California Frequently Asked Questions

HealthySteps National Office Policy & Finance Team

About This Document

Have a question? The HealthySteps National Office Policy & Finance Team is here to help!

Our team has developed this Frequently Asked Question (FAQ) document to highlight the most common questions and answers about billing and coding for HealthySteps and HealthySteps-aligned services in California. It is designed to provide quick and easy access to information for our HealthySteps sites.

If you do not see your question here, please do not hesitate to contact us at CAhealthysteps@zerotothree.org.

Frequently Asked Questions (FAQs)

Family Health Benefit (preventive psychotherapy)

Q: What do we know about Medi-Cal's Family Health Benefit and other psychotherapy benefits (billing codes 90832-90853) eligible for reimbursement?

A: The Family Health Benefit includes unlimited preventive dyadic supports via family psychotherapy, and individual psychotherapy for patients under the age of 21 when either the patient, or a parent, presents with one of the approved risk factors that supports medical necessity for the psychotherapy sessions. In addition, psychotherapy sessions are eligible for reimbursement for the following:

- When a patient is diagnosed with a mental health disorder or a developmental disorder of infancy and early childhood.
- When a patient of any age presents with persistent mental health symptoms in the absence of a mental health disorder, i.e., doesn't yet reach diagnostic threshold.
- When rendered to pregnant and postpartum women of any age, who are at risk of perinatal depression, when they present with at least one of the approved risk factors.

Helpful links:

- Non-Specialty Mental Health Services: Psychiatric and Psychological Services (non spec mental)
- https://www.2020mom.org/blog/2019/8/12/californias-medicaid-program-now-reimburses-screening-and-treatment-to-prevent-maternal-depression

Disclaimer: This document is not intended to give billing advice or guidance to any specific provider or HealthySteps site and does not consider the fact that payors, providers, and sites may have their own policies and procedures that may affect or prohibit implementation of these recommendations. Additionally, billing guidance is updated often. If there are any updates you recommend, please reach out to HSPolicyandFinance@zerotothree.org.

Q: What are the approved risk factors that support medical necessity for the family health benefit psychotherapy sessions?

A: There are two sets of risk factors. One set is applicable to the children who have a history of any of the factors, and the other is applicable to the parent(s) or guardian(s). Only 1 risk factor needs to be present to support the medical necessity for the service. Risk factors are as follows:

If the child has a history of at least one of the following:

1. Neonatal or pediatric intensive care unit hospitalization
2. Separation from a parent/guardian (e.g., due to incarceration, immigration, or military deployment)
3. Death of a parent/guardian
4. Foster home placement
5. Food insecurity, housing instability
6. Exposure to domestic violence or other traumatic events
7. Maltreatment
8. Severe and persistent bullying
9. Experience or discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability.

Or if the child has a parent/guardian with one of the following:

1. A serious illness or disability
2. A history of incarceration
3. Depression or other mood disorder
4. Post-traumatic stress disorder (PTSD)
5. Anxiety disorder
6. Psychotic disorder under treatment
7. Substance use disorder
8. Job loss
9. A history of intimate partner violence or interpersonal violence
10. Is a teen parent.

Q: What are the approved risk factors that support medical necessity for psychotherapy sessions rendered to pregnant and postpartum women of any age, who are at risk of perinatal depression?

A:

1. A history of depression
2. Current depressive symptoms (that do not reach a diagnostic threshold)
3. Certain socioeconomic risk factors such as low income, adolescent, or single parenthood
4. Mental health-related factors such as elevated anxiety symptoms or a history of significant negative life events

Q: Can you report interactive complexity (90785), when using interpreters and translator services?

A: No, you may not. To align with federal and Center of Medicaid/Medicare Services (CMS) guidelines, effective 1/1/2022, the use of interpreters and translator services was removed from the list of communication factors that support medical necessity when coding for interactive complexity.

Comprehensive Perinatal Services Program

Q: What is the Comprehensive Perinatal Services Program (CPSP)?

A: The CPSP is an enhanced obstetric care model for prenatal and postpartum care, available to eligible low-income pregnant patients from the date of conception, through 60 days after the month of delivery. Under this benefit, women can receive traditional obstetric services, and enhanced services in the areas of nutrition, psychosocial services, and health education, including lactation services (billing codes: Z6200-Z6414, Z1032, Z1034, Z1038, Z6500, S0197).

Q: Who can render CPSP services?

A: All practices (FQHCs, RHCs, hospital, community or county clinics, group medical practices and alternative birthing centers) rendering CPSP services must have a Medi-Cal enrolled CPSP physician. Additionally, certified, and licensed midwives, registered nurses, licensed vocational nurses, nurse practitioners, physician assistants, health educators, certified childbirth educators, registered dieticians or registered dietician nutritionist consultants, comprehensive perinatal health workers, social workers, psychologists, and marriage and family therapists, can become CPSP practitioners and render services when enrolled as CPSP providers.

Information on the CPSP program can be found at the following helpful links:

- Comprehensive Perinatal Services Program (ca.gov)
- https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregcomlis.pdf
- https://files.medi-cal.ca.gov/pubsdoco/county_contacts.pdf

Health and Behavior Assessments and Intervention Services

Q: What types of services are the health and behavior assessments, and intervention billing codes utilized for?

A: The health and behavior assessments and intervention services billing codes (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171) identify and assess any psychological, behavioral, emotional, cognitive, and relevant social factors that may prevent successful treatment or management of a patient's *physical* health problems, such as missing appointments for a physical health problem because there are transportation difficulties. It can also be related to a caregiver not fully understanding all the avenues of care for his or her child. For example, if a child has bilateral hearing loss and the parent(s) or caregiver(s) are not making them wear their hearing aids, due to the lack of understanding regarding their importance, then this is impeding the care and treatment of the patient. The most important thing to remember about these services is that they should only be reported when there is a physical health diagnosis where psychological, behavioral, emotional, cognitive, and social factors are impeding on the successful treatment and management of the patient's physical health diagnosis.

Q: Can a DSM diagnosis code be reported with health and behavioral assessments and interventions?

A: No, only an ICD-10 physical diagnosis code should be used to report these services since health and behavior assessment and interventions focus on patients whose primary diagnosis is a physical health diagnosis.

Associate and Behavioral Health Providers

Q: Is supervision of associate behavioral health providers required when billing for their services?

A: Yes, direct (face-to-face) supervision is a requirement for those providers supervising associate behavioral health practitioners. Weekly face-to-face contact is required that should occur within the same week as the hours claimed. More information on direct supervision requirements of associate providers can be found in the California Board of Behavioral Sciences Statues and Regulations: https://www.bbs.ca.gov/pdf/publications/lawsregs.pdf.

Q: Are associate behavioral health clinicians eligible for insurance carrier reimbursement when rendering services at FQHCs and RHCs?

A: Yes, services rendered by associate behavioral health clinicians are eligible for reimbursement at FQHCs and RHCs when billed under a supervising clinician, including dyadic services (behavioral health well-child visit, comprehensive community support services, psychoeducational services, and dyadic family training and counseling for child development).

Screenings

Q: Are postpartum depression screenings reimbursed by Medi-Cal when rendered to the mom during their infant's well-child visit?

A: Yes, Medi-Cal will reimburse for up to four postpartum screenings rendered during an infant's first year of life, when they are rendered by the infant's pediatrician during a well-child visit, where the billing is done under the infant's Medi-Cal number.

Dyadic Services

Q: Who are the clinicians that can provide dyadic services?

A: Dyadic services may be proved by the following providers when working under their scope of practice:

- Physicians (MD/DO), including psychiatrists
- Licensed Clinical Social Workers
- Licensed Professional Clinical Counselors
- Licensed Marriage and Family Therapists
- Psychiatric Physician Assistants
- Psychiatric Nurse Practitioners
- Licensed Psychologists

- Associate Marriage and Family Therapists under clinical supervision
- Associate Professional Clinical Counselors under clinical supervision
- Psychology Associates under clinical supervision

Q: When reporting the billing codes for dyadic services on a claim, are there any billing modifiers required?

A: Yes, when reporting billing codes for dyadic services (dyadic behavioral health visit, dyadic comprehensive community support services, dyadic family training and counseling for child development, and dyadic psychoeducational services) on a claim, modifier U1 is always required as this modifier identifies the services as a dyadic service. Additional billing modifiers (in addition to modifier U1) are required when reporting dyadic caregiver services (ACE screenings, annual alcohol misuse screenings, alcohol and/or drug screenings, alcohol and/or drug services, brief emotional/behavioral assessments, depression screenings, health and behavior assessments/reassessments, and interventions, psychiatric diagnostic evaluations with and without medical services, and smoking and tobacco use cessation counseling). For these services, modifier UK must also be reported, if a parent/caregiver is not enrolled in Medi-Cal or modifier HB is a parent/caregiver is enrolled in Medi-Cal.

Billing Modifiers Required When Reporting Dyadic Services	
Billing Modifier	**When The Modifier is Required**
U1	Required to report all dyadic services, including dyadic caregiver services
UK	Required in addition to modifier U1 when reporting dyadic caregiver services when the parent/caregiver is not enrolled in Medi-Cal
HB	Required in addition to modifier U1 when reporting dyadic caregiver services when the parent/caregiver is enrolled in Medi-Cal

Q: Are there frequency limitations to dyadic services?

A: Yes, Medi-Cal published guidance on the frequency limitations to dyadic services. See table below:

Dyadic Service		
Dyadic Service	**Billing Code**	**Medi-Cal's Frequency Limitation**
Behavioral Health Visit	H1011	Two visits per year
Comprehensive Community Support Services, per 15 minutes (1 unit of service=15 minutes)	H2015	24 units per year
Family Training and Counseling for Child Development, per 15 minutes (1 unit of service=15 minutes)	T1027	24 units per year
Psychoeducational Services, per 15 minutes (1 unit of service+15 minutes)	H1017	24 units per year
Dyadic Caregiver Services Under the Dyadic Service Benefit		
Ace Screening (high risk) when score is four or greater	G9919	One per year for ages 0-20 and one per lifetime for ages 21-64
Ace Screening (low risk) when score is between 0-3.	G9920	
Annual Alcohol Misuse Screening, 15 minutes	G0042	

Alcohol and/or Drug Screening	H0049	One screening per day, per provider (annual limitations should be verified with Medi-Cal.)
Alcohol and/or Drug Services, Brief Intervention, per 15 minutes	H0050	One per day, per provider (annual limitations should be verified with Medi-Cal
Brief Emotional/Behavioral Assessment	96127	Two assessments per day, per provider (annual limitations should be verified with Medi-Cal)
Depression Screening (positive outcome with follow-up plan)	G8431	One screening per year
depression Screening (Negative outcome)	G8510	
Health and Behavior Assessment/Re-assessment	96156	One per day, any provider (annual frequency limitations should be verified with Medi-Cal)
Health and Behavior Intervention with the family, with the patient present and without the patient present	96167 96170	Six per day, any provider (annual frequency limitations should be verified with Medi-Cal)
Health and Behavior Intervention with the family, with the patient present and without the patient present, each additional 15 minutes.	96168 96171	
Psychiatric Diagnostic Evaluation with and without Medical Services	90791 90792	One per day (annual frequency limitations should be verified with Medi-Cal)
Smoking and Tobacco Use Cessation, greater than 3 minutes and up to 10 minutes	99406	One per day (annual frequency limitations should be verified with Medi-Cal)
Smoking and Tobacco Use Cessation, greater than 10 minutes	99407	