Health and Behavior (H&B) Codes for Psychologists: A Working Manual using Pediatric Obesity as a Model

A product of APA Division 54's Pediatric Obesity SIG: Reimbursement Subcommittee

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INTRODUCTION

This workbook has been designed to provide the most up to date information available on the use of health and behavior (H&B) codes for psychologists as of January 1, 2013, particularly those working in pediatric obesity. It is meant to be an introductory guide to those that are new or beginning to explore using H&B codes and a reference guide to the more experienced user of these codes.

H&B codes were developed as a way to bill for the services of pediatric and health psychologists working with patients who may not have a psychiatric condition, but the widespread use of the codes has been hindered by numerous factors. It is only by the continued attempts to use H&B codes, and identifying ways to overcome barriers, that the field can move towards more effective implementation of these codes.

This workbook covers many areas related to H&B codes including their history, how to document using these codes, how to successfully use the codes, and ethical concerns to consider. The appendix contains forms that may be useful in your clinical practice.

It is anticipated that this manual will be reissued as new information is obtained on a periodic basis assuming there is support for this. We welcome your feedback and suggestions on improvement and additions to the workbook. Please contact Melissa Santos to provide corrections or follow-up information.

Section 2:
Overview of insurance and billing in America

Section 2.1: Public vs. private insurance

The current health care insurance system can be broken down into two parts:

1. Private health insurance (e.g. insurance individuals obtain, typically through their employers)
2. Public health insurance (e.g., Medicaid, Medicare) which is subsidized by the government

The goal of health insurance is to help individuals afford their medical care. Based on the type of insurance an individual has, access to care may differ based on multiple factors such as:

1. Which providers the individual may see
2. How often an individual may see their provider
3. How much an individual pays to see a provider

As such, significant differences can be seen among insurance plans. One of these significant differences affects the Health and Behavior codes. In 2006, all Medicare plans began to provide coverage for health and behavior codes. However, no other insurance plan, including Medicaid, provides such broad coverage. Therefore, a psychologist treating an adult with Medicare for behavioral weight management may be reimbursed after billing a health and behavior code utilizing obesity as their presenting concern and diagnosis. However, a psychologist treating a child with Medicaid may not be reimbursed after billing the same code with the same diagnosis.

Section 2.2 Health care reform

With health care reform on our doorstep, psychologists will have to work hand in hand with medical providers. Under health care reform, it is going to be critical for psychologists to:

1. Be able to integrate their work into the medical setting
2. Appropriately document for their time and services
3. Provide cost-effective care.

In this effort, a more widespread use of H&B codes would be beneficial.

Section 3:
Determining the appropriate use of H & B codes and mental health codes for obesity

Section 3.1 : Mental Health

Mental health CPT codes can be used when the patient has a psychiatric condition along with their obesity:

Pre 2013 CPT codes	New 2013 CPT codes	Procedure
90801	90791	Initial Evaluation
90804 (20-30 minutes)	90832 (16-37 minutes)	Individual Therapy
90806 (45-50 minutes)	90834 (38-52 minutes)	Individual Therapy
90808 (75-80 minutes)	90837 (53 minutes +)	Individual Therapy
90853	90853	Group Psychotherapy
90846	90846	Family therapy without patient present

From http://www.apapracticecentral.org/reimbursement/billing/psychotherapy-codes.aspx?__utma=12968039.974466671.1227061014.1363203494.1363641558.70&__utmb=12968039.2.10.1363641558&__utmc=12968039&__utmx=-&__utmz=12968039.1351719596.61.26.utmcsr=apapracticecentral.org|utmccn=(referral)|utmcmd=referral|utmcct=/reimbursement/billing/index.aspx&__utmv=-&__utmk=196548396

Patients are assessed for psychiatric conditions and treatment of these disorders if the primary focus of the treatment plan. Billing is conducted using mental health CPT codes under DSM-IV diagnoses (e.g. Major Depressive Disorder), using the patient's mental health insurance dollars.

Common Psychiatric Diagnoses Associated with Obesity:

- Adjustment disorders
- Depressive disorders (Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS)
- Anxiety disorders (Generalized Anxiety Disorder, Specific Phobia, Social Phobia, Post Traumatic Stress Disorder)
- Eating Disorders (Eating Disorder NOS)

- Behavioral disorders (Oppositional Defiant Disorder, Conduct Disorder, Disruptive Behavior Disorder NOS).

Considerations:

- The treatment plan should consider the severity of the psychological disorder and the interplay between obesity and psychological disorder.
    - If psychological condition is fairly independent of obesity, or is so severe that safety of the patient is at risk, treat the psychological disorder first to achieve mood and behavior stabilization before focusing on nutrition and physical activity behaviors.
        - Ex: adolescent with pervasive mood disorder that causes emotion and behavior dysregulation across settings and situations.
    - If the patient's obesity impacts or accounts for the symptoms of a psychological disorder, then the treatment plan should focus on health behavior change as primary.
        - Ex: etiology of depressive symptoms is partially due to social rejection and poor self esteem related to obesity, or depressive symptoms include anhedonia , loss of energy, and appetite disturbance, causing poor health behaviors that exacerbate obesity. In these cases, health behavior change would be an integral part of the treatment plan.

- Challenge: what to do when the patient does not meet criteria for a major psychiatric disorder, but the patient's difficulty with health behavior is affecting his or her obesity?
    - DSM diagnosis 316: Psychological factors affecting a medical condition.
        - Criteria include both the presence of a medical diagnosis, and the presence of psychological factors affecting the medical condition in at least one way (see DSM-IV).
        - The diagnosis allows for psychological factors to range from an Axis I disorder to the presence of psychiatric symptoms to maladaptive health behaviors (e.g. poor diet and exercise).
        - In the case of obesity, the diagnosis of 316 can frequently be used due to the presence of poor health behaviors in many patients.

<u>Section 3.2 : Health and Behavior</u>

Health and behavior CPT codes provide a billing mechanism to consider behavioral health as an integral part of comprehensive treatment for a medical disorder. Patients are assessed for their behavioral health needs and treatment integrates an understanding of social emotional needs regardless of mental health disorder. Billing is conducted using Health and

Behavior CPT codes using the patient's medical insurance dollars, and using the patient's medical diagnosis rather than mental health diagnosis.

History and Facts related to H&B Codes:

- Proposed by the American Psychological Association in 1998 and approved by the American Medical Association for inclusion in the CPT system in 2002.
- Allow psychologists to address challenges associated with a medical illness, without labeling the patient as having a psychiatric disorder.
- The codes cannot be used to treat a psychiatric disorder only.
- The codes are used along with the patient's medical diagnosis according to the ICD-9, diagnosed by the physician. When a child has multiple medical diagnoses, the code is used for the primary medical condition that resulted in the need for behavioral health services.
- Health and Behavior codes are used in 15 minute increments.
- The codes, associated service, and estimated Medicare reimbursement rate are included below (note that private insurance and Medicaid reimbursement rates may vary) :

Code	**Procedure**	**Approximate 2012 Medicare Reimbursement**	
		15 minute – 1 unit	*1 hour – 4 units*
96150	Initial Assessment	*15 minute – 1 unit*	*1 hour – 4 units*
96151	Re-assessment	$20.42	$81.68
96152	Intervention – Individual	$19.74	$78.96
96153	Intervention – group (per person)	$18.38	$74.88
98154	Intervention – family w/ patient present	$4.42 (per person)	$17.68 (per person)
96155	Intervention – family w/o patient present	$18.38	$73.52

From **http://flash1r.apa.org/apapractice/hbcodes/player.html**

Section 4:
Documentation

Section 4.1 What needs to be documented

Proper documentation when billing using health and behavior codes should focus broadly on:
1. how the patient's medical condition is being managed and
2. how the patient is coping emotionally, cognitively, and behaviorally with the medical condition, its treatment, and impact on daily functioning. Specifically, documentation should include:

1. An assessment of current levels of treatment adherence and how adherence (whether reported or objectively measured) deviates or is in line with medical recommendations.
2. Describe how the patient is currently managing symptoms, and whether this is done independently or in conjunction with caregivers or other individuals who provide support.
3. Document assessment information pertaining to engagement in health-promoting behaviors as well as health-related risk behaviors, potential barriers, and the treatment plan for how to address these behaviors.
4. Include an analysis of how modifying specific biopsychosocial factors may be and/or will impact physical and emotional functioning.

Section 4.1a: Initial assessment (96150)

Recommended documentation, for the 96150 code includes the following:

1. Rationale and support for why the assessment is medically and clinically reasonable and necessary. This includes documenting which medical provider sent the referral and the referral concern.
2. Date of initial diagnosis of physical illness and medical history
3. Mental status and ability to understand and participate in assessment
4. Goals, objectives, and expected duration of specific psychological intervention(s), if recommended
5. Evidence of coordination of care with medical provider
6. Time duration spent face to face with patient
7. Who was present during assessment

4.1b :Re-assessment (96151)

Recommended documentation for the 96151 code includes the following:

1. Rationale for reassessment which may include:
    a. gap in treatment provision
    b. new treatment issue
    c. change in mental or physical status discussion of the precipitating event (including date if possible) that necessitates reassessment
2. Time duration spent face to face with patient
3. Who was present during assessment

4.1c: Intervention (96152-96154)

Recommended documentation for these codes includes the following:

1. Mental status and documentation that the individual has the capacity to understand and to participate in intervention
2. Clearly defined psychological intervention plan and goals
3. Goals of the psychological intervention should clearly state how the psychological intervention is expected to improve compliance with the medical treatment plan
4. Response to and progress with the intervention
5. Rationale for frequency and duration of services as evidenced by progress toward goals or lack thereof, and/or new and continued stressors and risk factors
6. Time duration (stated in minutes) for each visit spent in the health and behavioral assessment or intervention encounter
7. Who was present during intervention

American Medical Association (2013). CPT manual: Professional Edition. Chicago, IL, page 543.

HHS.Gov CMS – Article for Health and Behavioral Assessment/Intervention – Medical Policy Article (A48209) located at: http://downloads.cms.gov/medicare-coverage-database/lcd_attachments/30514_1/L30514_031610_cbg.pdf

Information adapted from materials developed by the National Council for Community Behavioral Healthcare, Health and Behavior Codes-The National Council. http://www.thenationalcouncil.org/

Section 5:
Steps to success for use of H&B codes

Section 5.1: Education

Of note: When checking for coverage, H&B codes are covered under the medical side of insurance, not the mental health side (where most traditional psychology codes are covered). In at least some states, psychologists must be paneled on the medical side of the insurance plan and pre-authorization must be obtained from the medical arm of the health insurance plan.

Division 54 members Christina Duncan and Kevin Smith developed a set of tools for use in pediatric psychology in general in relation to the use of H&B codes. These include:

1. Two sample appeals letter
2. A caregiver H&B code fact sheet
3. A general H & B code fact sheet

All of these documents (located in the Appendix) were informed by Drs. Duncan & Smith's work with the Interdivisional Healthcare Committee (IHC), the body within APA which developed the codes.

Currently, the issue of the use of H&B codes within the APA falls to the Practice Directorate and they have several documents online regarding the use of H&B codes which may be helpful for practitioners, including:

1. A flash presentation for members about how to use H&B codes
2. FAQs on Billing for Health and Behavior Services
3. Practitioners Find Many Benefits in Using Health and Behavior Codes
4. Medicare Milestone: All Carriers Now Cover Health and Behavior Services
5. Health and Behavior CPT® Codes

These documents can all be found on the APA Practice Directorate's website: http://www.apapracticecentral.org/reimbursement/billing/index.aspx.

Dr. Daniel Bruns has also developed an educational tool about the use of H&B codes by psychologists. These educational materials are available for free online at www.healthpsych.com/tools/resolving_h_and_b_problems.pdf.

Although H & B codes are approved at the federal level by Medicare, their approval from state to state varies. Current data from the National Council for Community Behavioral Healthcare (see appendix) indicate that H & B codes are only approved in about 50% of all states. Be sure to check with your state Medicaid office to see if the codes are covered for your state. And, if they are, they may not be covered by all local insurance companies, or by all company plans.

Section 6:
Funding clinical obesity programs

Section 6.1: Other sources of financial support for programs

Given the difficulties with insurance reimbursement for multidisciplinary treatment of pediatric obesity, programs may have to look beyond insurance reimbursement for payment to create a financially viable program. Some other sources of funding programs include:

Funding Source	What is it	Pros	Cons
Research Grants	Applying for various research grants to demonstrate program effectiveness or test a model of treatment	Can help offset the costs of program staff	Work needs to be done to maintain sustainability of funding and getting repeated funding.
Foundation	Foundations may be able to fund portions of programs for families. This may include covering costs for gym memberships or providing rewards. They may also help to offset the start up costs of programs.	Allows programs to establish themselves and eliminate expenses for non-reimbursable items.	May not be sustainable for long periods of time.
Institutional Support	Institutions may decide to support their obesity program. This may be done in numerous ways such as providing scholarships for families to participate to offset costs not covered by insurance, providing services with little to no cost and/or covering staff salaries.	Provides opportunities for programs to get off the ground and demonstrate effectiveness	May not be sustainable for long periods of time
Bundling of Services	Rather than billing for each service rendered, a package is presented to insurance companies and reimbursement is given for a program which involves multiple specialties. For example, an insurance company will pay a lump sum to a program for a patient to see the dietitian, psychologist and medical provider six times each. Any additional services over the six would not be billable.	Covers services that might not otherwise be reimbursed	Additional services with those specialties that may be needed are not reimbursed

- Slusser summarizes ways to increase funding, along with challenges, to weight management programs in Slusser et al (2011). Payment for Obesity Services: Examples and Recommendations for Stage 3 Comprehensive Multidisciplinary Intervention Programs for Children and Adolescents. *Pediatrics,* 128, S78 -S85.

Section 7:
Communication within and outside your team

Section 7.1: Staying up to date on health care reform, state regulations, reasons for rejection

It can be a challenge to stay up to date on billing codes and procedures. State legislative policies, insurance carrier policies, institutional contracts and policies, clinic policies all change over time. It is helpful to build relationships with billing and coding personnel, with periodic meetings over the year to review changes. Sometimes you as a provider will learn of the policy change first, other times they will learn of the change first from educational information received to their office. Both you and the billing and coding personnel should actively seek ongoing education to stay on top of these changes. Communicating is critical to reduce billing errors and "lost" revenue. It is also helpful to review billing and receivables with them on a periodic basis to look for problems or errors in the billing process that neither of you were aware of.

Helpful questions and practicies to avoid errors and maximize reimbursement:

1. What insurance companies am I approved to see?
2. What is the average reimbursement for the 10 most commonly used billing codes from each insurance company I am approved to see? Which of these services require a prior-authorization? What form do I use for each?
3. For each service that was denied reimbursement, why was it denied? How long do we have to resubmit? Is it possible to resubmit or can we learn from this denial and avoid future similar denials? How can we change our process (clinician or administrative or both) to avoid future denials of this nature?
4. Request a monthly statement of billables and receivables and look for trends upward or downward and discuss why these are occurring.

Section 7.2: Communicating policies
Subsection 7.2.a: Psychology trainees

In the midst of important training goals, psychology trainees (including graduate students in training clinics, interns, and fellows) often do not receive enough education regarding billing and coding issues. They often do not feel prepared for the "real world" in terms of business practices including billing and coding (Sales et al., 2005; Barnett & Walfish, 2012; Knapp et al., 2008). It is critical to inform them of current billing/coding practices as it relates to each training environment they are in. Given the diversity of training experiences they will likely learn a variety of billing/coding models, policies, and procedures. Further, ongoing education regarding the ebb/flow of policy changes is important, and the necessity for

staying up to date. Including didactics within the context of their training at all levels is most beneficial in assisting their learning in this area.

Subsection 7.2.b: Billing personnel

In some settings, billing and coding personnel are not used to working with psychological services, codes, policies, and procedures. This is particularly true if the institution has few psychologists. In those cases, it is helpful to meet and review general information and also track reimbursement of initial patients seen to identify errors or issues that arise. Advocating for one or a few billing and coding personnel to process psychology billings often cuts down on the errors, as these individuals can become "experts" in psychology billing.

Subsection 7.2.c: Hospital staff

Hospital or clinic staff are often part of the billing and coding process. They take calls from patients wanting an appointment and asking if a referral is needed or if a certain provider is able to see a patient. Staff may also handle billing paperwork prior to its completion (printing out the correct billing form) or after its completion (scanning into the system or routing to the billing/coding personnel) or tracking that billing is submitted for every patient seen. An internal billing and coding process is critical to identify the flow of this information, and should include all providers and personnel that are part of the process from start to finish, including receipt of denials or reimbursement and communication back to the provider. Regular communication between all personnel involved in this process to communicate changes in coding or the billing process it self, to answer questions, and to solve issues that arise is helpful.

Section 8:
Ethics

Section 8.1: Ethics of coding diagnosis and billing

This section will focus on the the ethics of coding, diagnosis, and billing and by extension medical recordkeeping in general. Specific topics to be included: access to records, timeliness of completion of records, maintenance of records, documentation of changes in the record, standards for documentation, etc.

Section 8.2 : APA Ethics Code

All psychologists should be thoroughly familiar with the APA Ethical Code and remain up to date in their knowledge of changes to the Code over time and applications of this code to emerging legal situations.

The justification for diagnositic codes and billing codes utilized for every patient encounter should be clearly documented. The reasons for using H&B codes rather than typical Mental Health codes may need to be clarified within the note. When concerns arise regarding potential harm (the potential impact of diagnoses or the impact of billing codes on the individual), attempts to investigate and resolve these issues should also be clearly documented. Further, open communication with the patient/family regarding diagnoses and billing codes should reinforce the establishment of trust and clarify roles and responsibilities. While a detailed discussion might not be necessary in all cases, some understanding on the part of the patient is typically helpful.

Another "hot topic" is the need to not bill a patient in a certain way just because of their insurance carrier. For instance, you would not ethically bill the same patient as a diagnostic interview with diagnosis "Psychological Factors Affecting Physical Condition" if their carrier did not cover H&B codes, but bill a Health Behavior Assessment with the diagnosis "Obesity" if they did. Clinical decisions regarding diagnoses and procedure codes should be consistent regardless of reimbursement.

The reader is strongly urged to review the current APA Ethical Code (found on www.apa.org) and to carefully evaluate the electronic health record with these ethical guidelines in mind. Issues of confidentiality, access to records, and timely documentation, to name only a few, are of central concern in the utilization of an electronic health record software tool.

Section 8.3: Content Documentable in EHR

A key issue in the area of ethics and billing is the need for accurate and timely record keeping. This is particularly true in a digital era where notes are digitally signed and date/time stamped. As noted above, there are ethical considerations related to treatment records including accuracy of diagnosis procedural code and the consistency between the billing document and the chart note. The maintenance of records over time is also critical.

Also critical with the increasing usage of EHR is the digital documentation of access. A practitioner's EHR system should allow for limited access (not all personnel need access to the full record to carry out their duties). In addition, EHRs typically document any users who access data and a policy should be in place to monitor for inappropriate access as well as list the institutional response when an individual has inappropriately accessed a medical record. This can include loss of employment or other individual ramifications, but also should include notification of the patient about a breach of confidentiality.

Section 9:
Links to resources and other articles

Section 9.1: Children's Hospital Association

FOCUS on a Fitter Future Survival Guide for Planning, Building and Sustaining a Pediatric Obesity Program. It includes a checklist for starting a program:
http://www2.aap.org/obesity/pdf/FitterFutureSurvivalGuide.pdf

Section 9.2: American Medical Association

The American Medical Association creates the CPT codes used for billing purposes. It published a policy paper (Article for Health and Behavior Assessment/Intervention – Medical Policy Article (A48209) that provides guidelines for the correct use of Health and Behavior codes. This is a comprehensive description of what can and cannot be covered.
http://apps.ngsmedicare.com/sia/ARTICLE_A48209.htm

Section 9.3: American Psychological Association

The American Psychological website provides a number of resources on the use of H&B codes for clinicians. To access these resources, an APA membership login is required.

Below are some links to articles on the site that can help practitioners navigate the use of the H&B codes.

- Newsletter article on use of H&B codes. This article consists of a flash presentation that provides an overview of what the codes are, how they're used, and a sample letter that can be used for advocating the use of the codes with an insurance company
  http://flash1r.apa.org/apapractice/hbcodes/player.html

- APA Practice Central for Reimbursement and billing
  http://www.apapracticecentral.org/reimbursement/billing/index.aspx

Section 9.4: American Academy of Pediatrics:

The American Academy of Pediatrics has a fact sheet on the use of the codes.
http://www2.aap.org/obesity/pdf/ObesityCodingFactSheet0208.pdf

Section 9.5: Other Resources

In addition to the organizations listed above which provide resources, there are other groups as well as articles written on the use of the codes which can be helpful to providers.

Section 9.5.a: SAHMSA

SAHMSA is a good resource for information by state. This is an excellent resource for clinicians looking for use of H&B codes specific to where they practice.
http://www.integration.samhsa.gov/images/res/Map_of_Available_HBAI_CPT_Codes1.pdf

They provide a good example of use of the codes in Maine that can provide useful information to practitioners in other states as an example of what types of information may be required to use the codes.
http://www.integration.samhsa.gov/financing/Maine_Health_code.pdf

Section 9.5.b: Articles on H&B Codes

The following are a selection of articles written on the use of H&B codes that provide information about specific uses of the codes.

- Barnett, Jeffrey E. Walfish, Steven ; The financial agreement between you and your client. 2012. Chapter in Barnett, J. E. & Walfish, S. (Eds). *Billing and collecting for your mental health practice: Effective strategies and ethical practice*.; Washington, DC, US: American Psychological Association,. pp. 27-37.
- Claar, R.L., Kaczynski, K.J., Lyons, M.M., LeBel, A.A. (2011). Commentary: Health and Behavior codes in a pediatric headache program: Reimbursement data and recommendations for practice. *Journal of Pediatric Psychology,* pp. 1-5.
- Gray, J., Filigno, S.S., Santos, M., Ward, W., & Davis, A. (2012). The Status of Billing and Reimbursement in Pediatric Obesity Treatment Programs. *Journal of Behavioral Health Services & Research*, pp. 1-7.
- Knapp, S., VandeCreek, L. (2008). The ethics of advertising, billing, and finances in psychotherapy. Journal of Clinical Psychology, Vol 64(5), Special issue: Ethics in psychotherapy. pp. 613-625

- Miyamoto, R.E. (2006). Billing effectively with the new health and behavior current procedural terminology codes in primary care and specialty clinics. *Journal of Clinical Psychology, 62,*1221-1229.
- Noll, B. & Fischer, S. (2004). Commentary. Health and Behavior CPT codes: An opportunity to revolutionize reimbursement in pediatric psychology. *Journal of Pediatric Psychology, 29,* 571-578.
- Sales, Bruce D.; Miller, Michael Owen; Hall, Susan R. Initiating Services. 2005 Chapter in Sales, Bruce D. Miller, Michael Owen Hall, Susan R. (eds). Laws Affecting Clinical Practice, Washington, DC, US: American Psychological Association, pp. 23-32.
- Sallinen, B. & Woolford, S. (2012). Commentary: Examination of health and behavioral code reimbursement from private payers in the context of clinical multidisciplinary pediatric obesity treatment. *Journal of Pediatric Psychology, 37,* 519-522.
- Slusser et al. (2011). Payment for Obesity Services: Examples and Recommendations for Stage 3 Comprehensive Multidisciplinary Intervention Programs for Children and Adolescents. *Pediatrics,* 128, S78 -S85.

Online articles and websites

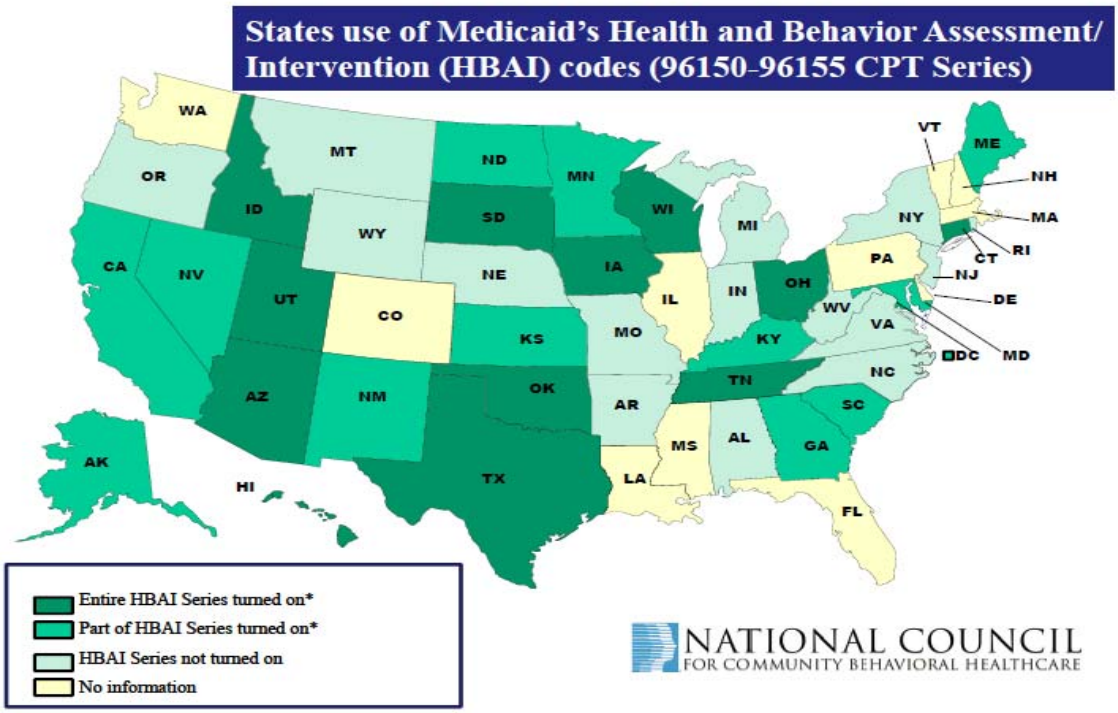
APA monitor article on CPT codes
http://www.apa.org/monitor/sep02/cptcodes.aspx

Policy brief on Medicaid and Obesity Treatment:
http://sphhs.gwu.edu/departments/healthpolicy/CHPR/downloads/RWJ%20Medicaid%20Obesity%20Policy%20Brief.pdf

Website with additional information about coding and billing maintained by Tony Puente, PhD. The information covers all CPT codes, not just H&B codes.

http://psychologycoding.com/

Section 10:
Appendix



State Restrictions*

State	Details
AK	96150-96154; Physicians, therapists, and audiologists can bill
CA	96150-96153 only
CT	Can bill only on physician fee schedule, not psychologist fee schedule
DC	96151-96155 only
GA	96150-96151; only billable for Level 2-4 practioners
HI	Prior Authorization for physicians (but not for FQHCs) under 96150, no prior authorization for 96151-96155
ID	Non-physicians receive 85% payment
KS	Only 96150 is billable and only for beneficiaries up to age 8
KY	96150-96154 only
ME	96150-96154 only
MD	96150-96152 only
MN	96150-96154 only
NV	96150-96154 only; billable for Qualified Mental Health Professionals or Qualified Mental Health Associate
NM	96150-96151 only; billable for psychologists
ND	96150-95152 & 96154; psychiatrists and psychologists
OH	96150 billable for individual physician, 96152 billable for individual psychologist or physician or physician group, 96153 billable for nurse practitioner
OK	96150 billable for individual physician, 96152 billable for individual psychologist or physician or physician group
SC	96150-96154; 96150 only billable for physician, 96151-96154 billable for physician and nurse practioners

Taken directly from the online information from the National Council for Community Behavioral Healthcare.

SAMPLE APPEAL LETTER#1

Dear [Medical Director's Name]:

It is my (our) understanding that your company does not reimburse psychologists for services provided under the Current Procedural Terminology (CPT) health and behavior assessment and intervention codes. Given the value of health and behavior assessment and intervention for individuals who need these services, we encourage your company to reconsider its decision not to reimburse psychologists for delivering these vital services.

This letter (e-mail, etc.) provides an overview of the health and behavior codes and discusses psychologists' roles in addressing physical health problems by providing health and behavior services.

An overview of the health and behavior assessment and intervention codes:

The health and behavior codes were developed to provide psychologists and other health care providers with a way to accurately capture services that focus on the biopsychosocial factors affecting physical health problems. Examples of physical health issues that psychologists might address under the new codes include: patient adherence to medical treatment, symptom management, health-promoting behaviors, health-related risk-taking behaviors and overall adjustment to physical illness. In almost all cases, a physician will already have diagnosed the patient's physical health problem before a psychologist sees the patient.

The assessment codes apply to services that identify biopsychosocial factors important to the treatment or management of physical health problems. The intervention codes reflect services used to modify biopsychosocial factors affecting a patient's physiological functioning, health and well being. The codes are published in the CPT© manual issued by the American Medical Association (AMA) as follows:

96150 – Health and behavior assessment, each 15 minutes face-to-face with the patient; initial

96151 – Health and behavior assessment, each 15 minutes face-to-face with the patient; re-assessment

96152 - Health and behavior assessment, each 15 minutes, face-to-face; individual

96153 - Health and behavior assessment, each 15 minutes, face-to-face; group (2 or more patients)

96154 - Health and behavior assessment, each 15 minutes, face-to-face; family (with the patient present)

96155 - Health and behavior assessment, each 15 minutes, face-to-face; family (without the patient present)

As you likely are aware, developing new CPT codes is a stringent process subject to review by various American Medical Association (AMA) coding committees. The American Psychological Association (APA) worked closely with the AMA on creating the health and behavior codes because psychologists are among the leading health care providers whose training prepares them to furnish these types of services. In 2000, assisted by the National Association of Social Workers, APA conducted a survey to determine appropriate values for the codes and made recommendations to the AMA's Relative Value Update Committee (RUC) concerning values for the new codes. In 2001, the RUC recommended that the Centers for Medicare and Medicaid Services (CMS) adopt the values forwarded by the RUC.

CMS accepted the RUC's recommendation and included the codes and their relative values in the 2002 Physician Fee Schedule published in the November 1, 2001 Federal Register (66 FR 55245, 55463, 55499). At that time CMS designated the codes as "active", meaning the codes would be reimbursable effective January 1, 2002 so long as Medicare covered them. Subsequently, CMS determined that Medicare would cover the health and behavior codes with the exception of code 96155 (family intervention without the patient present). CMS excluded code 96155 from coverage because Medicare pays only for services provided directly to Medicare beneficiaries.

Psychologists' role in addressing physical health problems through the use of health and behavior assessments and interventions:

According to CPT, the codes may be utilized by psychologists, advanced practice nurses, and other health care professionals within their scope of practice who have specialty or subspecialty training in health and behavior assessment / intervention procedures. However, physicians performing these services are directed to use the Evaluation and Management or Preventive Medicine services codes.

As noted earlier, the new health and behavior codes are intended to be used with patients who have a physical health, not a mental health, problem. Although historically more widely recognized for their mental health services, psychologists also use their skills and abilities to treat patients suffering from physical health problems. When treating a patient for a mental health diagnosis, a psychologist would use the appropriate psychotherapy code, not one of the health and behavior codes.

I (we) trust this letter (email, etc) explains the purpose for which the health and behavior codes were developed and clarifies that psychologists are among the health care professionals who are authorized to provide services under the codes. I (we) look forward to hearing that your company has decided to provide coverage of health and behavior services by psychologists.

Sincerely,

Steven Jones, PhD
Pediatric Psychologist
Children's Hospital

SAMPLE APPEALS LETTER #2

June 9th, 2010

Billy Smith
Policy Number:
MR#999999
DOB: 1/1/02
DOS: 1/12/10

To Whom It May Concern:

I am writing to request coverage of services that were provided for Billy Smith, who was referred to us by the Sleep Disorders Center at X Hospital due to behavioral and emotional concerns surrounding sleep disturbances.

Coverage is apparently being denied because services were billed under the child's medical diagnosis of sleep disturbance utilizing the Health and Behavior CPT codes. When verifying coverage under the Insurance X member's employee health plan, we are often told that there is no coverage for the codes under the medial plan, but coverage would fall under the member's behavioral health plan. However, the Health and Behavior Assessment and Intervention codes are assigned to the Medicine section of the CPT code book and are not considered mental health services. Moreover, according to the American Medical Association (AMA) and Center for Medicaid and Medicare Services (CMS), the use of these CPT codes requires a physical health diagnosis.

The use of Health and Behavior Assessment and Intervention codes is subject to the National Correct Coding Initiative (NCCI). As you know, the NCCI is a series of correct coding methodologies based in part on coding standards defined in the AMA's CPT manual, coding guidelines of numerous national specialty societies, principles of customary medical practice, and a continuous assessment of current coding practice. CMS developed the NCCI to help health care providers to coding services properly for reimbursement. Under the NCCI, the Health and Behavior Assessment and Intervention cannot be used for treating patients with a psychiatric diagnosis. They must be billed to medical services using physical health diagnosis.

Psychologists who provide services to children with sleep disorders or patients with other physical health diagnoses have a more accurate, refined way of billing for services with the use of six reimbursement codes under the Current Procedural Terminology (CPT) coding system. As of January 1, 2002, codes for health and behavior assessment and intervention

services applied to behavioral, social, and psycho-physiological procedures for the prevention, treatment or management of physical health problems. The codes capture services addressing a wide range of physical health issues, such as patient adherence to medical treatment, symptom management, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to physical illness. In almost all of these cases a physician will already have diagnosed the patient's physical health problem. See table below for the CPT codes and their affiliated services.

The codes listed below which took effect in January 2002, apply to psychological services that address behavioral, social, and psycho-physiological conditions in the treatment or management of patients diagnosed with physical health problems.

Insert list of codes from fact sheet on reverse side and/or from the APA website

As Pediatric Psychologists, we use these codes because often the referring physician is interested in behaviors surrounding the medical diagnosis (rather than a mental health condition). In fact, the use of these codes is not permitted if the patient suffers exclusively from a mental health diagnosis. Hence, this provides more reason for the codes to be utilized in the case of Billy.

In sum, I believe that the psychological services provided to Billy are medically necessary based on the behavioral and emotional issues surrounding his sleep disorder. The treatment provided has important implications for clinical medical management of his disease.

Thank you for your attention to this matter. I look forward to hearing from you regarding benefits disposition in this case.

Sincerely Yours,

Steven Jones, PhD
Pediatric Psychologist
Children's Hospital

*Adapted from: www.apapracticecentral.org: reimbursement/billing and coding/Integrated Health Care: How to Use Health and Behavior CPT Codes/resources/Advocating for Change

Caregiver H & B Codes Fact Sheet

Health & Behavior codes are insurance billing codes often used by a Psychologist in inpatient and outpatient medical settings and in private practice settings to address behavioral, social, and psychophysiological services for the prevention, treatment or management of physical health problems. **[Insert name of referring physician/medical team member]** recommended these services for your child to address **[insert presenting problem, e.g., adherence to his diabetes regimen.]**

Health & Behavior codes differ from traditional mental health insurance codes because they do not require a mental health diagnosis, and fall under traditional medical benefits (instead of your separate mental health benefits). Health and Behavior codes do require a medical diagnosis, which per your referring physician is **[insert medical diagnosis]**. The associated code for this diagnosis is **[insert ICD-9 code].**

Below are the Health and Behavior Codes that coincide with the services recommended by the Psychologist. When speaking with your insurance company to determine if these services are covered under your plan, use the number associated with the code as reference:

[Only insert codes that are relevant to the specific patient. Codes can be found on the H & B Codes Fact Sheet or the APA website.]

If your insurance company indicates that it does not cover these services, the psychologist and/or the referring physician may be able to provide additional documentation regarding the need for these psychological services.

August 13, 2010 APA Convention: Using Health and Behavior Codes to Help Sustain Clinical Practice in Pediatric Psychology

Health and Behavior Code Fact Sheet

- Developed to facilitate billing for psychosocial services provided to patient *with* physical health diagnosis (ICD-10 codes), *without* requiring a psychiatric diagnosis.

- Enable psychologists to deliver psychological services within a biopsychosocial framework to enhance health-promoting behaviors and/or address acute and chronic physical health problems.

- Cannot deliver psychiatric-based services on same day as health-behavior base service.

- In even that patient has multiple medical diagnoses, the services should be billed with one H&B code and primary medical diagnosis for which behavioral health services requested/recommended.

- Common Obstacles: Medical insurance not familiar with them and/or will not credential psychologist as non-physician provider; psychologist is considered as mid-level provider; H&B codes not recognized by behavioral health side.

  While federal government is drawing from medical funds to reimburse H&B services, private third party insurance companies vary widely; Medicaid providers have typically rejected H&B codes, although under review.
- Consider coordinating systematic efforts with clinical practice managers, business/billing manager who can serve as liaison between you and third party payer, and collect information regarding recognition of codes, monitor reimbursement, appeal rejected claims.