

HealthySteps Billing & Coding Opportunities – Pathways to Reimbursement

National Office Policy & Finance Team



The National Office has compiled this comprehensive list of updated billing and coding opportunities for sites to increase billing practices and inform sustainability planning. It represents codes actively in use, or being explored for use, by HealthySteps sites, Medicaid health plans, and/or other payers.

This is a technical guide for the billing and reimbursement experts at your site. It is based on national billing and coding guidelines (that are subject to annual changes). The goal is to maximize their understanding of HealthySteps-related services and potential reimbursement.

This document expands upon the previously released Billing and Coding opportunities document to enhance your site's understanding of potential utilization of the codes by providing detailed standard definitions, tips for reporting, and examples of clinical encounters that may qualify for reimbursement.

The service requirements and guidelines for each billing code vary from state to state, and you should determine with your implementation team and billing manager the most appropriate codes to use for your site. The National Office also advises that to maximize appropriate reimbursement and utilization of procedure codes, sites should always contact health insurance companies to verify billing for services rendered. For more information on HealthySteps billing and coding opportunities, please contact HSpolicyandfinance@zerotothree.org.

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Screenings

Tier 1 of the HealthySteps model includes practice-wide universal screenings for all children ages birth through three and their families. The model’s core components include child development, social-emotional and behavioral screenings, as well as screening for family needs (i.e., maternal depression and social determinants of health). Screenings are a core component of the HealthySteps model because optimal child development and well-being begins with screenings to monitor for progress or concerns across multiple domains. The following guidance provides the CPT codes, descriptions, general information, and examples of screening tools for both children and caregivers.

Tips for Reporting Screenings:

- Documentation for all screenings must include scoring and the standardized instrument utilized. Accepted standardized instruments are at the discretion of payers and/or the state Medicaid agency. Verification of which tool(s) to utilize is recommended.
- Screenings may be submitted for reimbursement by a physician or other qualified healthcare professional. Those considered to be qualified healthcare professionals can vary from state to state. Verification with your state’s Medicaid agency and/or insurance carriers is required.
- Codes include all discussions regarding results with the caregiver.
- In some states, CPT code 96161 (caregiver-focused health risk assessment) should be reported when providing a maternal depression screening during a well-child visit. Verification with your state’s Medicaid agency and/or insurance carriers is required.

Developmental Screenings

The physician or other qualified health care professional reviews a developmental screening, such as a developmental milestone survey or speech and language delay screening. The screening is to determine whether the patient requires additional work up for developmental disorders or ongoing surveillance at periodic intervals.

<u>CPT Code</u>	<u>Description</u>
96110	Developmental milestone survey, speech and language delay with scoring and documentation, per standardized instrument.

Depression Screenings (for caregivers)

Depression screenings are an essential part of the detection, treatment, and referral to mental health professionals for persons with depressive disorders. These Medicaid codes are state-specific. Verification with your state Medicaid agency is required.

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<u>CPT/HCPCS Code</u>	<u>Description</u>
G8510	Screening for depression documented as negative.
G8431	Screening for depression documented as positive: follow-up plan is required.
96161	Caregiver-focused health risk assessment with scoring and documentation, per standardized instrument (some state insurance carriers recognize this code for the reporting of maternal depression screenings during a well-child visit).

Social-Emotional Screenings

The physician or other health care professional reviews a brief assessment of the patient’s emotions and behaviors associated with conditions such as attention-deficit/hyperactivity disorder using inventory or scale methods. The screening is used to determine whether the patient requires additional workup or treatment.

<u>CPT Code</u>	<u>Description</u>
96127	Social-emotional-brief emotional/behavioral assessments.

Health Risk Assessments

Health Risk Screenings (also called Health Hazard Appraisals)

A health risk assessment includes a questionnaire, an assessment of health status, and personalized feedback about actions that can be taken to reduce risk, maintain health, prevent disease, and maintain emotional health. A caregiver-focused assessment also serves to identify areas of concern such as stress levels, depression, and the burdens placed on the caregiver.

<u>CPT/HCPCS Code</u>	<u>Description</u>
96160	Patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument.
96161	Caregiver-focused health risk assessment instrument with scoring and documentation, per standardized instrument.
G9920	ACE screening-lower risk, patient score of 0-3

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<u>CPT/HCPCS Code</u>	<u>Description</u>
G9919	ACE screening-higher risk, patient score of 4 or greater

Tips for Reporting Caregiver-Focused Health Risk Assessments:

- When using the Edinburgh Postnatal Depression Scale (EPDS) to screen for depression in pregnant or postpartum patients, it is more appropriate to report CPT code 96160 (when mother is the patient).
- Code 96161 will be reported via a standardized instrument to screen for health risks in the caregiver for the benefit of the patient (when completed during a well child visit). Thus, when using the EPDS, PHQ-2, or PHQ-9 to screen the mother during the well child visit, bill CPT code 96161, which must be reported under the child's health plan.
- Payment for SDOH screening is not yet common but may be available from your payers using 96160 and/or 96161 – your payers' policies will clarify which code to use for SDOH screenings.

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Examples of Screening & Assessment Tools:

Developmental Screenings

- Ages and Stages Questionnaires, Third Edition (ASQ-3) - Provides reliable, accurate developmental and social-emotional screening for children between birth & age six.
- Modified Check List for Autism-Revised (M-CHAT-R) - A screen that evaluates risk for autism spectrum disorder in children ages 16 - 30 months.
- Parents' Evaluation of Developmental Status (PEDS) - A surveillance and screening tool for children birth to eight that enables a swift view of children's skills in development and mental health, including expressive and receptive language, fine and gross motor skills, self-help, academics, and social-emotional skills.

Depression Screenings

- Patient Health Questionnaire-9 (PHQ-9) - Nine questions for the screening, diagnosing, monitoring, and measuring the severity of depression. (Use of the PHQ-2 alone, without the PHQ-9, should be verified with insurance carriers).
- Edinburgh Postpartum Depression Screening - See second bullet under "Health Risk Assessments."

Social-Emotional Screenings

- Ages and Stages Questionnaires: Social Emotional, Second Edition (ASQ:SE-2) - Set of questions about behavior and social-emotional development in young children.

Health Risk Assessments

- Pediatric ACEs and Related Life-events Screener (PEARLS) for Adverse Childhood Experiences – Patient-focused and/or caregiver-focused. An evaluation of children and adults for adverse childhood experiences experienced by age 18 (e.g., physical, emotional, and sexual abuse, physical and emotional neglect). Includes screening for potential risk factors for toxic stress (e.g., domestic violence, bullying, community violence, substance misuse, food or housing insecurity).
- Edinburgh Postpartum Depression Scale - Caregiver-focused - for the benefit of the child (see last bullet under "Tips for Reporting Screenings") and developed to identify women who have postpartum depression.
- Survey of Well-Being of Young Children (SWYC) - Focuses on early identification of and screening for risks of developmental-behavioral disorders and family/social determinants of toxic stress. Additionally, the SWYC is multi-dimensional, covering development and social emotional too.
- Safe Environment for Every Kid (SEEK) - Screening for parents for prevalent psychosocial problems that are risk factors for child maltreatment.

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Health and Behavior Assessments/Re-Assessments and Interventions

Billing Guidance Definition: Health and behavior assessments/re-assessments and interventions are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems.

HealthySteps Specific Note: In practices where the HS Specialist is an independently billable clinician with a scope of practice that allows for the rendering of this service (e.g., clinical psychologist), they may provide an assessment and intervention to the child and caregiver. The service addresses a specific issue identified by the caregiver or provider and may be provided to children in Tiers 2 or 3. See sample clinical encounter below.

CPT Code	Description
96156	Health and behavior assessment or re-assessment (e.g., health-focused clinical interview, behavioral observations, clinical decision making)
96158	96158-Health and behavior intervention, <i>individual, face-to-face; initial 30 minutes</i>
96159	96159-Health and behavior intervention, <i>individual, face-to-face; each additional 15 minutes</i>
96164	96164-Health and behavior intervention, <i>group (2 or more patients), face-to-face; Initial 30 minutes</i>
96165	96165-Health and behavior intervention, <i>group (2 or more patients), face-to-face; each additional 15 minutes</i>
96167	96167-Health and behavior intervention, <i>family with patient present. Face-to-face; initial 30 minutes</i>
96168	96168-Health and behavior intervention, <i>family with patient present. Face-to-face; each additional 15 minutes</i>
96170	96170-Health and behavior intervention, <i>family without the patient present. Face-to-face; initial 30 minutes</i>
96171	96171-Health and behavior intervention, <i>family without the patient present. Face-to-face; each additional 15 minutes</i>

Tips for Reporting Health and Behavior Assessments/Re-assessments and Interventions:

- The assessment must be associated with a physical health problem - the prevention of a physical illness or disability, and the maintenance of health. For example, within HealthySteps, it may be working with the family around a child's recent diagnosis of torticollis. (See below for a more in-depth example).
- The physical health diagnosis should be listed as the primary diagnosis when reporting these codes.
- Services do not focus on the mental health of a patient, but rather on the biopsychosocial factors that are, or could affect the treatment of, or severity of the patient's physical condition.
- Patients must have an established physical illness or symptom(s) and the intervention/service cannot be related to a mental health diagnosis.

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- Coding for group services and/or services where the patient is not present may not be covered in some states or clinic types such as Federally Qualified Health Centers (FQHCs). Health Insurance carrier verification is highly recommended.
- Health and behavior interventions are time-based services and documentation must include the time spent rendering services to the patient.
- Assessments or re-assessments require a health-focused interview, behavioral observation, and clinical decision making.
- Interventions include the promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery and management, and improved coping with medical condition(s). Interventions also emphasize active patient and family engagement and involvement.
- 96168, 96171, 96159, and 96165 are add-on codes, signifying they can only be billed with another code, and not independently. Thus, 96168 is an add-on code to 96167, 96171 is an add-on code to 96170, 96159 is an add-on code to 96158, and 96165 is an add-on code to 96164. They are to be reported in conjunction with one another, when an additional 15 minutes of service is rendered, after the first 30 minutes.

Sample Clinical Encounter

A child who has been diagnosed with sensorineural bilateral hearing loss and has hearing aids arrives for a well-child visit, without their hearing aids on. The physician questions the parent, who informs the provider that their child seems frustrated when they wear them. The physician asks the HealthySteps Specialist (HS Specialist) to intervene, and an assessment is provided. During the assessment, the HS Specialist asks why the child is not wearing the aids and asks about the child's adjustment to using them. The parent reports that the child seems frustrated when the aids are on, and there is an increase in negative behaviors; therefore, the parent does not make the child wear them. During the assessment, the HS Specialist identifies factors that impede the child's treatment progress and personalizes interventions and education on the increased negative behaviors and adjustment to auditory stimuli. Since the family benefits from better understanding the connection between their child being able to hear and wearing hearing aids as a pathway to communication, this becomes the focus of the intervention, with an additional referral back to the hearing specialist for maintenance or adjustments to the hearing aids.

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Psychiatric Diagnostic Evaluation

Billing Guidance Definition: A psychiatric diagnostic evaluation is the process of gathering information about a person within a psychiatric service, with the purpose to establish whether a mental disorder or other condition is present. It is an evaluation designed to diagnose emotional, behavioral, or developmental conditions or disorders. It includes the assessment of the patient’s psychosocial history, current mental status, review, and ordering of diagnostic studies followed by appropriate treatment recommendations.

HealthySteps Specific Note: In practices where there is an independently billable clinician with a scope of practice that allows for the rendering of this service (e.g., psychiatrist), they may evaluate a child to identify a specific issue. They will provide referrals for additional specialized services or develop a treatment plan as needed. Typically, these children will be in Tiers 2 or 3.

<u>CPT Code</u>	<u>Description</u>
90791	Psychiatric diagnostic evaluation <i>without</i> medical services.

Tips for Reporting Psychiatric Diagnostic Evaluations:

- This service may be performed by a physician (psychiatrist) or other qualified healthcare professional. Those considered to be qualified healthcare professionals can vary from state to state. Verification with state Medicaid agencies and/or insurance carriers is required.
- Evaluations should include a description of behaviors present, when they occur, how long they last and which behaviors happen most often. Evaluations should also include how behaviors impact others and a description of symptoms, both physical and psychiatric.
- In some cases, family members, guardians, or others may be consulted with results, instead of the patient. Verification with your state Medicaid agency and/or other insurance carriers is required.

Sample Clinical Encounter

Disorders such as attachment disorders are known to arise in very early childhood. However, the detection and accurate diagnosis of these conditions in very young children can be complicated and challenging for the clinician. If a primary care provider or HS Specialist identifies red flags for a concern during a parent interview or a formal screening, the next step would be to make a referral for a psychiatric diagnostic evaluation for further assessment.

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Developmental Testing and Psychological Testing Evaluations

Billing Guidance Definition: Testing and evaluations involve services beyond screenings. Screenings are used to identify if someone is at risk, and if a screening reveals that further testing is required, testing and evaluation help determine appropriate follow-up and care and, if appropriate, a diagnosis.

HealthySteps Specific Note: In practices where there is an independently billable clinician with a scope of practice that allows for the rendering of this service (e.g., a clinical psychologist), they may test or evaluate a child to identify a specific issue. They will provide referrals for additional specialized services or develop a treatment plan as needed. Typically, these children will be in Tiers 2 or 3.

Developmental Test Administration

Developmental test administration includes assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed, by physician or other qualified health care professional. The test provides information regarding the milestones a child has attained and can help in determining the course of intervention to attain further milestones.

<u>CPT Code</u>	<u>Description</u>
96112	Developmental test administration including assessment of fine and gross motor, language, cognitive level, social, and memory or executive functions by standardized developmental instruments with interpretation and report, <i>initial hour</i>
96113	Developmental test administration; <i>each additional 30 minutes after the first hour of service</i>

Tips for Reporting Psychological and Developmental Testing:

- These codes are time based, requiring the documentation of the time spent rendering the service(s), including the start and stop times of testing.
- Although the time in the description of CPT codes 96130, 96132, and 96112 state “first hour,” or “initial hour,” CPT guidelines indicate that a minimum of 31 minutes can be provided before assigning these codes. State Medicaid guidelines must be verified on time requirements.
- Standardized testing instruments, dependent on those selected in your state, must be utilized and a report must be generated.
- 96131 and 96133 are add-on codes, signifying they can only be billed with another code. 96131 is an add-on code to 96130, and 96133 is an add-on code to 96132. They are to be reported in conjunction with one another, when an additional hour of service is rendered, after the first hour of service.

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- 96113 is an add-on code, signifying it can only be billed with another code, and not independently. 96113 is an add-on code to 96112, and they are to be reported in conjunction with one another, when an additional 30 minutes of service is rendered, after the first hour of service.
- This service may be performed by a physician or other qualified healthcare professional. Qualified healthcare professionals, per individual service, can vary with state Medicaid agencies and other health insurance carriers. Verification is recommended.

Psychological Testing Evaluation

Psychological testing evaluation services are performed by a physician or other qualified health care professional and include integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s).

CPT Code	Description
96130	Psychological testing and evaluation; <i>first hour (31 minutes minimum)</i>
96131	Psychological testing, evaluation; <i>each additional hour after the first hour of service</i>

Sample Clinical Encounters

Psychological Testing and Evaluation

Psychological testing and evaluation may be necessary when a young child demonstrates behaviors, such as significant social withdrawal, difficulties with speech and concentration, or significant difficulties with social activities, including daycare or pre-school. Psychological testing is part of a comprehensive assessment to provide information, inform a diagnosis, and guide treatment.

Developmental Testing

Testing or assessment for developmental concerns should develop a more concrete picture and profile of a child's strengths and weaknesses in all developmental areas and may be used to determine if the child needs an early intervention or treatment program. Examples are sensory-motor, speech and hearing, preschool psychoeducational batteries, and early learning profiles.

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Interactive Complexity (add-on code and services to Psychiatric Diagnostic Evaluations and Psychotherapy Services)

Interactive complexity is used when services have been complicated by difficult communication with discordant or emotional family members and/or engagement of young and verbally undeveloped or impaired patients.

<u>CPT Code</u>	<u>Description</u>
90785	Interactive complexity

Interactive complexity can be reported when ***at least one*** of the following communication factors is present during the visit:

- The need to manage maladaptive communication (related to high anxiety, high reactivity, repeated questions, or disagreement) among participants and/or caregivers that complicates delivery of care.
- Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
- If reporting to a third party is required, due to an incident in the patient’s life, that may have caused psychological damage. The incident must be newly discovered (e.g., abuse, neglect).
- Use of play equipment or other physical devices to communicate with patient to overcome barriers to diagnostic or therapeutic interaction with a patient between the physician or other qualified health care professional; and a patient who has not developed, or has lost, either the expressive language communication skills to explain his or her symptoms and respond to treatment; or a patient who lacks receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication (**Note: In 2022, the use of interpreters and translator services were removed.**)

Tips for Reporting Interactive Complexity:

- 90785 is an add-on code, meaning it cannot be reported independently, and can only be added in the reporting of another service.
- Interactive complexity can only be reported with psychotherapy services or diagnostic psychiatric evaluations.
- Some states will not reimburse for interactive complexity when rendered during psychotherapy for crisis or with family psychotherapy. Verification with insurance carriers is recommended.
- The time spent rendering services due to interactive complexity cannot be included in the time spent rendering a time-based service such as psychotherapy. Add-on codes only represent the increased intensity of the service rendered and are not considered an additional service.

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Sample Clinical Encounter

During a Psychotherapy visit or a Psychiatric Diagnostic Evaluation:

- The caregiver demonstrates significant emotional behavior, such as high anxiety, reactivity and/or repeated questioning, displaying aggression regarding the treatment plan being discussed.
- It is newly discovered that the patient may be a victim of abuse, where it will be mandated to report to a third party, with initiation of discussion.
- The parent/caregiver is not fluent in the same language as the physician or other qualified healthcare professional, and it takes additional time to arrange for interpreter services. This can vary from state to state and/or health insurance carrier. Verification is recommended.

Therapeutic Services

Psychotherapy

Billing Guidance Definition: Psychotherapy, sometimes called “talk therapy” or simply, “therapy” is the process whereby psychological problems are treated through communication and relationship factors between an individual, and/or group, and a trained mental health professional. Mental health professionals approved for reimbursement may vary in states. Verification is required.

HealthySteps Specific Note: In practices where there is an independently billable clinician with a scope of practice that allows for the rendering of this service (e.g., an LCSW), they may provide short-term, session-limited psychotherapy to a child and family to address a specific issue. If more specialized or long-term treatment is necessary, the HS Specialist will refer to an appropriate professional. Typically, these children and caregivers will be in Tiers 2 or 3.

<u>CPT Code</u>	<u>Description</u>
90832	Psychotherapy with patient; <i>30 minutes</i>
90834	Psychotherapy with patient; <i>45 minutes</i>
90837	Psychotherapy with patient; <i>60 minutes</i>
90839	Psychotherapy for crisis; <i>first 60 minutes</i>
90840	Psychotherapy for crisis; <i>each additional 30 minutes, after the first 60 minutes of service is rendered</i>

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<u>CPT Code</u>	<u>Description</u>
90846	Family Psychotherapy <i>without</i> the patient present; 50 minutes (<i>face-to-face with family</i>)
90847	Family Psychotherapy <i>with</i> patient present; 50 minutes (<i>face-to-face with patient and family</i>)
90849	Multiple family group psychotherapy

Tips for Reporting Psychotherapy Services:

- Psychotherapy services *cannot be reported with a psychiatric diagnostic evaluation (90791)*.
- A signed and dated treatment plan is required and must include, but is not limited to:
 - The patient’s diagnosis
 - Treatment goals
 - Number of sessions ordered by the physician, Nurse Practitioner, or Physician’s Assistant.
 - The practitioner involved in the treatment plan for the patient must sign the plan, certifying medical necessity.
- The time spent rendering psychotherapy services must be included in your documentation, as psychotherapy services are time-based codes. Documenting a start and stop time is advisable.
- Although CPT coding guidelines advise that each code may be reported if **more than 50%** of the time allotted in each code’s description is used to render service(s), insurance carriers can mandate the time requirement of each code’s description to be rendered in full or can determine minimum time requirement of services. Insurance carrier verification is **required**.
- When coding for family psychotherapy:
 - Therapy is most often used to help treat a patient’s problem that is affecting the entire family/caregiver(s).
 - Family dynamics, as they relate to the patient’s mental status and/or behavior, should be the focus of the sessions.
 - Attention should be given to the impact the patient’s condition has on the family, with therapy aimed at improving interactions between the patient and family member(s)/caregiver(s).
- Reviewing records, communication with other providers, observing, interpreting patterns of behavior, communication between the patient and family, and decision making is included in the psychotherapy codes.
- If coding for psychotherapy for a caregiver crisis:
 - A patient must have a life threatening or highly complicated psychiatric crisis. The patient must be a danger to themselves or others. The provider must devote full attention to the patient and cannot provide services to other patients during this time period.
 - Used to report total duration of face-to-face time with the patient and/or family providing psychotherapy for crisis.
 - Time does not have to be continuous but must occur on same day.
 - A mental status examination, disposition, and that the patient presented in a high level of distress and complexity or with a life-threatening problem(s) that required immediate attention, is required.

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- In a crisis scenario, 90839 is billed for the first 60 minutes and 90840 is billed for each additional 30 minutes. Using both codes together requires that the session lasts 75 minutes or longer. If you do not meet the time required to bill one or both crisis codes, you can bill the standard CPT code (90832 - Individual psychotherapy, 30 minutes).
- In some states, psychotherapy for crisis cannot be reported with any other mental health service, on the same day. Verification with insurance carrier(s) is recommended.

Sample Clinical Encounter

A 4-month-old baby presents for his well child visit. Upon reviewing the screenings, the HS Specialist engages in a dialogue with the parents and discovers that the caregivers are experiencing a high rate of conflict, which is creating difficulties in their relationship and the overall structure of the household. The parents report that the child's constant crying, fussiness, and whining fuels existing tension between the young couple who are already dealing with housing instability, under employment, and financial concerns.

A licensed HS Specialist can provide a clinical diagnosis (as necessary and appropriate) and engage this family in short-term psychotherapy that consists of increasing communication among family members, teaching conflict resolution, and better understanding the dyadic relationship with their young child, and teaching strategies to address the whole family concerns.

Alcohol and Substance Abuse

Alcohol and Substance Abuse Screening and Intervention (for caregivers)

Billing Guidance Definition: The Healthcare Common Procedure Coding System (HCPCS) codes, otherwise known as “H” codes, for alcohol and substance abuse screening/intervention, are codes that were commonly created for use by Medicaid agencies in states mandated by law to establish separate codes for identifying mental health services that include alcohol and drug treatment services.

Commercial insurers and some Managed Care Organizations will reimburse for Current Procedure Terminology (CPT) codes 99408 and 99409, which are also alcohol and/or substance abuse screening and intervention services codes. It is recommended to verify with insurance companies which codes are reimbursed.

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HealthySteps Specific Note: In practices and states where there is an independently billable clinician with required training and with a scope of practice that allows for the rendering of this service (e.g., SBIRT credentialed provider), the clinician may bill for caregiver participation in screening and short-term, session-limited encounters to address a substance misuse. If more specialized or long-term treatment is necessary, the HS Specialist will refer to an appropriate professional.

<u>HCPCS Code</u>	<u>Description</u>
G0442	Annual alcohol misuse screening, 15 minutes
H0049	Alcohol and substance abuse screening (<i>screening only</i>); completed screening tool with scoring
H0050	Alcohol and substance abuse brief intervention; <i>per 15 minutes</i>

<u>CPT Code</u>	<u>Description</u>
99408	Alcohol and/or substance (<i>other than tobacco</i>) abuse structured screening and brief intervention services; <i>15 minutes, up to 30 minutes</i>
99409	Alcohol and/or substance (<i>other than tobacco</i>) abuse brief intervention services; <i>greater than 30 minutes (31 minutes or more)</i>

Tips for Reporting Alcohol and/or Substance Abuse Screenings and Interventions:

- An alcohol and substance abuse intervention can only be rendered if there is a positive screening.
- Documentation for alcohol and substance abuse screening must include scoring and the standardized instrument utilized. Accepted standardized instruments are at the carriers and/or state Medicaid agency's discretion. Verification of which tool(s) to utilize is recommended.
- H0050, 99408, and 99409 are time-based codes. The documentation of the time rendering the service is required.
- Some states will require an approved training or certification for a clinician to render the services. Insurance carrier verification is recommended.
- Depending on the result of the screening, the physician could engage in a brief intervention, advising the patient to cut back or quit alcohol use. In practices with integrated behavioral health services, a behaviorist could meet with the patient for a more in-depth discussion or refer the patient to more formal alcohol treatment resources.
- Brief interventions include feedback about personal risk, explicit advice to change, emphasis on a patient's responsibility to change, and feedback on a variety of ways to effect change.

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Smoking and Tobacco Use

Smoking and Tobacco Use Cessation (for caregivers)

Billing Guidance Definition: Smoking and Tobacco Use Cessation are considered behavior change interventions for what is considered an illness itself, such as substance abuse/misuse. Behavior changes interventions have their own billing codes that are time based and should be reported according to the time spent rendering the service.

HealthySteps Specific Note: A caregiver may participate in screening and short-term, session-limited encounters to address smoking and/or tobacco misuse. If more specialized or long-term treatment is necessary, the provider will refer the caregiver to an appropriate professional. Issues related to substance misuse may be identified during Tier 1 universal screenings for family needs or maternal depression. There may also be instances in Tiers 2 or 3 where caregivers come to know and trust a HS Specialist, and misuse is disclosed or becomes suspected. At this point, a provider may screen and provide short-term, session-limited encounters to the caregiver to address the need or refer to an appropriate professional.

<u>CPT Code</u>	<u>Description</u>
99406	Smoking and tobacco use cessation counseling visit; intermediate, <i>more than 3 minutes, up to 10 minutes</i>
99407	Smoking and tobacco use cessation counseling visit; intensive, <i>more than 10 minutes</i>

Tips for Reporting Smoking and Tobacco Use Cessation:

- Face-to-face service must be provided.
- Documentation of the counsel and/or intervention is required. The advisable content of the counsel would be to at least address the first three of the five steps below. The *advisable content of the intervention* would be to address all five steps below:

Smoking and Tobacco Use Cessation-Five Major Steps to Intervention (The 5 As):

1. **Ask** - Identify and document tobacco use status for every patient at every visit.
2. **Advise** - In a clear and personalized manner, urge every tobacco user to quit.
3. **Assess** - Is the tobacco user currently willing to make a quit to attempt?
4. **Assist** - For the patient willing to make a quit-attempt, use counseling and pharmacotherapy to help them quit.
5. **Arrange** - Schedule follow-up contact, preferable within the first week after the quit date.

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- Smoking cessation and intervention codes are time-based, requiring documentation of time spent rendering the service. Documentation of a start and stop time is recommended.
- When rendered with an evaluation and management service, a modifier 25 will be applicable and should be appended to the evaluation and management code.
- Smoking cessation may not be separately billable when rendered with preventive care. Guidelines may vary from state to state for Medicaid agencies and other health care carriers. Insurance verification is advisable.

Sample Clinical Encounters

Counseling Visit - During a patient's visit, the physician inquires if the caregiver is a smoker, in which s/he responds affirmatively. The physician then asks a series of questions such as how long the caregiver has been a smoker, how much they smoke (daily, weekly, monthly, socially), if they are aware of the implications smoking has on their health and the health of their child. The provider encourages the patient to quit, offering health-related reasons why quitting is highly advisable. The patient confirms that they are not ready to quit.

Intervention Visit - Involves the above patient and caregiver, (but the caregiver confirms that they are ready to quit) with additional counseling involving a treatment plan and options available to the patient, including pharmacology. A follow-up visit is scheduled at least one week after the patient's attempt to quit.

Preventive Medicine Counseling

Preventive Medicine Counseling and Risk Factor Reduction Intervention

Billing Guide Definition: These codes are used to report services provided face-to-face by a physician or other qualified health care professional, for the purpose of promoting health and preventing illness or injury. These services are used for persons without a specific illness for which the counseling might otherwise be used as part of the treatment.

HealthySteps Specific Note: In practices where there is an independently billable clinician with a scope of practice that allows for the rendering of this service (e.g., physician or nurse practitioner), they may provide this service to a child to address a specific issue. If more specialized or long-term treatment is necessary, they will make a referral to an appropriate professional. Typically, these children will be in Tiers 2 or 3.

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CPT Code	Description
99401	Preventive medicine counseling and risk factor reduction intervention; <i>15 minutes</i>
99402	Preventive medicine counseling and risk factor reduction intervention; <i>30 minutes</i>
99403	Preventive medicine counseling and risk factor reduction intervention; <i>45 minutes</i>
99404	Preventive medicine counseling and risk factor reduction intervention; <i>60 minutes</i>

Tips for Reporting Preventive Medicine Counseling:

- Health and behavior and assessment/re-assessment and intervention services should not be reported on the same day as preventive medicine counseling and risk factor reduction intervention services.
- Well-child visits should not be reported on the same day as preventive medicine counseling and risk factor reduction intervention services.
- The licensures considered to be “other qualified health care professionals” can vary across state Medicaid agencies and other insurance carriers. Health care professionals considered for reimbursement should be verified with all insurance carriers.
- Preventive medicine counseling codes are time-based, requiring documentation of the time spent rendering the service. It is recommended that the clinician document the start (admission) and stop (discharge) times.

Education Services

Behavioral Health Prevention Education Services

Billing Guide Definition: Behavioral health prevention education is used to deliver services to individuals of a target population on issues of mental health education, affecting individuals’ knowledge, attitude, and behavior. It may include screenings to assist individuals in obtaining appropriate treatment.

HealthySteps Specific Note: In practices where there is an independently billable clinician with a scope of practice that allows for the rendering of this service (e.g., an LCSW), they may provide prevention services to a child and family to address a specific issue. If more specialized or long-term treatment is necessary, they will refer to an appropriate professional. Typically, these children will be in Tiers 2 or 3.

HCPC Code	Description
H0025	Behavioral health prevention education service

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Tips for Reporting Behavioral Health Prevention Education Services:

- HCPCS code H0025 was created for behavioral health prevention education services, mainly to target alcohol and drug abuse treatment services, but states can vary on how they utilize this code, and if they will reimburse for it. Insurance follow-up is highly recommended.
- The service may include screenings to assist patients in obtaining appropriate treatment.
- Services and supporting documentation should include discussion of causes and symptoms to encourage early intervention and reduce severity.
- Guidelines for the compliance of reporting this code vary from state to state. Verification with your state Medicaid agency and other insurance carriers is recommended.

Lactation Services

State Medicaid agencies and other healthcare insurance carriers reimburse for evidence-based breastfeeding education and lactation counseling consistent with the United States Preventive Task Force (USPSTF) recommendation, with specific guidelines for reimbursement eligibility. Verification with your state Medicaid agency and other health insurance carriers is required.

HCPCS Code	Description
S9443	Lactation services, non-physician; per session

Tips for Reporting Lactation Services:

- Some states only allow services to be rendered to one patient at any given time, with services billable only under the caregiver. Other states do not separately bill for lactation services and at times bundle the services into an evaluation and management code. Verification with insurance carriers is highly recommended.
- Documentation requirements may vary from state to state. Verification with your local state’s Medicaid and/or insurance carriers is highly recommended.
- Diagnosis code Z39.1 (Encounter for care and examination of lactating mother) will support medical necessity for the services.

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Professional licensures vary for reimbursement. Reimbursable non-physician licensures vary from state to state and should be verified. Approved lactation consultant certification agencies vary from state to state. Verification is required.

Sample Clinical Encounter

Infant has a well-child visit where the caregiver expresses to the provider that she is having difficulty breastfeeding and needs help. The provider may refer the mother to the HealthySteps Specialist who is also a certified lactation consultant.

During her appointment with the HS Specialist, the following services can be provided:

- Help with positioning the baby,
- Solving latch problems,
- Painful nursing, and
- Handling night feedings.

Case Management Medical Team Conference

State Medicaid agencies and other healthcare insurance carriers reimburse for interdisciplinary team medical conferences when conducted with or without the patient and/or family member(s) present, **to discuss a patient’s treatment plan**. The interdisciplinary **team must consist of more than one medical specialty**. (e.g., medical provider(s) and behavior/mental health providers).

<u>CPT Code</u>	<u>Description</u>
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician health care professional .
99368	Medical team conference with interdisciplinary team of health care professionals when patient and/or family is not present. 30 minutes or more, participation by nonphysician health care professional .

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Tips for Reporting Case Management Medical Team Conference Services:

- These codes can only be reported for the participation of a non-physician qualified health care professional, when the medical conference is comprised of an interdisciplinary team of professionals (more than one specialty-e.g., primary care physician, specialized physicians, and behavior/mental health provider, when the patient’s treatment plan is reviewed, and discussed.
- All participants must be immediately involved in the care or recovery of the patient.
- Documentation requirements include, the names of the medical team participants and their professional specialty, the name of the family member(s) who participated and their relationship to the patient, the treatment plan discussed, including the patient's diagnosis, the behavioral health clinician’s participation in the conference, and the length of time of the medical conference.
- If the codes are open in your state, verification with your local state’s Medicaid and/or insurance carriers is highly recommended on which professional licensures are authorized to bill for the service.
- A concrete mental health diagnosis may be required to bill for the services. Verification with your local state’s Medicaid and/or insurance carriers is highly recommended.

Sample Clinical Encounter

A child has autism. During a well-child visit, the caregiver expresses to the HS Specialist that the child gets stiff sometimes or has jerking movements of their arms and legs. The HS Specialist relays this information to the child’s primary care physician, who after speaking with the caregiver, suspects the child may be suffering from seizures and refers him/her to a neurologist. The neurologist confirms the primary care physician’s suspicions. The primary care physician, neurologist, and HS Specialist meet to discuss the patient’s treatment plan with the family. The behavior/mental health provider (HS Specialist) participation in the conference can be billed.

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