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 New Jersey. 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 HSpolicyandfinance@zerotothree.org.

Frequently Asked Questions (FAQs)

Screenings

Q: What are the billing codes for maternal depression screenings? Are they reimbursable when rendered during a well-child visit?

A: New Jersey Medicaid and Medicaid Managed Care Organizations recognize CPT code 96127 for the reporting of a postpartum depression screening but will not reimburse when rendered during a well-child visit. They will reimburse for the screening when billed under the mother when the mother is being seen by her medical provider, where bills are submitted under her Medicaid identification number.

Q: Can you bill for multiple screenings that share the same billing code, if provided on the same date of service?

A: Yes. An example is when screening and billing for autism and developmental delays since both screenings utilize CPT code 96110 for billing and reporting purposes. A modifier 59 must be appended to the billing code upon billing for the services to identify that two different screenings were rendered. In addition, two units of service should be reported since two screenings were provided.

Q: Can behavioral health providers bill for screenings?

A: New Jersey Medicaid and Medicaid Managed Care Organizations will only reimburse for screenings when billed by a physician, physician assistant and at times for an advance practice nurse. Verification with insurance carriers must be made for an advanced practice nurse.

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Psychotherapy

Q: Can you bill for psychotherapy, including family psychotherapy under the child, when there is a diagnosis in place for the mother that places the child in jeopardy?

A: No, you may not. When billing for psychotherapy, including family psychotherapy, you can only bill under the patient who carries the diagnosis.

Q: Can you bill for psychotherapy sessions if rendered for less time than indicated in the code's descriptions?

A: Although there are sources indicating the ability to report psychotherapy services when more than 50% of the time allotted in the billing code descriptions was spent rendering the service, insurance carriers can require the entire time in the billing code descriptions to be rendered or allow a minimum time requirement for reimbursement of services. Verification with insurance carriers is required. If insurance carriers do allow the billing for psychotherapy services with minimum time requirements, the following source will provide the time requirements for each code: https://www.apaservices.org/practice/reimbursement/health-codes/psychotherapy.

Q: What is the difference between multiple family group psychotherapy and group psychotherapy?

A: Multiple family group psychotherapy services are psychotherapy sessions rendered to two or more different families in a group setting. Group psychotherapy are psychotherapy sessions rendered to 2 or more individual patients without their family members.

Interactive Complexity

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

A: No, you may not. To align with federal and the Center of Medicaid/Medicare Services (CMS) guidance 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.

Q: Can interactive complexity be billed independently?

A: No, it may not. The code for interactive complexity, 90785, is known as an add-on code, indicating that it can only be billed in conjunction with another code. Code 90785 can be billed with psychotherapy services and with psychiatric diagnostic evaluations.

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 billing codes (96156, 96167, 96168, 96158, and 96159) identify and assess any psychological, behavioral, emotional, cognitive, and relevant social factors that may be preventing successful treatment or management *of a patient's physical health problems*, such as missing appointments because there is an economic factor that can be related to transportation or housing. It can also be related to a parent not fully understanding all the avenues of care for their child. For example, if a child has bilateral hearing loss and the caregiver(s) are not making the child wear their hearing aids due to the lack of understanding their importance, then this impedes

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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 interpersonal factors are impeding on the successful treatment and management of the patient's physical health diagnosis.

General Behavioral Health Integration Care Management

Q: Regarding general behavioral health care management services that utilize CPT code 99484, how do you bill for its time requirement of at least 20 minutes of care when services are provided during multiple visits throughout the month?

A: Code 99484 can only be billed once, per patient, per calendar month; therefore, a workflow must be in place where the practice can track the visits and the time spent with the patient during each visit. The service can be billed if the cumulative time rendering services is equivalent to 20 minutes or more. Upon claim submission, billing code 99484 should be entered once, utilizing "From and To" dates of service. The "From" date should be the first day of the month you are billing for, and the "To" date should be the last day of the month for which you are billing.

Psychiatric Diagnostic Evaluation

Q: Is a psychiatric diagnostic evaluation a requirement prior to billing for psychotherapy services when rendered due to a mental health diagnosis?

A: Most insurance carriers do require that a psychiatric diagnostic evaluation be rendered to the patient prior to providing psychotherapy services.

Medical Credentialing

Q: Will a site receive medical insurance reimbursement for providers that are not yet credentialed with the site's participating medical insurance carriers?

A: No. Credentialing is a vital process for healthcare institutions. It is the process of assessing the academic qualifications of a provider such as their education and training experience as well as their clinical practice history. Provider credentialing is a medical insurance carrier necessity required for the reimbursement of the provider's services to your facility/site.

Social Workers Guidelines for Billing

Q: Can a licensed clinical social worker independently bill for the services they provide?

A: New Jersey Medicaid guidelines advise that licensed clinical social workers cannot bill Medicaid fee-for-service as part of a private physician practice group. The social workers located at non-private physician group practices that are licensed by the New Jersey Department of Health can enroll as non-billable providers and can bill for rendered services under their facility's Medicaid provider identification number.

Q: Where are bills for behavioral health sent for Medicaid members?

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A: For most Medicaid members (excluding those enrolled as a member with an intellectual or developmental disability,) outpatient behavioral health services are billed to Medicaid Fee-For-Service.

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