Commentary: The Use of Health and Behavior Codes in Pediatric Psychology: Where Are We Now?

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This article focuses on the current status of the use of Health and Behavior (H&B) codes by pediatric psychologists. We address the rationale for the use of these codes in a pediatric psychology setting, practice updates since the codes were initiated, and our experience with utilizing these codes in one pediatric hospital. We conclude with a summary of our assertions and future directions for policy and practice.

History of the H&B Codes

The Current Procedural Terminology (CPT) codes were developed in 1966 by the American Medical Association (AMA) as a way to define and document medical procedures and services. Today, these codes are utilized not only for documentation, but also as the primary method by which third-party reimbursement for services is obtained. Psychologists have historically used Mental Health (MH) CPT codes to bill for the therapy and assessment services that they provide. While these codes are certainly relevant to the practice of pediatric psychologists in a healthcare setting, they are not sufficient for documenting all of the work that these providers do. Pediatric psychologists are often involved in behavioral procedures for the treatment of physical health problems, and this treatment differs significantly from traditional psychotherapy (Table I). In these cases, the role of the psychologist is to treat issues related to a patient’s medical condition rather than treating mental illness. Examples include adherence to treatment regimen, management of medical symptoms, adjustment to medical illness, or distress related specifically to medical procedures.

To address this type of practice, the American Psychological Association (APA) proposed, in 1998, a set of “Health & Behavior” (H&B) codes to address the gap between documentation and practice. The H&B codes are a set of codes intended for use by nonphysician practitioners to identify assessment and treatment for biopsychosocial factors related to a patient’s physical health problems (APA, 2004; see Table II). These codes may be reported by, but are not limited to, psychologists, advanced practice nurses, and licensed clinical social workers. The APA Practice Directorate was a strong advocate for the adoption of these codes and petitioned the AMA CPT Coding Committee to approve them for use. In 2002, the H&B codes were published in the CPT manual, and the Centers for Medicare and Medicaid Services (CMS) approved payment for the codes.

The Relevance of H&B Codes in Integrated Care

An important consideration for the use of H&B codes is that psychologists using the codes are associating a medical diagnosis, rather than a psychological diagnosis, with their billing. However, the scope of practice for a psychologist prohibits the diagnosis of a physical health condition. Therefore, the medical diagnosis made by a physician will be used when reporting health behavior services provided by a psychologist (APA, 2006). This suggests a relationship between medical and psychological services that is inherent to integrated care models. The benefits of integrated care have been documented for many decades, but an appropriate billing structure to support this practice was not in effect prior to the advent of H&B codes.
Without effective coding, psychologists practicing in integrated care settings either provide services as part of the medical practice without billing for them, or use MH codes to bill for behavioral health services. Diagnoses from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) such as Adjustment Disorder in which the stressor is a serious general medical condition, Psychological Factors Affecting a General Medical Condition, and Disorder (e.g., Anxiety, Depression) Due to a General Medical Condition are MH codes that are often used when billing for behavioral health services (American Psychiatric Association, 2000). However, none of these codes accurately reflects the medical condition as the primary reason for treatment. Moreover, the use of these codes purports that a mental health condition is present, which often is not the case and presents a serious ethical quandary for psychologists.

The workarounds that have been used in the past have not been effective in accurately reflecting the role of the psychologist practicing in an integrated care setting. Thus the adoption of H&B codes represents a formal step toward recognition of the broad role of psychologists in the healthcare setting (Shigaki, 2004). The recent release of the APA Guidelines for Psychological Practice in Health Care Delivery Systems (APA, 2011), which indicate that “psychologists have special expertise in communication, behavioral issues, patient decision making, human interaction and systems that is relevant to the full spectrum of health and mental health issues and settings,” represents an additional effort to recognize and elevate the work of psychologists in this setting.

**Payer Adoption and Reimbursement**

Over the past 9 years, there has been a gradual uptake of this new H&B coding system. From the beginning, Medicare agreed to cover five of the six codes (96150–96154), excluding coverage for the 96155 code in which the family is seen without the patient present. By October 2004, Medicaid was reimbursing these codes in two states (Dittman, 2004), and this has been increasing over time. As others (e.g., Kessler, 2008) have documented, it is difficult to gather a definitive list of insurance carriers that are currently reimbursing this service. Therefore, direct contact with state payers is recommended. In the state of Delaware, Medicaid reimbursement rates for codes 96150–96154 are competitive (Table III).

While it has been documented that many payers now accept these codes and reimbursement for H&B codes is generally higher than reimbursement for MH codes, success with obtaining reimbursement varies. In 2004, Delamater reported results of a national survey in which the majority of psychologists who were using H&B codes at the time reported a low (less than 50%) reimbursement rate. When claims were denied, the majority (73%) of
the time it was due to “the use of a medical diagnosis by a psychologist.” In 2006, Brosig and Zahart reported on the use of these codes in a pediatric hospital and found that 69% of claims were reimbursed. For claims that were paid, the reimbursement varied from 58% to 85%.

Reimbursement of H&B Codes in a Pediatric Hospital

In order to examine the progress that has been made since these data were reported, we have examined the 2011 H&B claims in a pediatric hospital in the Mid-Atlantic. Within our hospital, we have 11 psychologists in the Division of Behavioral Health, three of whom have joint appointments with a medical division as well. With the Division of Rehabilitation, we have one neuropsychologist. H&B codes have been used sporadically for over 5 years; utilization has increased significantly over the past year as reimbursement rates have improved.

In this setting between January and October of 2011, 1,614 claims were submitted and approximately 62% of these claims were either partially or fully paid. The majority (1,466) of the claims submitted were for outpatient treatment. Payments varied widely with an average rate of reimbursement of 46% for claims that were paid.

An examination of breakdown across settings within the hospital revealed that outpatient claims were covered more frequently than inpatient claims (64% vs. 44%). We also examined these claims in three separate pediatric divisions to determine if there were differences in rate of payment between claims submitted through the Division of Behavioral Health and integrated medical divisions. The findings were mixed: 68% of claims submitted through the Rehabilitation division were covered, versus 44% of claims for Behavioral Health and 37% of claims from the Weight Management clinic within the Division of Consultative Pediatrics. The reason for this discrepancy across divisions is unclear and further examination is necessary. The Division of Rehabilitation may have a higher rate of reimbursement due to the sheer volume of claims submitted. During the time period assessed, approximately 73% of all claims were submitted by the Division of Rehabilitation. It is also possible that the specific diagnoses coded by this division or other factors may have affected rate of reimbursement.

Finally, we examined the rate of payment across payers. Not surprisingly, out-of-state Medicaid demonstrated the highest rate of denial, reimbursing only 16% of the claims submitted. With few exceptions, the claims reimbursed for out-of-state Medicaid were submitted by the neuropsychologist in the Division of Rehabilitation. Further exploration regarding the relative success of this provider is warranted. In-state Medicaid and commercial insurance providers had much lower denial rates (59% and 74% of claims reimbursed, respectively), though still not ideal. A breakdown of reimbursement rates for each of the six H&B codes is provided in Table IV.

As a relatively new process, no set procedures are in place for rebilling or advocating for reimbursement of the H&B codes in our hospital. It has been challenging to garner support for allocation of significant billing staff time for advocating for the H&B codes due to the relatively small revenue stream for Behavioral Health as opposed to other specialties. However, the coding staff has begun to advocate internally for the use of these codes and we are hopeful that this will influence billing.

Importance of Open Codes

Historically, psychologists have been advised by the APA and other professional organizations to use the H&B codes when they bill Medicaid and private payers for the health behavior services they provide. If they do not get reimbursement, they have been guided to appeal those denials (e.g., APA, 2006). However, appeals will be unsuccessful if the insurers in the state have not “opened” the H&B codes for billing by mental health providers in their provider panels. “Opening a code” means that Medicaid through their policy, or private insurers through their contracts, have authorized the use of designated codes for billing for specified health behavior services which are covered benefits under their plans. These are administrative decisions that cannot be done by simply appealing a denial of charges. The insurance provider then needs to ensure that the psychologists are credentialed on their medical panel. In addition, the providers must correctly specify whether the health behavior service they have provided to individuals was in one-on-one or group modalities, and that they

| Table III. Delaware Medicaid Reimbursement Rates for H&B Codes |
|-------------------|------------------|
| Code              | Reimbursement rate per 15 min of service |
| 96150             | $20.88           |
| 96151             | $20.22           |
| 96152             | $19.19           |
| 96153             | $4.64            |
| 96154             | $18.86           |
| 96155             | Limited to Part C Social Worker Taxonomy with provider-specific pricing |
are providing it in a setting in which they are authorized to perform the service.

If Medicaid has not opened an H&B code in a state, providers through their professional organizations may advocate with the Medicaid leadership for the code to be opened for use by licensed mental health professionals, demonstrating the rationale and benefits to be derived for better compliance with medical treatment protocols and improved health outcomes for patients. It has been shown that when Medicaid opens a code to add a covered service, private insurers tend to follow the precedent that has been established to continue to be competitive in that marketplace.

As an illustration of how the process to advocate for policy change could be used, several of the authors worked with a local school district to arrange for mental health services to be provided by a credentialed provider to Medicaid-enrolled students at two local elementary schools. The services were covered in the Medicaid benefit available to the students if those services were provided in a traditional office, but not in a school setting. The authors contacted Medicaid officials requesting the ability to offer the services in the school setting as a means to increase access to the service for children who had demonstrated need and were having difficulty getting the services. Medicaid recognized the need and facilitated contact with the senior leadership of the two Managed Care organizations under contract with Medicaid to manage the outpatient mental health benefits for eligible Medicaid clients. The authors then convened a meeting with representatives of Medicaid, Managed Care organizations, the school district, the mental health provider who was a member of the Managed Care organizations’ provider networks, and the one selected to provide the services in the school settings. After much discussion about the need for the service to be accessible in the school setting and how the requirements for an eligible service site could be met, Medicaid and the Managed Care organizations agreed to approve a formal request from the mental health provider to add the school setting to their office site as service sites for their work. After approval was received, the mental health provider worked with the Managed Care organizations to test actual billings for services to make sure that the reimbursement process worked. Then the Managed Care organizations changed their policy to add a code for schools to be an authorized service site and wrote a formal protocol for the members of their provider networks to bill for services provided in school settings. Based upon this experience, we believe that a similar process could be followed for H&B codes.

### Table IV. Reimbursement Rates by CPT Code and Payer

<table>
<thead>
<tr>
<th>Code</th>
<th>DE Medicaid (%)</th>
<th>Out-of-state Medicaid (%)</th>
<th>Commercial (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>96150</td>
<td>49</td>
<td>16</td>
<td>79</td>
</tr>
<tr>
<td>96151</td>
<td>83</td>
<td>0</td>
<td>77</td>
</tr>
<tr>
<td>96152</td>
<td>41</td>
<td>7</td>
<td>66</td>
</tr>
<tr>
<td>96153</td>
<td>67</td>
<td>20</td>
<td>63</td>
</tr>
<tr>
<td>96154</td>
<td>40</td>
<td>25</td>
<td>65</td>
</tr>
<tr>
<td>96155</td>
<td>0</td>
<td>0</td>
<td>100*</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>16</td>
<td>74</td>
</tr>
</tbody>
</table>

*Although 100% of claims were reimbursed, this was a very low sample size (n = 3) so may not be representative.

**Conclusions and Future Directions**

Where are we now? At this stage of the journey, it is safe to say that we are no longer where we once were but have not yet arrived at where we are going. Over the past decade, the field has begun a paradigm shift in which psychologists are beginning to garner recognition for their vital role in medical care. The advent of the H&B codes mark a critical juncture in the road, and the use of these codes is steadily increasing over time. However, many remain reticent to bill with the H&B codes due to the variability in reimbursement to date. Our current data suggest that progress is evident but slow, and we have not yet reached a point at which reimbursement of these codes has become common practice. Despite the many challenges, it is critical for psychologists to use the codes, as they may be discontinued if they are not utilized (Dittman, 2004; Noll & Fischer, 2004).

In many states, the 96155 code (family therapy with the patient not present), in particular, is not open for psychologists. However, there is a strong rationale for the provision of treatment to parents and families, especially in the case of very young children with chronic illness. Moreover, in our experience the open codes are not consistently being reimbursed with reason codes such as “Provider may not bill this service” and “Noncovered charges” atop the list, suggesting that there are additional barriers to appropriate reimbursement in place. It is recommended that psychologists work with their state Medicaid office, State Insurance Commissioner, as well as insurance providers to advocate for the proper reimbursement for these codes. Moreover, the Society for Pediatric Psychology, APA, and state psychological associations may be able to work with payers to increase reimbursement rates.

There are exciting future possibilities with H&B codes as well. The individual assessment and intervention H&B...
codes (96150–96152) have been approved by Medicare for telehealth services (APA, 2009). There is a growing movement towards the provision of telehealth for serving patients in rural and underserved areas, and the H&B codes may make reimbursement for this service possible. Additionally, while preventive services are not typically covered for psychologists, the H&B codes do allow billing for services aimed at the prevention of problems associated with an existing medical illness. This may open the door for future possibilities to reimburse for preventive services.

Conflicts of interest: None declared.

References


