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The New Health and Behavior Assessment & Intervention Codes: A New Paradigm for Psychology

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4 Current Procedural Terminology: Overview

- Background
- Codes & Coding
- Existing Codes
- New Codes (effective 01.01.02; revised 03.15.02)
- Model System X Type of Problem
- Medical Necessity
- Documenting
- Time

5 CPT: Highlights

- New Codes
- Medical Necessity
- Documentation

6 CPT: Background

- American Medical Association
  - Developed by Surgeons (& Physicians) in 1966 for Billing Purposes
  - 7,500+ Discrete Codes
- CMS
  - AMA Under License with CMS
  - CMS Now Provides Active Input into CPT

7 CPT: Background/Direction

- Current System = CPT 5
- Categories
  - I= Standard Coding for Professional Services
  - II = Performance Measurement
  - III = Emerging Technology

8 CPT: Applicable Codes

- Total Possible Codes = Approximately 7,500
- Possible Codes for Psychology = Approximately 40 to 60
- Sections = Five Separate Sections
  - Psychiatry
  - Biofeedback
  - Central Nervous Assessment
  - Physical Medicine & Rehabilitation
  - Health & Behavior Assessment & Management
  - Evaluation & Management

9 CPT: Development of a Code

- Initial
  - Health Care Advisory Committee (non-MDs)
- Primary
  - CPT Work Group
  - CPT Panel
- Time Frame
  - 3-6 years

10 CPT: Psychiatry

- Sections
  - Interview vs. Intervention
  - Office vs. Inpatient
  - Regular vs. Evaluation & Management
  - Other
- Types of Interventions
  - Insight, Behavior Modifying, and/or Supportive vs. Interactive

11 CPT: Psychiatry (cont.)

- Time Value

- 30, 60, or 90
- Interview
  - 90801
- Intervention
  - 90804 - 90857

12 CPT: Biofeedback

- Psychophysiological Training
  - 90901
- Biofeedback
  - 90875

13 CPT: CNS Assessment

- Interview
  - 96115
- Testing
  - Psychological = 96100; 96110/11
  - Neuropsychological = 96117
  - Other = 96105, 96110/111

14 CPT: Physical Medicine & Rehabilitation

- 97770 now 97532
- Note: 15 minute increments

15 CPT: Health & Behavior Assessment & Mngmt.

- Purpose: Medical Diagnosis
- Time: 15 Minute Increments
- Assessment
- Intervention

16 Rationale: General

- Acute or chronic (health) illness may not meet the criteria for a psychiatric diagnosis
- Avoids inappropriate labeling of a patient as having a mental health disorder
- Increases the accuracy of correct coding of professional services
- May expand the type of assessments and interventions afforded to individuals with health problems

17 Rationale: Specific Examples

- Patient Adherence to Medical Treatment
- Symptom Management & Expression
- Health-promoting Behaviors

- Health-related Risk-taking Behaviors
- Overall Adjustment to Medical Illness

18 Overview of Codes

- New Subsection
- Six New Codes
  - Assessment
  - Intervention
- Established Medical Illness or Diagnosis
- Focus on Biopsychosocial Factors

19 Assessment Explanation

- Identification of psychological, behavioral, emotional, cognitive, and social factors
- In the prevention, treatment, and/or management of *physical health* problems
- Focus on biopsychosocial factors (not mental health)

20 Assessment (continued)

- May include (examples);
  - health-focused clinical interview
  - behavioral observations
  - psychophysiological monitoring
  - health-oriented questionnaires
  - and, assessment/interpretation of the aforementioned

21 Intervention Explanation

- Modification of psychological, behavioral, emotional, cognitive, and/or social factors
- Affecting physiological functioning, disease status, health, and/or well being
- Focus = improvement of health with cognitive, behavioral, social, and/or psychophysiological procedures

22 Intervention (continued)

- May include the following procedures (examples);
  - Cognitive
  - Behavioral
  - Social
  - Psychophysiological

23 Diagnosis Match

- Associated with acute or chronic illness
- Prevention of a physical illness or disability

- Not meeting criteria for a psychiatric diagnosis or representing a preventative medicine service

24 Related Psychiatric Codes

- If psychiatric services are required (90801-90899) along with these, report predominant service
- Do not report psychiatric and these codes on the same day

25 Related Evaluation & Management Codes

- Do not report Evaluation & Management codes the same day

26 Code X Personnel (examples)

- Physicians (pediatricians, family physicians, internists, & psychiatrists)
- Psychologists
- Advanced Practice Nurses
- Clinical Social Workers *Excluded for now*
- Other health care professionals within their scope of practice who have specialty or subspecialty training in health and behavior assessments and interventions

27 Health & Behavior Assessment Codes

- 96150
  - Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires)
  - each 15 minutes
  - face-to-face with the patient
  - initial assessment
- 96151
  - re-assessment

28 Health & Behavior Intervention Codes

- 96152
  - Health and behavior intervention
  - each 15 minutes
  - face-to-face
  - individual
- 96153
  - group (2 or more patients)
- 96154
  - family (with the patient present)
- 96155
  - family (without the patient present)

29 Relative Values for Health & Behavior A/I Codes

- 96150 = .50
- 96151 = .48
- 96152 = . 46
- 96153 = .10

- 96154 = .45
- 96155 = .44

30 Expected Payment for Health & Behavior Codes

- Individual (per hour)
  - Range $98-106
- Group (per person/ per hour)
  - Approximately $22

31 Sample of Commonly Asked Questions

- When Are These Codes to be Used for Psychotherapy Codes?
  - Depends on the disorder
  - DSM = psychotherapy
  - ICD = health and behavior

32 Samples Questions (continued)

- Do These Codes Include Neuropsychological Testing?
  - No
  - Formal testing should be coded between 96100 and 96117, depending on the situation

33 Sample Questions (continued)

- Who Can Perform These Services?
  - Physicians can perform these services
  - Application of these codes will vary according to licensure/credentialing requirements of the state, area, providence and/or institution
  - Payment may also vary

34 96150 Clinical Example

- A 5-year-old boy undergoing treatment for acute lymphoblastic leukemia is referred for assessment of pain, severe behavioral distress and combativeness associated with repeated lumbar punctures and intrathecal chemotherapy administration. Previously unsuccessful approaches had included pharmacologic treatment of anxiety (ativan), conscious sedation using Versed and finally, chlorohydrate, which only exacerbated the child's distress as a result of partial sedation. General anesthesia was ruled out because the child's asthma increased anesthesia respiratory risk to unacceptable levels.

35 96150 Description of Procedure

- The patient was assessed using standardized tests and questionnaires (e.g., the Information-seeking scale, Pediatric Pain Questionnaire, Coping Strategies Inventory) which, in view of the child's age, were administered in a structured format. The medical staff and child's parents were also interviewed. On the day of a scheduled medical procedure, the child completed a self-report distress questionnaire.Behavioral observations were also made during the procedure using the CAMPIS-R, a structured observation scale that quantifies child, parent, and medical staff behavior.
- An assessment of the patient's condition was performed through the administration of various health and behavior instruments.

36 96151 Clinical Example

- A 35-year-old female, diagnosed with chronic asthma, hypertension and panic attacks was originally seen ten months ago for assessment and follow-up treatment. Original assessment included extensive interview regarding patient's emotional, social, and medical history, including her ability to manage problems related to the chronic asthma, hospitalizations, and treatments. Test results from original assessment provided information for treatment planning which included health and behavior interventions using a combination of behavioral cognitive therapy, relaxation response training and visualization. After four months of treatment interventions, the patient's hypertension and anxiety were significantly reduced and thus the patient was discharged. Now six months following discharge, the patient has injured her knee and has undergone arthroscopic surgery with follow-up therapy

37 96151 Description of Procedure

- Patient was seen to reassess and evaluate psychophysiological responses to these new health stressors. A review of the records from the initial assessment, including testing and treatment intervention, as well as current medical records was made. Patient's affective and physiological status, compliance disposition, and perceptions of efficacy of relaxation and visualization practices utilized during previous treatment intervention are examined. Administration of anxiety inventory/questionnaire (e.g., Burns Anxiety Inventory) is used to quantify patient's current level of response to present health stressors and compared to original assessment levels. Need for further treatment is evaluated.
- A reassessment of the patients condition was performed through the use of interview and behavioral health instruments.

38 96152 Clinical Example

- A 55-year-old executive has a history of cardiac arrest, high blood pressure and cholesterol, and a family history of cardiac problems. He is 30 lbs. overweight, travels extensively for work, and reports to be a moderate social drinker. He currently smokes one-half pack of cigarettes a day, although he had periodically attempted to quit smoking for up to five weeks at a time. The patient is considered by his physician to be a "Type A" personality and at high risk for cardiac complications. He experiences angina pains one or two times per month. The patient is seen by a behavior medicine specialist. Results from the health and behavior assessment are used to develop a treatment plan, taking into account the patient's coping skills and lifestyle.

39 96152 Description of Procedure

- Weekly intervention sessions focus on psychoeducational factors impacting his awareness and knowledge about his disease process, and the use of relaxation and guided imagery techniques that directly impact his blood pressure and heart rate. Cognitive and behavioral approaches for cessation of smoking and initiation of an appropriate physician-prescribed diet and exercise regimen are also employed.

40 96153 Clinical Example

- A 45-year-old female is referred for smoking cessation secondary to chronic bronchitis, with a strong family history of emphysema. She smokes two packs per day. The health and behavior assessment reveals that the patient uses smoking as a primary way of coping with stress. Social Influences contributing to her continued smoking include several friends and family members who also smoke. The patient has made multiple previous attempts to quit "on her own". When treatment options are reviewed, she is receptive to the recommendation of an eight-session group cessation program.

41 96153 Description of Procedure

- The program components include educational information (e.g., health risks, nicotine addiction), cognitive-behavioral treatment (e.g., self-

monitoring, relaxation training, and behavioral substitution), and social support (e.g., group discussion, social skills training). Participants taper intake over four weeks to a quit date and then attend three more sessions for relapse prevention. Each group sessions lasts 1.5 hrs.

42 96154 Clinical Example

- Tara is a 9-year-old girl, diagnosed with insulin dependent diabetes two years ago. Her mother reports great difficulty with morning and evening insulin injections and blood glucose testing. Tara whines and cries, delaying the procedures for 30 minutes or more. She refused to give her own injections or conduct her own blood glucose tests, claiming they "hurt". Her mother spends many minutes pleading for her cooperation. Tara's father refuses to participate, saying he is "afraid" of her needles. Both parents have not been able to go to a movie or dinner alone, because they know of no one who can care for Tara. Tara's ten year old sister claims she never has any time with her mother, since her mother is always occupied with Tara's illness. Tara and her sister have a very poor relationship and are always quarreling. Tara's parents frequently argue; her mother complains that she gets no help from her husband. Tara's father complains that his wife has no time for anyone except Tara.

43 96154 Description of Procedure

- A family-based approach is used to address the multiple components of Tara's problem behaviors. Relaxation and exposure techniques are used to address Tara's father's fear of injections, which he has inadvertently has been modeling for Tara. Tara is taught relaxation and distraction techniques to reduce the tension she experiences with finger sticks and injections. Both parents are taught to shape Tara's behavior, praising and rewarding successful diabetes management behaviors, and ignoring delay tactics. Her parents are also taught judicious use of time-out and response cost procedures. Family roles and responsibilities are clarified. Clear communication, conflict-resolution, and problem-solving skills are taught. Family members practice applying these skills to a variety of problems so that they will know how to successfully address new problems that may arise in the future.

44 96155 Clinical Example

- Greg is a 42-year-old male diagnosed with cancer of the pancreas. He is currently undergoing both aggressive chemotherapy and radiation treatments. However, his prognosis is guarded. At present, he is not in the endstage disease process and therefore does not qualify for Hospice care. The patient is seen initially to address issues of pain management via imagery, breathing exercises, and other therapeutic interventions to assess quality of life issues, treatment options, and death and dying issues.

45 96155 Description of Procedure

- Due to the medical protocol and the patient's inability to travel to additional sessions between hospitalizations, a plan is developed for extending treatment at home via the patient's wife, who is his primary home caregiver. The patient's wife is seen by the healthcare provider to train the wife in how to assist the patient in objectively monitoring his pain and in applying exercises learned via his treatment sessions to manage pain. Issues of the patient's quality of life, as well as death and dying concerns, are also addressed with assistance given to the wife as to how to make appropriate home interventions between sessions. Effective communication techniques with her husband's physician and other members of his treatment team regarding his treatment protocols are facilitated.

46 CPT: Modifiers

- Acceptability
  - Medicare = about 100%
  - Others = approximating 90%
- Modifiers
  - 22 = unusual or more extensive service
  - 51 = multiple procedures
  - 52 = reduced service
  - 53 = discontinued service

47 ## CPT: Model System

- Psychiatric
- Neurological
- Non-Neurological Medical
- Evaluation & Management

48 ## CPT: Psychiatric Model (Children & Adult)

- Interview
  - 90801
- Testing
  - 96100, or
  - 96110/11
- Intervention
  - e.g., 90806
  - The challenge of New Mexico

49 ## CPT: Neurological Model (Children & Adult)

- Interview
  - 96115
- Testing
  - 96117
- Intervention
  - 97532

50 ## CPT: Non-Neurological Medical Model (Children & Adult)

- Interview & Assessment
  - 96150 (initial)
  - 96151 (re-evaluation)
- Intervention
  - 96152 (individual)
  - 96153 (group)
  - 96154 (family with patient)
  - 96155 (family without patient)

51 ## CPT: New Paradigms

- Initial Psychiatric
- Next Neurological
- Now Medical
- Evaluation & Management

52 CPT: Evaluation & Management

- Role of Evaluation & Management Codes
  - Procedures
  - Case Management
- Limitations Imposed by AMA's House of Delegates for CMS but not for Private Payors
- Health & Behavior Codes as an Alternative to E & M Codes
- The Use of E & M Codes is Accepted by Some Third Party Reimburses (e.g., MedCost)
  - Example; 99201 New Patient

53 CPT: Diagnosing

- Psychiatric
  - DSM
    - The problem with DSM and neuropsych testing of developmentally-related neurological problems
- Neurological & Non-Neurological Medical
  - ICD (or see NAN Paio web page; membership directory)
  - Neurological Code Updates Available by 01.01.03

54 CPT: Medical Necessity

- Scientific & Clinical Necessity
- Local Medical Review or Carrier Definitions of Necessity
- Necessity = CPT x DX
- Necessity Dictates Type and Level of Service
- Necessity Can Only be Proven with Documentation

55 CPT: Documenting

- Purpose
- Payer Requirements
- General Principles
- History
- Examination
- Decision Making

56 Documentation: Purpose

- Medical Necessity
- Evaluate and Plan for Treatment
- Communication and Continuity of Care
- Claims Review and Payment
- Research and Education

57 Documentation: Payer Requirements

- Site of Service
- Medical Necessity for Service Provided
- Appropriate Reporting of Activity

58 ☐ Documentation: General Principles

- Rationale for Service
- Complete and Legible
- Reason/Rationale for Service
- Assessment, Progress, Impression, or Diagnosis
- Plan for Care
- Date and Identity of Observe
- Timely
- Confidential

59 ☐ Documentation: Basic Information Across All Codes

- Date
- Time, if applicable
- Identify of Observer (technician ?)
- Reason for Service
- Status
- Procedure
- Results/Finding
- Impression/Diagnoses
- Disposition
- Stand Alone

60 ☐ Documentation: Mental Status

[1]
- Language
- Thought Processes
- Insight
- Judgment
- Reliability
- Reasoning
- Perceptions

[2]
- Suicidality
- Violence
- Mood & Affect
- Orientation
- Memory
- Attention
- Intelligence

61 ☐ Documentation: Neurobehavioral Status Exam

- Attention
- Memory

- Visuo-spatial
- Language
- Planning

62 Documentation: Testing

- Names of Tests (including edition/version)
- Interpretation of Tests (narrative; possibly quantitative)
- Disposition
- Time/Dates
  - In Hours (rounded to nearest hour)
  - Document on Day Service is Provided
  - Might be Best to Separate from Interview

63 Documentation: Intervention

- Reason for Service
- Status
- Intervention
- Results
- Impression
- Disposition
- Time

64 Documentation: Ethical Issues

- How Much and To Whom Should Information be Divulged
- Medical Necessity vs. Confidentiality
- HIPAA vs. Documentation

65 Time

- Defining
  - Professional (not patient) Time Including:
    - pre, intra & post-clinical service activities
- Interview & Assessment Codes
  - Generally use hourly increments
  - For new codes, use 15 minute increments
- Intervention Codes
  - Use 15, 30, or 60 minute increments

66 Time: Defined Further

- Evaluation Versus Therapy Time
  - Therapy is Essentially Face to Face
  - Testing is Essentially Professional Time

- Inpatient Versus Outpatient
  - If Outpatient: face to face only for E & M
  - If Inpatient: time on floor for E & M

67 Time: Testing

- Quantifying Time
  - Round up or down to nearest increment
  - Testing = 15 or 60 (probably soon 30)
- Time Does Not Include
  - Patient completing tests, forms, etc.
  - Waiting time by patient
  - Typing of reports
  - Non-Professional (e.g., clerical) time
  - Literature searches, learning new techniques, etc.

68 Time (continued)

- Preparing to See Patient
- Reviewing of Records
- Interviewing Patient, Family, and Others
- *When Doing Assessments*:
  - Selection of tests
  - Scoring of tests
  - Reviewing results
  - Interpretation of results
  - Preparation and report writing

69 CPT x RVU

70 Current Problems

- Definition of Physician
- Incident to
- Supervision
- Face-to-Face
- Time
- RVUs
- Work Values
- Qualification of Technicians
- Practice Expense & Testing Survey
- Payment
- Prospective Payment System
- Skilled Nursing Facilities
- Provider Based Facilities
- ***Focus*** for Fraud & Abuse

71 Defining Fraud

- Fraud
  - Intentional
  - Pattern

- Error
  - Clerical
  - Dates

72 Problem: Fraud & Abuse

- 26 Different Kinds of Fraud Types
- Mental Health Profiled
- Estimates of Less Than 10% Recovered
- Psychotherapy Estimates/Day = 9.67 hours
  - Review Likely if Over 12 Hours Per Day
- Problems with Methodology;
  - MS level and RN
  - Limited Sampling

73 Problem: Fraud
Office of Inspector General

- Primary Problems
  - Medical Necessity (approximately $5 billion)
  - Documentation
- Psychotherapy (oig.hhs/gov/reports/region5/50100068)
  - Individual
  - Group
  - # of Hours
  - Who Does the Therapy
- Psychological Testing
  - # of Hours
  - Documentation

74 Problem:
Fraud & "The Orange Book"

- Contractor Operations
  - Strengthen Regional Offices Oversight
  - Improve Evaluation of Fraud Unit
  - Prevent Duplicate Payments for Same Service
- Hospital Operations
  - Identify Patterns of Aberrant Overpayment
  - Improve External Review of Psychiatric Hospitals
- Managed Care
  - Retool Medicaid Programs for Managed Care
- Nursing Homes
  - Improve Assessments of Mental Illness
  - Identify Patients with Mental Illness
  - Supervision and Bundled Services

75 Problem:
The "Orange Book" (continued)

- Physicians/Allied Health Professionals
  - Improve Oversight of Rural Health Clinics
  - Eliminate Inappropriate Payments for Mental Health Services
  - Yet, Improve Medicaid Mental Health Programs

76 Problem: Fraud (cont.)

- Nursing Homes
  - Identification
  - Overuse of Services
- Children
- Experience
  - California; Texas
  - Corporation Audit
  - Company Audit
  - Personal Audit

77 Problem: Fraud (cont.)

- Estimated Pattern of Fraud Analysis
  - For-profit Medical Centers
  - For-profit Medical Clinics
  - Non-profit Medical Centers
  - Non-profit Medical Clinics
  - Nursing Homes
  - Group Practices
  - Individual Practices

78 Possible Solutions: General Approaches

- Better Understanding & Application of CPT
- More Involvement in Billing (especially in large, medical, multidisciplinary, and academic settings)
- Comprehensive Understanding of LMRP
- More Representation/Involvement with AMA, CMS, & Local Medical Review Panels
- Meetings with CMS
- Survey for Testing Codes
- APA: Increased Staff & Relationship with CAPP
- Enjoying the Estimated Five Weeks per Year That Health Care Professionals are Expected to Take

79 Possible Solutions: Resources

- General Web Sites
  - www.cms.org (medicare/medicaid)
  - www.hhs.org (health & human services)
  - www.oig.hhs.gov (inspector general)
  - www.ahrq.gov (agency for healthcare research)
  - www.medpac.gov (medical payment advisory comm.)
  - www.whitehouse.gov/fsbr/health (statistics)
  - www.nanonline.org (nan)
  - www.div40.org (clinical neuropsychology div of apa)

- www.healthcare.group.com (staff salaries)

80 Resources (continued)

- LMRP Reconsideration Process
  - www.cms.gov/manuals/pm_trans/R28PIM.pdf
- Coding Web Sites
  - www.aapcnatl.org (academy of coders)
  - www.ntis.gov/product/correct-coding (coding edits)
- Compliance Web Sites
  - www.apa.org (psychologists & hipaa)
  - www.cms.hhs.gov/hipaa. (hipaa)
  - www.hcca-info.org (health care compliance assoc.)

81 Resources (continued)

Publications

- Testing Times: Camara, Puente, & Nathan (2000)
- NAN/Division Practice Suveys (in The Clinical Neuropsychologist & Archives of Clinical Neuropsychology; Sweet & Peck)
- General CPT: NAN & Div 40 Newsletters

82 Future Perspectives

- New Paradigm = Change (lots of it)

ARE YOU READY?...

83 Questions? Answers...

- Questions?

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