New York State: HealthySteps PPS Billing and Coding Guide

The HealthySteps National Office Policy & Finance Team

About this Document

The purpose of this document is to support HealthySteps sites (practices) that have opted into New York's Prospective Payment System (PPS) Medicaid Reimbursement methodology, in coding and billing for HealthySteps-aligned services. HealthySteps sites can bill Medicaid and Medicaid Managed Care carriers for some of the services they provide to children and families.

This document provides a list of open Current Procedural Terminology (CPT)[1] and Healthcare Common Procedure Coding System (HCPCS)[2] codes, with applicable billing, coding, and documentation guidelines.

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

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

[1] Current Procedural Terminology (CPT) is a medical code set that is used to report and bill for medical, surgical, and diagnostic services.

[2] The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes used to report and bill for medical services, supplies, and procedures

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.

Table of Contents

What is the Prospective Payment System (PPS)?....3

Applicable CMS Guidelines....4

New York State Medicaid Reimbursable Clinicians Rendering HealthySteps-Aligned Services....4

Use of Medical Coding Modifiers Applicable to HealthySteps-Aligned Services/ Reporting of Units....5

Services Rendered by Social Workers....6

HealthySteps-Aligned Services....8

Child Developmental, Social-Emotional Screenings....8

Screening for Depression....9

Screening for Adverse Childhood Experiences (ACEs)....10

Health and Behavior Assessment/Re-assessment/Intervention with/without the Family Present.... 11

Care Management: General Behavioral Health Intervention....13

Psychiatric Diagnostic Evaluation....14

Psychological, Neuropsychological, Developmental Test Administrations and Evaluations....15

Interactive Complexity....18

Psychotherapy....20

Health and Behavior Assessment, Re-assessment/Individual Intervention....24

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services....25

Smoking Cessation....27

Lactation Services....28

eVisits....29

Community Health Worker Services....30

Sources....34

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What is the Prospective Payment System (PPS)?

A Prospective Payment System (PPS) refers to the Center for Medicare and Medicaid Services (CMS) reimbursement system where a fixed payment rate is assigned to reimbursable treatments. While these rates may change over time due to factors such as inflation, they are not adjusted to accommodate individual patients. A healthcare provider will always receive the same payment amount for the specific treatment, regardless of the intensity of the service provided.

When billing under a PPS, New York State Medicaid offers billing guidance in provider manuals, personalized for each specific provider type, which deliver information on claim submission, reimbursable codes, and remittance guidelines. For more information, please see: https://www.emedny.org/ProviderManuals/.

Parent/Caregiver Services:

HealthySteps-aligned services include services for the entire family, and NY Medicaid and Medicaid Managed Care Plans provide reimbursement for services on the adult and caregiver side when the parent/caregiver is a patient at the same site where the child receives services. Although these services cannot be billed under a child's Medicaid number, reimbursement for services such as,

- Smoking cessation counseling,
- Alcohol and substance abuse interventions,
- Individual psychotherapy,
- Family psychotherapy, and
- Virtual communication,

may be available when the parent/caregiver is also a patient, where the services would be billed under the parent(s)/caregiver (s) Medicaid number.

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Applicable CMS Guidelines

New York State Medicaid Reimbursable Clinicians Rendering HealthySteps-Aligned Services:

NY State Medicaid recognizes reimbursement for HealthySteps-aligned services rendered by the following provider types, when working under their scope of practice.

- Physician
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Certified Nurse Midwife (CNM)/Licensed Nurse Midwife (LNM)- Verification with insurance carriers is required.
- Registered Nurse (RN) or Licensed Practical Nurse (LPN)-for limited circumstances only. Verification with insurance carriers is required. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) may not be eligible for reimbursement for claims submissions for RNs and LPNs)
- Certified Lactation Professionals:
    - International Board-Certified Lactation Consultant (IBCLC)
    - Certified Lactation Specialist (CLS)
    - Certified Breastfeeding Specialist (CBS)
    - Certified Lactation Educator (CLE)
    - Certified Clinical Lactationist (CCL)
    - Certified Breastfeeding Educator (CBE)
- Psychiatrist
- Licensed Clinical Psychologist (LCP)
- Licensed Clinical Social Worker (LCSW) and Licensed Master Social Worker (LMSW)-Supervised by an LCSW or Psychiatrist.
- Licensed Mental Health Counselor (LMHC)
- Licensed Marriage and Family Therapist (LMFT)

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Use of Medical Coding Modifiers Applicable to HealthySteps-Aligned Services

Medical coding modifiers, referred to as modifiers, are composed of two alpha or numeric characters, that when appended to a billing code, will provide additional information about the services rendered, without changing the meaning of the billing code.

The following modifiers are applicable to the billing of HealthySteps-aligned services:

- **Modifier 25** (Distinct Service): This modifier is used when there is a significant, separately identifiable evaluation and management (E&M) service by the same physician on the same date of service as a significant procedure.
  Modifier 25 should be used on an E&M code only when the patient's condition requires a significant, separately identifiable service above and beyond the significant procedure performed on the same date of service (e.g., unexpected screening during a well child visit).

- **Modifier 59** (Separate Procedures or Distinct Procedural Service): This modifier is used to designate instances when distinct and separate multiple services with the same CPT are provided to the patient on a single date of service (e.g., Different screenings that utilize the same CPT code).

- **Modifier HD** (pregnant/parenting women's program): This modifier is used to designate when a depression screening is rendered for the screening of postpartum depression. New York State Medicaid requires its use when billing for G8510 (Screening for depression, documented as negative), and G8421 (Screening for depression documented as positive with a required follow-up plan).

- **Modifier XE** (Separate encounter, a service that is distinct because it occurred during a separate encounter.): This modifier is used to describe 2 separate patient encounters that occurred on the same date of service, by the same provider. It is reported when a patient has two distinct visits with the same provider, on the same day, with a clear break in care between the encounters.

- **Modifier XP** (Separate practitioner, a service that is distinct because it was performed by a different practitioner)**:** This modifier is reported when two different providers render services on the same day for the same patient, as it indicates that the service was performed by a "separate practitioner' and is distinct from the other service provided on the same date; essentially signifying that the services were not bundled together even though they occurred on the same day.

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Reporting of Units

There may be times when your practice is required to report units upon claim submission for services. Units of service can be measured by units of time, or number of services. An example of when the reporting of units for a billing code is applicable to a HealthySteps-aligned service can be seen when billing for the ASQ®-3 and the M-CHAT. Both screenings utilize CPT code 96110 for reporting. If both are rendered on the same day, a quantity of, "2," will need to be appended to the billing code upon claim submission. With this example, there will also be a modifier required to identify that the 2 screenings being billed for are distinct procedural services and when looking to the modifiers that are applicable to the billing of HealthySteps-aligned services, you will see that modifier 59 would be the correct choice.
CMS guidelines surrounding the reporting of units include:

- Multiple lines on a single claim with the same billing code, to signify the provision of multiple units of a single procedure/service should not be submitted.
- One must enter a given CPT code, once, on an APG claim, with the number of units of service provided on that same line.

Services Rendered by Social Workers

The New York State Department of Health will allow licensed clinical social workers (LCSWs) to receive reimbursement for **services provided within their scope of practice in private practice settings** for all Medicaid members, and they continue to recognize services rendered by licensed master social workers (LMSWs) when services are supervised by an LCSW, or LCP, or psychiatrist.

Population Approved for Services

Prior to September 2024, coverage for mental health counseling provided by LCSWs and LMSWs **rendered in Article 28 clinics,** were limited to patients under the age of 21, and pregnant women up to 12 months postpartum (based on the date of delivery or end of pregnancy)**.** Effective post September 2024, NYS Medicaid and Medicaid Managed Care Organizations , in accordance with changes to Public Health Law (PHL) §2807, have expanded the coverage of mental health counseling provided by a Licensed Clinical Social Worker (LCSW) or licensed Master Social Worker (LMSW). Coverage of mental health counseling now **includes ALL ages and patient populations.**

Services

- Mental Health Service-Psychotherapy
    - Individual and family counseling
- Smoking and tobacco use cessation
    - 3-10 minutes

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    - More than 10 minutes
- Virtual Communication
    - At least 5 minutes of telephone communication which is initiated by the patient for a medical discussion.
- Psychiatric Diagnostic Evaluation

LCSW/ Psychologist/Psychiatrist Supervision of an LMSW

LCSWs may supervise up to six (6) LMSWs in either a private practice or clinical setting.

LCSW's supervise LMSW's by providing at least 2 hours, per month, of in-person or secure virtual individual/group supervision, discussing diagnoses, treatment plans, and reviewing the LMSW's work, with the LCSW bearing legal responsibility for the client's care and maintain records. This supervision ensures the LMSW gains skills in psychotherapy under direct oversight, as the LMSW cannot practice clinical social work independently and requires a qualified LCSW, psychologist, or psychiatrist.

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Child Developmental and Social-Emotional Screenings

Evaluating and promoting optimal child development and well-being includes screenings. Screenings, including those for social-emotional and child development, are core components of HealthySteps-aligned services. The table below highlights pertinent billing codes, their descriptions, reimbursable clinicians, and applicable guidelines.

CPT Code	Description	ICD-10 Code	Reimbursable Clinician(s)	Applicable Guidelines
96110	Developmental milestone survey, speech and language delay with scoring and documentation, per standardized instrument. Examples: **ASQ-3, M-CHAT-R/F, Milestones, PEDS, SWYC-milestones, POSI**	Z13.42-Developmental delays (Milestones) Z13.41 -Autism screening	Physician Qualified Health Care Professionals: • Physician Assistant, • Nurse Practitioner, • Certified Nurse Midwife	When rendering services for more than one screening with the same CPT code, Modifier 59 must be appended to the billing code upon claim submission. Medicaid will reimburse for global developmental (milestone) screenings provided by the primary care physician for up to one time per year in the first three years of a child's life. Medicaid will reimburse for Autism screenings, provided by the primary care physician, up to two times in a child's first three years of life, beginning at 18 months of age. Effective 1/1/2022 for FFS Medicaid and 4/1/2022 for Medicaid Managed Care Plans, NYS Medicaid will provide separate reimbursement (in addition to the reimbursement for Evaluation and Management Office Visit Services) for general developmental screenings (Milestones), and autism screenings. Verification with insurance carriers must be made on if psychologists, LCSWs and LMSWs working under clinical supervision, can render screenings to patients to be billed under those reimbursable clinicians.
96160	Patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument.	Z13.9-Report for health risk assessments		
96161	Caregiver-focused health risk assessment instrument with scoring and documentation, per standardized instrument.	Z13.9-Report or health risk assessments (for caregiver)		
96127	Social-Emotional Brief emotional/behavioral assessments. Examples: **ASQ®:SE-2, ASAS, BYI-2, BASC-2, BRIEF®-2, BISTEA, CRS-R™, BPSC, PPSC, SCARED, ECSA, GAD-7, ASC-Kids, TSCC, & TSCYC, ADHD Rating Scales**	Z13.89-Screenings for all other		

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Screening for Depression

CMS recognizes depression screenings, including postpartum depressions screenings, for reimbursement, when utilizing a validated screening tool.

Postpartum maternal depression screenings may be reimbursed up to four times within the first year of the infant's life. Screening can be done by either the mother's and/or the infant's health care provider, following the birth of the baby. The infant's primary health care provider has a unique opportunity to identify postpartum maternal depression and help prevent unfavorable development and mental health outcomes. Screening should be integrated into the well-infant visit schedule.

CPT Code	Description	ICD-10 Code	Reimbursable Clinicians	Applicable Guidelines
G8510	Screening for depression, documented as negative. Exemples : **PHQ-9, EPDS, BDI, CES-D Scale, PDSS**	Z13.32- Maternal depression screening Z13.31- Depression screening, other than maternal	Physician Licensed Clinical Psychologist (LCP) <u>Qualified Health Care Professionals:</u> • Physician Assistant (PA) • Nurse Practitioner (NP) • Certified Nurse Midwife (CNM) Licensed Clinical Social Worker and Licensed Master Social Worker under their clinical supervision or the supervision of an LCP. - Verification at FQHCs and RHCs is required	NYS Medicaid recognizes both "G" codes for the reimbursement of depression screenings. The diagnosis selected will identify the population the screening was rendered to. (Maternal depression, or depression screenings other than maternal). When rendering services for a postpartum maternal depression screening, modifier "HD" must be appended to the billing code upon claim submission. Postpartum depression screenings can be billed either under the infant's Medicaid number or the mother's Medicaid number and will be reimbursed for up to four times within the first year of an infant's life. Verification with insurance carriers must be made on if LCSWs and LMSWs working under clinical supervision can render screenings to patients to be billed under those reimbursable clinicians.
G8431	Screening for depression documented as positive: follow up plan is required. Examples: **PHQ-9, EPDS, BDI, CES-D Scale, PDSS**			

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

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Screening for Adverse Childhood Experiences (ACEs)

ACEs are associated with increased risk of poor mental health outcomes. They are strongly related to brain development and a wide range of health problems throughout the lifetime of an individual. Currently, approximately 30% of HealthySteps sites use ACEs screeners with their families, and effective January 1, 2024, with New York State Medicaid Fee-for-Service (FFS), and **effective April 1, 2024, with Medicaid Managed Care (MMC) plans, reimbursement will be made available for the ACEs screening when conducted in the primary care setting for children and adolescents up to 21 years of age with an expansion effective 1/1/2025 that includes the coverage of an ACEs screening, once in their lifetime for adult patients ages 21-65 years of age.** The table below highlights pertinent billing codes, their descriptions, reimbursable clinicians, and applicable guidelines.

CPT Code	Description	ICD-10 Code	Reimbursable Clinicians	Applicable Guidelines
G9919	Screening was performed and positive and provision of recommendations. Examples: **PEARLS, ACEs Questionnaire for adults**	Recognized diagnoses to report with an ACEs screening was not included in the NYS Medicaid guidance but if there is an ICD-10, Z-code that represents any present social determinant(s) of health, it should be reported upon billing	Physician Nurse Practitioner Licensed or unlicensed providers under the supervision of a licensed provider (to be billed under that licensed provider) with training and experience using the screening tools and delivery of trauma-informed care	Screening is included within the PPS primary care rate for FQHCs. Caregivers should complete the screening on behalf of children under 13 years of age. Identification of a positive or negative result must be documented. A review of the screening must also be done with the patient and/or the parent/caregiver. If the result is positive, the provider must consider the factors that influence the risk of the child for associated negative outcomes and develop a treatment plan in partnership with the patient or parent/caregiver. Providers can make referrals to appropriate resources such as mental health providers or community-based organizations.
G9920	Screening performed and negative. **PEARLS, ACEs Questionnaire for adults**			

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Health and Behavior Assessment/Re-assessment, and Interventions with or without the Family Present

Health and behavior assessment/re-assessment, and interventions, are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the 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 and intervention is on factors complicating the medical conditions and treatments. These codes describe assessments and interventions to improve the patient's health and wellbeing utilizing psychological and/or psycho-social assessments designed to ameliorate specific disease-related problems.

The Health and Behavior Assessment or Re-assessment code identifies and reports the assessment of psychological, behavioral, emotional, cognitive, and relevant social factors that can prevent the treatment or management of physical health problems. The assessment or re-assessment must be associated with an acute or chronic illness. Health and Behavior Intervention codes report intervention services for the factors relevant to and affecting the patient's physical health problem(s).

The table on the following page highlights the billings codes, their descriptions, the reimbursable clinicians, and guidelines for health and behavior assessments/re-assessments, and interventions with or without the family present.

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Health and Behavior Assessment/ Re-assessment		Reimbursable Clinician(s)	Applicable Guidelines
CPT Code	**Description**		
96156	Health and behavior assessment or re-assessment (e.g., health-focused clinical interview, behavioral observations, clinical decision making)	Physician Nurse Practitioner (NP) Physician Assistant (PA) Certified Nurse Midwife (CNM) Licensed Clinical Psychologist (LCP)	Services do not focus on the mental health of a patient, but rather on the biopsychosocial factors that are, or could affect the treatment of, or severity of, the patient's **physical condition.** Patient must have an established illness or symptom(s) and cannot have been diagnosed with a mental illness. 96156 can be billed only once per day regardless of the amount of time required to complete the overall service. These services cannot be reported on the same day as preventive medical counseling or risk factor reduction codes, when rendered by the same provider. These services cannot be reported on the same day as psychiatric services. 96168 is an add-on code for 96167, indicating that it can only be reported with 96167 if the additional time indicated in its description was rendered and documented for. When services are rendered by a physician, PA, and NP, these codes may not be recognized for reimbursement. Insurance carriers may require the billing of evaluation and management office visit codes. Verification is required. Documentation for assessment or reassessment services should include, but is not limited to, the patient's physical illness (health focus interview), and identification of the factors that are either preventing successful treatment and/or management of the illness. Documentation should also include how these risk factors that are impeding on the successful management of the illness or are preventing treatment. 96171 is an add-on code for 96170, indicating that it can only be reported with 96170 if the additional time indicated in its description was rendered, and documented for. Documentation for intervention services should include, but is not limited to, the time spent rendering the service, the patient's physical diagnosis, identification of the factors and the reasons why they are impeding successful treatment and/or management of the patient's physical illness. Additionally, the name of the family members, their relationship to the patient, and their involvement in the patient's care must also be documented.
Health and Behavior Intervention with and without Family Present			
96167 and 96168	96167-Health and behavior intervention, family **with** patient present. Face-to-face; initial 30 minutes 96168-Healh and behavior intervention, family **with** patient present. Face-to-face; each additional 15 minutes		
96170 and 96171	96170-Health and behavior intervention **without** the patient present. Face-to-face; initial 30 minutes 96181-Health and behavior intervention **without** the patient present. Face-to-face; each additional 15 minutes		

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Care Management: General Behavioral Health Integration

Integrating mental and behavioral health in the primary care setting is an effective strategy for improving outcomes for patients with behavioral health conditions. Medicaid recognizes General Behavioral Health Integration services for the reimbursement of care management services for patients with behavioral health conditions, when at last 20 minutes of services have been rendered to the patient, per calendar month, when **billed by a supervising physician (primary care physician) for services rendered by that physician and/or other clinical staff members. Examples of clinical staff members include, but are not limited to, social workers and psychologists.** (Verification with insurance carriers on the additional clinicians recognized as eligible clinical staff, is required.)

The table below highlights the billings codes, their descriptions, and pertinent service guidelines for General Behavioral Health Integration Care Management.

CPT Code	Description	ICD-10 Code	Reimbursable Clinicians	Applicable Guidelines
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	Diagnosis codes for mental/ behavioral health conditions	Supervising Physician	Services must be prescribed and billed by a supervising physician. Care planning is required and must be related to behavioral /psychiatric health problems, including revision for patients who are not progressing or whose status has changed. Services include facilitating and coordinating treatment such as pharmacotherapy, psychotherapy, and/or psychiatric consultation (if required), and continuity of care with a designated member of the patient's care team (supervising physician and clinical staff), follow-up monitoring and use of applicable rating scales. Documentation of the time spent with the patient rendering the service is required in each note, where the cumulation of at least 20 minutes of service per month must be accounted for. Time spent strictly on administrative duties should not be counted towards the time threshold to bill for general behavioral health integration case management.
G0511 *(For FQHCs and RHCs)*	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 **(Medicaid designated this billing) code for FQHCs and RHCs reporting this service)**			

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Psychiatric Diagnostic Evaluation

A psychiatric diagnostic evaluation is used to diagnose problems with behaviors, thought processes, and memory. Assessments must be provided, followed by appropriate recommendations for treatment.

The table below highlights the billing code, its description, reimbursable clinicians, and guidelines for reporting psychiatric diagnostic evaluations.

CPT Code	Description	Reimbursable Clinicians	Applicable Guidelines
90791	Psychiatric diagnostic evaluation	Licensed Clinical Psychologist (LPC) Psychiatrist Licensed Clinical Social Worker (LCSW) and Licensed Master Social Worker (LMSW) under the supervision of an LCSW or LCP or psychiatrist	Services for an evaluation assessment includes assessment of the patient's psychosocial history, current mental status, reviewing and ordering diagnostic studies followed by appropriate treatment recommendations, a description of behaviors and when they occur and how long they last, which behaviors most often happen and under what conditions, and how behaviors impact performance in school, daycare, and other activities and relationships with others (E.g., parent(s)/caregiver(s), sibling(s). Interviews and communication with family members or other sources are included with the reporting of 90791. Communication factors that complicate diagnostic evaluations may result in the need for interactive complexity and can be reported in conjunction with the evaluation (See interactive complexity). Since diagnostic evaluations include continuing psychiatric evaluation, psychotherapy codes are not to be reported with diagnostic evaluations on the same date of service. Care managers can include psychologists and licensed clinical social workers, but psychiatric evaluations are only reimbursable when billed under those clinicians that are indicated as reimbursable. All services that are required and rendered must be included in the documentation.

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Psychological, Neuropsychological, and Developmental Test Administrations and Evaluations

Not to be confused with screenings, psychological, neurological, and developmental testing and evaluation involves more extensive services to be rendered. Information for each of these services is highlighted below.

Psychological Test Administration and Evaluation

Psychological testing and evaluation are measures of mental functioning including personality, emotions, and intellectual functioning. Rendering this service is at the clinician's judgement, where the reason(s) for his/her decision to render the service should be documented in the medical record. Some signs that psychological testing and evaluation may be necessary include significant social withdrawal, difficulties with speech and concentration, and significant difficulties with social activities including school and daycare. Approved testing tools must be verified with insurance carriers.

The table below highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for the reporting of psychological testing and evaluation.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96130	Psychological testing and evaluation; first hour	Licensed Clinical Psychologist (LCP)	Testing is reimbursable when a current medical or mental health evaluation has been conducted, and a specific diagnostic or treatment question still exists which cannot be answered by a psychiatric diagnostic evaluation and history-taking. Integration of patient data, interpretation of standardized test results, clinical data, decision making and interactive feedback to patient(s)/caregiver(s), including treatment plan and reporting mut be rendered and documented for in the patient's medical record. Because these are time-based codes, the total time rendering and interpreting the service must be documented, E.g., a start and stop time.
96131	Psychological testing, evaluation, each additional hour after the first hour of service		96131 is an add-on code for 96130, signifying it can only be billed with 96130, when an additional hour of service is rendered, after the first hour of service was rendered.

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Neuropsychological Test Administration and Evaluation

Neuropsychological testing and evaluation measure a child's intellectual abilities, attention, learning, memory, visual-spatial skills, visual-motor integration, language, motor coordination, neurocognitive abilities, and executive functioning skills such as organization and planning. It may also address emotional, social, and behavioral functioning.

The table below highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for reporting neuropsychological testing evaluation services.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96132	Neuropsychological test(s) administration(s) and evaluation(s); first hour. Face-to-face services	Licensed Clinical Neuropsychologist Licensed Clinical Psychologist (LCP) **(verification with insurance carriers is required)**	Service and documentation requirements include its medical necessity, test with results and interpretation, clinical data and decision making, treatment planning, and interactive feedback to the patient and/or parent(s)/caregiver(s). Because these are time-based codes, the total time rendering and interpreting the service must be documented for. E.g., a start and stop time. Neuropsychological testing may be rendered by a licensed clinical psychologist when consistent with the scope of license and competency of the provider.
96133	Neuropsychological test administration and evaluation, each additional hour after the first hour of service		96133 is an add-on code for 96132, signifying it can only be billed with 96132, when an additional hour of service is rendered, after the first hour of service was rendered.

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Developmental Testing with Interpretation

Developmental testing is not to be confused with developmental screenings. Screenings identify who may be at risk, while testing develops more of a concrete picture. Testing involves the assessment of fine and/or gross motor/language, cognitive level, social, and memory or executive functions where the interpretation of the standardized test results and clinical data is included. Testing is reimbursable when a child has signs concerning developmental delay or loss of previously acquired developmental skills or when a developmental screening test presents red flags. Approved testing tools must be verified with insurance carriers.

The table on the following page highlights the billing codes, their descriptions, reimbursable clinician, and guidelines for reporting a developmental test administration.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96112	Developmental test administration including assessment of fine and /or gross motor, language, cognitive level, social, and memory or executive functions by standardized developmental instruments with interpretation and report, initial hour	Licensed Clinical Psychologist (LCP) Psychiatrist	The billing code applies to testing for developmental disorders. Reporting should include objective and subjective assessment. Why testing was provided, which standardized test instrument was used, test results, interactive feedback with patient and/or parent(s)/caregiver(s), and any appropriate actions taken are required and must be included in your documentation. Because these are time-based codes, the total time rendering and interpreting the service must be documented for. E.g., a start and stop time.
96113	Developmental test administration; each additional 30 minutes after the first hour of service		96113 is an add-on code for 96112, signifying it can only be billed with 96112, when an additional 30 minutes of service is rendered, after a full hour of service was rendered.

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Interactive Complexity

Interactive complexity is an add-on code specific for reporting with certain psychiatric services. It is billed to report communication difficulties during the visit. Interactive complexity can involve the use of:

- Physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or
- Has lost either expressive language, communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if she/he was to use ordinary adult language for communication.

Interactive complexity can be reported when **at least one** of the following communication factors is present during the visit (these communication factors are considered to additionally increase the intensity of services):

- The need to manage maladaptive communication related to high anxiety, high reactivity, repeated questions, or disagreement among participants 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 the patient to overcome barriers to therapeutic or diagnostic interaction 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: To align with federal and the Center of Medicaid/Medicare Services (CMS) required language, effective 1/2022, Current Procedural Terminology (CPT) guidelines removed the use of interpreters and translator services from the list of communication factors that support medical necessity when coding for interactive complexity but when **Licensed Clinical Social Workers, Licensed Mental Health Counselors and Licensed Marriage and Family Therapists render sign language or oral interpreter services**, CMS recognizes the reporting of HCPCS code T1013 for 15 minutes of these services when rendered to patients by these mental health professionals.

The table below highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for reporting interactive complexity.

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CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90785	Interactive complexity	Licensed Clinical Psychologist (LCP) Psychiatrist Licensed Clinical Social Worker (LCSW) and Licensed Master Social Worker (LMSW) under the clinical supervision of an LCSW or an LCP or a Psychiatrist Licensed Mental Health Counselor (LMHC) Licensed Marriage and Family Therapist (LMFT)	90785 is an add-on code, meaning it cannot be reported on its own and can be billed in conjunction with other services. The approved services that interactive complexity can be billed with are, • Psychiatric evaluations (90791, 90792) • Psychotherapy services (90832, 90833, 90834, 90836,90837, 90838, 90853) Psychotherapy with crisis and family psychotherapy are not approved as reportable services with interactive complexity. When reported with psychotherapy services, the additional time spent with a patient due to interactive complexity should not be calculated towards the time reported for the psychotherapy service. Documentation must include communication factors and how they increased the intensity of the services being rendered by the additional difficulty in either delivering the service or providing treatment to the patient. Modifier 59 is not applicable. Coding for the interactive complexity component represents the increased work intensity of the services rendered.

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Psychotherapy

Psychotherapy, known as talk therapy, counseling, psychosocial therapy, or simply, therapy, is reimbursed by Medicaid and Medicaid Managed Care Organizations. Psychotherapy services can be provided and billed for patients with a behavioral/mental health diagnosis and for the prevention of a childhood behavioral health issue or illness.

For when a diagnosis is present, services can be rendered to all ages and populations.

For when providing psychotherapy for the prevention of a childhood behavioral health issue and/or illness, the absence of a mental health diagnosis is required where two-generational and preventative approaches are recognized via psychotherapy services for patients under the age of 21 and/or the parent/caregiver of the patient through individual, family and group sessions.

The table below highlights the billing codes, their descriptions, and reimbursable clinicians for psychotherapy.

CPT Code	Description	Reimbursable Clinician(s)
90832	Psychotherapy with patient-30 minutes	Licensed Clinical Psychologist (LCP) Psychiatrist Licensed Clinical Social Worker (LCSW) Licensed Master Social Worker (LMSW) under the clinical supervision of an LCSW, or an LCP, or a Psychiatrist Licensed Mental Health Counselor (LMHC) Licensed Marriage and Family Therapist (LMFT)
90834	Psychotherapy with patient-45 minutes	
90837	Psychotherapy with patient-60 minutes	
90847	Family psychotherapy with patient present-50 minutes	
90839 90840	Psychotherapy for crisis; first 60 minutes Psychotherapy for Crisis; each additional 30 minutes.	
90849	Multiple family group psychotherapy (A group consisting of 2 or more different families.)	
90853	Group Psychotherapy (Other than multiple family group) (A group of at least 2 or more patients without the family present	

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The table below highlights the guidelines for reporting psychotherapy.

Applicable Guidelines	
Psychotherapy when a Diagnosis is Present	**Psychotherapy for Prevention of a Childhood Behavioral Health Issues/Illness**
For All Psychotherapy Session Types:	
Psychotherapy is not to be reported on the same date of service with psychiatric diagnostic evaluations.	
A notation of the duration (time) of the psychotherapy session is required for all time-based psychotherapy sessions.	
Reviewing records, communicating with other providers, observing, and interpreting patterns of behavior, communication between the patient and family and family with other family members, and decision making are included in psychotherapy services and are not separately billable. Additional time spent on these services should not be calculated and incorporated into the time-based psychotherapy code being billed.	
Medicaid and Medicaid Managed Care Plans have adopted The CPT (Current Procedural Terminology) midpoint rule regarding billing for time-based psychotherapy services. The midpoint rule allows for a time-based code to be billed when the time the provider has spent rendering the psychotherapy session has exceeded (not reached) the time in the psychotherapy code's description. E.g. a 30-minute session can be billed for a 16-minute psychotherapy session, a 45-minute session can be billed for a 23-minute psychotherapy session, a 50-minute session can be billed for a 26-minute psychotherapy session, and a 60-minute session can be billed for a 31-minute psychotherapy session.	
The overall goal of therapy is to improve the mental health and well-being of the patient and family by addressing the emotional, cognitive, mental, and behavioral diagnosis by reducing symptoms, improving with coping mechanisms, enhancing self-awareness, promoting personal growth, resolving any conflicts, and changing maladaptive patterns. -A Behavioral/mental health diagnosis will support medical necessity for the services.	Overall goal of preventive measures is to improve the well-being of the patient and family by addressing their psycho-social circumstance(s) that if not attended to, can lead to a behavioral health issue or illness in the child. - Diagnosis code Z65.9 (Unspecified Psycho-Social Circumstance) will support medical necessity for the services.
A Treatment plan is required.	
Informed consent by patient (if of age) or parent/caregiver is required.	
All psychotherapy session types apart from psychotherapy for crisis, are not included in psychotherapy when provided for the prevention of a behavioral health issue and/or illness	
For Family Psychotherapy (In addition to guidelines for all psychotherapy session types):	
The patient must be present for the entire or majority of the service with family/caregiver(s).	
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).	**Attention should be given to the impact or potential impact the patient and/or family's psycho-social circumstance will have on the patient and family with therapy aimed at ameliorating the circumstance(s).**
Family therapy can only be billed under the child, the patient, when rendered due to his/her diagnosis. Family dynamics as they relate to the patient's mental status and/or behavioral should be a focus of the sessions.	Family therapy can only be billed under a child under Medicaid and Medicaid Managed Care Plans that is less than 21 years of age for either their or their caregiver's psycho-social circumstance that can affect the child. Family dynamics as they relate to the patient's and/or caregiver(s) psycho-social circumstance should be a focus of the session.

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Psychotherapy for Crisis (In addition to guidelines for all psychotherapy session types):	
The patient (parent/caregiver regarding HealthySteps) must present a high level of distress with a complex or life-threatening problem that requires immediate attention.	**NOT APPLICABLE.** Psychotherapy for crisis is not a psychotherapy session type approved for psychotherapy for prevention.
Psychotherapy for crisis cannot be reported with any other mental health service, on the same day.	
Multiple Family Group Psychotherapy (In addition to guidelines for all psychotherapy session types):	
Multiple family group psychotherapy consists of two or more different families where the patient	
The group of families must share the same or similar diagnoses and/or symptoms	The groups of families must share the same or similar psycho-social circumstance(s) and/or symptoms where a mental/behavioral health diagnosis is absent in the patient.
FQHC's, RHC's, Article 28 clinics may not be eligible for reimbursement for group services. Verification with insurance carriers is required.	
Group psychotherapy is not time-based, therefore documentation of the time spent providing the session is not required.	
Group Psychotherapy-Other than a Multiple Camily Group (In addition to guidelines for all psychotherapy session types):	
Group psychotherapy-other than a multiple family group, consists of two or more patients without their families. (Applicable to parent/caregiver regarding HealthySteps)	
The patients in the group must share the same or similar diagnoses and/or symptoms.	The patients in the group must share the same or similar psycho-social circumstance(s) and/or symptoms where a mental/behavioral health diagnosis is absent in the patient.
FQHC's, RHC's, Article 28 clinics may not be eligible for reimbursement for group services. Verification with insurance carriers is required.	
Group psychotherapy is not time-based, therefore documentation of the time spent providing the session is not required.	

Note: The reporting of individual versus family psychotherapy is at the clinical discretion of the provider, but insurance carrier guidelines must be verified, as some carriers may have an age minimum guideline in place for reporting individual psychotherapy. Please review the guidelines indicated in the family psychotherapy section to assist with your decision in reporting.

Sources for Additional Information for Psychotherapy for Prevention of a Childhood Behavioral Health Issue/Illness:

Medicaid FFS billing and claims questions should be directed to the eMedNY Call Center at (800) 343-9000.

Medicaid FFS coverage & policy questions should be directed to the Office of Health Insurance Programs Division of Program Development and Management by telephone at (518) 473-2160, or by email FFSMedicaidPolicy@health.ny.gov.

Medicaid Managed Care (MMC) Plans enrollment, reimbursement, billing and/or documentation requirement questions should be directed to the specific MMC plan of the patient/enrollee. Providers can refer to the eMedNY New York State Medicaid Program Information for All Providers-Managed Care Information Document at https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf for contact information per MMC plan.

Medicaid Managed Care (MMC) Plans enrollment, reimbursement, billing and/or documentation requirement questions should be directed to the specific MMC plan of the patient/enrollee. Providers can refer to the eMedNY New York State Medicaid Program Information for All Providers-Managed Care Information Document at https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf for contact information per MMC plan.

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Service Requirements for Psychotherapy-A Table of Comparison for Psychotherapy when a Diagnosis is Present Versus for Prevention:

Psychotherapy when a Mental or Behavioral Health Diagnosis is Present	**Psychotherapy for the Prevention of Behavioral Health Issues and/or Illness**
Individual, family, group, and crisis sessions are approved for patients of all ages and populations that have a mental and/or behavioral health diagnosis.	Individual, family, and group sessions are approved for all Medicaid and Medicaid Managed Care patients under the age of 21 without a mental and/or behavioral health diagnosis, utilizing diagnosis Z65.9 (Unspecified Psychosocial Circumstance) to support medical necessity for the services
Summary of the patient's history and the issues that led them to therapy.	Summary of the patient's history and the issues that with attention can prevent behavioral health issues and/or illness.
Functional status/mental status examination **https://mentalhealthathome.org/2018/04/17/mental-status-exam/.**	
A notation of the duration (time) spent providing psychotherapy to the patient for all time-based psychotherapy sessions.	
Consent from patient and/or caregiver for the psychotherapy - If your health system does not have an informed consent policy in place, see our National Office Informed Consent Resource **https://www.healthysteps.org/?post_type=resource&p=3449?timestamp=1754575412.**	Consent from patient and/or caregiver for the preventive psychotherapy (explaining to the patient and/or caregiver that measures taken to ameliorate their psychosocial circumstance is considered preventive psychotherapy) – If your health system does not have an informed consent policy in place, see our National Office Informed Consent Resource **https://www.healthysteps.org/?post_type=resource&p=3449?timestamp=1754575412.**
The number of sessions ordered by the referring provider.	
Treatment Plan: (A structured, personalized documentation that outlines the patient's goals, methods used by practitioners to help obtain goals, and timeline for a patient's treatment)	
Patient's diagnosis.	There will not be a diagnosis in place but there will be psychosocial circumstance(s). (DX Code: Z65.9) This must be included.
Treatment goals surrounding the amelioration of the mental or behavioral health diagnosis with objectives that are the specific and measurable steps the patient and/or family and the provider will take to help the patient and/or family achieve the goals. (Goals to ameliorate the diagnosis and/or symptoms of the diagnosis).	Treatment goals surrounding amelioration of the psychosocial circumstances with objectives that are specific and measurable steps the patient and/or family as well as the provider will take, to help the patient and/or family achieve the goal(s). (Goals to ameliorate the issues/psychosocial circumstances the patient and/or family have that could lead to behavioral health issues and/or illness).
Prognosis - likely course of disease or ailment.	Prognosis - likely course of the psychosocial circumstance(s) with the prevention methods taken.
Progress and how the patient is benefiting from therapy in reaching goals, regularly tracking their improvement, evaluating the effectiveness of the treatment, and determining if adjustments may be needed to the treatment plan.	Progress and how the patient is benefiting from the therapy in reaching goals, regularly tracking the improvement of their psychosocial circumstance(s), evaluating the effectiveness of the assistance the provider is giving and adjusting, if needed, to the treatment plan).
Techniques used to treat the patient.	

Overall Goal:	
To improve the mental health and well-being of the patient and family by addressing the emotional, cognitive, mental, and behavioral diagnosis by reducing symptoms, improving with coping mechanisms, enhance self-awareness, promote personal growth, resolve any conflicts, and change maladaptive patterns.	To improve the well-being of the patient and family by addressing their psychosocial circumstances with the goal in preventing behavioral health issues and/or illness, understanding that the prevention is the intervention.

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Health and Behavior Assessment, Re-Assessment, and Individual Intervention

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**. The patient's primary diagnosis must be physical in nature, and the focus of the assessment and intervention is on factors complicating the physical health's medical condition(s) and treatment(s). These codes describe assessments and interventions to improve the patient's health and well-being, utilizing psychological and/or psycho-social assessments designated to ameliorate specific disease-related problems.

Services can be rendered to both the patient and the parent(s)/caregiver(s) but those services whose description includes **"**Individual" are services that can be rendered to the parent(s)/caregiver(s) when they too are patient(s) at the practice**,** where the billing occurs under their insurance carrier ID number and services are documented in their medical record.

The **Health and Behavior Assessment or Re-assessment** code is used to report the identification and assessment or re-assessment of psychological, behavioral, emotional, cognitive, and interpersonal (social) factors that can prevent, treat, or manage a patient's physical health problem(s). The assessment or re-assessment must be associated with an existing acute or chronic illness, the prevention of a physical illness or disability, and the maintenance of health.

Health and Behavior Intervention services are to modify the psychological, behavioral, emotional, cognitive, and social factors relevant to and affecting the patient's physical health problems, not with the focus not on mental health issues, but rather on how such factors may be contributing to the treatment of their established illness(s). If the patient has a mental health diagnosis, this code would not be appropriate to report**.** The patient's primary diagnosis must be physical in nature and the goals of the interventions should be to improve the patient's health and wellbeing utilizing psychological and/or psychosocial procedures designed to ameliorate specific disease-related problems.

The table below highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for reporting health and behavior assessments/re-assessments, and intervention services.

Health and Behavior Assessment/ Re-assessment		Reimbursable Clinician(s)	Applicable Guidelines
CPT Code	Description		
96156	Health and behavior assessment or re-assessment (e.g., health-focused clinical interview, behavioral observations, clinical decision making)	Physician Nurse Practitioner (NP) Physician Assistant (PA) Certified Nurse Midwife	Services do not focus on the mental health of a patient, but rather on the biopsychosocial factors that are, or could affect the treatment of, or severity of, the patient's **physical condition.** Patient must have an established illness or symptom(s) and cannot have been diagnosed with a mental illness. Assessments identify the factors that are directly affecting the patient's physiological function, disease status, health, and general well-being. Patients must have an established illness and cannot be diagnosed with a mental health illness.

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		(CNM) (**Verification with insurance carriers is required)** Licensed Clinical Psychologist (LCP)	Documentation for assessment or re-assessment services should include, but is not limited to, the patient's physical illness(s) (health focused interview), identification of the factors that are either preventing successful treatment and/or management of the illness and how these risk factors are impeding on the successful management of the illness(s). 96156 can be billed only once per day regardless of the amount of time required to complete the overall service. These services cannot be reported on the same day as preventive medical counseling or risk factor reduction codes, when rendered by the same provider. These services cannot be reported on the same day as psychiatric services. Intervention services are for the modification of the psychological, behavioral, emotional, cognitive, and social factors that have been identified as directly affecting the patient's physiological function, disease status, health, and general well-being. Patients must have an established illness and cannot be diagnosed with a mental health illness. 96159 is an add-on code for 96158, indicating that it can only be reported with 96158 if the additional time indicated in its description was rendered. Because 96158 and 96159 are time-based codes, therefore, the total time rendering the service must be documented for. E.g., a start and stop time. When services are rendered by a physician, PA, and NP, these codes may not be recognized for reimbursement. Insurance carriers may require the billing of evaluation and management office visit codes. Verification is required.
Health and Behavior Intervention			
96158 and 96159	96158-Health and behavior intervention, individual. Face-to Face; initial 30 minutes 96159-Healh and behavior intervention, individual. Face-to Face; each additional 15 minutes		

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

SBIRT services is an evidence-based approach to identifying patients who use alcohol and other drugs.

Medicaid reimbursement will be available for screening for alcohol and substance abuse when the parent/caregiver is also a patient of the practice.

The table on the following page highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for reporting SBIRT services.

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HCPCS Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
H0049	Alcohol and substance abuse screening (Screening ONLY)- Completed screening tool with scoring	Physician Nurse Practitioner (NP) Licensed Clinical Psychologist (LCP) Certified Nurse Midwife (CNM) Code H0049 also includes Licensed Clinical Social Worker (LCSW) and Licensed Master Social Worker under their supervision or the clinical supervision of an LCP.	OASAS approved training/certification required. For the screening only (H0049): If patient does not have an established diagnosis related to alcohol or substance abuse, append ICD-10 code Z02.83 (Screening for blood-alcohol and blood-drug test) For intervention services (H0050): All diagnoses related to alcohol/substance abuse will support medical necessity for the service. Because an intervention (H0050) is a time-based code, the total time rendering the service must be documented for. E.g., a start and stop time. Commonly used pre-screening tools are AUDIT-C, NIDA Quick Screen, Four Ps, DAST1. Commonly used full screening tools are AUDIT, ASSIST, DAST10, and T-ACE, TWEAK for pregnant patients. Each unit reported for H0050 is equivalent to 15 minutes of time spent rendering the service to the patient. Depending on time spent rendering the service, billing for more than 1 unit may be required. H0049 and H0050 are the billing codes recognized by Medicaid and Medicaid Managed Care carriers, billing codes 99408 (Alcohol and/or substance abuse structured screening and brief intervention services; 15-30 minutes) and 99409 (Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes, should be reported when billing commercial insurance carriers.
H0050	Alcohol and substance abuse brief intervention, per 15 minutes (Group services may not be provided)		

OASAS Training Requirements:

- 4 hours of OASAS approved training/certification https://webapps.oasas.ny.gov/training/searchresults.cfm?sbirt=4
- 12 hours of OASAS approved training/certification https://webapps.oasas.ny.gov/training/searchresults.cfm?sbirt=12

For information on the OASAS Certification process: https://webapps.oasas.ny.gov/training/index.cfm
For billing questions: SBIRTNY@oasas.ny.gov

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Smoking Cessation

Effective April 1, 2021, Medicaid expanded the list of practitioners who can be reimbursed for providing smoking cessation counseling services. The table below highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for reporting smoking cessation services.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
99406	Smoking and tobacco use cessation counseling visit; intermediate, g**reater than** 3 minutes, up to 10 minutes	Physician Physician Assistant (PA) Nurse Practitioner (NP) Licensed Certified Midwife (CNM) during medical visits Licensed Clinical Psychologist (LCP) Licensed Clinical Social Worker (LCSW) Licensed Master Social Worker (LMSW) under clinical supervision of an LCSW or an LCP Registered Nurse (RN) Licensed Practical Nurse (LPN)	Medicaid expanded coverage for smoking cessation counseling to include LCSW's and when affiliated with a smoking cessation counseling program at their clinic. Group sessions (2-8 patients) are available for reimbursement for sessions greater than 10 minutes. Billing requires a modifier HQ appended to CPT code 99407**. (For those FQHCs, FQHC look-a-likes, and RHCs billing under the PPS methodology: Clinics may not be eligible to bill for group services-verification with insurance carrier(s) is required**.) Documentation of the time spent providing the services is required, as well as the content of the counseling. When 3 minutes or less is spent counseling patients, the service is not separately reimbursable. Billing for services provided by Registered Nurses and Licensed Practical Nurses at FQHCs and RHCs must be verified with insurance carriers-services may need to be billed under the ordering physician. Medicaid covers unlimited cessation counseling but verification with Medicaid Managed Care carriers must be made on if they will also reimburse for unlimited smoking cessation counseling visits. All smoking related diagnoses will support medical necessity for the services. Services and documentation requirements for smoking cessation are: • The patient's tobacco use • Interventions of assessing readiness for change and barriers to change. • Advising a change in behavior • Assisting by providing specific suggested actions • Motivational counseling • Arranging for services and follow-up • Time spent rendering smoking cessation services.
99407	Smoking and tobacco use cessation counseling visit; Intensive, **greater than** 10 minutes		

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Lactation Services

New York State Medicaid provides reimbursement for evidence-based breastfeeding education and lactation counseling consistent with the United States Preventive Task Force (USPSTF) recommendation with specific guidelines for reimbursement eligibility.

The table below highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for reporting lactation services.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
S9445	Patient education, not otherwise classified, non-physician provider, **individual**, per session	Physician, Physician Assistant, Nurse Practitioner, Nurse Midwife, Registered Nurse, **With the following Certifications:** International Board-Certified Lactation Consultant" credentialed by the International Board of Lactation Consultant Examiners (IBCLE) Certified Lactation Specialist (CLS) Certified Breastfeeding Specialist (CBS) Certified Lactation Educator (CLE) Certified Clinical Lactationist (CCL) Certified Breastfeeding Educator (CBE)	The descriptions listed for HCPCS codes S9445 and S9446 are the national description for the billing codes, but Medicaid recognizes **S9445** for an initial lactation counseling session where the **minimum** duration of the session is 45 minutes. The follow-up session(s) should be a minimum of 30 minutes each and occur within the 12-month period immediately following delivery. Medicaid recognizes **S9446** for group sessions that consist of 2 patients and a maximum of 8, where the minimum duration of the group session is 60 minutes. One prenatal and one postpartum class (total of 2), per patient, per pregnancy is covered. **(For those FQHCs, FQHC look-a-likes, and RHCs billing under the PPS methodology: Clinics may not be eligible to bill for group services-verification with insurance carrier(s) is required**.) Because minimum time frames have been placed on both S9445 and S9446, documentation of the time spent rendering the services to the patient is required in addition to the services provided during each session. Diagnosis code Z39.1 (Encounter for care and examination of lactating mother) should be included when reporting for any other diagnosis pertinent to the patient's visit, where the mother must be the patient. (Services cannot be billed under the infant.) Verification with insurance carriers is required on the covered limitation of services.
S9446	Patient education not otherwise classified, non-physician provider, **group**, per session		

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e-Visits

e-Visits are a type of virtual check-in involving patient-initiated communications with a provider through a text-based and Health Insurance Portability and Accountability ACT (HIPAA) compliant digital platform, such as a patient portal. **E-Visits are intended to remotely assess non-urgent conditions and prevent unnecessary in-person visits**. E-Visits reimburse providers for the problem-focused communication and medical decision-making they do outside of normal visits.
e-Visits encompass patient or patient caregiver-initiated communication with a provider, for an established patient.

The table below highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for the reporting of e-Visits.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
98970	Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 5-10 minutes.	Licensed Clinical Social Worker (LCSW) Verification required with insurance carriers on if a Licensed Master Social Worker (LMSW) under the clinical supervision of an LCSW can also render the service. Licensed Clinical Psychologist Licensed Marriage and Family Therapist Licensed Professional Clinical Counselor	e-Visits **MUST BE** patient-initiated communication with the provider and must be via a text-based and HIPAA compliant digital platform, such as a patient portal. e-Visits can only be provided to established patients though the presenting problem may be new. Communication of test results, scheduling appointments, medication refills, and any other communications outside the scope of evaluation and management, are not considered e-Visits. Verbal or written consent must be obtained from the patient/patient caregiver, where documentation of the consent must be in the patient's medical record. Billing for e-Visits is based on cumulative time spent with a single patient within a seven-day period. For example, if five to ten minutes are spent with a single patient for an e-Visit over a seven-day period, CPT code 98970 may be billed. For an encounter to qualify as an e-Visit, the patient must not have been seen for the same clinical issue within the previous seven days. e-Visit codes may be billed **once** per 7-day period (When billing, the date of service must be the last date of communication between the patient and provider within that 7-day period.) Because e-Visit codes are time-based where the service time is cumulative up to a seven-day period, documentation of the time spent rendering the service is required, in each note. The seven-day period starts with the review of the initial patient communication by the provider. The provider must begin their review within 3 business days of the patient inquiry. The service time must include the review of pertinent medical records, interaction with clinical staff about the presenting problem and subsequent communication which are not included in a separately reported service. In addition to the total time spent rendering the service to the patient, documentation requirements for e-Visits include the patient-initiated inquiry and the presenting problem of the patient, as well as the clinical assessment and recommendations of the provider. According to the emedNY list of procedure codes and fee schedule for licensed clinical social workers, e-Visit codes should only be used to report e-consults. Verification with insurance carriers of what this means to the services rendered must be made at the site level.
98971	Qualified non-physician health care professional online assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 11-20 minutes.		
98972	Qualified non-physician health care professional online assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 21 minutes or more.		

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Community Health Worker Services

The Community Health Worker (CHW) functions as a liaison between healthcare systems, social services, and community-based organizations to improve overall access to services and resources and to facilitate improved health outcomes, overall health literacy, and preventing the development of adverse health conditions, injury, illness, or the progression of either.

York State Medicaid reimburses CHW services for the following populations:

- Pregnant patients during their pregnancy and up to 12 months postpartum
- Children under the age of 21
- Adults with chronic conditions
- Justice-involved individuals
- Those with unmet health-related social care needs
- Individuals experiencing community violence

CHW services are reimbursable by Medicaid fee-for-service (FFS), NYS Managed Care Organizations (MCOs), Human Immunodeficiency Virus-Special Needs Plans (HIV SNPs), and Health and Recovery Plans (HARPs). **Note:** NYS Medicaid members who receive care coordination services through the health home program, a health home care organization, a certified community behavioral health clinic, and assertive community treatment, are not eligible for CHW service coverage.

Under NYS Medicaid guidelines, CHW services must involve **direct, face-to-face interaction** with the patient, and they are as follows:

- **Health Advocacy**
  - Advocating on a patient's individual and healthcare service needs.
  - Connect patients with community-based resources and programming.
  - Advocacy efforts of the CHW are to promote empowerment and self-confidence of patients to ensure respectful and equitable care and support to prevent health conditions, illness, problem or injury or the progression of illness. CHWs bridge cultural, communication, and language gaps between the health care system and the patients accessing care and services.

- **Health Education**
  - Provide education to:
    - optimize health and address barriers to accessing health care, health education and/or community resources that incorporate the needs, goals, and life experience of the patient.
    - prevent health conditions, illness, problem or injury, or the progression of an illness with evidence-based standards.
    - support informed decision-making, agency, problem-solving, active collaboration, and self-efficacy related to health and social care needs.

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- Optimize the patient's experience in the healthcare system.

- **Health Navigation**
  - CHW services may include assistance to the patient for health navigation in the following areas:
    - Community-based and healthcare-related referrals and follow-up referral services.
    - Completion of screening tools that do not require a licensed provider to complete.
    - Identifying health and social care needs and follow-up to connect to services including, but not limited to transportation, employment, job training, food insecurity, childcare, and housing (the CHW may not provide these services directly).
    - Resource coordination is directed to the individual (not case management).
    - Help with enrollment or maintain enrollment in government programs or other assistance programs (can assist and educate but cannot directly select services/benefits).
    - Accompaniment to in-person and virtual healthcare visits and to get established with community resources that will improve or maintain the patient's health.

CHW services **do not** include the following:

- Clinical case management/care management services that require a license, including comprehensive Medicaid case management services.
- The provision of companion services/socialization, respite care, transportation, direct patient care, personal care services/homemaker services (e.g., chore services including shopping, cleaning, and cooking, assistance with activities of daily living, errands), or delivery of medication, medical equipment, or medical supplies.
- Services that duplicate another covered Medicaid service or that are otherwise billed to Medicaid/Medicaid managed care.
- Services outside the level of training the CHW has attained.
- Advocacy for issues not directly related to the patient's health or social care needs.
- Bill for language interpretation services.
- Time and activities that do not include direct engagement with the patient.

The tables on the following pages highlight the billing codes, their descriptions, reimbursable supervising clinicians, and additional guidelines for the reporting of CHW services.

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CPT Code	Description	Reimbursable Supervising Clinician(s)
98960	Self-management education and training face-to-face using standardized curriculum for an individual NYS Medicaid member-each 30 minutes	Physician, Nurse Practitioner, Midwife
98961	Self-management education and training face-to-face using standardized curriculum for two-four (2-4) NYS Medicaid members-each 30 minutes	Licensed Clinical Psychologist
98962	Self-management education and training face-to-face using standardized curriculum for five-eight (5-8) NYS Medicaid members-each 30 minutes	Licensed Clinical Social Worker Licensed Mental Health Counselor Licensed Marriage and Family Therapist

Applicable Guidelines
CHW services are reimbursable for the following populations: • Pregnant patients during their pregnancy, and up to 12 months postpartum, regardless of the results of the pregnancy • All children under the age of 21 • Adults with chronic conditions • Individuals with justice system involvement within the past 12 months • Those with unmet health-related social care needs in the domains of housing, nutrition, transportation, or interpersonal safety, which have been identified through screening using the Centers of Medicare & Medicaid Services (CMS) Accountable Health Communities Health-Related Social Needs Screening Tool • Individuals exposed to community violence or have a personal history of injury sustained because of an act of community violence, or who are at an elevated risk of violent injury or retaliation resulting from another act of community violence.
CHWs are not eligible to enroll with NYS Medicaid. Their services are to be billed by an approved Medicaid-enrolled, licensed billable supervising clinician acting within their scope of practice under state law. Those recognized are listed under the "Reimbursable Supervising Clinicians" column above.
All clinic types are eligible to bill for CHW services, including Federally Qualified Health Centers (FQHCs) if the FQHC has elected to be reimbursed under the APG Medicaid reimbursement methodology. Additionally, FQHCs that have opted into the APG reimbursement methodology can only bill if the CHW service is provided in conjunction with a threshold visit (sick, follow-up, well-child) with a licensed health care provider.
A CHW is a public health worker that reflects the community served through lived experience that may include but is not limited to: • Pregnancy and birth • Housing • Mental health conditions • Substance use or other chronic conditions • Share race, ethnicity, language, and/or sexual orientation or community of residence.

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CHW's providing the direct service must have obtained the following: • A 20-hour minimum training that includes the CDC-endorsed CHW Core Consensus Competencies (C#) which can be seen at, **https://www.c3project.org/roles-competencies** or 1400 hours of experience working as a CHW in formal paid or volunteer roles within the past three years. • Basic HIPAA training.
CHW services must involve direct face-to-face interaction with the patient. NYS Medicaid will reimburse for up to 12 units total (30 minutes=1 unit) per patient, per year of CHW services for adult populations. They will reimburse up to 24 units (30 minutes =1 unit) for the pediatric population (under 21 years of age).
Although each unit of service indicates to be for 30 minutes of service, NYS Medicaid will reimburse for each 30-minute self-management code (98960, 98961, 98962), for CHW services, when at least 16 minutes of service is rendered, with a maximum of 37 minutes.
When billing for all CHW services, **except** for community violence prevention services, both billing modifiers U1 and U3 must appear consecutively, and in this order, on the CHW service CPT code (98960, 98961, 98962) claim line. When billing for community violence prevention services the order of the billing modifiers changes, whereas U3 and U1 must appear consecutively, and in that order.
For Managed Care Organization members, providers must contact the managed care plan of the patient, for billing instructions. The managed care plan contact information can be found at: **NYhttps://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All-Providers_Managed_Care-Information.pdf.**
FFS Coverage and policy questions should be directed to, **MaternalandChild.HealthPolicy@health.ny.gov.**
Documentation requirements include the services listed and provided under either of the approved CHW services (health advocacy, education, navigation) rendered, and the clinicians' recommendation for CHW services, and the duration of the time the CHW service was provided.
Clinicians' recommendations for CHW services can be made by physicians or other licensed practitioners of the healing arts acting within his or her scope of practice under state law. Licensed practitioners of the healing arts are licensed psychiatrists, licensed clinical social workers, nurse practitioners, physicians, physician assistants or licensed psychologists practicing within the scope of their state license.
Medicaid guidelines advise of the following diagnosis types that support medical necessity for CHW services: • For patients 21 years of age and older, providers must include a diagnosis on the claim that identified either the chronic condition, social care need, or qualifying risk criteria of the NYS Medicaid member using the appropriate diagnosis code and/or the ICD-10 Z code. • For pregnant or postpartum patients, the appropriate pregnancy diagnosis or postpartum diagnosis should be reported. • For patients under the age of 21, a diagnosis is not required to support medical necessity for CHW services, but the Z-code relevant to the patient, should be reported.

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