New York Frequently Asked Questions

HealthySteps National Office Policy & Finance Team

About This Document

Have a question? The HealthySteps National Office Policy & Finance Team is here to help! Our team has developed this Frequently Asked Question (FAQ) document to highlight the most common questions and answers about billing and coding for HealthySteps and HealthySteps-aligned services in New York. 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

Screenings

Q: What are the billing codes for maternal depression screenings?

A: Medicaid and Medicaid Managed Care Organizations recognize HCPCS code G8510 for the reporting of a depression screening documented as negative, and G8431 for the reporting of a depression screening documented as positive. Both require appending modifier HD, upon claim submission.

Q: Can you bill for maternal depression screenings under the child, and if so, how many can you bill when rendered during a well-child visit?

A: Yes, you can. Effective 4/1/2022 with fee-for-service (FFS) Medicaid, and 10/1/2022 with Medicaid Managed Care Organizations, the number of maternal depression screenings recognized for reimbursement have increased from their previous limit of three times within the first 12 months after the end of the pregnancy, to four times within the first 12 months postpartum. Screenings can be provided by the maternal health care provider and/or by the infant's health care provider.

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

A: Yes, you can. An example can be seen when screening and billing for autism and developmental delays since both screenings utilize CPT code 96110 for billing and reporting purposes. There are two different ways you can bill for multiple screenings that utilize the same CPT code. Some insurance carriers may want the CPT code entered twice, while others will not accept duplicate codes on a single claim. Verification with insurance carriers should be made prior to billing, according to the method they prefer. Below are the billing directions for both.

1. Steps for billing when the insurance carrier requires the CPT code to be entered twice for two different screenings:

- Enter diagnosis code (ICD-10) Z13.40 for the developmental screen.
- Enter ICD-10 Z13.41 for the autism screen.
- Enter 96110 twice, linking Z13.40 ICD-10 to one of the 96110 CPT codes, and linking Z13.41 ICD-10 to the other 96110 CPT code entered.
- Apply a modifier 59 to the second 96110 CPT code entered.

2. Steps for billing when the insurance carrier will not accept duplicate CPT codes on a claim:

- Enter ICD-10 Z13.40 for the developmental screen.
- Enter ICD-10 Z13.41 for the autism screen.
- Enter 96110, once, with a quantity of "2".
- Link both ICD-10 Z13.40 and Z13.41 ICD-10 to the 96110 code.
- Apply modifier 59 to the 96110 CPT code.

Q: Is there a specialized training required for the delivery of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services?

A: Yes, the Office of Addiction Services and Supports (OASAS) requires either a 4- or a 12-hour training and certification to render SBIRT services.

- For information on the OASAS certification process, the following link can be helpful: https://webapps.oasas.ny.gov/training/index.cfm.
- For information on the 4 hours of OASAS approved training/certification, the following link can be helpful: https://webapps.oasas.ny.gov/training/searchresults.cfm?sbirt=4.
- For information on the 12 hours of OASAS approved training/certification, the following link can be helpful: https://webapps.oasas.ny.gov/training/searchresults.cfm?sbirt=12.

Psychotherapy

Q: Who can bill for psychotherapy services?

A: New York State Medicaid FFS and New York State Medicaid Managed Care Organizations will provide reimbursement for psychotherapy services when rendered by Licensed Clinical Social Workers (or Licensed Master Social Workers under supervising clinician), Licensed Clinical Psychologists, Licensed Mental Health Counselors and Licensed Marriage and Family Therapists.

Q: Who can provide clinical supervision to a Licensed Master Social Worker?

A: Yes. In addition to Licensed Clinical Social Workers, Licensed Clinical Psychologists and Psychiatrists can provide clinical supervision to a Licensed Master Social Worker.

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. The exception to this is for prevention-based psychotherapy where individual, multi-family group, group, and family psychotherapy is recognized for reimbursement when rendered to patients under the age of 21 and/or the parent/caregiver of the patient, to prevent childhood behavioral health issues and/or illness, in absence of a mental health diagnosis.

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

A: Insurance carriers can require the entire time in the billing codes description to be rendered, or alternatively, they can determine a *minimum time requirement* for reimbursement of services. There are sources indicating the ability to report psychotherapy services *if at least 50%* of the time allotted in the billing code description is spent rendering the service. Verification with insurance carriers is required. If insurance carriers do allow billing for psychotherapy services with minimum time requirements, the following source will provide you with 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 services are psychotherapy sessions rendered to 2 or more individual patients without their family members present.

Q: Are there limitations placed on psychotherapy services when rendered by a Licensed Clinical Social Worker in Article 28 facilities and FQHCs?

A: Yes. New York State Medicaid FFS and New York State Medicaid Managed Care Organizations will only provide reimbursement for psychotherapy services when rendered to patients up until the age of 21 and to pregnant and/or up to 12 months postpartum patients, when rendered by a Licensed Clinical Social Worker in Article 28 facilities and FQHCs.

Preventive Psychotherapy

Q: What is the purpose of the January 2023 preventive psychotherapy guidance?

A: As NYS Medicaid states, "two-generational and preventative approaches are critical when supporting and caring for the health and well-being of children." To support these approaches, NYS Medicaid created a clarification for medical necessity related to individual, group, and family psychotherapy services, allowing for the reimbursement for services to be provided to the child and/or caregiver to prevent childhood behavioral health issues and/or illness. NYS Medicaid accepts International Classification of Diseases, Tenth Revision (ICD-10) code Z65.9 (problem related to unspecified psychosocial circumstances) as an indication of medical necessity on claims for psychotherapy services.

Q: Is there an age limitation placed on preventive psychotherapy services?

A: Yes. New York State Medicaid FFS and New York State Medicaid Managed Care Organizations will reimburse for *preventive psychotherapy* when rendered to patients under the age of 21 and/or the parent/caregiver of the patient, to prevent childhood behavioral health issues and/or illness, in the absence of a mental health diagnosis.

Lactation Services

Q: Who can render and/or bill for lactation services?

A: Physicians, physician assistants (PAs), nurse practitioners (NPs), nurse midwives (NMs), and registered nurses (RNs) are recognized for the rendering of lactation services, but only if they hold one of the approved specialized certifications to do so. Effective 7/1/2022, for Medicaid FFS and 9/1/2022 for Medicaid Managed Care Organizations, CMS expanded the specialized lactation certifications recognized for the rendering of lactation services. Prior to these dates, CMS only recognized International Board-Certified Lactation Consultants (IBCLCs) when credentialed by the International Board of Lactation Consultants. The additional certifications recognized are as follows:

- Certified Lactation Specialist (CLS)
- Certified Breastfeeding Specialist (CBS)
- Certified Lactation Educator (CLE)
- Certified Clinical Lactationist (CCL)
- Certified Breastfeeding Educator (CBE)

Regarding billing, RNs and PAs cannot independently report lactation services for reimbursement purposes, but the ordering physician can submit the claim, and when billing under the APG Medicaid billing methodology, physicians are the only professionals recognized to receive Medicaid reimbursement for lactation services. The reimbursement for PAs, NPs, NWs, and RNs is included in the All Patients Refined Diagnosis Related Group (APR DRG), or the APG payment to the facility.

Interactive Complexity

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

A: No, you may not. To align the Centers for Medicare & Medicaid Services (CMS), effective 1/1/2022, the use of interpreters and translator services were removed from the list of communication factors that support medical necessity when coding for interactive complexity. For those clinicians who can bill for sign language or oral interpreter services, CMS recognizes HCPCS code T1013 for 15 minutes of these services.

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, 96158, 96159, 96164, 96165, 96167, 96168, 96170, and 96171 identify and assess any psychological, behavioral, emotional, cognitive, and relevant social factors that may prevent successful treatment or management of a patient's *physical health* problems, such as missing appointments, 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 of their importance, then this impedes 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. For more information, see the Health and Behavior Assessment and Intervention Codes resource on the HealthySteps website: https://www.healthysteps.org/wp-content/uploads/2023/09/HB_Quick-Reference-Tool_Document_2023_Final.pdf

General Behavioral Health Integration Care Management

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

A: 99484 or G0511 when billing from an FQHC or RHC, can only be billed once per patient, by a physician, per calendar month. Therefore, a workflow must be in place where the practice tracks the visits and the time spent with the patient during each visit, where the service can be billed if the cumulative time rendering services is equivalent to 20 minutes or more. Upon claim submission, billing code 99484 or G0511 should be entered once, utilizing "From and To" dates of service. The "From" date should be first day of the month you are billing for, and the "To" date should be the last day of the month of 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.

Q: Can a Social Worker provide and bill for psychiatric diagnostic evaluations?

A: Yes, Licensed Clinical Social Workers (LCSWs) can provide and bill for psychiatric diagnostic evaluations. Licensed Master Social Workers (LMSWs) can render the service, while working under the clinical supervision of an LCSW or a Psychiatrist or Licensed Clinical Psychologist, where the service is billed under the supervising clinician.

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.