth | Department of Vermont Health Access

THIRD PARTY LIABILITY

Vermont Medicaid is the payer of last resort. Providers are required to pursue and apply all third-party payment resources prior to billing Vermont Medicaid. Third party resources include, but are not limited to,

Medicare, private/group health insurance plans, military and veteran's benefits, Worker's Compensation and accident (automobile, homeowners, etc.) insurance.

For more information, please see the Vermont Medicaid General Billing Manual

If a CCBHC provides one or more services on the same day to a Vermont Medicaid member with insurance other than Medicare, the visit should first be billed to the other insurer using the appropriate CPT code(s). The facility may bill Vermont Medicaid for the balance between the other insurance payment and the facility's encounter rate using T1040 as the encounter code. (Refer to the instructions for Section 29 of CMS-1500 form.) Insurance plans impose various rules for members covered by their plan including a commercial HMO. If a Vermont Medicaid member has other insurance, the member must follow the rules (such as network limitation) of that insurer. Vermont Medicaid will not make a payment for which another insurer is responsible or would be responsible if the member had followed that insurer's rules. If the other insurer requires a co-payment for office visits that are paid under the capitated rate, Vermont Medicaid will reimburse the provider for this office visit co-pay charge only. To bill the co-pay amount, use procedure code T1040.

For more detailed information, refer to the **Vermont Medicaid General Provider Manual**

CODING & REPORTING

CORRECT CODING AND ACCURATE REPORTING OF PROCEDURE CODES

DMH/DSU requires strict adherence to coding guidelines based on the **Current Procedural Terminology (CPT)**, the **Healthcare Common Procedure Coding System (HCPCS)**, and the **International Classification of Diseases-10 Clinical Modification (ICD-10-CM)**. This section outlines the rules for billing time-based procedure codes and untimed codes to ensure compliance with state and federal requirements, but providers should always use the most current CPT/HCPCS/ICD-10-CM guidance.

Providers must ensure accurate and compliant billing for time-based and untimed services under the Vermont CCBHC program. For more detailed information, refer to the **Vermont Medicaid General Provider Manual** or the Medicare Claims Processing Manual.

Caution: Providers should be aware that changes to reimbursement policies, including those related to demonstration billing, are subject to updates from CMS and other regulatory bodies. It is crucial to regularly consult the most current versions of Internet Manuals and Code Lists to ensure compliance with evolving regulations. Staying informed will help avoid billing discrepancies and potential non-reimbursement. Always review the latest guidance to ensure that all services are billed in accordance with the most up-to-date policies. [Link to website] and/or cite appendix no.

TIME-BASED CODES

Several procedure codes for therapy modalities, procedures, and tests specify direct (one-on-one) time spent with the patient in 15-minute increments. For time-based billing, follow these guidelines:

- Services must be billed using the appropriate procedure code and the number of 15-minute units of service delivered within a single calendar day.
- Services lasting less than 8 minutes should not be billed.

- Only the time spent actively delivering the service counts towards billing. Pre- and post-service activities (e.g., setup, charting) should not be included.
- When multiple 15-minute timed services are performed in a single day, the total number of minutes determines the units billed.

Note: Each service performed should be submitted as a separate line item for each date of service. Claims must reflect accurate reporting of time spent, or they will be rejected.

Caution: While the following guidance outlines general practices, providers must always consult the most current coding manuals and official code books for definitive billing information. Be especially mindful of codes that deviate from standard billing practices, such as those using a 15-minute unit but requiring specific guidance beyond the typical mid-point rule. Ensuring accuracy by referencing the official code books is essential to avoid billing discrepancies or non-compliance.

TIME-BASED CODE BILLING CHART

Units	Number of Minutes
0 Units	≤ 7.99 minutes or fewer
1 unit	≥ 8 minutes through 22 minutes
2 units	≥ 23 minutes through 37 minutes
3 units	≥ 38 minutes through 52 minutes
4 units	≥ 53 minutes through 67 minutes
5 units	≥ 68 minutes through 82 minutes
6 units	≥ 83 minutes through 97 minutes
7 units	≥ 98 minutes through 112 minutes
8 units	≥ 113 minutes through 127 minutes

UNTIMED OR MINIMUM UNIT CODES

For untimed procedure codes, units are reported based on how many times the procedure is performed as described in the HCPCS code definition (often once per day). When reporting service units for codes where the procedure is not defined by a specific timeframe (untimed codes), a 1 should be entered in the unit's field on the claim form.

Note: Always ensure that untimed codes are reported accurately, as time spent does not affect the units billed.

COMPLIANCE & AUDITS

In accordance with federal and Vermont state law, DMH/DSU has the authority to audit and, if necessary, decertify CCBHCs. Providers must comply with all Medicaid auditing requirements and maintain thorough documentation to ensure the integrity of services and billing practices under the CCBHC program.

DOCUMENTATION STANDARDS

Each provider participating in the CCBHC program must maintain written documentation for all services rendered, including case notes for any medical services performed and business records related to members, services provided, and payments claimed or received. All documentation must be:

- Legible
- Complete and thorough
- Dated appropriately
- Co-signatures, appropriate
    - Note: For all supervised billing, providers are required to refer to the **Supervised Billing Provider Manual**. This manual outlines the necessary procedures and requirements for proper billing under supervision and must be consulted to ensure compliance with Vermont Medicaid guidelines. For detailed instructions and rules, please review the manual available at: Supervised Billing Provider Manual.

Providers must submit documentation upon request by DMH/DSU, Department of Vermont Health Access (DVHA), the Vermont Agency of Human Services, the Office of the Vermont Attorney General, or the U.S. Secretary of Health and Human Services, without any charge to the requesting entity. Documentation must be retained for a minimum of **ten years** from the date of service and must be accessible for on-site audits at any time.

FINANCIAL AUDITS

DMH/DSU will perform regular financial audits of CCBHC billing, cost reporting, contracting, and service volumes. These audits will be scheduled and conducted at the discretion of DMH/DSU.

CCBHCs are required to provide access to all relevant records, audits, claims, documentation, and other materials requested by DMH/DSU during these audits. Providers must maintain records of business transactions between themselves and any wholly owned suppliers or subcontractors, which must be available within **35 calendar days** of a request. These records should cover transactions during the **five-year** period preceding the request.

AUDIT FINDINGS AND FINANCIAL CORRECTIVE ACTION

After completing a Medicaid financial audit, DMH/DSU will issue a report detailing any findings and recommendations. Depending on the nature of the findings, DMH/DSU may take one of the following actions:

1. **Immediate Action:**
   DMH/DSU may impose penalties, fines, or restrictions, up to and including decertification or exclusion from the Medicaid program.

2. **Financial Corrective Action Plan (FCAP):**
   Alternatively, CCBHCs may be required to submit a Financial Corrective Action Plan (FCAP) within **30**

calendar days of receiving the audit report. This plan should outline how the CCBHC will address the audit findings and achieve compliance. Providers can also present additional information that demonstrates compliance at the time of review.

DMH/DSU will review the submitted FCAP and either seek clarification or additional information or approve the plan within **30 calendar days** of receipt.

PENALTIES AND RESTRICTIONS

Depending on the audit findings, the FCAP may need to include provisions for penalties, fines, or restrictions. These requirements will be specified in the audit report.

FAILURE TO COMPLY

Failure to meet the remediation requirements and timelines outlined in the FCAP may result in further penalties, fines, or restrictions, up to and including decertification or exclusion from participation in the CCBHC demonstration or the Medicaid program.

DMH/DSU QUALITY REVIEWS AND ON-SITE AUDITS

DMH/DSU regularly conducts reviews to ensure quality services are provided and that providers are complying with CCBHC program requirements. These reviews typically involve desk audits, where records are examined off-site, but may also include on-site visits from the quality unit. Additionally, DMH/DSU reserves the right to conduct unannounced site visits or audits at any time to further ensure compliance and the delivery of high-quality care.

By adhering to these audit requirements and maintaining accurate documentation, providers help ensure compliance with Medicaid regulations and support the integrity of services and billing under the CCBHC program.

UPDATES, ALERTS, AND CHANGE PROCESS

VERMONT MEDICAID BANNERS

The Vermont Medicaid Banner is the first page of the Remittance Advice (RA), a weekly report that details the status of each claim and any related financial information. Messages on the Vermont Medicaid Banner are a key resource for providers, as they contain important updates regarding policy changes, billing procedures, and other critical information. In some cases, the Vermont Medicaid Banner may be the only or the first notification of changes that affect billing or policy.

Provider Responsibility:
It is the provider's responsibility to review the Vermont Medicaid Banner each week and stay informed of any updates to DMH/DSU and/or DVHA policies or procedures. Missing or overlooking this information can lead to compliance issues or delays in reimbursement.

Accessing the Vermont Medicaid Banner:

- The Vermont Medicaid Banner is posted online weekly and can be accessed at: https://vtmedicaid.com/#/bannerMain
- Archived banners are also available at the same location for reference.

Email Subscription for Updates:
Providers can receive the Vermont Medicaid Banner and other important communications directly via email by joining the communications email distribution list. To subscribe, send your email address to vtpubs-comm@gainwelltechnologies.com.

By staying connected to the Vermont Medicaid Banner, providers can ensure they are up to date on all essential changes impacting their participation in the Medicaid program.

ANNUAL REVIEW PROCESS FOR CCBHC CODES AND MANUAL UPDATES

DMH/DSU will conduct an annual review of the CCBHC billing codes and manual to ensure that all procedures, codes, and policies remain current and compliant with state and federal regulations. **Please note that the timeline provided, including the approximate months, is intended as a general guide and not a binding agreement.** The steps of this process are outlined as follows:

1. Notification of Review (August)
DMH/DSU will notify all current and prospective CCBHC providers about the upcoming review. This notification will be disseminated through multiple channels:

- Email
- Vermont Medicaid Banner
- Posting on the Vermont CCBHC website

2. Initial Code Review Preparation (September)
DMH/DSU will conduct an internal audit of the existing CCBHC billing codes, identifying codes that require updates or clarifications based on:

- Regulatory changes from the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA)
- Feedback from providers and billing staff
- Analysis of the previous year's claims data

3. Drafting Updates to CCBHC Billing Codes and Manual (October)
Following the internal review and stakeholder input, DMH/DSU will determine if revisions are necessary. If changes are required, DMH/DSU will draft revisions to the CCBHC billing codes and procedures. Updates may include:

- Addition, modification, or removal of CPT/HCPCS codes
- Adjustments to existing codes reflecting new service types or reimbursement models
- Clarifications to current billing processes
- Updates to comply with state or federal regulatory changes

4. Draft Circulation (November)
The draft of the updated CCBHC billing manual will be:

- Posted on the Vermont CCBHC website
- Circulated to key stakeholders for final feedback before implementation

Stakeholders will have **two weeks** to review and provide feedback. DMH/DSU will carefully consider this feedback. DMH/DSU retains the sole authority to make final decisions on whether to incorporate suggested changes.

5. Approval and Posting (December)
Once finalized, the updated CCBHC billing manual will be posted on the Vermont CCBHC website. A notification of the updates and their effective date will be shared through:

- Vermont Medicaid Banner
- Email distribution list
- Additional communication channels as needed

6. **Implementation of New Code List (January)**

In most cases, new billing codes will effectuate on the calendar year.

This structured process ensures that CCBHC billing codes and policies are kept up to date and reflect the needs of providers, regulatory compliance, and service delivery improvements.

TRAINING AND SUPPORT FOR BILLING

- Gainwell provider rep roles
- Senior Auditor
- Contact information

MEDICAID ENROLLMENT RESOURCES

MEDICAID ENROLLMENT AND VERIFICATION RESOURCES

Providers are responsible for verifying Medicaid eligibility and other insurance information for members. Below are resources and tools to help with this process. These resources ensure that providers can efficiently verify eligibility and that members receive the public benefits they are entitled to under Vermont's Medicaid program.

MEDICAID ELIGIBILITY VERIFICATION TOOLS

Providers can confirm Medicaid eligibility and access other insurance information through the following options:

- **Vermont Medicaid Provider Portal**:
  Access Medicaid-related information and verify eligibility at www.vtmedicaid.com.
- **Automated Voice Response System (VRS)**:
  Call **802-878-7871** for automated eligibility inquiries.

MEDICAID ENROLLMENT PROCESS

The **Department of Vermont Health Access** determines Medicaid eligibility. Applications for Medicaid benefits can be submitted online:

- **Vermont Health Connect Portal**:
  Submit Medicaid applications here.

OTHER PUBLIC BENEFIT PROGRAMS

In addition to Medicaid, applications for other public benefits in Vermont, such as food or fuel assistance, can be submitted through the **Department for Children and Families (DCF)**. Here are the ways to apply:

- **Online**: Apply for Benefits
- **By Phone**: Call the DCF Benefits Service Center at **(800) 479-6151**
- **In Person**: Visit a local DCF district office. Find office locations here.

STATEWIDE BENEFICIARY SUPPORT

For questions or assistance with Medicaid benefits, beneficiaries can contact the **Green Mountain Care Member Services Unit** at **1-800-250-8427**.