California: HealthySteps 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) in coding and billing for HealthySteps-aligned services. HealthySteps sites can bill Medi-Cal 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 specific applicable Medi-Cal billing, coding, and documentation guidelines.

There are a variety of requirements and restrictions that can impact your practice's ability to bill for 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-aligned 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.

Contents

What is Medi-Cal?

Medi-Cal is California's Medicaid health care program. The Department of Health Care Services (DHCS) administers and oversees the Medi-Cal program. With a few exceptions (e.g., children in foster care and some children with special health care needs), most children and women receive their Medi-Cal benefits through managed care plans.

Currently Medi-Cal provides a core set of health benefits to beneficiaries. The Affordable Care Act ensures all Medi-Cal managed care plans (MCPs) offer what are known as Essential Health Benefits (EHBs) in accordance with practice guidelines established in the American Academy of Pediatrics Bright Futures guidelines. These benefits include:

- Emergency services, hospitalization, laboratory services, and prescription drugs
- Outpatient (ambulatory) services, preventive and wellness services, and chronic disease management
- Children's (pediatric) services, including oral and vision care
- Maternity and newborn care
- Programs such as physical and occupation therapy (known as rehabilitative and habilitative services) and devices
- Mental health and substance use disorder services

Medi-Cal Contact Information

The HealthySteps National Office Policy & Finance Team is here to support your billing efforts, but for issues and questions regarding Medi-Cal and Medi-Cal insurance carriers, your local county office manages most Medi-Cal cases for DHCS and can be reached either online at **http://www.benefitscal.com/** or via phone at 1-800-541-5555.

Applicable Guidelines

Medi-Cal Reimbursable Clinicians Rendering HealthySteps-Aligned Services:

Medi-Cal reimburses for services rendered by certain provider types, when working under their scope of practice. Below is a list of Medi-Cal reimbursable providers that can render HealthySteps-aligned services.

- Physician
- Physician Assistant **(PA)** [Unless exempt due to PA type, supervision is required by a physician at the same location or by telephone where all reimbursements for Medi-Cal are usually made through a supervising physician. Verification is required for other carriers]
- Nurse Practitioner **(NP)**
- Certified Nurse Midwife **(CNM)**
- Psychiatric Nurse Practitioner **(PNP)**
- Psychiatric Physician Assistant **(PPA)**
- Psychiatrist (Psychiatric MD)
- Licensed Clinical Psychologist
- Psychology Associate under clinical supervision of a licensed billable behavioral health provider
- Licensed Marriage and Family Therapist **(LMFT)**
- Associate Marriage and Family Therapist under clinical supervision of a licensed billable behavioral health provider
- Licensed Professional Clinical Counselor **(LPCC)**
- Associate Professional Clinical Counselor under clinical supervision of a licensed behavioral health provider
- Licensed Clinical Social Worker **(LCSW)**
- Associate Clinical Social Worker under clinical supervision of a licensed behavioral health provider

Use of Billing Modifiers Applicable to HealthySteps-Aligned Services:

Modifiers are used in conjunction with billing codes to either identify the provider type that has rendered the service, indicate that a specific service type has been rendered, or that a service or procedure has been altered by some specific circumstance(s), without changing the definition or code for the service. Throughout the guide, you will find references regarding the below modifiers, and the need for them, upon billing for certain services.

The following modifiers are applicable to HealthySteps-aligned services:

- Modifier KX:
  - Because the same billing code is used for the reporting and billing for all developmental screening types, modifier KX has been assigned to identify when billing for an autism screening. Modifier KX should be appended to the billing code for developmental screenings when billing for an autism screening.

- Modifier HD:
  - This modifier is used to identify when billing for a maternal depression screening when rendered during a well-child visit and billed under the infant. Modifier HD should be appended to the billing code for the maternal depression screening, upon billing for the service.

- Modifier 33:
  - Medi-Cal reimburses for preventive psychotherapy sessions for patients who are at risk of depression during **the prenatal period and/or during the 12 months following childbirth**. Modifier 33 is used to identify the billing of these services and should be appended to the applicable psychotherapy codes to distinguish these services from other psychotherapy services.

- Modifier U1:
  - Medi-Cal reimburses for specified dyadic services for patients 0-20 years of age and their caregivers when billed under a child's Medi-Cal Identification number. Modifier U1 is used to identify the billing of these services and should be appended to the applicable dyadic service codes to distinguish the services as those delivered under the Dyadic Benefit.

Supervision of Associate Behavioral Health Providers:

Direct supervision (face-to-face) contact is a requirement for those providers supervising associate behavioral health practitioners. Weekly face-to-face contact is required within the same week as the hours claimed. California's Board of Behavioral Sciences provides statutes and regulations relating to the practices of professional clinical counseling, marriage and family therapy, educational psychology, and clinical social work. For more information and additional guidance on supervising associate providers, please see the California Board of Behavioral Sciences Statutes and Regulations, **https://www.bbs.ca.gov/pdf/publications/lawsregs.pdf**-(page 39).

The Initial Health Appointment

The Initial Health Appointment (IHA) occurs during a patient's visit with a provider in the primary care setting. The IHA is used to assess and manage any acute, chronic, and preventative health needs of the patient. Effective January 1, 2023, the Department of Health Care Services updated the policies to streamline the Initial Health Assessment process.

The Individual Health Education Behavior Assessment (IHEBA/Staying Healthy Assessment (SHA), an age-specific questionnaire developed to for primary care providers to assess any acute, chronic, and preventive health needs, is no longer required for the IHA. References to what is required for the IHA can be found in the Department of Health Care Services Medi-Cal Managed Care Health Plans All-Plan Letter https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf. Elimination of the IHEBA/SHA does not change the requirement to include a history of the patient's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services, and health education, and the diagnosis and plan for treatment of any diseases as part of the IHA. Providers may continue to use the IHEBA/SHA as their preferred tool to identify behaviors that place members at risk. For both children and youth (individuals under the age of 21), Early and Periodic Screening, Diagnostic and Treatment EPSDT) screenings will continue to be covered in accordance with the American Academy of Pediatrics (AAP/Bright Futures periodicity schedule. Managed care network providers will still be held accountable for providing all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all these elements to be completed during the initial appointment, as long as patients receive all required screenings in a timely manner consistent with the USPSTF guidelines.

The SHA is not a specific HealthySteps-aligned service, but it does contain questions that are parallel to validated screening tools, including those universal screening tools that are HealthySteps-aligned services (e.g., developmental milestones, ASQ). IHEBA tools do not replace required, validated screening tools and are not intended to replace clinical screenings or assessments.

Separate reimbursement is not available for the SHA, but may be available when billing for those required screenings in the AAPs periodicity schedule https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf which are required. Reference of the reimbursable screening tools can be found in the "Screenings" section of this guide.

Screenings

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 a significant component of HealthySteps-aligned services. The table below highlights pertinent billing codes, their descriptions, reimbursable clinicians, and applicable guidelines.

CPT Code	Description	ICD10 Code(s)	Reimbursable Clinician(s)	Applicable Guidelines
96110	Developmental milestone survey, speech and language delay with scoring and documentation, per standardized instrument Examples: ASQ, ASQ®-3, BDI-ST, BINS, Brigance Screens-II, Infant Development Inventory, Child Developmental Inventory, M-CHAT, PEDS DM	Z13.42-Developmental delays (milestones) Z13.41-Autism screening Z13.40-Encounter for unspecified developmental delays	Licensed Clinical Social Worker Licensed Clinical Psychologist Licensed Professional Clinical Counselor Licensed Marriage and Family Therapist Physician, Physician Assistant, Nurse Practitioner	• Modifier KX is applicable when billing for autism screenings. Medi-Cal reimburses for autism screenings at 18 and 24 months and when medically indicated. • Medi-Cal reimburses for general developmental screenings at 9,18, and 30 months or when medically indicated. • A general developmental screening and autism screening are both reimbursable when performed on the same day. The claim should list CPT code 96110 twice, where modifier KX is appended to one of the codes.
96127	Social-emotional screening. (Psychosocial/behavioral assessments) Examples: ASQ:SE, ADHD Rating Scales	Z13.39-Encounter for screening for other mental health and behavioral disorders		• Documentation for social-emotional and developmental screenings include: the name of the tool, the tool itself, the score, and how results were discussed with the patient/family. • Medi-Cal's reimbursement for social-emotional screenings is limited to two per day, per provider, per patient.

Depression Screenings

Medi-Cal will provide reimbursement for depression screenings, including for prenatal and postpartum depression. Postpartum screenings can be conducted and billed by an infant's primary care provider (PCP) when rendered to the mom during a well-child visit. This provides the infant's PCP with the opportunity to identify postpartum maternal depression and help prevent unfavorable development and mental health outcomes. Postpartum screenings should be integrated into the well-child visit schedule. The table below highlights pertinent billing codes for depression screenings including postpartum screenings, their descriptions, reimbursable clinicians, and applicable guidelines.

CPT Code	Description	ICD10 Code(s)	Reimbursable Clinician(s)	Applicable Guidelines
G8510	Screening for depression; documented as a **negative** result Examples: EDPS, PHQ-9, BDI	Z13.32- Encounter for screening for maternal depression screening	Physician and Physician Assistant, Nurse Practitioner Providers of prenatal and postnatal care: OB-GYN provider, Certified Nurse Midwife	Guidelines for Postpartum Depression Screenings when Rendered to the mom by an Infant's Pediatrician During a Well-Child Visit: • Medi-Cal will reimburse for up to four postpartum screenings rendered during the infant's first year of life, when they are rendered by the infant's pediatrician during a well-child visit, where the billing is conducted under the infant's Medi-Cal number.
G8431	Screening for depression; documented as a **positive** result Examples: EDPS, PHQ-9, BDI	Z13.31- Encounter for screening for depression screening (for patients who are not pregnant or post-partum)	(When billing under the mother when she is a patient)	• HIPAA compliant documentation for the screening results and recommendations/referrals provided can be placed in the infant's medical record. Verification with your administrative, or legal, or your compliance department is required on the protocol for HIPAA compliant documentation. • Medi-Cal billing guidelines require the use of modifier, "HD" when billing for a postpartum screening rendered by a pediatrician during a well-child visit, that is being billed under the infant's Medi-Cal number. The modifier will be linked to the billing code (CPT code) for the screening to identify that the service was rendered during a well-child visit.

				• If the infant has not yet been assigned a Medi-Cal ID number, the screening can be billed the birthing parent's ID for the month of with birth and the following month only <u>Guidelines for Prenatal Depression Screenings and Postpartum Depression Screenings Rendered to a mom or mom to be, When She Too is a Patient at the Practice, and Services are Rendered by the OB-GYN Provider or a Certified Nurse Midwife:</u> • Medi-Cal will also reimburse for up to two screenings per year (once when the patient is pregnant and once when they are postpartum). This does not include when billing under the infant's Medi-Cal number when the screening was rendered by a pediatrician during a well-child visit. • Providers must include a pregnancy or postpartum diagnosis code on the claim. • Medi-Cal does not require a modifier to identify these screenings. <u>Depression Screenings Other than for Prenatal or Postpartum Depression:</u> • Medi-Cal will also provide reimbursement for depression screenings other than for prenatal or postpartum depression, to all patients 12 years of age or older, including caregivers when they too are patients at the practice. • Medi-Cal will provide reimbursement for each Medi-Cal patient for one screening per year, per provider.

Adverse Childhood Experience (ACEs)

Adverse childhood experiences (ACEs) are linked with adverse child and adult health outcomes. HealthySteps Specialists are integral in identifying traumatic childhood events and offering supportive measures to minimize negative effects. The table below highlights pertinent billing codes, their descriptions, reimbursable clinicians, and applicable guidelines.

CPT Code	Description	ICD10 Code	Reimbursable Clinician(s)	Applicable Guidelines
G9920	ACE screening-lower risk, patient score of 0-3 (PEARLS)	Z13.30-Encounter for screening examination for mental and behavioral disorders, unspecified	Licensed Clinical Social Worker Licensed Clinical Psychologist Licensed Professional Clinical Counselor Licensed Marriage and Family Therapist Licensed Certified Nurse Midwife Physician, Physician Assistant, Nurse Practitioner	• Providers billing for ACE screenings must complete the California Department of Health Care Services (DHCS) training for ACEs screening and trauma-informed care. https://training.acesaware.org/ • For patients **under 21 years of age**, Medi-Cal will reimburse for one screening, per year, per provider. • For patients **21 years of age and over**, Medi-Cal will reimburse for one screening, per provider, during the patient's adult lifetime (ages 21-64.) • Billing for the screenings (G9920 and G9919) includes a completed screen with review, interpretation of results, discussion with patient and/or family, and any appropriate clinical decisions, if required. All must be documented in the medical record.
G9919	ACE screening-high risk, patient score of 4 or greater (PEARLS)			

Health and Behavior Assessments/Re-assessments and Interventions

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.

The Health and Behavior Assessment or Re-assessment code 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 psychological, behavioral, emotional, cognitive, and social factors relevant to, and affecting the patient's physical health problem(s).

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# and services are documented in their medical record.

The tables on the following pages highlight the billings codes, their descriptions, the reimbursable clinicians, and guidelines for health and behavior assessments/re-assessments, and interventions.

Health and Behavior Assessment/ Re-assessment		ICD10 Code(s)	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) (can only be billed once per day)	Medical diagnosis must be reported, in addition to the biopsychosocial factor(s)	Licensed Clinical Social Worker Licensed Professional Clinical Counselor	• Documentation for assessment or re-assessment services should include, but is not limited to, the patient's physical illness(s) (health focused interview), and identification of the factors that are either preventing successful treatment, and/or management of the illness. Documentation should also include how these factors are impeding on the successful management of the illness(s) or are either preventing treatment.
Health and Behavior Interventions-Family (With or Without the patient)			Licensed Clinical Psychologist Licensed Marriage and Family Therapist	• Services do not focus on the mental health of a patient, but rather on the biopsychosocial factors that are either affecting the treatment of, or severity of the patient's physical medical condition. Patient must have an established illness and cannot have been diagnosed with a mental illness.
96167 and 96168	96167-Health and behavior intervention, **family with patient present** face-to face; initial 30 minutes (can only be billed once per day) 96168-Health and behavior intervention, **family with the patient present** face-to-face, each additional 15 minutes (up to 6 units per day can be billed)		Physician, Physician Assistant, Nurse Practitioner	• 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. 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.
				• Evaluation and Management services (office visits), smoking cessation services (99406, 99407), and CPT codes 90785-90899, which includes psychiatric diagnostic evaluation and interactive complexity, will not be reimbursed, if billed with assessments, re-assessments, and interventions.

96170 and 97171	96170-Health and behavior intervention, **family without the patient** present face-to-face; initial 30 minutes (can only be billed once per day) 96171-Health and behavior intervention, **family without the patient present** face-to-face; each additional 15 minutes (can only be billed once per day)			• Documentation for intervention services provided to the patient and family should include, but it not limited to, the time spent rendering the service, the patient's physical illness, 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 Interventions-Individual and Group		**ICD10 Code(s)**	**Reimbursable Clinician(s)**	**Applicable Guidelines**
CPT Code	**Description**			
96158 and 96159	96158-Health and behavior intervention, **Individual** face-to-face; initial 30 minutes (can only be billed once per day) 96159-Health behavior intervention, **individual**, face-to-face; each additional 15 minutes (up to 4 units per day can be billed)	Medical diagnosis must be reported, in addition to the biopsychosocial factor(s)	Licensed Clinical Social Worker Physician, Physician Assistant, Nurse Practitioner Licensed Professional Clinical Counselor	• 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 medical condition. Patient must have an established illness and cannot have been diagnosed with a mental 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. 96165 is an add-on code for 96164, indicating that it can only be reported with 96164, if the additional time indicated in its description was rendered.

96164 and 96165	96164-Health and behavior intervention, **group (2 or more patients)** face-to-face; initial 30 minutes (can be billed once per day) 96165-Health and behavior intervention, **group (2 or more patients)** face-to-face; each additional 15 minutes (up to 6 units per day, can be billed)		Licensed Clinical Psychologist Licensed Marriage and Family Therapist	• Some services are not reimbursable if billed on the same day assessments and interventions are billed when they are billed by the same provider. Codes for Evaluation and Management services (office visits), smoking cessation services (99406 and 99407), and CPT codes 90785 thru 90899, which includes psychiatric diagnostic evaluation, and interactive complexity, will not be reimbursed, if billed with assessments, re-assessments, and interventions. • Documentation for intervention services provided to the patient should include but is not limited to, the patient's physical illness(s), identification of the factors impeding successful treatment and/or management of them, and the reasons why they are preventing treatment, and/or successful management of them. Additionally, the intervention services being rendered to help ameliorate the factors that are either impeding successful treatment and/or management of them, should also be documented. Because the billing codes for intervention services are time-based, documentation of the time spent rendering the service must also be included. • Group services may not be eligible for reimbursement at FQHCs/RHCs. Insurance verification is required.

Note: As explained in the introduction page for these services, individual intervention services are rendered to the patient only. They are intended for older children or the parent(s)/caregiver(s), when they too are patients at the practice.

Psychiatric Diagnostic Evaluation/Psychiatric Diagnostic Evaluation with Medical Services

A psychiatric diagnostic evaluation is used to diagnose problems with behaviors, thought processes, and memory. Services for an evaluation should include assessment of the patient's psycho-social history, current mental status, reviewing and ordering diagnostic studies followed by appropriate treatment recommendations, a description of behaviors present, when they occur, how long they last, and which behaviors most often happen and under what conditions. A description of symptoms (physical and psychiatric), a family mental health history, as well as interviews and communication with family members should also be provided.

Interactive complexity can be reported with a psychiatric diagnostic evaluation. A description and guidelines for interactive complexity can be found on page 20.

The below table highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for reporting psychiatric diagnostic evaluations.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90791	Psychiatric diagnostic evaluation	Licensed Clinical Social Worker Licensed Professional Clinical Counselor Licensed Clinical Psychologist Licensed Marriage and Family Therapist Psychiatrist (Psychiatric MD) Psychiatric Physician Assistant Psychiatric Nurse Practitioner	• Psychiatric diagnostic evaluations are not reimbursable when billed on the same day as psychotherapy services. • Rendering and billing for psychiatric diagnostic evaluations must be consistent with the scope of license and competency of the mental health provider. • Documentation requirements include presenting problem(s)/change(s) in functioning/history, mental and medical health history, including current medications if applicable, social, and cultural factors, risk, and safety factors, and a diagnostic summary.
90792	Psychiatric diagnostic evaluation with medical services	Psychiatrist (Psychiatric MD) Psychiatric Physician Assistant Psychiatric Nurse Practitioner	• Same guidelines as services as above are applicable but this code also includes any medical services rendered during the visit.

Testing with Interpretation, Testing and Evaluation, and Test Administration

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-**e.g., Bayley Scales of Infant and Toddler.

The below table 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 by standardized instrument, with interpretation and report; initial hour	Physician, Physician Assistant, Nurse Practitioner	• Claims for developmental testing must include an itemization of the test performed. It must be listed either in the "Additional Claims Information" field box (Box 19) on the claim or on an attachment.
96113	Developmental test administration; each additional 30 minutes after the initial hour of service	Licensed Clinical Psychologist	• 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. • 2020 Medi-Cal guidance advises that the state will reimburse for one test, per year. Limits placed on frequency can change and may not include when medically necessary. Verification is required. • For physicians, physician assistants and nurse practitioners, developmental testing must be consistent with the scope of license and competency of the provider. • The time spent rendering services, why testing was provided, which standardized test instrument was used, test results, interactive feedback with patient and/or family, and any appropriate actions taken are required and must be included in your documentation.

Psychological Testing and Evaluation

Not to be confused with screenings, psychological testing and evaluation involve more extensive services. Psychological testing 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. **Approved testing tools must be verified with insurance carriers.**

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

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96130	Psychological testing and evaluation; first hour	Physician, Physician Assistant, Nurse Practitioner Licensed Clinical Psychologist	• For physicians, physician assistants and nurse practitioners, psychological testing must be consistent with the scope of license and competency of the provider. • Testing and evaluation are measures of mental functioning including personality, emotions, and intellectual functioning. • 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. The clinical data, the time spent rendering services, why testing was provided, the standardized test instrument used with results, interactive feedback with patient and/or family, and any actions taken are required and must be in your documentation. • Medi-Cal will reimburse once per year for 96130, and twice per year for 96131.
96131	Psychological testing and 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. • Claims for psychological testing must include an itemization of the test performed. It must be listed either in the "Additional Claims Information" field box (Box 19) on the claim or on an attachment.

Neuropsychological Testing and Evaluation

Neuropsychological testing and evaluation measure a child's intellectual abilities, attention, learning, memory, visual-spatial skills, visual-motor integration, language, motor coordination, and executive functioning skills such as organization and planning. It may also address emotional, social, and behavioral functioning. The patient's medical necessity for testing and evaluation must be met for the compliant reporting of the service. Medical necessity criteria for neuropsychological testing can be found on page 9 and page 10 of the Non-Specialty Mental Health volume of the Medi-Cal Provider Manual at: **https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf.** Although a HealthySteps Specialist may not render this service, traditionally, it is included in this guide for those HealthySteps Specialists that may be neuropsychologists.

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 testing evaluation services; first hour E.g., California Verbal Learning Test-2nd Edition (CVLT-II), Rey Auditory Verbal Learning Test (RAVLT), Wechsler Intelligence Scale for Children-5th Edition (WISC-V)	Physician, Physician Assistant, Nurse Practitioner Licensed Clinical Psychologist Licensed Neuropsychologist	• The patient must present with medical necessity for testing. . • Medi-Cal will reimburse for one testing and evaluation service per year. Verification with other insurance carriers is required. • 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. • Documentation requirements include the time spent rendering services, its medical necessity, test with results and interpretation, clinical data and decision making, treatment planning, and interactive feedback to the patient and/or family. • Neuropsychological testing must be consistent with the scope of license and competency of the provider, where neurology must be included in their scope of practice. • Claims must include an itemization of the test performed. It must be listed either in the "Additional Claims Information" field box (Box 19) on the claim, or on an attachment.
96133	Neuropsychological testing evaluation services; each additional hour after the first hour of service		

Psychological or Neuropsychological Test Administration and Scoring

Services for psychological or neuropsychological test administrations and scoring do not include evaluation, as psychological testing with evaluation and neuropsychological testing with evaluation do. Some practices may provide services for the test administration and scoring, but not for evaluation services, and if so, these are the codes to report. Although a HealthySteps Specialist may not render these services, traditionally, they are included in this guide for those HealthySteps Specialists that may be psychological and/or neuropsychological technicians.

The patient must present with medical necessity for testing and scoring. Medical necessity criteria for neuropsychological testing can be found on pages 9 and 10 of the Non-Specialty Mental Health Volume of the Medi-Cal Provider Manual at: **https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf.**

The table below highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for reporting psychological or neuropsychological testing and scoring.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96136	Psychological or neuropsychological test administration and scoring, by physician or other qualified health care professional, two or more tests; first 30 minutes	Physician, Physician Assistant, Nurse Practitioner Licensed Clinical Psychologist Licensed Neuropsychologist Technician authorized to render psychological or neuropsychological tests with soring	• With reference to service descriptions for the billing codes, "Other qualified health care professionals" are physician assistants and nurse practitioners. For these providers and physicians, including psychologists, testing must be consistent with the scope of license and competency of the provider, where neurology is included in their scope of practice. • Documentation and service requirements include, but are not limited to, the test with scoring, patient's medical necessity for the test, time spent rendering the services, communication with patient and/or family members including next steps. Post-test interviews, pre-test instructions, and test materials are included. • Verification of the type of technicians eligible to render testing and scoring must be made with insurance carriers. Additionally, billing protocols must also be verified, as technicians may not be able to independently bill for services. • Claims for testing must include an itemization of the test performed. It must be listed either in the “Additional Claims Information” field box (Box 19), on the claim, or on an attachment.
96137	Psychological or neuropsychological test administration and scoring, by physician or other qualified health care professional, two or more tests; each additional 30 minutes		
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests; first 30 minutes		
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests; each additional 30 minutes		

96146	Psychological or neuropsychological test administration, via electronic platform, with automatic result, only.		• Medi-Cal will reimburse for the billing of codes 96136 (when services are rendered by a physician), 96138 (when services are rendered by a technician), and 96146 (when services are rendered via electronic platform), once per year. Medi-Cal will provide reimbursement for the billing codes 96137 (each additional 30 minutes of service rendered by a physician) and 96139 (each additional 30 minutes of service rendered by a technician) nine times per year. In the code descriptions, you will find reference to the code pertaining to "two or more tests." This indicates that the codes can only be billed when rendering two or more tests. A physician can only bill for one test if they are conducting evaluation services (96132). A technician can only bill for one test, if delivered via electronic platform (96146).

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 were 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.

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

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90785	Interactive complexity	Licensed Clinical Psychologist Licensed Marriage and Family Therapist Licensed Professional Clinical Counselor Licensed Clinical Social Worker Psychiatrist (psychiatric physician) Psychiatric Physician Assistants and Psychiatric Nurse Practitioners, when rendering services for psychiatric diagnostic evaluations and psychotherapy	• 90785 is an add-on code, meaning it cannot be billed on its own and can only be added in the reporting of another service(s). • The applicable approved services that interactive complexity can be reported with are diagnostic psychiatric evaluations (90791, 90792) and certain psychotherapy services. The approved psychotherapy service codes are 90832, 90834, 90837, and 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 factor(s) and how they increased the intensity of the services being rendered, by the additional difficulty in either delivering the service or providing treatment to the patient.

Case Management Medical Team Conference

Medi-Cal will reimburse for interdisciplinary team medical conferences, when conducted either 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.

The table below highlights the billing codes for the participation of non-physician qualified health care professionals, their descriptions, and applicable guidelines.

CPT Code	Description	Reimbursable Clinician(s)	ICD10 Code	Applicable Guidelines
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 non-physician health care professional	Licensed Marriage and Family Therapist Licensed Professional Clinical Counselor Licensed Clinical Social Worker Licensed Clinical Psychologist	Concrete behavior/mental health diagnoses may be required to support the medical necessity for these services. Insurance carrier verification is required.	• Coding for 99366 indicates that either the patient or their family was present during the conference. • Coding for 99368 indicates that the conference was conducted between the members of the interdisciplinary team where the patient and family were not present. • 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 behavioral/mental health providers) where the patient's treatment plan is reviewed and discussed. All participants must be immediately involved in the case or recovery of the patient.
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 non-physician health care professional			

		.		• 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. • The frequency limit for these services is: One per day, per provider. Insurance carrier verification must be made if there are weekly, monthly, or yearly limitations, and if there are limitations to how many providers can bill on the same date of service, if under the same specialty. • Services indicate to be rendered face-to-face. Insurance verification is recommended if services want to be rendered via telehealth. • The code for this service is for the time spent in the medical conference and not the time spent on associated services such as e-mails or prior medical record review.

Alcohol and Drug Screening, Assessment, Brief interventions, and Referral to Treatment (SABIRT Services)

Medi-Cal reimburses for screening alcohol and drug use screening, assessment, brief interventions, and referral to treatment when the parent/caregiver is also a patient at the practice, including pregnant women, when conducted in a primary care setting. These services can only be billed under the patient who is directly receiving SABIRT services, also recognized as SBIRT services.

Although CPT codes 99408 and 99409 are widely used for the reporting of SABIRT services, Medi-Cal guidelines indicate to use the below codes. Verification with insurance carriers on their preferred billing codes for claim submission should be made.

The table below highlights the billing codes, their descriptions, the approved diagnosis codes, and applicable guidelines.

CPT Code	Description	ICD10 Code	Reimbursable Clinician(s)	Applicable Guidelines
G0442	Annual alcohol misuse screening, 15 minutes Validated Screening Tools: 1. Cut Down Annoyed Guilty Eye-opener Adapted to Include Drugs (CAGE-AID), 2. Tobacco, Alcohol, Prescription Medication and Other Substances (TAPS), 3. National Institute on Drug Abuse (NIDA) Quick Screen for Adults, 4. Parents, Partner, Past and Present (4 Ps) for pregnant women and adolescents, 5. Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents, 6. Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population, 7. Alcohol Use Disorders Identification Test (AUDIT-C)	Z13.89-Encounter for screening for other disorder	Physician, Physician Assistant, Nurse Practitioner Licensed Clinical Social Worker Certified Nurse Midwives and Licensed Midwives Licensed Marriage and Family Therapist Licensed Clinical Psychologist Licensed Professional Clinical Counselor	• Annual alcohol misuse screenings and drug screenings are reimbursed once per year, per provider, utilizing a validated screening tool. Exception: With regard to using the screening and assessment tools chart provided by the National Institute on Drug Abuse (NIDA), alcohol misuse screenings are reimbursable when the single NIDA Quick Screen alcohol-related question is used without including the additional NIDA Quick Screen questions. • When a screening is positive, clinicians must use an appropriate validated assessment tool to determine if an alcohol or substance use disorder is present. Validated assessment tools include: 1. NIDA-modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST), 2. Drug Abuse Screening Test (DAST-20), and 3. Alcohol Use Disorders Identification Test (AUDIT C). Medi-Cal permits billing for alcohol and/or drug screening when a validated alcohol and/or drug assessment tool is used, without initial use of a validated screening tool. • Annual alcohol misuse screenings are only reimbursable once per year, per provider.

H0049	Alcohol and/or drug screening **(Medi-Cal recognizes this code for drug screening only)** E.g., Drug Abuse Screening Test (DAST-10), Tobacco, Alcohol, Prescription Medication, and other Substances (TAPS), National Institute on Drug Abuse (NIDA) Quick Screen for Adults	Z02.83- Encounter for blood-alcohol and blood-drug test		• Alcohol and/or drug screenings are only reimbursable once per year, per provider. • Intervention services are reimbursable once per day, per provider. • Intervention services are only reimbursable when a validated assessment tool is used. • Brief intervention services can be provided on the same date of service as alcohol or drug use screening. • Services are reimbursable when rendered to patients 11 years of age and older. • Verification with insurance carriers must be made if there are frequency limitations to weekly, monthly, or yearly intervention sessions. • Services and documentation requirements for intervention services include, but are not limited to the time spent rendering the service, screening and assessment tool used (with scoring), providing feedback to the patient regarding screening and assessment results, the discussion on negative consequences that have occurred and overall severity of the problem, supporting the patient in making behavioral changes, and discussing and agreeing on plans for follow-up with the patient, including referral to other treatment, if indicated. • Screenings and intervention services may be provided on the same date of service. The reporting of CPT code H0050 may cover both screening and intervention services. Verification with insurance carrier is required.
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes Validated assessment tools: NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST), Drug Abuse Screening Test (DAST-20), Alcohol Use Disorders Identification Test (AUDIT)	Z71.41- Alcohol services- brief intervention Z71.51- Drug services- brief intervention		

Smoking and Tobacco Use Cessation

Smoking can negatively affect babies through infancy and childhood. Among the risks are developmental delays and learning disabilities. Furthermore, secondhand smoke is particularly harmful to children because it can increase their risk of multiple health issues. Primary care physicians and licensed behavioral health providers have an excellent opportunity to identify and treat smoking and tobacco use and help prevent adverse outcomes.

Medi-Cal will reimburse for smoking and tobacco use cessation counseling when the parent(s)/caregiver(s) are also patients at the practice. These services can only be billed under the patient who is directly receiving smoking and tobacco use cessation services. Successful intervention begins with identifying users and providing appropriate interventions based upon the patient's willingness to quit.

The table below highlights the billing codes for smoking cessation counseling, their descriptions, the approved diagnosis codes, and applicable guidelines.

CPT Code	Description	Reimbursable Clinician(s)	ICD10 Code	Applicable Guidelines
99406	Smoking and tobacco use cessation counseling visit; intermediate, **greater than 3 minutes,** up to 10 minutes (4 minutes-10 minutes)	Licensed Professional Clinical Counselor Licensed Clinical Social Worker Licensed Clinical Psychologist Licensed Marriage and Family Therapist Physician, Physician Assistant, Nurse Practitioner Certified Nurse Midwife and Licensed Midwife	Tobacco use disorder code applicable to the patient	• Tobacco use disorder example diagnoses are: F17.210-Nicotine dependence, cigarettes, uncomplicated. F17.220-Nicotine dependence, chewing tobacco, uncomplicated. O99.332-Smoking (tobacco) complicating pregnancy, second trimester. When pregnant, an additional F code that represents the kind of tobacco used must be coded with the pregnancy diagnosis. • Service and documentation requirements include total time spent rendering services, what was discussed including cessation techniques, resources provided, follow-up for each visit, and that the patient was provided information on the California Smokers Helpline (1-800-NO-BUTTS). • Reimbursement for smoking cessation counseling services include when services are rendered to those patients who are not currently ready to make a quit attempt. • 3 minutes or less of smoking and tobacco use cessation counseling is not eligible for reimbursement and should not be billed.
99407	Smoking and tobacco use cessation counseling visit; intensive, **greater than 10 minutes** (11 minutes or more)			

				• Medi-Cal provides reimbursement for one counseling session, per day, with no yearly frequency limits, but does advise of a clinical minimum of 4 sessions in the year. Verification with other insurance carriers is required. • When prescribing medication, verification on covered treatment is required. • For pregnant woman, tobacco cessation counseling must be covered for at least 60 days after delivery. Verification on if smoking cessation services are among those Medi-Cal postpartum care expansion services eligible for reimbursement for up to 12 months postpartum, must be made with insurance carriers. • Providers should refer to the Tobacco Cessation Guidelines by The American College of Obstetrics and Gynecology (ACOG) before prescribing tobacco cessation medications during pregnancy.

The Comprehensive Perinatal Services Program (CPSP)

The Comprehensive Perinatal Services Program (CPSP) was implemented in 1987, by the California Department of Health Services (DHS) to provide enhanced prenatal and postpartum care to eligible low income pregnant and postpartum women. It is a Medi-Cal benefit described as an enhanced obstetric care model, that offers a range of services to pregnant patients from the date of conception, through 60 days after the month of delivery. Verification on if CPSP services are among those Medi-Cal postpartum care expansion services eligible for reimbursement for up to 12 months postpartum, must be made with insurance carriers. Under this benefit, women can receive traditional obstetric services and enhanced services in the areas of nutrition, psychosocial services, and health education. Provider enrollment is required prior to rendering services under the program. CPSP training will include information for each service, and a provider manual that contains an array of information for successful rendering of CPSP services.

If physicians are interested in becoming CPSP providers, they should contact their local perinatal services coordinator (PSC) at the local county health jurisdiction. For the CPSP provider application, training resources, and how to contact your local perinatal services coordinator, the following California Department of Public Health website can assist**: Comprehensive Perinatal Services Program (ca.gov).**

Additional information on CPSP services is available by calling the CPSP toll-free line at 1-866-241-0395 or by addressing correspondence to**:** CPSP Applications, California Department of Public Health Maternal, Child and Adolescent Health Division, 1615 Capitol Avenue-MS8300 Sacramento, CA 95814 OR California Department of Public Health Maternal, Child and Adolescent Health Division, P.O. Box 997420-MS8300 Sacramento, CA 95899-7420.

To verify Medi-Cal patient eligibility for the program, the patient's social security number can be used in the Eligibility Verification System, or if the patient does not have a Benefits Identification Card (BIC), the Medi-Cal County Contact for Providers can assist. The following website can help you to search for your County Contact for Providers: **https://files.medi-cal.ca.gov/pubsdoco/county_contacts.pdf.** The link to the Eligibility Verification System is: **https://www.medi-cal.ca.gov/Eligibility/Login.asp.**

This section contains a summary of CPSP information that will assist in understanding the program's billing policies, services, documentation, and billing requirements.

The following CPSP information is available on the Medi-Cal and California Department of Health Websites. Additional information and/or clarification on program regulations that is needed by the providers at your practice must be verified with the California Department of Health and with your local Perinatal Services Coordinator at the practice's local county health jurisdiction.

Universal Comprehensive Perinatal Services Program (CPSP) Policies

The CPSP has its own policies for rendering and billing for the services that fall under the program's auspices. The following policies are applicable:

- All practices rendering CPSP services must have a Medi-Cal enrolled CPSP physician, where CPSP services must be provided by, or under the personal supervision of a physician. Personal supervision is evaluation in accordance with protocols, by a licensed physician, or services performed by others through direct communication either in person or through electronic means.

- Physicians must possess a current provider number/National Provider Identifier (NPI) and must complete the application to participate as a CPSP physician. CPSP practitioners, who are those clinicians that can work hands-on with the patients, must be listed as a CPSP practitioner with the California Department of Public Health. Information on how to be identified as a CPSP practitioner can be obtained from the CPSP training, your administrative staff, your practice's CPSP physician, or from your local Perinatal Services Coordinator (PSC) at the local county health jurisdiction.

- Treatment Authorization Requests (TARs) are not required for the billing and rendering of CPSP services unless exceeding the maximum units of service allowable. If TARs are not required at your practice (e.g., FQHCs/RHCs), chart documentation for additional CPSP services must include the same justification necessary to obtain a TAR. For patients under Medi-Cal managed care organizations (MCOs), FQHCs and RHCs should bill the MCO first, then Medi-Cal should be billed for the remainder of the Prospective Payment System (PPS) rate.

- CPSP services are not intended to be provided to inpatients.

- CPSP services are in addition to, not a replacement for, the services that are part of the American College of Obstetrics and Gynecology (ACOG) visit standards.

- Reimbursement for nutritional, psychosocial and health education services is made on an itemized basis (per visit).

- CPSP visits in FQHC/RHC settings are paid at a flat fee rate, per visit, as defined in the prospective payment system, where the one visit, per day, flat rate reimbursement guideline still applies.

- CPSP services can be rendered via telephone and telehealth under California's COVID state of emergency medical and billing guidelines, but once these guidelines have been lifted, verification must be made with your insurance carriers, if CPSP services will continue to be eligible for reimbursement when rendered via telephone and other approved telehealth avenues. Insurance carrier verification is required.

- The patient must provide consent of all enhanced services. This can be done verbally and noted on the CPSP forms.

Eligible Organization/Clinical Setting that Can Render CPSP Services (CPSP Providers)

Rendering CPSP services is not reimbursable in all settings. The following organization and clinic types are eligible to render CPSP services:

- Clinics-FQHC, RHC, hospital, community, or county

- Group medical practices

- Alternative Birthing Centers

Eligible Practitioners that Can Render and Bill for CPSP Services (CPSP Practitioners)

The following clinicians, when enrolled as CPSP practitioners, can render CPSP services. Services rendered by those clinicians that are not authorized to independently bill for services can be billed under the CPSP physician. Practitioners must have one year of experience in perinatal care.

- Physician (general practice, family practice, OB/GYN, pediatrician)

- Certified Nurse Midwives (CNMs)

- Licensed Midwives (LMs)

- Registered Nurses (RNs)

- Licensed Vocational Nurses (LVNs)

- Nurse Practitioners (NPs)

- Physician Assistants (PAs)

- Health Educators (HEs)
- Certified Childbirth Educators (CCEs)
- Registered Dieticians (RDs)/Registered Dietician Nutritionist Consultant (RDN)
- Comprehensive Perinatal Health Workers (CPHWs)
    - Person who is at least 18 years of age, is a high school graduate or equivalent, and has at least one year of perinatal care (additional requirements must be verified)
- Social Workers (SWs)
- Psychologists (PSYs)
- Marriage and Family Therapists (MFTs)
- Verification is required if Licensed Professional Clinical Counselors can render CPSP services.

Note 1: Although not listed in the guidance, because International Board-Certified Lactation Consultants (IBCLCs) are recognized by Medi-Cal, verification with insurance carriers is recommended to verify if IBCLCs who do not possess any of the clinical licensures as the providers above, may be able to also render CPSP services when billed under a supervising physician.

Note 2: Some of the clinicians listed above may or may not require licensure. Verification of the education and credential requirements to render CPSP services must be verified with your administrative staff, your practice's CPSP physician, or from your local Perinatal Services Coordinator (PSC) at the local county health jurisdiction.

CPSP Services

CPSP services, in addition to traditional obstetric services are nutritional, health education, and psychosocial services. The following provides a description of these services and what they include:

1. **Nutrition Services**

   Nutrition is vital before, during, and after pregnancy to help ensure the optimal health of both the mother and the infant. Ongoing nutrition services are a critical aspect of a woman's perinatal care. Although not required, including Registered Dieticians (RD)/ Registered Dietitian Nutritionists (RDNs) on the CPSP team is encouraged, as these health care providers are specifically qualified to provide nutrition services and education for patients and technical assistance to other CPSP team members.

   Nutrition Services include:

   - Nutrition initial assessment and follow-up reassessment for each trimester. Assessments, re-assessments, and interventions are carried out by designated and trained CPSP staff and should occur at the initial assessment, trimester re-assessments, postpartum, and anytime as needed.
   - Education and interventions which are needed for nutritional problems detected in the assessment.
   - An individualized care plan addressing the patient's nutritional needs and goals.
   - Medical nutrition therapy may be provided to women presenting with complex medical conditions which may require more in-depth nutrition, assessment, diet modification, frequent monitoring, and revision of the nutrition care plan. Rendering medical nutrition therapy may be required by a registered dietician or registered dietician nutritionist. Verification is required.

2. **Health Education Services**

   Pregnancy and expectant parenthood create new leaning needs for women. These needs may include accurate health and perinatal care facts, active learning for specific behavior change, and the practice of new skills or modification of current habits for optimal health. Although not required, including health educators on the CPSP team is encouraged, as they can render services to the patients and can provide technical assistance to other CPSP team members.

   Health Education Services include:

   - An initial assessment which identifies current health practices, strengths, and health education needs.

- Initial orientation and ongoing training in health education during the entire perinatal period to reinforce information given initially and to help understand new procedures, tests, or services, so that a patient's consent and participation will reflect her being informed.

- An individualized care plan that includes health education objectives that specify the health education services and interventions she will receive to meet her needs.

- Subsequent trimester and postpartum reassessments to evaluate the effectiveness of teaching, evaluate the progress towards achieving health education objectives, adjust the care plan as necessary, and evaluate patient satisfaction with services.

- Protocols that include topics such as prenatal care, self-care, the progress of pregnancy, fetal development, labor and deliver, postpartum care, safety topics, infant care, and common conditions in pregnancy.

- Health interventions, which include individual instruction, small group, and class sessions provided throughout the prenatal period and to the end of the postpartum period.

3. Psychosocial Services

Psychosocial services help patients to understand and deal effectively with the biological, emotional, and social stresses of pregnancy. CPSP psychosocial care assists women with crisis intervention, community resources, transportation needs, or any psychosocial problem affecting her care. Although not required, including a social work professional such as a Master of Social Work (MSW) or other master's prepared psychosocial professional on the CPSP team is encouraged as these health care providers are specifically qualified to provide psychosocial services and support to patients.

Psychosocial Services include:

- Initial psychosocial assessment which is used in determining what impact social, emotional, and economic issues and needs have on a woman during her pregnancy.

- Psychosocial re-assessments, every trimester and in the postpartum period. Many of the problems presented can be ameliorated by brief social work interventions.

- Psychosocial interventions which are provided for problems discovered in the assessment. These interventions are directed at assisting the client to understand and effectively manage the biological, emotional, and social stresses of a pregnancy.

Breastfeeding Services

Nutrition, health education, and psychosocial services are also applicable to breastfeeding services when the services are centered around breastfeeding.

Education and support for breastfeeding is another aspect of basic nutrition, health education, and psychosocial supports. Breastfeeding services are best provided by someone who is specialized in breastfeeding training and has experience. Medi-Cal and Medi-Cal managed care plans recognize breastfeeding promotion, education, and counseling services and are required to provide these services either into integrated perinatal care, postpartum care, or pediatric services. These services, which include breastfeeding counseling and support after delivery, referrals to WIC, and ensuring that postpartum mothers receive necessary interventions, are offered under the CPSP via nutrition, health education, and psychosocial services.

All services and documentation requirements are the same when billing for nutrition, health education, and psychosocial supports, either when the services are centered around breastfeeding, or centered around any reason of care during pregnancy and the 365 after the pregnancy ends. The only difference will be what the patient's orientation and nutrition, health education, psychosocial assessments, individualized care plans and interventions, and coordination of care will target.

(Additional specificities for these services, as well as provider credential information will be offered during the CPSP program training.)

Billing for CPSP Services:

Billing for nutrition, health education, and psychosocial services under the CPSP comes with its own set of billing guidelines, codes, and billing frequency limitations. CPSP providers can receive reimbursement for the cost of delivering CPSP services. To bill Medi-Cal for CPSP services, a physician must have already applied and been approved by the Maternal and Child Health Division of the California Department of Public Health, as a CPSP physician, and practitioners rendering services must already be enrolled as CPSP practitioners.

The following are reimbursement guidelines under CPSP:

- Reimbursement for obstetric services is the same for all Medi-Cal providers. It can be billed globally, which is when it is billed once, utilizing the appropriate code that includes antepartum care, the delivery, and postpartum care, or on a per visit billing basis. However, to bill globally, a provider must render total obstetric care. Providers may not bill a global fee if the patient transfers care during her pregnancy. Nutrition, health education, and psychosocial services may not be billed globally.

- Bonus Possibility:

- Information published in 2019 advises that in addition to standard obstetric reimbursement, CPSP offers an Early Entry into Care Bonus. According to published information, to qualify for this bonus, a patient's very first obstetric visit must occur within 16 weeks from their last menstrual period. More information on if this bonus is still a CPSP benefit, and if so, how to bill for the bonus, must be obtained in the CPSP training.

- If the bonus is still an effective CPSP benefit: If the patient declines support services, the provider may still bill for the Early Entry into Care Bonus, but only if clear documentation exists in the patient's medical record that indicates the CPSP support services were offered and refused.

- Case Coordination is provided via initial assessments and care plans for nutrition, health education, and psychosocial services. A one-time case coordination fee is available when the initial assessments and care plans in nutrition, health education, and psychosocial services are completed within four weeks of the comprehensive obstetric visit. More information regarding eligibility for the one-time case coordination fee and how to bill for it must be obtained in the CPSP training.

- Billing for initial assessments should be done, individually, apart from when all three (nutrition, health education, and psychosocial services) are rendered within four weeks of entry into care. Information can be found in the billing code table for CPSP services beginning on page 56.

- Nutrition, health education, and psychosocial services are billed in 15-minute increments except for the initial assessments which require a minimum of 30 minutes.

- When billing for services, a diagnosis of pregnancy according to the patient's trimester, or a postpartum diagnosis, is applicable as the primary diagnosis. Any condition(s) applicable to the patient must also be diagnosed as well as any additional reason(s) for the rendering of services-e.g., if rendering psychosocial services, adding a social determinant of health ICD-10 Z code if applicable.

Documentation Guidelines for CPSP Services

CPSP services, like all services, have documentation guidelines for the rendering and billing of services. The following are documentation guidelines for CPSP services:

- Reimbursement for nutrition, health education and psychosocial services include initial assessments, care plan development, antepartum and postpartum reassessments, and interventions. The following must be documented in the patient's medical record:

    - A brief description of all services provided including:

        - Initial assessment and re-assessments on the approved forms

- Initial assessments must be at least 30 minutes for each support service discipline, including development of the individualized care plan with the patient.
- Complete and updated care plans on the approved forms
- Documentation of all interventions; and
- Ensure that all completed and dated forms are in the medical record.

- Additional documentation requirements include:
  - Patient refusal of any assessment, intervention, treatment, or referral offered.
  - A signature of the clinician providing the service, including their CPSP title and the CPSP physician's signature; and
  - The date of service and length of time (in minutes) that the service was provided.
- When Documenting for Group Nutrition, Health Education, and Psychosocial Services:
  - Two or more CPSP patients compromise a group.
  - Documentation must maintain outlines identifying the group's discussions and content covered during the session.
  - Documentation must include the date, topic, and name of the clinician on the patient sign-in sheets.
  - Record attendance at the session in each patient's medical record, including the elapsed time (in minutes) of actual time the patient spent in the session.
  - Providers must retain the sign-in sheet and the class outline in a file separate from individual patient records to avoid a HIPAA violation. They must be available to auditors, if requested.

Billing Codes and Frequency Limitations for CPSP Services

The following table highlights the CPSP billing codes and their descriptions for nutrition, health education, and psychosocial services. The maximum units of service approved for reimbursement are also included. Verification must be made with insurance carriers if CPSP services are among those services eligible for reimbursement for up to 12 months postpartum.

HCPCS Code	Description	Maximum Units of Service That Can be Billed During Pregnancy and the Postpartum Period
Nutritional Counseling Services (including when related to breastfeeding)		
Z6200	Initial nutrition assessment and development of care plan; first 30 minutes	1
Z6202	Initial nutrition assessment and development of care plan; each subsequent 15 minutes (maximum of 1.5 hours)	6
Z6204	Follow-up antepartum nutrition assessment, treatment and/or intervention; individual, each 15 minutes (maximum of 2 hours)	8
Z6206	Follow-up antepartum nutrition assessment, treatment and/or intervention; group, per patient, each 15 minutes (maximum of 3 hours)	12
Z6208	Postpartum nutrition assessment, treatment and/or intervention; including development of care plan, individual, each 15 minutes (maximum of 1 hour)	4
Psychosocial Support Services (including when related to breastfeeding)		
Z6300	Initial psychosocial assessment and development of care plan; first 30 minutes	1
Z6302	initial psychosocial assessment and development of care plan; each subsequent 15 minutes (maximum of 1.5 hours)	6
Z6304	Follow-up antepartum psychosocial assessment, treatment and/or intervention; individual, each 15 minutes (maximum of three hours)	12

Z6306	Follow-up antepartum psychosocial assessment, treatment and/or intervention; group, per patient, each 15 minutes (maximum of four hours)	16
Z6308	Postpartum psychosocial assessment, treatment, and/or intervention, including development of care plan; individual, each 15 minutes	6
Comprehensive Health Education Services (including when related to breastfeeding)		
The time following another	Client orientation (health education) each 15 minutes (maximum of two hours)	8
Z6402	Initial health education assessment and development of care plan, first 30 minutes	1
Z6404	Initial health education assessment and development of care plan, each subsequent 15 minutes (maximum of two hours)	8
Z6406	Follow-up antepartum health education assessment, treatment and/or intervention; individual, each 15 minutes (maximum of two hours)	8
Z6408	Follow-up antepartum health education assessment, treatment and/or intervention; group, per patient, each 15 minutes (maximum of two hours)	8
Z6410	Perinatal education; individual, each 15 minutes (maximum of four hours)	16
Z6412	Perinatal education; group per patient, each 15 minutes	16 per day, with a maximum of 72 units in total during pregnancy
Z6414	Postpartum health education assessment, treatment and/or intervention, including development of care plan; individual, each 15 minutes (maximum of one hour)	4

Additional Codes and Services		
Antepartum Medical Visits and Postpartum Medical visit		
Z1032	Initial antepartum office visit performed within 16 weeks of the patient's last menstrual period (billed if a patient's very first obstetric visit occurs within 16 weeks of their last menstrual period **(verification with program is required)**, even if a patient declines CPSP services where the provider's documentation clearly indicates that the services were offered and refused). *If Services are rendered by a physician, modifier ZL must be appended to Z1032.If the service was rendered by a certified midwife (CNM), physician assistant (PA), or nurse practitioner (NP), modifier 99 must be appended to Z1032, along with the modifier that identifies the provider type.-Modifier SB identifies a CNM, modifier U7 identifies a PA, and modifier SA identifies an NP. Modifiers must be in the Remarks Field Box of the claim (Box 80) or in the Additional Claim information field (Box 19) when billing with modifier 99 (e.g., modifier 99 and modifier SB would be placed either in Box 80 or Box 19 when a CNM rendered the service).*	1
Z1034	Antepartum medical visit (can be billed for 13 visits total, per pregnancy-2nd through 14th visit) - can only be billed by a CPSP physician	13
Z1038	Postpartum medical visit (can only be billed by a CPSP physician)	Must be verified with insurance carrier(s)
Initial Nutrition, Psychosocial and Health Education Assessments (when billing for all three)		
Z6500	Initial comprehensive nutrition, psychosocial, and health education assessments and development of care plan within 4 weeks of entry into care. Individual, first 30 minutes of each assessment (90 minutes total), including ongoing coordination of care. *May only be reported if all three initial assessment and development of care plans were rendered within 4 weeks of the patient's entry into care, and if the initial pregnancy-related exam was also completed within the same 4-week period. Summary: This code is used when the initial CPSP assessment was completed within 4 weeks of the initial prenatal exam. The 90-minute timeframe is for health education, nutrition, and psychosocial initial assessment times only (30 minutes each), but you can bill for re-assessments throughout the time the patient is in the program.*	1

Prenatal Vitamins		
S0197	Prenatal vitamins, 30-day supply (when prescribed by a provider during nutritional services). 1 unit of service is equivalent to a prescription of 30 vitamins, which may be billed, per date of service. The maximum number of vitamins that can be prescribed during pregnancy is 300-making 10 the max number of units that can be billed, per pregnancy. Can be billed and reimbursed on the same date of service with other nutritional services.	10 during duration of pregnancy

Note: The use of modifiers is exempt when billing for CPSP services except for the billing of code, Z1032 (Initial antepartum office visit performed within 16 weeks of a patient's last menstrual period), when modifier ZL should be appended upon claim submission.

Reporting of Units when Billing for Time-Based Codes

Because CPSP services are billed in 15-minute time increments except when billing for initial assessments, the units of service reported on a medical claim can change according to the time the provider rendered and documented for. When billing for time-based codes, national coding guidelines advise of the midpoint rule, also known as the time rule. Time-based services are services whose description indicates a time requirement for rendering the service. The time rule is applicable to those time-based service codes whose descriptions provide an exact time requirement, and not a range (e.g., 5-10 minutes or greater than 10 minutes). The time rule for time-based services indicates that if **more than half** of the time allotted in a code's description is spent rendering the service, then the service code can be billed. (e.g., codes that contain 15 minutes in their description can be billed if 8 minutes or more of time was spent rendering the services.)

Insurance carriers have the option of either adapting the time rule (A.K.A. midpoint rule) for all time-based codes or applying it to only some of the time-based codes, and they also have the option of not adapting the rule at all where the time indicated in a code's description must be rendered in full. **Medi-Cal's guidance for CPSP services indicates their approval to use the time rule for the coding of CPSP services, but only for those CPSP billing codes whose descriptions indicate that they are for "each 15 minutes of service"**.

When looking to the codes for CPSP services in the table above (starting on page 54), the following codes indicate they are for 15 minutes of service, therefore, making them **eligible to bill when at least 8 minutes of services has been rendered:**

CPSP Services That Can Be Billed When 8 Minutes or More of Services Have Been Rendered			
Z6202	Initial nutrition assessment and development of care plan; each subsequent 15 minutes (maximum of 1.5 hours	Z6400	Client orientation (health education) each 15 minutes (maximum of two hours)

Z6204	Follow-up antepartum nutrition assessment, treatment and/or intervention; individual, each 15 minutes (maximum of 2 hours)	Z6404	Initial health education assessment and development of care plan, each subsequent 15 minutes (maximum of two hours)
Z6206	Follow-up antepartum nutrition assessment, treatment and/or intervention; group, per patient, each 15 minutes (maximum of 3 hours)	Z6406	Follow-up antepartum health education assessment, treatment and/or intervention; individual, each 15 minutes (maximum of two hours)
Z6208	Postpartum nutrition assessment, treatment and/or intervention; including development of care plan, individual, each 15 minutes (maximum of 1 hour)	Z6408	Follow-up antepartum health education assessment, treatment and/or intervention; group, per patient, each 15 minutes (maximum of two hours)
Z6302	initial psychosocial assessment and development of care plan; each subsequent 15 minutes (maximum of 1.5 hours)	Z6410	Perinatal education; individual, each 15 minutes (maximum of four hours)
Z6304	Follow-up antepartum nutrition assessment, treatment and/or intervention; individual, each 15 minutes (maximum of 2 hours)	Z6412	Perinatal education; group per patient, each 15 minutes
Z6306	Follow-up antepartum psychosocial assessment, treatment and/or intervention; group, per patient, each 15 minutes (maximum of four hours)	Z6414	Postpartum health education assessment, treatment and/or intervention, including development of care plan; individual, each 15 minutes (maximum of one hour)
Z6308	Postpartum psychosocial assessment, treatment, and/or intervention, including development of care plan; individual, each 15 minutes		

When looking to the codes for CPSP services in the table starting on page 54, the following codes indicate they are for 30 minutes of service, therefore, making them **ineligible** to bill when at least 8 minutes of services has been rendered, and can **ONLY be billed when 30 minutes of services have been rendered and documented for:**

CPSP Services That Can Only Be Billed When 30 Minutes of Services Have Been Rendered	
Z6200	Initial nutrition assessment and development of care plan; first 30 minutes
Z6300	Initial psychosocial assessment and development of care plan; first 30 minutes
Z6402	Initial health education assessment and development of care plan, first 30 minutes

Note: Codes listed under "Additional Codes and Services" and "Initial Nutrition" and "Psychosocial and Health Education Assessments (when billing for all three)" located on page 56, and the code listed under "Prenatal Vitamins" located on page 57, are not time-based codes and therefore are exempt.

Calculating Billing Units for Time-Based Codes

The table below provides an outline of how Medi-Cal calculates billing units based on the midpoint rule for CPSP services whose descriptions indicate the services are to be billed for "each 15 minutes." It contains the required minutes of services that must be rendered to bill for each unit of service.

Calculating Billing Units	
Time Rendering Care	**Billable Units for Time Spent Rendering Care**
00-07 Minutes	Not payable, do not bill
08-22 Minutes	1 unit of service can be billed for
23-37 Minutes	2 units of service can be billed for
38-51 Minutes	3 units of service can be billed for
EXCEPTIONS: Z6200, Z6300 and Z6402 must be billed in 30-minute units	

Note: Medi-Cal's guidance did not supply information on the ability to use the midpoint rule when billing for more than 51 minutes of service, therefore the table above does not include 51 minutes or more. If you follow national coding guidelines, once 52 minutes of services have been rendered, you can bill for the full hour of service.

Breastfeeding (Lactation) Services when rendered outside of the Comprehensive Perinatal Services Program

Medi-Cal reimburses for lactation services, both within the Comprehensive Perinatal Services Program (CPSP) and outside of the program, when billed by a physician. Because the Medi-Cal website offers limited information regarding breastfeeding services when rendered outside of the CPSP program, the following section will contain the information readily available on the Medi-Cal website. Additional verification with insurance carriers is highly recommended for a more robust explanation of benefits.

The following table contains billing codes, reimbursable clinicians, diagnoses information, and applicable guidelines when billing for breastfeeding services when rendered outside of CPSP:

CPT Code	Description	Reimbursable Clinician(s)	ICD10 Code	Applicable Guidelines
99202 through 99205	Evaluation and Management **(E/M)** codes for new patient office visits	Physician (including OB/GYN physician and Pediatrician) Registered Nurse-under the supervision of a physician Registered dietician-under the supervision of a physician	Diagnosis code(s) related to persistent discomfort to the woman while breastfeeding. Diagnosis code(s) related to infant weight gain concerns. Diagnosis code(s) related to milk extraction. Diagnosis code(s) related to suck dysfunctions of the infant. Z39.1-Care and examination of lactating mother (as the secondary diagnosis when billing under the mother)	• Medi-Cal will reimburse for lactation services outside of the CPSP program when related to nutritional services listed as: Persistent discomfort to the woman while breastfeeding, infant weight concerns, milk extraction, and suck dysfunctions of the infant. For additional services, insurance verification is required. • Although Medi-Cal guidance advises that a physician must bill for the approved lactation services when billed outside of the CPSP program, Medi-Cal does recognize International Board-Certified Lactation Consultants (IBCLCs) for the rendering of lactation services. Insurance carrier verification must be made on IBCLC billing guidelines. • Medi-Cal will reimburse for services billed under the infant, by a pediatrician, in addition to when billed under the mom, when the diagnoses are specific to the infant, such as: diagnoses related to infant weight gain concerns and diagnoses related to suck dysfunctions of the infant.
99211 through 99215	Evaluation and Management **(E/M)** codes for established patient office visits			• When a patient visits a physician for a separate service, other than lactation services, and receives care from a registered dietician for lactation services, on the same day, the physician must bill the evaluation and management office visit code that reflects the combined level of service.

				• If the physician is not present with the registered dietician upon the rendering of lactation services, E/M code 99211 should be billed. • For FQHCs/RHCs, billing may need to include HCPCS code T1015 (all-inclusive clinic visit), in addition to the reporting of the evaluation and management code. Verification with insurance carriers is required.

Psychotherapy

Medi-Cal will reimburse family, group, and individual psychotherapy services for the treatment of mental health and/or developmental disorders, and for the prevention of mental health disorders. The following are the psychotherapy benefits eligible for reimbursement:

1. Psychotherapy when a patient is diagnosed with a mental health disorder or developmental disorder of infancy and early childhood:

    - Patients of any age that are diagnosed with a mental health disorder as defined by the Diagnostic and Statistical Manual of Mental Health Disorders (for adults), and/or as defined by the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) (for children).

2. Psychotherapy when a patient is not diagnosed with a mental health disorder or developmental disorder of infancy and early childhood:

    - Patients under the age of 21 that are not diagnosed with a mental health and/or developmental disorder but have a history of at least one of the approved Medi-Cal risk factors, and/or if they have a parent/guardian with one of the approved Medi-Cal risk factors.

3. Psychotherapy when a patient presents with persistent mental health symptoms, with the potential of a mental health disorder, in the absence of a mental health diagnosis where the symptoms do not reach clinical threshold:

    - Patients under the age of 21 that have persistent mental health symptoms in the absence of a mental health disorder.

4. Psychotherapy for the prevention of perinatal depression:

    - Pregnant and postpartum women, of any age, who are at risk of perinatal depression, that present with at least one of the approved Medi-Cal risk factors.

Below is an overview of each psychotherapy service eligible for reimbursement with medical necessity requirements, and billing and coding guidelines for each service. The services are numbered, as they are, above.

1. Psychotherapy When a Patient ***is Diagnosed with a Mental Health Disorder or Developmental Disorder*** of Infancy and Early Childhood

Medi-Cal provides reimbursement for individual and family psychotherapy services when patients of any age are diagnosed with a mental health disorder as defined by the Diagnostic and Statistical Manual of Mental Health Disorders (for adults), and/or as defined by the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) (for children).

The table below and those on the following pages, highlight the billing codes, their descriptions, reimbursable clinicians, and guidelines for reporting psychotherapy when a patient is diagnosed with a mental health and/or developmental disorder of infancy and early childhood.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90832	Individual psychotherapy with patient-30 minutes	Licensed Clinical Psychologist and Psychologist Assistant under supervision	• Because psychotherapy services, when rendered to a patient that is diagnosed with a mental health and/or developmental disorder include evaluation of functional and mental status, a psychiatric diagnostic evaluation (90791,90792) cannot be billed on the same date of service.
90834	Individual psychotherapy with patient-45 minutes	Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under supervision	• Associate behavioral health providers and assistants must bill under, and be supervised by a licensed billable behavioral health provider. The claim must list the associate/assistant's name in the "Additional Claim Information" (Box 19) field or in an attachment with the supervising clinician's National Provider Identifier (NPI) as the "billing provider."
	Individual psychotherapy with patient-60 minutes	Licensed Clinical Social Worker and Associate Clinical Social Worker under supervision	• A signed and dated treatment plan is required and must include, but is not limited to, the patient's diagnosis, treatment goals, and the number of sessions ordered by the PCP. The treatment plan should also be signed by the PCP.

90847	Family psychotherapy **with** the patient present-50 minutes with patient and family	Licensed Professional Clinical Counselor and Associate Professional Clinical Counselor under supervision	• Reviewing of 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. • Documentation should include the above services in addition to the patient's diagnosis, symptoms, functional status, mental status examination, treatment plan, prognosis, progress, and how the patient is or has benefited from therapy in reaching goals. When documenting for time and selecting the time-based psychotherapy code, providers should only attribute the time spent rendering the psychotherapy session. • The number of psychotherapy sessions eligible for reimbursement must be verified with insurance carriers. • Family therapy can still be billed under an infant, when rendered due to his/her diagnosis, who has not yet been assigned a Medi-Cal number. The sessions may be billed with the birthing parent's Medi-Cal ID for the month of birth and the following month only.
90846	Family psychotherapy **without** the patient present-50 minutes with patient and family (FQHC's and RHC's must verify with insurance carriers if this service is eligible for reimbursement)	Psychiatrist (Psychiatric Physician) and Psychiatric Physician Assistant and Psychiatric Nurse Practitioner under supervision	
90849	Multiple-family group psychotherapy (a group consisting of different patients, and their families) with either the same, or similar issues or conditions.	Behavior/mental health assistant and associate providers may be able to be supervised by any of the licensed, billable behavior/mental health providers listed above. Verification with insurance carriers is required.	

90853	Group psychotherapy (a group composed of patients, only) with either the same, or similar issues or conditions		• Family 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 condition has on the family and the patient, with therapy aimed at improving interactions between the patient and family member(s)/caregiver(s). Family psychotherapy must be composed of at least two family members. • Documentation for family therapy must include the diagnosis, symptoms, functional status, mental/developmental status, treatment plan, prognosis, and progress. The time spent rendering the services, family communication and dynamics (verbal or non-verbal) and how the patient and family is or has benefited from therapy in reaching goals, must also be included. • Medi-Cal's examples of family therapy include Child-parent psychotherapy (ages 0 through 5), Parent-child interactive therapy (ages 2 through 12), and Cognitive-behavioral couple therapy for adults. • Medi-Cal provides reimbursement for family psychotherapy for a maximum of 50 minutes, per therapy session, per day, when the patient is not present (90846), and a maximum of 110 minutes, per session, per day, for family therapy when the patient is present (90847). Although Medi-Cal guidelines provided maximum time requirements for these services, it did not provide minimum time requirements for services. Verification on if there is an allowable minimum time requirement, must be made with insurance carriers.
90839	Psychotherapy for crisis; first 60 minutes; face-to-face with patient		
90840	Psychotherapy for crisis; each additional 30 minutes; after the first 60 minutes of services is rendered; face-to-face with patient.		

			• Medi-Cal does not define separate guidelines for the billing of multiple-family group therapy. This can indicate that the guidelines for group therapy pertain to multiple-family group therapy as well. Insurance carrier verification is advised. Multiple-family group therapy (90849) cannot be reported on the same day as family therapy (90846, 90847). • Documentation requirements for both group and multi-family group therapy include, but are not limited to, documentation in each patient's medical record, a start and stop time of the session, primary focus of the therapy session, summarization of the clinical intervention used, and whether the patient (for group therapy) and the patient and/or family members (for multiple-family group therapy) participated and how they participated. Personal and group dynamics, the patient's current clinical status, and progress of the patient or the group should also be included. • Interactive complexity (90785) can be reported with psychotherapy services except for group therapy (90849) and psychotherapy for crisis (90839, 90840). • Not all group services may not be eligible for reimbursement at FQHCs/RHCs. Verification with insurance carriers is required. • Psychotherapy for crisis cannot be reported with any other mental health service on the same day. Documentation requirements include, but are not limited to, the time spent rendering the service, a mental status examination with functional status, and that the patient presented in a high level of distress with a complex or life-threatening problem (specificity needed) that required immediate attention.

2. Psychotherapy ***When a Patient is NOT Diagnosed with a Mental Health Disorder or Developmental Disorder*** of Infancy and Early Childhood (Prevention)

In addition to the reimbursement for psychotherapy services when a patient of any age is diagnosed with a mental health or developmental disorder of infancy and childhood, Medi-Cal will also reimburse for unlimited individual and family psychotherapy for patients that are **under the age of 21,** if either they, or their parent(s)/guardian(s), present with any of the risk factors specified and approved by Medi-Cal. There are

two sets of risk factors recognized for these psychotherapy sessions. One set is applicable to children who have a history of any of the factors listed and the other is applicable to the parent(s) or guardian(s).

The following are the risk factors that support medical necessity for unlimited therapy sessions for patients under the age of 21:

Risk Factors That Support Medical Necessity for Unlimited Therapy Services for Children Under the Age of 21		
If the child has a history of at least ONE of the following risk factors:		**If the child, under 21 years of age, has a parent/guardian with ONE of these risk factors:**
1. Neonatal or pediatric intensive care unit hospitalization		1. A serious illness or disability
2. Separation from a parent/guardian (for example, due to incarceration, immigration, or military deployment)		2. A history of incarceration
3. Death of a parent/guardian		3. Depression or other mood disorder
4. Foster home placement		4. Post-traumatic stress disorder (PTSD) or other anxiety disorder
5. Food insecurity, housing instability		5. Psychotic disorder under treatment
6. Exposure to domestic violence or other traumatic events		6. Substance use disorder
7. Maltreatment		7. Job loss
8. Severe and persistent bullying		8. A history of intimate partner violence or interpersonal violence
9. Experience of discrimination based on race, ethnicity, gender identify, sexual orientation, religion, learning differences or disability		9. Is a teen parent

The tables on the following pages highlight the approved billing codes, their descriptions, the approved diagnosis code, reimbursable clinicians, and guidelines for reporting psychotherapy when a patient, under the age of 21, is **NOT** diagnosed with a mental health disorder or a developmental disorder of infancy and early childhood, when either the patient or their parent/guardian have one of the approved risk factors.

CPT Code	Description	ICD-10 Code	Reimbursable Clinician(s)	Applicable Guidelines
90832	Individual psychotherapy with patient-30 minutes	Z65.9-Problem related to unspecified psychosocial circumstances	Licensed Psychologist and Assistant Psychologist under supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under supervision Licensed Professional Clinical Counselor and Associate Professional Clinical Counselor under supervision	• Documentation must include but is not limited to the patient's and/or parent(s) risk factor(s), attention given to the impact the risk factor(s) are or can have on the patient, therapy goals, and how the patient is benefiting from the therapy. • Additional time taken for other related services such as: Reviewing records, communicating with other providers, patient observation, and decision making cannot be factored into the time spent rendering psychotherapy services. The psychotherapy code billed should only reflect the time spent on rendering actual psychotherapy, where the time spent on any other services must not be incorporated. • Time indicated in each code's description must be rendered with a maximum of 1.5 hours per day, by the same provider. • An associate marriage and family therapist, associate clinical social worker, associate professional clinical counselor, and a psychology assistant must be clinically supervised and bill under a licensed billable behavioral health provider where the claim must list the associate/assistant's name in the "Additional Claim Information" field (Box 19) or in an attachment, along with the supervising clinician's National Provider Identifier Number (NPI) as the "billing provider." • Services for psychiatric diagnostic evaluations (90791 and 90792) cannot be billed on the same day as psychotherapy services.
90834	Individual psychotherapy with patient-45 minutes		Behavioral/mental health assistant and associate providers may be able to be supervised by any of the licensed behavioral/mental health providers listed above-verification with insurance carriers is required.	
90837	Individual Psychotherapy with patient-60 minutes			

CPT Code	Description	ICD10 Code	Reimbursable Clinician(s)	Applicable Guidelines
90846	Family psychotherapy **without** the patient present-50 minutes	Z65.9-Problem related to unspecified psychosocial circumstances	Licensed Clinical Psychologist and Psychology Assistant under supervision	• Family therapy rendered to an infant who has not yet been assigned a Med-Cal ID number may be billed with the birthing parent's ID for the month of birth and the following month only. • The service time requirement indicated in each family therapy code's description must be rendered since Medi-Cal does not advise of a minimum time allowance in the guidance. • Medi-Cal provides reimbursement for a maximum of 50 minutes, per family therapy session, per day, when billing for family therapy when the patient is **not present-** 90846, and a maximum of 110 minutes, per session, per day, for family therapy when the patient **is present** (90847). • Medi-Cal guidance advises that family psychotherapy must be composed of at least two family members. • Services for psychiatric diagnostic evaluations cannot be billed on the same date of service as psychotherapy services. • Medi-Cal guidance advises that family psychotherapy must be composed of at least two family members. Additional clarification on if this includes the patient must be made with the insurance carriers.
90847	Family psychotherapy **with** the patient present-50 minutes		Licensed Clinical Social Worker and Associate Clinical Social Worker under supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under supervision Licensed Professional Clinical Counselor and Associate Professional Clinical Counselor under supervision Behavior/mental health assistant and associate providers may be able to be supervised by any of the licensed behavior/mental health providers listed above-verification with insurance carriers is required	
90849	Multiple family group psychotherapy (a group consisting of different families) Cannot be billed on the same day as family therapy (90846, 90847)			

				• An associate marriage and family therapist, associate clinical social worker, associate clinical counselor, and a psychology assistant must be clinically supervised and bill under a licensed billable behavioral health provider where the claim must list the associate or assistant's name in the "Additional Claim Information" field (Box 19) or in an attachment along with the supervising clinician's National Provider Identifier Number (NPI) as the "billing provider." • Documentation must include but is not limited to the patient's and/or parent(s) risk factor(s), attention given to the impact the risk factor(s) are having or can have on the family, patient-family dynamics, and therapy goals including how the patient and family member(s) are benefiting from therapy. Medi-Cal's examples of family therapy are child-parent psychotherapy (ages 0 through 5), parent-child interactive therapy (ages 2 through 12), and cognitive-behavioral couple therapy for adults. • Additional time taken for other related services such as: reviewing records, communicating with other providers, observing & communicating between the patient and family, and decision making cannot be factored into the time spent rendering psychotherapy services. The psychotherapy code billed should only reflect the time spent on rendering actual psychotherapy, where the time spent on any other services must not be incorporated. • Multiple family group therapy is usually provided to a patient and their family, with other patients and families that share similar issues and risk factors. Documentation should

				be in each patient's chart for the sessions and billed under the patient. • Medi-Cal guidelines advise that group therapy is defined as counseling of at least two persons, but not more than eight persons at any session, where group sessions of less than 1.5 hours are not reimbursable.

3. Psychotherapy ***When a Patient Presents with Persistent Mental Health Symptoms in the Absence of a Mental Health Diagnosis***

In addition to the reimbursement for individual and family psychotherapy services for patients who are:

- Any age, diagnosed with a mental health and/or developmental disorder of infancy and early childhood, or
- Patients under the age of 21 that are not diagnosed with a mental health and/or developmental disorder, but either they, or their parent(s)/guardian(s) present with any of the approved risk factors.

Medi-Cal will also reimburse for a combination of individual or family psychotherapy, when provided to patients under the age of 21**,** when the patient has persistent mental health symptoms in the absence of a mental health disorder. Medi-Cal will also reimburse for up to 6 individual psychotherapy sessions, per year, when provided to patients 21 years and older with persistent mental health symptoms in the absence of a mental health disorder.

The table below and on the following pages highlights the approved psychotherapy billing codes, their descriptions, the approved diagnosis code, and applicable guidelines when billing for psychotherapy when a patient presents with persistent mental health symptoms in the absence of a mental health diagnosis.

CPT Code	Description	ICD10 Code	Reimbursable Clinician(s)	Applicable Guidelines
90832	Individual psychotherapy with patient-30 minutes	Z71.89-Other specified counseling	Licensed Clinical Psychologist and Psychologist Assistant under supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under supervision Licensed Professional Clinical Counselor, and Associate Professional Clinical Counselor under supervision. Behavior/mental health assistant and associate providers may be able to be supervised by any of the licensed behavioral/mental health providers. Verification with insurance carriers is required.	• Documentation should include the patient's symptoms, patient's functional status, mental/developmental status, and the time spent rendering the service. • Additional time taken for other related services such as: reviewing records, communicating with other providers, patient observation, and decision making cannot be factored into the time spent rendering psychotherapy. The psychotherapy code billed should only reflect the time spent on actual psychotherapy, where the time spent on any other services must not be incorporated. • Medi-Cal provides reimbursement for a maximum of 50 minutes, per family therapy session, per day, when billing for family therapy when the patient is not present (90846), and a maximum of 110 minutes, per session, per day, for family therapy when the patient is present (90847). Minimum time guidelines were not provided by Medi-Cal and must be verified with insurance carriers. • Medi-Cal provides reimbursement for individual psychotherapy services, for up to 1.5 hours per day, by the same provider. Nov. 2022 Medi-Cal guidance does not advise if there is a limitation on the number of visits for patients under the age of 21. Insurance verification is required. Nov. 2022 guidance advises that up to 6 visits per year will be reimbursed for patients 21 years of age and older.
90834	Individual psychotherapy with patient-45 minutes			
90837	Individual psychotherapy with patient-60 minutes			
90839 and 90840	90839-Individual psychotherapy for crisis; first 60 minutes 90840-Individual psychotherapy for crisis; each additional 30 minutes of service in addition to the first 60 minutes.			

				• Psychotherapy for crisis cannot be reported with any other mental health service on the same day. Documentation requirements include, but are not limited to, the time spent with the patient, a mental examination, disposition, and that the patient presented in a high level of distress with a complex or life-threatening problem (specificity needed), that required immediate attention.
90846	Family psychotherapy **without** the patient present-50 minutes			• Associate and assistant behavioral health providers must provide service and bill under a licensed billable behavioral health provider where the claim must list the associate, or assistant's name in the "Additional Claim Information" field (box 19) or in an attachment, along with the supervising clinician's National Provider Identifier number as the "billing provider."
90847	Family psychotherapy **with** the patient present-50 minutes			• Not all group sessions may be eligible for reimbursement at FQHCs/RHCs. Verification with insurance carriers is required. • Services for psychiatric diagnostic evaluation (90791,90792) cannot be billed on the same date of service as psychotherapy services.
90849	Multiple family group psychotherapy (a group consisting of different families)			• Family therapy rendered to an infant who has not yet been assigned a Medi-Cal ID number, may be billed under the birthing parent's ID for the month of birth and the following month, only.

				• Medi-Cal guidance advises that when billing for multiple family group therapy counseling, the group must consist of at least two people, but not more than eight persons at any session. Although group sessions do not have a time requirement in the description, Medi-Cal will not reimburse for group sessions of less than 1.5 hours. Verification with other insurance carriers is required. • Family and multiple-family group therapy is used to help treat a patient's problem/symptoms, that are affecting the entire family/caregiver(s). Family dynamics as they relate to the patient's mental status and/or behavior symptoms should be the focus of the sessions with therapy aimed at improving interactions between the patient and family members/caregivers. Medi-Cal's examples of family therapy are child-parent psychotherapy (ages 0 through 5), parent-child Interactive therapy (ages 2 through 12), and cognitive-behavioral couple therapy for adults.

4. Psychotherapy ***for the Prevention of Perinatal Depression***

Consistent with the U.S. Preventive Services Task Force recommendation, Medi-Cal provides reimbursement for 20 sessions of individual or group counseling (psychotherapy) or a combination of both, for pregnant and postpartum women, of any age, who are at risk of perinatal depression, and that present with one or more of the below approved risk factors:

Risk Factors
A history of depression
Current depressive symptoms (that do not reach a diagnostic threshold)
Certain socioeconomic risk factors such as low income, adolescent, or single parenthood
Recent intimate partner violence
Mental health-related factors such as elevated anxiety symptoms or a history of significant negative life events

Authorized diagnosis codes to report with this service are, if pregnant, a pregnancy diagnosis code which is assigned according to the trimester the patient is in at the time of the visit, and the diagnosis code for a postpartum follow-up visit.

The table on the following pages highlights the approved billing codes, their descriptions, range of diagnosis codes, reimbursable clinicians, and guidelines when billing for psychotherapy for prevention of perinatal depression.

CPT Code	Description	ICD-10 Code(s)	Reimbursable Clinician(s)	Applicable Guidelines
90832	Individual psychotherapy with patient-30 minutes; face-to face with patient **(Modifier 33 required)**	Z34.9_ for pregnant patients **(the last digit in the ICD-10 code should represent the trimester the patient is in at the time of the visit)** and Z39.2 for postpartum patients	Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Counselor and Associate Professional Counselor under clinical supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under clinical supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under clinical supervision Behavior/mental health assistant and associate providers may be able to be supervised by any of the licensed behavior/mental health providers listed above - verification with insurance carriers is required.	• Up to a total of 20 individual counseling sessions, or up to 20 group counseling sessions, or up to 20 sessions of a combination of both are reimbursable when delivered during the prenatal period and/or during the 12 months following childbirth. • Upon billing, modifier 33 must be appended to the psychotherapy code. Modifier 33 is reported to identify psychotherapy services provided to prevent perinatal depression and the modifier must be present on the claim. • An associate marriage and family therapist, associate clinical social worker, associate professional clinical counselor, and psychology assistant must be clinically supervised and bill under a licensed behavioral health provider where the claim must list the associate/assistant's name in the "Additional Claim information" field (Box 19) or in an attachment, along with the supervising clinician's National Provider Identifier Number (NPI) as the "billing provider." • Documentation must include, but is not limited to, the patient's risk factor(s), symptoms being evaluated, goals of the 20 therapy sessions, and next steps when applicable. Additional services included in the codes, where the time spent on rendering the services should not be calculated into the time spent rendering psychotherapy, are reviewing records, communicating with other providers, observing, interpreting patterns of behavior, and decision making. • Psychotherapy services are not to be reported with psychiatric diagnostic evaluation services (90791, 90792). • Medi-Cal will reimburse for a maximum of 1.5 hours per day, by the same provider, for individual psychotherapy services.
90834	Individual psychotherapy with patient-45 minutes; face-to-face with patient **(Modifier 33 required)**			

90837	Individual psychotherapy with patient-60 minutes; face-to face with patient **(Modifier 33 required)**			• Group therapy is defined as counseling of at least 2 persons, but not more than eight persons per session. Group sessions are to be billed, per patient receiving the therapy, using CPT code 90853, once per session. Although group psychotherapy does not have a time requirement in its description, Medi-Cal advises that group sessions of less than 1.5 hours are not reimbursable. Verification with other insurance carriers is required.
90853	Group psychotherapy **(Modifier 33 required)** A group composed of patients with separate or distinct risk factors. This code should be used for group psychotherapy with other patients and not members of the patients' families.			

Dyadic Services

Dyadic services involve treatment delivered to a parent(s) and child simultaneously that provide important support to families and children. Medi-Cal will reimburse specified dyadic services under the Dyadic Care Benefit when rendered to patients ages 0-20 years of age and/or their caregivers in outpatient and medical settings, when billed under the child's Medi-Cal ID, appending billing modifier U1 with eligible services/billing codes. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), including Tribal FQHCs and Indian Health Service Memorandum of Agreement (HIS-MOA) clinics are also eligible for reimbursement for the services at the Medi-Cal fee-for-service (FFS) rate.

The following table highlights the approved dyadic services with their billing codes and descriptions, reimbursable clinicians, and service and billing guidelines.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
H1011	Dyadic behavioral health (DBH) well-child visit (**Modifier U1 required)**	Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Clinical Counselor and Associate Professional Counselor under clinical supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under clinical supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under clinical supervision. Behavioral/mental health assistant and associate providers may	**Dyadic Behavioral Health (DBH)Well-Child Visit**: • Reimbursed according to the Bright Futures/American Academy of Pediatrics Periodicity Schedule for psychosocial/behavioral assessment, and when medically necessary. • DBH well-child visits should occur on the same day as the medical well-child visit. (If not possible, the service should be scheduled as close as possible to the medical well-child visit.). • ICD-10 code Z13.39 must be reported for a DBH well-child visit. • The following service components are included in DBH well-child visit, and the documentation should reflect as such: ○ Behavioral health history of child and caregiver(s) including caregiver(s) interview addressing child's temperament, relationship with others, interests, abilities, and caregiver concerns. ○ Developmental history of the child ○ Mental status assessment of caregiver(s) ○ Observation of behavior of child and caregiver(s) and interaction between child and caregiver(s) ○ Appropriate screenings for the parent and/or child, including screening for family needs which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.

		be able to be supervised by any of the licensed behavioral health providers listed. Verification with insurance carriers is required. Psychiatric Physician Assistant Psychiatric Nurse Practitioner Psychiatrist	○ Screening for social determinants of health such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence ○ Age-appropriate anticipatory guidance focused on behavioral health promotion/risk factor reduction, which may include educating caregiver(s) on how their life experiences (for example (ACEs) impact their child's development and their parenting, and/or on how their child's life experiences impact their child's development, and information and resources to support the child through different stages of development as indicated. ○ Making essential referrals and connections to community resources through care coordination and helping caregiver(s) prioritize needs.
H2015	Dyadic comprehensive community support services (**Modifier U1 required)**	Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Clinical Counselor and Associate Professional Counselor under clinical supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under clinical supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under clinical supervision. Behavior/mental health assistant and associate providers may be able	**<u>Dyadic Comprehensive Community Support Services:</u>** • Reimbursed for the initial and periodic family encounter, assessment, and service plan development for the benefit of the child, where each billable unit is for 15 minutes of service. • Services are geared to help the child and their caregiver gain access to needed medical, social, educational, and other health-related services such as connection with public and/or private assistance including the welfare program, social services, and behavioral health programs. • A dyad's service plan consists of specific medical, social, educational, and other health-related needs identified during medical visits, dyadic behavioral health visits, or other communications with the child and/or caregiver. • Details regarding identified needs may be documented in the child's medical record (for example, in progress notes, telephone encounters, and/or sections of the child's medical record) • Any diagnosis code may be used for the reporting of H2015. • The following service components are included in Dyadic Comprehensive Community Support Services, and the documentation should reflect as such: ○ Assistance in maintaining, monitoring, and modifying covered services outlines in the dyad's service plan to address an identified clinical need.

		to be supervised by any of the licensed behavior/mental health providers listed above– verification with insurance carriers is required. Psychiatric Physician Assistant Psychiatric Nurse Practitioner	○ Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of helping in accessing an identified clinical service. ○ Assistance in finding and connecting to necessary resources other than covered services to meet basic needs. ○ communication and coordination of care with the person's family, medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community, and other state agencies. ○ Outreach and follow-up of crisis and contacts and missed appointments. ○ Other activities as needed to address the dyad's identified treatment and/or support needs. ○ The time spent rendering the service.
H2027	Dyadic Psychoeducational Services **(Modifier U1 required)**	Psychiatrist Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Clinical Counselor and Associate Professional Counselor under clinical supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under clinical supervision. Licensed Clinical Social Worker and Associate Clinical Social Worker under clinical supervision. Behavioral/mental health assistant and associate providers May be able to be	**Dyadic Psychoeducation Services:** • Reimbursed for the initial and periodic psychoeducational service where each billable unit is for 15 minutes of service. • Any diagnosis code can be used for the reporting of H2027. • The following components are included in Dyadic Psychoeducational Services, and the documentation should reflect as such: ○ Planned, structured intervention services. ○ Intervention services that involve presenting or demonstrating information with the goal of preventing the development or worsening of behavioral health conditions and achieving optimal mental health and long-term resilience. ○ The time spent rendering the service. • Services also include behavioral health education and screenings.

		supervised by any of the licensed behavioral health providers listed above- verification with insurance carriers is required. Psychiatric Physician Assistant Psychiatric Nurse Practitioner Psychiatrist	
T1027	Dyadic Family Training and Counseling for Child Development **(Modifier U1 required)**	Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Clinical Counselor and Associate Professional Counselor under clinical supervision Licensed Marriage and Family Therapist and Associate Marriage and Family therapist under clinical supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under clinical supervision. Behavioral/mental health assistant and associate providers may be able to be supervised	**<u>Dyadic Family Training and Counseling for Child Development:</u>** • Reimbursed for Dyadic Family Training and Counseling for Child Development provided to the child/caregiver(s), where each billable unit is for 15 minutes of service. • Any diagnosis code can be used for the reporting of T1017. • The following components are included in Dyadic Family Training and Counseling for Child Development services, and the documentation should reflect as such: ○ Brief training and counseling related to a child's behavioral issues, developmentally appropriate parenting strategies, parent/child interactions, and related issues. ○ The time spent rendering the service.

		by any of the licensed behavioral/mental health providers listed above- verification with insurance carriers is required. Psychiatric Physician Assistant Psychiatric Nurse Practitioner Psychiatrist	

In addition to these four new dyadic services, the Dyadic Services Benefit also contains dyadic caregiver services which are existing specified services services that are approved for Medi-Cal reimbursement when rendered to a caregiver during a child's visit for the benefit of the child when the visit is attended by the child and caregiver(s). The approved caregiver services are to be billed under the child's Medi-Cal ID with billing modifier U1 appended to the service codes. HIPAA-compliant documentation is required in the child's medical record, including the time spent rendering the service(s) for all time-based codes. The frequency limit per caregiver for these dyadic services follows the same Medi-Cal guidelines found under the existing guidelines for the services, located in the Evaluation and Management section of the Medi-Cal manual. The following pages contain tables with the eligible dyadic caregiver services approved for Medi-Cal reimbursement, their descriptions, the professionals that can render the services, and both the existing applicable service guidelines in addition to any new billing guidelines when rendered as part of the Dyadic Services Benefit.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
G9920	ACE screening-lower risk, patient score of 0-3 **(Modifier U1 required)**	Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Clinical Counselor and Associate Professional Counselor under clinical supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under clinical supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under clinical supervision. Behavior/mental health assistant and associate providers may be able to be supervised by any of the licensed behavior/mental health providers listed above – verification with insurance carriers is required. Psychiatric Physician Assistant Psychiatric Nurse Practitioner Psychiatrist Pediatrician	**Existing Applicable Guidelines:** • Providers billing for ACE screenings must complete the California Department of Health Care Services training for ACEs screening and trauma-informed care **https://training.acesaware.org/** • For patients under 21 years of age, Medi-Cal will reimburse for one screening, per year, per provider. • Billing for an ACE screening includes a completed screen with review, interpretation of results, discussion with patient, and any appropriate clinical decision making, if required. **Additional New Guidelines Under the Dyadic Caregiver Benefit:** • ACE screenings can be billed by either the medical well-child provider or the dyadic behavioral health provider, but not by both providers, when the dyad is seen on the same day by both providers. • ACE screenings can be rendered to both the patient (ages 0-20), and their caregiver. • Any diagnosis code can be used to bill for the service. • Modifier U1 must be appended to code upon claim submission. • When services are rendered under the dyadic benefit, associate and assistant behavioral health providers may render and bill for the services under a licensed billable behavioral health provider. Insurance carrier verification must be made on if they can render these services if rendered outside of the dyadic benefit.
G9919	Ace Screening-high risk, patient score of 4 or greater **(Modifier U1 required)**		

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
G8431	Screening for depression, documented as a positive result. **(Modifier U1 required)**	Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Clinical Counselor and Associate Professional Counselor under clinical supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under clinical supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under clinical supervision. Behavior/mental health assistant and associate providers may be able to be supervised by any of the licensed behavior/mental health providers listed above- verification with insurance carriers is required. Psychiatric Physician Assistant Psychiatric Nurse Practitioner Psychiatrist Pediatrician	**Existing Applicable Guidelines:** • Medi-Cal will reimburse for up to four postpartum screenings rendered during the infant's first year of life, when they are rendered by the infant's pediatrician during a well-child visit, where the billing is reported under the infant's Medi-Cal number. • Service and documentation requirements for a depression screening includes a completed screen with review, interpretation of results, discussion with patient, and if the screening result is positive, any appropriate clinical decision making. **Additional New Guidelines Under the Dyadic Caregiver Benefit:** • Depression screenings can be billed by either the medical well-child provider or the dyadic behavioral health provider, but not by both providers, when the dyad is seen on the same day by both providers. • Any diagnosis can be used to bill for the service. • Modifier U1 must be appended to code upon claim submission. • Medi-Cal will also provide reimbursement for depression screenings other than for prenatal or postpartum depression, to all patients 12-20 years of age, and the caregiver. Frequency limitations should be verified with insurance carrier(s). • When services are rendered under the dyadic benefit, associate and assistant behavioral health providers may render and bill the services under clinical supervision of a licensed behavioral health provider. Insurance carrier verification must be made on if they can render these services if rendered outside of the dyadic benefit.
G8510	Screening for depression, documented as a negative result. **(Modifier U1 required)**		

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
G0442	Annual alcohol misuse screening, 15 minutes **(Modifier U1 required)**	Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Clinical Counselor and Associate Professional Counselor under clinical supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under clinical supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under clinical supervision. Behavior/mental health assistant and associate providers may be able to be supervised by any of the licensed behavior/mental health providers listed above – verification with insurance carriers is required. Psychiatric Physician Assistant Psychiatric Nurse Practitioner Psychiatrist Pediatrician	**Existing Applicable Guidelines:** • Annual alcohol misuse screenings and drug screenings are reimbursed once per year, per provider, utilizing a validated screening tool. Exception: With regard to using the screening and assessment tools chart provided by the National Institute on Drug Abuse (NIDA), alcohol misuse screenings are reimbursable when the single NIDA Quick Screen alcohol-related question is used without including the additional NIDA Quick Screen questions. • When a screening is positive, clinicians must use an appropriate validated assessment tool to determine if an alcohol or substance use disorder is present. Medi-Cal permits billing for alcohol and/or drug screening when a validated alcohol and/or drug assessment tool is used, without initial use of a validated screening tool. • Annual alcohol misuse screenings (G0442) are only reimbursable once per year, per provider and should not be reported if the patient already meets the criteria for dependence. • Intervention services (H0050) are reimbursable once per day, per provider when a validated assessment tool is used. • Verification with insurance carriers must be made if there are frequency limitations to weekly, monthly, or yearly intervention sessions (H0050). • Services and documentation requirements for intervention services include, but are not limited to the time spent rendering the service, screening and assessment tool used (with scoring), providing feedback to the patient regarding screening and assessment results, the discussion on negative consequences that have occurred and overall severity of the problem, supporting the patient in making behavioral changes, and discussing and agreeing on plans for follow-up with the patient, including referral to other treatment, if indicated. • Screenings and intervention services may be provided on the same date of service. The reporting of CPT code H0050 may cover both
H0049	Alcohol and/or drug screening ***(Medi-Cal recognizes this code for drug screening only)*** **(Modifier U1 required)**		
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes **(Modifier U1 required)**		

G0442, H0049, H0050 -continued			screening and intervention services. Verification with insurance carrier is required. **<u>Additional New Guidelines Under the Dyadic Caregiver Benefit</u>:** • Services can be billed by either the medical well-child provider or the dyadic behavioral health provider, but not by both providers, when the dyad is seen on the same day by both providers, when the services are under the providers scope of practice. • Any diagnosis code can be used to bill for G0442 and H0049, but when billing for H0050, diagnosis code Z71.89 (Unspecified Counseling) must be reported. • Medi-Cal will also provide reimbursement for services to all patients 11-20 years of age, and their caregivers. • Modifier U1 must be appended to code upon claim submission. • When services are rendered under the dyadic benefit, associate and assistant behavioral health providers may render and bill the services under a licensed billable behavioral health provider. Insurance carrier verification must be made on if they can render these services if rendered outside of the dyadic benefit.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96127	Social-emotional screening. Psychosocial/behavioral assessments **(Modifier U1 required)**	Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Clinical Counselor and Associate Professional Counselor under clinical supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under clinical supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under clinical supervision. Behavior/mental health assistant and associate providers may be able to be supervised by any of the licensed behavior/mental health providers listed above – verification with insurance carriers is required. Psychiatric Physician Assistant Psychiatric Nurse Practitioner Psychiatrist Pediatrician	**Existing Applicable Guidelines:** • Documentation for social-emotional and developmental screenings include: the name of the tool, the tool itself, the score, and how results were discussed with the recipient of services. • Medi-Cal's reimbursement for social-emotional screenings is limited to two per day, per provider, per patient. **Additional New Guidelines Under the Dyadic Caregiver Benefit:** • Social-emotional screenings can be billed by either the medial well-child provider or the dyadic behavioral health provider, but not by both providers, when the dyad is seen on the same day by both providers, when the services are under the providers scope of practice. • Brief emotional/behavioral assessments can be rendered to both the patient (ages 0-20), and their caregiver(s). • Modifier U1 must be appended to code upon claim submission. • Diagnosis code Z13.39 (Encounter for screening examination for other mental health and behavioral health disorders) must be reported when services are rendered to the caregiver.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90791	Psychiatric diagnostic evaluation **(Modifier U1 required)**	Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Clinical Counselor and Associate Professional Counselor under clinical supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under clinical supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under clinical supervision. Behavior/mental health assistant and associate providers may be able to be supervised by any of the licensed behavior/mental health providers listed above –verification with insurance carriers is required. Psychiatric Physician Assistant Psychiatric Nurse Practitioner Psychiatrist Pediatrician	**Existing Applicable Guidelines:** • Psychiatric diagnostic evaluations are not reimbursable when billed on the same day as psychotherapy services. • Documentation requirements include presenting problem(s)/change(s) in functioning/history, mental and medical health history, including current medications if applicable, social, and cultural factors, risk, and safety factors, and a diagnostic summary. • Reimbursement frequency must be verified with insurance carriers. • Evaluations with medical services (90792) are only applicable to psychiatrists, psychiatric physician assistants and psychiatric nurse practitioners. **Additional New Guidelines Under the Dyadic Caregiver Benefit:** • Psychiatric diagnostic evaluations can be billed by either the medical well-child provider or the dyadic behavioral health provider, when services are under their scope of practice, but not by both providers, when the dyad is seen on the same day by both providers. • Psychiatric diagnostic evaluations can be rendered to both the patient (ages 0-20), and the caregiver. • Diagnosis code Z13.39 (Encounter for screening examination for other mental health and behavioral disorders) must be reported when services are rendered to the caregiver. • Modifier U1 must be appended to code upon claim submission. • When services are rendered under the dyadic benefit, associate and assistant behavioral health providers may render and bill for the services under a licensed billable behavioral health provider. Insurance carrier verification must be made on if they can render these services if rendered outside of the dyadic benefit.
90792	Psychiatric diagnostic evaluation with medical services **(Modifier U1 required)**		

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
99406	Smoking and tobacco use cessation counseling visit; intermediate, **greater than 3 minutes,** up to 10 minutes (4 minutes-10 minutes) **(Modifier U1 required)**	Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Clinical Counselor and Associate Professional Counselor under clinical supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under clinical supervision. Licensed Clinical Social Worker and Associate Clinical Social Worker under clinical supervision. Behavior/mental health assistant and associate providers may be able to be supervised by any of the licensed behavior/mental health providers listed above –verification with insurance carriers is required. Psychiatric Physician Assistant Psychiatric Nurse Practitioner Psychiatrist Pediatrician	**Existing Applicable Guidelines:** • Service and documentation requirements include total time spent rendering services, what was discussed including cessation techniques, resources provided, and that the patient was provided information on the California Smokers Helpline (1-800-NO-BUTTS). • Reimbursement for smoking cessation counseling services include when services are rendered to those patients who are not currently ready to make a quit attempt. • 3 minutes or less of smoking and tobacco use cessation counseling is not eligible for reimbursement and should not be billed. • Medi-Cal provides reimbursement for one counseling session, per day, with no yearly frequency limits, but does advise of a clinical minimum of 4 sessions in the year. Verification with other insurance carriers is required. **Additional New Guidelines Under the Dyadic Caregiver Benefit:** • Smoking and tobacco use cessation can be billed by either the medical well-child provider or the dyadic behavioral health provider, when services are under their scope of practice, but not by both providers, when the dyad is seen on the same day by both providers, when the services are under the providers scope of practice. • Psychiatric diagnostic evaluations can be rendered to both the patient (ages 0-20), and the caregiver. • Diagnosis code Z71.89 (Other specified counseling) must be reported when services are rendered to the caregiver. • Modifier U1 must be appended to code upon claim submission. • When services are rendered under the dyadic benefit, associate and assistant behavioral health providers may render and bill
99407	Smoking and tobacco use cessation counseling visit; intensive, **greater than 10 minutes** (11 minutes or more) **(Modifier U1 required)**		

99406, 99407- continued			for the services under a licensed billable behavioral health provider. Carrier verification must be made on if they can render these services if rendered outside of the dyadic benefit.
CPT Code	**Description**	**Reimbursable Clinician(s)**	**Applicable Guidelines**
96156	Health and behavior assessment or re-assessment (e.g., health focused clinical interview, behavioral observations, clinical decision making) (can only be billed once per day) **(Modifier U1 required)**	Licensed Clinical Psychologist and Associate Psychologist under clinical supervision. Licensed Professional Clinical Counselor and Associate Professional Counselor under clinical supervision. Licensed Marriage and Family Therapist and Associate Marriage and Family Therapist under clinical supervision Licensed Clinical Social Worker and Associate Clinical Social Worker under their supervision. Behavior/mental health assistant and associate providers may be able to be supervised by any of the licensed behavior/mental	**Existing Applicable Guidelines:** • 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 medical condition. Patient must have an established illness and cannot have been diagnosed with a mental illness. • Service and documentation requirements for assessment or re-assessment services (96156) should include, but is not limited to, the patient's physical illness(s) (health focused interview), and identification of the factors that are either preventing successful treatment, and/or management of the illness. Documentation should also include how these factors are impeding the successful management of the illness(s) or are either preventing treatment. • 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. 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. • Documentation for intervention services (96167, 96168 and 96170, 96171) provided to the patient should include but is not limited to, the patient's physical illness(s), identification of the factors impeding successful treatment and/or management of them, and the reasons why they are preventing treatment,
96167	Health and behavior intervention, family with patient present face-to face; initial 30 minutes (can only be billed once per day) **(Modifier U1 required)**		
96168	Health and behavior intervention, family with the patient present face-to-		

96168-continued	face, each additional 15 minutes (up to 6 units per day can be billed) **(Modifier U1 required)**	health providers listed above –verification with insurance carriers is required. Psychiatric Physician Assistant Psychiatric Nurse Practitioner Psychiatrist Pediatrician	and/or successful management. Additionally, the intervention services being rendered to help ameliorate the factors that are either impeding successful treatment and/or management of them, should also be documented. Because the billing codes for intervention services are time-based, documentation of the time spent rendering the service must also be included. • Smoking cessation services (99406, 99407), and CPT codes 90785-90899, which includes psychiatric diagnostic evaluation, will not be reimbursed, if billed with assessments, re-assessments, and interventions (96156, 96167, 96168, 96170, 96171) **Additional New Guidelines Under the Dyadic Caregiver Benefit:** • All services can be billed by either the medical well-child provider or the dyadic behavioral health provider, but not by both providers, when the dyad is seen on the same day by both providers, when the services are under the provider's scope of practice. • Services can be rendered to both the patient (ages 0-20), and their caregiver. • Diagnosis code Z71.89 (Other specified counseling) must be reported when services are rendered to the caregiver. • Modifier U1 must be appended to the billing code upon claim submission. • When services are rendered under the dyadic benefit, associate and assistant behavioral health providers may render and bill for the services under a licensed billable behavioral health provider. Insurance carrier verification must be made on if they can render these services if rendered outside of the dyadic benefit.
96170	Health and behavior intervention, family without the patient present face-to-face; initial 30 minutes (can only be billed once per day) **(Modifier U1 required)**		
96171	Health and behavior intervention, family without the patient present face-to-face; each additional 15 minutes (can only be billed once per day) **(Modifier U1 required)**		

Community Health Worker Benefit

Community Health Workers (CHWs) are eligible for Medi-Cal reimbursement when rendered by qualified CHWs to those patients eligible to receive their services. Reimbursement will be provided when services are rendered at clinics, including Tribal Federally Qualified Health Centers (FQHCs), and Indian Health Services-Memorandum of Agreement (HIS-MOA), Hospitals, community-based organizations, and local health jurisdictions with no place of service restrictions.

The following section of the billing and coding guide will provide information on CHW services, including the required guidelines for practicing CHW's, and eligibility of patients.

Recommendation for CHW Services

Prior to rendering CHW services to a patient, a written recommendation for the services is required by either a physician, or by another "licensed practitioner of the healing arts" working within their scope of practice.

Medi-Cal identifies the following professionals as licensed practitioners of the healing arts:

• Physician	• Registered Nurse
• Physician assistant	• Licensed Vocational Nurse
• Podiatrist	• Public Health Nurse
• Dentist	• Psychologist
• Pharmacist	• Licensed Educational Psychologist
• Nurse Practitioner	• Licensed Marriage and Family Therapist
• Clinical Nurse Specialist	• Licensed Clinical Social Worker
• Nurse Midwife	• Licensed Professional Clinical Counselor
• Licensed Midwife	

It is the responsibility of the recommending practitioner to ensure that the patient he or she is recommending for CHW services meets the eligibility criteria that supports medical necessity for CHW services.

Patient Eligibility for CHW Services

Medi-Cal patients are eligible for CHW services when **one or more** of the approved medical necessity, and approved patient issue requirements, have been met.

The provider who recommends the patient for CHW services shall determine whether a patient is eligible for services, by referring to two lists provided in Medi-Cal's guidance. One list contains the approved medical necessity requirements and the other contains the approved patient issues allowed to be addressed by a CHW.

If a Medi-Cal patient who is younger than 21, has a parent or guardian who either is not enrolled in Medi-Cal, or is not eligible to be a patient at the practice, presents with **one or more** of the criteria eligible for CHW services, CHW services can be rendered to the parent or guardian as long as the issue or issues being addressed are **directly affecting the patient**.

The table below provides a bulleted list of the approved medical necessity requirements, where only **one or more** need to be present to support medical necessity for CHW services.

• A patient who has a diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental health disorder or substance use disorder that has not yet been diagnosed
• When there is a presence of medical indicators of the risking risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, that indicate risk but do not yet warrant diagnosis of a chronic condition)
• Positive Adverse Childhood Events (ACEs) screening
• Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse
• Results of a social drivers of health screening indicating unmet health-related social needs, such as housing or food insecurity
• One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization
• One or more visits to a hospital emergency department within the previous six months

• One or more stays at a detox facility within the previous year
• Two or more missed medical appointments within the previous six months
• Patient expressed need for support in health system navigation or resource coordination services
• A need for recommended preventive services
• A need for violence preventive services: CHW violence preventive services are available to Medi-Cal patients who meets any of the following circumstances: ✓ The patient has been violently injured as a result of community violence ✓ A licensed health provider has determined that the patient is at significant risk of experiencing violent injury as a result of community violence ✓ The patient has experienced chronic exposure to community violence

CHW violence preventive services are evidence-based, trauma-informed, and culturally responsive preventive services for the purpose of reducing:

- ✓ The incidence of violent injury or reinjury,
- ✓ Trauma, and related harms and promoting trauma recovery,
- ✓ Stabilization, and
- ✓ Improved health outcomes.

Once the patient's eligibility criteria have been confirmed, and a written recommendation for the patient to receive CHW services has been provided, CHW services may be rendered for Medi-Cal reimbursement.

Patient Issues That Can Be Addressed by CHWs and the Approved Services That Can Be Rendered by The CHW

Patient Issues that Can be Addressed by CHWs

CHWs are recognized by Medi-Cal for the reimbursement of services that address certain issues. The recognized issues a CHW can provide services for, are either for the patient and/or for the parent(s)/guardian(s), when the issue(s) directly affect(s) the patient.

The table below includes, but is not limited to, the identified issues that are recognized by Medi-Cal, for CHW services:

• The control and prevention of chronic conditions or infectious diseases (1 or more)
• Mental health conditions and substance use disorders
• A need for preventive services
• Perinatal health conditions
• Sexual and reproductive health
• Environmental and climate sensitive health issues
• Child health and development issues
• Oral health
• Issues with aging
• Issues with injury
• Issues with domestic violence and violence prevention

Note: In addition to the issues above, certified CHWs who have completed either a certificate from the California Department of Public Health Asthma Management Academy, or a certificate demonstrating completion of a training program consistent with the guidelines of the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma, may provide evidence-based asthma self-management education, and asthma trigger assessments. Asthma services may also be rendered by a licensed provider working within their scope of practice.

Medi-Cal guidelines for the CHW benefit currently do not include additional information regarding the rendering of asthma services by a CHW, but guidelines do advise to look under the Asthma Preventive Services section in Part 2 of the Medi-Cal Provider Manual **https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/asthprev.pdf** and **https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/chwprev.pdf** for more information.

Approved CHW Services

There are four (4) categories of services a CHW can provide to address at least one of the approved patient issues, and they are:

1. Health Education,
2. Health Navigation,
3. Screening and Assessment, and
4. Individual Support and Advocacy.

The table below provides the specificity of services that fall under each category of service.

Health Education
• To promote the patient's health, or address barriers to physical and mental health care, including providing information or instruction on health topics. The content of the education must be consistent with established or recognized health care standards. Health education may include coaching and goal setting to improve a patient's health or ability to self-manage their condition or conditions.
Health Navigation
To provide information, training, or support, to assist patients to:
• Access health care,
• Understand the health care system or engage in their own care,
• Connect to community resources necessary to promote a patient's health, address health care barriers, including connecting to medical translation and/or interpretation, or transportation services, or
• Address health related social needs.
Under Health Navigation, CHWs may also:
• Serve as a cultural liaison or assist the licensed health care provider in creating a plan of care, as part of the health care team.
• Provide outreach and resource coordination to encourage and facilitate the use of appropriate preventive services.
• CHWs can help patients to enroll or maintain enrollment in government or other assistance programs that are related to improving their health if such health navigation services are provided in accordance with the patient's plan of care.
Screening and Assessment
• Any screening and assessment services that do not require a license, which assists the patient in connecting to the appropriate services needed to improve their health care.
Individual Support or Advocacy
• Individual support or advocacy that assists a patient in preventing the onset or exacerbation of a health condition, or that assists the patient in preventing injury or violence.

Note 1: *CHW violence preventive services include all the CHW services listed under health education, health navigation, and screening and assessment, if the services* **apply specifically** *to violence prevention.*

Note 2: All CHW **services may also be provided to a parent or legal guardian** of a Medi-Cal patient that is under the age of 21, **for the direct benefit of the patient (child),** in accordance with a recommendation from a licensed provider. The CHW service must be for the direct benefit of the patient, and must be billed under the patient's Medi-Cal ID. If the parent or legal guardian is not enrolled in Medi-Cal, the patient must be present during the session.

Minimum Qualification Requirements for CHWs

Medi-Cal guidance advises of the following minimum qualification requirements for practicing CHWs:

- Lived experience,
- Certifications with field experience, or
- Work experience.

Lived Experience

Lived experience is an important qualification for a CHW. CHWs must have lived experience that aligns with, and provides a connection between the CHW, and the community or population being served.

The table below includes, but is not limited to, the recognized experiences listed in the Medi-Cal guidance for the CHW benefit.

• Incarceration
• Military service
• Pregnancy and birth
• Disability
• Foster system placement
• Homelessness
• Mental health conditions or substance use
• Being a survivor of domestic abuse or intimate partner violence or abuse and exploitation
Lived experience may also include the same:
• Race,
• Ethnicity,
• Sexual orientation,

• Gender identity, or
• Language or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

CHW Certifications

In addition to the lived experience to determine which patients would be a good match for a given CHW, the CHW must demonstrate minimum qualifications through either the approved certificate pathway, or the temporary work experience pathway.

The table below contains the certification requirements for a CHW and applicable guidelines.

Certification Required	Applicable Guidelines
CHW Certificate of Completion (Will allow the CHW to provide all covered CHW services, including violence preventive services)	• CHW Certificate of Completion must be issued by the State of California or a state designee where the curriculum for the certification attests to the demonstrated skills and/or practical training in the following areas: ✓ Communication, ✓ Interpersonal and relationship building, ✓ Service coordination and navigation, ✓ Capacity building, ✓ Advocacy, ✓ Education and facilitation, ✓ Individual and community assessment, ✓ Professional skills and conduct, ✓ Outreach, ✓ Evaluation and research, and ✓ Basic knowledge of public health principles and social determinants of health, as determined by the supervising provider. • The certification program in which the CHWs certification was acquired must have field experience included as a requirement. • A CHW must annually complete a minimum of 6 hours of additional training for any certification they possess.

Violence Prevention Certificate (Will allow the CHW to provide violence preventive services, only)	• The Violence Prevention Certificate as a Violence Prevention Professional (VPP) must be issued by Health Alliance for Violence Intervention or must be a Certificate of Completion in gang Intervention, issued by the Urban Peace Institute. • A Violence Prevention Certificate allows a CHW to **only** provide CHW violence preventive services. A CHW providing services other than violence preventive services should have a CHW Certificate of Completion, or as a temporary pathway, demonstrate qualifications through work experience.

Work Experience

In the absence of a certification, work experience can serve as a temporary qualification to render CHW services.

The table below contains information on work experience and the applicable guidelines.

Work Experience Pathway	**Applicable Guidelines**
Working Hours and Skills & Practical Training	• In the absence of a certification, a CHW who within the previous three years, has 2,000 hours working as a CHW in either a paid or volunteer position, and is working towards certification, may render CHW services for a maximum of 18 months from the first CHW visit rendered to a Medi-Cal patient. • In addition, to the 2,000 hours, the CHW must have demonstrated skills and practical training in the areas in which they are providing CHW services.

Supervising Providers for CHWs

Medi-Cal guidance indicates that CHWs require a supervising provider.

The table below encompasses Medi-Cal guidelines regarding supervising providers for CHWs.

• Supervising providers must be, licensed, Medi-Cal enrolled providers, who will directly or indirectly oversee the services a CHW delivers to patients, where those services delivered fall under the supervising provider's scope of practice and are billed under the supervising provider. (The list of provider types that can recommend CHW services located in the beginning of the guide under, "Recommendation for CHW Services", can be utilized as a guide to the **licensed providers** eligible to supervise CHWs.)
• The supervising provider ensures and maintains evidence on the minimum continuing education units required for a CHW. A minimum of 6 additional hours of training is required annually.
• Supervising providers can identify any additional training required by the CHW and/or can provide the additional training required by the CHW.
• The supervising provider does not have to be the same professional who provides the patient's written recommendation for CHW services. Supervising providers can be based on: ✓ Your practice's clinical administrative decision makers, and ✓ Pairing the scope of practice of the supervising provider's professional license to align with the CHW services he or she will be providing supervision for.
• Medi-Cal advises that in addition to licensed, Medi-Cal enrolled providers, supervising providers can also be a hospital and an outpatient clinic. Medi-Cal also advises that a Local Health Jurisdiction (LHJ) or a Community-Based Organization (CBO) can be supervising providers, where a licensed provider does not have to be on staff-Medi-Cal's guidance does not offer specificity on how to bill for CHW services in this manner. If a practice is interested in these billing guidelines, verification with Medi-Cal must be made at the site level.

Non-Covered Services for CHWs

Medi-Cal has identified services that are not covered when rendered by a CHW. The table below contains the identified non-covered services.

• Clinical case management/care management that requires a license
• Childcare
• Chore services, including shopping and cooking meals
• Companion services
• Employment services
• Helping a patient enroll in government or other assistance programs that are not related to improving their health as part of a Plan of Care
• Delivery of medication, medical equipment, or medical supplies
• Personal care services/homemaker services
• Respite care
• Services that duplicate another covered Medi-Cal service already being provided to the patient
• Transporting patients
• Services provided to individuals not enrolled in Medi-Cal, except for when the services are rendered to the parent(s) or guardian(s) of a Medi-Cal patient who is younger than 21, where the services are for the direct benefit of the Medi-Cal patient.
• Services that require a license
• Although CHWs may provide services to patients with mental health and/or substance use disorders, CHW services do not include peer support services as covered under the:
✓ Drug Medi-Cal Program
✓ Drug Medi-Cal Organized Delivery System
✓ Specialty Mental Health Services Program
• Medi-Cal advises that peer support services are distinct and separate from CHW services.

Plan of Care

A patient's Plan of Care (POC) is a written document that is developed by one or more licensed providers, to describe the supports and services that the CHW will provide, to address the ongoing needs of the patient. The table below provides Medi-Cal guidelines for a patient's POC.

General Medi-Cal Guidelines for a Patient's Plan of Care (POC)	• A POC is only encouraged when providing ongoing or multiple CHW services to a patient, but it becomes a requirement after 12 units of CHW services are provided to a patient, in a single year.
	• Because each billable unit of CHW services is for the billing of 30 minutes of care, billing for 12 units of CHW services, would be the equivalent of billing for six (6) hours of CHW services, therefore, if more than 6 hours of CHW services have been rendered to a patient in a single year, a POC is required. This sum of time must not include CHW services rendered in the emergency department.
	• Each POC may not exceed a period of one year and should be reviewed every six months from its effective date, by the licensed provider(s) who developed it. Upon the review, he/she/they must determine if any progress has been made towards the objectives listed in the patient's POC and whether CHW services are still medically necessary. If objectives have been met, the determination of discontinuing CHW services can be made by the licensed provider(s).
	• Medi-Cal guidance advises that the licensed provider developing the POC does not need to be the same provider that supplied the patient's initial recommendation for CHW services, nor does it have to be the CHWs supervising provider, and only advises that the provider(s) must be licensed, where the CHW may assist in the development of the POC.

Information that Must be Included in a Patient's Plan of Care (POC)	• The POC must contain the following: ✓ Specification of the condition that the service is being ordered for and the services rendered must be relevant to the condition.
	✓ It must include a list of other health care professionals providing treatment for the condition or barrier.
	✓ Contains written objectives that specifically address the recipient's condition or barrier affecting their health.
	✓ Lists the specific services required for meeting the written objectives.
	✓ Includes the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the POCs objectives.

Billing, Coding, and Documentation Requirements for CHW Services

The CHWs supervising provider can bill for the services provided by the CHW. The table below provides the billing codes for CHW services, their descriptions, and the applicable guidelines.

CPT Billing Code	Description	Applicable Guidelines
98960	Self-management education and training, face-to-face, 30 minutes, for **one patient.**	• The billing for codes 98960-98962 includes if the parent/caregiver/family are present. • The maximum frequency for all codes is four (4) units per patient, per day, which is equivalent to 2 hours of service. Additional units may be billed with an approved Treatment Authorization Request (TAR). TARs may be submitted after the service is provided. • Medi-Cal does not have a Place of Service (POS) restriction for CHW services. • Billing codes 98961 and 98962 for group services (more than 1 patient). Certain practice types, such as Federally Qualified Health Care Centers (FQHCS), and Rural Health Clinics (RHCs) may not be eligible to receive reimbursement for group services. Verification with insurance carriers is required. • If billing 98961 (2-4 patients) and 98962 (5-8 patients), the number of patients present for the services provided should be included in the documentation for each patient. • CHW documentation of the services rendered to a patient must always be accessible to the supervising provider upon his/her request.
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.**	

		• Minimum documentation requirements for CHW services must include the following: ✓ Documentation of medical necessity that supports the patient's eligibility for CHW service(s). (Refer to the section of this document that contains the patient eligibility criteria for CHW services.) ✓ A documented patient POC, if required. If not required, some of its mandated contents should still be in the patient's documentation, as it supports medical necessity for CHW services such as the patient's condition(s)/barrier(s) that are affecting health, where the CHW services rendered are relevant to that/those condition(s) and/or barrier(s). ✓ The patient's recommendation for CHW services. ✓ Because CHW services are represented by time-based codes, which are codes that include a time frequency in their description, the length of time spent rendering CHW services must be included in the documentation. ✓ Documentation of the nature of the services provided, which must also support reasoning for the length of time spent with the patient. *Example provided by Medi-Cal: "Discussed the patient's challenges accessing healthy food and options to improve the situation for 15 minutes. Assisted with SNAP application for 30 minutes. Referred patient to XYZ food pantry."* • Medi-Cal guidelines do not indicate that less than 30 minutes of CHW services are billable. The time documented for CHW services must reach or exceed 30 minutes.

Telehealth and CHW Services

Medi-Cal guidance for providing CHW services via telehealth, directs CHW supervising providers to refer to the Telehealth section in Part 2 of the Medi-Cal Provider Manual, for guidance. This is an indication that CHW services can be rendered via the approved telehealth modes of delivery, where all existing guidelines are applicable.

The source below can direct you to information regarding billing for services via the approved telehealth modalities:

- For telehealth information and guidelines please visit: **https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf**

Doula Services

Effective January 1, 2023, Medi-Cal will reimburse for doula services when there is a written recommendation of a physician or other licensed practitioner of the healing arts working within their scope of practice. Providers interested in becoming billable doulas may apply for enrollment in the Medi-Cal fee-for-service program by submitting an electronic application through the Provider Application and Validation for Enrollment (PAVE) online enrollment portal at, **https://pave.dhcs.ca.gov/sso/login.do**.

For more detailed information on the requirements, the following websites provide a plethora of information:

- **https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/Medi-Cal_Enrollment_Requirements_and_Procedures_for_Doulas.pdf**

- **https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx**

Medi-Cal Program Requirements for Doulas

Doulas must be:

- At least 18 years old at the time the application is submitted.
- Provide proof of an adult cardiopulmonary resuscitation (CPR) certification from the American Red Cross or American Heart Association.
- Attest they have completed basic Health Insurance Portability and Accountability Act of 1996 (HIPAA) training.
- Must complete three hours of continuing education in maternal, perinatal, and/or infant care every three years.

- Must enroll as an individual billing provider with Medi-Cal via the enrollment portal (PAVE) listed above.
- Must either have the training pathway or the experience pathway by completing an application, as outlined below:

    - **Training Pathway:**

        - The doula applicant must provide DHCS with a Certificate of Completion for a minimum of 16 hours of training which includes all of the following topics:
            - ✓ Lactation support,
            - ✓ Childbirth education,
            - ✓ Foundations on anatomy of pregnancy and childbirth,
            - ✓ Nonmedical comfort measures, prenatal support, and labor support techniques; and
            - ✓ Developing a community resource list.

        - If the doula applicant has a Certificate of Completion that does not detail the total number of hours completed and topics covered or if the doula applicant does not have a Certification of Completion, the applicant is required to provide a copy of a syllabus from the completed course(s) and complete the applicable attestation provided within the e-Form application attesting that they have satisfactorily completed course(s) covering the required topics above with the name of the organization providing the training course, the total number of hours completed and the date the course was completed.

        - In addition to providing the Certification of Completion or attestation that 16 total hours of training have been completed by the doula applicant, the applicant must also provide an attestation within the e-Form application attesting that they have provided support at three births in the capacity of a birth doula.

    - **Experience Pathway:**

        - Doulas may also apply to become a doula through the Experience Pathway.

        - The applicant must attest within the e-Form application that they have provided services in the capacity of a doula in either a paid or volunteer capacity for at least five years.

        - The five years of experience must have occurred within the last 7 years from the date the application is submitted.

- In addition, the applicant must attest to skills in prenatal, labor, and postpartum care, as demonstrated by the following:
  - ✓ Three written client testimonial letters or professional letters of recommendation using the testimonial templates provided within the regulatory provider bulletin from any of the following:
    - A physician,
    - A licensed behavioral health provider,
    - A nurse practitioner,
    - A nurse midwife,
    - A licensed midwife,
    - An enrolled doula, or
    - A community-based organization.

  - ✓ Letters must be written within the last seven years, and one letter must be either from a licensed provider, a community-based organization, or an enrolled doula.
  - ✓ Testimonial letter templates can be found at:https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/Medi-Cal_Enrollment_Requirements_and_Procedures_for_Doulas.pdf (Pages 4-7)

The table below provides the billing codes for doula services, their descriptions, and additional applicable guidelines.

HCPCS/CPT Billing Code	Description	Applicable Guidelines
Z1034	Prenatal visit **(DX codes: Z32.2, Z32.3)**	• A recommendation for services authorizes the following: ✓ one initial visit, ✓ up to eight additional visits that may be provided in any combination of prenatal and postpartum visits, and ✓ up to two extended three-hour postpartum visits after the end of a pregnancy.
Z1032	Extended initial visit, 90 minutes **(Dx codes: Z32.2, Z32.3, Z39.1, Z39.2)**	
Z1038	Postpartum visit **(DX codes: Z39.0, Z39.1, Z39.2)**	
T1032	Extended postpartum support, per 15 minutes **(DX codes: Z39.0, Z39.1, Z39.2)**	

Services Provided Outside of the Primary Care Setting	
59409	Doula support during vaginal delivery only **(DX codes: Z33.1, Z39.0)**
59620	Doula support during caesarian section **(Dx codes: Z33.1, Z39.0)**
59612	Doula support during vaginal delivery after previous caesarian section **(DX codes: Z33.1, Z39.0**)
T1033	Doula support during or after a miscarriage **(DX code: Z33.1)**
59840	Doula support during or after an abortion **(DX code: Z33.1)**

- Up to nine additional postpartum visits billed with Z1038 can be billed for with an additional recommendation from a physician or other licensed practitioner of the healing arts acting within their scope of practice.
- All visits are limited to one per day, per patient.
- Only one doula may bill for a visit provided to the same patient on the same day, excluding labor and delivery.
- One prenatal visit or one postpartum visit may be provided on the same day as labor and delivery, abortion, or miscarriage support.
- The prenatal visit or postpartum visit billed on the same calendar day as labor and delivery, abortion, or miscarriage may be billed by a different doula.
- Extended postpartum visits lasting up to three hours may be billed with T1032 for 12 units per visit, and up to two visits (24 units) per pregnancy per patient, provided on separate days.
- Doulas may bill for services proved by telehealth using either modifier 93 for synchronous audio-only, or modifier 95 for synchronous video.

This concludes with the California Billing and Coding Guide for HealthySteps-related services. The HealthySteps National Office is here to support you with billing and coding for HealthySteps-aligned services. To maximize appropriate reimbursement, we recommend always contacting health insurance carriers for verification on billing for services provided.

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