Priority Health

MEDICAL POLICY
No. 91546-R6

PSYCHOLOGICAL EVALUATION AND MANAGEMENT OF NON-MENTAL HEALTH DISORDERS

Effective Date: June 1, 2024

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Date Of Origin: October 10, 2007

Status: Current

Summary of Changes

Additions:

- Added LMFT (Licensed Marriage and Family Therapist) as an additional licensed clinician throughout policy.

I. POLICY/CRITERIA

Priority Health covers health and behavioral assessment and brief intervention provided by licensed clinicians (LP, LLP, LMSW, LPC, LMFT) 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 96156, 96158-96159 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 or re-assessment, (CPT code 96156, and Intervention services (CPT codes 96158-96159) 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. 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
3. The member is alert, oriented and has the capacity to understand and to respond meaningfully during the face-to-face encounter, and
4. The member has a documented need for psychological support in order to successfully manage his/her physical illness, and activities of daily living, and

5. The assessment is not duplicative of other provider assessments

B. Health and Behavioral Re-assessment (CPT code 96156) 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 96164-96165) 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 96167) 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. Who have no documented indication that a biopsychosocial factor may be significantly affecting the treatment, or medical management of an illness or injury, or
3. 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 cognitive impairment
    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 II, 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 96156,96158-96159) may be performed by licensed clinicians (FLP, LLP, LMSW, LPC, LMFT). 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:

Prior authorization for certain drug, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the Priority Health Provider Manual.

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. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***
- **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) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.***
- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify 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-10 Codes that **Do Not Support Medical Necessity**

F01-F99	Mental, Behavioral and Neurodevelopmental disorders
R45.0-R4589	Symptoms and signs involving emotional state
R46.0 – R46.89	Symptoms and signs involving appearance and behavior

CPT/HCPCS Codes

Not covered for social worker (MSW) for Priority Health Medicare.
Payment to facility providers limited to Behavioral Health service providers.
Not covered in the home setting.

96156 Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, 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)
96164 Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
96165 Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

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 *(not covered)*
96170 Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes *(not covered)*
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)

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, LMFT) must include:

1. Evidence of a referral, for the initial assessment and for each reassessment, to the licensed clinician (LP, LLP, LMSW, LPC, LMFT) 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-10 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 96156)** documentation in the medical record by the licensed clinician (LP, LLP, LMSW, LPC, LMFT) 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 96156)** 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 96158 – 96159)** 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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