HealthySteps Billing & Coding Opportunities – Pathways to Reimbursement

National Office Policy & Finance Team

The National Office has compiled this comprehensive list of updated billing and coding opportunities for sites to increase billing practices and inform sustainability planning. It represents codes actively in use, or being explored for use, by HealthySteps sites, Medicaid health plans, and/or other payers.

This is a technical guide for the billing and reimbursement experts at your site. It is based on national billing and coding guidelines (that are subject to annual changes). The goal is to maximize their understanding of HealthySteps-related services and potential reimbursement.

This document expands upon the previously released Billing and Coding opportunities document to enhance your site's understanding of potential utilization of the codes by providing detailed standard definitions and tips for reporting.

The service requirements and guidelines for each billing code vary from state to state, and you should determine with your implementation team and billing manager the most appropriate codes to use for your site. The National Office also advises that to maximize appropriate reimbursement and utilization of procedure codes, sites should always contact health insurance companies to verify billing for services rendered. For more information on HealthySteps billing and coding opportunities, please contact HSpolicyandfinance@zerotothree.org.

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

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Screenings

Tier 1 of the HealthySteps model includes practice-wide universal screenings for all children ages birth through three 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 optimal child development and well-being begins with screenings to monitor progress or concerns across multiple domains. The following guidance provides the CPT codes, descriptions, general information, and examples of screening tools for both children and caregivers.

Tips for Reporting Screenings:

- Documentation for all screenings must include scoring and the standardized instrument utilized. Accepted standardized instruments are at the discretion of payers and/or the state Medicaid agency. Verification of which tool(s) to utilize is recommended.
- Screenings may be submitted for reimbursement by a physician or other qualified healthcare professional. Those considered to be qualified healthcare professionals can vary from state to state. Verification with your state's Medicaid agency and/or insurance carriers is required.
- Codes include all discussions regarding results with the caregiver.
- In some states, CPT code 96161 (caregiver-focused health risk assessment) should be reported when providing a maternal depression screening during a well-child visit. Verification with your state's Medicaid agency and/or insurance carriers is required.

Developmental Screenings

The physician or other qualified health care professional reviews a developmental screening, such as a developmental milestone survey or speech and language delay screening. The screening is to determine whether the patient requires additional work up for developmental disorders or ongoing surveillance at periodic intervals.

CPT Code	Description
96110	Developmental milestone survey, speech and language delay with scoring and documentation, per standardized instrument.

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Depression Screenings (for caregivers)

Depression screenings are an essential part of the detection, treatment, and referral to mental health professionals for persons with depressive disorders. These Medicaid codes are state-specific. Verification with your state Medicaid agency is required.

CPT/HCPCS Code	Description
G8510	Screening for depression documented as negative.
G8431	Screening for depression documented as positive: follow-up plan is required.
96161	Caregiver-focused health risk assessment with scoring and documentation, per standardized instrument (some state insurance carriers recognize this code for the reporting of maternal depression screenings during a well-child visit).

Social-Emotional Screenings

The physician or other health care professional reviews a brief assessment of the patient's emotions and behaviors associated with conditions such as attention-deficit/hyperactivity disorder using inventory or scale methods. The screening is used to determine whether the patient requires additional workup or treatment.

CPT Code	Description
96127	Social-emotional-brief emotional/behavioral assessments.

Health Risk Assessments

Health Risk Screenings (also called Health Hazard Appraisals)

A health risk assessment includes a questionnaire, an assessment of health status, and personalized feedback about actions that can be taken to reduce risk, maintain health, prevent disease, and maintain emotional health. A caregiver-focused assessment also serves to identify areas of concern such as stress levels, depression, and the burdens placed on the caregiver.

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CPT/HCPCS Code	Description
96160	Patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument.
96161	Caregiver-focused health risk assessment instrument with scoring and documentation, per standardized instrument.
G9920	ACE screening-lower risk, patient score of 0-3
G9919	ACE screening-higher risk, patient score of 4 or greater

Tips for Reporting Caregiver-Focused Health Risk Assessments:

- When using the Edinburgh Postnatal Depression Scale (EPDS) to screen for depression in pregnant or postpartum patients, it is more appropriate to report CPT code 96160 (when mother is the patient).
- Code 96161 will be reported via a standardized instrument to screen for health risks in the caregiver for the benefit of the patient (when completed during a well child visit). Thus, when using the EPDS, PHQ-2, or PHQ-9 to screen the mother during the well child visit, bill CPT code 96161, which must be reported under the child's health plan.
- Payment for SDOH screening is not yet common but may be available from your payers using 96160 and/or 96161 – your payers' policies will clarify which code to use for SDOH screenings.

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Examples of Screening & Assessment Tools:

Developmental Screenings

- Ages and Stages Questionnaires, Third Edition (ASQ-3) - Provides reliable, accurate developmental and social-emotional screening for children between birth & age six.
- Modified Check List for Autism-Revised (M-CHAT-R) - A screen that evaluates risk for autism spectrum disorder in children ages 16 - 30 months.
- Parents' Evaluation of Developmental Status (PEDS) - A surveillance and screening tool for children birth to eight that enables a swift view of children's skills in development and mental health, including expressive and receptive language, fine and gross motor skills, self-help, academics, and social-emotional skills.

Depression Screenings

- Patient Health Questionnaire-9 (PHQ-9) - Nine questions for the screening, diagnosing, monitoring, and measuring the severity of depression. (Use of the PHQ-2 alone, without the PHQ-9, should be verified with insurance carriers).
- Edinburgh Postpartum Depression Screening - See second bullet under "Health Risk Assessments."

Social-Emotional Screenings

- Ages and Stages Questionnaires: Social Emotional, Second Edition (ASQ:SE-2) - Set of questions about behavior and social-emotional development in young children.

Health Risk Assessments

- Pediatric ACEs and Related Life-events Screener (PEARLS) for Adverse Childhood Experiences – Patient-focused and/or caregiver-focused. An evaluation of children and adults for adverse childhood experiences experienced by age 18 (e.g., physical, emotional, and sexual abuse, physical and emotional neglect). Includes screening for potential risk factors for toxic stress (e.g., domestic violence, bullying, community violence, substance misuse, food or housing insecurity).
- Edinburgh Postpartum Depression Scale - Caregiver-focused - for the benefit of the child (see last bullet under "Tips for Reporting Screenings") and developed to identify women who have postpartum depression.
- Survey of Well-Being of Young Children (SWYC) - Focuses on early identification of and screening for risks of developmental-behavioral disorders and family/social determinants of toxic stress. Additionally, the SWYC is multi-dimensional, covering development and social emotional too.
- Safe Environment for Every Kid (SEEK) - Screening for parents for prevalent psychosocial problems that are risk factors for child maltreatment.

Health and Behavior Assessments/Re-Assessments and Interventions

Billing Guidance Definition: Health and behavior assessments/re-assessments and interventions 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.

HealthySteps Specific Note: In practices where the HS Specialist is an independently billable clinician with a scope of practice that allows for the rendering of this service (e.g., clinical psychologist), they may provide an assessment and intervention to the child and caregiver. The service addresses a specific issue identified by the caregiver or provider and may be provided to children in Tiers 2 or 3. See sample clinical encounter below.

CPT Code	Description
96156	Health and behavior assessment or re-assessment (e.g., health-focused clinical interview, behavioral observations, clinical decision making)
96158 96159	96158-Health and behavior intervention, *individual, face-to-face; initial 30 minutes* 96159-Health and behavior intervention, *individual, face-to-face; each additional 15 minutes*
96164 96165	96164-Health and behavior intervention, *group (2 or more patients), face-to-face; Initial 30 minutes* 96165-Health and behavior intervention, *group (2 or more patients), face-to-face; each additional 15 minutes*
96167 96168	96167-Health and behavior intervention, *family with patient present. Face-to-face; initial 30 minutes* 96168-Health and behavior intervention, *family with patient present. Face-to-face; each additional 15 minutes*
96170 96171	96170-Health and behavior intervention, *family without the patient present. Face-to-face; initial 30 minutes* 96171-Health and behavior intervention, *family without the patient present. Face-to-face; each additional 15 minutes*

Tips for Reporting Health and Behavior Assessments/Re-assessments and Interventions:

- The assessment must be associated with a physical health problem - the prevention of a physical illness or disability, and the maintenance of health. For example, within HealthySteps, it may be working with the family around a child's recent diagnosis of torticollis. (See below for a more in-depth example).
- The patient's physical health diagnosis should be listed as the primary diagnosis when reporting these codes.
- Services do not focus on the mental health of a patient, but rather on the biopsychosocial factors that are, or could affect the treatment of, or severity of the patient's physical condition.
- Patients must have an established physical illness or symptom(s) and the intervention/service cannot be related to a mental health diagnosis.

- Coding for group services and/or services where the patient is not present may not be a covered in some states or clinic types such as Federally Qualified Health Centers (FQHCs). Health Insurance carrier verification is highly recommended.
- Health and behavior interventions are time-based services and documentation must include the time spent rendering services to the patient.
- Assessments or re-assessments require a health-focused interview, behavioral observation, and clinical decision making.
- Interventions include the promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery and management, and improved coping with medical condition(s). Interventions also emphasize active patient and family engagement and involvement.
- 96168, 96171, 96159, and 96165 are add-on codes, signifying they can only be billed with another code, and not independently. Thus, 96168 is an add-on code to 96167, 96171 is an add-on code to 96170, 96159 is an add-on code to 96158, and 96165 is an add-on code to 96164. They are to be reported in conjunction with one another, when an additional 15 minutes of service is rendered, after the first 30 minutes.

Psychiatric Diagnostic Evaluation

Billing Guidance Definition: A psychiatric diagnostic evaluation is the process of gathering information about a person within a psychiatric service, with the purpose of establishing whether a mental disorder or other condition is present. It is an evaluation designed to diagnose emotional, behavioral, or developmental conditions or disorders. It includes the assessment of the patient's psychosocial history, current mental status, review, and ordering of diagnostic studies followed by appropriate treatment recommendations.

HealthySteps Specific Note: In practices where there is an independently billable clinician with a scope of practice that allows for the rendering of this service (e.g., psychiatrist), they may evaluate a child to identify a specific issue. They will provide referrals for additional specialized services or develop a treatment plan as needed. Typically, these children will be in Tiers 2 or 3.

CPT Code	Description
90791	Psychiatric diagnostic evaluation *without* medical services.

Tips for Reporting Psychiatric Diagnostic Evaluations:

- This service may be performed by a physician (psychiatrist) or other qualified healthcare professional. Those considered to be qualified healthcare professionals can vary from state to state. Verification with state Medicaid agencies and/or insurance carriers is required.

- Evaluations should include a description of behaviors present, when they occur, how long they last and which behaviors happen most often. Evaluations should also include how behaviors impact others and a description of symptoms, both physical and psychiatric.
- In some cases, family members, guardians, or others may be consulted with results, instead of the patient. Verification with your state Medicaid agency and/or other insurance carriers is required.

Developmental Testing and Psychological Testing Evaluations

Billing Guidance Definition: Testing and evaluations involve services beyond screenings. Screenings are used to identify if someone is at risk, and if a screening reveals that further testing is required, testing and evaluation help determine appropriate follow-up and care and, if appropriate, a diagnosis.

HealthySteps Specific Note: In practices where there is an independently billable clinician with a scope of practice that allows for the rendering of this service (e.g., a clinical psychologist), they may test or evaluate a child to identify a specific issue. They will provide referrals for additional specialized services or develop a treatment plan as needed. Typically, these children will be in Tiers 2 or 3.

Developmental Test Administration

Developmental test administration includes assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed, by physician or other qualified health care professional. The test provides information regarding the milestones a child has attained and can help in determining the course of intervention to attain further milestones.

CPT Code	Description
96112	Developmental test administration including assessment of fine and gross motor, language, cognitive level, social, and memory or executive functions by standardized developmental instruments with interpretation and report, *initial hour*
96113	Developmental test administration; *each additional 30 minutes after the first hour of service*

Psychological Testing Evaluation

Psychological testing evaluation services are performed by a physician or other qualified health care professional and include integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s).

CPT Code	Description
96130	Psychological testing and evaluation*; first hour (31 minutes minimum)*
96131	Psychological testing, evaluation; *each additional hour after the first hour of service*

Tips for Reporting Developmental and Psychological Testing:

- These codes are time based, requiring the documentation of the time spent rendering the service(s), including the start and stop times of testing.
- Although the time in the description of CPT codes 96130, 96132, and 96112 state "first hour," or "initial hour," CPT guidelines indicate that a minimum of 31 minutes can be provided before assigning these codes. State Medicaid guidelines must be verified on time requirements.
- Standardized testing instruments, dependent on those selected in your state, must be utilized and a report must be generated.
- 96131 and 96133 are add-on codes, signifying they can only be billed with another code. 96131 is an add-on code to 96130, and 96133 is an add-on code to 96132. They are to be reported in conjunction with one another, when an additional hour of service is rendered, after the first hour of service.
- 96113 is an add-on code, signifying it can only be billed with another code, and not independently. 96113 is an add-on code to 96112, and they are to be reported in conjunction with one another, when an additional 30 minutes of service is rendered, after the first hour of service.
- This service may be performed by a physician or other qualified healthcare professional. Qualified healthcare professionals, per individual service, can vary with state Medicaid agencies and other health insurance carriers. Verification is recommended.

Interactive Complexity (add-on code and services to Psychiatric Diagnostic Evaluations and Psychotherapy Services)

Interactive complexity is used when services have been complicated by difficult communication with discordant or emotional family members and/or engagement of young and verbally undeveloped or impaired patients.

CPT Code	Description
90785	Interactive complexity

Interactive complexity can be reported when ***at least one*** of the following communication factors is present during the visit:

- The need to manage maladaptive communication (related to high anxiety, high reactivity, repeated questions, or disagreement) among participants and/or caregivers that complicates delivery of care.
- Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
- If reporting to a third party is required, due to an incident in the patient's life, that may have caused psychological damage. The incident must be newly discovered (e.g., abuse, neglect).
- Use of play equipment or other physical devices to communicate with patient to overcome barriers to diagnostic or therapeutic interaction with a patient between the physician or other qualified health care professional; and a patient who has not developed, or has lost, either the expressive language communication skills to explain his or her symptoms and respond to treatment; or a patient who lacks receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication **(Note: In 2022, the use of interpreters and translator services were removed.)**

Tips for Reporting Interactive Complexity:

- 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 psychotherapy services or diagnostic psychiatric evaluations.
- Some states will not reimburse for interactive complexity when rendered during psychotherapy for crisis or with family psychotherapy. Verification with insurance carriers is recommended.
- 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.

Therapeutic Services

Psychotherapy

Billing Guidance Definition (Psychotherapy with a Mental/Behavioral Health Diagnosis: Psychotherapy, sometimes called "talk therapy" or simply, "therapy" is the process whereby psychological problems are treated through communication and relationship factors between an individual, and/or group, and a trained mental health professional. Mental health professionals approved for reimbursement may vary in states. Verification is required.

Prevention Based Psychotherapy (Without a Mental/Behavioral Health Diagnosis: In some states, prevention-based psychotherapy is recognized as a process whereby psychotherapy is provided to prevent childhood behavioral health issues and/or illness as seen in one state

and provided when persistent mental health symptoms are present in the absence of a mental health diagnosis, in another. If prevention-based psychotherapy is recognized in your state, verification is required on those mental health professionals approved for reimbursement.

HealthySteps Specific Note: In practices where there is an independently billable clinician with a scope of practice that allows for the rendering of this service (e.g., an LCSW), they may provide short-term, session-limited psychotherapy to a child and family to address a specific issue. If more specialized or long-term treatment is necessary, the HS Specialist will refer to an appropriate professional. Typically, these children and caregivers will be in Tiers 2 or 3.

CPT Code	Description
90832	Psychotherapy with patient; *30 minutes*
90834	Psychotherapy with patient; *45 minutes*
90837	Psychotherapy with patient; *60 minutes*
90839	Psychotherapy for crisis; *first 60 minutes*
90840	Psychotherapy for crisis; *each additional 30 minutes, after the first 60 minutes of service is rendered*
90846	Family Psychotherapy *without* the patient present; *50 minutes (face-to-face with family)*
90847	Family Psychotherapy *with* patient present; *50 minutes (face-to-face with patient and family)*
90849	Multiple family group psychotherapy

Tips for Reporting Psychotherapy Services:

- Psychotherapy services *cannot be reported with a psychiatric diagnostic evaluation (90791).*
- A signed and dated treatment plan is required and must include, but is not limited to:
  - The patient's diagnosis
  - Treatment goals
  - Number of sessions ordered by the physician, Nurse Practitioner, or Physician's Assistant.
  - The practitioner involved in the treatment plan for the patient must sign the plan, certifying medical necessity.
- The time spent rendering psychotherapy services must be included in your documentation, as psychotherapy services are time-based codes. Documenting a start and stop time is advisable.
- Although CPT coding guidelines advise that each code may be reported if ***more than*** *50%* 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.**
- When coding for family psychotherapy:
  - Therapy is most often used to help treat a patient's problem that is affecting the entire family/caregiver(s).
  - Family dynamics, as they relate to the patient's mental status and/or behavior, should be the focus of the sessions.

  - Attention should be given to the impact the patient's condition has on the family, with therapy aimed at improving interactions between the patient and family member(s)/caregiver(s).
- Reviewing records, communication with other providers, observing, interpreting patterns of behavior, communication between the patient and family, and decision making is included in the psychotherapy codes.
- If coding for psychotherapy for a caregiver crisis:
  - A patient must have a life threatening or highly complicated psychiatric crisis. The patient must be a danger to themselves or others. The provider must devote full attention to the patient and cannot provide services to other patients during this time.
  - Used to report total duration of face-to-face time with the patient and/or family providing psychotherapy for crisis.
  - Time does not have to be continuous but must occur on the same day.
  - A mental status examination, disposition, and that the patient presented in a high level of distress and complexity or with a life-threatening problem(s) that required immediate attention, is required.
  - In a crisis scenario, 90839 is billed for the first 60 minutes and 90840 is billed for each additional 30 minutes. Using both codes together requires that the session lasts 75 minutes or longer. If you do not meet the time required to bill one or both crisis codes, you can bill the standard CPT code (90832 - Individual psychotherapy, 30 minutes).
  - In some states psychotherapy for crisis cannot be reported with any other mental health service on the same day.

Individual and Family Therapeutic Behavioral Services

Billing Guidance Definition: Therapeutic behavioral services are provided face-to-face to an individual or a group and is used when the service provided does not fully meet the definition of psychotherapy. Instead, the provider uses behavioral intervention to assist patients with specific behavioral problems when there is a behavioral/mental health disorder present. These services may be provided to an individual or group.

HealthySteps Specific Note: As when providing psychotherapy services, individual and family therapeutic services also require treatment goals for the patient, therapeutic interventions to reach those goals, and documentation of the progress toward those treatment goals, and if there is no reportable progress, providing the barriers or reasons on why. Therapeutic behavioral services can be considered "light" psychotherapy, as 1 unit of its billing code represents 15 minutes of service, where in some states, only 8 minutes providing the service is required to bill for the service. Practices where there is an independently billable mental health clinician or those that can provide services under the clinical supervision of an independently billable mental health clinician where these services fall under their scope of practice, can provide these services to children and their families. Typically, these children will be in Tiers 2 or 3.

CPT Code	Description
H2019	Individual/Family therapeutic behavioral services, per 15 minutes

Tips for Reporting Individual/Family Therapeutic Behavioral Services:

- When providing these services to individual patients in a group setting, the number of patient's allowed, per group, is dependent on decisions made by insurance carriers. In some states, groups may not exceed more than 24 patients in a group and when providing services to multiple family groups, some states have a limit of ten families in a group. Insurance verification is required.
- When billing for services that are provided in a group setting, billing modifier HQ may be required. Insurance verification is required.
- Therapeutic behavioral services are time-based services indicating that the time spent rendering the service must be present in a clinician's documentation.
- Some state Medicaid agencies may allow the time rule for this billing code/service, indicating that if half of the time indicated within a code's description was spent rendering the service, the service is billable. E.g., these services indicate to be per 15 minutes, but some state Medicaid agencies will recognize the billing for this service when 8 minutes was spent providing the service.

Alcohol and Substance Abuse

Alcohol and Substance Abuse Screening and Intervention (for caregivers)

Billing Guidance Definition: The Healthcare Common Procedure Coding System (HCPCS) codes, otherwise known as "H" codes, for alcohol and substance abuse screening/intervention, are codes that were commonly created for use by Medicaid agencies in states mandated by law to establish separate codes for identifying mental health services that include alcohol and drug treatment services.

Commercial insurers and some Managed Care Organizations will reimburse for Current Procedure Terminology (CPT) codes 99408 and 99409, which are also alcohol and/or substance abuse screening and intervention services codes. It is recommended to verify with insurance companies which codes are reimbursed.

HealthySteps Specific Note: In practices and states where there is an independently billable clinician with required training and with a scope of practice that allows for the rendering of this service (e.g., SBIRT credentialed provider), the clinician may bill for caregiver participation in screening and short-term, session-limited encounters to address a substance misuse. If more specialized or long-term treatment is necessary, the HS Specialist will refer to an appropriate professional.

HCPCS Code	Description
G0442	Annual alcohol misuse screening, 15 minutes
H0049	Alcohol and substance abuse screening (*screening only*); completed screening tool with scoring
H0050	Alcohol and substance abuse brief intervention; *per 15 minutes*

CPT Code	Description
99408	Alcohol and/or substance (*other than tobacco*) abuse structured screening and brief intervention services; *15 minutes, up to 30 minutes*
99409	Alcohol and/or substance (*other than tobacco*) abuse brief intervention services; *greater than 30 minutes (31 minutes or more)*

Tips for Reporting Alcohol and/or Substance Abuse Screenings and Interventions:

- Annual alcohol misuse screenings are provided to patients with unhealthy drinking habits that do not yet meet the medical requirements for alcohol dependency.
- An alcohol and substance abuse intervention can only be rendered if there is a positive screening.
- Documentation for alcohol and substance abuse screening must include scoring and the standardized instrument utilized. Accepted standardized instruments are at the carriers and/or state Medicaid agency's discretion. Verification of which tool(s) to utilize is recommended.
- H0050, 99408, and 99409 are time-based codes. Documentation of the time rendering the service is required.
- Some states will require approved training or certification for a clinician to render the services. Insurance carrier verification is recommended.
- Depending on the result of the screening, the physician could engage in a brief intervention, advising the patient to cut back or quit alcohol use. In practices with integrated behavioral health services, a behaviorist could meet with the patient for a more in-depth discussion or refer the patient to more formal alcohol treatment resources.
- Brief interventions include feedback about personal risk, explicit advice to change, emphasis on a patient's responsibility to change, and feedback on a variety of ways to effect change.

Smoking and Tobacco Use

Smoking and Tobacco Use Cessation (for caregivers)

Billing Guidance Definition: Smoking and Tobacco Use Cessation are considered behavior change interventions for what is considered an illness itself, such as substance abuse/misuse. Behavior changes interventions have their own billing codes that are time based and should be reported according to the time spent rendering the service.

HealthySteps Specific Note: A caregiver may participate in screening and short-term, session-limited encounters to address smoking and/or tobacco misuse. If more specialized or long-term treatment is necessary, the provider will refer the caregiver to an appropriate professional.

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Issues related to substance misuse may be identified during Tier 1 universal screenings for family needs or maternal depression. There may also be instances in Tiers 2 or 3 where caregivers come to know and trust a HS Specialist, and misuse is disclosed or becomes suspected. At this point, a provider may screen and provide short-term, session-limited encounters to the caregiver to address the need or refer to an appropriate professional.

CPT Code	**Description**
99406	Smoking and tobacco use cessation counseling visit; intermediate, *more than 3 minutes, up to 10 minutes*
99407	Smoking and tobacco use cessation counseling visit; intensive, *more than 10 minutes*

Tips for Reporting Smoking and Tobacco Use Cessation:

- Face-to-face service must be provided.
- Documentation of the counsel and/or intervention is required. The advisable content of the counsel would be to at least address the first three of the five steps below. The *advisable content of the intervention* would be to address all five steps below:

  Smoking and Tobacco Use Cessation-Five Major Steps to Intervention (The 5 As):

  1. **Ask** - Identify and document tobacco use status for every patient at every visit.
  2. **Advise** - In a clear and personalized manner, urge every tobacco user to quit.
  3. **Assess** - Is the tobacco user currently willing to make a quit to attempt?
  4. **Assist** - For the patient willing to make a quit-attempt, use counseling and pharmacotherapy to help them quit.
  5. **Arrange** - Schedule follow-up contact, preferable within the first week after the quit date.

- Smoking cessation and intervention codes are time-based, requiring documentation of time spent rendering the service. Documentation of a start and stop time is recommended.
- When rendered with an evaluation and management service, a modifier 25 will be applicable and should be appended to the evaluation and management code.
- Smoking cessation may not be separately billable if rendered during a preventive exam. Guidelines may vary from state to state for Medicaid agencies and other health care carriers. Insurance verification is advisable.

Preventive Medicine Counseling

Preventive Medicine Counseling and Risk Factor Reduction Intervention

Billing Guide Definition: 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 people without a specific illness for which the counseling might otherwise be used as part of the treatment.

HealthySteps Specific Note: Preventive medicine counseling codes are usually recognized for those providers who render physical medical services such as MDs, PAs, NPs, and RNs, but negotiations with Medicaid agencies may alter these guidelines to include behavioral health providers.

CPT Code	Description
99401	Preventive medicine counseling and risk factor reduction intervention; *15 minutes*
99402	Preventive medicine counseling and risk factor reduction intervention; *30 minutes*
99403	Preventive medicine counseling and risk factor reduction intervention; *45 minutes*
99404	Preventive medicine counseling and risk factor reduction intervention; *60 minutes*

Tips for Reporting Preventive Medicine Counseling:

- 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.
- Well-child visits should not be reported on the same day as preventive medicine counseling and risk factor reduction intervention services.
- The licensures considered to be “other qualified health care professionals” can vary across state Medicaid agencies and other insurance carriers. Health care professionals considered for reimbursement should be verified with all insurance carriers.
- Preventive medicine counseling codes are time-based, requiring documentation of the time spent rendering the service. It is recommended that the clinician document the start (admission) and stop (discharge) times.

Education Services

Behavioral Health Prevention Education Services

Billing Guide Definition: Behavioral health prevention education is used to deliver services to individuals of a target population on issues of mental health education, affecting individuals' knowledge, attitude, and behavior. It may include screenings to assist individuals in obtaining appropriate treatment.

HealthySteps Specific Note: Behavioral health prevention education service may not be open for reimbursement in your state, but negotiations with state Medicaid agencies can result in opening the code for reimbursement for specific services, including HealthySteps and HealthySteps related services. One state has successfully negotiated with their Medicaid agency which has resulted the in the recognition of this code for HealthySteps practices with specific fidelity guidelines.

HCPC Code	Description
H0025	Behavioral health prevention education service

Tips for Reporting Behavioral Health Prevention Education Services:

- HCPCS code H0025 was created for behavioral health prevention education services, mainly to target alcohol and drug abuse treatment services, but states can vary on how they utilize this code, and if they will reimburse for it. Insurance follow-up is highly recommended.
- The service may include screenings to assist patients in obtaining appropriate treatment, other than for alcohol and or drug use. Each state can negotiate what these services can be used for with their local Medicaid agency.
- Guidelines for the compliance of reporting with this code vary from state to state. Verification with your state Medicaid agency and other insurance carriers is recommended.

Family Psychoeducation Services

Billing Guidance Definition: Family psycho-education services are planned, structured face-to-face interventions that involve presenting or demonstrating information with a goal to help present relapses or development of co-morbid disorders and achieve optimal mental health and long-term resilience.

HealthySteps Note: In practices where there is an independently billable clinician with a scope of practice that allows for the rendering of this service (E.G., Licensed clinical social worker) and those that can provide services under the clinical supervision of an independently billable mental health clinician where these services fall under their scope of practice, can provide these services to children and their families. Typically, these children will be in Tiers 2 or 3 to support the patient and their family in understanding the patient's symptoms of mental illness, the impact on the patient's development, and the needed components of treatment.

HCPCS Code	Description
H2027	Family Psychoeducation individual, group, family, and family group

Tips for Reporting Family Psychoeducation for Individuals, Groups, the Family, and a Group of Families

- In some states a patient receiving psychoeducation must have a diagnosis or emotional disturbance or mental illness determined by a diagnostic assessment. Insurance verification is required. If an assessment is required, it must reflect the medical necessity for psychoeducation services (e.g., a concrete diagnosis).
- In some states this code is exclusive to patients under the age of 21. Insurance verification is required.
- Services can be rendered to individual patients, groups of individual patients, the family of a patient, and groups of the families of patients.
- Reporting the HCPCS Code for family psychoeducation services may require a billing modifier when reporting services provided to individual groups of patients (modifier HQ), multiple family groups with patients present (modifiers HQ and HR) and without patients present (modifiers HQ and HS), family psychoeducation with a patient and their family when the patient is present (modifier HR) and without the patient present (modifier HS). Insurance verification is required.
- Medical insurance authorization may be required prior to rendering services. Insurance verification is required.

Lactation Services

State Medicaid agencies and other healthcare insurance carriers reimburse for evidence-based breastfeeding education and lactation counseling consistent with the United States Preventive Task Force (USPSTF) recommendation, with specific guidelines for reimbursement eligibility. Verification with your state Medicaid agency and other health insurance carriers is required.

HCPCS Code	Description
S9443	Lactation services, non-physician; per session

Tips for Reporting Lactation Services:

- Some states only allow services to be rendered to one patient at any given time, with services billable only under the caregiver. Other states do not separately bill for lactation services and at times bundle the services into an evaluation and management code. Verification with insurance carriers is highly recommended.
- Documentation requirements may vary from state to state. Verification with your local state's Medicaid and/or insurance carriers is highly recommended.
- Diagnosis code Z39.1 (Encounter for care and examination of lactating mother) will support medical necessity for the services.
- Professional licensures vary for reimbursement. Reimbursable non-physician licensures vary from state to state and should be verified. Approved lactation consultant certification agencies vary from state to state. Verification is required.

Self-Management Education and Training/Community Health Integration Services

State Medicaid agencies and other healthcare insurance carriers reimburse for self-management education and training, and Community Health Integration services, for the services provided by a Community Health Worker.

Billing Guide Definition: ***Self-management education and training,*** face-to-face, 30 minutes for either 1 patient, 2-4 patients, and 5-8 patients. In some states, self-management education and training codes are being utilized to report those services rendered by a community health worker. ***Community Health Integration services,*** performed by certified or trained auxiliary personnel, including a community health care worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, and each additional 30 minutes, per calendar month. These codes are recognized in one state to report specific CHW services. (See," Tips for Reporting Services," on next page.)
HealthySteps Specific Note: In states and practices where community health worker services are recognized for reimbursement, a HealthySteps Specialist whose license may not be recognized for independent billing for HealthySteps services and/or related services, can consider becoming a community health worker for revenue maximization opportunities, where their services will be supervised and billed by an eligible, billable provider.

CPT Code	Description
98960	Self-management education and training, face-to-face, 30 minutes, for 1 patient
98961	Self-management education and training, face-to-face, 30 minutes, for 2-4 patients
98962	Self-management education and training, face-to-face, 30 minutes, for 5-8 patients
G0019	Community Health Integration (CHI) services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month.
G0022	CHI Services, each additional 30 minutes per calendar month (Report in addition to G0019, when applicable.)

Tips for Reporting Services:

- Face-to-face service must be provided.
- Self-management education and training codes are time-based, requiring documentation of time spent rendering the service. Documentation of a start and stop time is recommended.
- If the codes are open in your state for community health worker services, verification with your local state's Medicaid and/or insurance carriers is highly recommended on the training and/or life experience requirements for becoming a community health worker.
- Community health worker service guidelines may differ from state to state, verification with insurance carriers is required.
- In addition to the time spent rendering the service, documentation requirements include patient's eligibility for community health worker services, the issues being addressed during the visit(s), and the applicable services being rendered to the patient to address the issues.
- CHI services are recognized to specifically address social determinants of health needs that are significantly limiting the ability to diagnose or treat problems. The time-based billing codes are reported monthly, meaning they are only reported once a month, when at least 60 minutes of accumulated time was spent providing the services throughout a given month.
- The billing codes for CHI services (G0019, G0022) include an add-on code. Add-on codes are codes that can never be reported by themselves, but only in conjunction with another code. G0022 is the add-on code to G0019, indicating that G0022 cannot be reported without G0019.

Case Management

Case Management Medical Team Conference

Billing Guidance Definition: State Medicaid agencies and other healthcare insurance carriers reimburse for interdisciplinary team medical conferences when conducted wither with or without the patient and/or family member(s) present, **to discuss a patient's treatment plan**. The interdisciplinary **team must consist of more than one medical specialty**. (e.g., medical provider(s) and behavior/mental health providers).

HealthySteps Specific Note: The billing codes for medical team conference with interdisciplinary team of health care professionals by a nonphysician health care professional, are for those billable mental health clinicians (HealthySteps Specialists) that participate in the medical team conference to discuss a patient's treatment plan. Typically, these children will be in Tiers 2 or 3.

CPT Code	Description
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, **participation by nonphysician health care professional.**
99368	Medical team conference with interdisciplinary team of health care professionals when patient and/or family is not present. 30 minutes or more, **participation by nonphysician health care professional.**

Tips for Reporting Case Management Medical Team Conference Services:

- These codes can only be reported for the participation of a non-physician qualified health care professional, when the medical conference is comprised of an interdisciplinary team of professionals (more than one specialty-e.g., primary care physician, specialized physicians, and behavior/mental health provider, when the patient's treatment plan is reviewed, and discussed.
- All participants must be immediately involved in the care or recovery of the patient.
- Documentation requirements include, the names of the medical team participants and their professional specialty, the name of the family member(s) who participated and their relationship to the patient, the treatment plan discussed, including the patient's diagnosis, the behavioral health clinician's participation in the conference, and the length of time of the medical conference.
- If the codes are open in your state, verification with your local state's Medicaid and/or insurance carriers is highly recommended on which professional licensures are authorized to bill for the service.
- A concrete mental health diagnosis may be required to bill for the services. Verification with your local state's Medicaid and/or insurance carriers is highly recommended.

General Behavioral Health Integration Care Management

State Medicaid agencies and other healthcare insurance carriers reimburse for general behavioral health integration management for care management services rendered to patients with behavioral health conditions, when at least 20 minutes of clinical staff time is provided to the patient, under the direction of a physician or other qualified health care professional, per calendar month.

Billing Guide Definition: At least 20 accumulative minutes per month of care management services are provided to a patient by a member(s) of the patient's care management team.

HealthySteps Specific Note: In states and practices where general behavioral health integration care management services are recognized for reimbursement, a HealthySteps Specialist whose license may not be recognized for the independent billing of HealthySteps services and/or

related services, can become part of a patient's care team (if provider guidelines in your state for these services allow) which permits the HealthySteps Specialist to be a contributing factor to the reimbursement received for services.

CPT Code	Description
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month.

Tips for Reporting General Behavioral Health Integration Care Management:

- General behavioral health integration care management services are provided by clinical staff, under the direct supervision of a physician (primary care physician) or other qualified health care professional, which must be verified with state Medicaid agencies and other health care providers. (Examples of clinical staff members include, but are not limited to, social workers and psychologists.) Services must be prescribed by a supervising physician (primary care physician).
- Patients must be diagnosed with a behavioral health condition, including substance use issues, that require care management services for a minimum of 20 minutes per calendar month (whether face to face or non-face to face).
- The elements of these services are as follows:
    - An initial assessment of behavioral health condition or follow-up monitoring, including the use of applicable validated rating scales.
    - Behavioral health care planning in relation to behavioral/psychiatric health problems including revisions for patients who are not progressing or whose status changes.
    - Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation.
    - Continuity of care with a designated member of a care team.
    - Patient consent (verbal or written) must be obtained.
- Documentation requirements include patient's consent, the names of the physician who is directing the services, if patient is a child, the name of the family member(s) who is responsible for the patient, in addition to their relationship to the patient, the care management provided, including the patient's diagnosis, the behavioral health clinician's participation and the care management services provided, including how they were provided (either face-to-face or non-face-to-face.) Documentation requirements also include the time spent with the patient rendering the service each time either a face-to-face or non-face-to-face encounter occurs, where the cumulation of at least 20 minutes of service, per calendar month must be accounted for. The time spent strictly on administrative duties should not be counted towards the time threshold to bill for general behavioral health integration case management.
- The reporting of these services can only occur once a month and is billed under the treating physician (primary care physician).

HealthySteps Billing & Coding Opportunities – Pathways to Reimbursement

Targeted Case Management

Billing Guidance Definition: Targeted case management (TCM) assists patients with complex healthcare needs in accessing and coordinating medical, social, education, and other necessary services tailored around their care plan. The services are billed in 15-minute increments and require a single case manager but not explicitly mandate a full care team structure.

HealthySteps Specific Note: The purpose of TCM is to address a patient's complex healthcare needs and to coordinate the assistance they may need, including addressing their social needs. The goal is to improve the patient's healthcare outcomes and ensure the patient has timely access to the services needed. Services are used to support the patient's overall well-being. Typically, working with the family and children receiving TCM services, will be in Tiers 2 or 3. Professionals that can bill for this service must be verified with insurance carriers.

CPT Code	Description
T1017	Targeted case management, each 15 minutes

Tips for Reporting Targeted Case Management:

- Key aspects of TCM services include a comprehensive assessment to evaluate a patient's medical, social, and psychological needs to identify areas requiring support, care plan development to outline goals and interventions, service coordination to facilitate arranging appointments, communication between health care providers and to ensure access to necessary services, patient education regarding their health condition and treatment options, and progress monitoring to review the patient's progress toward goals and adjusting the care plan as needed.
- A chronic medical condition (e.g., pediatric feeding disorders, low birth weight and prematurity, asthma, anemia) is required and/or a concrete mental health disorder (e.g., attention-deficit/hyperactivity disorder, reactive attachment disorder, separation anxiety disorder), and/or a developmental disability (e.g., autism spectrum disorder). Insurance verification is required as this can vary within state Medicaid agencies.

General Case Management

Billing Guidance Definition: General case management (General CM) aims to help patients navigate the healthcare system, ensuring they get appropriate care that may require coordination among multiple providers or assistance in helping access needed community resources or support services. The services are billed in 15-minute increments where the rendering of services requires a single case manager and does not explicitly mandate a full care team. Verification with insurance carriers is required.

HealthySteps Specific Note: The purpose of General CM is to provide support, representing the patient's and their family's interests and navigating complex systems to access the services needed to help them achieve the goals in their personalized care plan. Typically, these children will be in Tiers 2 or 3.

CPT Code	Description
T1016	General case management, each 15 minutes

Tips for Reporting General Case Management:

- Keys aspects of General CM services include intake and assessment to evaluate a patient's needs, including medical history, social situation and potential risks, it also involves development of a personalized plan with goals and interventions based on the assessment. Keys aspects also include communication and coordination with other healthcare providers, community agencies, and patient support systems (their family) to ensure care delivery. Monitoring the patient's progress towards goals and representing the patient' interests while navigating complex systems to help them access the services they need, are also key aspects of the service.
- In most states a behavior/mental health diagnosis is required. Insurance verification is required.
- Example of behavior/mental health/ developmental conditions recognized for TCM are autism spectrum disorder and attention-deficit/hyperactivity disorder. Insurance verification is required as this can vary within state Medicaid agencies.

Interpretation of Results

Interpretation and/or Explanation of Results

Billing Guide Definition: Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons or advising them how to assist patient.

HealthySteps Specific Note: In states where interpretation of results is recognized for insurance carrier reimbursement. A HealthySteps Specialist who is recognized for the billing of the service, can report its billing code when there is a mental/behavioral health diagnosis and a

more in depth conversation is being had on the results of any of the tests or procedures that were rendered, as well as a conversation on how to care for the patient due to the results of the tests and/or evaluated data on the patient's diagnosis.

CPT Code	Description
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons or advising them how to assist patient.

Tips for Reporting Interpretation or Explanation of Results:

- The procedures may be performed by a physician or other qualified healthcare professional (HealthySteps Specialist who can, under their licensure, provide the service(s).
- The service indicates that the provider has explained to the patient's family/caretaker, the examinations, procedures and other accumulated data performed on the patient to obtain the responsible parties' participation and/or support in the patient's treatment.
- Documentation should clearly identify all evaluated data, was well as the provider's interpretation of the data evaluation.

Mental Health Consultation

Children's Mental Health Clinical Consultation

Billing Guide Definition: A children's mental health consultation is communication between the treating mental health professional and other providers or educators who are working with the same patient, to discuss issues about the patient's symptoms, and strategies for effective engagement and care interventions, including treatment expectations.

HealthySteps Specific Note: In states where children's mental health clinical consultations are recognized for insurance carrier reimbursement, a HealthySteps Specialist who is recognized for the billing of the service, can report its billing code when there is a mental/behavioral health diagnosis and a conversation between the patient's healthcare providers is being had on how to care for the patient. Services also include providing clinical service components to the family of the child. Typically, these children will be in Tiers 2 or 3.

CPT Code	Description
90899	Children's mental health clinical care consultation, face-to-face; 5-10, 11-20, 21-30, and 31+ minutes.

Tips for Reporting Interpretation or Explanation of Results:

- The billing code for children's mental health clinical consultation is to be reported by the mental health professionals eligible within your state Medicaid agency, to bill for the services.
- In addition to discussing issues about the patient's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations, discussions should also surround the clinical service components provided to the patient and their family and any changes that may be needed to assist the patient in care.
- These services are time-based services where some state Medicaid agencies will require the reporting of billing modifiers, dependent on the time spent in a children's mental health clinical consultation (E.g., 5-10 minutes requires a U8 modifier, 11-20 minutes requires a U9 modifier, 21-30 minutes requires a UB modifier, and 31 minutes or more requires a UC modifier). Insurance carrier verification is required.

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