

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 Gillaspy, 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 section, our presenters will provide several health behavior intervention service clinical examples.

Meghann Dugan-Haas: Just to briefly review, depicted here are the three parts of what makes up the base codes for HBAI intervention services. While, each of the intervention service base codes are considered to be 30-minute codes as described in their code descriptors, each code is made up of these three parts and three... the three parts account for a portion of the relative value unit and have a typical amount of time assigned to each of them based on survey data that was collected when APA was surveying through the AMA RUC process. So, first is the pre-service work and this is typically about five minutes' worth of work performed by the physician prior to the patient arriving for their services. This includes preparing to see the patient, reviewing records, and communicating with other professionals. Additionally, the intra-service work is where the provider is actually providing the service described in the code descriptor and this accounts for 30 minutes, which is the typical amount of time stated in each of the code descriptors for intervention services. This is the face-to-face time with the patient spent providing treatment and then documentation of services and clinical decision-making. And finally, the post-service work typically takes about 10 minutes to perform and this is done when the patient leaves after treatment. This includes arranging for further services and communicating with the patient, their family, the referring provider, or other providers and team members.

And as a reminder, the pre- and post-service activities are performed only once as depicted here on this slide. This is the structure of an add-on code. Each of the add-on codes are considered to be 15-minute codes as described in their code descriptors. The add-on codes have both the pre- and post-service activities and their associated RVU values removed. They allow just the intra-service work to be reported in multiple units, when appropriate, to accurately reimburse for the amount of time and work performed by the provider.

Dr. Stephen Gillaspy: So, for our first example, we have our health behavior individual intervention. For this example, we have a 55-year-old female with heart disease, migraines, and hypertension who's been referred for health behavior services to improve patient treatment compliance and increase engagement in self-management. So, in this example - again as has Meghann discussed, you would have your pre-service work - so, your preparation before you see your patient - and in this example, the individual intervention time is 45 minutes. So, the clinician would spend 45 minutes engaging in the intervention and again this would be focused on improving compliance and engagement in self-management. And again, then after the intra-service time, there'd also be some time spent in post-service work; that post-service work might be relaying information back to the referring provider, sharing information with the multidisciplinary team, and making arrangements for additional services and follow-up.

Meghann Dugan-Haas: So, as Dr. Gillaspy noted on the previous slide, the typical patient that was described took 45 minutes to perform the individual intervention service. So, when converting 45 minutes to the appropriate number of base and add-on code units, you would report one unit of the base code - nine six one five eight (96158) - for the first 30 minutes of service and then one unit of the add-on code - nine six one five nine (96159) - to account for the additional 15 minutes it took to complete the individual intervention service.

Dr. Stephen Gillaspy: For our second example... here for our second example, we have our group intervention code. So, here the case example is a 35-year-old female who presents post-bariatric surgery with poor adherence to treatment regimen, multiple medical complications; so, she's referred for group health behavior intervention to improve post-surgery adjustment as well as treatment compliance. So, it's important to note for the group intervention, just like all the other intervention codes, there's going to be some pre-service work. So, with this would be again

reviewing the patient record, reviewing notes from last time, gathering information from other medical providers: that again would be your pre-service work. Your post-service... your intra-service work would be your time spent directly engaged with the patient providing the intervention service. And then, post service is going to be again following up with other health care providers, dropping your note, and arranging for follow-up and things like that. So, again it follows the same pattern; in this case example, the actual intra-service time - so it's the time that you spend with the patient in the group setting - for this case example, we had for... we had it for 55 minutes. A couple of other things is important to note with group intervention: group intervention has to have at least two patients. So, for it to be considered a group, you have to have at least two or more patients and again what you would end up doing is you would end up billing for each individual participant in the group.

Meghann Dugan-Haas: So, for the 55 minutes of time that was spent providing the group intervention service, you would convert your minutes to the appropriate number of base and add-on code units. So, as indicated here on this example claim form, we have reported one unit of the base code - nine six one six four (96164) - for the initial thirty minutes of service, and then we have reported two units of the add-on code. The first unit was to represent the additional 15-minute increment beyond the initial 30 minutes and then a second unit of the add-on code was used to report the remaining ten minutes that it took to complete the service. Now as stated in the code descriptor for the add-on code, it says that the service should take 15 minutes; however, for time-based services, you have to remember that the CPT time rule applies. The CPT time rule states that a unit of time is attained when the midpoint is passed, therefore for a 15-minute code, a minimum of 8 minutes of service must be performed in order to meet the minimum threshold to build... bill an additional unit of the add-on code. Had this service only been performed for, you know, between the range of 46 to 52 minutes instead of for 55 minutes, the second unit of the add-on code could not have been reported because you would not have met the minimum threshold requirement.

Dr, Stephen Gillaspay: So, our next example is for our health behavior family intervention with the patient present code. For this example, we have a 36-year-old married female diagnosed with breast cancer who is undergoing aggressive chemotherapy and radiation therapy with poor adherence to treatment regimen and multiple medical complications. So, the patient's... patient and her family referred for intervention to improve patient adjustment to the diagnosis and compliance with the patient's management and treatment plan. So, a frequent question that comes up is "What is the definition of family?" And so, from a CMS perspective, family... a family representative or who can... who you think about for the family codes are immediate family members only: so i.e., husband, wife, siblings, children, grandchildren, grandparents, mother and father, or any primary caregiver who provides care on a voluntary uncompensated regular and sustained basis or a guardian or health care proxy. So, there are some definitions as far as a who... who can qualify as a family representative when you're using the family codes. So, it's important to be aware of that. So, in this example again like the previous examples, you would have your pre-service work in preparing to see the patient or see the family. You have your intra-service work that would be conducted with the patient and family together. And then again, you'd have your post-service work which would be coordination of care with other medical providers and the like. For this example, the amount of time spent in that intra-service period - that direct face-to-face interaction where you're providing the intervention service and engaging in clinical decision making - the amount of time spent in direct intraservice time with the patient and family would be 50 minutes for this example.

Meghann Dugan-Haas: So, for that 50 minutes of family intervention when the patient is present, you would then convert to the appropriate units of base and add-on codes. So, the first unit of the base code - nine six one six seven (96167) - would be reported for the first 30 minutes and then one unit of the add-on code - nine six one six eight (96168) - would be reported for the next 15-minute increment beyond the initial 30 minutes. However, you may notice that there are five minutes that are left unaccounted for. These minutes could not be converted to an additional unit of the add-on code because according to the CPT time rule, the minimum threshold for reporting a 15-minute timed code is attained when the midpoint is reached and because you did not reach eight minutes of service, you could not report the second unit of the add-on code for this service.

Dr. Stephen Gillaspay: So, here we have our final example. Our final intervention example: this is for health behavior family intervention without the patient present. So, before we get into the example, it's important to note that this code - family intervention without the patient present - is not reimbursed by Medicare. Services offered when there is no direct interaction with the patient are typically not covered by many health care many payers, but Medicare definitely

does not reimburse for this this code, so that's important to note. So, if you're using this code and you're working with populations that have other payers, it's important for you to be familiar with what the payment policy is regarding this code. So, in regards to the example, for this we have the family of a nine-year-old boy diagnosed with type 1 diabetes is referred for intervention because the patient's continual refusal to self-inject his insulin and test his own glucose levels. So again, a very common presentation for pediatric diabetes. So, in this example, again the intervention is focused on helping the parents or the caregivers of this child to work with them so they can make adjustments and help manage the child's behavior to improve compliance with the the diabetic... diabetes management. So again, like you know all the other examples, there would be some pre-service work – so again, review of the records, might be discussion with other health care providers about the case, and factors involved in that. For this example, the intra-service time again would be just the time that the clinician spends with the caregivers without the patient present, focused on improving compliance. And then again, you'd have your post-service work which would involve follow-up with other health care providers and coordination of care.

Meghann Dugan-Haas: And here you will find our final claim form example that represents providing 60 minutes of family intervention services without the patient present. To convert that 60 minutes to the appropriate number of units of base and add-on codes, you would report one unit of CPT code nine six one seven oh (96170) to account for the first 30 minutes of service and then two units of the add-on code nine six one seven one (96171) to account for the remaining 30 minutes it took to complete this service to the patient's family.

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 Gillaspie: 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 pralegal at APA dot org. If you are unsure of who to direct your questions to, you can also reach out to the Office of Health Care Finance and they will help direct you to the right person. Thank you and have a great day.