CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE (CYBHI) FEE SCHEDULE PROGRAM

Guidance for Local Educational Agencies and Institutions of Higher Education

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Overview and Purpose

As part of Governor Newsom's Master Plan for Kids' Mental Health and the Children and Youth Behavioral Health Initiative (CYBHI), the Department of Health Care Services (DHCS) is expanding access to school-based (or school-linked) behavioral health services provided to students of public Transitional Kindergarten (TK)-12th grade local educational agencies (LEAs) and public institutions of higher education (IHEs) - specifically, the California Community Colleges (CCC), California State University (CSU) and University of California (UC) campuses. DHCS, in collaboration with the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), established a statewide, multi-payer, school-linked fee schedule (CYBHI Fee Schedule) program to facilitate the reimbursement of school-linked providers for the provision of specified outpatient mental health and substance use disorder (SUD) services furnished to students 25 years of age or younger at a schoolsite.[1]

Commencing July 1, 2024,[2] Medi-Cal Fee-for-Service (FFS), Medi-Cal managed care plans (MCPs), commercial health care services plans, and disability insurers (collectively referred to herein as "MCPs and Insurers") are obligated under state law[3] to reimburse eligible LEAs, IHEs, and designated community-based school-linked providers for the provision of the CYBHI Fee Schedule program covered services to plan enrollees. Eligible school-linked providers (CYBHI Providers) include local educational agencies' (LEAs) and public institutions' of higher education (IHEs) employed practitioners (e.g., Pupil Personnel Services (PPS) credentialed practitioners, licensed practitioners), embedded providers (i.e., contracted community-based school-linked providers, clinics, or individual licensed practitioners) providing services on behalf of the LEA or IHE, and affiliated providers (e.g., non-contracted community-based school-linked providers, clinics, counties, or individual licensed practitioners) to which the LEA or IHE refers students for services.

DHCS contracted with a statewide third-party administrator (TPA) to support successful implementation of the CYBHI Fee Schedule program with the goal of reducing administrative burdens on LEAs, IHEs, and MCPs and Insurers. In its role as the TPA,

[1] See Appendix A for a glossary of key terms.
[2] The statute requires MCPs and Insurers to reimburse school-linked providers for covered services beginning January 1, 2024; however, the statute also authorizes DHCS to implement the provisions only to the extent that DHCS obtains necessary federal approvals. As a result, DHCS determined it necessary to establish July 1, 2024, as the first date of service eligible for reimbursement under the CYBHI Fee Schedule program.
[3] Welfare and Institutions Code § 5961.4; California Health and Safety Code § 1374.722; California Insurance Code § 10144.53

Carelon Behavioral Health (CBH),[4] will serve as the single statewide entity responsible for operational administration of the CYBHI Fee Schedule program. CBH's responsibilities, at a high level, include:

- **Oversight and management of the school-linked, behavioral health provider network -** This includes but is not limited to conducting screening and verification of school-linked providers' eligibility and qualifications (i.e., screening and credentialing); maintaining a roster of participating LEAs, IHEs and designated community-based school-linked providers; establishing processes to monitor the network and provision of services, as well as to ensure program integrity and prevent fraud, waste and abuse; managing and implementing data-exchange frameworks to guide data exchange between providers and payers in compliance with state and federal requirements pertaining to data quality, privacy, confidentiality, and security.
- **Claims administration, claims adjudication and payment remittance for services rendered by school-linked providers as part of the CYBHI Fee Schedule program -** This includes capabilities such as claims validation and adjudication, reconciliation and payment remittance, data management, and data quality and security.
- **Onboarding, implementation, and ongoing technical assistance services for participating LEAs, IHEs, designated community-based school-linked providers and practitioners, and MCPs and Insurers -** This includes but is not limited to providing support to LEAs, IHEs, designated community-based school-linked providers, and MCPs and Insurers; serving as the designated point of contact program administration; collecting and reporting data; and committing to partnership with DHCS, and other partners identified by DHCS, to provide cohesive support to LEAs, IHEs, designated community-based school-linked providers, and MCPs and Insurers.

Pursuant to DHCS' authority in the Welfare and Institutions Code § 5961(g), this guidance document outlines the policy and operational requirements for the CYBHI Fee Schedule program. To learn more about the CYBHI Fee Schedule, please visit DHCS' CYBHI Fee Schedule program webpage or contact DHCS at DHCS.SBS@dhcs.ca.gov.

[4] DHCS contracted (Agreement #23-30348) with CBH to serve as the state's TPA. CBH was selected through a completive Request for Information (RFI) process. Since January 2024, CBH has been, in partnership with DHCS, administering the operational framework for the CYBHI Fee Schedule program.

Vision and Guiding Principles for the Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule Program

Studies find that more students will receive behavioral health services when they are provided at school.[5] The CYBHI aims to increase access to behavioral health services for children, youth, and families by expanding access to school-based behavioral health programs. The CYBHI Fee Schedule program[6] enables LEAs and IHEs to be reimbursed for behavioral health services without needing to negotiate directly with health insurance plans and disability insurers to establish network provider agreements. By establishing this sustainable funding mechanism for school-linked behavioral health services, the CYBHI Fee Schedule program aims to:

- Increase access to school-linked behavioral health services for children and youth;
- Ease administrative complexities for LEAs and IHEs by streamlining processes and requirements for reimbursement of covered school-linked behavioral health services furnished to students and alleviating LEA and IHE burdens related to negotiating contracts and rates with MCPs and Insurers;
- Apply to multiple payers, easing uncertainty for school-linked providers identifying student's coverage;
- Expand the types of practitioners eligible for reimbursement for school-based behavioral health services to include Pupil Personnel Services (PPS) credentialed practitioners, Community Health Workers, and Certified Wellness Coaches;[7,8] and,
- Provide state-funded supports for payers and providers, including contracting with the single statewide TPA to manage the provider network and facilitate claims administration/payment remittance.

[5] Refer to The Landscape of School-Based Mental Health Services

[6] Introduction to the CYBHI Fee Schedule (YouTube)

[7] Pending State Plan Amendment approval by the Centers for Medicare and Medicaid Services

[8] State Plan Amendment (SPA) 23-0027, approved by CMS on December 19, 2024, with an effective date of January 1, 2024, added Pupil Personnel Services (PPS) Credentialed School Counselors as eligible to render and bill for CYBHI Fee Schedule services. SPA 20-0014 was submitted to CMS on March 27, 2025, proposes to add Certified Wellness Coaches (CWC) services to the CYBHI Fee Schedule program, with a proposed effective date of January 1, 2025.

CYBHI Fee Schedule Program Requirements

Fee Schedule Definition

A 'fee schedule' establishes the rates at which health care providers are reimbursed by health insurance plans for specific services. A fee schedule typically includes a scope of services and defines the appropriate billing codes, rates, modifiers, and practitioner types for each service.

Eligible Students

CYBHI Covered Services provided to LEA or IHE students, under the age of 26 who are enrolled in a participating MCP or insurer, are eligible for reimbursement. In accordance with state law, the following entities are mandated to reimburse LEAs, IHEs, and designated community-based school-linked providers and practitioners for the provision of services to a student as part of the CYBHI Fee Schedule program:

- Medi-Cal MCPs;[9]
- Medi-Cal FFS;[10]
- Commercial health care service plans (i.e., commercial health plans) regulated by the Knox Keene Health Care Service Plan Act;[11] and,
- Disability insurers that cover hospital, medical or surgical benefits.[12]

Participating LEAs and IHEs will implement processes and procedures to determine if services provided to a student and/or their family, as applicable, are eligible for reimbursement under the CYBHI Fee Schedule program.

Students remain eligible for CYBHI Fee Schedule program covered services during school breaks (e.g., summer break). Students are also eligible regardless of academic status (i.e., there is no requirement to be in academic good-standing to receive CYBHI Fee Schedule program covered services).

[9] Welfare and Institutions Code § 5961.4
[10] Welfare and Institutions Code § 5961.4
[11] Health and Safety Code §1374.722(a)
[12] California Insurance Code § 10144.53

Excluded Coverage Types

The CYBHI Fee Schedule program statute does not cover all students. Specific excluded populations include:

1. Students without health insurance coverage;
2. Students enrolled in a self-funded insurance plans[13] (e.g., CalPERS Preferred Provider Organizations);
3. Students covered under federally regulated insurers (e.g., Employee Retirements Income Security Act (ERISA) or TRICARE, a military service member insurer);
4. Students covered Sistemas Médicos Nacionales, S.A. de C.V. (SIMNSA), a health maintenance organization (HMO) that provides healthcare services in Northern Mexico and border communities such as San Ysidro and Calexico, and Medi-Excel.

Claims submitted for a student enrolled in a coverage type listed above will be denied.

Students enrolled in a Health Savings Account (HSA) qualified High-Deductible Health Plan (HDHP) must meet their health plan deductible before the plan or insurer can cover services, unless those services meet the federal definitions of preventative services, as defined by the Internal Revenue Service (IRS). HDHPs are a type of health plan product which combines a Health Savings Account (HSA) with traditional medical coverage. If an HDHP is required to pay for non-preventative services before the enrollee reaches their annual deductible, the enrollee's HSA may lose its tax-free status, and the health plan or insurer may lose its designation as an HDHP.

According to 2025 data published by California Health Benefits Review Program,[14] approximately 13.7 million Californians enrolled in a health plan (regulated by DMHC or CDI) have any type of deductible. Of these 14 million individuals, of all ages, only 7% (approximately 960,000) are enrolled in an HSA-Qualified HDHP and required to meet their deductible requirement before being eligible for reimbursement under the CYBHI Fee Schedule program. Only a portion of these enrollees are children and youth, meaning the percentage of students between the ages of 0-25. Furthermore, HDHPs *are*

[13] A self-funded insurance plan is a, "type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims." (Healthcare.gov)

[14] California Health Benefits Review Program Deductibles in State-Regulated Health Insurance (2025)

required to provide reimbursement to LEAs for all preventative services listed on the CYBHI fee schedule and any service provided after the enrollee has met their deductible.

Similarly, some Medi-Cal beneficiaries may still be required to pay a monthly dollar amount for the Share of Cost (SOC) prior to qualifying for Medi-Cal benefits. This may be determined through the Automated Eligibility Verification System (AEVS). If AEVS indicates a beneficiary has a SOC, the SOC must be met before a beneficiary is eligible for benefits. The SOC amount is determined by the county welfare department and is administered by Medi-Cal.

Important Note: If CBH determines that an individual is not eligible because the HSA-qualified HDHP deductible or SOC, as applicable, the provider will be notified by CBH and the claim ***must be*** rejected. Unfortunately, it is not likely that an LEA, IHE, or designated community-based school-linked designated provider or practitioner) will know prior to claim submission that the student and/or family are enrolled in this type of coverage.

Reimbursement Options for Non-Eligible Students

It is important to note that the CYBHI Fee Schedule program is a school-based services ***reimbursement program***. It is not the intent of the CYBHI Fee Schedule program to limit or dictate the types of services that are, or can be, provided to students by LEA and IHEs. While not all services may be eligible for reimbursement under this program, LEAs and IHEs are still required to furnish services to students in accordance with state and federal laws.

For those students who are not covered by state-regulated MCPs and insurers, or for students who have not met their HSA-qualified HDHP or SOC deductible requirements, LEAs and IHEs may use alternative funding sources (e.g., Local Control Funding Formula (LCFF) entitlements, grant funds) to fund behavioral health services provided in schools.

In addition, LEAs and IHEs are encouraged to provide assistance for eligible students and families to enroll in the Medi-Cal program and may participate in the School-based Medi-Cal Administrative Activities (SMAA)[15] program while also participating in the CYBHI Fee Schedule program. LEAs and IHEs may also reach out to local community partners and county health or social services departments to provide the students with assistance regarding Medi-Cal enrollment.[16]

[15] SMAA program
[16] DHCS "Ways to Apply for Medi-Cal"

LEAs that participate in the Local Educational Agency Billing Option Program (LEA BOP) may receive reimbursement of Medicaid Federal Financial Participation for services covered under the LEA BOP, in accordance with program requirements for the LEA BOP, CYBHI and the Medi-Cal program.

Eligible Service Locations

State law requires DHCS to develop and maintain the CYBHI Fee Schedule for outpatient mental health and substance use disorder treatment provided to a student 25 years of age or younger at a schoolsite.[17]

A schoolsite is defined[18] as:

- A facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes.
- A facility or location not owned or operated by a public school, or public school district, if the school or school district provides or arranges for the provision of medically necessary treatment of a mental health or substance use disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

Since eligible schoolsite locations include off-campus clinics, mobile counseling services, and other similar locations where the LEA or IHE "arranges for the provision of services," designated community-based school-linked providers (e.g., county behavioral health agency providers, clinics, community-based organizations (CBOs)) are eligible, when designated by the LEA or IHE, to participate in the CYBHI Fee Schedule program and receive reimbursement for school-linked behavioral health services provided to eligible students.

Telehealth

Services covered under the CYBHI Fee Schedule program may be billed by participating LEAs, IHEs, and/or designated community-based school-linked providers and practitioners, as applicable, when delivered in-person during face-to-face visits or via telehealth, in accordance with DHCS' telehealth policy.[19, 20] Telehealth services are

[17] Welfare and Institutions Code § 5961.4
[18] Health and Safety Code §1374.722(b)(6)
[19] Refer to DHCS Telehealth & Medi-Cal.
[20] Refer to DHCS Telehealth provider manual.

reimbursable if the practitioner believes that the service being provided is clinically appropriate based upon evidence-based medicine or best practices or both. The practitioner must inform the student and/or their authorized representative, prior to the initial delivery of telehealth services, about the use of telehealth, including that students who receive services delivered via telehealth also have the right to access services in-person. The provider must also obtain consent from the student for the use of telehealth as an acceptable mode of delivering health care services.

CYBHI Fee Schedule Program Covered Services

CYBHI Fee Schedule program covered services (CYBHI Covered Services) include medically necessary outpatient mental health and substance use disorder (SUD) services, including preventative, screening, assessment, and treatment services.[21] CYBHI Covered Services, including service descriptions, procedure codes, time increments, eligible practitioners, and rates are specified in the published fee schedule[22] on the DHCS website.

Generally, CYBHI Covered Services are grouped into four categories:

- **Psychoeducation Services:** Psychoeducation services involve providing individuals, and their families, when applicable, with information and education about mental health conditions, SUDs, and related treatment options. Typically, this can include topics like understanding diagnoses, learning about medications and their side effects, and developing coping strategies. In school-settings, psychoeducation services may also be provided to students, and their families, when applicable, for the purposes of identifying strategies and/or treatment options associated with a child's behavioral health needs with the goal of preventing or minimizing the negative effects of mental illness, emotional disturbances, substance abuse, or associated environmental stressors. This could include skill-building, such as mindfulness, de-escalation, and emotional regulation. Community Health Worker (CHW) Services and Certified Wellness Coach (CWC) Services[23] are also covered psychoeducation services.

[21] For the purposes of the Medi-Cal program, CYBHI covered services are Medi-Cal managed care and Medi-Cal FFS benefits, including the Non-Specialty Mental Health Services benefit; Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT); Community Health Worker Services; and (pending CMS approval) Certified Wellness Coach Services.

[22] CYBHI Fee Schedule Scope of Services, Codes, and Reimbursement Rates

[23] See CWC Guidance for details about reimbursement timelines

- **Screening and Assessment Services:** Screening and assessments can help identify students at risk for mental illness and/or substance use disorders, ensure that appropriate supports are provided to students across risk levels,[24] and inform prevention and early intervention strategies. Information from screenings and assessments can be used by LEAs and IHEs to identify students who may need additional services and supports, including services covered by MCP and Insurers and delivered via network providers.
- **Treatment Services**: Treatment services may include crisis intervention, individual, group or family counseling; and/or individual, group, or family psychotherapy.
- **Care Coordination / Case Management:** Care coordination / case management services support and guide individuals and their families to community-based care options, social services support (e.g., Food Bank, housing), as well as support treatment planning and/or case-conferences with a Coordination of Services Team (COST), or another type of multidisciplinary treatment team.

Educationally Related Mental Health Services (Special Education Services)

LEAs and IHEs have existing obligations under state and federal law to provide or arrange for the provision of services rendered pursuant to an Individualized Education Plan (IEP), an Individualized Family Services Plan (IFSP), or a 504 plan, including all services for which the LEA receives state or federal funding. The Individuals with Disabilities Education Act (IDEA) requires LEAs to provide Free Appropriate Public Education (FAPE) for students with disabilities and creates a legal obligation for LEAs/IHEs to ensure services included on a student's IEP or IFSP are provided to the student.[25] The CYBHI statutes specify that the CYBHI Fee Schedule program does not "relieve [an LEA or IHE] from requirements to accommodate or provide services to students with disabilities pursuant to any state and federal law."[26] This exclusion in CYBHI does not mean that LEAs, IHEs, or designated community-based school-linked providers, may not seek reimbursement for CYBHI covered services provided to any student with a disability. Instead, DHCS operationalizes this requirement to mean the following:

- LEAs, IHEs, and designated community-based school-linked providers **may not seek** reimbursement for services rendered pursuant to an IEP or IFSP.

[24] High risk = same day; Moderate risk = within the week; Low risk = communicate findings to staff, students, and parents within a reasonable time frame; Refer to School Mental Health Quality Guide
[25] Individuals with Disabilities Education Act (IDEA) Part B. Assistance for All Children with Disabilities
[26] Welfare and Institutions Code § 5961.4(i)

Specifically, this means that services that are specified in a student's IEP or IFSP are not eligible for reimbursement as part of the CYBHI Fee Schedule program.

- LEAs and IHEs **may seek** reimbursement for medically necessary CYBHI covered services furnished to a student with an identified disability, so long as the specific services claimed for reimbursement were not specified in the student's IEP or IFSP and/or the services listed in the IEP or IFSP are not directly related to the student's qualifying disability.[27,28]
- LEAs, IHEs, and community-based school-linked designated providers **may seek** reimbursement for **initial** IEP assessments (specifically related to a mental health or substance use disorder condition or symptoms), including screenings and psychological testing utilized to inform initial disability determination under the IDEA, for students that did not previously have an IEP or IFSP. If it is determined the student meets disability criteria and an IEP and/or IFSP is established, subsequent reassessments would not be eligible for reimbursement.[29]

LEAs and IHEs that are participating in both the CYBHI Fee Schedule program and the Local Educational Agency Billing Option Program (LEA BOP), for physical health services for all Medi-Cal eligible students and/or behavioral health services furnished to a student with a disability as specified in the student's IEP or IFSP, LEAs and IHEs may submit Medi-Cal claims as part of the LEA BOP. All other claims for CYBHI covered behavioral health services not furnished pursuant to an IEP or IFSP should be submitted to CBH for reimbursement as part of the CYBHI Fee Schedule program.

[27] Illustrative example: A student has an IEP related to anxiety disorder symptoms that adversely affect the student's academic progress. Pursuant to the IEP, the student will receive individual counseling services one time per week. However, during the school year, the student's beloved pet dies, and the student experiences subsequent feelings grief, sadness and loneliness. The PPS-credentialed school counselor leads a weekly group counseling session focused on grief and loss and the student participates in that group for a several weeks. In this example, the weekly individual counseling services are not eligible for reimbursement, but the weekly group counseling sessions are eligible for reimbursement under the CYBHI Fee Schedule program.

[28] For avoidance of doubt, if services listed in the IEP or IFSP are identified for care coordination services only and are not directly related to the student's qualifying disability, the services are still eligible for reimbursement under the CYBHI Fee Schedule program.

[29] The CYBHI Fee Schedule program only provides reimbursement for outpatient behavioral health (mental health and substance use disorder) services. Initial IEP assessments for students with cognitive disorders, intellectual disabilities, physical health conditions, or other non-behavioral health (i.e., mental health and substance use disorder) conditions or symptoms are not reimbursable under the CYBHI Fee Schedule program.

Please note: LEAs and IHEs are strongly encouraged to participate in both the CYBHI Fee Schedule program and LEA BOP to maximize reimbursements for school-linked behavioral health services.

Medically Necessary Treatment

Under the CYBHI statutory authority, MCPs and Insurers are mandated to reimburse school-linked providers for the provision of ***medically necessary*** CYBHI covered services to a student under the age of 26.[30]

Defining medical necessity

The Mental Health Parity and Addiction Equity Act (MHPAEA) federally mandates parity in the treatment of behavioral health and medical/surgical benefits by group health plans or health insurance issuers (including for individual health insurance coverage) across all ages.[31,32]

For commercial health care services plans and disability insurers, the California Health and Safety Code section 1374.72(a)(3)(A) and the California Insurance Code section 10144.5(a)(3)(A) specify that "medically necessary treatment of a mental health or substance use disorder means a service or product addressing the specific needs of that patient, **for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression**…."

For Medi-Cal students who are under the age of 21, a service is "medically necessary" if it is provided to correct or ameliorate health defects, physical and mental illnesses, and conditions discovered by screening services, whether or not such services are covered under the State Plan.[33,34] Services that maintain or improve a child's current health condition are covered because they "ameliorate" a condition. Services are covered when they prevent a condition from worsening and/or prevent the development of additional health problems.

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[30] Welfare and Institutions Code § 5961.4; California Health and Safety Code § 1374.722; California Insurance Code § 10144.53

[31] CMS. The Mental Health Parity and Addiction Equity Act (MHPAEA)

[32] DHCS's All Plan Letter 22-006 (or superseding guidance, as applicable) explains the responsibilities of Medi-Cal MCPs for the provision or arrangement of clinically appropriate and covered non-specialty mental health services (NSMHS) and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F).

[33] DHCS Medi-Cal for Kids and Teens Provider Information website

[34] 42 U.S.C. §1396d(r)(5)[35] and Institutions Code § 14059.5; APL 22-006

For students who are 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.[35]

Determining medical necessity

Eligible rendering practitioners, within their scope of practice, will determine if a service provided to a student is medically necessary. To determine whether a service is medically necessary, LEAs, IHEs, and designated community-based school-linked providers must:[36]

1. Take into account the particular needs of the child; and,
2. Be made on a case-by-case basis.

LEAs, IHEs and designated community-based school-linked providers are not required to submit documentation demonstrating medical necessity (i.e., assessments and treatment plans are not required to demonstrate that services were medically necessary) to substantiate a claim for reimbursement.

CYBHI Fee Schedule Provider Network

State law requires DHCS to develop and maintain a statewide network of community-based school-linked providers.[37] As such, to be eligible for reimbursement under the CYBHI statutes, eligible entities must either: 1) apply to DHCS to participate in the statewide network of school-linked behavioral health providers; 2) have direct contracts with MCPs and Insurers;[38] or, 3) be designated by an eligible entity. Provider entities eligible to apply directly with DHCS include:

- LEAs, including county offices of education (COEs), school districts, charter schools, California Schools for the Deaf, and the California School for the Blind; and,
- Public institutions of higher education (IHEs), including California Community Colleges, California State Universities, University of California campuses.

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[35] and Institutions Code § 14059.5; APL 22-006

[36] DHCS Medi-Cal for Kids & Teens Provider Information – Medical Necessity

[37] Welfare and Institutions Code § 5961.4(b)

[38] LEAs, IHEs, and designated community-based school linked providers / practitioners are **not** required to have direct contracts with MCPs or insurers to be reimbursed, at published rates, for CYBHI covered services and MCPs and Insurers must provide reimbursement regardless of provider network status. Welfare and Institutions Code § 5961.4(c); Health and Safety Code § 1374.722(a)(1); Insurance Code § 10144.53(a)(1)

The LEA or IHE is the central figure in the CYBHI Fee Schedule program. However, as part of the CYBHI statutes,[39] the California Health and Safety Code § 1374.722(b)(6) and Insurance Code § 10144.53(b)(6) define a 'schoolsite' to mean a location where a "public school or public school district… provides or arranges for the provision of medically necessary treatment of a mental health or substance use disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations."[40] DHCS operationalizes this to mean LEAs and IHEs may designate community-based school-linked providers and practitioners as eligible entities able to receive reimbursement as part of the CYBHI Fee Schedule program. For a designated community-based school-linked provider to be eligible to participate, LEAs and/or IHEs **must** designate that the designated community-based school-linked provider is part of their 'network of designated providers and practitioners' serving enrolled students of the district, college or university. Therefore, in alignment with the statute, services of a designated community-based school-linked provider are furnished at a location where the LEA or IHE "arranges for the provision" of medically necessary mental health or substance use disorder services (behavioral health services). The LEA's or IHE's designated community-based school-linked provider and practitioner network may include:

- **Practitioners directly employed** by an LEA or IHE, including Pupil Personnel Services (PPS) credentialed practitioners, licensed behavioral health practitioners, Certified Wellness Coaches[41], Community Health Workers[42] and other qualified professionals eligible to furnish medically necessary services under the CYBHI Fee Schedule program,
- **Embedded providers or practitioners** – including but not limited to community-based school-linked providers, clinics, or individual licensed behavioral health practitioners that are **contracted** to provide medically necessary services **on behalf of** the LEA or IHE; and/or,

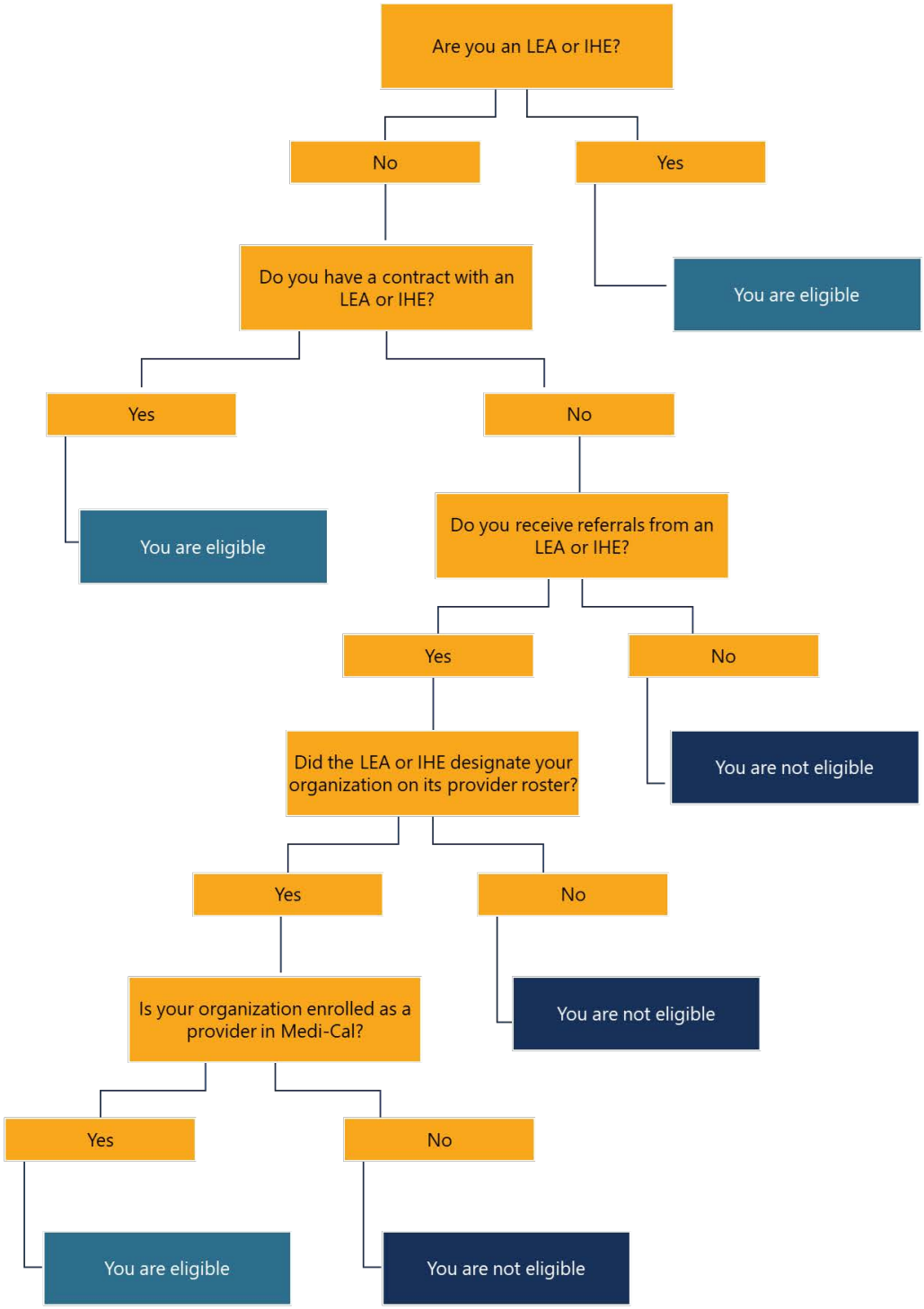
[39] Welfare and Institutions Code § 5961.4; Health and Safety Code § 1374.722; Insurance Code § 10144.53
[40] Services covered under the CYBHI Fee Schedule may be billed by participating LEAs, IHEs, and/or their designated community-based school-linked providers and practitioners, as applicable, when delivered in-person during face-to-face visits or via telehealth, in accordance with DHCS' telehealth policy. Telehealth services are reimbursable if the practitioner believes that the service being provided is clinically appropriate based upon evidence-based medicine or best practices or both.
[41] For Medi-Cal reimbursement (only), pending approval of State Plan Amendment 25-0014
[42] Refer to All Plan Letter 22-016

- **Affiliated providers or practitioners** – including but not limited to community-based school-linked providers, clinics, counties, or individually licensed behavioral health practitioners to which the LEA or IHE **refers students for services but does not have a formal agreement** or financial relationship.

To be eligible for reimbursement of covered services under the CYBHI Fee Schedule program, community-based school-linked providers must be either employed by, contracted by or affiliated with a participating LEA or IHE **and** designated by the LEA or IHE. An LEA/IHE can designate a community-based school-linked provider by including them on the Standard Provider Import (SPI) roster file submitted to CBH or—for select "statewide" affiliated providers—by providing the affiliated provider with an Affiliated Provider Designation and Acknowledgement Letter. Further, as a condition of participation, designated community-based school-linked providers and practitioners must be actively enrolled in the Medi-Cal program via DHCS' Provider Application and Validation for Enrollment (PAVE) system. For additional information, see Guidance for the Participation of Community Providers.

The CYBHI Fee Schedule program is intended to reimburse schools, school districts (i.e., school-based providers) and their community partners (i.e., designated community-based school-linked providers) that furnish outpatient behavioral health services to students under the age of 26. While state law provides DHCS authority to allow community-based ***school-linked*** providers and practitioners to participate in the CYBHI Fee Schedule program, the statute does not intend to circumvent existing MCPs' and Insurers' network contracting authorities. Only "designated" community-based school-linked providers may be reimbursed for services furnished to students covered by an MCP or Insurer who are enrolled in the LEA or IHE that designated the community-based school-linked provider. Without a formal designation by an LEA or IHE, community-based school-linked providers are not eligible for reimbursement under the CYBHI Fee Schedule program.

Exhibit 1: ***Is your organization eligible to participate in the CYBHI Fee Schedule program?***



Eligible Individual Provider (i.e., Practitioner) Types

LEAs, IHEs, or designated community-based school-linked providers may embed (e.g., employ or contract with) or affiliate with individual practitioners to render services to a

student in accordance with scope of practice requirements in state law. Eligible individual practitioners vary by service code and include the following:[43,44,45]

Licensed practitioners:

- Physicians, including DOs and Psychiatrists
- Licensed Psychologists
- Licensed Educational Psychologists
- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists
- Licensed Professional Clinical Counselors
- Licensed Nurses (e.g., Nurse Practitioners, Registered Nurses, Registered Credentialed School Nurses, Licensed Vocational Nurse)
- Physician Assistants

Non-licensed practitioners:

- Alcohol and Other Drug (AOD) Counselors[46]
- Community Health Workers[47]
- Registered Associate Marriage and Family Therapists
- Registered Associate Social Workers
- Registered Associate Professional Clinical Counselors

[43] See the published CYBHI Fee Schedule program scope of services, codes, and reimbursement rates for details

[44] Allowing for reimbursement of a specific service activity by a practitioner does not equate to deeming the activity within the provider's scope of practice under state law. All practitioners are obligated under state law, as well as the terms of their license and/or credential, to determine if a specific service activity is within their scope of practice.

[45] At this time, the following individual practitioners are not eligible to participate in the CYBHI Fee Schedule program: Unlicensed clinical trainees and bachelor's-level interns, Registered Behavioral Technicians (RBT), Licensed Vocational Nurses (LVN), Speech Language Pathologists (SLP), Occupational Therapists, and Board-Certified Behavioral Analysts (BCBA).

[46] Refer to AOD counselors certified by a National Commission for Certifying Agencies accredited organization

[47] Refer to All Plan Letter 22-016

- Registered Psychology Associates
- PPS Credentialed School Counselor
- PPS Credentialed School Psychologist
- PPS Credentialed School Social Worker
- Certified Wellness Coaches[48]

LEAs, IHEs, and designated community-based school-linked providers may only seek reimbursement for services if the provider is eligible for reimbursement for that specific service activity as specified in DHCS' published fee schedule and if the service performed is within the scope of practice of the practitioner under state law. Practitioner eligibility is not impacted by the practitioner's salary or wage source (e.g., federal match dollars or Elementary and Secondary School Emergency Relief Fund).

All designated community-based school-linked practitioners participating in the CYBHI Fee Schedule must meet the following requirements:

- Have appropriate licensure or credentials per the specific requirements for their field;
- Have a Type 1 individual provider NPI;[49, 50, 51] and,
- If they are an Ordering, Referring and Prescribing (ORP) practitioner with an existing Medi-Cal enrollment pathway, enroll in the Medi-Cal program as an ORP-only provider.[52]

National Provider Identifier Requirements

CYBHI Providers, including billing providers and rendering or furnishing providers, must obtain a National Provider Identifier (NPI) as a pre-requisite for participation in the CYBHI Fee Schedule program. The NPI is a unique, 10-digit identification number assigned to healthcare providers by the Centers for Medicare & Medicaid Services (CMS).[53] LEAs, IHEs, designated community-based school-linked providers, and individual practitioners need an NPI for various reasons, such as billing for services, compliance with regulations, or improving care delivery.[54]

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[48] For Medi-Cal reimbursement (only), pending approval of State Plan Amendment 25-0014
[49] According to 45 CFR 162.410
[50] Refer to CMS NPI Final Rule
[51] Refer to National Plan and Provider Enumeration System
[52] https://www.dhcs.ca.gov/provgovpart/Pages/Ordering_Referring_Prescribing_Providers.aspx
[53] DHCS does not assign NPIs
[54] For more information, please refer to CMS-approved resources on NPIs

There are two types of NPI numbers: Type I for individual practitioners/providers (e.g., PPS school psychologist, PPS school counselor, LCSW, CWC) and Type II for organizational providers (e.g., LEAs, IHEs, outpatient clinics). Each provider must select an applicable taxonomy code and apply for an NPI based on that taxonomy class.[55]

Applications can be submitted through the CMS National Plan and Provider Enumeration System (NPPES) website. The amount of time it takes to obtain an NPI is dependent upon the volume of applications being processed by CMS, whether the application was submitted electronically or by mail, and whether the application was complete and free of errors. That said, CMS states that a provider who submits a properly completed electronic application could receive an NPI in fewer than 10 business days. Paper application reviews take approximately 20 business days. Application errors may delay assignment. LEAs, IHEs, designated community-based school-linked providers or practitioners submitting applications online may track the progress of their application and will receive an email with its new NPI number when the application is processed and approved.

Ordering, Referring and Prescribing Practitioners

Federal law defines Medicaid services eligible for Federal Financial Participation (i.e., federal funding) as services that are "recommended by a physician or licensed practitioners of the healing arts within their scope of practice under state law…."[56] In addition, Medicaid rules require State Medicaid Agencies (DHCS) to enroll Ordering, Referring and Prescribing (ORP) providers in the state's Medicaid (Medi-Cal) program.[57] Contextually, a "referring provider" is the provider that "recommends" Medicaid services eligible for federal reimbursement. Billing providers are required to list the National Provider Identifier (NPI) of the provider who ordered, referred, or prescribed the services that are being billed.

It is not required for ORP providers to be employees of the LEA or IHE. In addition, ORP requirements are **only** applicable to the Medi-Cal program and Medi-Cal claiming. Claims for services furnished to students with commercial health insurance or disability health insurance do not require an ORP Provider to be listed on the claim.

[55] There are more than 800 taxonomies available covering multiple types of providers
[56] See 42 C.F.R. § 440.130(d)
[57] See ORP enrollment requirements

Clinical Supervision Requirements

Clinical supervision is distinct from the requirement that services be "recommended by a physician or licensed practitioner of the healing arts." The referral (or recommendation) of services by an ORP provider is a determination that the services are medically necessary and appropriate. The ORP requirements do not require that ORP providers "sign off" (i.e., co-sign) on treatment plans or progress notes.

Clinical supervision requirements vary based on the practitioner type and the practitioner's credential or license status. For example, clinical supervision by a licensed practitioner of the healing arts, as applicable under state law, is required for pre-licensed individuals (e.g., post-graduate associates). Clinical supervision is also required for non-licensed paraprofessionals (e.g.., CHWs, Wellness Coaches, AOD counselors) in accordance with state requirements.[58, 59, 60, 61]

In accordance with CMS guidance, DHCS is not imposing additional ***clinical supervision*** requirements for practitioners who hold a valid PPS credential in accordance with the California Commission on Teacher Credentialing.[62] PPS credentialed practitioners may only perform services authorized under their current scope of practice.[63,]

[58] Refer to DHCS "Medi-Cal Coverage of Community Health Worker (CHW) Services is Effective July 1, 2022"

[59] Refer to California Department of Health Care Access and Information (HCAI). "Wellness Coaches Model."

[60] Refer to DHCS All Plan Letter 22-016

[61] 2023 CMS guidance (Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming)

[62] ORP requirements still apply to PPS Credentialed practitioners for services furnished to Medi-Cal members

[63] Refer to Pupil Personnel Services Credential For Individuals Prepared In California (CL-606C)

Third-Party Administrator (TPA), MCP and Insurer Roles and Responsibilities

State law authorizes DHCS to contract with an entity to administer the school-linked statewide behavioral health provider network, administer claims and payment remittance, and support LEAs, IHEs, designated community-based school-linked providers and practitioners, and MCPs/insurers.[64] MCPs and Insurers must delegate certain functions to the state's TPA, Carelon Behavioral Health (CBH),[65] which will serve as the single statewide entity responsible for operational administration of the CYBHI Fee Schedule program. In this role, CBH will perform the following delegated functions:

- Create and administer a process for enrolling and screening all eligible practitioners and providers seeking to provide medically necessary schoolsite services described;
- Create and administer a process for the submission and reimbursement of claims eligible to be reimbursed as part of the CYBHI Fee Schedule program;
- Resolve disputes related to the CYBHI Fee Schedule program;
- Create and administer a mechanism for the sharing of data between CBH and MCPs and Insurers, that is necessary to facilitate timely claims processing, payment, and reporting; avoid duplication of claims; allow for tracking of grievance remediation; and facilitate coordination of care and continuity of care for MCP or Insurer enrollees;[66] and,
- Other functions specified by DHCS.

MCPs and Insurers that cover medically necessary CYBHI Covered Services must comply with all administrative requirements necessary to cover and reimburse those services set forth by DHCS and/or CBH.[67] To the extent that an MCP or Insurer has a direct contract with an LEA, IHE, or designated community-based school-linked provider of an LEA or IHE, the MCP or Insurer must comply with all administrative requirements necessary to cover and reimburse medically necessary schoolsite services subject to the CYBHI statutes.[68] This means that an MCP or Insurer that contracts directly with an LEA or IHE must comply with the CYBHI Fee Schedule program guidance and policies herein. Further, unless the MCP or Insurer has a direct contract with **all LEAs and IHEs** in the

[64] Welfare and Institutions Code § 5961.4(d)
[65] DHCS contracted (Agreement #23-30348) with CBH to serve as the state's TPA. CBH was selected through a completive Request for Information (RFI) process. Since January 2024, CBH has been, in partnership with DHCS, administering the operational framework for the CYBHI Fee Schedule program. See Appendix B for CBH's Scope of Work pursuant to its contract with DHCS.
[66] Welfare and Institutions Code § 5961.4(d)(2)
[67] Welfare and Institutions Code § 5961.4(f)(1)
[68] Welfare and Institutions Code § 5961.4(f)(2)

MCP or Insurer's service area, the MCP or Insurer must enter into all necessary agreements with the CBH, utilize DHCS-approved forms/templates, and streamline the provision and reimbursement of school-based behavioral health services in accordance with this guidance.

For additional information and detailed guidance about CBH-specific operational procedures, please visit Carelon Behavioral Health's CYBHI Fee Schedule program website.

Provider Network Oversight Functions

Upon approval by DHCS of an LEA, IHE, or designated community-based school-linked provider,[69] to participate in the CYBHI Fee Schedule program, CBH is responsible to carry out all applicable provider network oversight functions for all participating providers and practitioners.

LEAs and IHEs, and designated statewide affiliated providers, will submit to CBH a detailed Standard Provider Import (SPI) roster file that includes all organizational, group and individual providers participating in the CYBHI Fee Schedule program. CYBHI Providers are required to obtain a National Provider Identifier, Type I or Type II, as applicable (See Chapter 3.7 for more information). CBH will conduct state and federally mandated screening (and re-screening, as required) of all CYBHI providers utilizing DHCS-approved procedures.[70] CBH will provide DHCS with a roster of all active providers in the network and DHCS, in turn, will make the roster available to MCPs and Insurers.

CBH will also carry out quality reviews and oversight responsibilities, including conducting ongoing quality monitoring and oversight activities for each participating LEA, IHE, and designated community-based school-linked provider. CBH will monitor the network of designated providers/practitioners, including performance monitoring and upholding of quality standards that are consistent with broader Medi-Cal, commercial health plans, and disability insurers' requirements and any additional quality standards as outlined by DHCS as part of the CYBHI. Examples of CBH's performance monitoring activities may include, but are not limited to: reviewing claims data to identify services

[69] For additional information, see CYBHI Fee Schedule program Guidance for the Participation of Community Providers

[70] See CBH's CYBHI TPA Screening Process

trends; auditing for fraud, waste and abuse; reviewing grievances; and, reporting trends regarding provider disputes.

Claims Payment and Member Eligibility Verification

CBH will act as a claims clearinghouse for all enrolled and participating LEAs, IHEs, and designated community-based school-linked providers. All CYBHI Fee Schedule program claims must be submitted to CBH for adjudication and payment. Upon receipt, CBH will adjudicate the claims to determine if the claim meets the "clean claim" requirements in state law.[71] If the claim does not meet the "clean claim" requirements, CBH will deny the claim and return the claim unpaid to the billing entity. CBH will then work with the LEA, IHE or designated community-based school-linked provider to make necessary corrections and resubmit the claim for payment.

Once CBH adjudicates the claim and determines the "clean claim" is eligible for payment, CBH will pay the claim within state mandated timeframes for timely payments (see below).

Payment Timelines

LEAs, IHEs, and designated affiliated providers must submit claims to CBH no later than 180 days after the date of service to be eligible for reimbursement. Note: DHCS will allow for "good faith exceptions" to this requirement during an LEA or IHE's first year of participation. Exceptions may be made on a case-by-case basis. Further, Cohort 1 LEAs may submit claims with dates of services on or after July 1, 2024.

Once claims are submitted, CBH will review and adjudicate the claims. CBH will issue payments to the billing entity on an approved claim. Timelines for payment remittance begin once CBH has received a "clean claim."

CBH's payment timelines, as determined by the appropriate regulating entity, are detailed below (see Table 1):

[71] Per Title 42 of the Code of Federal Regulations (CFR), Section 447.45(b), the definition of "clean claim" is, "one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity." Refer to 42 CFR Part 447.45(b).

Table 1: Timely payment requirements

MCP or Insurer type	Timely payment requirement	Source
Medi-Cal – FFS and MCPs	No later than 30 calendar days after claim receipt by CBH for 90% of all clean claims In addition, 99% of all clean claims shall be paid within ninety (90) days of receipt	APL 23-020
Commercial full service health plans[72]	No later than 30 working days after receipt of clean claim by CBH (45 working days for HMOs)	CA Health and Safety Code section 1371
Disability insurance	No later than 30 working days after receipt of clean claim by CBH	California Insurance Code sections 10123.13 and 10123.147

Prior Authorization and Cost Sharing Prohibitions

MCPs and Insurers shall not require prior authorization for CYBHI covered services furnished to an individual under the age of 26, who is an enrollee of the MCP and Insurer, at a schoolsite.[73]

Continued Member Access to MCP/Insurer Services

MCPs and Insurers must not reduce member benefits or limit access to its outpatient behavioral health services provider network because a member is receiving services from an LEA, IHE, or designated community-based school-linked provider. Further, if a CYBHI Provider furnishing services to an enrollee through an LEA or IHE contacts the MCP or Insurer to request that the enrollee be seen by an in-network provider—either to 1) obtain services not available through the CYBHI Fee Schedule program or 2) to access a level of care beyond what can reasonably be provided in a school-linked setting—the MCP or Insurer must contact the member/enrollee to arrange an appointment with an in-network provider. If no in-network provider is available, the MCP or Insurer must arrange for an appointment with an out-of-network provider, pursuant to state law including any applicable laws regarding patient privacy,

[72] State law is changing in 2026 to revise this requirement to 30 calendar days per AB 3275. See DMHC's guidance

[73] Health and Safety Code § 1374.722(c)(1); Insurance Code § 10144.53(c)(1)

confidentiality, and sensitive services.[74] Use of CYBHI Fee Schedule services, however, does not create an obligation by the enrollee to transition to in-network care, and shall not prevent an enrollee from using both CYBHI Fee Schedule services and in-network behavioral health services concurrently.

Cost-Sharing Prohibitions

CYBHI covered services shall not be subject to cost-sharing, including co-payment, coinsurance, deductible or any other form of cost-sharing.[75] Neither an MCP, Insurer, LEA, IHE nor designated community-based school-linked provider may bill the enrollee or subscriber (i.e., the student or their parent/guardian) nor seek reimbursement from the enrollee or subscriber (i.e., the student or their parent/guardian) for the provision of CYBHI covered services.

Other Administrative Functions of the TPA

Member Grievances and Appeals

CBH is delegated for handling all member grievances and appeals pertaining to the CYBHI Fee Schedule program. This includes, but is not limited to:

- Receiving grievances and appeals from members regarding covered services.
- Investigating and resolving grievances and appeals in a timely manner as specified by applicable regulations.
- Documenting and maintaining records of all grievances and appeals and the resolutions provided.

CBH will develop and make available to LEAs and IHEs a single CYBHI Fee Schedule program member grievance form for use by members receiving services at a school-linked schoolsite.

When a grievance is received by CBH from an LEA, IHE, or designated community-based school-linked provider, CBH will promptly acknowledge its receipt, providing the student, and/or their authorized representative (e.g., parent or guardian),[76] if applicable,

[74] Health and Safety Code § 1374.72 and 1374.721; Insurance Code § 10144.5(d) and 10 Cal. Code Regs. section 2240.1(e).

[75] Health and Safety Code § 1374.722(c)(7) and (8); Insurance Code § 10144.53(c)(7) and (8)

[76] In the case of minor consent for services, CBH will work with the LEA, IHE or affiliated provider to resolve the grievance. When submitting the grievance on behalf of a student, who consented to services pursuant to state law, LEA's should indicate that the grievance is associated with minor consent to ensure appropriate handling of the grievance resolution.

and the submitting LEA, IHE, or affiliated provider with a reference number, a summary of the issue, and an estimated timeline for resolution. CBH will conduct a comprehensive review and investigation of the grievance related to covered services rendered as part of the CYBHI Fee Schedule program. This activity involves gathering necessary information and consulting with experts as needed to understand the issues thoroughly.

CBH will complete the investigation within state-regulated timeframes in accordance with state laws and regulations. At the conclusion of the investigation, CBH will make a determination about the appropriate resolution and communicate its decision, in writing, to the member. The written communication will include all required elements as specified in state and federal law.

CBH will log and track grievances, as well as document the resolution of the grievance. Records will be securely maintained according to regulatory requirements. CBH will provide regular reporting to DHCS on its grievance activities.

If it is determined that the grievance does not directly relate to the CYBHI Fee Schedule program and/or CBH's scope of work under its contract with DHCS, CBH will provide written notification to the member and the submitting entity notifying them that grievance has been forwarded to the applicable MCP or Insurer for resolution.

Since LEAs, IHEs, and designated community-based school-linked providers are out-of-network providers (unless the MCP or Insurer otherwise has a contract, whereby the contract would prevail), DHCS does not anticipate a high volume of adverse benefit determinations and/or member appeals. For any appeals received, CBH will adhere to similar processes as for grievances and in alignment with state and federal requirements pertaining to timelines and noticing.

Provider Dispute Resolution

CBH will oversee the provider dispute resolution processes,[77] in the event a provider has any dispute with respect to the performance or interpretation of the CYBHI Fee Schedule program requirements and/or state and federal claiming requirements. Any provider disputes that cannot be resolved by CBH will be escalated to DHCS, DMHC, and/or CDI, as applicable. Further escalation may be resolved through binding arbitration pursuant to the Rules of the American Arbitration Association for Arbitration of Commercial Disputes, as applicable.

Providers may utilize the provider dispute resolution process to dispute any of the following:

[77] https://s18637.pcdn.co/wp-content/uploads/sites/78/Provider-Dispute-Resolution-Form.pdf

- A claim that has been denied, adjusted or contested.
- Resolution of a billing issue, payment timeliness, or payment determination.
- Disputing a request for reimbursement of an overpayment of a claim.

LEAs, IHEs, and/or designated affiliated providers may submit provider disputes directly to CBH using the approved CYBHI Provider Claims Based Dispute Resolution Request form.[78] The form includes submission instructions. LEAs and IHEs may designate approved submitters (e.g., third-party billing entities) for the purpose of dispute resolution requests.

Each provider dispute submission will contain, at a minimum, the following information: provider's name, billing provider's tax ID number or provider ID number, provider's contact information, and:

- If the provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from CYBHI to a provider, the following must be provided: original claim form number (located on the Remittance Advice), a clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, or other action is incorrect.
- If the provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue.
- If the provider dispute involves a patient or group of patients, the name and identification number(s) of the patient or patients, a clear explanation of the disputed item, including the date of services and the provider's position on the dispute, and the patient's written registration for the provider to represent said benefits.

A provider dispute must be received by CBH within 365 calendar days of the date of the remittance statement. CBH will acknowledge the dispute within 15 business days if received by mail or two business days if received electronically of the date of receipt of the provider dispute. A provider dispute that does not include all required information may be returned to the submitter for completion. An amended provider dispute that includes the missing information may be submitted to CBH within 45 calendar days of receipt of a returned provider dispute. The written determination is sent within 45 business days of receipt of the provider dispute or the amended provider dispute.

[78] https://s18637.pcdn.co/wp-content/uploads/sites/78/Provider-Dispute-Resolution-Form.pdf

Minor Consent Management

As the state's health care authority, and the State Medicaid Agency, DHCS is uniquely aware of protected health information (PHI) protections pursuant to state and federal law, and we have taken several important steps to ensure student PHI and other sensitive data are appropriately collected, stored, transmitted, and shared in accordance with state and federal requirements, including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and California's Confidentiality of Medical Information Act.

The intersections between the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and California's Confidentiality of Medical Information Act pose unique challenges for LEAs and IHEs in determining which requirements prevail related to the provision of behavioral health services in a school setting. State and federal guidance is complex and there are many nuances in the state and federal laws.

Given the complexities, DHCS, in consultation with DMHC and CDI, instructed CBH to suppress all billing notifications to subscribers for the CYBHI Fee Schedule program. Given that cost-sharing is not permitted under the CYBHI Fee Schedule program, the billing notifications do not need to be provided to the subscriber. MCPs and insurers must also suppress all notifications to subscribers pertaining to services furnished as part of the CYBHI Fee Schedule program.[79]

[79] For avoidance of doubt, all notifications about services for all students will be suppressed.

Conditions of Participation for LEAs, IHEs, and Designated Providers

DHCS is implementing the CYBHI Fee Schedule program in a cohort model. On a bi-annual basis, LEAs and IHEs may apply with DHCS to participate in a cohort. All LEAs and IHEs participating in the CYBHI fee schedule must meet the following requirements:

- Be certified public educational institutions;[80,81]
- Have a type 2 organization NPI as a HIPAA-covered entity;[82,83,84] and,
- Be enrolled in Medi-Cal.

Further, as a condition of participation, LEAs and IHEs, as well as certain designated providers, must complete the following billing pre-requisites:

1. Complete a DHCS Provider Participation Agreement (PPA) and enroll in the Medi-Cal program.
2. Execute a Data-Use Agreement (DUA) with CBH.
3. Establish a secure file transfer protocol (sFTP) connection (e.g., ProviderConnect[85] account) with CBH.
4. Create an Availity[86] account for claims submission to CBH.
5. Submit a Standard Provider Import (SPI) Roster to CBH.
6. Collect and submit student health insurance information to CBH using the student batch registration file.

Provider Participation Agreement and Medi-Cal Enrollment

LEAs, IHEs, and designated affiliated providers must be enrolled in the state's Medi-Cal program to be eligible to participate in the CYBHI Fee Schedule program. [87] To enroll in the Medi-Cal program, an LEA or IHE must do the following:

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[80] As defined in 34 CFR 303.23
[81] As defined in 34 CFR 600.4
[82] According to 45 CFR 162.410
[83] Refer to CMS NPI Final Rule
[84] Refer to National Plan and Provider Enumeration System
[85] ProviderConnect is a secure file transfer portal (SFTP)
[86] Availity is the claims submission interface used by CBH. See CBH's webpage for additional information about Availity: https://cybhi.carelonbehavioralhealth.com/providers/provider-training-materials-and-resources/provider-claims-and-availity/
[87] This requirement does not apply to LEAs or IHEs that are participating members in a consortium model and will not be included as the "billing provider" on any claims

- Obtain a Type II NPI; and,
- Submit to DHCS a CYBHI Fee Schedule Program Provider Participation Agreement (PPA) and Business Associates Addendum (BAA).[88]

Upon receipt, DHCS will process the agreement and add the approved LEA or IHE to the DHCS Provider Master File (PMF). Designated affiliated providers must enroll in Medi-Cal independently through the Provider Application and Validation for Enrollment (PAVE) system via an existing Medi-Cal enrollment pathway.[89] CYBHI billing providers must have a CYBHI Fee Schedule program designation in the PMF prior to submitting claims for reimbursement.

If the LEA, IHE, or designated affiliated provider is already enrolled in the state's Medi-Cal program, it must still complete a modified CYBHI Fee Schedule program Provider Participation Agreement to be eligible for CYBHI Fee Schedule program reimbursement.

Consortium Models

LEAs and IHEs may enroll in the CYBHI Fee Schedule program individually, or as part of a consortium. A consortium model may be beneficial for LEAs and IHEs that can share or already have shared administration services for claims submission and reimbursements. LEA or IHEs that share a common designated community-based school-linked provider and practitioner base may also benefit from participating in a consortium.

In a consortium, one Lead LEA or one Lead IHE serves as an intermediary between the participating Consortium members (participating member LEAs) and CBH. The specific consortium model may vary depending on which program requirements (e.g., data sharing, submitting claims, receiving reimbursement) are delegated to a Lead LEA or IHE by its participating members. For example, the Lead LEA or IHE may be responsible for collecting and submitting required pre-requisite documentation[90] and claims, as well as receiving and distributing payments on behalf of consortium members.

Only the Lead LEA / IHE is required to be Medi-Cal enrolled in a consortium if the participating members will not submit claims to or receive reimbursement directly from CBH. Therefore, the consortium model provides a path for LEAs or IHEs that are not currently Medi-Cal enrolled to participate in the CYBHI Fee Schedule program.

To build a consortium within the CYBHI Fee Schedule program, Lead LEAs / IHEs and participating members must complete the following minimum steps (note that there

[88] Please email DHCS at DHCS.SBS@dhcs.ca.gov to request a copy of the PPA. See the example PPA
[89] For additional information, see Guidance for the Participation of Community Providers.
[91] See DUA templates and trainings for more information

may be additional requirements depending on the division of responsibilities between Lead and participating member LEAs / IHEs):

- Identify a consortium Lead and participating members.
- Lead obtains a Type II National Provider Identifier (NPI).
- Lead submits a signed PPA to DHCS.
- Lead signs two-party Data Usage Agreement (DUA) with CBH.
- Lead sets up Secure File Transfer Protocol (SFTP) connection (e.g., ProviderConnect) with CBH.
- Lead sets up Availity account.
- Lead collects attestation letters from participating member LEAs / IHEs and submits them to DHCS.
- Participating member(s) sign modified PPA or full PPA, depending on delegation model.

Operationally, Lead LEAs / IHEs and participating members will collaborate to design the consortium model and determine roles and responsibilities for CYBHI Fee Schedule program. Lead LEAs / IHEs will inform DHCS and CBH about the selected delegation model for the Consortium.

Data-Use Agreement (DUA)

LEAs and IHEs must execute a DUA with CBH.[91] The DUA enables data-sharing, including exchange of protected health information (PHI) in compliance with HIPAA requirements. If an LEA or IHE is working with a third-party billing entity or is the lead LEA of a billing consortia, the LEA or IHE should execute a tri-party DUA that includes any third-party billing entities and/or consortium participating members.

CBH's Provider Relations (PR) team can answer LEA or IHE questions about which DUA is the right vehicle for the LEA or IHE depending on their specific circumstances. To set up a call with a PR team member, please contact CBH at CYBHITPA@carelon.com.

Standard Provider Import (SPI) Roster

LEAs, IHEs and designated affiliated providers must submit to CBH a provider roster that lists all participating individual and group (i.e., community-based school-linked) providers. The provider roster, or Standard Provider Import (SPI) roster, submission will enable CBH to conduct mandatory screening of all providers to determine eligibility for

[91] See DUA templates and trainings for more information

the program. Providers must be listed on the SPI roster submitted by the LEA, IHE or designated affiliated provider before claims are submitted for services rendered (furnished) by that provider. If the provider is NOT listed on the SPI roster, CBH will deny the claims until such time as the provider or practitioner is added to the SPI roster.

As such, submission of the SPI roster by participating LEAs, IHEs, and designated affiliated providers is a required pre-requisite for billing. Upon submission, the LEA, IHE or designated affiliated provider may proceed with submitting claims for those providers listed in the SPI roster. It is NOT necessary for the LEA, IHE or designated affiliated provider to wait for approval or results of the screening process from CBH. CYBHI Providers may participate and submit claims for reimbursement as part of the CYBHI Fee Schedule program for up to 120 days while the screening process is underway. CBH will notify the LEA, IHE or designated affiliated provider if any of the listed providers did not pass the screening requirements. If that occurs, that provider will no longer be eligible to participate in the CYBHI Fee Schedule program. LEAs, IHEs, and designated affiliated providers may dispute any such findings by following the instructions provided by CBH in the notification. Although routine updates of the SPI roster are not specifically required, an LEA, IHE or designated affiliated provider may update its SPI roster as often as necessary to ensure its providers are appropriately identified and screened for participation in the CYBHI Fee Schedule program, including employed individual providers or contracted individual or group providers (e.g., community-based providers). Best practices for updating the SPI roster include, but are not limited to, the following:

- The LEA, IHE or designated affiliated provider has staffing changes (e.g., new hires, staff terminations or resignations) that necessitate a change in the SPI roster data.
- The LEA or IHE contracts with a new community-based provider.
- The provider data (e.g., licensure or credential status) is outdated, inaccurate, or otherwise requires updates.

To ensure all providers are duly eligible for reimbursement as part of the CYBHI Fee Schedule program, DHCS recommends LEAs, IHEs and designated affiliated providers develop protocols for regular updates to the SPI roster file and submission to CBH.[92]

[92] The CYBHI Fee Schedule program PPA requires a monthly submission frequency, or another frequency specified by DHCS. This guidance supersedes the PPA.

For additional information on completing the SPI roster, please visit CBH's SPI roster webpage. For additional information about designating community-based school linked providers, please review DHCS' Guidance for the Participation of Community Providers.

Collect and Submit Student Health Insurance Information

LEAs, IHEs and certain designated providers will need to collect and transmit student health insurance information for eligible members (students) to CBH using the student batch registration file and must establish policies and procedures for collecting, storing and transmitting student health insurance information to CBH. The policies and procedures may include systems and strategies to proactively collect student health insurance information from eligible members and/or their authorized representatives, as applicable; and/or to collect student health insurance information at the point of service.

LEAs and IHEs are NOT required to collect student health insurance information for all students enrolled in the district or campus; it is only for students for whom the LEA or IHE is seeking reimbursement for services as part of the CYBHI Fee Schedule program. The required information can be collected, and updated as necessary, from the student and/or their parent or legal guardian at the time of service or before claims for reimbursement are transmitted to CBH. In addition, DHCS and CBH are committed to ensuring that only the minimum necessary data are required to be reported.

Early participants in the CYBHI Fee Schedule program will likely need to collect and report more data points at the beginning of the CYBHI Fee Schedule program to match students to the appropriate MCP or Insurer. In the future, fewer data points will be required as CBH and MCPs/Insurers implement new system interfaces that make it easier for CBH to match student records to health plan/insurer enrollment data. However, that infrastructure will take time to implement, and, in the meantime, LEAs will need to provide MCP and Insurer-specific details for the student (e.g., plan/insurer name, policy and group number, subscriber information) to submit claims for reimbursement.

LEAs, IHEs, and designated affiliated providers must submit a student's health information using the student batch registration file to CBH at least 24 hours prior to submitting a claim for that student. Student health information that has not changed does not need to be resubmitted if it was included in a prior student batch registration file transmission.

Other LEA and IHE Participation Requirements

Care Coordination

Pursuant to the CYBHI Fee Schedule program Provider Participation Agreement,[93] LEAs, IHEs, and designated community-based school-linked providers must coordinate care delivery with the student's MCP or Insurer and/or the county behavioral health agency (as applicable for Medi-Cal members) when any of the following conditions are met:

- The student is experiencing a mental health crisis or is a danger to themselves or others. The CYBHI Provider is made aware by the student or the student's legal representative that the student is actively engaged in behavioral health services with a network provider of the MCP or Insurer.
- A CYBHI Provider determines that the student requires a referral to a level of care that is not available or appropriate in the school-linked setting (e.g., inpatient or residential treatment).
- A CYBHI Provider determines that the student would benefit from evidence-based therapies that the CYBHI Provider does not have the capacity, training, or licensure necessary to furnish.
- The student requires continuation of services during a period when the CYBHI Provider is out-of-session (e.g., summer or winter holidays) or otherwise unable to provide timely access to medically necessary treatment.
- The student and/or the student's legal representative requests a referral.

CYBHI Providers must agree to share relevant and applicable treatment records (e.g., assessments/presenting issues, screening outcomes, treatment plans, IEPs) and, when necessary, provide professional to professional consultation to ensure a student's MCP or Insurer network provider has the necessary documentation, information, and data necessary to provide clinically appropriate treatment to a student who is also receiving psychoeducation, screening, treatment, and/or care coordination services from the CYBHI Provider. Note: To comply with FERPA, it may be necessary for the CYBHI Provider to obtain applicable consents before sharing treatment records. A release of information may be necessary to facilitate information sharing for the purposes of care coordination.

CBH will assist MCPs and Insurers, as well as LEAs, IHEs, and designated community-based school-linked, with care coordination activities, including providing the MCP or Insurer or the LEA, IHE, or designated community-based school-linked provider with necessary data, facilitating connections between the MCP or Insurer and the LEA, IHE, or designated community-based school-linked provider, or other activities as appropriate.

[93] CYBHI Fee Schedule program Provider Participation Agreement

When notified, MCPs and Insurers are responsible for coordination of care in accordance with state and federal requirements, as applicable. For example, if a student receives services both under and outside of the CYBHI Fee Schedule, it is the responsibility of the MCP or Insurer to coordinate services for that student and communicate with all involved stakeholders as needed (e.g., providers, caregiver) to ensure student needs are being met.

Claiming and Billing Guidance

MCPs and Insurers must reimburse LEAs, IHEs, and designated community-based school-linked providers, for the provision of ***medically necessary*** CYBHI covered services to a student, who is an enrollee of the MCP or Insurer, when services are delivered at a schoolsite.[94] An MCPs or Insurer must provide reimbursement at the greater of the following amounts:

- The fee-for-service reimbursement rate published by DHCS pursuant to Welfare and Institutions Code Section 5961.4(a);[95] or,
- The MCP or Insurer's contracted rate with an LEA, IHE or designated community-based school-linked provider. NOTE: The state's TPA will only reimburse eligible providers at the rates published in DHCS' fee schedule. MCPs and Insurers will reimburse LEAs, IHEs, or designated community-based school-linked providers at contracted rates only when claims for reimbursement are submitted directly to the MCP or Insurer for payment.

This requirement applies to MCPs and Insurers even when the MCP or Insurer has a direct contract with an LEA, IHE or designated community-based school-linked provider participating in the CYBHI Fee Schedule program.

LEAs and IHEs, as well as their third-party billing vendors and designated providers and practitioners, must comply with all claiming and billing requirements for the CYBHI Fee Schedule program. CBH offers extensive training and technical assistance to LEAs and IHEs regarding claiming and billing.[96] Requests for additional training and technical assistance can be made to CBH at CYBHITPA@carelon.com.

Claims Submission Requirements

CYBHI Fee Schedule program claims must be submitted to CBH for reimbursement, unless the LEA, IHE or designated community-based school-linked provider has a direct contract with an MCP or Insurer.[97] CBH's claims submissions platform, Availity Essentials,

[94] See Health and Safety Code § 1374.722(b)(6)
[95] See "CYBHI Fee Schedule Scope of Services, Codes and Reimbursement Rates"
[96] Reference the Carelon Behavioral Health website for claiming and billing guidance
[97] If a provider has a direct contract with an MCP or insurer, it may continue to bill that MCP or insurer directly pursuant to those contract terms. Per Welfare and Institutions Code 5964.1, MCPs or insurers with direct contracts must reimburse providers at or above the CYBHI Fee Schedule program rate for a given behavioral health service. CBH does not track claims that are submitted directly to an MCP or insurer by providers.

is a secure, one-stop, self-service portal for direct data entry claims submissions (i.e., single manual-entry claims) and electronic data interchange (EDI) claims (i.e., bulk claims transactions) using the Availity EDI Clearinghouse. Detailed trainings, quick start guides, and tutorials are available on CBH's website.[98]

Claims Submission Format Requirements

CYBHI Providers can submit claims to CBH via three methods:

1. **Electronic, manual claim entry:** Providers complete the claims form for each individual claim on Availity, a secure, one-stop portal utilized by CBH for direct data entry claim submissions and tracking.
2. **Electronic Data Interchange (EDI) Clearinghouse connection**: Providers securely submit batch files of X12 EDI transactions through a secure file transfer protocol (SFTP) or through Availity Essentials.
    a. **Note:** X12 EDI transactions, also known as ASC X12, are standardized electronic data interchange (EDI) formats used to electronically exchange information between healthcare providers, MCPs and insurers, and clearinghouses, as mandated by HIPAA, for tasks like claims and payments.
3. **Paper CMS 1500 claims**: Provider completes a paper-based CMS-1500 professional claim form and mails claims to: Carelon Behavioral Health, Woburn Claims, PO Box 1866, Hicksville, NY 11802.

For questions on how to set up or use any of these methods, contact Carelon Behavioral Health at CYBHITPA@carelon.com.

Timely Claims Filing Requirements

To be eligible for reimbursement CYBHI Providers must submit claims to CBH no later than 180 days from the date of service. Approximate dates and timely filing deadlines are detailed in the table below.

[98] See https://cybhi.carelonbehavioralhealth.com/providers/provider-training-materials-and-resources/provider-claims-and-availity/

Table 2: Timely Filing Deadlines

Date of Service	Timely Filing Deadline
July 1st	December 28th
August 1st	January 28th
September 1st	February 28th
October 1st	March 30th
November 1st	April 30th
December 1st	May 30th
January 1st	June 30th
February 1st	July 31st
March 1st	August 28th
April 1st	September 28th
May 1st	October 28th
June 1st	November 28th

Claims submitted for behavioral health services after 180 days from the date of service may be accepted on a case-by-case basis for "good cause" (e.g., technical difficulties during the CYBHI Fee Schedule program onboarding process) as determined by the state. Please contact DHCS at DHCS.SBS@dhcs.ca.gov to request a good cause exception.

Payment for approved claims

CBH will authorize payment for approved claims and payment will be made to the billing provider listed on the claim form. The first payment will be sent as a paper check to the mailing address listed in the 'Billing Provider' field. After receiving the first payment via paper check, the billing provider can choose to receive subsequent payments electronically from CBH. Instructions for setting up electronic payments will be included with the first paper check.

Explanation of Payment (EOP)

An Explanation of Payment (EOP) is a document containing claims payment summary information. Once CBH has processed the claim, the EOP information is shared with the

provider in a Provider Summary Voucher (PSV) that can be accessed electronically or mailed to the billing provider. Contact CBH at CYBHITPA@carelon.com for additional information on how to access these documents.

Information included in the EOP and PSV includes, but is not limited to:

- Dates of service for CYBHI Fee Schedule program behavioral health services provided;
- Amount paid to provider for behavioral health services provided to students on dates of service;
- Descriptions or notes on specific issues with denied claims; and
- Provider Dispute Resolution information and contact information.

Note: Explanation of benefits (EOBs) documents are typically sent to health plan members explaining how reimbursement was determined for behavioral health services received and any remaining member share of cost. However, EOBs will be suppressed for claims submitted as part of the CYBHI Fee Schedule program to preserve student confidentiality. There is no student and family cost-sharing for behavioral health services received as part of the CYBHI Fee Schedule program.

Reasons for Denials of Claims, Audits and Overpayment Recovery

LEAs, IHEs and designated affiliated providers, or third-party billing entities on behalf of a CYBHI provider, must submit a Clean Claim to be eligible for reimbursement. A Clean Claim is a claim for covered services that has no defect, impropriety, or lack of substantiating documentation. This means that the claim is complete and includes all required fields and data elements for the claim, as indicated on the standard CMS-1500 format (or electronic HIPAA-compliant 837 transaction).[99]

The claim must include the information necessary to meet the requirements for encounter data (clinical information and data with content and in a format that comports with the HIPAA 837 requirements) using a completed CMS-1500 form or respective successor forms or alternative electronic equivalents (which electronic equivalents must comport with all HIPAA Administrative Simplification Act requirements for electronic transactions). Claims or bills from a participating Provider who is under

[99] https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1500.pdf

investigation for fraud or abuse, or otherwise ineligible to participate in the Medicaid program, are not Clean Claims.

In addition, the CYBHI statutes permit MCPs and Insurers, or CBH on behalf of the MCPs and Insurers, to conduct a post-claim review to determine appropriate payment of a CYBHI Fee Schedule program claim; however, payment may be denied only if CBH, the MCP, or Insurer reasonably determines that the services were provided to a student not covered by the MCP or Insurer, were never performed, or were not provided by a health care provider appropriately licensed or authorized to provide the services.[100] The statute does not permit MCPs and Insurers to deny a claim because the MCP or Insurer determines, as part of a post-claim review, the service was not medically necessary.[101]

Claims that are denied because of clean claim errors (e.g., claim is missing the rendering provider's NPI), provider eligibility (i.e., the provider was not listed on the LEA, IHE or designated affiliated provider's SPI roster), or student eligibility errors (i.e., inaccurate student health insurance information was furnished to CBH) may be corrected and resubmitted to CBH for payment.

Duplicate claims

LEAs, IHEs, and designated affiliated providers are responsible for ensuring duplicate claims are not submitted for payment. Providers may not duplicate claims for the same student with the same date of service and procedure codes, including as follows:

1. Within the CYBHI Fee Schedule program (i.e., same claim submitted multiple times to CBH);
2. Between the CYBHI Fee Schedule program and any direct contracts with MCPs and Insurers; and
3. Between the CYBHI Fee Schedule program and other state-or federally funded programs (e.g., the Local Educational Agency Medi-Cal Billing Option Program).

If a CYBHI provide submits an identical claim for payment to both CBH and the MCP or Insurer, CBH is the primary delegated payer in all such instances. The MCP or Insurer must either deny the claim or, if identified as part of a post-payment audit, issue an overpayment and recoup the funds, if applicable.

[100] Health and Safety Code § 1374.722(c)(2); Insurance Code § 10144.53(c)(2)
[101] For additional information, see DMHC APL 23-026 and CDI guidance AB 133

Duplicate claims are not permitted and will be denied.[102] Both CBH and MCPs or Insurers may identify and deny duplicate claims as they are reviewed or upon subsequent audits. CYBHI Providers that erroneously receive payment for duplicate claims (i.e., overpayment) may be required to return duplicate payments to the respective program, MCP, or Insurer, as applicable.

Post-payment audits of claims and overpayment recovery

Although the CYBHI statutes limit the reasons that a claim may be denied, CYBHI Fee Schedule claims may be subject to a post-payment audit to verify the claim's validity. Either CBH, the MCP or Insurer, and/or DHCS may conduct a post-payment audit of LEA, IHE or designated community-based school-linked provider records and claims. LEAs, IHEs and designated community-based school-linked providers must retain CYBHI Fee Schedule program documentation for a period of ten (10) years in accordance with federal Medicaid requirements.[103]

Overpayments may occur if a claim is initially paid by CBH but subsequently there is a determination that the claim was not eligible for payment (see reasons for denials above). When an overpayment occurs, the billing provider is responsible for returning the payment.

Illustrative example of a valid overpayment
An LEA or IHE reports a student's health insurance on the student batch registration template and subsequently submits a clean claim for payment. CBH adjudicates the claim and remits payment, but later determines the student was not enrolled in the identified health plan on the date of service. In this scenario, CBH must recoup the funds paid in error. If applicable, the LEA or IHE may resubmit the claim for payment with the corrected health insurance information.

Overpayments may result from any of the following:

- Claims paid in error.
- Claims allowed or paid greater than billed.
- Duplicate payments.
- Payments made for individuals (i.e., students or family members of students) whose benefit coverage is or was terminated.

[102] DHCS remittance advice details code 010: Denials for Duplicate Claims
[103] 42 C.F.R. § 438.3(h)

- Payments made for behavioral health services in excess of applicable benefit limitations.
- Claims submitted contrary to national and industry standards such as the CMS National Correct Coding Initiative (NCCI) and medically unlikely edits (MUE) described in the Claims Submission Guidelines.
- Fraud, waste or abuse.
- As a result of a post-payment audit, it is later determined to be ineligible for payment.

CBH will recover overpayments by either:

- Creating of a negative balance for the CYBHI Provider in Availity by CBH. Future claims payments may then be offset by the amount of the overpayment; or,
- Notifying the CYBHI Provider, in writing, of the overpayment and requests repayment.

Service Documentation Requirements

CYBHI providers should document services in alignment with clinical practice standards for the profession. For example, the provider should determine if it is appropriate and necessary to develop a problem list or treatment plan based on the clinical practice standards and the needs of the student. At a minimum, as a condition of participation in the CYBHI Fee Schedule program, LEAs and IHEs must comply with service documentation and availability of records requirements specified in Medi-Cal regulations,[104] including maintenance of records necessary to fully disclose the type and extent of services provided, such as:

- Billings.
- All health records, service delivery reports, and orders prescribing treatment plans.
- Copies of all remittance advices (i.e., explanation of payment or payment summary vouchers)[105] which accompany reimbursement to providers for services furnished to students.
- Identification of the person directly providing services to the student. For non-licensed practitioners (e.g., ACSW) working under the direction of a licensed

[104] Cal. Code Regs. tit. 22 § 51476(a) and (f); DHCS Provider Regulations (April 2021)
[105] See Section 6 for more information

practitioner (e.g., LCSW), this includes the supervising licensed practitioner to the extent required by the applicable professional licensing statutes and regulations.
- Records of logs, appointment books, or similar documentation showing the date and time allotted for appointment of each individual or group of individuals and the time actually spent with such individuals or groups.

LEAs and IHEs participating in the CYBHI Fee Schedule program are not required to complete annual cost reports (e.g., Cost and Reimbursement Comparison Schedule) or participate in Random Moment in Time Surveys (RMTS), as is required for LEA BOP.

Other Information to Know Before Submitting a Claim

Third-Party Billing Entities

LEAs and IHEs may opt to use a third-party entity to submit claims on their behalf. If a third-party entity submits claims on behalf of an LEA or IHE, the LEA or IHE's NPI (Type II) will be included on the claim as the billing provider. Remittance (i.e., payment) for claims will be sent only to the billing provider listed on the claim.

Note: This may also apply to a Lead LEA or Lead IHE for a Consortia; however, the Lead LEA or IHE may opt to receive the remittance as a billing provider and subsequently remit payment to the participating member LEA/IHE; OR, the Lead LEA/IHE may alternately list the participating member LEA/IHE as the billing provider so that the participating member LEA/IHE receives the remittance directly. This will depend on the delegation model and terms of any agreements between the Lead LEA/IHE and the participating member LEA/IHE.

Obtaining Consent for Billing

If required, CYBHI Providers must obtain consent to submit claims for reimbursement. However, CYBHI Providers are not required to attach any consent or care plan documents with claims submitted as part of the CYBHI Fee Schedule program.

Billed Time Increments – Midpoint Rule

Some behavioral health services are billed based on time increments, and some billing codes are linked to a specific length of time or time range. Services may be billed to the CPT code with the appropriate time increment. In order to be eligible, the service must have lasted at least half + one minute of the billing increment specified for that code. This is known as the "mid-point rule." For example, to be eligible for reimbursement, a psychotherapy session with an individual, 16-37 minutes (procedure code 90832; rate $67.83), the service must have a duration of at least 9 or more minutes.

If the provider furnishes a psychotherapy session with an individual with a service duration of 40 minutes (per session), the provider will have met the minimum required mid-point to claim reimbursement for the psychotherapy session, individual, 53+ minutes (procedure code 90837; rate $131.97). However, in the case of psychotherapy codes, there is a code with a service duration of 38-52 minutes (procedure code 90834; rate $89.64). If there is a code option with the appropriate timeframe that matches the service delivered, the provider/LEA should select that code option and not submit a claim for reimbursement at the higher rate because of the midpoint. Here, the provider of the 40 minute psychotherapy session should submit under procedure code 90834 for the 38-52 minute service duration.

All procedure codes that pay providers based on time include a definition of how many minutes (e.g., 15 minutes) equal one unit of that service. For codes that are billed per 15 minutes, a minimum of eight (8) minutes of service must be provided to bill for one unit – this is known as the 8-minute rule. Partial units must be rounded up or down to the nearest quarter hour.

Note: Time billed for reimbursable behavioral health services should include only direct service time, which should be documented in the medical or student record to identify "time spent" with the individual receiving services. Indirect service time has been included in the reimbursement rate and should not be billed.

Diagnosis Codes on the Claim

In alignment with DHCS policy for the provision of services without a diagnosis, there is no CYBHI requirement for providers to diagnose students. The requirement for a diagnosis code; however, is a federal claiming requirement. CYBHI Providers can use the codes below when services are provided but a diagnosis is not determined:

ICD-10 code(s)	Description for usage
F99	"Other specified" and "Unspecified" disorders may be used in cases where behavioral health services are provided due to a **suspected disorder that has not yet been diagnosed**
Z55-Z65	"Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate **during the assessment period prior to diagnosis** and do not

	require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA)
Z03.89	"Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

Note: For additional instructions on ICD-10 F codes, please see the ICD-10-CM Official Coding Guidelines.

Application of Service Code Billing Limitations

Service limitations refer to non-frequency related restrictions or limits placed on a specific procedure or behavioral health service (e.g., only reimbursable for children of a certain age), often enforced by MCPs and insurers to ensure appropriate care. Some CYBHI Fee Schedule program codes have service limitations. See Appendix B for additional details about service code billing limitations.

Checking for claims that are rejected for insufficient information (claims submitted through Availity only)

Due to Health Insurance Portability and Accountability Act (HIPAA) regulations, claims that are electronically submitted through Availity may be rejected if the student information on the claim does not match information submitted to CBH (e.g., student is not listed on the LEA's student batch registration file).

Such claims will be flagged as "rejected" in the Availity provider portal. Billing providers must fix all such errors in Availity before the claim can be resent to CBH for processing.

Required Billing Code Modifiers

CYBHI Providers must include the modifier 'U4' on all CYBHI Fee Schedule program claims. Claims will not be reimbursable if the 'U4' modifier is missing from the claim and CBH will reject the claim.

Other potential modifiers for use in the CYBHI Fee Schedule program

Modifier	Description

U4	Required on all CYBHI Fee Schedule program claims; modifier allows DHCS and CBH to identify claims as CYBHI Fee Schedule program behavioral health services.[106]
93	Telehealth modifier: Required for behavioral health services provided via synchronous telephone or other real-time interactive audio-only telecommunications system. *For more information on telehealth services, visit DHCS Medi-Cal and Telehealth website.*
95	Telehealth modifier: Required for behavioral health services provided via synchronous, interactive audio and visual telecommunications systems
U1	Dyadic behavioral health services modifier: Required for dyadic behavioral health services provided to the caregiver of an eligible student ages 0-20 [CPT codes 96127, G9919, G9920, G0442, G8431, G8510, 96156, 90791, T1027, and H2027] *For more information on telehealth services, visit Dyadic Services as a Medi-Cal Benefit website.*
HA	Psychoeducation modifier: Required for individual psychoeducational services [CPT codes H2014 and H2027]
HQ	Psychoeducation modifier: Required for group psychoeducational services [CPT codes H2014 and H2027]
U2	Provider-specific modifier: Required for behavioral health services rendered by a Community Health Worker [CPT codes 98960, 98961, and 98962]

Dual enrollment in the CYBHI Fee Schedule program and the LEA Billing Options Program (LEA BOP)

For LEAs and IHEs participating in both programs, behavioral health services not pursuant to an Individualized Education Plan (IEP)/Individualized Family Services Plan (IFSP) should be billed to the CYBHI Fee Schedule program. Behavioral health services pursuant to an Individualized Education Plan (IEP)/Individualized Family Services Plan (IFSP) should be billed through LEA BOP, including billing codes using the modifiers 'TM'

[106] Identification of CYBHI covered services on the claim will also ensure appropriate suppression of billing notifications in accordance with Section 4.4 of this Manual.

(IFSP) or 'TL' (IEP). Covered physical health services for Medi-Cal enrolled students, under the age of 22, may be covered as part of the LEA BOP.[107]

NOTE: Participation in both the CYBHI Fee Schedule Program and the LEA BOP will maximize reimbursement to LEAs and IHEs. For more information, please contact DHCS at DHCS.SBS@dhcs.ca.gov

[107] https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/LEA%20BOP/Program Req and Info/LEAProgramOverview.pdf

HIPAA/FERPA and Data Sharing

Federal laws and regulations

All participants in the CYBHI Fee Schedule program (MCPs and Insurers, LEAs, IHEs, designated community-based school-linked providers, and CBH) must adhere to all applicable federal laws and regulations regarding confidentiality and protection of health and education information. The CYBHI Fee Schedule program does not alter existing laws or regulations.

Family Educational Rights and Privacy Act (FERPA)

FERPA protects the privacy of students' education records held by "educational agencies or institutions" that receive federal funds under programs administered by the U.S. Department of Education (ED) and either provide direct instruction or educational services to students. These include schools and educational agencies that direct or control schools, such as school districts, county offices of education, and state education departments.[108]

FERPA controls the disclosure of individually identifiable student information maintained in the "education record." An "education record" is defined as records, files, documents, and other materials that contain information directly related to a student and are maintained by an educational agency or institution, or by a person acting for such agency or institution.[109] In California, the term "pupil record" is often used as well.[110]

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is a federal law that protects the privacy of individually identifiable health information held by "covered entities."[111,112] HIPAA defines "covered entity" as health plans, health care clearinghouses, and health care providers who transmit health information in electronic form for certain transactions.[113]

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[108] 34 C.F.R. § 99.1.
[109] 34 C.F.R. § 99.3.
[110] See Ca. Ed. Code § 49060 et seq.
[111] HIPAA covered entities in the context of schools can be private schools, schools that provide healthcare services to the public, and schools that conduct transactions electronically outside of the education record.
[112] 45 C.F.R. §§ 160.102, 160.103.
[113] 45 C.F.R. § 160.103.

HIPAA has several regulations, or "Rules," including the Privacy Rule, Security Rule, and the Enforcement Rule. The HIPAA Privacy Rule sets national standards for the confidentiality of protected health information (PHI) held by covered entities. The HIPAA Security Rule imposes rules for the confidentiality, integrity, security, storage and exchange of *electronic* protected health information (ePHI) held by covered entities, including Electronic Health Records (EHRs).[114]

The HIPAA Privacy Rule protects sensitive patient health information from being disclosed without the patient's consent or knowledge. Covered entities subject to the Privacy Rule include:[115]

- Healthcare providers who electronically transmit health information in connection with certain transactions (e.g., claims, referrals)
- Health plans, including health insurers and Medicaid insurers
- Healthcare clearinghouses who process health information
- Business associates who perform functions or provide services for other covered entities (e.g., claims processing, data analysis, billing).

In the context of schools, HIPAA covered entities could include private schools, schools that provide healthcare services to the public, and schools that conduct transactions electronically outside of the education record. LEAs and IHEs participating in the CYBHI Fee Schedule program could be considered HIPAA covered entities because electronic transmission of claims to the TPA would qualify the LEA or IHE.

Intersection of FERPA and HIPAA

NOTE: This section is meant to provide guidance only. Always include legal counsel in discussions related to the law. Legal decisions should not be made without their guidance.

FERPA and the HIPAA Privacy Rule will never apply to the same record at the same time.

[114] See 45 C.F.R. § 164.302 et seq. It is important to understand whether, when, and how the HIPAA Security Rule applies, as well as all its technical requirements, when selecting health information systems and developing electronic data storage and exchange policies and practices, to ensure compliance with federal law.

[115] Refer to Covered Entities and Business Associates, U.S. Department of Health and Human Services

HIPAA explicitly states that its rules do not apply to individually identifiable health information held in an education record subject to FERPA.[116] This means that if FERPA applies to a particular record, the HIPAA Privacy Rule does not apply—even if the school or school health care provider otherwise qualifies as a covered entity under HIPAA. However the HIPAA Security Rule could still require a school to implement security measures when sharing a student's data under certain situations. The HIPAA Privacy Rule applies to PHI created when a covered entity delivers services on a school campus – as long as FERPA does not apply.

Application of FERPA to education records containing health information where the health care provider can be considered a "school official."

FERPA applies to the education records of public school students under 18 years of age that contain student health information and that are maintained by the school in the school's health clinic or nurse's office. Such records are subject to FERPA if the person or agency that created the record is an educational institution, the employee of an educational institution, or the agent or contractor of an educational institution and can be considered a "school official." The term "school official" includes school staff, such as teachers, counselors, and school nurses.

It also can include a "board member, trustee, registrar, …attorney, accountant, human resources professional…, and support or clerical personnel."[117] Individuals and agencies, including health agencies that contract with an educational agency, can also be considered school officials in some cases, as discussed below.

Some contractors can be considered "school officials" for purposes of disclosing a student's PHI without consent under FERPA. ED guidance and FERPA regulations provide factors that help determine whether a provider of health care can or should be considered a school official. These factors include types of services offered, administrative and operational control of service delivery, and financing of the service delivery.[118] For more information, see HIPAA or FERPA? A Primer on Sharing School Health Information in California, 2nd Edition. Further, FERPA limits the scope of the PHI

[116] 45 C.F.R. §160.103.
[117] ED, https://studentprivacy.ed.gov/faq/who-school-official-under-ferpa#:~:text=A%20%E2%80%9Cschool%20official%E2%80%9D%20includes%20a,and%20support%20or%20clerical%20personnel
[118] See ED, https://studentprivacy.ed.gov/resources/letter-university-new-mexico-re-applicability-ferpa-health-and-other-state-reporting

disclosed to only that information which matches the recipient's "legitimate educational interest" in the information.[119]

A written release is often necessary to submit a reimbursement claim that contains FERPA-protected record information to an insurer, unless the insurer is acting as a "school official" with "legitimate educational interest" in the information as defined by school policy and has a contract with the LEA that subjects the insurer to the confidentiality and disclosure requirements of FERPA.

For additional information about the intersections of HIPAA and FERPA rules, please review, "Navigating HIPAA and FERPA for Integrated School Behavioral Health Services."[120]

State laws and regulations

The CYBHI Fee Schedule program does not alter existing laws and regulations. All entities participating in the provider network and utilizing the CYBHI Fee Schedule program (designated providers, payers, TPA) must adhere to all state laws and regulations around beneficiary confidentiality and protection of health and education information.

California Confidentiality of Medial Information Act (CMIA)

CMIA is a set of state statutes that protect the confidentiality of medical and mental health information and applies to information held by health care providers, health care services plans and contractors. CMIA largely parallels HIPAA. In addition, CMIA allows patients to take legal action for violations, inclusive of compensation, attorney fees, and damages. LEAs and IHEs are recommended to train their staff on the CMIA requirements.

California Civil Code

California Civil Code section 56.10[121] obligates health care providers, health care service plans, and their contractors to not disclose medical information regarding a patient of a provider or, an enrollee or a subscriber of a health service plan without first obtaining an authorization.[122]

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[119] 34 CFR 99.31(a)
[120] https://cybhi.chhs.ca.gov/resource/navigating-hipaa-and-ferpa/
[121] Refer to California Civil Code section 56.10
[122] See California Civil Code section 56.10 for applicable exceptions - e.g., court orders, subpoenas

In addition, health care services plans are obligated to protect confidentiality of a subscriber's or enrollee's medical information as outlined in California Civil Code section 56.107.[123]

California Insurance Information and Privacy Act

The California Insurance Information and Privacy Act[124] provides similar protections to the CMIA but applies to health insurance products regulated by the Department of Insurance. This includes protecting the confidentiality of an insured's medical information as set forth in California Insurance Code section 791.29.[125]

Consent to and confidentiality of behavioral health services

Consent

The CYBHI Fee Schedule program does not alter existing parental consent or consent to treatment requirements.

Confidentiality

All medical records under the CYBHI Fee Schedule program are confidential and cannot be released without the written consent of the member or an authorized representative. According to State Medi-Cal laws and regulations, information can be shared or released between individuals or institutions providing care, fiscal intermediaries, and State or local official agencies. The release of information must continue to follow the FERPA, HIPAA and state law and regulations stated above.

If the parents or legal guardians, as applicable, do not consent to release insurance information for billing purposes, schools will be responsible for finding alternative sources of funding (e.g., Local Control Funding Formula) to reimburse the provision of CYBHI Fee Schedule program services. Educational entities should provide parents / guardians with appropriate information about the CYBHI Fee Schedule program.

[123] Refer to California Civil Code section 56.107
[124] Refer to California Insurance Information and Privacy Act
[125] More information can be found here: Privacy Information

Appendix A – Glossary of Terms

Authorized Representatives are individuals legally responsible for a student (e.g., parent, caregiver, legal advocate) or someone formally (i.e., legally) designated by a student, age 18 or older, to act on their behalf.

Covered Services (i.e., CYBHI Fee Schedule Services) are those outpatient mental health and substance use disorder (SUD) services specified in DHCS' published CYBHI Fee Schedule, when furnished to students twenty-five (25) years of age or younger at a schoolsite, in accordance with state law. See Welfare and Institutions Code section 5961.4; Health and Safety Code section 1374.722; and Insurance Code section 10144.53

Clean Claim is a claim or bill for covered services that has no defect, impropriety, or lack of substantiating documentation. The claim includes the information necessary to meet the requirements for encounter data (clinical information and data with content and in a format that comports with the HIPAA 837 requirements), and uses a completed CMS-1500 form or respective successor forms or alternative electronic equivalents (which electronic equivalents must comport with all HIPAA Administrative Simplification Act requirements for electronic transactions), that is received timely from an eligible Provider, and complies with standard industry coding guidelines, and/or other government program requirements where applicable. The claim requires no further documentation, information or alteration in order to be processed and paid timely. Claims or bills from a participating Provider who is under investigation for fraud or abuse are not Clean Claims.

CYBHI Fee Schedule program means the statewide, multi-payer, school-linked fee schedule program established by DHCS, pursuant to the Welfare and Institutions Code section 5961.4, Health and Safety Code section 1374.722, and Insurance Code section 10144.53.

FERPA means The Family Educational Rights and Privacy Act (FERPA) codified at 20 U.S.C. § 1232g, and the FERPA regulations codified at 34 CFR Part 99.

HIPAA is the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191), including without limitation its privacy, security and administrative simplification provisions, and the rules and regulations promulgated there under, each as may be amended from time to time.

Insurer means a commercial disability insurer that covers hospital, medical or surgical benefits as defined in Insurance Code section 106(b).

Managed Care Plan or MCP means a health care service plan, as defined in Health and Safety Code section 1345(f). MCP includes both Medi-Cal and commercial lines of business. MCPs must be licensed by the Department of Managed Health Care, as applicable.

Member means an individual who is enrolled and receives health insurance coverage from an MCP or Insurer and who meets all of the eligibility requirements for membership in the MCP or Insurer based on the registration file received by CBH from a Provider. For the purposes of the CYBHI Fee Schedule program, the term "member" may be interchangeable with the term "student" or "pupil" throughout this Manual.

Provider or CYBHI Provider means a locational educational agency (LEA), county office of education (COE), institution of higher education (IHE) or participating provider or practitioner in the DHCS CYBHI school-linked behavioral health provider network. Only participating providers or practitioners, COEs, LEAs, IHEs and designated providers and practitioners appropriately identified as part of this DHCS network will be eligible for reimbursement under the CYBHI Fee Schedule.

Non-Covered Services means those services specified by the MCP or Insurer or DHCS as not covered benefits under the CYBHI fee schedule. A non-covered service may include services that were provided to a student not covered by the MCP or Insurer, were never performed, or were not provided by a health care provider appropriately licensed or authorized to provide the services.

Protected Health Information ("PHI") shall have the meaning as defined in 45 C.F.R §160.103 and/or applicable state law, but shall also include "Patient Identifying Information" ("PII") as defined in 42 C.F.R. Part 2, Subpart B, §2.11.

"Schoolsite" has the meaning described in paragraph (6) of subdivision (b) of Section 1374.722 of the California Health and Safety Code and Section 10144.53(b)(6) of the Insurance Code.

State Regulators means the California Department of Managed Health Care (DMHC), California Department of Health Care Services (DHCS), and California Department of Insurance (CDI).

Appendix B – CYBHI Billing Codes and Reimbursement Rates

1. Eligible Rendering Practitioners

The following practitioners are eligible to render behavioral health services for reimbursement to the CYBHI Fee Schedule program. Please refer to the list of acronyms for each practitioner to determine if said practitioner can bill for specific codes.

Licensed practitioners	MD: Medical Doctors, including Psychiatrists RN: Registered Nurses, including Registered Credentialed School Nurses NP: Nurse Practitioners PA: Physician Assistants LP: Licensed Psychologists, including Educational Psychologists LCSW: Licensed Clinical Social Workers LMFT: Licensed Marriage and Family Therapists LPCC: Licensed Professional Clinical Counselors
Credentialed practitioners	PPS Psych: Pupil Personnel Services (PPS) Credential School Psychologists PPS-SW: Pupil Personnel Services (PPS) Credentialed School Social Workers PPS-C: Pupil Personnel Services (PPS) Credentialed School Counselors
Non-licensed practitioners	PSY ASSOC: Psychological Associates ASW: Associate Social Workers AMFT: Associate Marriage and Family Therapists APCC: Associate Professional Clinical Counselors AOD*: Alcohol and Other Drug Counselors

	CHW*: Community Health Workers CWC*: Certified Wellness Coaches

* AODs, CHWs, and CWCs may only bill for a limited set of codes

2. Billing Code Details

For detailed information about covered billing codes, service descriptions, eligible practitioners, and reimbursement rates, please review the current CYBHI fee schedule posted on the CYBHI Fee Schedule program webpage.

3. Non-licensed practitioners with billing limitations

Alcohol and Other Drug Counselors (AODs)

AODs must be supervised by a licensed practitioner and can bill for the following procedure codes.

Table 5: Procedure codes and descriptions for AODs

Procedure Code	Service Description	Reimbursement Rate
G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment, 5- 14 min	$14.81
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment, 15- 30 min	$31.24
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment, 30+ min	$60.61

For more information regarding educational requirements for becoming an AOD counselor in California, contact DHCS Counselor Certification Organizations.

Community Health Workers (CHWs)

Pending the approval of State Plan Amendment (SPA) 25-0023, LEAs and IHEs are not currently eligible to supervise CHWs and therefore cannot submit claims for behavioral health services furnished by a CHW. However, some affiliated providers like community-based organizations may be eligible to supervise CHWs and submit claims on their behalf.

4. Service Limitations by Code

Please refer to the following table to see the specific service limitations and restrictions that apply to certain CYBHI Fee Schedule program behavioral health services. Limitations apply regardless of insurance coverage type.

Table 7: Service limitations by procedure code

Procedure code	Service description	Service limitations
T1027	Dyadic family training and counseling for child development, per 15 min	Reimbursable for children ages 0 to 20 years and/or their caregiver(s) when billed with 'U1' modifier for Dyadic Services. Reimbursable for the initial and periodic training and counseling for child development, per 15 minutes
H2027	Health behavior intervention – Psychoeducation; Individual or Group; 15 min	Reimbursable for children ages 0 to 20 years and/or their caregiver(s) when billed with 'U1' modifier for Dyadic Services. Reimbursable for the initial and periodic psychoeducational services, per 15 minutes
G9919	Screening for ACEs/Trauma (High Risk); 30 min	Reimbursable only for practitioners who have taken a certified Core Training and self-attested to their completion of the training. For more information, refer to the ACEs AWARE website
G9920	Screening for ACES/Trauma (Low Risk); 30 min	

Procedure code	Service description	Service limitations
G0442	Screening for Annual Alcohol misuse, 15 min	Reimbursable for recipients ages 11 and older, or their parents/caregivers when billed with 'U1' modifier for Dyadic Services.
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services, 15-30 min	
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services, 30 + min	
90791	Psychiatric Diagnostic Evaluation, 16-90 min	May be used to bill for psychiatric diagnostic evaluation without medical services. Must be documented in the medical record with the following items included: • Presenting problem, changes in functioning, and/or 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

Procedure code	Service description	Service limitations
96130	Psychological Testing and Evaluation, first 60 min	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
96131	Psychological Testing and Evaluation, each additional 60 min; Must be performed in conjunction with 96130 by the same provider on the same day	
96136	Psychological or neuropsychological testing and scoring, first 60 min	
96137	Psychological or neuropsychological testing and scoring, each additional 60 min; Must be performed in conjunction with 96136 by the same provider on the same day	
90832	Psychotherapy session, individual, 16-37 min	Limited to a maximum of one and one-half hours per day by the same provider. Providers should use the appropriate code based on the direct patient care time frames.
90834	Psychotherapy session, individual, 38-52 min	
90837	Psychotherapy session, individual, 53+ min	
90853	Psychotherapy session, group of 2-8 patients, 60 min	Session must consist of at least two but not more than ten people at any session. No restrictions as to the number of CYBHI Fee Schedule program-eligible persons who must be

Procedure code	Service description	Service limitations
		included in the group's composition. Code may be billed once per CYBHI Fee Schedule program-eligible person attending the session (e.g., if three patients in the group are eligible for the CYBHI Fee Schedule program, the MCP or insurer may be billed three times – once for each eligible patient)
90847	Family psychotherapy session; single family with patient present, 50 min	Must be composed of at least two family members CYBHI Fee Schedule program recipient must be present for the entire session or at least a portion of the session
90846	Family psychotherapy session; single family without patient present, 50 min	Must be composed of at least two family members CYBHI Fee Schedule program recipient must not be present during the session
90849	Family psychotherapy session; multiple families; 50 min	Must be composed of multiple families

Procedure code	Service description	Service limitations
		Provider must bill using the insurance ID of only one family member per family
99366	Case Management with patient or family present (Face to Face), 30 min	Medical team conferences are limited to conferences with persons immediately involved in the case or recovery of the client