Washington, D.C. HealthySteps Billing & Coding

HealthySteps National Office Policy and Finance Team, 2023

About this Document

HealthySteps (HS) sites can bill the Department of Health Care Finance (DHCF), Washington D.C.'s Medicaid agency and DC Medicaid Managed Care Organizations, for some of the services they provide to children and their families. The purpose of this document is to support HS sites in billing for HS and HS-aligned 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 site's ability to bill specific codes, including the provider type, provider licensure, scope of practice, location of service, frequency, and maximum billing units. This document aims to facilitate an understanding of these requirements and restrictions and help guide your site in coding and billing for HS-aligned services.

To maximize appropriate reimbursement, the HS National Office highly recommends always contacting DHCF and other health insurance carriers, including Medicaid Managed Care Organizations (MCOs), to verify billing requirements for services provided.

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Washington, D.C. Medicaid Reimbursable Provider Types

Washington, D.C.'s Medicaid program only reimburses licensed and enrolled providers for HS-aligned services. The following reimbursable provider types are included below:

- Physician/Qualified Physician (Medical Doctor [MD]/Doctor of Osteopathic Medicine [DO])
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Psychiatrist (MD)
- Psychologist (Psych/PhD/PsyD)
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Independent Social Worker (LISW)
- Licensed Professional Counselor (LPC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Graduate Social Worker (LGSW)
- Licensed Social Worker Associate (LSWA)
- Advanced Practice Registered Nurse (APRN)
- Registered Nurse (RN)

Typically, Washington D.C. Medicaid does not reimburse for services provided by interns, postdoctoral graduate students, and fellows who are in training and based in a hospital and/or clinic. It is highly recommended that all clinics contact DHCF and other payors for specifics regarding these particular providers.

Guidelines for the Supervision of Associated/Mental & Behavioral Health Providers

The supervision of all associate behavioral health providers, including post-doctorate and associated psychologists, is required when they are rendering services to patients where the services are billed under the supervising provider. There are three types of supervision.

General Supervision – when the supervisor does not have to be located on the premises but must be accessible by phone or other electronic device.

Immediate Supervision – supervision in which the supervisor maintains direction and control of the services provided by the supervisee through in-person, face-to-face observation or in physical proximity to the individual being supervised.

Primary/Original Supervisor – the supervising licensed psychologist who provides supervision, training, and mentoring of a supervisee accruing psychological practice experience and oversees the supervisee's practice, including the practice and services performed under supervision of delegated supervisor(s). The primary supervisor retains full responsibility over the quality of the supervisee's learning and practice.

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Supervision of Social Workers:

Social work is separated into categories:

Clinical Practice of social work – involves the application of the professional knowledge and training to the diagnosis and treatment of individuals or groups in accordance with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM–5).

Non-clinical practice of social work – involves the application of social work theory and methods to a broad range of other, non-clinical activities to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, groups, organizations, or communities.

The social worker supervisor must be an LISW or LICSW, and if the supervisor practices at a different site from where the LSWA or LGSW is located, both supervisor and supervisee must have a contract of supervision in place and keep documentation of supervisory session with dates, duration, and focus of supervision.

Each licensure type is authorized to practice within the following scope and requirements:

LICSW: Must have at minimum a master's degree in social work and is authorized by law to practice both clinical and non-clinical social work independently. Additionally, LICSWs are authorized to provide supervision of social work practice, both clinical and non-clinical, in the District of Columbia.

LISW: Must have at minimum a master's degree in social work and may perform nonclinical practice of social work independently. However, an LISW who has sufficient educational and training in clinical practice may engage in clinical practice only under the supervision of an LICSW.

LSWA: Must have at minimum a bachelor's degree in social work and may perform only non-clinical practice. Additionally, an LSWA must be supervised at all times by an LISW or LICSW.

LGSW: Must have at minimum a master's degree in social work and may perform both clinical and non-clinical practice. LGSW may receive supervision for non-clinical practice from either an LISW or LICSW. However, LGSW may perform clinical practice only under the supervision of an LICSW.

Supervision of Psychology Post-Graduates:

A post-graduate may practice only under the primary supervision of a psychologist licensed in the District of Columbia. The primary supervising psychologist may, based on his or her professional judgment, delegate some supervisory responsibility to another psychologist and a psychiatrist licensed in the District of Columbia, provided that he or she retains full responsibility for ensuring that the supervisee comply with the laws and regulations governing the practice of psychology.

Supervision of Psychology Associates:

The supervisor of a psychology associate shall supervise only in those areas within the supervisor's competence based on the supervisor's education, training, and experience. The supervisor shall delegate supervisory responsibility to another psychologist and psychiatrist to ensure that the psychology associate receives appropriate supervision in areas outside of the expertise of the original supervisor.

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Verification at all clinic types must be made regarding if and/or when the supervising licensed practitioner is required to co-sign the notes of the associate behavior/mental health provider.

Billable Modifiers Required for Specific HS-Aligned Services

The use of D.C. modifiers allows providers to indicate that a particular service has been rendered, a service or procedure has been altered by some specific circumstance(s), without changing the definition or the code for the service or identifying why a doctor or other qualified healthcare professional provided a specific service and procedure. The following modifiers are applicable to HealthySteps-related services.

- **Modifier AH:**
  - This modifier is used to designate a service performed by a Clinical Psychologist.
- **Modifier AJ:**
  - This modifier is used to designate the services performed by a Clinical Social Worker. (*Note LMSW & LGSW have not be designated with a modifier, as both providers must bill under the supervision of a licensed professional (e.g.: LICSW, Psychologist).
- **Modifier HA:**
  - This modifier is used to designate specified services were provided to individuals ages 0 – 21.
- **Modifier HE:**
  - This modifier is used to designate behavioral health services.
- **Modifier HF:**
  - This modifier is used to designate substance abuse services.
- **Modifier HK:**
  - This modifier is used to designate specialized mental health services.
- **Modifier HQ:**
  - This modifier is used to designate group setting.
- **Modifier HR:**
  - This modifier is used to designate Family/Couple Therapy with Patient Present.
- **Modifier HS:**
  - This modifier is used to designate Family/Couple Therapy without Patient Present.
- **Modifier HQ:**
  - This modifier is used to designate group setting.
- **Modifier UN:**
  - This modifier is used to designate two clients served.
- **Modifier UP:**
  - This modifier is used to designate three clients served.
- **Modifier TG:**

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  - This modifier is used to designate Behavioral Health Assessment, On-going, Risk Rating.
- **Modifier TS:**
  - This modifier is used to designate Screening and/or Assessment uncovered a potential problem that requires follow-up or a referral.
- **Modifier GT:**
  - This modifier is used to designate services delivered via interactive audio and video telecommunication systems.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are eligible to request enrollment as a provider in the D.C. Medicaid program. Each FQHC must be approved by the Centers for Medicare and Medicaid Services (CMS) and meet the requirements governing FQHCs set forth in the applicable provisions of Title XVIII of the Social Security Act and implementing regulations. All FQHCs must be screened and enrolled in the Medicaid program pursuant to the requirements set forth in Chapter 94 of Title 29 of the District of Columbia Municipal Regulations (DCMR). When applying to D.C. Medicaid for participation, the FQHC will need an NPI number for each site and a distinct taxonomy number for each service type rendered. In turn (once approved), a new DC provider number will be issued for each service type (*provider's self-identified specialty*) rendered at the FQHC location.

District of Columbia EPSDT/HealthCheck Program:

All District of Columbia children eligible for the Medicaid program are entitled to receive the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit (*also known as the HealthCheck Program*) through D.C.'s Medicaid Program. This program promotes access to and ensures availability of quality health care for Medicaid-eligible children, teens, and young adults and establishes preventive care standards for children under the age of 21. Preventive health care services allow for early identification and treatment of health problems before they become medically complex and costly to treat.

A core component of the EPSDT benefit requires periodic well-child visits which should be done in accordance with the D.C. HealthCheck Periodicity Schedule (https://www.dchealthcheck.net/documents/DC-HealthCheck-Periodicity-10-21.pdf). The D.C. HealthCheck Periodicity Schedule outlines what a well-child visit should consist of according to the child's age and risk factors. When conducting a well-child visit (WCV), a primary care provider (PCP) must perform all components of well-child visit and all age-appropriate screenings and/or assessments as required in the D.C. Medicaid HealthCheck Periodicity Schedule.

Screenings

Child Developmental & Social-Emotional Screenings and Risk Assessments

The HealthySteps model includes practice-wide universal screenings for all children ages zero (0) through three (3) 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 evidence has shown that early identification is essential for providing adequate treatment and is vital for optimal child development and well-being.

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To facilitate early identification, the American Academy of Pediatrics (AAP) recommends that pediatric primary care providers perform mental health screenings during a well-child visit. Additionally, a maternal depression screening (MDS) is also considered an integral part of a risk assessment during an infant's well-child visit.

Thus, as an incentive for primary care providers to perform mental health screens during a well-child visit, DHCF reimburses for the administration of the following validated screenings:

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96110	Developmental milestone survey, speech and language delay with scoring and documentation, per standardized instrument. (ASQ-3, M-CHAT-R, PEDS, SWYC, SWYC-MA)	Physicians, Physician Assistant, Nurse Practitioner, & Nurse Midwife	Per the American Academy (AAP) of Pediatrics Bright Future's Periodicity Schedule recommends Developmental Screening be administered during the child's 9, 18, and 30-month-old well-child visits. The AAP also recommends during the child's 18 & 24-month-old (or whenever there is a valid concern) well-child visits, providers administer the *Autism Spectrum Disorder Screening,* which is also billed under *CPT Code 96110.* Developmental screening tools may be administered by appropriate office staff; however, the tool should be interpreted by the enrolled DHCF billing provider. Typically, the daily maximum is 2 units per visit. However, DHCF has not clearly specified the daily and/or yearly maximum allowable visits for Developmental Surveys; thus, we highly recommend that all clinics contact D.C. Medicaid and/or other payers directly for their patient's benefit limitations. When rendering services for more than one screening with the same CPT code, Modifier 59 must be appended to the screening code. If the screening uncovers a potential problem that requires follow-up or a referral, the provider must append the TS modifier CPT code 96110; the modifier can be utilized on the WCV if the problem is not specific to the screening performed. Children from birth to 3 years of age who are identified as having a developmental delay or disability should be referred to the District of Columbia's Early Intervention Program (EIP). This service can be provided face-to-face. Telemedicine services may be allowed; however, we highly recommend all clinics contact D.C. Medicaid and/or other payers directly for specific billing and coding guidelines.

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CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96127	Brief Emotional/Behavioral Health Screening. (PHQ-9, ASQ-SE, BITSEA, SCARED, ECSA)	Physicians, Physician Assistant, Nurse Practitioner, Nurse Midwife, Psychiatrist, Psychologists, LICSWs, LPCs, and LMFTs	Per the American Academy of Pediatrics Bright Future's Periodicity Schedule recommends Behavioral Health Screenings be administered in the child's infancy (*newborn – 9 months)* and early childhood (12 - 36 months). A behavioral health screen should be administered and scored at each of these specified preventive health visits. Typically, the daily maximum is 2 units per visit. However, DHCF has not clearly specified the daily and/or yearly maximum allowable visits for Brief Emotional/Behavioral health screening; thus, we highly recommend that all clinics contact D.C. Medicaid and/or other payers directly for their patient's benefit limitations. If the screening uncovers a potential problem that requires follow-up or a referral, the provider must append the TS modifier CPT code 96127; the modifier can be utilized on the WCV if the problem is not specific to the screening performed. Children from birth to 3 years of age who are identified as having a developmental delay or disability should be referred to the District of Columbia's Early Intervention Program (EIP). This service can be provided face-to-face. Telemedicine services may be allowed; however, we highly recommend all clinics contact DC Medicaid and/or other payers directly for specific billing and coding guidelines.

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CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96161	Maternal Depression Screening (PHQ-9, EPDS, ACES-Caregiver focused)	Physicians, Physician Assistant, Nurse Practitioner, & Nurse Midwife	Per the American Academy of Pediatrics Bright Future's Periodicity Schedule recommends an MDS be performed during the 1, 2, 4, and 6-month-old well-child visits. All caregivers (mother/father/adoptive parents/guardian) can be screened under this code. These screenings are covered under the child's EPSDT Medicaid benefit for both Medicaid-eligible and non-Medicaid-eligible caregivers during the WCV, because they are for the direct benefit of the child. MDS is billable by DHCF enrolled providers with a WCV at a maximum of 4 units during the first year of the child's life. Typically, this code is not allowable after the child reaches 13-months old. If the screening uncovers a potential problem that requires follow-up or a referral, the provider must append the TS modifier CPT code 96161; the modifier can be utilized on the WCV if the problem is not specific to the screening performed. This service can be provided face-to-face. Telemedicine services may be allowed, it is highly recommended to contact the payers directly for billing guidelines.

Mental Health Coverage in the District of Columbia

Mental Health Rehabilitation Services (MHRS) is a Medicaid carve-out program that provides coverage for a collection of mental health and somatic support services. These services, collectively referred to as MHRS, are delivered by community-based providers to treat Medicaid-eligible or income-limited patients with serious mental health issues as well as children and youth with serious emotional disturbances and/or adolescents with substance use disorders. The DC Department of Behavioral Health (DBH) oversees the administration of MHRS, which are generally funded through the Medicaid fee-for-service payment model for Medicaid beneficiaries.

DBH providers are reimbursed on an FFS basis by Medicaid for MHRS and by DBH for locally funded services, including any children's SUD services paid on an FFS basis. In FY 2020, DBH transitioned billing for MHRS and SUD services to DHCF to enable the individual provider agencies to bill Medicaid directly.

Additionally, Washington D.C. MCOs reimburse certain provider types for delivery of particular mental health services, including diagnostic and assessment services, individual counseling, group counseling, family counseling, FQHC services, and medication/somatic treatment. MCOs will also reimburse for certain additional services to support individuals enrolled in DBH services.

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Psychiatric Diagnostic Evaluation (90791)

Psychiatric Diagnostic Evaluation without Medical Services is a clinical service for the purpose of diagnosing problems with behaviors, thought processes, and memory, mental illness, or related disorders, as described in the current allowable Diagnostic and Statistical Manual of Mental Disorders (DSM).

Services for an evaluation can occur either face-to-face or via telemedicine, and include assessing the patient's psycho-social, medical history, diagnostic findings, current mental status, reviewing and ordering diagnostic studies followed by appropriate treatment recommendations, description of present behaviors, when they occur, how long they last, and which behaviors happen most often and under what conditions. A description of symptoms (physical and psychiatric), a family mental health history, as well as interviews and communications with family members should also be provided.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90791	Psychiatric Diagnostic Evaluation without Medical Service	Psychologists, LICSW, LPC, and LMFT	The daily and yearly maximum allowable visits for Psychiatric Diagnostic Evaluation without Medical Services is not clearly specified by DHCF; thus, we highly recommend that all clinics contact D.C. Medicaid directly for their patient's benefit limitations. Psychiatric Diagnostic Evaluations without Medical Services must be consistent with the scope of license and competency of the mental health provider. Modifiers may be required for billing for Psychiatric Diagnostic Evaluation without Medical Service. If uncertain which modifier to apply, please contact D.C. Medicaid directly for specifics. CPT code 90971 cannot be billed on the same date of service as 90792, 90839, & 90840. This service can be provided either Face-to-face or via Telemedicine. Documentation requirements include date of service, presenting problem(s)/change(s) in functioning/history, mental and medical health history, including current medications (if applicable), social and cultural factors, risk, and safety factors, duration of issues, mental status (clinical observations and impressions), referral reason, a diagnostic summary, treatment recommendations, staff signature/credentials/date of signature.

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Psychiatric Diagnostic Evaluation with Medical Services (90792)

Psychiatric Diagnostic Evaluation with Medical Services is a face-to-face psychodiagnostics assessment conducted by a licensed physician. This service is provided to determine the existence, type, nature, and most appropriate treatment of behavioral health disorder. This service is not required for patients to receive Counseling Level Services.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90792	Psychiatric Diagnostic Evaluation with Medical Services	Psychiatrists	The daily and yearly maximum allowable visits for Psychiatric Diagnostic Evaluation with Medical Services is not clearly specified by DHCF; thus, we highly recommend that all clinics contact D.C. Medicaid directly for their patient's annual benefit limitations. Reauthorization will be required to obtain additional services after the initial benefits are exhausted. Psychiatric Diagnostic Evaluations with Medical Services must be consistent with the scope of license and competency of the mental health provider. Modifiers may be required for billing for Psychiatric Diagnostic Evaluation with Medical Service. If uncertain which modifier to apply, please contact D.C. Medicaid directly for specifics. CPT code 90792 cannot be billed on the same date of service as CPT code 90791, 90839, & 90840. This service can be provided either face-to-face or via telemedicine. Documentation requirements include date of service, start, and stop times of face-to-face encounter with the patient, place of service, referral reason, the presenting problem (including symptoms and functional impairments), relevant life circumstances and psychological factors, history of problems, treatment history, response to prior treatment interventions (if applicable), medical history (and examination as indicated). • *For patient under eighteen (18) years of age:* An interview of a parent (*preferably both*), the guardian, and the primary caretaker, foster parents (as applicable), to obtain clarification of the reason for the referral, clarify the nature of the current symptoms, obtain a detailed medical, family, and developmental history, culturally and age-appropriate psychosocial history and assessment, mental status/clinical observations and impressions, current functioning and strengths in specified life domains, treatment recommendations, and staff signature/credentials/date of signature.

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Individual Psychotherapy: (90832, 90834, 90837)

Individual Psychotherapy services are comprised of a direct, interactive process conducted in individual, group, or family settings and are focused on assisting a patient who is manifesting a mental illness or emotional disturbance. Psychotherapy services are the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable. Psychotherapy services aim to cultivate the awareness, skills, and supports to facilitate long-term recovery from mental illness and emotional disturbance, and address the specific issues identified in an individual's treatment plan. Psychotherapy services shall be conducted in accordance with the requirements established in District of Columbia regulations as follows.

Individual Psychotherapy services are individual, family, or group face-to-face services for symptom and behavior management; development, restoration, or enhancement of adaptive behaviors and skills; and enhancement or maintenance of daily living skills. Adaptive behaviors and skills and daily living skills include those skills necessary to access community resources and support systems, interpersonal skills, and restoration or enhancement of the family unit and/or support of the family.

Individual Psychotherapy services are designed for the purpose of treatment and remediation of a condition as described in the current allowable DSM. The treatment service must reduce or alleviate identified symptoms related to either mental/behavioral health or substance abuse, and maintain or improve level of functioning, and/or prevent deterioration.

Individual Psychotherapy services provided must be congruent with the objectives and interventions articulated in the most recent Psychiatric Diagnostic Evaluation. Additionally, psychotherapy services are allowed as a covered service when provided by certified DBH physicians or qualified practitioners, within the District of Columbia, to patients who have a Behavioral Health diagnosis as described in the DSM-5.

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CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90832 90834 90837	Individual Psychotherapy Services with patient, 30 minutes (Time Range: 16-37 min) Individual Psychotherapy Services with patient, 45 minutes (Time Range: 38-52 min) Individual Psychotherapy Services with patient, 60 minutes (Time Range: >53 min)	Psychologists, LICSWs, LPCs, and LMFTs	The daily and yearly maximum allowable visits for Individual Psychotherapy is not clearly specified by DHCF; thus, we highly recommend that all clinics contact D.C. Medicaid directly for their patient's annual benefit limitations. These services are for the overall benefit of the patient; however, may include contact with informants (e.g., parents, caregivers, other family members). The patient must be present for the entire or majority of the time to bill this encounter. Do not report psychotherapy of less than 16 minutes in duration. Modifiers may be required for billing for Individual Psychotherapy services. If uncertain which modifier to apply, please contact D.C. Medicaid directly for specifics. Individual Psychotherapy services must be consistent with the scope of license and competency of the mental health provider. Reauthorization will be required to obtain additional services after the initial benefits are exhausted. This service can be provided either face-to-face or via telemedicine. Documentation requirements include date of service, start and stop times of encounter with patient, place of service, diagnosis and pertinent interval history, brief mental status and observations, rationale and description of the treatment used that must coincide with the most recent intake assessment, mental health diagnosis, patient's response to treatment that includes current progress or regression, prognosis, single or recurrent episode, degree of depression, the presence of psychotic features or symptoms, and/or partial/full remission, any revisions indicated for the diagnosis or medication concerns, plan for next individual therapy session including any homework assignments and/or advanced psychiatric directive or crisis plans, and staff signature/credentials/date of signature.

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Family Psychotherapy Services (90846 & 90847)

Family Counseling/Therapy is a planned, goal-oriented therapeutic interaction between a qualified practitioner, the patient, and his or her family. Family Counseling/Therapy may occur without the consumer present if it is for the benefit of the consumer and related to recovery from mental illness or emotional disturbance. A family member is someone with whom the consumer has a significant relationship and whose participation is important to the consumer's recovery.

Family therapy services that involve the participation of a non-Medicaid eligible are for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

Family Psychotherapy Services without Patient Present (90846)

Family Psychotherapy without patient present is a face-to-face treatment provided to one or more family members outside the presence of a patient. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support, and to develop alternative strategies to address familial issues, problems, and needs. Services pertain to a patient's (a) mental health and/or (b) substance abuse condition, or both.

Family Psychotherapy Services with Patient Present (90847)

Family Psychotherapy with Patient Present is a face-to-face treatment provided to one (1) or more family members in the presence of the patient. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems, and needs. Services should pertain to a patient's (a) mental health and/or (b) substance abuse condition, or both.

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Psychotherapy Vignette

Diagnosis: Adjustment Disorder with Mixed Disturbance of Emotion and Conduct (F43.25)

Assessment: During the two-year-old well visit, Sarah's mom reports concerns about Sarah's challenging behaviors, indicating that she is often aggressive with others and has frequent and prolonged tantrums. After a "warm hand off" the HealthySteps Specialist conducted an assessment which indicted age-appropriate development, but significant concern for lack of structure/ routine, inconsistent sleep/wake and meal-times, and unclear behavioral expectations, all of which appeared to be contributing to Sarah's dysregulation.

Intervention (Family Therapy): The HealthySteps Specialists provided short term dyadic interventions including implementing a daily schedule, a sleep hygiene program, strategies to address behavior concerns including prescribing "time-in", practicing parent-child play based interactions in clinic, as well as coaching/modeling about ways to intervene early to deescalate and redirect Sarah's behavior without reinforcing negative behaviors.

Importantly, this very common behavioral challenge (tantrums/dysregulation) was addressed by improving sleep and behavioral regulation first, then by strengthening the positive parent-child interaction, and finally by coaching mom on responding to challenging behaviors while rewarding pro-social behaviors. This short-term intervention, improved and contained a very normative concern, replaced negative parent-child interactions with positive interactions, and decreased problems with emotional/behavioral regulation. Breaking this cycle of negative parent-child interactions and challenging behavior is critical in mitigating against more serious and chronic behavioral health concerns.

Documentation requirements: Should also include start/stop times, observations in room, treatment modality and frequency, timeline to monitor progress, functional status, focused mental status examination, the patient or client's personal information, symptoms, the diagnosis, a general outline of the treatment prescribed, and a treatment plan (including goals and objectives), which should include space to measure outcomes as the client progresses through treatment.

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CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90846 90847	Family Psychotherapy without Patient Present Family Psychotherapy with Patient Present	Psychologists, LICSW, LPC, and LMFT	The daily and yearly maximum allowable visits for Family Psychotherapy with & without Patient Present are not clearly specified by DHCF; thus, we highly recommend that all clinics contact D.C. Medicaid directly for their patient's annual benefit limitations. Modifiers may be required for billing for Family Psychotherapy with & without Patient Present. If uncertain which modifier to apply, please contact D.C. Medicaid or other payors directly for specifics. Family Counseling with or without Patient Present must be consistent with the scope of license and competency of the mental health provider. Reauthorization will be required to obtain additional services after the initial benefits are exhausted. This service can be provided either Face-to-face or via Telemedicine. Documentation requirements include date of service, start and stop times of actual encounter, spouse/family, place of service, participants present and relationship to beneficiary, diagnosis and pertinent interval history, brief observations with spouse/family, rationale for and description of treatment used that must coincide with the Psychiatric Diagnostic Evaluation/Mental Health Diagnosis and improve the impact the patient's condition has on the family, and/or improve family interactions between the patient and the family, or both, the patient parents/caregiver/family's response to treatment that includes current progress or regression and prognosis, any changes indicated for the diagnosis, or medication concerns, plan for next session including any homework assignments and/or crisis plans, or both, staff signature/credentials/date of signature, Health Insurance Portability and Accountability Act (HIPAA) compliant Release of Information completed, signed, and dated. *Although CPT coding guidelines advise that each code may be reported if more than 50% (26 minutes) 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.*

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Multiple Family Group Psychotherapy Services: (90849)

Multi-family group therapy is a conjoined treatment modality that combines the key essences of group therapy and family therapy to address the social element of mental illness and well-being, in addition to providing yet another set for individuals to seek mental healthcare, especially if other forms of therapy are less than effective for them.

Multi-family group therapy is used more often in the treatment of eating disorders and illnesses on the schizophrenic spectrum but can also be adapted for use in the treatment of depression, anxiety disorders, and other conditions.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90849	Multiple family group psychotherapy	Psychologists, LICSW, LPC, and LMFT	The daily and yearly maximum allowable visits for Multiple family group psychotherapy are not clearly specified by DHCF; thus, we highly recommend that all clinics contact D.C. Medicaid and/or other payors directly for the patient's benefit limitations. Multiple family group psychotherapy is to be conducted with patients and their families where similar issues will be addressed. The number of patients and their families that are allowed in a group session must be verified by the insurance carriers. Multiple family group psychotherapy must be consistent with the scope of license and competency of the mental health provider. Modifiers may be required for billing Multiple family group psychotherapy. If uncertain which modifier to apply, please contact D.C. Medicaid and/or other payors directly for specifics. Reauthorization will be required to obtain additional services after the initial benefits are exhausted. This service can be provided face-to-face. Typically, telemedicine is not allowed for multiple family group psychotherapy. However, we highly recommend the clinic to contact DHCF and/or other payors regarding telehealth services as it relates to CPT code 90849. Reauthorization may be required to obtain additional services after the initial benefits are exhausted.

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Group Psychotherapy Services: (90853)

Group Psychotherapy services involve face-to-face engagement with two or more patients that facilitates disclosure of issues that permit generalization to a larger group; promotes help-seeking and supportive behaviors; encourages productive and positive interpersonal communication; provides psychoeducation; and develops motivation through peer collaboration and encouragement, and structured and constructive feedback.

Group Psychotherapy services leverage the emotional interactions of the group's members to assist in each patient's treatment process, support his/her/their rehabilitation effort, and to minimize relapse. Services should pertain to the patient's (a) mental health and/or (b) substance abuse, or both.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90853	Group Psychotherapy	Psychologists, LICSWs, LPCs, and LMFTs	The daily and yearly maximum allowable visits for Group Psychotherapy are not clearly specified by DHCF; thus, we highly recommend that all clinics contact D.C Medicaid directly for their patient's annual benefit limitations. Group Psychotherapy must be consistent with the scope of license and competency of the mental health provider. Modifiers may be required for billing Group Psychotherapy. If uncertain which modifier to apply, please contact D.C. Medicaid or other payors directly for specifics. Reauthorization may be required to obtain additional services after the initial benefits are exhausted. This service can only be provided face-to-face. All patients are required to be present for Group Psychotherapy sessions. Telemedicine is *not allowed*. Documentation requirements include date of service, start and stop times of actual group encounter that includes identified beneficiary, place of service, number of participants, diagnosis, focus of group, brief mental status and observations, rationale for group counseling must coincide with Mental Health Assessment, patient's/parent's/caregiver's response to the group counseling that includes current progress or regression and prognosis, any changes indicated for diagnosis, or medication concerns, plan for next group session, including any homework assignments and/ or crisis plans, or both, and staff signature/credentials/date of signature.

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Interactive Complexity (90785)

Interactive complexity refers to specific communication factors that complicate the delivery of psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical patients are those who have third parties, such as parents, guardians, other family members, agencies, court officers, or school involved in their psychiatric care.

This add-on code is meant to reflect increased intensity, not increased time, and must be used in conjunction with primary service codes and typically with diagnostic psychiatric evaluation, psychotherapy, psychotherapy when performed with an evaluation and management service, and group psychotherapy.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90785	Interactive Complexity	Psychologists, LICSW, LPC, and LMFT	The daily and yearly maximum allowable visits for Interactive Complexity have not been clearly specified by DHCF; thus, we highly recommend that all clinics contact D.C Medicaid or other payors directly for their patient's annual benefit limitations. 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 either Psychiatric evaluation (90791 & 90792) and/or Psychotherapy services (90832, 90834, 90837, 90853). Psychotherapy with crisis 90839 & 90840), family psychotherapy (90846 & 90847), and Multiple family group psychotherapy (90849) are not typically billable with interactive complexity, thus, it is highly recommended that all clinics contact DHCF or other payors directly for specific guidelines regarding billing Interactive complexity with CPT codes 90846, 90847, 90839, 90840, 90849. Per Center for Medicare and Medicaid Services (CMS), providers generally shouldn't bill CPT code 90785 solely for the purpose of translation or interpretation services. Federal laws prohibit discrimination, "which in this case would take the form of higher beneficiary payments and copayments for the same service, based on disability or ethnicity." Documentation must include communication factor(s) and how they increased the intensity of the services being rendered by the additional difficulty in either delivering the service or providing treatment to the patient. When billing for interactive complexity, your billing form needs to include both the primary service code and the interactive complexity code, one after the other. You should use the same date for both codes and your documentation must explain what the interactive complexity was exactly.

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			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.

Psychotherapy for Crisis (90839 & 90840)

Psychotherapy for Crisis is an unscheduled, immediate, short-term treatment activity(s) provided to patients who are experiencing an acute psychiatric or behavioral crisis, in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the patient or others are at risk for imminent harm, or to prevent significant deterioration of the patient's functioning.

This service is designed to stabilize the person in crisis, prevent further deterioration and provide the immediate indicated treatment in the least restrictive setting, which could include evaluating a patient to determine if the need for crisis services is present.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90839 90840	Psychotherapy for Crisis, first 60 minutes Psychotherapy for Crisis, each additional 30 minutes (*must list separately in addition to code for primary service*)	Psychologists, LICSWs, LPCs, and LMFTs	The daily and yearly maximum allowable visits for Psychotherapy for Crisis are not clearly specified by DHCF; thus, we highly recommend that all clinics contact D.C. Medicaid directly for their patient's annual benefit limitations. The patient must be present for all or the majority of the encounter. Psychotherapy for Crisis must be consistent with the scope of license and competency of the mental health provider. Psychotherapy for Crisis cannot be reported with any other mental health service on the same day. The full attention of the clinician must be given to the patient and ***no other services*** may be provided to any other patient during the same period. Psychotherapy for crisis should be used only once per date, even if the time spent by the provider is not continuous on the date. Psychotherapy for crisis of less than 30 minutes total duration on a given day should be reported with 90832.

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			Modifiers may be required for billing Psychotherapy for Crisis. If uncertain which modifier to apply, please contact D.C. Medicaid directly for specifics. Reauthorization will be required to obtain additional services after the initial benefits are exhausted. This service can be provided either Face-to-face or via Telemedicine. Documentation requirements include date of service, start and stop time of actual encounter with patient and possible collateral contacts with caregivers or informed persons, place of service, specific persons providing pertinent information in and relationship to patient, diagnosis and synopsis of events leading up to crisis situation, brief mental status and observations, utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized, patient's response to the intervention that includes current progress or regression and prognosis, clear resolution of the current crisis and/or plans for further services, development of a clearly defined crisis plan or revision to existing plan and staff signature/credentials/date of signature(s).

Interpretation of Diagnosis (90887)

The Interpretation of Diagnosis is a direct service that includes an interpretation from a broader perspective, explanation of results of psychiatric, other medical examinations and procedures, other accumulated data, efforts to identify and prioritize the patient's needs, establishment of a diagnosis, and helping to determine the care and services to be provided.

Additionally, services may include diagnostic activities or advising the patient's parent/caregiver or other relevant family members on how to assist the patient with a specific illness and/or condition (e.g., mental health and/or substance abuse).

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90887	Interpretation of Diagnosis	Psychologists, LICSWs, LPCs, and LMFTs	The daily and yearly maximum allowable visits for Interpretation of Diagnosis are not clearly specified by DHCF; thus, we highly recommend that all clinics contact D.C. Medicaid directly for their patient's annual benefit limitations. Interpretation of Diagnosis must be consistent with the scope of license and competency of the healthcare provider.

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CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
			Patients who are under 18 years of age: time may be spent either face-to-face with the patient, the patient's parent/caregiver, or alone with the parent/caregiver. This service can be provided either Face-to-face or via telemedicine. This service can be provided via Telemedicine (*patients ages seventeen (17) years of age and under with documentation of parental or guardian involvement during the service. This documentation must be included in the medical record*). Documentation requirements include date of service, start and stop times of face-to-face encounter with patient and/or parent(s) or guardian(s), place of service, participants present and relationship to patient, diagnosis and pertinent interval history, rationale for and description of the treatment used that must coincide with the most recent intake assessment and objective used that must coincide with the Mental Health Diagnosis, participant(s) response and feedback, consent form for parent/caregiver/family involvement (may be required), recommendation for additional supports including referrals, resources, and information, and staff signature/credentials/date of signature(s).

Health and Behavior Assessments/Re-assessments, and Interventions (96156, 96158, 96159)

Health and behavior assessments/re-assessments, and interventions (HBAI) 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**. The patient's primary diagnosis must be physical in nature, and the focus of the assessment and intervention is on factors complicating the physical health condition(s) and treatment(s). These codes describe assessments and interventions to improve the patient's health and well-being, utilizing psychological and/or psycho-social procedures designated to ameliorate specific disease-related problems. *For further reference, please review a Health and Behavior Assessment HBAI Clinical Vignette sample.*

HBAI services performed by a qualified health care provider (QHCP) other than a clinical psychiatrist, must be reported with the appropriate Evaluation and Management (E/M) codes.

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CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96156 96158 96159	Health Behavior Assessment or Re-assessment Health Behavior Intervention, Individual, face-to-face; initial 30 minutes Health behavior intervention, individual, face-to-face; each additional 15 minutes	Psychologists	The daily and yearly maximum allowable visits for HBAIs are not clearly specified by DCHF; thus, we highly recommend that all clinics contact D.C. Medicaid directly for their patient's annual benefit limitations. Reauthorization will be required to obtain additional services after the initial benefits are exhausted. HBAI must be consistent with the scope of license and competency of the mental health provider. HBAI codes and psychotherapy codes cannot be billed on the same date of service. This service can be provided either Face-to-face or via Telemedicine. Medical diagnosis must be reported, in addition to the bio-psychosocial factor(s). Services do not focus on the mental health of a patient, but rather on the biopsychosocial factors that are either affecting the treatment of, or severity of the patient's medical condition. Patient must have an established illness and cannot have been diagnosed with a mental illness. Documentation for assessment or re-assessment services should include, but is not limited to, the patient's physical illness(s) (health focused interview), and identification of the factors that are either preventing successful treatment, and/or management of the illness. Documentation should also include how these factors are either preventing treatment, and/or with time, providing successful management of them. HBAI services performed by a QHCP *other than a clinical psychiatrist* must be reported with the appropriate Evaluation and Management (E/M) codes.

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Psychological Testing & Evaluation (96130 & 96131)

Patients who have received a mental health diagnostic assessment by an allowable licensed professional, and have begun psychotherapy services, can receive a psychological (testing) evaluation to confirm the diagnosis in order to guide continued behavioral health counseling services.

Psychological Testing Evaluations are reimbursable when a current medical or mental health evaluation has been conducted and a specific diagnostic or treatment question still exists which cannot be answered by a psychiatric diagnostic evaluation and history-taking. Psychological Testing Evaluations are billed per hour for both face-time administering tests and time interpreting these tests and preparing the report. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, intellectual functioning, emotional, and personality characteristics of the patient.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96130 96131	Psychological Evaluation, 1st 60 minutes Psychological Evaluation, each additional hour	Physician, PA, NP, Psychologists, LICSWs, LPCs, and LMFTs	The daily and yearly maximum allowable visits for Psychological Testing and Evaluations are not clearly specified by DCHF; thus, we highly recommend that all clinics contact D.C. Medicaid directly for their patient's annual benefit limitations. Modifiers may be required for billing Psychological Testing Evaluations. If uncertain which modifier to apply, please contact D.C. Medicaid directly for specifics. Questions to be answered by the evaluation could not be resolved by a Mental Health Diagnosis or Psychiatric Assessment, observation in therapy, or an assessment for level of care at a mental health facility. This code may not be billed for the completion of testing that is considered primarily educational or utilized for employment, disability qualification, or legal or court related purposes. The service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions. History and symptomatology are not readily attributable to a particular psychiatric diagnosis. The service provides information relevant to the patient's continuation in treatment and assists in the treatment process. This service can only be provided face-to-face. Telemedicine may not be allowed. Please, contact DCHF directly for specific coverage. Documentation requirements include date of service, start and stop times of actual encounter with patient, start and stop times of scoring, interpretation, and report preparation, place of service, rationale for referral, presenting problem(s), culturally and age-appropriate psychosocial history and assessment, mental status/clinical observations and impressions, reason testing was provided, psychological tests used, results, and interpretations, interactive feedback with patient

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CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
			and/or family, DSM diagnostic impressions to include in all axes, if applicable, treatment recommendations and findings related to rationale for service and guided by test results, and staff signature/credentials/date of signature(s).

Smoking/Tobacco Cessation (99406, 99407)

Behavioral change interventions are for persons with a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by behavior that has not yet resulted in illness.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
99406 99407	Smoking and tobacco use cessation counseling visit; intermediate, more than 3 minutes, up to 10 minutes Smoking and tobacco use cessation	MD, PA, NP, CNM	Face-to-face service must be provided. Documentation of the counsel and/or intervention is required. Cessation and intervention codes are time-based, requiring documentation of time spent rendering the service. Documentation of a start and stop time is recommended. 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.

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	counseling visit; intensive more than 10 minutes		When rendered with an evaluation and management service, a modifier 25 will be applicable and should be appended to the evaluation and management code. Per DC Medicaid HealthCheck and the AAP Periodicity Schedules, the recommended age for Smoking and tobacco Cessation counseling should be for ages 11-21 years old. We highly recommend all clinics contact DHCF directly for specifics related to the children <11 years old.

Alcohol and Substance Abuse (99406, 99407)

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
99408 99409	Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services; 15 – 30 minutes. Alcohol and/or substances (other than tobacco) abuse structured screening and brief intervention. *Examples of structured screening tools are the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screen Test (DAST).*	Psychologist, LICSW, LPC, and LMFT	If services are being rendered in addition to evaluation and management services, modifier 25 is required. Some insurance carriers require modifier 59 to be appended to the service code if services are rendered with evaluation and management codes. Verification is required. Codes include time spent administering the screening/assessment, reviewing the results, and counseling. When billing for only a screening, without a diagnosis, reporting ICD10 code Z13.89 (encounter for screening for other disorders) to support medical necessity for the screening, is required. When there is a diagnosis in place that involves alcohol or substance abuse, the diagnosis code applicable to the patient is required. Documentation of the time spent rendering the services is required for the reporting of all CPT codes. Also included in your documentation should be the test, the results, and details of the brief intervention service provided. Per DC Medicaid HealthCheck and the AAP Periodicity Schedules, the recommended age for Smoking and tobacco Cessation counseling should be for ages 11-21 years old. We highly recommend all clinics contact DHCF directly for specifics related to the children <11 years old.

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Preventive Medicine Counseling (99401, 99402, 99403, 99404)

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 patients without a specific illness for which the counseling might otherwise be used as part of the treatment.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
99401 99402 99403 99404	Preventive medicine counseling and risk factor reduction intervention; *15 minutes* Preventive medicine counseling and risk factor reduction intervention; 30 *minutes* Preventive medicine counseling and risk factor reduction intervention; *45 minutes* Preventive medicine counseling and risk factor reduction intervention; 60 *minutes*	MD, PA, NP, CNM. Psychologist, LICSW, LPC, and LMFT	***Preventive medicine counseling codes are only covered for D.C. Medicaid beneficiaries diagnosed with a serious emotional disturbance, SMI, or SUD by a licensed behavioral health practitioner.*** Well-child visits should not be reported on the same day as preventive medicine counseling and risk factor reduction intervention services. These codes are included in the preventive medicine visit codes. Do not report CPT codes 99381-99397 together with 99401-99403. Counseling will vary with age and address such issues as family dynamics, diet and exercise, sexual practices, injury prevention, dental health, and diagnostic or laboratory test results available at the time of the encounter. Preventive medicine counseling codes are time-based, where the appropriate code is selected according to the approximate time spent providing the service. It is recommended that the clinician document the start (admission) and stop (discharge) times. Codes may be reported when the midpoint for that time has passed. (i.e.: once 8 minutes are documented, report 99401). The extent of counseling or risk factor reduction intervention must be documented in the patient chart to qualify the service based on time. 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. This service can be provided face-to-face. Telemedicine services may be allowed, it is highly recommended to contact the payers directly for billing guidelines.

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Lactation Services (S9443)

Lactation consultation, education, and support services are covered by DHCF for Medicaid-eligible D.C. residents who receive Medicaid through fee-for-service providers. In the District of Columbia Lactation consultation, education, and support services are under D.C.'s Medicaid program as "pregnancy-related services." Pregnant-related services are defined as those that are necessary to the health of the pregnant woman and fetus, or that of have become necessary as a result of the woman having been pregnant. The state must provide coverage of pregnancy-related services during the woman's pregnancy and extending through the end of the month in which the 60-day period following termination of pregnancy ends.

Additionally, these services are provided by currently enrolled Medicaid providers.

According to the D.C.'s Breastfeeding Coalition, the following criteria are required to provide lactation services:

1. The Lactation consultant is required to enroll with their state issued National Provider Identifier (NPI) via www.dcpdms.com to become a provider.
2. Demonstrate current international board certification by the International Board of Lactation Consultant Examiners (IBLCE) to deliver lactation consultation, education, and support to breastfeeding mothers.
3. Lactation consultation services offered by Lactation Consultants shall be billed under Health Common Procedure Coding System (*HCPCS*) S9443.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
S9443	Lactation classes, per session. 15 minutes	Non-physicians (e.g.: Certified Nurse Midwives, Nurse Practitioner, Registered Lactation Consultants, and IBLCE)	The maximum of four (4) units (*1 Units = 15 minutes*) per visit and a total of four (4) visits or sixteen (16) units for one hundred twenty (120) days after delivery. Lactation consultation services may be provided during inpatient stay, in an outpatient clinic, physician's office, clinic or freestanding birth center or in the home during the 60-day postpartum period. Lactation consultation, education, and support includes education on the proper use of a breast pump. To be enrolled as a Medicaid provider, a lactation consultant must demonstrate current certification by International Board of Lactation Consultant Examiners (IBCLC). IBCLC certification must be in good standing with the International Board of Lactation Consultant Examiners. Diagnosis code Z39.1 (*Encounter for care and examination of lactating mother*) will support medical necessity for the services.

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			This service can only be provided face-to-face. Telemedicine is *not allowed*.

Care Management: General Behavioral Health Integration (99484)

General Behavioral Health Integration (BHI) services can be billed solely by the primary care provider. CPT code 99484 (*FQHC & RHC: G0511*) may be utilized to document care management activities. While this CPT code does require a mental, behavioral health, or psychiatric diagnosis, it is still less prescriptive than the Psychiatric Collaborative Care Management (CoCM) services, which requires a care team that consist of a behavioral health care manager (BHCM) who checks in with patients at least once a month and works under the direction and license of the billing practitioner. Additionally, the care team will include of an on/off-site psychiatric consultant who provides a BH assessment, including establishing, starting, revising, or monitoring a care plan as well as providing brief interventions to a patient with a mental health disorder, and offering advice to the care team on patient registry enrollment and/or removal, diagnoses, and prescription management.

However, the BHI code simply requires practitioners to deliver at least 20 minutes of general integrated behavioral health services per month, which includes checking on each enrolled patient, administering validated rating tools, systematic assessments, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, or psychiatric consultation, developing, monitoring, revising the patient's care plan, and continuous relationship with a member of the care team, and patient consent (verbal or written) documented in the medical record.

Additionally, the BHI code does not require clinical staff providing care management services to have additional education or training in behavioral health. However, any services provided to the patient must always be documented with start and stop times, reasons for the encounter, and recommendations. Note, time spent strictly on administrative duties (e.g.: completing patient forms) should not be counted towards the time threshold to bill for general behavioral health integration.

Currently, DHCF indicates "zero reimbursement" for BHI services. We highly recommend that all clinics contact DHCF or other payors directly for verification on providing this service in a primary care setting.

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Telehealth Services

The D.C. Telehealth Reimbursement Act of 2013 directs Medicaid to *"cover and reimburse for healthcare services appropriately delivered through telehealth if the same services would be covered when delivered in person."*

Telehealth is defined as the delivery of healthcare services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment, provided that services delivered through electronic mail messages or facsimile transmissions are not included.

Telemedicine is a service delivery model that delivers healthcare services through a two-way, real-time interactive video-audio communication or audio-only communication for the purpose of evaluation, diagnosis, consultation, or treatment. Eligible services can be delivered via telemedicine when the beneficiary is at the originating site, while the eligible "distant" provider renders services via the video-audio or audio-only connection.

The D.C. Medical Assistance program will reimburse eligible providers for eligible healthcare services rendered to program participants via telemedicine in the District of Columbia. The program will implement this telemedicine service for both providers and participants in the Medicaid fee-for-service.

Providers must be enrolled in the program and licensed by the applicable Board, to practice in the jurisdiction where services are rendered.

The program shall reimburse approved telemedicine providers only if participants meet the following criteria:

1. Participants must be enrolled in the D.C. Medical Assistance Program;
2. Participants must be physically present at the originating site at the time the telemedicine service is rendered; and
3. Participants must provide written or verbal consent to receive telemedicine services in lieu of in-person healthcare services, consistent with all applicable District laws.

A provider shall document the beneficiary's consent to receive telemedicine services. Written consent includes any method that documents in writing the beneficiary's agreement to receive the service via telemedicine, including but not limited to an e-mail, text message, or signed PDF. If verbal consent is obtained, a detailed service note that describes the beneficiary's verbal consent is required.

The following locations that qualify as *originating sites* for service delivery via telemedicine:

1. Hospital
2. FQHC
3. Clinic
4. Physician Group/Office
5. Nurse Practitioner Group/Office
6. District of Columbia Public School
7. The beneficiary's home or other settings identified in guidance published on the DHCF website at dhcf.dc.gov.

The following places of service that qualify as *distant sites* for service delivery via telemedicine:

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1. Hospital
2. FQHC
3. Clinic
4. Physician Group/Office
5. Nurse Practitioner Group/Office
6. MHRS provider, ASARS provider, and ASTEP provider

D.C. Medicaid enrolled providers are eligible to deliver telemedicine services, using fee-for-service reimbursement, at the same rate as in-person consultations. All reimbursement rates for services delivered via telemedicine are consistent with the District's Medical State Plan and implementing regulations.

Telemedicine providers will submit claims in the same manner the provider uses for in-person services.

When billing for services delivered via video-audio telemedicine, distant site providers shall enter the "GT" procedure modifier on the claim.

When billing for any audio-only telemedicine services, distant site providers shall enter the "93" procedure modifier on the claim.

Additionally, the distant site provider must appropriately specify the place of service (POS) using the following POS codes:
1. In the event the beneficiary's home is the originating site, the distant site provider must specify the place of service "10" which is defined as "telehealth provided in patient's home."
2. In the event the beneficiary is at any other eligible originating site, the distant site provider must specify the place of service "02" which is defined as "telehealth provided other than in patient's home." When utilizing place of service "02," the distant site provider must also report the National Provider Identifier (NPI) of the originating site provider in the "referring provider" portion of the claim.

In accordance with the District's Prospective Payment System (PPS) or alternative payment methodology (APM) for FQHCs, the following reimbursement parameters will be established for the purposes of telemedicine in the District:
1. Originating Site: An FQHC provider must deliver an FQHC-eligible service in order to be reimbursed the appropriate PPS, APM, or fee-for-service (FFS) rate at the originating site;
2. Distant Site: An FQHC provider must deliver an FQHC-eligible service in order to be reimbursed the appropriate PPS, APM, or FFS rate; and
3. Originating and Distant Site: If both the originating and the distant site are FQHCs, for both to receive reimbursement, each site must deliver a different PPS or APM service (e.g., medical or behavioral). If both sites submit a claim for the same PPS or APM service (e.g., medical), then only the distant site will be eligible to receive reimbursement.

Covered Services that can be delivered via telemedicine include:
1. Evaluation and management (E/M);
2. Consultation of an evaluation and management (E/M) of a specific healthcare problem requested by an originating site provider; and
3. Behavioral healthcare services including, but not limited to, psychiatric evaluation and treatment, psychotherapies, and counseling.

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The provider shall determine if the service can reasonably be delivered at the standard of care via telemedicine. Providers may only deliver services that fall within their normal scope of practice and all telehealth transmissions must be HIPAA compliant.

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