2020 Health Behavior Assessment and Intervention
Billing and Coding Guide

EXECUTIVE SUMMARY

Effective January 1, 2020, Current Procedural Terminology (CPT®) codes 96150–96155 were deleted and a new code set was implemented to report Health Behavior Assessment and Intervention (HBAI) services. APA Services, Inc. developed this guide to provide an explanation of the extensive changes as well as describe the structure, function, and utilization of the new code set established through APA’s collaborative work with the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS).

The information contained in each of the guide’s sections is provided to the right. APA encourages payers and providers to utilize the guide to navigate the new landscape of health behavior assessment and intervention services, and to become familiar with the coding guidelines and payment policies associated with these procedures.

Please direct any questions about this guide to APA’s Office of Health Care Finance at OHCF@apa.org and the appropriate APA Services expert will contact you. Additional APA Services’ resources are publicly available on APA’s website (https://www.apaservices.org/practice/reimbursement/health-codes/health-behavior).

SECTIONS

- **Coverage Indications, Limitations, and Medical Necessity:**
  This section provides descriptions of the assessment and treatment services; specifics on determining medical necessity (pages 3-5); and limitations of coverage (pages 5-6).

- **Coding Information:**
  This section contains a complete listing and description of the new health behavior CPT® codes effective January 1, 2020 (pages 6-7).

- **General Information:**
  This section describes the documentation elements that are typically necessary to include in the patient record to support use of the codes as well as coding guidelines and instruction for proper reporting (pages 7-9).

- **Utilization Guidelines:**
  This section provides instructions to assess coverage provisions and appropriateness of services provided to a patient(s) and/or their family. The instructions are intended to improve quality and efficiency of care, reduce unnecessary and/or inappropriate services, and manage the cost of health care benefits (page 9).

- **Sources of Information:**
  This section lists the scientific evidence and educational resources to support the contents of this guide (pages 9-11).
The initial development of health behavior services began in 1998 to satisfy the need for psychological assessment and intervention services for patients who presented with a known or established medical illness. These services were developed to assess how the medical illness was affecting the patient’s physical health and well-being and address any identified impact by modifying the associated psychological, behavioral, emotional, cognitive, and social factors (CPT Assistant, March 2002). As a result, a CPT codes 96150–96155 were implemented in 2002 and health behavior service began to be more widely provided.

Over the past two decades, there has been a significant increase in the development and adaptation of evidence-based techniques to address psychological factors impacting physical illness (Roditi et al., 2011; Richards et al., 2018; Wysocki et al., 2006; Willfley et al., 2018). Treatment strategies have evolved from the general application of behavioral expertise to physical health conditions to the application of specific psychological principles in the global treatment of physical health conditions. Interventions commonly used include (but are not limited to) cognitive restructuring, operant behavior therapy and contingency management, stimulus control, graded activation and behavioral activation, coping skills training, problem solving training, functional and structural family therapy, family communication training, relaxation skills training, and motivational interviewing. These changes have resulted in greater specialization in training, as well as the development of treatment guidelines for psychologists providing these services in both the primary care (McDaniel et al., 2014) and specialty care settings for chronic non-communicable diseases such as cardiovascular disease (Bosworth et al., 2018), obesity (APA, 2018), pain (Wandner et al., 2019), diabetes (ADA, 2018), traumatic brain injury (Ponsford et al., 2016), stroke (Hildebrand, 2015), spinal cord injury (Russell et al., 2016), amputations (Highsmith et al., 2016) and bariatrics (Sogg et al., 2016).

As clinician and medical condition specification continued to develop, health behavior services were used with increasing frequency in outpatient settings for both primary and specialty care, a finding that is supported by Medicare claims data (2002-2017). For example, in 2002, only 9% of the claims for the Health and Behavior Assessment service (CPT code 96150) were in General Outpatient compared to 24% in 2017. The same time period saw a 20% increase in the use of the Health and Behavior Individual Treatment service (CPT code 96152) in General Outpatient and 10% increase in the use of this code in Physician Offices (AMA, 2019). The higher frequency of use of the codes in outpatient settings can be attributed to the increased focus on integrating behavioral health services into both primary and specialty care settings (APA, 2016; SAMSA-HRSA, 2018).

The population of patients with chronic noncommunicable diseases like the ones listed above has also grown since the code set was initially developed resulting in a significant increase in complexity and cost of care (The US Burden of Disease Collaborators, 2018). For example, it is estimated that just 5% of patients account for 50% of health care costs. The National Academy of Medicine identified four core groups of high cost patients: 1. children with severe disabilities; 2. adults with significant chronic illness (two or more complex conditions, and one complex plus one to five noncomplex conditions); 3. frail elderly; and 4. disabled patients under 65. Within these high-cost groups, there is a subgroup of high needs patients defined as complex medical high cost patients. These individuals typically have functional limitations and their circumstances often require behavioral services (Hayes et al., 2016; Long et al., 2017; Nahin, 2015).
Effective and efficient treatment of these high-cost and high-need patients necessitates health behavior assessment to evaluate the behavioral and psychological variables contributing to poor health care monitoring, adherence, and health-promoting behaviors to determine specific behavioral interventions and other service needs.

As the types and severity of these conditions have also evolved, there is a greater need for inclusion of health behavior services in patient treatment plans. In fact, the six risk factors contributing to over a third of all health care costs: tobacco use, poor diet, substance abuse, high Body Mass Index, high systolic blood pressure, and high resting glucose levels (The US Burden of Disease Collaborators, 2018) all have clear behavioral determinants that can be effectively addressed by HBAI services.

Given how health behavior services have dramatically changed over time, especially in areas of provider technique and knowledge, patient population, and the health care settings in which they are offered, APA worked in collaboration with the AMA and CMS to establish the 2020 Health Behavior Assessment and Intervention (HBAI) code set. This new/revised family of codes more accurately reflect current clinical practice, providing greater focus on psychological and/or psychosocial factors in health as well as the increased role these services have in interdisciplinary care, particularly in primary, specialty care, post-acute, rehabilitation, and skilled nursing facility settings.

**COVERAGE INDICATIONS, LIMITATIONS, AND MEDICAL NECESSITY**

Health Behavior Assessment and Intervention (HBAI) services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems. The patient’s primary diagnosis is physical in nature and the focus of the assessment and intervention is on factors complicating medical conditions and treatments. These codes describe assessments and interventions to improve the patient’s health and well-being by utilizing psychological and/or psychosocial interventions by a qualified health provider designed to ameliorate specific disease-related problems.

Health behavior assessment includes evaluation of the patient’s responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment. Assessment is conducted through health focused clinical interviews, observation, and clinical decision making.

Health behavior intervention includes promotion of functional improvement, minimization of psychological or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active patient/family engagement and involvement (AMA, 2020).

**Health Behavior Assessment or Re-Assessment**

Health behavior assessment and re-assessment (CPT code 96156) consist of assessing multiple domains and their degree of impact, which can include but are not limited to:

- Relevant medical history
- Adjustment to the medical illness or injury
- Psychological and environmental factors affecting management of the medical condition
- Health beliefs, perception, and outlook
- Understanding of treatment plan, benefits and risks of procedures
- Health care decision-making skills
- Coping strategies, patient strengths
- Motivation and self-efficacy beliefs
- Treatment adherence and expectations
- Daily activities, level of behavioral activation, and functional impairment
- Sleep, diet, physical activity, and other health risk behaviors
- Mental health and substance use (including tobacco and alcohol use)—current and past
- Social support, family and interpersonal relations
- Academic and vocational histories
- Mood
- Quality of life

**Components of Health Behavior Assessment and/or Re-Assessment**

Three **required** elements that must be performed and documented in order to report CPT code 96156:

i. **Health-focused clinical interview:** Depending on the nature of the referral question, the qualified health care professional (QHP) conducts the face-to-face health-focused clinical interview with the patient that may assess multiple domains as outlined above. Collateral interviews are conducted as appropriate. When it precedes a health behavior intervention, the
clinical assessment would determine the type(s) of intervention that would best benefit the patient.

ii. Behavioral observations: The QHP evaluates how the patient is responding throughout the health-focused clinical interview through direct behavioral observation. There will be variability across patients depending on a wide variety of factors including patient complexity, comorbidities, severity of medical condition(s), and other factors that drive the clinical decision-making process.

iii. Clinical decision making: The QHP integrates information learned prior to the interview (record review, discussions with other health care providers) with information gained during the health-focused clinical interview and behavior observations to formulate the case conceptualization/clinical impressions, established or suspected medical diagnoses, any additional diagnoses determined by the QHP, and treatment recommendations.

Medical Necessity: Health Behavior Assessment or Re-Assessment
The Health Behavioral Assessment or Re-Assessment service may be considered reasonable and necessary for the patient who meets all the following criteria:

• The patient has an established or suspected underlying physical illness or injury and the purpose of the assessment or re-assessment is not primarily for the diagnosis or treatment of mental illness;
• There are indications that psychological, behavioral, and/or psychosocial factors may be affecting the treatment or medical management of an illness or an injury;
• The patient is alert, oriented, and has the capacity to understand and to respond meaningfully during the face-to-face encounter;
• The patient has an established or suspected underlying physical illness or injury needing a health behavior evaluation and/or intervention to successfully manage their physical illness and activities of daily living.
• The patient can be referred from a medical or mental health care provider, or self-referred to seek assistance in addressing the role of psychological and/or behavioral factors affecting an underlying physical health condition.

Re-Assessment
In addition to meeting all the criteria stated above, medical necessity for re-assessment must be further established through documentation of one of the following:

• Change in the mental or medical status warranting re-evaluation;
• Specific concern from the primary medical provider or member of medical team;
• Need for re-assessment as part of the standard of care;
• Change in providers; or
• At least a 6-month period of time has elapsed since the last assessment.

Health behavior assessment or re-assessment is considered medically necessary for one or more of the following indications, where there is a need to:

1. Assess psychological and/or behavioral factors that impact the management of a patient’s acute or chronic medical condition (e.g., assessment of stress and its impact on diabetes management); or
2. Assess patient’s responses to disease, illness or injury, outlook (e.g. health beliefs and attitudes), coping strategies, motivation, and adherence to medical treatment; or
3. Assess behavioral and contextual factors that impact disease management in scenarios that include, but are not limited to:
   a. pre-surgical evaluation to identify psychological factors that may potentially affect or complicate the outcome of surgical procedures and/or aftercare (e.g., spinal surgery, bariatric surgery, implantable therapies, organ transplant);
   b. assessment of emotional/personality factors impacting physical disease management and ability to comply with and/or benefit from medical interventions;
   c. assessment of psychosocial and/or environmental factors that can impact a patient’s ability to comply with and/or benefit from medical interventions; or
4. Assess psychological barriers and strengths to aid in treatment planning, including but not limited to:
   a. the selection of treatment options when several evidence-based approaches may be indicated;
   b. determining treatment prognosis and outcomes;
   c. identifying reasons for poor response to medical treatment; or
5. Assess and monitor psychological factors and impact on medical condition and management over time (repeated assessments); or

6. Assess health related risk behaviors (e.g., sleep, diet, physical activity, tobacco use) and their impact on the medical condition and management.

**Health Behavior Intervention**

Intervention services may be provided to:

- An individual (and is billed with CPT codes 96158, +96159);
- A group of two or more patients (and is billed with CPT codes 96164, +96165 for each individual patient in the group);
- A family, with the patient present (and is billed with CPT codes 96167, +96168); or
- A family, or without the patient present (and is billed with CPT codes 96170, +96171)
  ‣ Note: APA firmly believes that Health Behavior Family Intervention without the patient present (96170/+96171) should be a reimbursable service as it benefits the patient’s medical treatment and management; however, as coverage varies, providers should check with their insurance carrier for verification of coverage.

Family intervention services, whether the patient is or is not present, involves face-to-face interaction with “family representative(s)” *(see definition in the Addendum B)* (CMS, 2018). Health behavior intervention includes promotion of functional improvement, minimization of psychological or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active patient/family engagement and involvement.

Evidence-based health behavior interventions address psychological/behavioral factors that can be influencing a person’s medical condition and consist of various types of treatment interventions, including but not limited to:

- Motivational interviewing
- Problem solving training
- Coping skills training
- Relaxation techniques and skills training
- Cognitive restructuring
- Emotional awareness and management
- Operant behavior therapy and contingency management
- Graded activation, behavioral activation, and pacing techniques
- Psychoeducation related to the psychological, behavioral, and/or psychosocial aspects of the patient’s illness or presenting problem
- Stimulus control
- Functional and structural family treatment
- Communication skills training
- Mindfulness techniques

**Medical Necessity: Health Behavior Intervention Services**

The health behavioral intervention services (CPT codes 96158/+96159, 96164/+96165, 96167/+96168, 96170/+96171) may be considered reasonable and necessary for the patient who meets all of the following criteria:

- The patient has an underlying physical illness or injury
- Specific psychological intervention(s) and patient outcome goal(s) have been clearly identified and documented
- Psychological intervention is necessary to address:
  ‣ Non-adherence with the medical treatment plan, or
  ‣ The psychological and/or psychosocial factors associated with a newly diagnosed physical illness, or an exacerbation of an established physical illness, when such factors affect:
    - symptom management and expression
    - health-promoting behaviors
    - health-related risk-taking behaviors
    - overall adjustment to medical illness.
- There are indications that psychological, behavioral, and/or psychosocial factors may be affecting the treatment or medical management of an illness or an injury
- The patient is alert, oriented and has the capacity to understand and to respond meaningfully during the intervention service

In addition to the criteria above, family intervention with patient present (CPT codes 96167/+96168) and without patient present (CPT codes 96170/+96171) is considered reasonable and necessary for the patient who meets all of the following criteria:

- The “family representative” *(see definition in the Addendum B)* directly participates in the overall care of the patient, and
- The psychological intervention with the patient and family is necessary to address psychological and/or psychosocial factors that affect adherence with the plan of care, symptom management, health-promoting behaviors, health-related
risk-taking behaviors, and overall adjustment to medical illness.

**Health behavior intervention services are considered medically necessary when one or more of the following needs are present:**

1. Modify and manage psychological and behavioral factors that are impacting the management of a patient’s acute or chronic medical condition (e.g., improve stress management to improve diabetes management); or

2. Modify and/or improve a patient’s cognitive or emotional responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment through the on-going maintenance or improvements resulting from evidence-based treatments; or

3. Modify and/or improve psychological and/or behavioral factors that impact disease management in scenarios that include but are not limited to:
   a. Psychological factors affecting or complicating the outcome of surgical procedures and/or aftercare (e.g., spinal surgery, bariatric surgery, implantable therapies);
   b. The emotional/personality impacts on physical disease management and/or the ability to comply with and benefit from medical interventions; or

4. Modify and/or improve a patient’s adherence to medical treatment and/or health risk-related behaviors; or

5. Modify and/or improve a patient’s engagement in self-management and participation in treatment; or

6. Modify and/or improve a patient’s understanding of the medical condition, its treatment, and the psychological, behavioral, emotional, cognitive, or social factors related to the prevention, treatment or management of the medical condition.

**Limitations of Coverage**

Health behavior assessment and intervention services will not be considered reasonable and necessary for the patient with any of or all the following criteria:

- Does not have a suspected or established underlying physical illness or injury; or
- For whom there is no indication that psychological and/or psychosocial factors may be significantly affecting the treatment, or medical management of an illness or injury (i.e., screening medical patient for psychological problems); or
- Does not have the capacity to understand and to respond meaningfully during the face-to-face encounter for reasons such as, but not limited to:
  - Cognitive status that indicates inability to actively participate and benefit from services;
  - Severe dementia that has produced a severe enough cognitive defect for the psychological intervention to be ineffective;
  - Severe or profound intellectual disability;
  - Persistent inability to engage in meaningful interpersonal interactions including inability to respond to cues and directions.

**The following would not be considered medically necessary if provided as the primary health behavior intervention service:**

- Updating or educating the family about the patient’s condition
- Educating family members who do not meet the definition of “family representative” (see definition in the Addendum B), and other members of the treatment team (e.g., health aides, nurses, physical or occupational therapists, home health aides, personal care attendants, and co-workers) about the patient’s care plan.
- Treatment-planning with staff
- Mediating between family members or providing family psychotherapy
- Education that does not include the psychological, behavioral, and/or psychosocial aspects of the patient’s illness or presenting problem
- Delivering Medical Nutrition Therapy (i.e., CPT codes 97802; *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes*, 97803; *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes*, and 97804; *Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes*)
- Retraining cognition due to dementia or memory enhancement training (i.e., CPT codes 97129; *Therapeutic interventions that focus on cognitive function* (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes and 97130; *Therapeutic interventions that focus*
on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes

- Provision of support services, not requiring the skills of an individual with health psychology training.
- Provide personal, social, recreational, and general support services.*

*While personal, social, recreational, and general support services may be valuable adjuncts to care, they are not considered psychological health behavior interventions. Example of these services are:
- Stress management for support staff
- Replacement for expected nursing home staff functions
- Recreational services, including dance, play, or art
- Music appreciation
- Craft skill training
- Cooking classes
- Individual or group social activities
- General conversation
- Consciousness raising
- Vocational or religious advice
- General educational activities
- Visits for loneliness relief
- Sensory stimulation
- Games, such as bingo
- Projects, such as shopping outings, even when used to reduce a dysphoric state
- Teaching grooming skills
- Grooming services
- Monitoring activities of daily living
- Teaching the patient simple self-care
- Teaching the patient to follow simple directives
- Wheeling the patient around the facility
- Orienting the patient to name, date, and place
- In-vivo exercise programs, even when designed to reduce a dysphoric state
- Case management services including but not limited to planning activities of daily living, arranging care or excursions, or resolving insurance problems
- Activities principally for diversion
- Planning for milieu modifications
- Contributions to patient care plans
- Maintenance of behavioral logs

Health Behavior Family Intervention services with the patient present (96167/+96168) and without the patient present (96170/+96171) will not be considered reasonable and necessary for the patient if:

- All medical necessity criteria for health behavioral intervention services are not met (see medical necessity criteria in the Section 1.E); and/or
- The family representative does not directly participate in the plan of care; and/or
- The family representative is not present.

Health Behavior Family Intervention without the patient present (96170/+96171) is not considered a covered service under Medicare and by some private insurers and state Medicaid programs.

Note: APA firmly believes that Health Behavior Family Intervention without the patient present (96170/+96171) should be a reimbursable service as it benefits the patient’s medical treatment and management; however, as coverage varies, providers should check with their insurance carrier for verification of coverage.

Please note that this document does not provide a guarantee that HBAI services are reimbursable under a particular plan, payer, medical, or behavioral health benefit; therefore, it is highly recommended that providers contact each plan regarding coverage decisions.

CODING INFORMATION

CPT Codes and Descriptors for HBAI Services

96156; Health behavior assessment or re-assessment (i.e., health-focused clinical interview, behavioral observation, clinical decision making)

96158; Health behavior intervention, individual face-to-face; initial 30 minutes

+ 96159; Health behavior intervention, individual face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

(Use 96159 in conjunction with 96158)

96164; Health behavior intervention, group (two or more patients), face-to-face; initial 30 minutes

+ 96165; Health behavior intervention, group (two or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

(Use 96165 in conjunction with 96164)

96167; Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes

+ 96168; Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

(Use 96168 in conjunction with 96167)
96170; Health behavior intervention, family (without the patient present), face-to-face initial 30 minutes

96171; Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

(Use 96171 in conjunction with 96170)

+ Indicates an Add-On Code to be reported with primary service/base code

Note: APA firmly believes that Health Behavior Family Intervention without the patient present (96170/+96171) should be a reimbursable service as it benefits the patient’s medical treatment and management; however, as coverage varies, providers should check with their insurance carrier for verification of coverage.

ICD-10-CM Codes that Support Medical Necessity for HBAI Services

Due to the wide range of physical health diagnoses a patient could have to necessitate Health Behavior Assessment and/or Intervention services, there is not a list of “approved” codes that support medical necessity. Instead, a list of ICD-10-CM codes that are known not to support medical necessity when reported as the primary diagnosis is provided in a separate addendum. (See Addendum C for a list of non-covered primary diagnosis codes.)

• ICD-10-CM diagnosis code(s) reflecting the physical condition(s) being treated must be documented on the claim form (Box 21 A of the CMS-1500 form) as the primary diagnosis.

• However, in the case where a patient also has a mental health diagnosis, it should be reported as a secondary condition using traditional mental health diagnosis codes.

• ICD-10-CM codes must always be coded to the highest level of specificity.

GENERAL INFORMATION

Documentation Requirements

The patient’s medical record should contain documentation that supports the medical necessity for health behavior services performed, including the following information:

• Referral question and suspected or established medical diagnosis

• Relevant medical history

• Relevant psychological and/or psychosocial history (when appropriate)

• Sources of information (e.g., patient interview, record review, behavioral observations)

• Services performed

• Clinical decision making (see description in the Section 1.B.iii)
  i. Impressions
  ii. Diagnosis
  iii. Treatment planning and recommendations

Documentation should be legible, signed, include the QHP’s credentials, and maintained in the patient’s medical record.

Medical records need not be submitted with the claim; however, all coverage criteria must be clearly documented, and the medical record, (e.g., nursing home record, doctor’s orders, progress notes, office records, and nursing notes), must be available to the payer upon request.

Because of the impact on the medical management of the patient’s disease, documentation should typically show evidence and/or attempts of communicating and coordination with the patient’s medical provider responsible for the medical management of the physical illness that the health behavior assessment and/or intervention was meant to address.

Documentation in the medical record must include:

• For the Assessment, evidence to support that the assessment is reasonable and necessary (see medical necessity criteria in the Section 1.C), and must include at a minimum the following elements:
  › Documented health-focused clinical interview,
  › Diagnosis of physical illness,
  › Clear rationale for why assessment or re-assessment is required,
  › Behavioral observations, including mental status and ability to understand or respond meaningfully,
  › Clinical decision-making related to the formulation of the case conceptualization/clinical impressions, and treatment recommendations (e.g. goals and expected duration of specific psychological intervention(s), if recommended).

• For Re-assessment, evidence to support that the re-assessment is reasonable and necessary must be documented in
detailed progress notes. In addition to meeting all the criteria for assessment (see medical necessity criteria in the Section 1.C), these detailed progress notes must include at least one of the following elements:

› Change in mental or medical status warranting re-evaluation;
› Specific concern from the primary medical provider or member of medical team for why re-assessment is required; or need for re-assessment as part of the standard of care; or a change in providers; or at least a 6-month period of time has elapsed since the last assessment;
› Clear indication of the precipitating event that necessitates re-assessment; and
› Changes in goals and/or frequency and duration of services.

• For the intervention services, evidence to support that the intervention is reasonable and necessary (see medical necessity criteria in the Section 1.E) must include, at a minimum, the following elements:

› Evidence that the patient has the capacity to understand and to respond meaningfully;
› Clearly defined psychological intervention provided
› Clearly stated goals of the psychological intervention
› Documentation that the psychological intervention is expected to benefit the patient’s physical disease management and ability to comply with and/or benefit from medical interventions
› Rationale for frequency and duration of services
› The response to the intervention

As is noted in the CPT code descriptor language of the health behavior intervention codes, these services are intended to be reported according to the time spent providing these services. Therefore, for all claims, start and stop times (stated in minutes) for the health behavioral intervention encounter should be documented in the medical record, and the quantity billed should reflect the appropriate number of base and add-on code units required to complete the face-to-face service.

Performance of a health behavior assessment or re-assessment includes a health-focused clinical interview, behavioral observations, and clinical decision making. Although the assessment code is an event-based/untimed service, it is recommended that start and stop times are documented for the face-to-face time with the patient(s) and/or family.

Coding Guidance
If the health behavior assessment or re-assessment (CPT code 96156) is unable to be completed during a single encounter, the date of service indicated on the claim should be the date on which the interview was finalized.

It is typical for psychological testing and health behavior assessment and/or intervention services to be provided to the same patient; often on the same date of service. Any psychological testing performed in addition to the health assessment or re-assessment should be additionally reported, based on the type of testing performed (AMA, 2004).

Health behavior assessment and intervention or two types of health behavior intervention services can be billed on the same date of service, but there must be clear documentation of the provision of the two separate services and documentation of start and stop times to distinctly delineate one service from the other.

HBAI codes should only be reported by QHP to identify assessment and treatment for psychological and/or psychosocial factors affecting a patient’s physical health problems. The HBAI guidelines direct that physicians, clinical nurse specialists (CNS), or nurse practitioners (NP), performing health and behavior assessment and/or interventions should report the appropriate code(s) in the Evaluation and Management (E&M) or Preventive Medicine services section of the CPT® manual. (AMA, 2014)

The HBAI CPT code family does not represent preventive medicine counseling and risk factor reduction interventions. Therefore, they should not be reported for the purpose of prevention of a physical illness or disability, and maintenance of health.

The family of Health Behavior services, used for patients with a primary diagnosis that is physical in nature, have an anomalous relationship to Psychotherapy services, used for patients with a primary mental health diagnosis.

Biofeedback (CPT code 90901; Biofeedback training by any modality) is not covered as a health behavioral intervention.

Services to patients for evaluation and treatment of mental illnesses should be coded using psychiatric services CPT codes (90791-90899).

AMA CPT Health Behavior Assessment and Intervention Guidelines

Codes in the HBAI series describe services associated with an
acute or chronic physical illness or symptoms and are offered to patients who may benefit from evaluations that focus on psychological and/or psychosocial factors. For patients that require psychiatric services (90785 - 90899), adaptive behavior services (97151-97158, 0362T, 0373T) as well as health behavior assessment and intervention, only the predominant service performed would be reported.

Do not report HBAI codes in conjunction with psychiatric services (90785-90899) on the same date.

Evaluation and management (E/M) service codes (including counseling risk factor reduction and behavior change intervention [99401-99412]) should not be reported on the same day as HBAI codes by the same provider.

HBAI can occur and be reported on the same date of service as E/M services, as long as:

- HBAI is reported by a physician or other QHP; and
- The E/M service is reported by a different physician or other QHP that is eligible to perform the services located in the E/M or Preventive Medicine Services section of the 2020 CPT® Manual.

In circumstances where telehealth is available and all requirements are met for a psychologist to bill for telehealth services, Health Behavior Assessment or Re-Assessment (96156), Individual Intervention (96158/+96159), Group Intervention (96164/+96165), and Family Intervention, when the patient is present (96167/+96168), may be furnished via telehealth to Medicare Part B beneficiaries enrolled in fee-for-service Medicare.

Per CPT guidelines for time-based codes, a unit of service is attained when the mid-point is passed. For example, 30 minutes is attained when 16 minutes have elapsed (more than midway between zero and 30 minutes). Therefore, the following standards shall apply to time measurement when reporting Health Behavior Intervention services:

- Do not report 30-minute Health Behavior Intervention base codes (96158, 96164, 96167, 96170) for less than 16 minutes of service.
- Do not report 15-minute Health Behavior Intervention add-on codes (96159, 96165, 96168, and 96171) for less than 8 minutes of service.

**UTILIZATION GUIDELINES**

According to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) and Medically Unlikely Edits (MUE) effective January 1, 2020 (CMS/NCCI, 2019):

- The initial assessment (CPT code 96156) is limited to once (1 unit) per episode of care.
- The individual intervention is limited to a maximum of 90 minutes (1 unit of 96158 and 4 units of 96159) per day, per patient.
- The group intervention is limited to a maximum of 120 minutes (1 unit of 96164 and 6 units of 96165) per day, per patient.
- The family intervention (with and without patient present) is limited to a maximum of 120 minutes (1 unit of 96167/96170 and 6 units of +96168/+96171) per day, per patient.

Cumulated time is then converted to units of CPT codes reported. A single unit of a base code should be reported with multiple units (as needed) of the corresponding add-on code for the individual services performed; however, add-on codes can never be reported as a stand-alone service. They can only be reported in conjunction with their respective base code. *(See Addendum A for clinical examples and tips for proper documentation, coding and billing.)*

If a health behavior intervention service exceeds the amount of time or number of units allowed for a single service (e.g., as stated by the NCCI and/or in an insurer policy), documentation must be present in the patient record to justify medical necessity for extended time provided and/or number of units reported.
SOURCES OF INFORMATION

References


Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions. Primary and behavioral health integration:


Additional References


