FQHC Behavioral Health Billing Tip Sheet

TYPE OF SERVICE	BILLING CODE	CAN BE BILLED UNDER			ELIGIBLE PROVIDER	DOCUMENTATION	TIME REQUIRE-MENT	COMMENTS
		Medicaid	Medicare*	Third Party/ Commercial				
Behavioral Health Assessment	**90792**	**X**	**X**	**X**	Psychiatric prescribers only (MD, NP, PA, APRN)	Psychiatric diagnostic evaluation with medical services. Medical though process clearly reflected in assessment plan (add 90785 for complexity and interactive assessment).	No time requirement per CMS	Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations.
								Additional exam elements (pertinent to care).
								Prescription of medication or coordination of medications as part of medical care order/review of medical diagnostic studies – lab, imaging, and other diagnostic studies. 90792 applies to new patients or to patients undergoing reevaluation. Use this code only once per day regardless of the number of sessions or time that the provider spends with the patient on the same day. When the patient goes for a psychiatric diagnostic evaluation, report either 90791 (Psychiatric diagnosis evaluation) or 90792 (Psychiatric diagnostic evaluation with medical services). In the past, most payers would allow you to only report one unit of psychiatric diagnostic evaluation code per patient. Now, guidelines have been revised and payers will allow you to claim for more than one unit of 90791 or 90792 if the initial psychiatric diagnostic evaluations extend beyond one session, if the sessions are on different dates. An example of this extended evaluation would be when the psychiatrist is evaluating a child and will see the child with parents and in another session, evaluate the child independently. So, depending on medical necessity, you can claim for more than one unit of 90791 or 90792 when the psychiatrist performs the evaluation in more than one session spread over more than one day. When billing for Medicare, CMS will allow only one claim of 90791 or 90792 in a year.
								However, in some cases, depending on the medical necessity, Medicare might allow reimbursement for more than one unit of 90791 or 90792. A modifier is not allowed to override this relationship.

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Behavioral Health Assessment	**90791**	**X**	**X**	**X**	Licensed Mental Health Provider (PsyD, PhD, LCSW, LMSW)	Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations (add 90785 for complexity and interactive assessment).	45 min recommended; no time requirement for CMS	No longer needs to be initial session for most payers.
		X	**X**	Based on credentialing guidelines for eligible providers/ contract restraints				When the patient goes for a psychiatric diagnostic evaluation, report either 90791 (psychiatric diagnosis evaluation) or 90792 (psychiatric diagnostic evaluation with medical services). In the past, most payers would allow you to only report one unit of psychiatric diagnostic evaluation code per patient. Now, guidelines have been revised and payers will allow you to claim for more than one unit of 90791 or 90792 if the initial psychiatric diagnostic evaluations extend beyond one session, if the sessions are on different dates. An example of this extended evaluation would be when the psychiatrist is evaluating a child and will see the child with parents and in another session, evaluate the child independently. So, depending on medical necessity, you can claim for more than one unit of 90791 or 90792 when the psychiatrist performs the evaluation in more than one session spread over more than one day. When billing for Medicare, CMS will allow only one claim of 90791 or 90792 in a year. However, in some cases, depending on the medical necessity, Medicare might allow reimbursement for more than one unit of 90791 or 90792. A modifier is not allowed to override this relationship.
Behavioral Health Psyco-therapy Codes	**90832**	**X**	**X**	**X**	Licensed Mental Health Provider (PsyD, PhD, LCSW, LMSW)	Diagnoses for therapy – reason for treatment, time of therapy (in minutes) that is face-to-face, method of therapy, assessment of symptoms, summary of therapy, identified goals and objectives for the therapy and the patient status with these, identified plan for return, homework and follow up, treatment planning, supervision as required by licensure level (add 90833 for behavioral medication or inclusion of collaterals).	Standard 30 min (16-37 min timeframe)	Psychotherapy is the treatment of mental illness and behavioral disturbance in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage growth and development.
		X	**X**	Based on credentialing guidelines for eligible providers/ contract restraints	Licensed Mental Health Provider (LAC, LCPC, LMFT)			

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Behavioral Health Assessments & Interventions	**96156**	**X**	**X**	Based on credentialing guidelines for eligible providers/ contract restraints		Health behavior assessment or re-assessment (e.g., health-focused clinical interview, behavioral observations, clinical decision making).		CPT code 96156 is used to describe health behavior assessment, or re-assessment, that is conducted through health-focused clinical interviews, observation and clinical decision-making. Assessment services are now event-based and CPT code 96156 is billed only once per day regardless of the amount of time required to complete the overall service. Only report 96156 for assessment of a patient with a primary diagnosis that is physical in nature. Do not report 96156 on the same day as psychiatric services (90785-90899) or adaptive behavior services (97151-97158, 0362T, 0373T). - For patients that require psychiatric services or adaptive behavior services, as well as health behavior assessment/intervention, report the predominant service performed.
Behavioral Health Assessments & Interventions	**96158**	**X**	**X**	Based on credentialing guidelines for eligible providers/ contract restraints		Health behavior intervention, individual, face-to-face; initial 30 min.	Initial 30 min	Reported for the initial 30 minutes of individual intervention and code 96159 is reported in conjunction with code 96158 for each additional 15 minutes needed to complete the intervention service. Only report add-on code 96159 in conjunction with 96158. Do not report 96158 for less than 16 minutes of service. Do not report 96159 for less than 8 minutes of service. Do not report 96158/96159 on the same day as psychiatric services (90785-90899) or adaptive behavior services (97151-97158, 0362T, 0373T). For patients that require psychiatric services or adaptive behavior services, as well as health behavior assessment/intervention, report the predominant service performed.
Behavioral Health Assessments & Interventions	**96159**	**X**	**X**	Based on credentialing guidelines for eligible providers/ contract restraints		Health behavior intervention, individual, face-to-face; each additional 15 min (list separately in addition to code for primary service).	Additional 15 min	

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Behavioral Health Assessments & Interventions	**96164**	**X**	**X**	Based on credentialing guidelines for eligible providers/ contract restraints		Health behavior intervention, group (two or more patients), face-to-face; initial 30 min.	Initial 30 min	CPT code 96164 is reported for the initial 30 minutes of group intervention services provided to two or more patients and code 96165 is reported in conjunction with code 96164 for each additional 15 minutes needed to complete the intervention service. Do not report 96164 for less than 16 minutes of service. Do not report 96164/96165 on the same day as psychiatric services (90785-90899) or adaptive behavior services (97151-97158, 0362T, 0373T). For patients that require psychiatric services or adaptive behavior services, as well as health behavior assessment/intervention, report the predominant service performed. Evaluation and Management (E/M) services codes, including counseling risk factor reduction and behavior change intervention (99401-99412), should not be reported on the same day as health behavior assessment and intervention codes by the same provider: These services can occur and be reported on the same date of service as long as the E/M service (99401-99412) is performed by a physician or other qualified health care professional (QHP) who may report E/M services. However, health behavior assessment and/or intervention services performed by a physician or other QHP who may report E/M services should do so using codes found in the E/M Services or Preventive Medicine Services sections of the CPT® Manual.
Behavioral Health Assessments & Interventions	**96165**	**X**	**X**	Based on credentialing guidelines for eligible providers/ contract restraints		Health behavior intervention, group (two or more patients), face-to-face; each additional 15 min (list separately in addition to code for primary service).	Each additional 15 min (list separately in addition to code for primary service)	96165 can only be billed for groups of two or more patients and are billed for each individual patient. Only report add-on code 96165 in conjunction with 96164. Do not report 96165 for less than 8 minutes of service. Do not report 96164/96165 on the same day as psychiatric services (90785-90899) or adaptive behavior services (97151-97158, 0362T, 0373T).

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Behavioral Health Assess-ments & Interven-tions	**96167**	**X**	**X**	Based on credentialing guidelines for eligible providers/ contract restraints		Health behavior intervention, family (with the patient present), face-to-face; initial 30 min.	Initial 30 min	Family intervention WITH patient present.
								CPT codes 96167 and 96168 have been added to report face-to-face family health behavior intervention. In order to report these codes the patient must be present. If the patient is not present, refer to CPT codes 96170 and 96717.
								Code 96167 is reported for the first 30 min of service and code 96168 is reported for each additional 15 min needed to complete the family intervention service.
								Do not report 96167 for less than 16 min of service.
								Do not report 96167/96168 on the same day as psychiatric services (90785-90899) or adaptive behavior services (97151-97158, 0362T, 0373T). For patients that require psychiatric services or adaptive behavior services, as well as health behavior assessment/intervention, report the predominant service performed.
								Evaluation and Management (E/M) services codes, including counseling risk factor reduction and behavior change intervention (99401-99412), should not be reported on the same day as health behavior assessment and intervention codes by the same provider: These services can occur and be reported on the same date of service as long as the E/M service (99401-99412) is performed by a physician or other qualified health care professional (QHP) who may report E/M services. However, health behavior assessment and/or intervention services performed by a physician or other QHP who may report E/M services should do so using codes found in the E/M Services or Preventive Medicine Services sections of the CPT® Manual.

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Behavioral Health Assess-ments & Interven-tions	**96168**	**X**	**X**	Based on credentialing guidelines for eligible providers/ contract restraints		Health behavior intervention, family (with the patient present), face-to-face; each additional 15 min (list separately in addition to code for primary service).	Each additional 15 min	Family intervention WITH patient present.
								CPT codes 96167 and 96168 have been added to report face-to-face family health behavior intervention. In order to report these codes the patient must be present. If the patient is not present, refer to CPT codes 96170 and 96717.
								Code 96168 is reported for each additional 15 min needed to complete the family intervention service.
								Only report add-on code 96168 in conjunction with 96167.
								Do not report 96167 for less than 16 minutes of service.
								Do not report 96168 for less than 8 minutes of service.
								Do not report 96167/96168 on the same day as psychiatric services (90785-90899) or adaptive behavior services (97151-97158, 0362T, 0373T). For patients that require psychiatric services or adaptive behavior services, as well as health behavior assessment/intervention, report the predominant service performed.
								Evaluation and Management (E/M) services codes, including counseling risk factor reduction and behavior change intervention (99401-99412), should not be reported on the same day as health behavior assessment and intervention codes by the same provider: These services can occur and be reported on the same date of service as long as the E/M service (99401-99412) is performed by a physician or other qualified health care professional (QHP) who may report E/M services. However, health behavior assessment and/or intervention services performed by a physician or other QHP who may report E/M services should do so using codes found in the E/M Services or Preventive Medicine Services sections of the CPT® Manual.

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Behavioral Health Assess-ments & Interven-tions	**96170**	**X**		Based on credentialing guidelines for eligible providers/ contract restraints		Health behavior intervention, family (without the patient present), face-to-face; initial 30 min	Initial 30 min	Family intervention WITHOUT patient present.
								CPT codes 96170 and 96171 have been added to report face-to-face family health behavior intervention. Reporting of these codes does not require the patient to be present; however, services offered when the patient is not present are not typically covered by Medicare. If the patient is present, refer to CPT codes 96167 and 96168.
								Code 96170 is reported for the first 30 min of service and code 96171 is reported for each additional 15 min needed to complete the family intervention service.
								Only report add-on code 96171 in conjunction with 96170.
								Do not report 96170 for less than 16 minutes of service.
								Do not report 96171 for less than 8 minutes of service.
								Do not report 96170/96171 on the same day as psychiatric services (90785-90899) or adaptive behavior services (97151-97158, 0362T, 0373T). For patients that require psychiatric services or adaptive behavior services, as well as health behavior assessment/intervention, report the predominant service performed.
								Evaluation and Management (E/M) services codes, including counseling risk factor reduction and behavior change intervention (99401-99412), should not be reported on the same day as health behavior assessment and intervention codes by the same provider: These services can occur and be reported on the same date of service as long as the E/M service (99401-99412) is performed by a physician or other qualified health care professional (QHP) who may report evaluation and management services. However, health behavior assessment and/or intervention services performed by a physician or other QHP who may report E/M services should do so using codes found in the E/M Services or Preventive Medicine Services sections of the CPT® Manual.

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Behavioral Health Assess-ments & Interven-tions	**96171**	**X**		Based on credentialing guidelines for eligible providers/ contract restraints		Health behavior intervention, family (without the patient present), face-to-face; each additional 15 min (list separately in addition to code for primary service).	Each additional 15 min (list separately in addition to code for primary service)	Family intervention WITHOUT patient present.
								CPT codes 96170 and 96171 have been added to report face-to-face family health behavior intervention. Reporting of these codes does not require the patient to be present; however, services offered when the patient is not present are not typically covered by Medicare. If the patient is present, refer to CPT codes 96167 and 96168.
								Code 96170 is reported for the first 30 min of service and code 96171 is reported for each additional 15 min needed to complete the family intervention service.
								Only report add-on code 96171 in conjunction with 96170.
								Do not report 96170 for less than 16 min of service.
								Do not report 96171 for less than 8 min of service.
								Do not report 96170/96171 on the same day as psychiatric services (90785-90899) or adaptive behavior services (97151-97158, 0362T, 0373T). For patients that require psychiatric services or adaptive behavior services, as well as health behavior assessment/intervention, report the predominant service performed.
								Evaluation and Management (E/M) services codes, including counseling risk factor reduction and behavior change intervention (99401-99412), should not be reported on the same day as health behavior assessment and intervention codes by the same provider: - These services can occur and be reported on the same date of service as long as the E/M service (99401-99412) is performed by a physician or other qualified health care professional (QHP) who may report evaluation and management services. - However, health behavior assessment and/or intervention services performed by a physician or other QHP who may report E/M services should do so using codes found in the E/M Services or Preventive Medicine Services sections of the CPT® Manual.

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Health & Well-being Coaching Services	**0591T**	**X**		**X**	See comments			Health and well-being coaching is a patient-centered approach wherein patients determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach. Eligible Provider: The coach is a nonphysician health care professional certified by the National Board for Health and Wellness Coaching or National Commission for Health Education Credentialing, Inc. Coaches' training includes behavioral change theory, motivational strategies, communication techniques, health education and promotion theories, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and well-being.
Health & Well-being Coaching Services	**0592T**	**X**		**X**			At least 30 min	Individual, follow-up session.
Health & Well-being Coaching Services	**0593T**	**X**		**X**			At least 30 min	Group (two or more individuals).
Behavioral Health Psycho-therapy Codes	**90834**	**X**	**X**	**X**	Licensed Mental Health Provider (PsyD, PhD, LCSW, LMSW)	Diagnoses for therapy – reason for treatment, time of therapy (in min) that is face-to-face, method of therapy, assessment of symptoms, summary of therapy, identified goals and objectives for the therapy and the patient status with these, identified plan for return, homework and follow up, treatment planning, supervision as required by licensure level (add 90833 for behavioral medication or inclusion of collaterals).	Standard 45 min (38-52 min time frame)	Psychotherapy is the treatment of mental illness and behavioral disturbance in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage growth and development.
		X	**X**	Based on credentialing guidelines for eligible providers/ contract restraints	Licensed Mental Health Provider (LAC, LCPC, LMFT)			

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Behavioral Health Psycho-therapy Codes	**90837**	**X**	**X**	**X**	Licensed Mental Health Provider (PsyD, PhD, LCSW, LMSW)	Diagnoses for therapy – reason for treatment. time of therapy (in min) that is face-to-face, method of therapy, assessment of symptoms, summary of therapy, identified goals and objectives for the therapy and the patient status with these, identified plan for return, homework and follow up, signed and dated, supervision as required by licensure level. (Add 90838 behind behavioral medication or inclusion of collateral. Add 90785 - see description.)	53 min or more	Can use multiple addons. Requires prior authorization from many payers.
		X	**X**		Licensed Mental Health Provider (LAC, LCPC, LMFT)			
Behavioral Health Psycho-therapy Codes	**90839**	**X**	**X**	**X**	Licensed Mental Health Provider (PsyD, PhD, LCSW, LMSW)	Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma (add 90840 see description).	60 mins recommended; 30-74 min may vary by state payer	The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress. All therapy services are time based and time must be documented within the record.
		X	**X**	Based on credentialing guidelines for eligible providers/ contract restraints	Licensed Mental Health Provider (LAC, LCPC, LMFT)			

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Behavioral Health Psycho-therapy Codes	**90840**	**X**	**X**	**X**	Licensed Mental Health Provider (PsyD, PhD, LCSW, LMSW)	Must clearly indicate complexity.	Use add on code with 90839 for each additional 30 min	Can be in addition to therapy codes. This code is meant to add intensity, not time. Not a "difficult" patient but rather involves third parties such as correctional facilities, schools etc. Mandated reporting situations, nonverbal.
		X	**X**	Based on credentialing guidelines for eligible providers/ contract restraints	Licensed Mental Health Provider (LAC, LCPC, LMFT)			
Behavioral Health Psycho-therapy Codes	**90887**	**X**	**X**	**X**	Psychiatric prescribers only (MD, NP, PA, APRN)	Clearly document communication with collaterals.	N/A suggested 15 min	Interpretation or explanation of medical evaluation or procedures or other data to collaterals and advising them.
Behavioral Health Psycho-therapy Codes	**90795**	**X**	**X**	**X**	Licensed Mental Health Provider (PsyD, PhD, LCSW, LMSW)	Must document interactive complexity.	Use add on code with 90839 for each additional 30 min	Interactive complexity code 90785. Add on code to the code for a primary psychiatric service. May be reported, as appropriate, with 90791, 90792, 90832, 90833, 90894, 90896, 90853, 90837, 99201-99255, 99304-99337+I20 and 99341-99350. One of the following must exist during the session in order to report 90785; maladaptive communication (for example, high anxiety, high reactivity, repeated questions or disagreement), emotional or behavioral conditions inhibiting implementation of treatment plan; mandated reporting/event exists (for example abuse or neglect). Play equipment, devices, interpreter or translator required due to inadequate language expression or different language spoken between patient and professional. Not used for standard interpretation services.
		X		Based on credentialing guidelines for eligible providers/ contract restraints	Licensed Mental Health Provider (LAC, LCPC, LMFT)			

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Chronic Care Manage-ment (case rate)	**99490 non-complex CCM**		**X**	Based on credentialing guidelines for eligible providers/ contract restraints	Physicians, Certified Nurse-Wives, CN's, NP, PA	Document two or more chronic conditions, must document clear risk and care plan.	20 min of staff time	Non- face-to-face sessions performed by a healthcare professional for patients with two or more chronic conditions expected to last 12 months or more. Effective January 2018.
Chronic Care Manage-ment	**99487**		**X**	Based on credentialing guidelines for eligible providers/ contract restraints	Prescriber in training practitioners.	Document two chronic conditions lasting 12 months or more. Document risk/acuteness establishment or revision of care plan. Moderate or high decision making (medical) (+99489 for each 30 min of staff time).	60 min of staff time	Non- face-to-face sessions performed by a healthcare professional for patients with two or more chronic conditions expected to last 12 months or more. Effective January 2018.
Collabor-ative Care	**99492 G-5011**	**X state specific**	**G-0571**	**X**	Eligible for billing: physicians, certified nurse-wives, CNs, NP, PA. Eligible to provide services: LCSW, LMSW, LCPC, LMHC, LMFT, RN, licensed psychologist.	For establishment of and engagement in collaborative care.	70 min per calendar month; assign 30 min of practitioner time	First month of collaborative care services. Must have all components of collaborative care: care manager, consulting psychiatrist, registry, etc.

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Collaborative Care	**99493 G-5012**	**X state specific**	**X G-0572**	**X**	Eligible for billing: physicians, certified nurse-wives, CNs, NP, PA. Eligible to provide services: LCSW, LMSW, LCPC, LMHC, LMFT, RN, licensed psychologist.	Subsequent months of collaborative care.	60 min per month; 26 min of practitioner time	FQHC providers must use G-codes to bill Medicare and CPT codes for Medicade and Commercial Plans. Subsequent months of collaborative care services. Must have all components of collaborative care: care manager, consulting psychiatrist, registry, etc. Note: Patients may not be in chronic care managament and collabortive care.
Collaborative Care	**99494**	**X state specific**	**X**	**X**	Eligible for billing: physicians, certified nurse-wives, CNs, NP, PA. Eligible to provide services: LCSW, LMSW, LCPC, LMHC, LMFT, RN, licensed psychologist.	Add-on codes for each 30 min of collaborative care per month.	30 min per calendar month; 13 min of practitioner time	Many payers will only reimburse for Max two codes per billing month. FQHC providers must use G-codes to bill Medicare and CPT codes for Medicade and Commercial Plans. Note: Patients may not be in chronic care managament and collabortive care.
Collaborative Care	**99484**	**X state specific**	**X**	**X**	Physicians, certified nurse-wives, CNs, NP, PA, physicians, LCSW, PA, clinical psychologists, CNS, medical assistant under PCP with psychiatrist.	Document clear process of behavioral health services and care coordination.	20 mins per month; 15 by prescriber	Meant to cover care coordination and telephonic services for patients not included in collaborative care or for which time spent did not meet criteria fo other collaberative care codes.
SBIRT Codes	**G0396**		**X**		Physicians, certified nurse-wives, CNs, NP, PA, physicians, LCSW, PA, clinical psychologists, CNS, medical assistant under PCP.	Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and brief intervention 15-30 min.		These HCPCS G-codes (G0396 and G0397) allow for appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services, but only those services that are performed for the diagnosis or treatment of illness or injury. Medicare Contractors will consider payment for HCPCS codes G0396 and G0397 only. You cannot bill for a negative SBIRT because there is no intervention when the results are negative.

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SBIRT Codes	**G0397**			**X**	Physicians, certified nurse-wives, CNs, NP, PA, physicians, LCSW, PA, clinical psychologists, CNS, medical assistant under PCP.	Alcohol and/or substance abuse (other than tobacco) structured assessment (for example, AUDIT, DAST) and intervention greater than 30 min.		These HCPCS G-codes (G0396 and G0397) allow for appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services, but only those services that are performed for the diagnosis or treatment of illness or injury. Medicare Contractors will consider payment for HCPCS codes G0396 and G0397 only. You cannot bill for a negative SBIRT because there is no intervention when the results are negative.
SBIRT Codes	**99408**	**Not above PPS rate**	**X G0396/ G0397**	**TBD**	Denote start/stop time or total face-to-face time with the patient (because some SBIRT Healthcare Common Procedure Coding System [HCPCS] codes are time-based codes). Document the patient's progress, response to changes in treatment, and revision of diagnosis. Document the rationale for ordering diagnostic and other ancillary services, or ensure it can be easily inferred. For each patient encounter, document: assessment, clinical impression, and diagnosis date and legible identity of observer/provider, physical examination findings and prior diagnostic test results, plan of care, reason for encounter and relevant history. Identify appropriate health risk factors. Include documentation to support all codes reported on the health insurance claim. Make past and present diagnoses accessible for the treating and/or consulting physician.		15 min	Must cover all components of screening, brief intervention, referral and treatment. Can be used with an EM code. Need to review prior to using codes, may be more beneficial to use EM or BH code. Time spent performing the evaluation management services cannot be counted for the 15 minutes of the codes. For positive codes but less than 15 min consider 99420.
	G2086		**X**					First month of an OUD treatment episode. https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf. Search for "H. Bundled Payments Under the PFS for Substance Use Disorders" (page 346 of the PDF).
	G2087		**X**					Any subsequent month of an episode. https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf. Search for "H. Bundled Payments Under the PFS for Substance Use Disorders" (page 346 of the PDF).
	G2088		**X**					Add-on code for eligible services provided in a given month beyond the requirements of G2086/G2087. https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf. Search for "H. Bundled Payments Under the PFS for Substance Use Disorders" (page 346 of the PDF).

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Medical Team Conference	**99366**		**X**	Based on credentialing guidelines for eligible providers/ contract restraints		Medical team conference with interdisciplinary team of health care professionals with patient or family present, non-physician.	30 min or more	Note time requirements.
Medical Consulta-tion Medical Team Conference	**99367**		**X**	Based on credentialing guidelines for eligible providers/ contract restraints	Health care professionals	Medical team conference with interdisciplinary team of health care professionals: face-to-face, physician present.	30 min or more	Minimum of three health professionals. Physician must be present.
Medical Consulta-tion Medical Team Conference	**99368**		**X**	Based on credentialing guidelines for eligible providers/ contract restraints		Medical team conference with interdisciplinary team of health care professionals - patient or family not present, non-physician.	30 min or more	Minimum of three health professionals. Bundled code with services they are incident to.
Medical Consulta-tion Medical Team Conference	**99369**		**X**	Based on credentialing guidelines for eligible providers/ contract restraints				Bundled code with services they are incident to.

TYPE OF SERVICE	BILLING CODE	CAN BE BILLED UNDER			ELIGIBLE PROVIDER	DOCUMENTATION	TIME REQUIRE-MENT	COMMENTS
		Medicaid	Medicare*	Third Party/ Commercial				
Multifamily Groups Not Threshold Visit	**90849**	**X**		Need to include in contract with payer	Licensed mental health provider (PsyD, PhD, LCSW, LMSW, LAC, LCPC, LMFT)	The therapist provides multiple family group psychotherapy by meeting with several patient's families together. This is usually done in cases involving similar issues. The session may focus on the issues of the patient's care needs and problems. Attention is also given to the impact the patient's condition has on the family. This code is reported once for each family group present.	Recommended 60 min	Will often be included in contracts if requested. Medicare is suspicious of group therapy not meeting medical necessity (not tailored to meet the individual patients). Some of these are approved because they have to observe and adjust the patients interactions with family members (90846,90847), but as an example in the attached they indicate that generally 90849 is not covered.
Family Therapy Without Patient Present	**90846**	**X**	**X**	Need to include in contract with payer	PsyD, PHD, LCSW, LMSW, LAC, LCPC, LMFT	The documentation must focus on the family dynamics and interactions or for subset of family. Use CPT codes for BH services (eg.90832) for occasional involvement of family members.	Must be at least 26 min	Medicare is suspicious of group therapy not meeting medical necessity (not tailored to meet the individual patients). Some of these are approved because they have to observe and adjust the patients interactions with family members (90846,90847), but as an example in the attached they indicate that generally 90849 is not covered.
Family Therapy With Patient Present	**90847**	**X**	**X**	Need to include in contract with payer	PsyD, PHD, LCSW, LMSW, LAC, LCPC, LMFT	The documentation must focus on the family dynamics and interactions or for subset of family. Use CPT codes for BH services (eg.90832) for occasional involvement of family members.	Must be at least 26 min	Will often be included in contracts if requested. The interactive complexity code can be added to this service for the specific patient for whom this issue applies. The +90785 is the add on code for this and the documentation in the specific patient record would need to reflect this component of care. Medicare is suspicious of group therapy not meeting medical necessity (not tailored to meet the individual patients). Some of these are approved because they have to observe and adjust the patients interactions with family members (90846,90847), but as an example in the attached they indicate that generally 90849 is not covered.

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		Medicaid	Medicare*	Third Party/ Commercial				
Group Therapy	**90853**			**X**	Licensed mental health provider (PsyD, PhD, LCSW, LMSW, LAC, LCPC, LMFT)	The psychiatric treatment provider conducts psychotherapy for a group of several patients in one session. Group dynamics are explored. Emotional and rational cognitive interactions between individual persons in the group are facilitated and observed. Personal dynamics of any individual patient may be discussed within the group setting. Processes that help patients move toward emotional healing and modification of thought and behavior is used, such as facilitating improved interpersonal exchanges, group support, and reminiscing. The group may be composed of patients with separate and distinct maladaptive disorders or persons sharing some facet of a disorder (add 90185 - see description).	Recommended 45-90 min	Used to document behavioral health group treatment for behavioral health disorder. For therapy other than multifamily groups. Generally, only reimbursed once per day. Each group member billed individually.
Psych Testing	**96101**	**X**	**X**	**X**	Psychologists or prescribers	Psychological testing documentation of emotional ability, personality, psychopathology.	Per hour	Includes face-to-face and preparing reports e.g. MMPI, WAIS, etc.
Psych Testing	**96102**	**X**	**X**	**X**	Everyone on health care team Team	Psychological testing documentation of emotional ability, personality, psychopathology.	Per hour of technician time	Health care professional provides the face-to-face time and interpretation.

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		Medicaid	Medicare*	Third Party/ Commercial				
Psych Testing	**96103**	**X**	**X**	**X**	Provided at computer	Psychological testing documentation of emotional ability, personality, psychopathology.	N/A	Testing by computer with qualified health care professional to interpret and report.
Screening (not a threshold visit)	**96127**	Not above PPS rate	**GO444**	15 min for reports only	MD, NP, PA, PsyD, PHD, LCSW, LMSW, LCPC, LMFT, any health professional	GO444 used for PHQ2. Tool must be recorded in record.	Tool included in record. No time	Often used as part of preventive medicine - example, PEDS visit in primary care with another EM code.
			G8510			G8510 used for PHQ9 with score <10. Tool must be recorded in record.		Screening is required as part of annual wellness visit (AWV) but is not billable so cannot use code, can use code 1 time yearly outside of an AWV.
			G8431	**G8431** (REPORTS only)		G8431 used for PHQ9 with score ≥ 10. Tool must be recorded in record.		Can only use one of these codes per visit
Screening (not a threshold visit)	**96110**	Not above PPS rate	**X**		MD, NP, PA, PsyD, PHD, LCSW, LMSW, LCPC, LMFT, any health professional	Tool must be recorded in record. ASQ, ASQ-SE, PSC, Vanderbilt, MCHAT.	Tool included in record. No time	Often used as part of preventive medicine - example, PEDS visit in primary care with another EM code. Almost all third party reimburses (possibly after adding to contract).
Screening (note depression Dx excluded) NOT THRES-HOLD VIST TYPE	**H0049/ 50**	Not above PPS rate	**G0442**	TBD	Any health professional	Tool must be recorded in record. DAST, CAGE, ORT.	Tool included in record. No time	Often used as part of preventive medicine - example, PEDS visit in primary care with another EM code.

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		Medicaid	Medicare*	Third Party/ Commercial				
Health Prevention	**99401**	**X**	**X**	Based on credentialing guidelines for eligible providers/ contract restraints	Psychologist only	Risk reduction and efforts, behavior change, modality and efforts. Notes contain orders. Description of status. Comprehensive discussion of findings and counselling.	15 min increments	Modifier 25 allows for same day visit.
Prescription of Medication	**99213-4 E and M Codes**	**X**	**X**	**X**	Psychiatric prescribers only (MD, NP, PA, APRN)	Patient/support staff can document the following that must be confirmed by the provider: chief complaint (CC), past medical history (PMH), medications (PMH), allergies (and reactions), social history (SH), family history (FH), review of systems (ROS), providers must document history of present illness (HPI), exam and medical decision making/plan.	No time recommended greater than 10 min	Must follow EM documentation guidelines for office visit.
Nursing Medication Prescrip-tion (Mental Health) Medication Reconciliation Done by RN	**99211**	**X**	**X**	**X**	RN only	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 min are spent performing or supervising these services.	No time recommended greater than 10 min	Primarily used when RN is part of care team providing education and support services.

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		Medicaid	Medicare*	Third Party/ Commercial				
Nursing Care Manage-ment and Nursing Visits NOT THRESHOLD VISIT TYPE MONTHLY RATE	**Nursing Visits 99211**	**X**	**X**	**X**	RN only	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 min are spent performing or supervising these services.	No time recommended greater than 10 min	Primarily used when RN is part of care team providing education and support services.
Telephone Services	**99441, 99442, 99443**		**X**	Based on credentialing guidelines for eligible providers/ contract restraints	Any provider on care team	Must document education and support services by physician or any other qualified health care person to establish patient.	99441, 10 min; 99442, 11-20 min; 99443, 21-30 min	Must be for services on established patient and must be for services within 7 days of visit or leading to services or procedure within the next 24 hours.

NOTES:
- *Medicare billing eligibility excludes LMHC, LMFT, LAC, LCPC
- FQHC Providers are reimbursed at PPS rate for all threshold visits regardless of service code for Medicaid visits.
- Differences in State Medicaid rules can vary greatly, please confirm information with Montana Medicaid.
- Reminder to change scope with HRSA when adding or changing services such as behavioral health or substance use.

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MONTANA HEALTHCARE FOUNDATION

MENTAL HEALTH FIRST AID NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
Healthy Minds. Strong Communities.