Utah Crosswalk of HealthySteps-Aligned Services with Billing Codes and Provider Types

HealthySteps National Office Policy & Finance Team

About This Document

Have you ever wanted a list of the reimbursable HealthySteps (HS)-aligned services and corresponding list of providers who can render the services to assist with hiring decisions or to quickly identify "open" codes in the Utah Medicaid program? If so, this document will provide you with helpful guidance. Knowing the HS-aligned services open in the Utah Medicaid program, their associated billing codes, and the professionals eligible to render the service and/or receive insurance carrier reimbursement for each service will assist your site in understanding potential billing opportunities available through Medicaid and may assist you in the decision-making process when hiring a HS Specialist.

The following table outlines HS-aligned services, the service types, and the provider types that can provide and/or render the services. At the bottom of the table, you will find a tally of the number of billable codes for each provider type.

In summary, the top provider types with the most opportunities to currently bill for HS-aligned services in Utah, under Medicaid, are:

- Psychologists
- Other Licensed mental health therapists

Disclaimer: This document is not intended to give billing advice or guidance to any specific provider or HealthySteps site and does not consider the fact that payors, providers, and sites may have their own policies and procedures that may affect or prohibit implementation of these recommendations. Additionally, billing guidance is updated often. If there are any updates you recommend, please reach out to HSPolicyandFinance@zerotothree.org.

		Licensed Mental Health Therapists							
Service Description	**Service Billing Code**	**Psychologist**	**Certified Psychology Resident** *(under the clinical supervision of a psychologist)*	**Licensed Clinical Social Worker (LCSW)**	**Certified Master Social Worker (CSW)** *(under the clinical supervision of an LCSW)*	**Licensed Marriage and Family Therapist (LMFT)**	**Associate Marriage and Family Therapist (AMFT)** *(under the clinical supervision of an LMFT)*	**Licensed Clinical Mental Health Counselor (LCMHC)**	**Associate Clinical Mental Health Counselor (ACMHC)** (under the clinical supervision of an LCMHC)
Developmental Screening	96110	Billed by the primary care physician during a well-child Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) visit							
Behavioral/Social-Emotional Screening	96127								
Caregiver Focused Health Risk Assessment Instrument (Postpartum Depression Screening)	96161								
Psychiatric Diagnostic Evaluation	90791	X	X	X	X	X	X	X	X
Psychological Testing and Evaluation, 1 hour, and Psychological Testing and Evaluation for each additional hour	96130 96131	X	X						
Developmental Test Administration with Interpretation and Report, first hour and for each additional 30 minutes	96112 96113	X	X						
Psychotherapy with Patient 30, 45, 60 minutes	90832, 90834, 90837	X	X	X	X	X	X	X	X
Family Psychotherapy without Patient Present, 50 minutes	90846	X	X	X	X	X	X	X	X
Family Psychotherapy with the Patient Present, 50 minutes	90847	X	X	X	X	X	X	X	X
Multiple Family Group Psychotherapy (different families in a group)	90849	X	X	X	X	X	X	X	X

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Group Psychotherapy (group of patients only)	90853	X	X	X	X	X	X	X	X
Psychotherapy for Crisis 1 hour, and for each additional 30 minutes	90839 90840	X	X	X	X	X	X	X	X
Interactive Complexity	90785	X	X	X	X	X	X	X	X
Individual/Family Therapeutic Behavioral Services per 15 minutes, and Group Therapeutic Behavioral Services, per 15 minutes	H2019, H2019-HQ Modifier	X	X	X	X	X	X	X	X
General Behavioral Health Integration, Care Management Services for Behavioral Health Conditions, requiring at least 20 minutes of services, per calendar month	99484	Billed by the primary care physician							
Health and Behavior Assessment and Re-assessment	96156	X	X	X	X	X	X	X	X
Health and Behavior Intervention-Individual, face-to-face; initial 30 minutes and for each additional 15 minutes	96158 96159	X	X	X	X	X	X	X	X
Health and Behavior Intervention, Group (2 or more patients), face-to-face, initial 30 minutes and each additional 15 minutes	96164 96165	X	X	X	X	X	X	X	X
Health and Behavior Intervention, Family (with the patient present), face-to-face, initial 30 minutes and each additional 15 minutes	96167 96168	X	X	X	X	X	X	X	X

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Health and Behavior Intervention, Family (without the patient present), face-to-face; Initial 30 minutes and for each additional 15 minutes	96170 96171	X	X	X	X	X	X	X	X
Number of Billable Codes Eligible for Reimbursement[1]		26	26	22	22	22	22	22	22

[1] Count based on number of discrete codes available to bill, not code sets.

Notes:

1. Providers:
    - Many of the providers recognized by Utah Medicaid as Mental Health Therapists can provide HealthySteps-related services. According to the Mental Health Professional Practice Act, Mental Health Therapists are individuals who provide services within the scope of practice defined in the individual's perspective licensing act and licensed under this title as:
        - ✓ Psychologists that are qualified to engage in the practice of mental health therapy and certified psychology residents working under the clinical supervision of a psychologist.
        - ✓ Licensed clinical social workers and master's degree level certified social workers under the clinical supervision of a licensed clinical social worker.
        - ✓ Licensed marriage and family therapists and associate marriage and family therapists working under the clinical supervision of a licensed marriage and family therapist.
        - ✓ Licensed clinical mental health counselors and associate clinical mental health counselors working under the clinical supervision of a licensed clinical mental health counselor.
    - There are additional professional licensures recognized as mental health therapists, such as psychiatrists (physicians engaged in the practice of mental health therapy), advanced practice registered nurses specializing in psychiatric mental health nursing, and master level addiction counselors.
    - Information on the rules of clinical supervision for those providers that can practice under a licensed mental health therapist (associate providers, psychology intern) can be located at the Utah Commerce Office of Professional Licensure Review and Division of Professional Licensing.
2. Utah Medicaid provides various provider manuals which offer an array of information on billable services. Medicaid manuals can be located on the following websites:
    - Utah Department of Health & Human Services Integrated Health Provider Manual

- Utah Department of Health & Human Services Medicaid Provider Manual for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Utah Department of Health & Human Services Autism Spectrum Disorder (ASD) Manual
- Utah Department of Health & Human Services Provider Manual for Behavioral Health Services
- Utah Department of Health & Human Services Rehabilitative Mental Health Services Provider Manual

3. Utah Department of Health & Human Services Office of Healthcare Policy and Authorization provides the PRISM Coverage and Reimbursement Code Lookup, a tool provided as a fee schedule where one can look up each billing code under a selected provider to verify if:
    - A billing code is open for reimbursement
    - The effective date of the billing code
    - The allowable age range of the patient the code can be billed for, and
    - A charge factor which provides a dollar amount for the billing service codes. The PRISM coverage and reimbursement code lookup tool can be located at: https://health.utah.gov/stplan/lookup/CoverageLookup.php.
4. Services:
    - Screenings applicable to HealthySteps services:
        - ✓ Developmental Screenings (96110):
            - ➢ Provided during the child's 9th, 18th, and 30th month well-child visits according to Utah's Department of Health & Human Services Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) Manual, e.g., screening for milestones.
            - ➢ According to the National Academy of State Health Policy (NASHP) Medicaid Developmental Screening Policies by State, Utah recognizes the Ages and Stages Questionnaire (ASQ), and the Parents' Evaluation of Developmental Status (PEDS) as the tools to use for the screening of developmental delays.

- Autism Spectrum Disorder (ASD) Screening provided during a child's 18th and 24th month well-child visits when medically indicated, using a standardized validated autism screening tool.

✓ Behavioral/Social-Emotional Screenings (96127):

- Provided throughout the child's infancy (newborn, 4-5 days, 1st, 2nd, 4th, and 9th month well-child visits), early childhood (12th, 14th, 18th, 24th, 30th month well-child visits, and a child's 3rd and 4th year well-child visits), middle childhood and adolescence according to the EPSDT manual.
- Insurance carrier verification is required on the screening tools recognized for behavioral/social-emotional screening.

✓ Caregiver Focused Health Risk Assessment Instrument (Maternal Depression Screening) (96161):

- According to NASHP's Medicaid Policies for Caregiver and Maternal Depression Screenings during Well-Child Visit, by State, Utah recommends a maternal depression screening, as part of a well-child visit, be billed under the child's Medicaid Identification Number.
- Provided in the child's 1st, 2nd, 4th, and 6th month well-child visits according to Utah's Department of Health & Human Services Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) Manual.
- The EPSDT Manual states that Utah Medicaid recommends the Edinburgh Postnatal Depression Scale (EPDS-10 or EPDS02), but will accept other evidence-based screening tools for the monitoring and identification of depression in new mothers.

- Psychiatric Diagnostic Evaluation (90791):

✓ Psychiatric diagnostic evaluations are integrated biopsychosocial assessments performed for the purpose of assessing and determining diagnoses. They include the assessment of the patient's psychosocial history, current mental status, review, and ordering of diagnostic studies followed by appropriate treatment recommendations. In certain circumstances, information may be obtained from family members and guardians instead of from the patient.

- ✓ When an evaluation is provided for the diagnosing of intellectual or developmental disabilities or organic disorders, the services are paid directly by FFS Medicaid. To ensure correct adjudication of the claim, report the billing code with a UC modifier.
- ✓ Interactive complexity (90785) can be reported with a psychiatric diagnostic evaluation if the requirement for this additional service is encountered while delivering the service (please see information under interactive complexity).
- ✓ Psychotherapy cannot be billed on the same day as an evaluation, if performed by the same provider.

- Psychological Testing and Evaluation (96130, 96131):
  - ✓ Psychological testing and evaluations are provided to assess the presence, type, and severity of a mental illness or disorder. This includes administering psychological tests that are specifically chosen to meet the patient's clinical needs. The service also incorporates the interpretation of the test results and reports.
  - ✓ The reporting of billing code 96130 covers the first hour of testing and evaluation, while 96131 is used to report each additional hour, after the first hour of service has been provided. Although 96131 is used to report each additional hour of service, after the first hour of service is provided, Utah Medicaid will allow the reporting of 96131 with 96130 if at least 31 minutes of additional services are provided. 96131 cannot be reported without 96130. It is reported on the same claim, in addition to 96130.
- Developmental Test Administration with Interpretation and Report (96112, 96113):
  - ✓ Developmental test administrations with interpretation and report are provided for the assessment of fine and/or gross motor, language, cognitive level, social, memory, and/or executive functions by standardized developmental instruments. This service also incorporates the interpretation of the test results and reports.
- Individual Psychotherapy with Patient and/or Family Members (90832, 90834, 90837)
  - ✓ Psychotherapy is the treatment for mental illness and behavioral disturbances. During therapy sessions, the provider attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage growth and development. Services are based on measurable treatment goals and an identified treatment plan. It includes the ongoing adjustment of psychotherapeutic interventions and may include involvement of family members or others in the treatment process.

- ✓ Although individual psychotherapy with patient and/or family members includes the involvement of family members or others in the patient's treatment, the therapy sessions should center around the individual's diagnosis treatment.
- ✓ The billing codes for psychotherapy are time-based, indicating that a specific time must be spent with the patient, providing the service, before a provider can bill for the service. The description of time for billing code 90832 is for the reporting of 30 minutes of psychotherapy services, 90834 is for the reporting of 45 minutes, and 90837 is for the reporting of 60 minutes of psychotherapy services.
- ✓ Although billing code descriptions for 90832, 90834, and 90837 indicate specific times for the reporting of individual psychotherapy services, Utah Medicaid recognizes the Center of Medicaid and Medicare Services time rules for the reporting of these services. The following rules apply for converting the duration of the service to the appropriate billing code:
  - ➢ Billing code 90832 can be reported when 16 minutes through 37 minutes of psychotherapy services are provided.
  - ➢ Billing code 90834 can be reported when 38 minutes through 52 minutes of psychotherapy services are provided.
  - ➢ Billing code 90837 can be reported when 53 minutes through 89 minutes of psychotherapy services are provided.
- ✓ Individual psychotherapy services can be reported with interactive complexity (90785) if the requirement for this additional service is encountered during the therapy sessions (please see information under interactive complexity).

- Family Psychotherapy (90846, 90847):
  - ✓ Family Psychotherapy with and without the patient present applies the same overall concepts and rules as individual psychotherapy services with one distinct difference. While individual psychotherapy sessions are centered around the patient's diagnosis and treatment, family psychotherapy also includes the goal of improving the interaction between the patient and family member(s) and how the patient's diagnosis has affected the family.

- ✓ The billing codes for psychotherapy are time-based, indicating that a specific time must be spent with the patient providing the service before a provider can bill for the service. The description of time for billing codes 90846 and 90847 is for the reporting of 50 minutes of services.
- ✓ Although billing code descriptions for 90847 and 90847 indicate that 50 minutes of time must be spent rendering family psychotherapy, Utah Medicaid recognizes the Center of Medicaid and Medicare Services time rules for the reporting of these services. The following rules apply for converting the duration of the service for billing codes 90846 and 90847:
  - ➢ Less than 8 minutes of service cannot be billed.
  - ➢ When 8-22 minutes of family therapy is provided, 1 unit of service is billed.
  - ➢ When 23-37 minutes of service is provided, 2 units of service are billed.
  - ➢ When 38-52 minutes of service is provided, 3 units of service are billed.
  - ➢ When 53-67 minutes of service is provided, 4 units of service are billed.
  - ➢ When 68-82 minutes of service is provided, 5 units of service are billed.
  - ➢ When 83-97 minutes of service is provided, 6 units of service are billed.
  - ➢ When 98-112 minutes of service is provided, 7 units of service are billed.
  - ➢ When 113-127 minutes of service is provided, 8 units of service are billed.
- ✓ Family psychotherapy services can be reported with interactive complexity (90785) if the requirement for this additional service is encountered during the therapy sessions (please see information under interactive complexity).

- Group Psychotherapy and Multiple Family Psychotherapy
  - ✓ Group psychotherapy includes psychotherapy sessions delivered to a group of individual patients while multiple family psychotherapy sessions are delivered to a group that consists of the multiple families of patients.

- ✓ Group psychotherapy involves providing interventions to two or more patients and multiple family psychotherapy involves providing interventions to two or more families. Both group psychotherapy and multiple family psychotherapy are used when similar issues or conditions are treated in a group. Group sessions are limited to twelve patients unless a co-provider is present, then the session may not exceed 16 patients. Multiple family psychotherapy sessions are limited to 12 families unless a co-provider is present, then the session can be provided to up to 16 families.
- ✓ Although group psychotherapy and multiple group psychotherapy do not have a timeframe included in their billing code descriptions, Utah Medicaid applies the same rules concerning time for converting the duration of the services provided to the specified number of units of service reported on a claim, as seen in family psychotherapy.
- ✓ Group and multiple family group psychotherapy services can be reported with interactive complexity (90785) if the requirement for this additional service is encountered during the therapy sessions (please see information under interactive complexity).

- Psychotherapy for Crisis (90839, 90840):
  - ✓ Psychotherapy for crisis is a psychotherapy session for patients and/or their family members that are in a state of crisis and disposition. It includes an urgent assessment and history, where treatment includes mobilization of resources to defuse the crisis and restore safety. Psychotherapeutic interventions are used to minimize the potential of psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.
  - ✓ The billing codes for psychotherapy for crisis are time-based, indicating that a specific time must be spent with the patient providing the service before a provider can bill for the service. The description of time for billing code 90839 is for the reporting of 60 minutes of services, and 90840 is for each additional 30 minutes after the first hour of service has been provided.
  - ✓ Psychotherapy for crisis can be reported with interactive complexity (90785) if the requirement for this additional service is encountered during the therapy sessions (please see information under interactive complexity).

- Interactive Complexity (90875):
  - ✓ Interactive complexity refers to communication difficulties that arise between the provider and the patient/family members during the delivery of a service. Interactive complexity can be reported when at least one of the following communication difficulties is present:
    - ➢ The need to manage maladaptive communication (e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
    - ➢ Caregiver emotions/behaviors that interfere with implementation of the treatment plan.
    - ➢ Evidence/disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants; or
    - ➢ Use of play equipment, physical devices, interpreters, or translator to overcome significant language barriers.
  - ✓ Interactive complexity is an add-on code, meaning it is a code that is reported only in conjunction with specific billing codes. Interactive complexity can be reported with all psychotherapy services (except for psychotherapy for crisis) and psychiatric diagnostic evaluations.
- Individual and Family Therapeutic Behavioral Services (H2019)
  - ✓ Therapeutic behavioral services are reported when a provider uses behavioral interventions to assist patients with a specific behavior problem that does not fully meet the definition of psychotherapy. *(Additional information must be obtained from insurance carriers regarding whether a mental health diagnosis must be present, but Utah Medicaid resources do advice that there must be treatment goals present, documentation of progress made towards the goals, and if there is not reportable progress, barriers and reasons must be indicated).* The service can be provided to individual patients or a group.
  - ✓ When providing these services to individual patients in a group setting, the group is not to exceed twelve patients unless a co-provider is present, then groups may not exceed 24 patients. When providing multiple family therapeutic behavioral services groups, there is a limit of ten families in a group.

- ✓ When billing for services that are provided in a group, appending an HQ modifier to the billing code for the service (H2019) is required.
- ✓ Utah Medicaid applies the same rules for converting the duration of the service provided to the specified number of units of service reported on a claim, as seen in family psychotherapy.

- General Behavioral Health Integration (99484):
  - ✓ General Behavioral Health Integration services are a care management service for patients with behavioral health conditions, prescribed by a physician (e.g., the patient's primary care physician). An initiating visit with the primary care physician is required for new patients or patients that have not been seen within a year is required, prior to prescribing general behavioral health integration services. This allows for the establishment of the patient's relationship with the physician which will give the provider an opportunity to conduct a baseline assessment prior to initiating general behavioral health integration services. Baseline assessments include the initial assessment or follow-up monitoring including the use of applicable validated rating scales.
  - ✓ Examples of conditions that may benefit from behavioral health integration include patients with attention-deficit/hyperactivity Disorder (ADHD) and developmental disorders.
  - ✓ Services under general behavioral health integration care management include:
    - ➢ Facilitating and coordinating treatment such as psychotherapy and/or psychiatric consultations (if medically required) and continuity of care with a designated member of the patient's care team (the supervising physician e.g. the primary care physician)
    - ➢ Follow-up monitoring and the use of applicable rating scales; and
    - ➢ Care planning related to a behavioral/psychiatric health problem, including revision for patients who are not progressing or whose status has changed.
  - ✓ Utah Medicaid recognizes these services for reimbursement when at least 20 minutes of services have been provided to a patient, per calendar month, when billed by a supervising physician (primary care provider) for services rendered by that physician and/or other clinical staff members, such as those indicated in the table located above (e.g., mental health therapists). When billing for this service, 1 unit per calendar month

is reported on a claim representing at least 20 minutes of services provided throughout the month you are billing.

- Health and Behavior Assessment and Re-assessment and Interventions (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171):
  - ✓ Health and behavior assessments, re-assessments, and intervention services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, re-assessment, treatment, and/or management of **physical health problems.** The patient's primary diagnosis must be physical in nature and the focus of the assessment, re-assessment, and intervention is on factors complicating the medical condition(s) and treatment(s).
- Health and Behavior Assessment/Re-Assessment:
  - ✓ The assessment is conducted using health-focused interviews, behavioral observation, and clinical decision-making. They include evaluating the patient's responses to disease, illness or injury, outlook concerning disease prognosis, coping strategies, motivation, and adherence to medical treatment. As part of the health-focused clinical interview, the provider conducts a face-to-face interview with the patient and family, while assessing multiple behavioral domains. Collateral interviews are conducted as appropriate. When it precedes the intervention services, the clinical assessment would determine the type(s) of intervention that would best benefit the patient.
  - ✓ Patient criteria for the medical necessity for Health and Behavioral Assessments/Re-assessments:
    - ➢ There is an established physical condition and purpose of the assessment is not for the diagnosis or treatment of a mental illness,
    - ➢ There are indications that psychological, behavioral, and/or psycho-social factors may be affecting the treatment or medical management of an illness or an injury,
    - ➢ The patient, and/or family member (during interventions with the family) is alert, oriented, and has the capacity to understand and to respond meaningfully during a face-to-face encounter,
    - ➢ The assessment, re-assessment, and/or the intervention will contribute to the patient's success in management of their daily activities, and

- The patient can be referred by a medical or mental health care provider, or self-referred (or by the family) to seek assistance in addressing the role of psychological and/or behavioral factors affecting an underlying physical health condition.

✓ Re-assessment requirements (in addition to meeting the criteria stated above, medical necessity must be further established through documentation of one of the following):

- Change in mental or medical status warranting re-evaluation,
- Specific concern from the primary medical provider or patient/family or member of the patient's medical team,
- The need for re-assessment as part of the standard of care,
- Change in providers, or
- At least a 6-month period has elapsed since the last assessment.

✓ The billing code for health and behavior assessment or re-assessment (96156) is limited to one unit per date of service.

✓ Re-assessments can only be billed every 6 months from either the date of the initial assessment or the previous re-assessment.

✓ Psychological testing can be reported on the same day as an assessment or re-assessment. Appropriate reporting for both services on the same date of service requires the appendage of one of the following billing modifiers to be appended to the billing code for the assessment/reassessment (96156):

- Modifier XE if separate encounters are being billed for on the same date of service, or
- Modifier 59 if the service is provided during the same encounter.

- Health and Behavior Interventions:

✓ Health and behavioral interventions emphasize active patient and family engagement and involvement. Interventions may be provided individually, to a group of two or more patients, and/or to the family, with or without the patient present.

- ✓ Interventions include:
  - ➢ Promoting functional improvement,
  - ➢ Minimizing psychological and/or psycho-social barriers to recovery, or
  - ➢ Managing and improving coping methods for patients and/or family associated with medical conditions.

Intervention services are considered medically necessary when one or more of the following needs are present:

- ➢ Management of psychological and behavioral factors that are impacting the trajectory of a patient's physical medical condition,
- ➢ Improvement of a patient's cognitive or emotional responses to disease, illness, or injury, outlook, coping strategies, motivation, and adherence to medical treatment,
- ➢ Improvement of psychological and/or behavioral factors that impact disease management in scenarios that include but are not limited to psychological factors affecting or complicating the outcome of surgical procedures and/or aftercare,
- ➢ Management of the emotional/personality impacts on physical disease management and/or the ability to comply with and benefit from medical interventions,
- ➢ Improvement of a patient's adherence to medical treatment and/or health risk-related behaviors,
- ➢ Improvement of a patient/patient's family engage in self-management and participation in treatment, and
- ➢ Improvement of a patient's/family understanding of the medical condition, its treatment, and the prevention, treatment or management of the medical condition.

- ✓ Interventions may be provided to an individual patient or a group of patients receiving similar interventions for health and behavior assessments, re-assessments, and interventions, and they may also be provided to a patient's family/caregiver(s), with or without the patient present (these intervention services involve face-to-face interaction with the family or caregiver(s) present).

- ✓ Health and behavior interventions include promotion of functional improvement, minimization of psychological or psycho-social barriers to recover, and management of the improved coping with medical conditions. These services emphasize active patient/family engagement and involvement.
- ✓ Evidence-based health behavior interventions are allowed. Examples can be located on page 26 of the provider manual.
- ✓ Interventions as well as assessments and re-assessments do not include adaptive behavior services, evaluation and management services (when provided on the same date of service by the same provider), and preventive medicine counseling services when provided by physicians, physician assistants and nurse practitioners (when they too are providing health and behavior services on the same date of service) and psychotherapy services.
- ✓ The billing codes for intervention services are time-based, indicating that specific time must be spent with the patient providing the service before a provider can bill for the service. The description of time for individual intervention services, group services, and intervention with or without the patient present is 30 minutes.
- ✓ Although billing code descriptions for individual, group, and family intervention services (96158, 96164, 96167, and 96170) state that 30 minutes must be spent rendering the service, Utah Medicaid recognizes the Center of Medicaid and Medicare Services time rules for the reporting of these services; therefore, they may be billed for when at least 16 minutes were spent providing the services.
- ✓ Additional billing codes are used to report intervention services (add-on codes). Add-on codes are used to describe a service provided in addition to a primary service and cannot stand alone for billing. Add-on codes can only be reported in conjunction with specific billing codes. The applicable add-on codes for intervention services are 96159, 96165, 96168, and 96171. Pages 28-30 of the provider manual provide time rules associated with the ability to report these add-on codes.