Non-Specialty Mental Health Services: Psychiatric and Psychological Services

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Mental health services are reimbursable for Medi-Cal eligible recipients when they are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.†

In addition, for recipients under 21 years of age, Medi-Cal covers all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services as specified in Section 1396d(r)(5) of Title 42 of the United States Code, including all Medicaid-coverable health care services needed to correct or ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are thus covered as EPSDT services.

The information found in this section applies only to Non-Specialty Mental Health Services (NSMHS) and does not apply to Specialty Mental Health Services (SMHS) delivered by county Mental Health Plans (MHPs). For information about SMHS, refer to Behavioral Health Information Notices. For help with billing, refer to the *Psychological Services: Billing Examples* section of this manual.

NSMHS are delivered via managed care and fee-for-service delivery systems and include the following:

- Mental health evaluation and treatment, including individual, group and family psychotherapy
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition
- Outpatient services for purposes of monitoring drug therapy
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies and supplements

Managed care plans are required to provide the NSMHS listed above to the following recipients:

- Recipients 21 years and over with mild to moderate distress or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*
- Recipients under age 21, to the extent otherwise eligible for services through EPSDT, regardless of level of distress or impairment or the presence of a diagnosis, and
- Recipients of any age with potential mental health disorders not yet diagnosed.

Note: A neurocognitive disorder (for example, dementia) or a substance-related and addictive disorder (for example, stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a recipient meets criteria to receive NSMHS. However, MCPs must provide or arrange for NSMHS for recipients with any of these disorders if they also have a mental health disorder (or potential mental health disorders not yet diagnosed) and meet criteria for NSMHS as described above.

SMHS are delivered via county MHPs and are covered for recipients who meet the following criteria.∞

Recipients 21 years and over must meet both criteria 1 and 2 below:

- Criterion 1: The recipient has one or both of the following:
  - Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities
  - A reasonable probability of significant deterioration in an important area of life functioning
- Criterion 2: The recipient's condition in criterion 1 is due to either of the following:
  - A diagnosed mental health disorder, according to the criteria of the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* and the *International Statistical Classification of Diseases and Related Health Problems*
  - A suspected mental disorder that has not yet been diagnosed

Recipients under 21 years of age must meet either criteria 1 or 2 below:

- Criterion 1: The recipient has a condition putting them at high risk for a mental health disorder due to experiencing trauma evidenced by at least one of the following:
  - Scoring in the high-risk range on a trauma screening tool approved by Medi-Cal
  - Involvement in the child welfare system
  - Juvenile justice involvement
  - Experiencing homelessness
- Criterion 2: The recipient meets both requirements A and B:

  A. The recipient has at least one of the following conditions:
     - ❖ A significant impairment
     - ❖ A reasonable probability of significant deterioration in an important area of life functioning.
     - ❖ A reasonable probability of not progressing developmentally as appropriate.

- ❖ A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide

B. The recipient's condition in requirement A above is due to at least one of the following:

- ❖ A diagnosed mental health disorder, according to the criteria of the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* and the *International Statistical Classification of Diseases and Related Health Problems*
- ❖ A suspected mental health disorder that has not yet been diagnosed.
- ❖ Significant trauma placing the recipient at risk of a future mental health condition, based on the assessment of a licensed mental health professional

Note: Neurocognitive disorders (for example, dementia) and substance-related and addictive disorders (for example, stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a recipient meets criteria to receive SMHS.

Clinically appropriate and covered NSMHS and SMHS prevention, screening, assessment and treatment services are covered Medi-Cal services even when:

- Services are provided prior to determination of a diagnosis or determination of whether NSMHS or SMHS criteria are met,
- Services are not included in an individual treatment plan,
- The recipient has a co-occurring mental health condition and substance use disorder,
- NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

When a recipient meets criteria for both NSMHS and SMHS, the recipient should receive services based on individual clinical need and established therapeutic relationships. Recipients receiving NSMHS who meet both NSMHS criteria and SMHS criteria may continue receiving NSMHS unless and until the treating clinician recommends SMHS exclusively and the recipient has been transferred to an MHP provider who accepts the care of the recipient.

Recipients may concurrently receive NSMHS via a managed care or fee-for-service provider and SMHS via an MHP provider when the services are coordinated and not duplicative (for example, a recipient may only receive psychiatry services in one network, but not both networks. A recipient may only access individual counseling in one network, but not both networks). Such decisions should be made via a patient-centered shared decision-making process.

Recipient Eligibility

Providers should verify the recipient's Medi-Cal eligibility for the month of service.

Provider Eligibility

NSMHS may be provided by Licensed Clinical Social Workers (LCSWs), Licensed Professional Clinical Counselors (LPCCs), Licensed Marriage and Family Therapists (LMFTs), licensed psychologists, Psychiatric Physician Assistants (PAs), Psychiatric Nurse Practitioners (NPs), and psychiatrists as consistent with the practitioner's training and licensing requirements.

Associate marriage and family therapists, associate professional clinical counselors, associate clinical social workers and psychology assistants may render psychotherapy services under a supervising clinician. The claim must list the associate or assistant's name in the *Additional Claim Information* field (Box 19) or in an attachment, along with the supervising clinician's National Provider Identifier (NPI) number as the "billing provider."

Services rendered by learning disability specialists are not Medi-Cal benefits. Psychological services are not covered under the County Medical Services Program (CMSP).

For information regarding which services are billable by each type of mental health practitioner, refer to the NSMHS Provider Table at the end of this section. This table does not apply to SMHS.

Authorization

A *Treatment Authorization Request* (TAR) is not required for NSMHS unless specified age restrictions or frequency limits are exceeded. Psychological services are covered services when ordered by a primary care physician.

Referral

Recipients may self-refer for any form of psychotherapy (CPT® codes 90832 thru 90853) delivered in an outpatient setting.

Place of Service

For information regarding place of service for NSMHS, refer to the NSMHS Place of Service Table later in this section. This table does not cover psychiatric hospitalizations or SMHS provided via county MHPs. For information about SMHS, refer to Behavioral Health Information Notices.

When using Place of Service code "99" (other), indicate the full name and address of the testing location in the *Additional Claim Information* field (Box 19) or on an attachment and leave the *Service Facility Location Information* field (Box 32) blank.

Telehealth

NSMHS may be delivered via telehealth when Medi-Cal requirements are met. For more information, refer to the *Medicine: Telehealth* section of this manual.

Maintenance of Records

Providers of NSMHS must retain a record of the type and extent of each service rendered as well as the date and time allotted for appointments and the time actually spent with patients (*California Code of Regulations* [CCR], Title 22, Section 51476[a] and 51476[f]).

Mental Health Services

ACE Screening

Adverse Childhood Experience (ACE) screening is reimbursable using HCPCS codes G9919 and G9920 for providers who have taken a certified Core Training and self-attested to their completion of the training. For more information, refer to the *Evaluation and Management (E&M)* section of the appropriate Part 2 manual and the ACEs Aware website.

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

Medi-Cal reimburses alcohol and drug use screening, assessment, brief interventions and referral to treatment for recipients ages 11 and older, including pregnant women, in primary care settings. Alcohol use screening is reimbursable with HCPCS code G0442, drug use screening is reimbursable with HCPCS code H0049, and brief interventions for alcohol and/or drug use are reimbursable with HCPCS code H0050. For more information, refer to the *Evaluation and Management (E&M)* section of the appropriate Part 2 manual.

Case Management Services

Medical team conferences (CPT codes 99366 and 99368) are limited to conferences with persons immediately involved in the case or recovery of the client. For more information, refer to the *Evaluation and Management (E&M)* section of the appropriate Part 2 manual.

Central Nervous System Assessments/Tests

Central nervous system assessments and tests are reimbursable for recipients who meet the criteria found below. Claims for the following central nervous system assessments/tests must include an itemization of the tests performed: CPT codes 96105, 96112, 96113, 96116, 96121, 96130 thru 96133, 96136 thru 96139 and 96146. Providers must list the tests performed either in the *Additional Claim Information* field (Box 19) or on an attachment.

Claims billed with CPT codes 96105, 96116 and 96121 must include an attachment specifying the amount of time spent completing each of the following:

- Administration of test(s)
- Interpretation of test results
- Preparation of the report

Frequency Limitations/Additional Billing Instructions

Frequency limitations and additional billing instructions apply to the following central nervous system assessments/tests:

Note: Please note that the general code descriptions included are provided to assist with interpreting and navigating the content; providers are responsible for referencing the appropriate codebooks for up-to-date full descriptions when considering which code is appropriate to bill for the services rendered.

Central Nervous System Assessments/Tests Codes Table

CPT Code	General Code Description	Frequency Limits
96105	Assessment of aphasia, per hour	Two episodes per year (3 hours each or less), any provider. All hours for each episode must be billed on the last day of service
96110*	Developmental screening, per standardized instrument	Two per year, any provider
96112	Developmental test administration; first hour	One per year, any provider
96113	Developmental test administration; each additional 30 minutes	One per year, any provider
96116	Neurobehavioral status exam; first hour	One per year, any provider
96121	Neurobehavioral status exam; each additional hour	One per year, any provider
96127	Brief emotional/behavioral assessment	Two per day, per provider
96130	Psychological testing evaluation services; first hour	One per year, any provider
96131	Psychological testing evaluation services; each additional hour	Two per year, any provider

Neuropsychological Tests Codes Table

CPT Code	General Code Description	Frequency Limits
96132	Neuropsychological testing evaluation services; first hour	One per year, any provider
96133	Neuropsychological testing evaluation services; each additional hour	Two per year, any provider
96136	Psychological or neuropsychological test administration and scoring, two or more tests; first 30 minutes	One per year, any provider
96137	Psychological or neuropsychological test administration and scoring, two or more tests; each additional 30 minutes	Nine per year, any provider
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests; first 30 minutes	One per year, any provider
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests; each additional 30 minutes	Nine per year, any provider
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	One per year, any provider

Note: Pre-test interviews, pre-test instructions and test materials are not separately reimbursable. Compensation for these services has been included in the maximum rate for test administration.

Aphasia Assessment

Aphasia assessment is considered medically necessary when more detailed linguistic information is needed to formulate a treatment plan for patients with aphasia.

Brief Emotional/Behavioral Assessment

Brief emotional/behavioral assessment is reimbursable using CPT code 96127. For more information refer to the *Evaluation and Management (E&M)* section of the appropriate part 2 manual.

Developmental Screening

General developmental and autism screening are reimbursable CPT code 96110. For more information refer to the *Preventive Services* section of the appropriate part 2 manual.

Developmental Testing

Developmental testing (CPT codes 96112 and 96113) is reimbursable when a child has signs concerning for developmental delay or loss of previously acquired developmental skills or when a developmental screening test is abnormal.

Neurobehavioral Examination

Neurobehavioral examinations (CPT codes 96116 and 96121) are reimbursable when there is concern that thinking, reasoning or judgment may be impaired.

Neuropsychological Testing

Neuropsychological testing (CPT codes 96132, 96133, 96136 thru 96139 and 96146 [when billing for neuropsychological testing]) is considered medically necessary:

- When there are mild deficits on standard mental status testing or clinical interview, and a neuropsychological assessment is needed to establish the presence of abnormalities or distinguish them from changes that may occur with normal aging, or the expected progression of other disease processes; or
- When neuropsychological data can be combined with clinical, laboratory and neuroimaging data to assist in establishing a clinical diagnosis in neurological or systemic conditions known to affect CNS functioning; or

- When there is a need to quantify cognitive or behavioral deficits related to CNS impairment, especially when the information will be useful in determining a prognosis or informing treatment planning by determining the rate of disease progression; or
- When there is a need for pre-surgical or treatment-related cognitive evaluation to determine whether it would be safe to proceed with a medical or surgical procedure that may affect brain function (for example, deep brain stimulation, resection of brain tumors or arteriovenous malformations, epilepsy surgery, stem cell transplant) or significantly alter a patient's functional status; or
- When there is a need to assess the potential impact of adverse effects of therapeutic substances that may cause cognitive impairment (for example, radiation, chemotherapy, antiepileptic medications), especially when this information is utilized to determine treatment planning; or
- When there is a need to monitor progression, recovery and response to changing treatments, in patients with CNS disorders, in order to establish the most effective plan of care; or
- When there is a need for objective measurement of patients' subjective complaints about memory, attention, or other cognitive dysfunction, which serves to inform treatment by differentiating psychogenic from neurogenic syndromes (for example, dementia vs. depression), and in some cases will result in initial detection of neurological disorders or systemic diseases affecting the brain; or
- When there is a need to establish a treatment plan by determining functional abilities/impairments in individuals with known or suspected CNS disorders; or
- When there is a need to determine whether a member can comprehend and participate effectively in complex treatment regimens (for example, surgeries to modify facial appearance, hearing, or tongue debulking in craniofacial or Down syndrome patients; transplant or bariatric surgeries in patients with diminished capacity), and to determine functional capacity for health care decision making, work, independent living, managing financial affairs, etc.; or

- When there is a need to design, administer, and/or monitor outcomes of cognitive rehabilitation procedures, such as compensatory memory training for brain-injured patients; or
- When there is a need to establish treatment planning through identification and assessment of neurocognitive conditions that are due to other systemic diseases (for example, hepatic encephalopathy; anoxic/hypoxic injury associated with cardiac procedures); or
- Assessment of neurocognitive functions in order to establish rehabilitation and/or management strategies for individuals with neuropsychiatric disorders; or
- When there is a need to diagnose cognitive or functional deficits in children and adolescents based on an inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional or physical demands.

Neuropsychological testing is not considered medically necessary when:

- The patient is not neurologically and cognitively able to participate in a meaningful way with the requirements necessary to successfully perform the tests; or
- Used as screening tests given to the individual or general populations; or
- Used as a screening test for Alzheimer's dementia; or
- Administered for educational or vocational purposes that do not inform medical management; or
- Performed when abnormalities of brain function are not suspected; or
- Used for self-administered or self-scored inventories, or screening tests of cognitive function such as AIMS, or Folstein Mini Mental Status Exam (MMSE); or
- Repeated when not required for medical decision making, (for example, to make a diagnosis, or to start or continue rehabilitative or pharmacological therapy); or
- Administered when the patient has a substance abuse background and any one of the following apply:
  - the member has ongoing substance abuse such that test results would be inaccurate, or
  - the member is currently intoxicated; or
- The member has been diagnosed previously with brain dysfunction, and there is no expectation that the testing would impact the member's medical management.

Test Scoring/Written Test Report

The appropriate test scoring or written test report procedure code must be billed on the same claim as the test administration. Claims with a test score or written report code billed without a test administration code will be denied.

When billing Place of Service code “99” (other), the full name and address of the testing location must be documented in the *Additional Claim Information* field (Box 19) or on an attachment or the claim will be denied.

Psychological Testing

Psychological testing (CPT codes 96130, 96131 and 96136-96146 [when used for psychological 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 interview and history-taking.

Cognitive Rehabilitation

Cognitive rehabilitation (CPT codes 97129 and 97130) is reimbursable when treating individuals following a traumatic brain injury or stroke when all of the following criteria are met:

- The recipient has the ability to actively participate, and
- The treatment regimen includes:
  - Specific interventions for functional communication deficits, including pragmatic conversation skills, or
  - Compensatory memory strategy training.

Cognitive Rehabilitation Codes Table

CPT Code	General Code Description	Frequency Limits
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	One per day, any provider
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)	Three per day, any provider

Evaluation and Management (E&M) Services

Psychiatrists, psychiatric PAs and psychiatric NPs may bill for the following evaluation and management codes: 99202 thru 99255, 99304 thru 99337, 99341 thru 99350 and 99417. For more information, refer to the *Evaluation and Management (E&M)* section of the appropriate Part 2 Manual.

Health Behavioral Assessment and Intervention Services

Health behavioral assessment and intervention services (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170 and 96171) are reimbursable when used to identify and address the psychological, behavioral, emotional, cognitive and interpersonal factors important to the assessment, treatment, or management of physical health problems. Health behavioral assessment and intervention codes are not reimbursable on the same day to the same provider as evaluation and management service codes (including CPT codes 99406 and 99407) or CPT codes 90785 thru 90899.

Billing codes and frequency limits for these services are as follows.

Note: Please note that the general code descriptions included are provided to assist with interpreting and navigating the content; providers are responsible for referencing the appropriate codebooks for up-to-date full descriptions when considering which code is appropriate to bill for the services rendered.

Health Behavioral Assessment and Intervention Codes Table

CPT Code	General Code Description	Frequency Limits
96156	Health behavior assessment, or re-assessment	One per day, any provider
96158	Health behavior intervention, individual; initial 30 minutes	One per day, any provider
96159	Health behavior intervention, individual; each additional 15 minutes	Four per day, any provider
96164	Health behavior intervention, group; initial 30 minutes	One per day, any provider
96165	Health behavior intervention, group; each additional 15 minutes	Six per day, any provider
96167	Health behavior intervention, family (with the patient present); initial 30 minutes	One per day, any provider
96168	Health behavior intervention, family (with the patient present); each additional 15 minutes	Six per day, any provider
96170	Health behavior intervention, family (without the patient present); initial 30 minutes	One per day, any provider
96171	Health behavior intervention, family (without the patient present); each additional 15 minutes	One per day, any provider

Hypnotherapy

CPT code 90880 may be used to bill for hypnotherapy. The frequency limit is one per day, any provider.

Interactive Complexity

Interactive complexity CPT code 90785 may be billed with CPT codes for psychiatric diagnostic evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when performed with an evaluation and management service (90833, 90836, 90838, 99201 thru 99255, 99304 thru 99337, 99341 thru 99350) and group psychotherapy (90853) when any of the following are present:

- Communication difficulties among participants that complicate care delivery, related to issues such as: high anxiety, high reactivity, repeated questions or disagreement
- Caregiver emotions or behaviors that interfere with implementing the treatment plan
- Evidence or disclosure of a sentinel event and mandated report to a third party. (for example, abuse or neglect with report to state agency)
- The mental health provider overcomes communication barriers by using any of the following methods: play equipment or other physical devices, interpreter, or translator for a recipient who:
  - Is not fluent in the same language as the mental health provider, or
  - Has not developed or has lost the expressive or receptive communication skills needed to use or understand typical language

Pregnancy and Postpartum-Related Services

Medi-Cal reimburses individual and group counseling for pregnant and postpartum individuals with one or more of the following risk factors for perinatal depression:

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

Up to a total of 20 preventative individual counseling (CPT codes 90832, 90834 and 90837) and/or group counseling (CPT code 90853) sessions are reimbursable when delivered during the prenatal period and/or during the 12 months following childbirth. Modifier 33 must be submitted on claims for counseling given to prevent perinatal depression.

When billing medically necessary mental health services during the prenatal or postpartum period, providers must include a pregnancy or postpartum diagnosis code on all claims. For example, ICD-10 code Z34.93 may be used for pregnant individuals and Z39.2 may be used for postpartum individuals. Claims submitted without a pregnancy or postpartum diagnosis code may be denied.

For information about depression screening in pregnant and postpartum individuals, refer to the *Evaluation and Management (E&M)* section of the appropriate Part 2 Manual. For information about other pregnancy-related services, providers may refer to the *Pregnancy: Early Care and Diagnostic Services* and the *Pregnancy: Postpartum and Newborn Referral Services* sections of the appropriate Part 2 manual.

Psychiatric Collaborative Care Management Services

Psychiatric collaborative care management services are reimbursable when billed by the treating physician or other qualified health professional for treatment of a patient's mental health or substance use disorder. For more information, refer to the *Evaluation and Management (E&M)* section of the appropriate Part 2 manual.

Psychiatric Diagnostic Evaluation

CPT code 90791 may be used to bill for psychiatric diagnostic evaluation without medical services and 90792 to bill for psychiatric diagnostic evaluation with medical services. Psychiatric diagnostic evaluations must be consistent with the scope of license and competency of the mental health provider and must be documented in the medical record with the following items included:

- Presenting problem/changes in functioning/history of presenting concern
- Mental health and substance use history
- Medical history and current medications
- Social and cultural factors
- Risk and safety factors
- Case conceptualization and diagnostic summary

Psychotherapy

Family, group and individual psychotherapy that is evidence-based or incorporates evidence-based components is reimbursable for eligible recipients.

Medi-Cal reimburses NSMHS psychotherapy for recipients 21 and older if the recipient is diagnosed with a mental health disorder as defined by the current edition of the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) resulting in mild-to-moderate distress or mild-to-moderate impairment of mental, emotional or behavioral functioning.

Medi-Cal reimburses NSMHS psychotherapy for recipients under age 21 if the recipient meets at least one of the following criteria:

- The recipient under age 21 has a diagnosis of a mental health disorder as defined by the current edition of DSM or as defined by the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). If DC: 0-5 is used for the diagnosis, the corresponding ICD-10 code, which can be found at the Zero to Three website, must be entered on the claim form.

- The recipient under age 21 has persistent mental health symptoms in the absence of a mental health disorder. Claims for psychotherapy for these recipients must be billed with ICD-10-CM code Z71.89
- The recipient under age 21 has a history of at least one of the risk factors below. Claims for family therapy for these recipients must be billed with ICD-10 code Z65.9:
  - Neonatal or pediatric intensive care unit hospitalization
  - Separation from a parent/guardian (for example, due to incarceration, immigration or military deployment)
  - Death of a parent/guardian
  - Foster home placement
  - Food insecurity, housing instability
  - Exposure to domestic violence or other traumatic events
  - Maltreatment
  - Severe and persistent bullying
  - Experience of discrimination, including but not limited to discrimination on the basis of race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability; or
- The recipient under age 21 has a parent/guardian with one of the risk factors below. Claims for family therapy for these recipients must be billed with ICD-10 code Z65.9:
  - A serious illness or disability
  - A history of incarceration
  - Depression or other mood disorder
  - Post-Traumatic Stress Disorder (PTSD) or other anxiety disorder
  - Psychotic disorder under treatment
  - Substance use disorder
  - Job loss
  - A history of intimate partner violence or interpersonal violence
  - Is a teen parent

Note: Neurocognitive disorders (for example, dementia) and substance-related and addictive disorders (for example, stimulant use disorder) are not “mental health disorders” for the purpose of determining whether a recipient meets criteria to receive psychotherapy.

Family Therapy

Family therapy must be composed of at least two family members. The primary focus of family therapy sessions is family dynamics as they relate to the patient's mental status and behavior(s). CPT code 90847 should be used when the Medi-Cal recipient who meets criteria for family therapy is present for the entire session or at least a portion of the session. CPT code 90846 should be used when the Medi-Cal recipient who meets criteria for family therapy is not present during the session. ‹‹Mental health providers must bill for family therapy using the Medi-Cal ID of only one family member per therapy session for CPT codes 90846, 90847, 99354 and 99356. Mental health providers must bill for multiple-family group therapy (90849) using the Medi-Cal ID of only one family member per family.››

Some examples of evidence-based family therapy are:

- Child-Parent Psychotherapy (ages 0 thru 5)
- Parent Child Interactive Therapy (ages 2 thru 12)
- Cognitive-Behavioral Couple Therapy (adults)

Billing Newborn Infant Family Therapy with Birthing Parent's ID
Family therapy rendered to an infant who has not yet been assigned a Medi-Cal ID number may be billed with the birthing parent's ID for the month of birth and the following month only.

Family Therapy Billing Codes
Reimbursement of family therapy is limited to a maximum of 50 minutes when the patient is not present (CPT code 90846) or a maximum of 110 minutes when the patient is present (CPT code 90847 plus CPT code 99354 or 99356).

When billing family therapy (CPT codes 90846, 90847, 90849, 99354 and 99356), providers should use the appropriate code, based on the following descriptions and direct patient care time frames.

Note: Please note that the general code descriptions included are provided to assist with interpreting and navigating the content; providers are responsible for referencing the appropriate codebooks for up-to-date full descriptions when considering which code is appropriate to bill for the services rendered.

Family Therapy Codes Table

CPT Code	General Code Description
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (with patient present), 50 minutes
90849	Multiple-family group psychotherapy
99354	Prolonged psychotherapy service, outpatient; first hour
99356	Prolonged psychotherapy, inpatient; first hour

CPT codes 99354 and 99356 are only reimbursable when billed on the same date of service as CPT code 90847.

CPT codes 90846, 90847, 90849 and 90853 may not be billed on the same day for the same recipient.

Group Therapy

Group therapy is defined as counseling of at least two but not more than eight persons at any session. There is no restriction as to the number of Medi-Cal-eligible persons who must be included in the group's composition. For example, if there are five patients in the group, and only one is a Medi-Cal recipient, then Medi-Cal should be billed using CPT code 90853, once per session.

Group therapy sessions of less than one and one-half hours are not reimbursable.

Individual Therapy

Individual therapy is limited to a maximum of one and one-half hours per day by the same provider.

When billing individual psychotherapy (CPT codes 90832, 90837, 90839 and 90840), providers should use the appropriate code, based on the following direct patient care time frames.

Note: Please note that the general code descriptions included are provided to assist with interpreting and navigating the content; providers are responsible for referencing the appropriate codebooks for up-to-date full descriptions when considering which code is appropriate to bill for the services rendered.

Individual Psychotherapy Codes Table

CPT Code	General Code Description
90832	Psychotherapy, 30 minutes
90833	Psychotherapy, 30 minutes with E/M service
90834	Psychotherapy, 45 minutes
90836	Psychotherapy, 45 minutes with E/M service
90837	Psychotherapy, 60 minutes
90838	Psychotherapy, 60 minutes with E/M service
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis each additional 30 minutes

Smoking and Tobacco Cessation Counseling

Counseling for smoking and tobacco cessation is reimbursable using CPT codes 99406 and 99407. For more information, refer to the *Evaluation and Management (E&M)* section of the appropriate Part 2 Manual.

NSMHS Provider Table

The CPT and HCPCS codes listed below are restricted to the following mental health practitioner types, as consistent with the practitioner's training and licensing requirements. This table does not apply to psychiatric hospitalizations or SMHS provided via county MHPs. The abbreviation "LP" refers to licensed psychologists.

Note: Please note that the general code descriptions included are provided to assist with interpreting and navigating the content; providers are responsible for referencing the appropriate codebooks for up-to-date full descriptions when considering which code is appropriate to bill for the services rendered.

Provider Types for NSMHS Table

Billing Code	General Code Description	MD, NP, PA	LP	LCSW, LPCC, LMFT
90785	Interactive complexity	Yes	Yes	Yes
90791	Psych diagnostic evaluation	Yes	Yes	‹‹No››
90792	Psych diagnostic evaluation with medical services	Yes	No	No
90832	Psychotherapy, 30 minutes	Yes	Yes	Yes
90833	Psychotherapy, 30 min with E/M service	Yes	No	No
90834	Psychotherapy, 45 minutes	Yes	Yes	Yes
90836	Psychotherapy, 45 min with E/M service	Yes	No	No
90837	Psychotherapy, 60 minutes	Yes	Yes	Yes
90838	Psychotherapy, 60 min with E/M service	Yes	No	No
90839	Crisis psychotherapy, first 60 minutes	Yes	Yes	Yes
90840	Crisis psychotherapy, each additional 30 minutes	Yes	Yes	Yes
90846	Family therapy without patient, 50 minutes	Yes	Yes	Yes
90847	Family therapy with patient, 50 minutes	Yes	Yes	Yes
90849	Multiple-family group psychotherapy	Yes	Yes	Yes
90853	Group psychotherapy	Yes	Yes	Yes
90880	Hypnotherapy	Yes	Yes	Yes
96105	Assessment of aphasia, per hour	Yes	Yes	No
96110	Developmental screening	Yes	Yes	Yes
96112	Develop testing; first hour	Yes	Yes	No
96113	Develop testing; each additional 30 minutes	Yes	Yes	No

Provider Types for NSMHS Table (continued)

Billing Code	General Code Description	MD, NP, PA	LP	LCSW, LPCC, LMFT
96116	Neurobehavioral exam; first hour	Yes	Yes	No
96121	Neurobehavioral exam; each additional hour	Yes	Yes	No
96127	Brief emotional/behavioral assessment	Yes	Yes	Yes
96130	Psychological testing; first hour	Yes	Yes	No
96131	Psychological testing; each additional hour	Yes	Yes	No
96132	Neuropsych testing; 1st hour	Yes	Yes	No
96133	Neuropsych testing; each additional hour	Yes	Yes	No
96136	Psych/neuropsych test admin; first hour	Yes	Yes	No
96137	Psych/neuropsych test admin; each additional 30 minutes	Yes	Yes	No
96138	Psych/neuropsych test admin (tech); first hour	Yes	Yes	No
96139	Psych/neuropsych test admin (tech); each additional 30 minutes	Yes	Yes	No
96146	Psych/neuropsych test admin (electronic)	Yes	Yes	No
96156	Health behavior assessment	Yes	Yes	Yes
96158	Health Behavior Intervention (HBI); initial 30 minutes	Yes	Yes	Yes
96159	Health Behavior Intervention (HBI); each additional 15 minutes	Yes	Yes	Yes
96164	HBI, group; initial 30 minutes	Yes	Yes	Yes
96165	HBI, group; each additional 15 minutes	Yes	Yes	Yes
96167	HBI, family with patient	Yes	Yes	Yes
96168	HBI, family with patient; each additional 15 minutes	Yes	Yes	Yes
96170	HBI, family without patient	Yes	Yes	Yes
96171	HBI, family without patient; each additional 15 minutes	Yes	Yes	Yes

Provider Types for NSMHS Table (continued)

Billing Code	General Code Description	MD, NP, PA	LP	LCSW, LPCC, LMFT
97129	Cognitive rehabilitation; initial 15 min	Yes	Yes	No
97130	Cognitive rehabilitation; each additional 15 minutes	Yes	Yes	No
99201 thru 99350	Evaluation and Management Services	Yes	No	No
99354	Prolonged service(s), outpatient	Yes	Yes	Yes
99356	Prolonged service(s), inpatient	Yes	Yes	Yes
99366	Medical team conference, patient and/or family present, nonphysician	No	Yes	Yes
99368	Medical team conference, patient and/or family not present, nonphysician	No	Yes	Yes
99406	Tobacco cessation, 3 to 10 minutes	Yes	Yes	Yes
99407	Tobacco cessation, more than 10 minutes	Yes	Yes	Yes
G0442	Annual alcohol misuse screening	Yes	Yes	Yes
G9919	ACE screening, high risk	Yes	Yes	Yes
G9920	ACE screening, lower risk	Yes	Yes	Yes
H0049	Drug use screening	Yes	Yes	Yes
H0050	Alcohol and drug services, brief intervention	Yes	Yes	Yes

NSMHS Place of Service Table

The CPT and HCPCS codes listed below are reimbursable only when delivered in places of service as specified below. This table does not apply to psychiatric hospitalizations or SMHS provided via county MHPs.

Psychological and psychiatric services that meet the definition of a visit, as defined in the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* section of the appropriate Part 2 manual, are reimbursable in RHCs and FQHCs. For information about billing codes for services delivered in RHCs and FQHCs, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes* section of the appropriate Part 2 manual.

Psychological and psychiatric services that meet the definition of a visit, as defined in the *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* section of the appropriate Part 2 manual, are reimbursable in IHS-MOA clinics. For information about billing codes for services delivered in IHS-MOA clinics, refer to the *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics: Billing Codes* section of the appropriate Part 2 manual.

Note: Please note that the general code descriptions included are provided to assist with interpreting and navigating the content; providers are responsible for referencing the appropriate codebooks for up-to-date full descriptions when considering which code is appropriate to bill for the services rendered.

NSMHS Place of Service Table

Billing Code	General Code Description	Outpatient §	Hospital Inpatient, Skilled Nursing, Subacute, Intermed. Care for Develop. Disabled	Emergency Hospital, Urgent Care Clinic
90785	Interactive complexity	Yes	Yes	Yes
90791	Psych diagnostic evaluation	Yes	Yes	Yes
90792	Psych diagnostic evaluation with medical services	Yes	Yes	Yes
90832	Psychotherapy, 30 minutes	Yes	Yes	No

NSMHS Place of Service Table (continued)

Billing Code	General Code Description	Outpatient §	Hospital Inpatient, Skilled Nursing, Subacute, Intermed. Care for Develop. Disabled	Emergency Hospital, Urgent Care Clinic
90833	Psychotherapy, 30 min with E/M service	Yes	Yes	No
90834	Psychotherapy, 45 minutes	Yes	Yes	No
90836	Psychotherapy, 45 min with E/M service	Yes	Yes	No
90837	Psychotherapy, 60 minutes	Yes	Yes	No
90838	Psychotherapy, 60 min with E/M service	Yes	Yes	No
90839	Crisis psychotherapy, first 60 minutes	Yes	Yes	Yes
90840	Crisis psychotherapy, each additional 30 minutes	Yes	Yes	Yes
90846	Family therapy without patient, 50 minutes	Yes	Yes	Yes
90847	Family therapy with patient, 50 minutes	Yes	Yes	Yes
90849	Multiple-family group psychotherapy	Yes	Yes	No
90853	Group psychotherapy	Yes	Yes	No
90880	Hypnotherapy	Yes	Yes	No
96105	Assessment of aphasia, per hour	Yes	Yes	No
96110	Developmental screening	Yes	No	No
96112	Developmental testing; first hour	Yes	Yes	No
96113	Developmental testing; each additional 30 minutes	Yes	Yes	No
96116	Neurobehavioral exam; first hour	Yes	Yes	Yes
96121	Neurobehavioral exam; each additional hour	Yes	Yes	Yes
96127	Brief emotional/behavioral assessment	Yes	Yes	Yes
96130	Psychological testing; first hour	Yes	Yes	No

NSMHS Place of Service Table (continued)

Billing Code	General Code Description	Outpatient §	Hospital Inpatient, Skilled Nursing, Subacute, Intermed. Care for Develop. Disabled	Emergency Hospital, Urgent Care Clinic
96131	Psychological testing; each additional hour	Yes	Yes	No
96132	Neuropsych testing, first hour	Yes	Yes	No
96133	Neuropsych testing, each additional hour	Yes	Yes	No
96136	Psych/neuropsych test admin; first hour	Yes	Yes	No
96137	Psych/neuropsych test admin; each additional 30 minutes	Yes	Yes	No
96138	Psych/neuropsych test admin (tech); first hour	Yes	Yes	No
96139	Psych/neuropsych test admin (tech); each additional 30 minutes	Yes	Yes	No
96146	Psych/neuropsych test admin (electronic)	Yes	Yes	Yes
96156	Health behavior assessment	Yes	Yes	Yes
96158	Health Behavior Intervention (HBI); initial 30 minutes	Yes	Yes	Yes
96159	HBI; each additional 15 minutes	Yes	Yes	Yes
96164	HBI, group; initial 30 minutes	Yes	Yes	Yes
96165	HBI, group; each additional 15 minutes	Yes	Yes	Yes
96167	HBI, family with patient	Yes	Yes	Yes
96168	HBI, family with patient; each additional 15 minutes	Yes	Yes	Yes
96170	HBI, family without patient	Yes	Yes	Yes
96171	HBI, family without patient; each additional 15 minutes	Yes	Yes	Yes
97129	Cognitive rehabilitation; initial 15 minutes	Yes	Yes	No
97130	Cognitive rehabilitation; each additional 15 minutes	Yes	Yes	No

NSMHS Place of Service Table (continued)

Billing Code	General Code Description	Outpatient §	Hospital Inpatient, Skilled Nursing, Subacute, Intermed. Care for Develop. Disabled	Emergency Hospital, Urgent Care Clinic
99202 thru 99350, 99417	Evaluation and Management Services	Yes	Yes	Yes
99354	Prolonged services, outpatient	Yes	No	Urgent care clinic settings only
99356	Prolonged services, inpatient	No	Yes	Emergency department settings only
99366	Medical team conference, patient and/or family present, nonphysician	Yes	Yes	No
99368	Medical conference, patient and/or family not present, nonphysician	Yes	Yes	No
99406	Tobacco cessation, 3 to 10 minutes	Yes	Yes	Yes
99407	Tobacco cessation, more than 10 minutes	Yes	Yes	Yes
G0442	Annual alcohol misuse screening	In primary care settings only	No	No
G9919	ACE Screening, high risk	Yes	Yes	Yes‡
G9920	ACE Screening, lower risk	Yes	Yes	Yes‡
H0049	Drug use screening	In primary care settings only	No	No
H0050	Alcohol and drug services, brief intervention	In primary care settings only	No	No

Medicare/Medi-Cal Crossovers

If Medicare denies payment because the following requirements are not met, payment will also be denied by Medi-Cal.

Requirements

Medicare covers both psychotherapy and central nervous system assessments/tests. Claims for testing and therapy must first be submitted to Medicare before billing Medi-Cal for Medicare-eligible recipients. When billing Medi-Cal, providers must submit an *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN) with the claim for services rendered to a Medicare/Medi-Cal recipient.

Diagnostic Testing Covered by Medicare When Ordered by a Physician

Diagnostic testing performed by a psychologist practicing independently of an institution, agency or physician's practice is covered by Medicare only when the service is ordered by a physician. When submitting a claim, Medicare requires the psychologist to include a copy of the report sent to the physician who ordered the testing and the name and address of the referring physician.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Refer to the *Preventive Services* section in the appropriate Part 2 manual for more information.
†	*California Code of Regulations* (CCR), Title 22, Section 51303
∞	See *Welfare and Institutions Code* (W&I Code), Section 14184.402
‡	The emergency room will not usually be an appropriate setting for this screening and any follow-up care. Information about required training, self-attestation, required screening tools, documentation requirements, frequency limits and billing can be found on the ACEs Aware website.
§	Outpatient includes: office, home, outpatient hospital, ambulatory surgery clinic, community mental health center, comprehensive rehabilitation facility, state or local public health clinic, or other.