New Jersey Coding Guide for HealthySteps Related Services

The HealthySteps National Office Policy and Finance Team

About this Document

HealthySteps sites can bill Medicaid for some of the services they provide to children and families. The purpose of this document is to support HealthySteps sites in medical coding for HealthySteps related services.

This document provides a list of open Current Procedural Terminology (CPT) and HealthCare Common Procedure Coding System (HCPCS) codes, with specific applicable Medicaid billing, coding, and documentation guidelines.

There are a variety of requirements and restrictions that can impact your sites' ability to bill specific codes, including the provider type, location of service, frequency, and maximum billing units. This document aims to facilitate an understanding of these requirements and restrictions and helps guide your practice in coding and billing for HealthySteps services.

To maximize appropriate reimbursement, we recommend always contacting health insurance companies for verification on billing for services provided.

Contents

What is the Division of Medical Assistance & Health Services (DMAHS)?

The Division of Medical Assistance and Health Services (DMAHS) administers the state Medicaid program for certain groups of low to moderate income people. NJ FamilyCare is the single program for all public medical assistance in New Jersey, including all adults and children eligible for services under any state or federal authority.

NJ FamilyCare provides health insurance to parents/caretakers and dependent children, pregnant women, and people who are aged, blind or disabled and/or those requiring long-term services.

DMAHS Contact Information

The HealthySteps National Office Policy and Finance Team is here to support your billing efforts, but for issues and questions regarding New Jersey billing and coding questions, please use the contacts listed below:

- State of New Jersey – Division of Medical Assistance and Health Services
  - Recipient Eligibility Verification System (REVS) (Providers can call to verify a member's eligibility at 1-800-676-6562)
  - Fiscal Agent Provider Services (Medicaid providers can contact the state's fiscal agent for claims processing issues) 1-800-776-6334
  - Medical Assistance Custer Centers for NJ FamilyCare: https://www.state.nj.us/humanservices/dmahs/info/resources/macc/MACC_Directory.pdf

Provider Guidelines

There are two provider types. The provider type impacts reimbursement opportunities.

Core Providers (those that can independently bill):

- Physician
- Physician Assistant (PA)
- Advanced Practice Nurse (APN)
- Advanced Practice Nurse-Psychiatric Mental Health (APN-PMH)
- International Board-Certified Lactation Consultant (IBCLC)
- Psychologist
- Licensed Clinical Social Worker (LCSW)*
- Licensed Social Worker (LSW) supervised and billed by an LCSW*
- Psychiatrist

Non-Core Providers (those that can provide therapy services that must be added into a core provider encounter and may not be billed independently):

- Alcohol and Drug Counselor
- Licensed Professional Counselor *(Verification with insurance carriers required on if professional will be recognized to bill for services independently.)*
- Clinical Mental Health Counselor
- Licensed Marriage and Family Therapist *(Verification with insurance carriers required if professional will be recognized to bill for services independently.)*

***Per New Jersey Medicaid, LSWs and LCSWs cannot bill as part of a private physician practice group. The LSWs and LCSWs located at non-private physician group practices that are licensed by the New Jersey Department of Health can enroll as non-billing providers and can bill for rendered services under the facility Medicaid provider ID number.**

HealthySteps Related Services

Child Development and Social-Emotional Screenings

Evaluating and promoting optimal child development and well-being includes screenings. Screenings are a significant component of HealthySteps services. There are many different types of screenings that include child development, social-emotional, and health and behavior. These screenings are usually incorporated into the well-child visit. The table below highlights pertinent billing codes, their descriptions, and guidelines.

CPT Code	Description	ICD-10 Code	Reimbursable Clinicians	Applicable Guidelines
96110	Developmental milestone survey, speech and language delay with scoring and documentation, per standardized instrument. Examples: **ASQ®-3, M-CHAT, PEDS**	Z13.42 - Developmental delays Z13.41 - Autism screening	Physician Physician Assistant (verify with insurance carriers) Advance Practice Nurse: 1. Certified in the advanced practice of pediatrics or family health can render a developmental screening during an EPSDT visit. 2. Certified as a Healthy Start provider can render social-psychological assessments	When rendering services for more than one screening with the same CPT code, Modifier 59 must be appended (example: The ASQ and PEDS utilize the same CPT code). The reporting of more than one unit is applicable when billing for more than one screening code. If an evaluation and management (E/M) service is being reported on the same date of service, Modifier 25 needs to be appended to the E/M code. New Jersey recommends health care facilities to follow the Bright Futures guidelines for health supervision of infants, children, and adolescents, utilizing their periodicity schedule. They are led by the American Academy of Pediatrics. Their periodicity schedule advises of the recommended age to provide screenings.
96160	Patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument. Examples: **ACEs-patient focused**	Z13.9 - Report for health risk assessments		
96127	Social-emotional brief emotional/behavioral assessments. Examples: **PHQ-2, PHQ-9, ASQ®:SE, ASAS, BYI-2, BASC-2, BRIEF, SCARED, GAD-7, ASC-Kids, TSCC, TSCYC**	Z13.31 - Screening for depression (other than maternal) Z13.89 - Screenings for all other		

Reporting of Units

Reporting units may be required when entering charges for a claim. For example, the ASQ®-3 and M-CHAT screenings both utilize CPT code 96110 for reporting. If both are rendered on the same day, a quantity of "2" will need to be on the claim.

Maternal Depression and Depression Screenings

Although New Jersey has mandated that providers screen all women for prenatal and postpartum depression, the National Academy for State Health Policy indicates that New Jersey will not reimburse for the screening, when rendered during a well-child visit. New Jersey Medicaid will provide reimbursement for postpartum maternal depression screenings, using a validated screening tool, when billed under the mother.

CPT Code	Description	ICD-10 Code	Reimbursable Clinicians	Applicable Guidelines
96127	Social-emotional brief emotional/behavioral assessments. Examples: **PHQ-9, Edinburgh postnatal depression screen (EPDS)**	Z13.32 - Maternal depression screening Z13.31- Depression screening other than maternal.	Physician Physician Assistant (verify with insurance carrier) Advanced Practice Nurse (verify with insurance carrier) Advanced Practice Nurse-Psychiatric Mental Health (verify with insurance carrier)	When billing for depression screenings, there is one CPT code (96127), but there are two ICD-10 codes that support medical necessity. Z13.31 is for a depression screening, other than maternal depression, and Z13.32 is for the reporting of a maternal depression screening. The correct ICD-10 for the service being rendered must be reported. If an E/M service is being reported on the same date of service, Modifier 25 needs to be appended to the E/M code. The National Academy for State Health Policy (NASHP) indicates that although postpartum depression screenings are not separately reimbursable when rendered to a mother during their child's well-child visit, it is still a requirement as part of the well-child visit in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and The American Academy of Pediatrics Bright Futures guidelines.

Health and Behavior Assessments/Re-assessments, and Intervention with the Family Present

Health and behavior assessment/re-assessment and health and behavioral intervention with family present 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.[1,2] The patient's primary diagnosis must be physical in nature, and the focus of the assessment and intervention is on factors complicating the medical conditions and treatments. These codes describe assessments and interventions to improve the patient's health and well-being utilizing psychological and/or psychosocial procedures designed to ameliorate specific disease-related problems. Reimbursable clinicians in New Jersey are PAs, psychologists, LCSWs, and APN-PMHs. **Please verify with insurance carriers which of these clinicians are reimbursable at your site.**
The table on the next page highlights the billing codes, reimbursable clinicians, and applicable guidelines for the services.

CPT Code	Description	Reimbursable Clinicians	Applicable Guidelines
Health and Behavior Assessment/Re-assessment		Physician Assistant Psychologist Licensed Clinical Social Worker Advanced Practice Nurse-Psychiatric Mental Health	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. Patient must have an established physical illness or symptom(s) and cannot have been diagnosed with a mental illness. 96156 can be billed only once per day regardless of the amount of time required to complete the overall service. The assessment/re-assessment code reports the assessment of psychological, behavioral, emotional, cognitive, and relevant social factors that can prevent, treat, or manage physical health problems. The assessment or re-assessment must be associated with an acute or chronic illness, the prevention of a physical illness or disability, and the maintenance of health. These services cannot be reported on the same day as psychiatric services. 96167 and 96168 are time-based services requiring documentation of the time spent rendering the service. 96168 is an add-on code for 96167, indicating that it can only be reported with 96167, if the additional time indicated in its description was rendered. Intervention codes are used to report modification of the psychological, behavioral, emotional, cognitive, and social factors relevant to, and affecting the patient's physical health problem. Components of Health and Behavior Assessment and Re-assessment: • Health-focused clinical interview: Depending on the nature of the reason for referral, the qualified health care professional (QHP) conducts a face-to-face clinical interview with the patient (or patient's family if patient is a child) that will outline the reasons for the assessment. • Behavioral observations: The QHP evaluates how the patient and/or family is responding throughout the health-focused clinical interview through direct behavioral observation. There will be
96156	Health and behavior assessment or re-assessment (e.g., health-focused clinical interview, behavioral observations, clinical decision making)		
Health and Behavior Intervention with Family Present			
96167 and 96168	96167 - Health and behavior intervention, family with patient present. Face-to face; initial 30 minutes		

	96168 - Health and behavior intervention, family with patient present. Face-to face; each additional 15 minutes		variability across patients depending on a wide variety of factors including patient complexity, or the severity of the medical condition(s). • Clinical decision making: The QHP integrates information learned prior to the interview, such as record review, discussions with other health care providers (e.g., the patient's PCP) and with information gained during the health focused clinical interview and the behavioral observations, the QHP can now provide a clinical impression. Components of Health and Behavioral Interventions: Intervention includes promotion of functional improvement, minimization of psychological or psychosocial barriers to recovery, and management of and improved coping with medical condition(s). These services emphasize active patient/family engagement and involvement. Evidence-based health and behavior interventions address psychological/behavioral factors that can influence a person's medical condition and consist of various types of interventions. Components may include but are not limited to: • Motivational interviewing • Problem solving, coping skills, relation techniques and skills training. • Emotional awareness and management • Pacing techniques • Functional and structural family treatment • Communication skills and mindful techniques • Psychoeducation related to the psychological, behavioral and/or psychosocial aspects of the patient's illness or presenting problem.

Care Management: General Behavioral Health Integration

Services for general behavioral health integration (CPT code 99484) must be rendered and billed by a psychologist, LCSW, or APN whose field is in psychiatric mental health, for services they render for a patient with a behavioral health condition, who requires care management services of 20 minutes or more, in a calendar month. A treatment plan as well as the required elements of the service are required. Services may be provided in any outpatient setting.

Guidelines:

- Behavioral health care planning [**must be related to behavioral/psychiatric health problem(s**)], including revision for patients who are not progressing or whose status has changed.
- Services include facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation (if required), and continuity of care with a designated member of the care team. Services also include follow-up monitoring and use of applicable validated rating scales.

- General behavioral health integration is a time-based service, which requires the reporting of time. Each note being utilized for the 20 minutes per month threshold must have the time spent with the patient documented.
- Time spent strictly on administrative duties should not be counted towards the time threshold to bill for general behavioral health integration.
- Referral for the commencement of care management services must be done by the primary care physician.

Psychiatric Diagnostic Evaluation

Psychiatric diagnostic evaluation (CPT code 90791) includes the assessment of the patient's psycho-social history, current mental status, and reviewing and ordering diagnostic studies followed by appropriate treatment recommendations. Interviews and communication with family members are included in these codes.

A psychiatric evaluation is more in-depth than a screening. Evaluations include the following:

- Description of behaviors present, when they occur, how long they last, and which behaviors most often happen, under what conditions.
- How the behaviors impact performance in school and other activities and relationships with others (e.g., parent/caregiver, siblings).
- Description of symptoms (physical and psychiatric), personal, and family mental health history.

Guidelines:

- Interviews and communication with family members or other sources are included in the CPT code.
- Communication factors that complicate the diagnostic evaluation may result in the need for interactive complexity and can be reported in conjunction with the evaluation (see interactive complexity).
- Since psychotherapy includes continuing psychiatric evaluation, psychotherapy codes are not to be reported with psychiatric diagnostic evaluations.

Reimbursable Clinicians:

- Psychologist
- Psychiatrist (can render with medical services reporting CPT code: 90792)
- LCSW
- LSW under clinical supervision of an LCSW, to be billed by the LCSW.
- APN with a specialty in psychiatric mental health

Psychological, Neuropsychological, and Developmental Test Administrations and Evaluations.

Not to be confused with screenings, these tests and evaluations involve more extensive services to be rendered. If testing and evaluation is being provided, the table below outlines the necessary elements for billing.

Psychological Test Administration and Evaluation			
CPT Code	**Description**	**Reimbursable Clinicians**	**Applicable Guidelines**
96130	**Psychological Testing and Evaluation; first hour** Integration of patient data, interpretation of standardized test results and clinical data, decision making and interactive feedback to patient, family members/caregiver(s) for first hour, including treatment plan and reporting. Service measures personality, emotions, intellectual functioning, and psychopathology. Psychological tests are formalized measures of mental functioning. Some signs that testing and evaluation may be necessary include significant social withdrawal, difficulties with speech and concentration, significant difficulties with social activities including school. Examples: Achievement, ability, and personality assessments with full evaluation.	Psychologist	Face-to-face service required. A written report must be generated. Because these are time-based codes, the total time rendering and interpreting the service must be documented, including a start and stop time.
96131	Psychological Testing, Evaluation, each additional hour after the first hour of service.		96131 is an add-on code to 96130, signifying it can only be billed with 96130, when an additional hour of service is rendered, after the first hour of service.

Neuropsychological Test Administration and Evaluation			
CPT Code	**Description**	**Reimbursable Clinicians**	**Applicable Guidelines**
96132	Service measures thinking, reasoning, judgement, and memory to evaluate the patient's neurocognitive abilities. It is an in-depth assessment of skills and abilities linked to brain function. It measures areas such as attention, problem solving, language, memory, visual-motor, fine motor deficits.	Neuropsychologist Psychologist to be verified with insurance carrier(s)	Face-to-face service required. A written report must be generated. Because these are time-based codes, the total time rendering and interpreting the service must be documented, including a start/stop time. Documentation should reflect all requirements and services rendered.
96133	Neuropsychological Test Administration and Evaluation, each additional hour after the first hour of service.		96133 is an add-on code to 96132, signifying it can only be billed with 96132, when an additional hour of service is rendered, after the first hour of service.
Developmental Testing			
CPT Code	**Description**	**Reimbursable Clinicians**	**Applicable Guidelines**
96112	Developmental Test Administration including assessment of fine and/or gross motor, language, cognitive level, social, and memory or executive functions by standardized developmental instruments with interpretation and report- initial hour. Testing develops a more concrete picture than screening alone. It provides a profile of a child's strengths and weakness in all developmental areas and may be used to determine if the child needs an early intervention or treatment program. Examples: sensory-motor, speech and hearing, preschool psychoeducational batteries, early learning profiles.	Psychologist	Code applies to testing for developmental disorders. Reporting should include objective and subjective assessment. This is a time-based code requiring documentation of the time spent rendering the service.
96113	Developmental Test Administration; each additional 30 minutes after the first hour of service.		96113 is an add-on code for 96112, signifying it can only be billed with 96112, when an additional 30 minutes of service is rendered, after a full hour of service. Documentation of time spent rendering the service is required.

The following section contains services that can also be provided but are not limited to the parent(s)/caregiver(s). If the services are rendered to the parent, a visit must be generated for the parent/caregiver, and services rendered are to be billed under the parent/caregiver's Medicaid number.

Psychotherapy

Medicaid reimbursement will be available for psychotherapy when the parent/caregiver is the primary patient, with the reporting of the following codes:

CPT Code	Description	Reimbursable Clinicians	Applicable Guidelines
90832	Individual Psychotherapy with Patient - 30 Minutes	Psychiatrist Psychologist Licensed Clinical Social Worker Licensed Social Worker under the clinical supervision of a Licensed Clinical Social Worker Advanced Practice Nurse-Psychiatric Mental Health	Psychotherapy is not to be reported with Psychiatric Diagnostic Evaluations. A signed and dated treatment plan for all psychotherapy session types, including family psychotherapy and group psychotherapy, is required and must include, but is not limited to: The patient's diagnosis, treatment goals, and number of sessions ordered by the physician, NP, or PA. The practitioner involved in the treatment plan of the patient must sign the plan, certifying the medical necessity. Documentation for all psychotherapy services, including family psychotherapy, must include the following: Time spent rendering the service (start and stop time), description of the techniques used to treat the patient's condition, and how the patient benefited from the therapy in reaching his/her goal(s). Group psychotherapy also requires the same documentation, except for the time the service was rendered, as group psychotherapy is not a time-based code, therefore, reporting the time spent with the patient is not required. If a diagnosis of depression is being reported, the episode is required, (single/recurrent), and when applicable, if the patient is in partial or full remission.
90834	Individual Psychotherapy with Patient - 45 Minutes		
90837	Psychotherapy with Patient-60 Minutes		
90837	Psychotherapy with Patient - 60 Minutes		
90847	Family Psychotherapy with Patient Present - 50 Minutes (face-to-face with patient and family). 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). Often these sessions entail family participation in the treatment process of the patient.		
90846	Family Psychotherapy without the Patient Present-50 minutes (face-to-face with the family) 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). Often these sessions entail family participation in the treatment process of the patient.		For 90847-The patient must be present for the entire or majority of the service with family/caregiver(s). 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 behavioral should be the focus of the sessions. For 90846-Effective 7/1/2023, NJ Medicaid will reimburse for Family Psychotherapy without the patient present where all guidelines apply as with 90847, with the exception that the patient does not have to be present during the session(s). 90846 and 90847 cannot be billed on the same date of service.
90853	Group Psychotherapy		

			Included in both codes: Reviewing records, communicating with other providers, observing, interpreting patterns of behavior, communication between the patient and family, and decision making. A mental/behavioral health diagnosis is required for reporting psychotherapy services. The only exception has been seen in the reporting and reimbursement of ICD-10 codes for parent/child conflict (Z62.820, Z62.821, Z62.822, with family psychotherapy services). Since New Jersey Medicaid may have distinct reimbursement arrangements with each county and/or clinic type, it is required that you verify prior to utilizing these diagnoses for billing. Group psychotherapy coded reported with CPT code 908853 is used when psychotherapy services are rendered to a group of at least 2 or more patients without their family members. The patients should share the same or similar diagnoses where therapy aims to bring about reduction in symptoms such as negative symptoms, poor motivation, as well as improvement in social functioning. Group psychotherapy can be rendered to the patient and/or family members of the patient, when they too are patients at the clinic. Prior to FQHCs and RHCs rendering services for 90846 and 90853, verification should be made with the insurance carriers as these services may not be reimbursable at these clinic types.

Psychotherapy with Medical Services

Reimbursement is available for psychotherapy with medical services with the reporting of the codes below.

CPT Code	Description	Reimbursable Clinicians	Applicable Guidelines
90833	Psychotherapy - 30 minutes with medical services.	Psychiatrist	Psychotherapy with medical services should always be coded secondary to the evaluation and management code reported by the mental health physician and the time involved medical services should not be included in the time spent rendering psychotherapy. Medical services are services rendered that are reported with level of service evaluation and management codes e.g., physical exam and a prescription of pharmaceuticals. Applicable guidelines for psychotherapy also apply to psychotherapy when rendered with medical services.
90836	Psychotherapy - 45 minutes with medical services.		
90838	Psychotherapy - 60 minutes with medical services.		

Important Notes:

The reporting of individual versus family psychotherapy is at the clinical discretion of the provider. Verification of age minimum requirements for reporting individual psychotherapy is required. In addition, guidelines for when to select billing for individual psychotherapy, versus when to bill for family psychotherapy, must be verified with insurance carriers. Please review the guidelines indicated in the family psychotherapy section to assist with your decision in reporting.

Although there are sources indicating the ability to report psychotherapy services when **more than** 50% of the time allotted in their billing code descriptions was spent rendering the service, insurance carriers can require the entire time in the billing codes description to be rendered, or if they have determined a minimum time requirement for reimbursement of services. Verification with insurance carriers is required.

Health and Behavior Intervention

Health and Behavior Intervention services are to modify the psychological, behavioral, emotional, cognitive, and social factors relevant to and affecting the patient's physical health problems, not with the focus on mental health issues, but rather on how such factors may be contributing to the treatment of their established illness(s).[1,2] If the patient has a mental health diagnosis, this code would not be appropriate to report. The patient's primary diagnosis must be physical in nature and the goals of the interventions should be to improve the patient's health and well-being utilizing psychological and/or psychosocial procedures designed to ameliorate specific disease-related problems. Physician assistants, psychologists, LCSWs, and APNs with a specialty in psychiatric mental health can all utilize these codes for billing purposes. **Please verify with insurance carriers on which of these clinicians are reimbursable.**

CPT Code	Description	Applicable Guidelines
96158	96158 - Health and behavior intervention, individual, face-to-face; **initial 30 minutes.**	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**. Patient must have an established illness or symptom(s) and cannot have been diagnosed with a mental illness. Codes are used when services for the modification of the psychological, behavioral, emotional, cognitive, and social factors have been identified as directly affecting the patient's physiological function, disease status, health, and general well-being. These services cannot be reported on the same day as preventive medical counseling or risk factor reduction codes when rendered by the same provider. These services cannot be reported on the same day as psychiatric services. 96159 is an add-on code for 96158, indicating that it cannot be billed independently but only in conjunction with 96158. One unit of service for CPT code 96159 represents each additional 15 minutes spent rendering the intervention, after the initial 30 minutes was spent rendering the service. Interventions are time-based services and the time spent rendering the service must be documented. (A start and stop time are effective.)
96159	96159 - Health behavior intervention, individual, face-to-face**; each additional 15 minutes.**	

[1] CPT codes effective as of 2020: 96158, 96159.

[2] CPT code effective prior to 2020: 96152. Description of previous code: 96152 - Intervention each 15 minutes with patient (crosswalk to 96158 and 96159).

Screening, Brief Intervention, Referral to Treatment (SBIRT) Services

SBIRT is a comprehensive, integrated, public health approach to identifying substance misuse and delivering early intervention services for persons at risk of developing substance use disorders. It is an approach to universal screening for substance use problems in healthcare settings. In New Jersey, SBIRT for substance use is a preventative health service.

New Jersey Medicaid reimburses for alcohol and substance use screening and brief interventions when reporting the following codes.

CPT Code	Description	Reimbursable Clinicians	Applicable Guidelines
H0049	Alcohol and/or drug screening.	Provided during a well care visit, to be billed under the provider's name, but can be rendered by most clinicians.	Prior to providing a screening and brief intervention, a universal pre-screen for drugs and alcohol must be provided during a routine medical visit. Pre-screening can be conducted by most clinicians. Authorized pre-screens are the AUDIT C for alcohol and the NIDA, which is a single item drug screen. Separate reimbursement is at the insurance carrier(s) discretion. Verification is required.
99408	Alcohol and substance use, structured screening and brief intervention, 15-30 minutes.	Physician Physician Assistant Advanced Practice Nurse-Psychiatric Mental Health Psychologist Licensed Clinical Social Worker	If the patient is at risk for alcohol/drug misuse, the use of a structured, validated screening tool is required. Validated tools are the AUDIT and the DAST-10. Screens must be in the patient's medical record and should immediately be reviewed with the patient. Documentation of the time spent rendering services is required. Provide a referral to specialty care for further assessment of those at high substance use risk. The maximum number of brief treatment sessions can vary with insurance carriers and must be verified. NJ SBIRT guidance advises that interventions should be rendered by master level behavioralists for patients who score as high risk.
99409	Alcohol and Substance use structured screening and brief intervention, **greater than** 30 minutes. The brief intervention is to increase the patient's insight and awareness of substance use/misuse, and to motivate toward behavioral change.		

Lactation Services

New Jersey promotes and supports lactation services. The "Lactation Consultants Licensing Act" allows for breastfeeding education and support services to educate and support mothers in meeting their breastfeeding goals.

There are services that can be rendered by professionals that are licensed and unlicensed, but only those licensed can incorporate the service into an Evaluation and Management code, since there is not a separately billable code in the primary care setting.

Guidelines:

- Clinicians must be International Board-Certified Lactation Consultants (IBCLCs). Some health insurance carriers will only recognize those certified by the International Board of Lactation Consultant Examiners; verification with carriers is required.
- Services should be billed under the mother.
- Clinicians that can bill for level of service Evaluation and Management codes are physicians, PAs, APNs, and RNs.
- Diagnosis code Z39.1 (encounter for care of a lactating mother) should be appended to the claim as the secondary diagnosis. The primary diagnosis should be the reason why the mom is receiving lactation services.

  Examples of reasons why lactation services may be rendered:

  a. Mastodynia (breast and nipple pain) - N64.4
  b. Hypogalactia (low milk supply) - O92.4
  c. Mammary duct ectasia (clogged ducts) - N60.4x9 (last digit is used to specify which breast)
  d. Engorgement - O92.29

For those IBCLCs who possess credentials that cannot bill for evaluation and management services, direction from insurance carrier(s) must be obtained on how to bill for the service.

IMPORTANT NOTE: Carriers other than NJ Medicaid may provide reimbursement for lactation services utilizing the following HCPCS codes. Insurance verification is required.

- S9443-Lacation classes, non-physician provider, per session
- S9446-Patient education, not otherwise classified, non-physician provider, group, per session.
- 99441-Telephone evaluation and management service by a physician or other qualified health care professional 5-10 minutes of medical discussion.
- 99442-Telephone evaluation and management service by a physician or other qualified health care professional 11-20 minutes of medical discussion.
- 99443-Telephone evaluation and management service by a physician or other qualified health care professional 21-30 minutes of medical discussion.

Interpretation or Explanation of Results

CPT code for interpretation or explanation of results (90887) is used to report when a clinician interprets the results of a patient's psychiatric and medical examinations and procedures, as well as any other pertinent recorded data, and spends time explaining in detail, the patient's condition to family members and other responsible parties involved with the patient's care and well-being. Advice is also given as to how family members can best assist the patient.

90887 is listed as a billable code under the New Jersey Medicaid FFS and children's rates procedure listings, but verification on who and when it can be reported is highly advisable. Verification with other insurance carriers is also highly advisable as the services linked to the reporting of this code are also services that may be bundled into other codes. Examples of services that include the interpretation and explanation of results are **screenings and tests.**

CPT code 90887 should be utilized when a diagnosis has been made, initial interpretation and results have already been advised of, but further detailed explanation and how to care for the patient is rendered, with additional accumulated data to share.

Examples of when additional support, direction and the sharing of on-going data occurs, can be seen, for example, when a child is diagnosed with:

- Developmental disorders of speech and language
- Autistic disorder
- Attention-deficit hyperactivity disorder
- Expressive language disorder

CPT Code	Reimbursable Clinicians	Description
90887	Psychiatrist Psychologist Advanced Practice Nurse-Psychiatric Mental Health Licensed Clinical Social Worker [to be verified with insurance carrier(s)]	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons or advising them how to assist patient.

Documentation should clearly identify all evaluated data, as well as the provider's interpretation of the data evaluation.

Caregiver Behavior Management Training (CBMT)

Effective January 1, 2023, Physicians, or other qualified health care professionals such as psychologists, can provide and report Caregiver Behavior Management Training (CBMT), via Multiple Family Group Behavioral Health Training, a new group-based service administered to parent(s)/caregiver(s) of patients that have been diagnosed with a physical or mental health condition. CBMT codes allow qualified professionals to bill for services that involve training a patient's parent(s)/caregiver(s) in interventions and strategies to help manage or treat the patient's condition, by using evidence-based behavioral management/modification procedures, strategies, and interventions in a face-to-face multiple-family group setting.

New Jersey Medicaid reimburses CBMT services when reporting the following codes.

CPT Code	Description	Applicable Guidelines
96202	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/ caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parents(s)/guardian(s)/ caregiver(s); **initial 60 minutes.**	Physicians and other qualified health care providers such as psychologists may render these services. Insurance carrier verification is required on the other qualified health care providers they will recognize for the reimbursement of CBMT services. For physicians reporting CBMT services, counseling and risk factor reduction intervention codes are included in CBMT services and may not be separately reported on the same date of service, by the same provider. Although CBMT services are provided without the patient present, the goals and outcomes are solely for the therapeutic benefit of the patient. Sessions are conducted to address: • How families can better manage common mental or physical health conditions. • How the families help to support accordance with the needed treatment and clinical plan of care by: ○ using verbal instruction, video and live demonstrations, and feedback from a physician or other qualified health care professional or from other parents/guardians/caregivers in the group, to use skills and strategies to address behaviors impacting the patient's mental or physical health diagnosis such as: ✓ helping to reduce challenging behaviors, ✓ set realistic and age-appropriate expectations for children's behavior, ✓ praise positive behaviors that parents want to encourage, ✓ provide positive attention, and ✓ ignore minor behaviors. • Parents and caregivers are taught to structure the patient's environment to actively provide for, and reinforce desired behaviors, reduce the negative impacts of the patient's diagnosis in their daily life, and develop highly structured technical skills to better manage specific behaviors. • Reviewing patient records, including those from the patient's physician and other team members, and reviewing results of any prior diagnostic services, is also included in the services.
96203	96203 - Multiple-family group behavior management/modification training for parents(s)/guardian(s)/ caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care	

	professional (without the patient present), face-to-face with multiple sets of parents(s)/ guardian(s)/ caregiver(s); **each additional 15 minutes.**	Documentation for the services should include: ○ the patient's diagnosis and status, ○ a description of the parents(s)/caregiver(s)status, ○ the services provided, ○ the progress toward and/or medication of treatment goals based on patient and/or parents/caregivers progress, and ○ the time of the total session (utilizing a start and stop time is effective). Group sessions are typically provided over a series of 8-12 closed group sessions, each session typically lasting between 60-90 minutes, but insurance carrier verification is required on the minimum and maximum amount of time they will reimburse for each group session, and the number of sessions the patient will be covered for. Although the service description specifies this to be a face-to-face service, insurance carrier verification should be made on if they will reimburse for the service if provided via a tele-health modality. The American Psychological Association advises that because CBMT is a time-based service, the CPT Time Rule applies. The CPT Time Rule advises that a unit of service can be reported once half of the total time stated in the code's descriptor has been passed (e.g., 31 minutes for a 60-minute code), but insurance carrier verification is required on if they will reimburse for minimum time reporting for this service. 96203 is an add-on code for 96202, signifying that it can only be reported in conjunction with 96202, and not independently. One unit of 96203 is reported for each additional 15 minutes spent in the group, after the initial 60 minutes of group time was provided.

Telehealth Services

Telehealth is the use of electronic information and communication to deliver healthcare, at a distance, to children/ parents/caregivers that are patients. Telehealth is not to be used as the only means of patient care, but a collection of means to enhance care and education delivery.

Because New Jersey health care plans have individual telehealth polices, guidelines are subject to change to accommodate social distancing/State of Emergency due to COVID-19. Guidelines such as covered services, reimbursable clinicians, and allowable delivery method(s) must be verified with insurance carriers.

Examples of Methods of Telehealth Delivery

- Interactive Live Video/Live Time: (Used to render behavioral/mental health services)

  Interactive live video/live time is real-time two-way communication utilizing two-way interaction between the patient and a provider using audio visual telecommunications technology. Delivery methods must be HIPAA compliant and via secure electronic communications, information technology, or other electronic or technological means. A secure electronic channel is required to be utilized by a telemedicine provider. **This is the original approved method of delivering services via tele-health. Verification with insurance carriers is essential to confirm the use of all other methods of delivery.**

- Store and Forward: (Primarily used to render physical health services)

  Store and forward is a form of asynchronous communication, which means the attaining and transmitting of images, diagnostics, data, and medical information either to or from an origination site (where the patient is located at the time of the service) or to/from the health care provider at a distant site, which allows for the patient to be evaluated without being physically present. Currently this method is not explicitly included in reimbursement; however, it could be covered within the definition of telemedicine and can be used in conjunction with live video/live time. If you want to bill for this method without the use of live video/live time**, insurance verification is required for approval.**

- Remote Patient Monitoring: (Used to render physical health services)

  Remote patient monitoring (RPM) uses digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations. **This form of monitoring is used for medical services,** such as chest sensors to

monitor heart and respiratory rates. Remote patient monitoring may not be a covered method with all insurance carriers, but it is included within the definition of telehealth in the state of New Jersey. **Insurance verification is required for approval.**

Documentation requirements and billing specificities:

- When rendering a time-based service, documentation of the time spent rendering the care is required.
- The reason why services are being rendered via tele-health should be documented.
- Oral, written, or electronic consent is required.
- Psychotherapy and psychiatric evaluation services cannot be billed together.
- The distant site (site where clinician is located) may bill for the service.
- Modifier GT must be appended to all service codes being billed, where services were rendered via live video/live time.
- Medical insurance carriers may reimburse the originating site (site where the patient is located at the time of service) for an administrative expense known as the originating site facility fee. Q3014 is the billing code for the facility fee. Verification with insurance carriers is required prior to billing, as **some carriers may not reimburse for this code**.

Billing Modifiers

Use of Billing Modifiers

The use of modifiers allows providers to indicate that a service or procedure has been altered by some specific circumstance(s) without changing the definition or the code for the service. The following modifiers are applicable to HealthySteps services:

- **Modifier 25 (Distinct Service):**
    - This modifier is used when there is a significant, separately identifiable evaluation and management (E&M) service rendered by the same physician on the same date of service as a significant procedure (e.g., sick visit and well child visit rendered on the same day, by the same physician).
    - It can only be linked to an evaluation and management code.
- **Modifier 59 (Separate Procedures or Distinct Procedural Service):**
    - This modifier is used to designate instances when distinct and separate multiple services with the same Current Procedural Terminology (CPT) code are provided to the patient on a single date of service (e.g., different screenings that utilize the same CPT code).
- **Modifier EP:**
    - This modifier is used to identify early, and periodic screens and services provided in association with the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) program. (To be applied to EPSDT visits.)
- **Modifier GT:**
    - This modifier is used to identify when services are rendered via the telehealth live video/live time modality. (To be applied to the corresponding billing code upon medical claim submission.
- **Modifiers HD, U7, U8, 22:**
    - Applicable to doula services only.

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