

Nicole Owings-Fonner: Welcome to today's webinar series entitled "Getting Reimbursed: Updates on Billing and Documentation for Health Behavior Assessment and Intervention Services in 2020". Our presenters today are Dr. Stephen Gillaspay, APA's senior director of health care financing, and Ms. Meghann Dugan-Haas, APA's coding and payment policy officer. This webinar series has been pre-recorded and broken down into segments to make it easier for you to understand and refer back to. Our objectives are to understand the H&B code set review and revision process, to introduce the 2020 Health Behavior Assessment and Intervention Services, and we'll review the new CPT codes, descriptions and coding structure, as well as provide an explanation of how the existing codes crosswalk to the new codes. We'll also apply the new codes using clinical examples and review coding guidelines, payment policies, and reimbursement values.

In this segment of the webinar series, our presenters will provide an introduction to the 2020 Health Behavior Assessment and Intervention code family. Meghann and Stephen?

Dr. Stephen Gillaspay: So, the health behavior assessment intervention services: they are used to identify and address the psychological, behavioral, emotional, cognitive, interpersonal factors that are important to the assessment, treatment, and management of physical health problems. One thing that's important to note is that when using the HBAI services and codes, the patient's primary diagnosis is always going to be physical in nature. Now, a point to clarify: it does not mean that the patient cannot have a traditional mental health diagnosis; that can be a secondary diagnosis, but it's important to know that the primary diagnosis needs to be medical in nature and the primary focus of your intervention. In regards to the services, the assessment intervention focus – those services are going to focus on factors complicating the medical condition and the treatments.

Meghann Dugan-Haas: As part of the code set revision process, a specific definition for health behavior assessment was adopted by the CPT editorial panel and that new definition can be found in the 2020 CPT manual. As defined, it says that 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 services are conducted through three required elements. Those three elements are a health-focused clinical interview, behavioral observations, and clinical decision-making.

So, effective for January 1, 2020, the existing codes for H&B assessment and reassessment - nine six one five zero (96150) and nine six one five one (96151) - will be deleted.

And on January first, a single code to report both health behavior assessment or reassessment will be implemented and should be used to report services that are provided on or after January 1, 2020.

Dr. Stephen Gillaspay: In this slide, you'll see on the left-hand side the two codes that were used previously to capture both the assessment and the reassessment services. So, the assessment service was nine six one five oh (96150) and nine six one five one (96151). In the new HBAI code set, we've collapsed that so it'll just be one code: nine six one five six (96156) that you will use for assessment as well as reassessment. So, a couple of important things to note: so again, we're going from an assessment and reassessment code to just one primary assessment code. Another important thing to note is that previously nine six one five oh (96150) and nine six one five one (96151) were both timed codes and you would report that in 15-minute increments. For our new assessment code, it is an untimed code; so, it's an event-based code and, as you can see, it's been modeled after... if we think in the psychotherapy code set, we think of nine oh seven nine one (90791), the diagnostic interview. So, it's been modeled after that, which is also an untimed code. Additionally, you'll see - and Meghann mentioned this before - if we think about the... the elements... the required elements, in the past, the assessment and reassessment code included... it could include physiological monitoring, health-oriented questionnaires, and again, if we look at those it was the "e.g.," and it would list those out. Now, with the assessment code, we have the "i.e."s. We've got three primary things that must occur in order for that... for you to use that assessment code and again, as Meghann stated, that was the health-focused clinical interview, behavioral observations, and clinical decision-making.

So, as we look at the health behavior, the intervention... the intervention codes, they're going to include promotion of functional improvement, minimizing psychological and psychosocial barriers to recovery, and management of and

improved coping with medical conditions. Again, these services emphasize active patient and family engagement and involvement.

As we look now at... as we continue to look at health behavior, the intervention... intervention services may be provided to an individual. So again, this is going to follow the same pattern of codes - the H&B codes prior... prior to the changes where we're going to have an individual code. You can provide it in a group format: so, a group of two or more patients. You can also provide it to a family with the patient present or a family without the patient present. So, those are going to have things... those aspects of the code sets are still in line with the previous H&B code set.

Meghann Dugan-Haas: There's an entirely new code structure for reporting intervention services that will go into effect on January 1. It involves a base code, which is a standalone code that describes the primary service, and then an add-on code, that describes additional work and time that is associated with the primary service.

Depicted here are the three parts that make up a typical standalone CPT code. This is also how a base code is structured; each of the three parts accounts for a portion of the overall work RVU, or relative value unit, for the code. The pre-service is the activities that are performed prior to the patient arriving for the service. This includes elements such as preparing to see the patient, reviewing records, and communicating with other professionals or team members; these are basically considered non-face-to-face services. Secondly is the intraservice work; this is the actual providing of the service as described in the code descriptor. This is the face-to-face time with the patient as well as documentation of clinical decision-making that will go into the written report. And finally, the post-service work, and this is the work that's typically performed after the patient leaves. It includes arranging for further services, communicating with the patient, the family, the referring provider or other professionals in the team. This can be done both in writing or verbally.

So, as I mentioned a typical CPT code or standard... standalone CPT code is very similar to the structure of a base code and that is what is depicted here on the slide. However, reimbursement for this type of code is inaccurate in instances where a single code is billed in multiple units as the existing H&B codes are currently billed to account for the total amount of time spent performing the service. Billing a base code multiple times can be looked at as something called "double dipping" and the reason for that is that typically when performing a service, the pre-service and the post-service activities are performed only once; therefore, they should only be billed for and reimbursed once using a base code.

Depicted here you will see the structure of an add-on code and add-on codes were created to resolve the issue of "double dipping". It allows that for just the intraservice work or the face-to-face time with the patient to be reported multiple times when appropriate to accurately depict the amount of time and work that is performed by the provider. Additionally, pre-service and post-service activities have their own RVU values that go into the total work RVU for the service. For add-on codes, the RVU value of the pre- and the post-service work are backed out or removed from the add-on code; therefore, the value or RVU of this service for add-on codes is lower.

Dr. Stephen Gillaspay: So, a question that we typically received when we rolled out the new testing and neuropsych testing codes - which had a base and add-on structure - we'd frequently receive comments like this: "I'm doing the same amount of work for the entirety of the intervention; why am I being paid less for my subsequent time performing the service?"

So, as Meghann pointed out, if we look at the top line with the base code - again, if we think about the RVU and the value of the base code - it represents pre-service work, intraservice work, as well as post-service work. When we look at the add-on codes, all it captures is the intraservice work. So, as Meghann said, for add-on codes we have to back out... we have to take out the pre-service and the post-service work. And so that is why base codes will always have a higher value than the add-on codes because the add-on codes, the pre- and post-, has been subtracted out of that. So, later on in the presentation, we're gonna show you what the RVU values are and I'll try to refer to that again to kind of show the difference in base code and add-on codes, but again, it's important to realize the add-on codes are always going to be a little less in value because the pre- and the post- has had to be subtracted out of that.

Meghann Dugan-Haas: Another important thing to consider when billing the new codes is the CPT time rule. For time-based codes or time-based services, CPT states that the following standards shall apply in time measurement. The first is a unit of time is attained when the midpoint is passed and the midpoint would be the midpoint of the stated time in the code descriptor for the service you're providing. This means that for a 30-minute code, you have to provide a minimum of 16 minutes of service in order to be able to bill for the 30-minute code. Similarly, when you're talking about a 15-minute code - such as the add-on codes - you must perform a minimum of eight minutes of service to meet the requirement to bill for a full unit. These are the rules that you need to attend to and document as you utilize these new codes moving forward.

For example, when performing individual intervention, if the psychologist takes a total of 38 minutes to complete the service, then you can bill one unit of the base code or CPT code nine six one five eight (96158) for the first 30 minutes of service and then one unit of the add-on code CPT code nine six one five nine (96159) for the additional time that it took to complete the service. However, if the total time for the end of actual intervention was only thirty seven minutes, then you can only bill one unit of the 30-minute base code because you did not meet the minimum requirement of eight minutes to bill an additional unit of the add-on code. These rules apply to all time-based intervention services in the new code set. However, it is important to pay close attention to the units of time that are stated in each of the code descriptors as they vary from 15 to 30 minutes.

So, beginning on January 1, the existing code that is used to report H&B individual intervention will be deleted and replaced with a new set of codes.

Those two codes are CPT code nine six one five eight (96158) - health behavior intervention for an individual face-to-face for the initial thirty minutes, which is the base code, and then CPT code nine six one five nine (96159) for the add-on code, which is used to report each additional 15-minute increment of time to perform the service.

Dr. Stephen Gillaspay: So, in this slide - this is another crosswalk that shows on the left-hand side the current H&B individual intervention code nine six one five two (96152), which is what you bill for that in 15-minute increments. Then on the right-hand side, you see the new base and add-on code structure. So, nine six one five eight (96158) is the new... will be the new base code for the inner... individual intervention and then nine six one five nine (96159) will be the add-on... excuse me, the add-on code for health and behavior... health behavior intervention for an individual. Again, as Meghann said, you know, what determines how many add-on units is the total amount of time and, again, you gotta follow the time rules that she just reviewed.

So, moving on we've discussed the individual intervention group; now we're going to discuss the HBAI group code. So, CPT code nine six one five three (96153) - which is the current health and behavior group code - effective January 1, 2020, will be deleted.

Beginning in January 2020, it will be replaced, again, with a base code and add-on code structure. The new base code will be nine six one six four (96164). One important thing to note: just like the intervention code, the base code will... has been increased from 15 minutes to 30 minutes. So, just like the intervention code, for group code, for all the other intervention codes, you're gonna have a base code of 30 minutes and then an add-on code of 15 minutes. So here, nine six one six four (96164) represents the 30-minute base code and then nine six one six five (96165) represents the 15-minute add-on code.

Meghann Dugan-Haas: As Stephen stated, here depicted on this slide is the crosswalk for the existing health and behavior group intervention code and then the two new codes for health behavior group intervention that will be used beginning January 1, 2020. And I would like to note that as previously billed with the nine six one five three code (96153), nine six one six four (96164) and nine six one six five (96165) should be billed for each individual patient in the group. So, it will not be billed for the entire group, but each patient in the group should have their own set of codes and the appropriate units billed for their individual service.

And moving on in January, you will now no longer report health behavior intervention for family when the patient is present with nine six one five four (96154).

Instead you will report it with the new base and add-on code for family intervention when the patient is present. Those codes are nine six one six seven (96167) for the first 30 minutes and then nine six one six eight (96168) for each additional 15-minute increment of time that it takes to perform and complete the service.

Dr. Stephen Gillaspay: And here you have... again, you have the crosswalk which shows on the left-hand side, the current code for... for the family health and behavior with the patient present - nine six one five four (96154) - and on the right-hand side shows you the two new codes: the base code, nine six one six seven (96167), and the add-on code, nine six one six eight (96168). And, again, this is for when the patient is present. If the patient is not present, there'll be another code that you would use for that, which we'll cover in the next set of slides.

So, again, effective January 1, 2020, the current code for health and behavior intervention face-to-face without the patient present which is nine six one five five (96155): that will be deleted.

That code will be replaced – again, following the same pattern - will be replaced with two codes: a base code, nine six one seven zero (96170), and an add-on code, nine six one seven one (96171). Again, this follows the same pattern; the base code is thirty minutes and then you have fifteen-minute increments for the add-on codes. Just a thing to note here that's important: this code, the “without the patient present”... in the current code structure we know across lots of payers there's discrepancies; some payers will not reimburse for this code. We are hoping that more payers will now adapt and allow for reimbursement for this code in the future.

Meghann Dugan-Haas: And again here, we show the crosswalk for the existing or 2019 H&B family intervention services without the patient present and then the new codes, their descriptors. And that should be used for family intervention services that are provided on or after January 1, 2020. And as Stephen mentioned, reporting of these codes does not require the patient to be present; however, services offered when the patient is not present are typically not covered by Medicare. However, if the patient is present, remember to refer back to CPT codes nine six one six seven (96167) and nine six one six eight (96168).

Nicole Owings-Fonner: In this next section, our presenters will share with you some resources for the 2020 Health Behavior Assessment and Intervention code family.

Meghann Dugan-Haas: Throughout this webinar series, we have reviewed all of the new CPT codes, the code descriptors, the RVU values, as well as the crosswalks for reporting the new HBAI services beginning on January 1, 2020. For your convenience, all of this information has been compiled into their own individual resources and are found on the Reimbursement section of the APA website. That website is above: the first link reported. We strongly encourage you to go and visit this site, download these resources, and begin familiarizing yourself - as well as your staff - with the new codes so that you're fully prepared to implement the new code set, come January 1.

Dr. Stephen Gillaspay: In addition to the current resources that we have available, we will be producing additional publications, new information and resources to assist you and your staff with making the transition and implementing the new HBAI codes that will go into effect in January. So, specifically one resource that is under development and will be coming your way in the near future: we are developing a health behavior assessment intervention billing and coding guide. This will be similar to the guide that was developed for the psychological testing and neuropsychological testing services; so, we're in the midst of developing that and we'll get that out and available. That will be available to not only members, but we'll also make that available to payers as well. Additionally, after the webinar and as questions start to come in, we will do... we'll have frequently asked questions and/or respond to that as well as additional resources will be forthcoming.

Nicole Owings-Fonner: Thank you for viewing our webinar series on the new HBAI family of codes and thank you to our presenters for sharing this important information to help us all prepare for 2020. APA Services, Inc., is available to help members with any health insurance or managed care issues, whether this involves private or government insurers. For issues related to billing codes and Medicare or any questions regarding the content of this webinar series, please contact the Office of Healthcare Finance at OHCF at APA dot org. For issues with Medicaid or private insurers, please contact the Office of Legal and Regulatory Affairs at praclegal at APA dot org. If you are unsure of who to direct your questions to,

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