



**PSYCHOLOGICAL EVALUATION AND MANAGEMENT
OF NON-MENTAL HEALTH DISORDERS**

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Status: Current

Summary of Changes

Clarifications:

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Deletions:

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Additions:

- Pg. 1, Section I and Pg 4, Section III, G, language updated to reflect the addition of palliative care and advance care planning to the list of comprehensive management programs for which health and behavioral assessment and brief intervention provided by a licensed clinician are covered.

I. POLICY/CRITERIA

Priority Health covers health and behavioral assessment and brief intervention provided by licensed clinicians (LP, LLP, LMSW, LPC) when provided as part of a comprehensive medical program approved by Priority Health. Examples include comprehensive spine, weight, feeding disorders, palliative care and advance care planning programs. Services are billed with a primary medical diagnosis in 15 minute units.

II. INDICATIONS:

CPT codes 96150-96155 are reported to describe services, performed to address difficulties associated with an acute or chronic illness, prevention of a physical illness or disability and maintain health, that do not meet criteria for a psychiatric diagnosis.

A. The Health and Behavioral Assessment, initial (CPT code 96150) and Reassessment (CPT code 96151), and Intervention services (CPT codes 96152-96153) may be considered reasonable and necessary for the member who meets all of the following criteria:

1. The member has an underlying physical illness or injury, and
2. The member has not been diagnosed with mental illness, and



3. There is reason to believe that a biopsychosocial factor may be significantly affecting the treatment, or medical management of an illness or an injury, and
 4. The member is alert, oriented and has the capacity to understand and to respond meaningfully during the face-to-face encounter, and
 5. The member has a documented need for psychological support in order to successfully manage his/her physical illness, and activities of daily living, and
 6. The assessment is not duplicative of other provider assessments
- B. Health and Behavioral Re-assessment (CPT code 96151) will be considered reasonable and necessary, if documentation indicates that there has been a sufficient change in mental or medical status warranting re-evaluation of the member's capacity to understand and to respond meaningfully to the psychological intervention.
- C. Health and Behavioral Intervention, individual or group (two or more members) (CPT codes 96152-96153) require that:
1. Specific psychological intervention(s) and member outcome goal(s) have been clearly identified, and
 2. Psychological intervention is necessary to address:
 - i. Non-adherence with the medical treatment plan, or
 - ii. The biopsychosocial factors associated with a new 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, and overall adjustment to medical illness.
- D. Health and Behavioral Intervention (with the family and member present) (CPT code 96154) is considered reasonable and necessary for the member who meets all of the following criteria:
1. The family representative directly participates in the overall care of the member, and
 2. The psychological intervention with the member and family is necessary to address biopsychosocial factors affecting adherence with the plan of care, symptom management, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to medical illness.

For the purpose of this policy, "family representative" is defined as: immediate family member's husband, wife, partner, siblings, children, grandchildren, grandparents, mother, and father), any primary caregiver who provides care on a voluntary, uncompensated, regular, sustained basis, guardian or healthcare proxy.

III. LIMITATIONS

- A. Health and Behavioral Assessment/Intervention is not considered reasonable and necessary for members who:
1. Do not have an underlying physical illness or injury, or
 2. Have been diagnosed with a chronic mental health condition clinically inappropriate to address in an outpatient setting, or
 3. Who have no documented indication that a biopsychosocial factor may be significantly affecting the treatment, or medical management of an illness or injury, or
 4. Do not have the capacity to understand and to respond meaningfully during the face-to-face encounter, because of:
 - a. Dementia that has produced severe enough cognitive defect for the psychological intervention to be ineffective.
 - b. Delirium
 - c. Severe and profound mental retardation
 - d. Persistent vegetative state or no discernible consciousness,
 - e. Impaired mental status (orientation to all three spheres), e.g.
 - i. disorientation to person, time, place, purpose, or
 - ii. inability to recall current season, location of own room, names and faces, or
 - iii. inability to recall that he or she is in a nursing home or skilled nursing facility
- Alternative codes exist for coding these conditions.
- B. Health and Behavioral Assessment/Intervention is not considered reasonable and necessary for members who do not require psychological support to successfully manage his/her physical illness through identification of the barriers to the management of physical disease and activities of daily living.
- C. Health and Behavioral Assessment/Intervention is not considered reasonable and necessary for members who do not have the conditions noted in Section III, A.
- D. Health and Behavioral Intervention with the family and member present is not considered reasonable and necessary for the member if:
1. It is not necessary to ensure member compliance with the medical treatment plan, or
 2. The family representative does not directly participate in the plan of care, or
 3. The family representative is not present.



4. There is no face-to-face encounter with the member.
- E. Health and Behavioral Intervention services are not considered reasonable and necessary to:
1. Update or educate the family about the member's condition
 2. Educate non-immediate family members, non-primary caregivers, non-guardians, the non-health care proxy, 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 member's care plan.
 3. Treatment-planning with staff
 4. Mediate between family members or provide family psychotherapy
 5. Educate diabetic members and diabetic members' family members
 6. Deliver Medical Nutrition Therapy
 7. Maintain the member's or family's existing health and overall well-being
 8. Provide personal, social, recreational, and general support services (these may be valuable adjuncts to care; however, they are not psychological interventions)..
- F. Health and Behavioral Assessment/Intervention (CPT codes 96150-96155) may be performed by licensed clinicians (FLP, LLP, LMSW, LPC). These codes are not intended for use with physician services (example: medical doctor, nurse practitioner, physician assistant, clinical nurse practitioner).
- G. Providers must be credentialed by Priority Health to provide these services. Providers credentialed to provide these services must be part of comprehensive management programs (e.g. spine, weight loss, feeding disorders, palliative care, advance care planning).
- H. Health and Behavioral Assessment/Intervention is not a covered benefit in the home setting.

Examples of services that are not considered part of Health and Behavioral Intervention services are:

1. Stress management for support staff
2. Replacement for expected nursing home staff functions
3. Music appreciation and relaxation
4. Craft skill training
5. Cooking classes
6. Comfort care services
7. Individual social activities
8. Teaching social interaction skills
9. Socialization in a group setting



10. Retraining cognition due to dementia
11. General conversation
12. Services directed toward making a more dynamic personality
13. Consciousness raising
14. Vocational or religious advice
15. General educational activities
16. Tobacco or caffeine withdrawal support
17. Visits for loneliness relief
18. Sensory stimulation
19. Games, including bingo games
20. Project, including letter writing
21. Entertainment
22. Excursions, including shopping outing, even when used to reduce a dysphoric state
23. Teaching grooming skills
24. Grooming services
25. Monitoring activities of daily living
26. Teaching the member simple self-care
27. Teaching the member to follow simple directives
28. Wheeling the member around the facility
29. Orienting the member to name, date, and place
30. Exercise programs, even when designed to reduce a dysphoric state
31. Memory enhancement training
32. Weight loss management, unless associated with comprehensive weight loss program
33. Case management services including but not limited to planning activities of daily living,
34. Arranging care or excursions, or resolving insurance problems
35. Activities principally for diversion
36. Planning for milieu modifications
37. Contributions to member care plans
38. Maintenance of behavioral logs

IV. MEDICAL NECESSITY REVIEW:

Required

Not Required

Not Applicable

V. APPLICATION TO PRODUCTS:

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans.*



- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.*
- ❖ **MEDICAID:** *If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual and the Michigan Medicaid Fee Schedule, the Michigan Medicaid Provider Manual and the Michigan Medicaid Fee Schedule at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--00.html will govern.*
- ❖ **MICHILD:** *For MICHILD members, this policy will apply unless MICHILD certificate of coverage limits or extends coverage.*

VI. DESCRIPTION

Health and Behavior Assessment procedures identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.

Health and Behavior Intervention procedures modify the psychological, behavioral, emotional, cognitive, and social factors important to or directly affecting the member’s physiological functioning, health and well being, or specific disease-related problems.

VII. CODING INFORMATION

ICD-9 Codes that Support Medical Necessity

Medical diagnoses only – see criteria

ICD-9 Codes that DO NOT Support Medical Necessity

- 290.0 - 290.9 Dementias
- 291.0 - 291.9 Alcohol-induced mental disorders
- 292.0 - 292.9 Drug-induced mental disorders
- 293.0 - 293.9 Transient mental disorders in conditions classified elsewhere
- 294.0 - 294.9 Persistent mental disorders due to conditions classified elsewhere
- 295.00 - 295.95 Schizophrenic disorders
- 296.00 - 296.99 Episodic mood disorders
- 297.0 - 297.9 Delusional Disorders
- 298.0 - 298.9 Other nonorganix psychoses
- 299.00 - 299.91 Pervasive developmental disorders
- 300.00 - 300.09 Anxiety states
- 301.0 - 301.9 Personality disorders
- 302.0 - 302.9 Sexual and gender identity disorders
- 303.00 - 303.93 Alcoholic dependence syndrome

304.00 - 304.93	Drug dependence
305.00 - 305.93	Nondependent abuse of drugs
306.0 - 306.9	Physiological malfunctions arising from mental factors
307.0 - 307.9	Special symptoms or syndromes, not elsewhere classified
308.0 - 308.9	Acute reaction to stress
309.0 - 309.9	Adjustment reaction
310.0 - 310.9	Specific nonpsychotic mental disorders due to brain damage
311	Depressive disorder not elsewhere classified
312.00 - 312.9	Disturbance of conduct, not elsewhere classified
313.0 - 313.9	Disturbance of emotions specific to childhood and adolescence
314.00 - 314.9	Hyperkinetic syndrome of childhood
315.00 - 315.9	Specific delays in development
316	Psychic factors associated with diseases classified elsewhere
317	Mild mental retardation
318.0 - 318.2	Other specified mental retardation
319	Unspecified mental retardation

CPT/HCPCS Codes

Not covered for Priority Health Medicaid.

Coverage for Priority Health Medicare limited to Psychologist or Behavioral Health Provider Group.

Payment to facility providers limited to Behavioral Health service providers.

Not covered in the home setting.

96150	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
96151	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual
96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
96154	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)
96155	Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present) <i>(Not covered for Priority Health Medicare)</i>

VIII. DOCUMENTATION REQUIREMENTS

Because of the impact on the medical management of the patient's disease, documentation must show evidence of coordination of care with the patient's primary medical care providers or medical provider responsible for the medical management of the physical illness that the psychological assessment/intervention addresses.



Documentation in the medical record by a licensed clinician (LP, LLP, LMSW, LPC) must include:

1. Evidence of a referral, for the initial assessment and for each reassessment, to the licensed clinician (LP, LLP, LMSW, LPC) by the medical provider responsible for the medical management of the member's physical illness.
2. Evidence of coordination of care with the member's primary medical care providers or medical provider responsible for the medical management of the physical illness that the psychological assessment/intervention was meant to address.
3. The diagnosis (ICD-9 CM code) that reflect the condition of the member, and indicate the reason(s) for which the service was performed
4. **Initial assessment (CPT code 96150)** documentation in the medical record by the licensed clinician (LP, LLP, LMSW, LPC) must include evidence to support that the assessment is medically and clinically reasonable and necessary, and must include, at a minimum, the following elements:
 - a. Date of initial diagnosis of physical illness, and
 - b. Clear rationale for why assessment is required, and
 - c. Assessment outcome including mental status and ability to understand and to respond meaningfully, and
 - d. Goals, objectives, and expected duration of specific psychological intervention(s), if recommended
5. **Reassessment (CPT code 96151)** documented must include the following elements:
 - a. Date of change in mental or physical status, and
 - b. Clear rationale for why re-assessment is required, and
 - c. Clear indication of the precipitating event that necessitates re-assessment
6. **Intervention service, (CPT code 96152 – 96154)** documentation to support that the intervention is reasonable and necessary must include, at a minimum, the following elements:
 - a. Evidence that the member has the capacity to understand and to respond meaningfully, and
 - b. Clearly defined psychological intervention plan and goals, and
 - c. The goals of the psychological intervention should clearly state how the psychological intervention is expected to improve compliance with the medical treatment plan, and
 - d. The response and progress to the intervention must be indicated, and
 - e. Rationale for frequency and duration of services as evidenced by progress toward goals or lack thereof, and/or new and continued



stressors and precipitants.

7. The time duration (stated in minutes) for each visit spent in the health and behavioral assessment or intervention encounter.

Medical records need not be submitted with the claim; however, the medical record, e.g., complete nursing home record, doctor's orders, progress notes, office records, and nursing notes, must be available to the carrier upon request.

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