About this Document

HealthySteps sites can bill Maryland Department of Health (MDH), Maryland's Medicaid Authority (referred throughout as Maryland Medicaid) for some of the services they provide to children and their families. The purpose of this document is to support HealthySteps sites in billing for HealthySteps and HealthySteps-aligned services.

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

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

To maximize appropriate reimbursement, the HealthySteps National Office highly recommends always contacting Maryland's Medicaid agency and other health insurance carriers to verify billing requirements for services provided.

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Maryland Medicaid HealthySteps – Enhanced Provider Payment

Effective January 1, 2023, Maryland Medicaid will provide additional reimbursement in the form of an enhanced payment to HealthySteps practices meeting or approaching Fidelity per the HealthySteps National Office. There are several steps eligible practices and providers will need to complete prior to billing for the enhanced payment.

In order to be eligible for the Maryland Medicaid HealthySteps enhanced reimbursement the following steps must be complete:

1. Medical groups must be currently and actively meeting the HealthySteps National Office (National Office) fidelity requirements or deemed as on track to fidelity via a National Office certification letter (attesting status).
2. Group practices will need to initiate and submit supplemental applications, attach their National Office certification letter, and HealthySteps addendum in ePREP.
3. Each individual rendering provider will also need to submit a supplemental addendum and attach their group's certification letter.

Once the above steps have been completed, the group practices will be allowed to add the code H0025 ‘Behavioral Health Prevention Education Service’ to each pediatric Evaluation and Management (E&M) or Well-Child Visit (WCV) encounters, which includes HealthySteps services and provided within a clinic or outpatient setting. This code will pay an additional $15 per participant per visit, up to age four (48 months).

**Note that while this is an H-code, this code should not be billed to the Administrative Service Organization (ASO).*

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Maryland Medicaid Reimbursable Providers

Maryland Medicaid only reimburses certain provider types for HealthySteps related services. The following list of reimbursable Provider Types (PT) are included below:

- Physician (MD/DO)
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Psychiatrist (Psychiatric MD)
- Licensed Nurse Psychotherapist (LNP)
- Licensed Clinical Psychologist (Psych/PhD/PsyD)
- Licensed Certified Social Worker – Clinical (LCSW-C)
- Licensed Clinical Alcohol & Drug Counselor (LCADC)
- Licensed Clinical Marriage and Family Therapist (LCMFT)
- Licensed Clinical Professional Counselor (LCPC)
- Psychiatric Mental Health Certification (PMH) Required– Certified Nurse Practitioner (CRNP)
- Psychiatric Mental Health Certification (PMH) Required – Advanced Practice Registered Nurse (APRN)

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Billable Modifiers Required for HealthySteps-Related Services

The use of modifiers allows providers to indicate that a particular service has been rendered, or a service or procedure has been altered by some specific circumstance(s), without changing the definition or the code for the service. The following modifiers are applicable to HealthySteps-related services:

- **Modifier UA:**
  - This modifier is used to designate a service for a child or adolescent under the age of 18 (ages 0-17).

- **Modifier UB:**
  - This modifier is used to designate the service was delivered telephonically (Phone Services only).

- **Modifier GT:**
  - This modifier is used to designate the services was delivered via interactive audio and video telecommunication systems.

Note:
*If claims are submitted **without the required modifier(s), insurance carriers may deny them for reimbursement**.*
For patients 18 years and older, please select the regular CPT/HCPCS codes (e.g., 90791: Psychiatric diagnostic evaluation, 96132: Neuropsychological test administration).
Modifier UA is not required for patients ages 18 – 21 years old.

Maryland's Preventive Care & EPSDT Program: Healthy Kids

EPSDT is the Early and Periodic Screening, Diagnosis and Treatment Program (*also known as the Healthy Kids Program*) through the State Medicaid Program. This program promotes access to and ensures availability of quality health care for Medicaid eligible children, teens, and young adults and establishes preventive care standards for children under the age of 21. Preventive health care services allow for early identification and treatment of health problems before they become medically complex and costly to treat.

The Maryland Healthy Kids Preventive Health Schedule reflects minimum standards required for all Maryland Medicaid recipients from birth to 21 years of age. The Maryland Healthy Kids Program requires yearly preventive care visits between ages 3 years through 20 years.

All primary care providers that treat Medicaid patients under the age of 21 must be EPSDT Certified.

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Maryland Medicaid Children and Adolescent (C&A) Services

Maryland Medicaid clinicians providing services to children and adolescents must select the Procedure Codes listed with the prefix "C&A" in the description (see example below):

CPT Codes	Description
90791	Psychiatric Diagnostic Evaluation
90791-UA	***C&A** Psychiatric Diagnostic Evaluation*
90792	Psychiatric Diagnostic Evaluation with Medical Services
90792-UA	***C&A** Psychiatric Diagnostic Evaluation with Medical Services*

Optum Maryland: ASO & PBHS

Effective January 1, 2020, Optum is the Administrative Service Organization (ASO) contracted with MDH to assist with the management of the Public Behavioral Health System (PBHS). Providers must enroll their individual/Group/Clinic NPIs via Optum Maryland's ePREP (electronic Provider Revalidation and Enrollment Portal). Once the provider completes the ePREP enrollment, they will receive their credential approval and token(s) for use within Optum's Incedo Provider Portal, which will provide licensed providers with varying system access; submission of medical claims, requests for prior authorization for specific behavioral health services, claim status, and patient eligibility.

Maryland's ASO, will make clinical decisions about each patient based on the clinical features of the participant's case, the medical necessity criteria, and the resources available. Under the auspices of MDH, Optum bases its decisions on medical necessity. Medical necessity is met when a patient has a behavioral health disorder that requires professional evaluation and treatment, and the level of care provided is the least intensive, least restrictive level of care that is able to safely meet the patient's behavioral health and medical needs.

Private practitioners of any discipline are not allowed to bill for services delivered by non- licensed/certified mental health professionals.

Billing under a private practitioner's or group practice's license for services provided by individuals who do not have their own Medicaid provider number will be denied.

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Screenings

Child Developmental and Social-Emotional Screenings

Evaluating and promoting optimal child development and well-being includes screenings. Screenings are a significant component of HealthySteps services. There are many different types of screenings that include child development, social-emotional, and health and behavior.

The below tables highlight pertinent billing codes, their descriptions, and guidelines.

CPT Code	Screening Description	Recommendation: Healthy Kids Preventive Health Schedule	Reimbursable Clinician(s)	Applicable Guidelines & Limitations
96110 •Ages and Stages Questionnaires (ASQ) •Age and Stage Questionnaire-Social Emotional (ASQ-SE) •Survey of Well-Being of Young Children (SWYC) •Parents' Evaluation of Developmental Status (PEDS)	Developmental Milestone Survey (*Screenings may only be billed when a standardized screening tool is used, and results documented.*)	Developmental Surveillance recommended at every well child visit; use of standardized screening tool required for all children at 6, 9, 12, 18, 24 & 30 months (or *whenever concern*).	Non-Psych Physicians (MD/DO/& PA)	Modifier UA is applicable when billing for surveillance screenings for children between ages 0-17 years. 96110: Reimbursed up to 8 units total per child through age 5 years. 0 units will be reimbursed age 6 years & older. A maximum of 2 units of 96110 will be reimbursed per visit when both general developmental screen and an autism screen are conducted; **OR** 96110 may be combined with other screening codes when appropriate (ex: 96127) for a maximum of 2 units of screening reimbursed per visit.
96110 • Modified Autism Checklist in Toddlers •Revised with Follow-up (MCHAT-R/F): 16 – 30 months	Autism Screenings (*Screening may only be billed when a standardized screening tool is used, and results documented.*)	Autism Surveillance recommended at every well child visit; use of standardized screening tool required for all children at 18 & 24 months (*and whenever concern*).	Non-Psych Physicians (MD/DO/& PA)	Modifier UA is applicable when billing for surveillance screenings for children between ages 0-17 years. 96110: Reimbursed up to 8 units total per child through age 5 years. 0 units will be reimbursed age 6 years & older.

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				A maximum of 2 units of 96110 will be reimbursed per visit; **OR** 96110 may be combined with other screening codes (ex: 96127) for a maximum of 2 units of screening per visit.
96127 •Pediatric Symptom Checklist (PSC) •Pediatric Symptom Checklist Youth Self-Report (PSC-Y) •Strengths and Difficulties Questionnaire (SDQ) •Age and Stage Questionnaire-Social Emotional (ASQ-SE) •Early Childhood Screening Assessment	Brief emotional/behavioral assessments *(May only be billed when a standardized screening tool is used, and results documented.)*	Mental health/behavioral Assessment. Recommended annually beginning at 3 years of age. Use of standardized screening tool is recommended.	Non-Psych Physicians (MD/DO/& PA)	Modifier UA is applicable when billing for surveillance screenings for children between ages 0-17 years. A maximum of 2 units of 96127 will be reimbursed per visit; **OR** 96127 may be combined with other screening codes (ex: 96110) for a maximum of 2 units of screening per visits.
96127 • PHQ-9 Modified for Teens • Pediatric Symptom Checklist (PSC-Y) • Center for Epidemiological Studies Depression Scale for Children (CES-DC) • Beck Depression Inventory (BDI)	Brief emotional/behavioral assessments *(May only be billed when a standardized screening tool is used, and results documented.)* ***PHQ-2 may not be billed.***	Depression Screening recommended annually beginning at 11 years of age. If providers choose, they can "pre-screen" with PHQ-2 to determine if a longer standardized screening tool is needed.	Non-Psych Physicians (MD/DO/& PA)	Modifier UA is applicable when billing for surveillance screenings for children between ages 0-17 years. A maximum of 2 units of 96127 will be reimbursed per visit; **OR** 96127 may be combined with other screening codes (ex: W7000) for maximum of 2 units of screening per visit.
96127 • Vanderbilt ADHD Diagnostic Rating Scales – Parent and Teacher • Conners-3 Ratings Scales • ADHD Rating Scale-5 for Children and Adolescents	Brief emotional/behavioral assessments *(May only be billed when a standardized screening tool is used, and results documented.)*	ADHD Assessment. AAP clinical policy recommends use of ADHD-focused parent and teacher rating scales as a component of screenings/diagnosis when there is concern.	Non-Psych Physicians (MD/DO/& PA)	Modifier UA is applicable when billing for surveillance screenings for children between ages 0-17 years. A maximum of 2 units of 96127 will be reimbursed per visit.

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96127 • Screen for Childhood Anxiety Related Disorders (SCARED) • Spence Children's Anxiety Scale	Brief emotional/behavioral assessments *(May only be billed when a standardized screening tool is used, and results documented.)*	Other disorder-focused mental health screening and assessment tools may be used when there is a specific concern, (ex. Anxiety)	Non-Psych Physicians (MD/DO/& PA)	Modifier UA is applicable when billing for surveillance screenings for children between ages 0-17 years. A maximum of 2 units of 96127 will be reimbursed per visit.
96161 •Patient Health Questionnaire (PHQ-9) •Edinburgh Postnatal Depression Scale (EPDS)	Caregiver-focused health risk (*Assessment may be billed only when a standardized screening tool is used.)*	Postpartum Depression Screening recommended for caregiver at 1, 2, 4, & 6 months well child check.	Non-Psych Physicians (MD/DO/& PA)	Modifier UA is applicable when billing for surveillance screenings for children between ages 0-17 years. 96161: Reimbursed up to 4 units total per child through age 12 months. 0 units will be reimbursed age 13 months & older. *Billing should occur under the child's Medicaid ID number.*

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 procedures designated to ameliorate specific disease-related problems. *For further reference, please review an Health and Behavior Assessment clinical encounter sample.*

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

Note: ASO requires Mental Health providers to obtain prior authorization for BH services via Incedo Provider Portal. It is highly recommended to obtain all medically necessary prior approvals to avoid claim denies and/or delays in patient care.

The below table highlights the billings codes, their descriptions, the reimbursable clinicians, and guidelines for health and behavior assessments/re-assessments, and interventions.

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CPT Code	Description	ICD10 Code(s)	Reimbursable Clinician(s)	Applicable Guidelines
96156	Health and behavior assessment or re-assessment (e.g., health-focused clinical interview, behavioral observations, clinical decision making). 96156 can only be billed once per day.	Medical diagnosis must be reported, in addition to the bio-psychosocial factor(s)	Health Behavior Assessment and Intervention - Health behavior assessment and/or intervention services performed by a QHCP *other than a clinical psychiatrist* must be reported with the appropriate Evaluation and Management (E/M) codes.	Documentation for assessment or re-assessment services should include, but is not limited to, the patient's physical illness(s) (health focused interview), and identification of the factors that are either preventing successful treatment, and/or management of the illness. Documentation should also include how these factors are either preventing, treatment and/or with time, providing successful management of them.
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 bio-psychosocial factor(s)	Health Behavior Assessment and Intervention - Health behavior assessment and/or intervention services performed by a QHCP *other than a clinical psychiatrist* must be reported with the appropriate Evaluation and Management (E/M) codes.	Services do not focus on the mental health of a patient, but rather on the biopsychosocial factors that are either affecting the treatment of, or severity of the patient's medical condition. Patient must have an established illness and cannot have been diagnosed with a mental illness.

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 assessing 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 happen most often 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.
Typically, only one initial evaluation/diagnostic interview (90791/90792) may be rendered per year.
The below table highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for reporting psychiatric diagnostic evaluations.

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CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90791	Psychiatric diagnostic evaluation	Clinical Psychiatist (MD) Non-Facility Licensed Clinical Psychologist (Psych/PhD/PsyD) Licensed Nurse Psychotherapist Licensed Certified Social Worker – Clinical (LCSW-C) Licensed Clinical Alcohol & Drug Counselor (LCADC) Licensed Clinical Marriage & Family Therapist (LCMFT) Licensed Clinical Professional Counselor (LCPC) PMH Certified Registered Nurse Practitioner (CRNP) PMH Certified Advanced Practice RN (APRN)	ASO requires Mental Health providers to obtain prior authorization for BH services via Incedo Provider Portal. It is highly recommended to obtain all medically necessary prior approvals to avoid claim denies and/or delays in patient care. Modifier UA is applicable when billing for Psychiatric Diagnostic evaluations *with and without* medical services for children between ages 0-17 years. Because psychotherapy (when rendering due to a mental health diagnosis) includes continuing psychiatric evaluation, they are not to be reported with psychiatric diagnostic evaluations. *Verification is required to confirm if the same guideline applies to psychotherapy when billing for prevention (when risk factors are present).* 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. Evaluations with medical services are only applicable to psychiatrists, psychiatric PAs, and psychiatric NPs. Psychiatric diagnostic evaluations must be consistent with the scope of license and competency of the mental health provider. May not bill a 90791/90792 and a 90832/90833 or 90834/90836 or 90837/90838 on the Same Day.
90792	Psychiatric diagnostic evaluation with medical services		

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Developmental Test Administration, with Interpretation and Report

Developmental testing is not to be confused with developmental screenings. Screenings identify who may be at risk, while testing provides a more 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 is abnormal.

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 w/o PMH Psychiatrist (MD)	*ASO requires Mental Health providers to obtain prior authorization for BH services via Incedo Provider Portal. It is highly recommended to obtain all medically necessary prior approvals to avoid claim denies and/or delays in patient care.* Maryland Medicaid does not provide specific limits on CPT code 96112. It is highly recommended to contact Maryland Medicaid for allowable annual frequency. 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. For MDs, PAs, and NPs, developmental testing must be consistent with the scope of licensure and competency of the provider.

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Psychological Testing and Evaluation

Not to be confused with screenings, psychological testing and evaluation involve more extensive services to be rendered. Psychological testing is at the clinician's judgement, where the reason(s) for his/her decision for rendering 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.

The number of units billed must equal the number of hours that testing was provided. A psychological associate, under the supervision of a clinical psychologist, may assist in administering a psychological evaluation. In these cases, the clinical psychologist (PhD/PsyD) should bill with CPT codes 96130/96131 or 96136/96137 as indicated and the associate should bill with CPT codes 96138/96139.

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

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
96130	Psychological testing and evaluation; first hour Testing and evaluation are formulized measures of mental functioning including personality, emotions, intellectual functioning, and psychopathology.	Physician, Physician Assistant, Nurse Practitioner w/o PMH Psychiatrist (MD) Licensed Clinical Psychologist	ASO requires Mental Health providers to obtain prior authorization for BH services via Incedo Provider Portal. It is highly recommended to obtain all medically necessary prior approvals to avoid claim denies and/or delays in patient care. 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 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. 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.
96131	Psychological testing and evaluation; each additional hour after the first hour of service		

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			For MD, PA, and NP, psychological testing must be consistent with the scope of licensure and competency of the provider. Maryland Medicaid does not provide the specific limits on CPT codes 96130 and 96131. It is highly recommended to contact Maryland Medicaid for allowable annual frequency.

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. Neuropsychological testing can overlap with psychological testing but is more detailed. Which of the tests to render to a patient would not only be at the provider's clinical judgment, but if seeking reimbursement, the patient must present with medical necessity for testing and evaluation.

If a patient presents with any of the medical necessity criteria for billing neuropsychological testing, the below table 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	Physician, Physician Assistant, Nurse Practitioner w/o PMH Psychiatrist (MD)	ASO requires Mental Health providers to obtain prior authorization for BH services via Incedo Provider Portal. It is highly recommended to obtain all medically necessary prior approvals to avoid claim denies and/or delays in patient care. The patient must present with medical necessity for testing. Maryland Medicaid does not provide the specific limits on CPT codes 96132 and 96133. It is highly recommended to contact Maryland Medicaid for allowable annual frequency. 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.
96133	Neuropsychological testing evaluation services; each		Documentation requirements for testing and evaluation services include the medical necessity for the services, the test, results with interpretation, clinical data, integration of patient data, clinical decision making, treatment planning, report generation, and

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	additional hour after the first hour of service		interactive feedback to the patient, family member(s) or caregiver(s). The time spent rendering the services must also be documented. For MD, PA, and NP, neuropsychological testing must be consistent with the scope of license and competency of the provider.

Psychological or Neuropsychological Test Administrations and Scoring

Once the potential for a mental health condition has been established by either screening or the presence of a comorbid condition, testing is used to determine the presence or absence of that mental health condition. For billing, test administration requires "medical necessity" and must be justified by a related ICD-10 code. Test administration can be performed by either a physician/ qualified healthcare professional, a technician under the supervision of a physician/ qualified healthcare professional, or a computer.

The below table 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 Technician trained to administer and score psychological and neuropsychological tests	ASO requires Mental Health providers to obtain prior authorization for BH services via Incedo Provider Portal. It is highly recommended to obtain all medically necessary prior approvals to avoid claim denies and/or delays in patient care. 96136, 96137, 96138, and 96139 are time-based codes. Documenting the start and stop times is the most effective way to stay within the guidelines of coding compliance. "Other qualified health care professionals" are physician assistants and nurse practitioners. For MD, PA, and NP, testing must be consistent with the scope of licensure and competency of the provider.
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		

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			Documentation and service requirements include, but are not limited to, the patient's medical necessity for the test, the test, the test score, and the time spent rendering testing and scoring. Communication with family members and next steps should also be included in the documentation. Verification of the type(s) of technicians eligible to render testing and scoring must be made with the Maryland Medicaid and/or the insurance carriers. Additionally, billing protocols must also be verified, as technicians may not be able to independently bill for services.
96139	Psychological or neuropsychological test administration and scoring *by technician*, two or more tests; each additional 30 minutes		

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Psychotherapy

When a Patient is Diagnosed with a Mental Health Disorder or Developmental Disorder in Infancy and Early Childhood

Maryland Medicaid 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 page, highlights 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	Psychiatrist (MD) Non-Facility Licensed Clinical Psychologist (Psych/PhD/PsyD) Licensed Nurse Psychotherapist Licensed Certified Social Worker – Clinical (LCSW-C) Licensed Clinical Alcohol & Drug Counselor (LCADC) Licensed Clinical Marriage & Family Therapist (LCMFT)	ASO requires Mental Health providers to obtain prior authorization for BH services via Incedo Provider Portal. It is highly recommended to obtain all medically necessary prior approvals to avoid claim denies and/or delays in patient care. Modifier UA is applicable when billing for Psychotherapy and group therapy services for children between ages 0-17 years. Because psychotherapy services rendered when a patient is diagnosed with a mental health and/or developmental disorder includes the evaluation of the patient's functional and mental status, psychiatric diagnostic evaluation services (90791, 90792) cannot be billed on the same date of service. Documentation should include diagnosis, symptoms, functional status, mental status examination, treatment plan, prognosis, and progress. The time spent rendering the service and how the patient is or has benefited from therapy in reaching goal(s) is also required. If psychotherapy is due to depression, specification of depression episode is required (single/recurrent), and when applicable, if the patient is in partial or full remission. A signed and dated treatment plan is required and must include but is not limited to: the patient's diagnosis, treatment goals, and number of sessions ordered by the
90834	Individual psychotherapy with patient-45 minutes		
90837	Psychotherapy-60 minutes		

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		Licensed Clinical Professional Counselor (LCPC) PMH Certified Registered Nurse Practitioner (CRNP) PMH Certified Advanced Practice RN (APRN)	physician, nurse practitioner, or physician's assistant. The practitioner involved in the treatment plan for the patient must sign the plan certifying the medical necessity.
90846	Family psychotherapy **without** patient present-50 minutes (face-to-face with patient and family)		Family and group 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). Documentation must include the diagnosis, symptoms, functional status, mental/developmental status, treatment plan, prognosis, and progress. The time spent rendering the service, family communication and dynamics (verbal or non-verbal) and how the patient and family is or has benefited from therapy in reaching goal(s), must also be included. Services also included in the codes are, reviewing records, communicating with other providers, observing, and interpreting patterns of behavior, communication between the patient and family, and decision making. Family psychotherapy must be composed of at least two family members. The time allotted in each family therapy code's description must be rendered with a *maximum of 50 minutes when the patient is not present, or a maximum of 110 minutes when the patient is present.* Group therapy is defined as counseling of at least two but not more than eight persons at any session. Group services may not be reimbursable at FQHCs/RHCs. It is highly recommended that your site contact Maryland Medicaid for billing and code guidelines.
90847	Family psychotherapy **with** the patient present-50 minutes		
90853	Group psychotherapy (a group composed of patients with separate and distinct disorders or persons sharing some facet of a disorder) **Group psychotherapy (90853) cannot be reported on the same day as family therapy (90846, 90847).**		

Important Notes:

The reporting of individual versus family psychotherapy is at the clinical discretion of the provider. Verification of age minimum requirements for reporting individual psychotherapy is required. In addition, guidelines for when to select billing for individual psychotherapy, versus when to bill for family psychotherapy, must be verified with insurance carriers. In addition to insurance verification, please review the guidelines indicated in the family psychotherapy section to assist with your decision in reporting.

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Although there are sources indicating the ability to report psychotherapy services when **more than** 50% of the time allotted in their billing code descriptions was spent rendering the service, insurance carriers can require the entire time in the billing codes description to be rendered, or if they have determined a minimum time requirement for reimbursement of services. Verification with Maryland Medicaid and/or insurance carriers is **required**.

Psychotherapy with Medical Services

Reimbursement is available for psychotherapy with medical services when the parent/caregiver is the primary patient, with the reporting of the codes below.

CPT Code	Description	Reimbursable Clinicians	Applicable Guidelines
90833	Psychotherapy-30 minutes with medical services.	Psychiatrist PMH Certified Registered Nurse Practitioner (CRNP) PMH Certified Advanced Practice RN (APRN)	ASO requires Mental Health providers to obtain prior authorization for BH services via Incedo Provider Portal. It is highly recommended to obtain all medically necessary prior approvals to avoid claim denies and/or delays in patient care. Modifier UA is applicable when billing for Psychotherapy *with* medical services for children between ages 0-17 years. Psychotherapy with medical services should always be coded secondary to the evaluation and management code reported by the mental health physician. The time providing medical services should not be included in the reporting of the time spent rendering psychotherapy. Medical services are services rendered that are reported with level of service evaluation and management codes (e.g., physical exam and a prescription of pharmaceuticals). Applicable guidelines for psychotherapy also apply to psychotherapy when rendered with medical services.
90836	Psychotherapy-45 minutes with medical services.		
90838	Psychotherapy-60 minutes with medical services.		

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

Maryland Medicaid reimburses for SBIRT (Screening, Brief Intervention, and Referral to Treatment) is a comprehensive, universal public health approach that integrates behavioral health into the primary care setting. The SBIRT model provides universal setting, prevention, and early intervention for substance use across a full continuum. Certified health care professionals use screening tools to briefly engage patients on substance use. Based on the screening assessment, the provider administers a brief intervention and, when indicated, makes a referral for treatment. Typically, SBIRT services are provided to patients 11 years and older. SBIRT services performed by behavioral health providers outside of primary care settings will not be reimbursed.

The below table highlights the billing codes, their descriptions, the approved health care professionals, and applicable guidelines.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
W7000 • Alcohol Use Disorders Identification Test (AUDIT) • Alcohol Use Disorders Identification Test (AUDIT-C) • Drug Abuse Screening Test (DAST) • Alcohol, Smoking, and Substance Involvement test (ASSIST) • CRAFFT (under 21) • CRAFFT 2.0 • CRAFFT 2.1 • CRAFFT N+ Interview	Alcohol and/or Substance (other than tobacco) Use Disorder screening, self-administered (Annually beginning at age 11 years.)	Physician Physician Assistant *(Must have Board of Physicians approval delegated agreement with physician that authorizes the rendering & supervision of other SBIRT providers before they may provide services.)* Nurse Practitioner Licensed Clinical Psychologist *(Only if services are provided in primary care setting.)* Licensed Certified Social Worker – Clinical *(Only if services are provided in primary care setting.)*	Maryland Medicaid encourages providers to participate in a brief training program. The Substance Abuse and Mental Health Services Administration (SAMHSA) offers free online training that can be completed in approximately 30 minutes. Completing the training qualifies the participant for Continuing Education Units (CEUs). Maryland Medicaid no longer pays for HCSPS codes 99408 & 99409. The new recognized CPT codes (W7000 – W7022) have been created to grant providers more flexibility when billing SBIRT services. These codes are not eligible for reimbursement through Beacon Health Options, as the MCO are responsible for payment of primary behavioral health services. Maryland Medicaid will reimburse providers for a maximum of 1 unit of W7000 or W7010 annually for patients ages 11 and up. Maryland Medicaid will reimburse providers for a maximum of 4 interventions (W7020, W2021, and/or W7022) annually per recipient ages 11 and up. W7000 may be combined with other screening codes (ex. 96127) for a maximum of 2 units of screening per visit. The initial screening and intervention (*if the intervention takes place on the same day as the screening*), should be billed with the office visit.

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W7010 • Alcohol Use Disorders Identification Test (AUDIT) •Drug Abuse Screening Test (DAST-10) • Drug Abuse Screening Tool Adolescent (DAST-A)	Alcohol and/or Substance (other than tobacco) Use Disorder screening, self-administered structured screening (Age 11 - 20 years)		When additional interventions are completed with a participant, the provider should only bill for the intervention if an office visit does not occur. If both self-screening and provider screening are both administered on the same day, the provider may only bill for one of the screenings, Maryland Medicaid will pay whichever is billed first. Only one intervention may be billed per participant, per day. Providers may bill Maryland Medicaid for time they spend screening, discussing the screening results, and providing recommendations to an individual. These are time-based codes and time spent with the patient must be documented in the medical record separately from time spent performing an E/M service. When documentation supports that a significant, separately identifiable problem-oriented evaluation and management (E/M) service is rendered, the appropriate code for the E/M service may be reported separately. Positive screens should be followed by brief intervention and referral for treatment when indicated (SBIRT: Screening, Brief Intervention, and Referral to Treatment). Modifier UA *may be* required for Alcohol and/or substance use disorder services. It is highly recommended that your site contact Maryland Medicaid for billing and code guidelines.
W7020 • CRAFFT • CAGE-AID	Alcohol and/or Substance (other than tobacco) Use Disorder Intervention; greater than 3 minutes up to 10 minutes (Age 11 - 20 years)		
W7021 • CRAFFT • CAGE-AID	Alcohol and/or Substance (other than tobacco) Use Disorder Intervention; greater than 10 minutes up to 20 minutes (Age 11 - 20 years)		
W7022 • CRAFFT • CAGE-AID	Alcohol and/or Substance (other than tobacco) Use Disorder Intervention; greater than 20 minutes (Age 11 - 20 years)		

***Not applicable to telemedicine services*

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Smoking and Tobacco Use Cessation

Bright Futures (3rd edition) recommends that health care professionals screen patients for tobacco use and secondhand smoke exposure, encourage patients and families to stop smoking, and provide cessation strategies and resources at most visits. Maryland Medicaid will reimburse for smoking and tobacco use cessation counseling for children ages 11 – 20 years. Currently, there is no specification on the annual limit on the number of smoking cessation counseling episodes Maryland Medicaid will cover. Thus, it is highly recommended that your site contact Maryland Medicaid for limitation guidelines.

One caveat to payment for tobacco cessation counseling is understanding who the patient is, meaning who is being counseled. This will affect which Current Procedural Terminology (CPT) and diagnostic codes should be used. Counseling to the patient: Smoking and tobacco use counseling to the patient is reported using CPT code 99406 (smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or code 99407 (smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes). Counseling lasting less than 3 minutes is considered part of an evaluation and management (E/M) service and is not paid separately. Services must be provided by a physician or other qualified health professional and must be provided face-to-face.

Please note, 99406 and 99407 can be reported only under the patient who is smoking or using tobacco. They are not to be reported under your patient when the parent or guardian is counseled on smoking cessation or tobacco use. One way to obtain payment when the parent or guardian smokes and is being counseled by the pediatrician (since carriers do not regard parents/guardians as patients of the pediatrician) is to report the E/M service (e.g., 99201-99215) using time as the key factor.

Successful interventions for tobacco use begins with identifying young children with tobacco use and focusing on enhancing tobacco users' motivation to change and connecting them with evidence-based resources to help make the next quit attempt a success.
Maryland Medicaid guidance advises that clinical documentation for services should include the total time spent rendering services, what was discussed including cessation techniques, resources, and follow-up for each visit. Maryland Medicaid also requires clinicians to offer information about Maryland's Tobacco Quitline (1-800-QUIT-NOW). There are 5 major steps to intervention and 5 steps to motivate those that are not ready to quit. Using these steps, in addition to documenting time and techniques, will ensure compliant documentation for all insurance carriers.

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the steps are as follows:

5 Major (5A's) Intervention Steps		5 Motivational (5R's) Steps When not Ready to Quit
1. **A**sk-Identify and document tobacco use status at every visit,		1. **R**elevance-Encourage to indicate why quitting is personally relevant.
2. **A**dvise-In clear personalized manner, urge to quit.		2. Risks-Ask patient to identify potential negative consequences of tobacco use.
3. **A**ssess-Currently, is patient willing to make a quit attempt.		3. **R**ewards-Ask patient to identify potential benefits of stopping tobacco use.
4**. A**ssist-If willing to make quit attempt, use counseling and pharmacotherapy to help him/her quit.		4. **R**oadblocks-Ask patient to identify barriers or impediments to quitting
5. **A**rrange-Schedule follow-up contact, preferably within the first week after the quite date.		5. **R**epetition-Motivational intervention should be repeated every time clinician interacts with patient.

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

CPT Code	Description	ICD10 Code	Reimbursable Clinician(s)	Applicable Guidelines
99406	Smoking and tobacco use cessation counseling visit; intermediate, **greater than** 3, up to 10 minutes. (4 minutes - 10 minutes) (Age 11 – 20 years)	Tobacco use disorder code applicable to the patient.	Physician, Physician Assistant, Nurse Practitioner w/o PMH	**Example diagnoses:** F17.210-Nicotine dependence cigarettes, uncomplicated. F17.220-Nicotine dependence, chewing tobacco, uncomplicated. E869.4 -Secondhand tobacco smoke (Use as a 2nd code to the primary illness.) 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 patient was provided information on the Maryland smokers helpline.
99407	Smoking and tobacco use cessation counseling visit; intensive, **greater than**10 minutes. (11 minutes or more)			If prescribing medication, verification on covered treatment is required. Clinical counselors are not approved to render services for reimbursement at FQHCs/RHCs. It is highly recommended that your site contact Maryland Medicaid for billing and code guidelines.

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	(Age 11 – 20years)			

Telehealth Services

Telehealth is a model of care delivery for medically necessary services by way of synchronous or asynchronous technology assisted communication. Synchronous telehealth means two-way audio-only or audio-video direct interaction between provider and participant. The telehealth care delivery model serves Medicaid participants regardless of geographic location.

Maryland Medicaid reimburses some covered services rendered via audio-only. Audio-only includes telephone conversations. Services rendered via audio-only are billed in the same manner as in-person services and must include the "UB" modifier. Reimbursement for services rendered via audio-only is program-specific. Please refer to specific program regulations or manuals for coverage of services rendered via audio-only.

The following tables highlight the original telehealth service codes, reimbursable clinicians, and coding and billing guidelines, and the documentation requirements for reporting telehealth services. It is highly commended that all clinics contact Maryland Medicaid to obtain verification regarding specific coverages and/or reimbursable service providers.

CPT Codes	Description	Reimbursable Clinician(s)	Guidelines
96127 96161	Social-emotional or Mental Health Screening Caregiver-focused health risk assessment instrument	Non-Psych Physicians (MD/DO/& PA)	Modifier UB – Required for telehealth services delivered via Audio-Only interactions.

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90791, 90792 90832, 90834, 90837 90833, 90836, 90838, 90839, 90840, 90846, 90847	Psychiatric Diagnostic Evaluation Psychiatric Diagnostic Evaluation w/Medical Services Psychotherapy - 30 minutes Psychotherapy - 45 minutes Psychotherapy - 60 minutes Psychotherapy w/Medical Services – 30 minutes Psychotherapy w/Medical Services – 45 minutes Psychotherapy w/Medical Services – 60 minutes Psychotherapy for Crisis; First 60 minutes Psychotherapy for Crisis; each additional 30 minutes Family Psychotherapy without Patient Present Family Psychotherapy with Patient Present	Clinical Psychiatist (MD) Non-Facility Licensed Clinical Psychologist (Psych/PhD/PsyD) Licensed Nurse Psychotherapist Licensed Certified Social Worker – Clinical (LCSW-C) Licensed Clinical Alcohol & Drug Counselor (LCADC) Licensed Clinical Marriage & Family Therapist (LCMFT) Licensed Clinical Professional Counselor (LCPC) PMH Certified Registered Nurse Practitioner (CRNP) PMH Certified Advanced Practice RN (APRN)	Modifier GT – Required for telehealth services delivered via Video-Only interactions. Providers may only deliver services that fall within their normal scope of practice All telehealth transmissions must be Health Insurance Portability and Accountability Act (HIPAA) compliant. Providers must follow consent and patient information protocol consistent with those followed during in-person visits.
96156, 96158, 96159	Health and Behavior Assessment or Re-assessment/Intervention	Clinical Psychiatrist (MD)	
96130 93131	Psychological testing and evaluation; first hour Psychological testing and evaluation; each additional hour after the first hour of service.	Physicians, Physician Assistant, Nurse Practitioner Psychiatist (MD) Licensed Clinical Psychologist (Psych/PhD/PsyD)	
96132 96133	Neuropsychological testing evaluation services; first hour Neuropsychological testing evaluation services; each additional hour after the first hour of service	Physicians, Physician Assistant, Nurse Practitioner Psychiatist (MD)	

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96136 96137	Psychological or neuropsychological test administration and scoring, by physician or other QHCP, two or more tests; first 30 minutes Psychological or neuropsychological test administration and scoring, by physician or other qualified health care professional, two or more tests; each additional 30 minutes	Physicians, Physician Assistant, Nurse Practitioner Psychiatrist (MD) Licensed Clinical Psychologist (Psych/PhD/PsyD)	
96138 96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests; first 30 minutes. Psychological or neuropsychological test administration and scoring by technician, two or more tests; each additional 30 minutes	Technician trained	
99406 99407	Smoking and tobacco use cessation counseling visit; intermediate, **greater than** 3, up to 10 minutes. (4 minutes - 10 minutes) Smoking and tobacco use cessation counseling visit; intensive, **greater than** 10 minutes.	Physician, Physician Assistant, Nurse Practitioner	
90853	Group psychotherapy (other than multiple family group) 45-60 minutes	Clinical Psychiatist (MD) Licensed Clinical Psychologist (Psych/PhD/PsyD) Licensed Certified Social Worker – Clinical (LCSW-C) Licensed Clinical Alcohol & Drug Counselor (LCADC) Licensed Clinical Marriage & Family Therapist (LCMFT) Licensed Clinical Professional Counselor (LCPC) PMH Certified Registered Nurse Practitioner (CRNP) PMH Certified Advanced Practice RN (APRN)	*Audio-Only is not allowed*. Modifier GT only – Required for Group Psychotherapy services.
96110	Developmental Milestone Survey, speech and language delay screening (Also used for Autism screenings)	Non-Psych Physicians (MD/DO/& PA) PMH Certified (NP, CRNP, APRN)	*Audio-Only is not allowed*. Modifier GT only – Required for Developmental delay screenings services.

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96112	Developmental test administration-including assessment of fine and/or gross motor, language, cognitive level, social, and memory or executive functions by standardized developmental instruments with interpretation and report; first hour	Physician, Physician Assistant, Nurse Practitioner Psychiatrist (MD)	*Audio-Only is not allowed*. Modifier GT only – Required for Developmental testing services.

Billing Specificities:

- Telehealth providers submit claims in the same manner the provider uses for in-person services.
- Providers must include the "GT" modifier to identify services rendered via telehealth (video-only). Services delivered by telephone (audio-only) must also be billed using the "UB" modifier.
- Services provided telephonically are subject to the same program restrictions, pre-authorizations, limitations, and coverage that exist for the service when provided in-person. *Services will be authorized using the normal mechanisms. Providers must contact the behavioral health, ASO, if they have questions regarding prior authorization requirements for services rendered via audio-only telephonic or telehealth.*
- Telehealth providers must be enrolled in the Maryland Medical Assistance Program before rendering services via telehealth.
- The "hub," or "distant site," is the location of the provider who will perform the services.
- The "distant site provider" is the rendering practitioner that is not physically present at the originating site. There are no geographic or facility restrictions on distant sites for services delivered via tele-health.
- The originating site is the location of the patient, at the time the service is being provided. There are no geographic or facility restrictions on originating sites.

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- For an initial appointment (new patient), the provider must review the patient's medical history and any available medical records with the patient, during the service.

- Providers should bill using the same place of service code that would be appropriate for a non-telehealth claim. The distant site should be billed using the location of the doctor. If a distant site provider is rendering services at an off-site office, the provider should bill using the Place of Service Code 11 for "Office." *Place of Service Code 02 (Telehealth) is not recognized for Maryland Medicaid HealthySteps patients under the age of 21 years.*

- Patient's and/or guardian's explicit consent is required for telehealth services. If the participant is unable to consent, the medical record must contain in writing an explanation as to why the participant was unable to consent to services rendered via telehealth. Consent only needs to be given and documented once per year.

- Providers must maintain documentation in the same manner as an in-person visit or consultation, using either an electronic or paper medical record. Providers must also reflect in their records whether the service was delivered using telehealth (Video-only) or telephone (audio-only). Providers must also be willing to provide telephone billing records to State auditors to justify services provided by telephone.

- Service minimums (*time-based requirements*) in individual outpatients remain as they would outside of telehealth.

- The fee structure is the same whether care is delivered in-person or by telehealth or audio-only telephone. They are designed for the care provided to be of sufficient clinical benefit.

- Maryland Medicaid will only reimburse telehealth Professional Provider fees, not facility fees.

- The Department of Health and Human Services has relaxed enforcement of strict HIPAA standards to allow providers to use "non-public facing" apps to provide telehealth. The following apps are acceptable forms of HIPPA-compliant "non-public-facing" apps:

    - Apple FaceTime,
    - Facebook Messenger video chat
    - Google G Suite Hangouts video
    - Zoom/Zoom for Healthcare

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    - Skype for Business/Microsoft Teams
    - Amazon Chime
    - GoToMeeting

- Public-facing applications ***are not permitted*** because there is no way of determining who is able to view your communication. These include:
    - Facebook Live
    - Twitch
    - Tik-Tok
    - Snapchat

- Psychotherapy and a Psychiatric Diagnostic Evaluation cannot be billed together.

- Group Treatment Codes (A telehealth group in this policy is defined as each member dialing into a central meeting, using HIPAA compliant video technology. Audio telephone groups are not covered). *Group services must still be offered through telehealth, not telephone.*

Billing Limitations:

Maryland Medicaid will not reimburse telehealth providers for the following:

- When technical difficulties prevent the delivery of part or all the telehealth session
- Consultation that occurs during ambulance transport
- Services that require in-person evaluation or cannot be reasonably delivered via telehealth
- Telecommunication between providers without the participant present
- An audio-only (*telephone*) conversation between a provider and participant
- An electronic mail message between a provider and participant
- A facsimile transmission between a provider and participant

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- A telephone conversation, electronic mail message, or facsimile transmission between the originating and distant site providers
- Currently, HCPCS Codes W7000, W7010, W7020, W7021, W7022 (Alcohol and/substance use disorder screenings and/or interventions) are *not covered* via telehealth.
- Currently, health and behavioral intervention codes for groups & families (*CPT Codes: 96164, 96165, 96167, 96168, 96170, 96171*) are *not covered* via telehealth.

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