Health Behavior Assessment / Intervention

Policy Number: SC17P0061A2 Effective Date: May 1, 2018

Last Update: July 24, 2024

PAYMENT POLICY HISTORY

DATE	SUMMER OF CHANGE
July 24, 2024	Annual policy review complete. Clarification updates made to definition and billing requirement sections. Additional grammar, formatting, and stylization updates applied.
May 11, 2023	Annual review completed. General updates made to definitions, payment information, and billing requirements sections.
September 19, 2022	Information regarding code-specific procedure CPT® or HCPCS was removed.
January 6, 2022	Policy review is completed. No update to the policy was needed.
February 9, 2021	Policy review is completed. No update to the policy was needed.
October 19 2020	Annual policy review completed. Updates were made to the code-set. In addition, the policy was updated to include the following Information: • Services require a referral from a physician or eligible advance practice provider; • Documentation guidelines 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 or intervention addresses; and • Covered providers were updated to include all licensed mental health professionals; and • Health behavior assessment included components and health behavior intervention desired outcomes were added as covered services. The policy we moved to UCare's updated branding format. As a result, some information may have been reformatted.
August 28, 2019	Information regarding comparison to the DHS MH Procedure CPT® or HCPCS Codes and Rates Chart and UCare fee schedules was removed from the document. The UCare Provider Manual contains information regarding how and when UCare updates fee schedules. A link to the UCare Provider Manual continues to be available within the document.
May 1, 2019	Annual policy review is completed. Other than updating the UCare logo and links within the document no changes were made to this policy.
May 1, 2018	Policy is implemented by UCare

APPLICABLE PRODUCTS

This policy applies to the products checked below:

UCARE PRODUCT	APPLIES TO
UCare MinnesotaCare	√
UCare Minnesota Senior Care Plus (MSC+)	√
UCare Prepaid Medical Assistance (PMAP)	√
UCare Connect	√
UCare Connect +Medicare (When MHCP is the primary payer)	√
UCare Minnesota Senior Health Options (MSHO) (When MHCP is the primary payer)	√

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PAYMENT POLICY INSTRUCTIONS

A payment policy assists in determining provider reimbursement for specific covered services. To receive payment, the provider must be in a contractual relationship with UCare and provide services to a member enrolled in one of UCare's products. This payment policy is intended to provide a foundation for system configuration, work instructions, call scripts, and provider communications. A payment policy describes the rules for payment, which include applicable fee schedules, additional payment rules by regulatory bodies, and contractual terms. This policy is a general guideline and may be superseded by specific provider contract language.

PAYMENT POLICY OVERVIEW

Health behavior assessment and intervention is intended to identify psychological, behavioral, emotional, cognitive, and relevant social factors that can prevent, treat, or manage physical health problems. Services must be associated with the patient's primary diagnosis, which is physical in nature, and focus on factors that could complicate the medical condition and treatment.

POLICY DEFINITIONS

TERM	NARRATIVE DESCRIPTION
Diagnostic Assessment	Means functional face-to-face evaluation resulting in a complete written assessment that includes clinical considerations and severity of the client's general physical, developmental, family, social, psychiatric, and psychological history, and current condition. The Diagnostic Assessment will also note strengths, vulnerabilities, and needed mental health services.
Health and Behavior Assessment	Means an assessment of the patient's psychological status in relation to a medical diagnosis, or in determining treatment. It is not intended to identify whether a person has a mental illness or emotional disturbance.
Mental Health Professional	Means one of the following providers: • Clinical nurse specialist (CNS) • Licensed independent clinical social worker (LICSW) • Licensed marriage and family therapist (LMFT) • Licensed professional clinical counselor (LPCC) • Licensed psychologist (LP) • Mental health rehabilitative professional • Psychiatric nurse practitioner (NP)

TERM	NARRATIVE DESCRIPTION
	• Psychiatry or an osteopathic physician • Tribal-certified professional

ENROLLEE ELIGIBILITY CRITERIA

THIS SECTION OF THE POLICY PROVIDES INFORMATION THAT IS SPECIFIC TO THE UCARE MEMBER, INCLUDING INFORMATION ABOUT THE CRITERIA THE MEMBER MUST MEET IN ORDER FOR THE SERVICE(S) IN THE POLICY TO BE ELIGIBLE FOR PAYMENT.

An individual must be enrolled and eligible for coverage in an UCare MHCP product to be eligible for this service. In addition, to receive a Health and Behavior Assessment as patient must be:

- Hospitalized in a medical bed; or
- Receiving ongoing medical services in an outpatient setting.

ELIGIBLE PROVIDERS OR FACILITIES

OUTLINED BELOW IS THE SPECIFIC CRITERIA A PROVIDER MUST MEET IN ORDER FOR THE SERVICE(S) IN THIS POLICY TO BE ELIGIBLE FOR PAYMENT.

Provider

Licensed mental health professionals are eligible to furnish a Health and Behavior Assessment.

Facility

Not applicable

Other and/or Additional Information

Not applicable

EXCLUDED PROVIDER TYPES

OUTLINED BELOW IS INFORMATION REGARDING PROVIDERS WHO ARE NOT ELIGIBLE TO FURNISH THE SERVICE(S) LISTED IN THIS POLICY.

Not applicable

MODIFIERS, CPT, HCPCS, AND REVENUE CODES

General Information

The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and Revenue codes listed in this policy are for reference purposes only. Including information in this policy does not imply that the service described by a code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee of claim payment.

Modifiers

The modifiers listed below are not intended to be a comprehensive list of all modifiers. Instead, the modifiers that are listed are those that must be appended to the CPT® / HCPCS codes listed below. Based on the service(s) provided, and the circumstances surrounding those services it may, based on correct coding, be appropriate to append an additional modifier(s) to the CPT® / HCPCS code.

When a service requires multiple modifiers, the modifiers must be submitted in the order listed below. If it is necessary to add additional modifiers, they should be added after the modifiers listed below.

MODIFIER(S)	NARRATIVE DESCRIPTION
U7	Service provided by an Intern or Resident

The –U7 modifier is an informational modifier and does not impact payment.

CPT and/or HCPCS Code(s)

CPT AND/OR HCPCS CODE(S)	MODIFIER(S)	NARRATIVE DESCRIPTION
96156		Health behavior assessment, or reassessment
96158		Health behavior intervention, individual, face-to-face; initial 30 minutes
99159		Health behavior intervention, individual, face-to-face; each additional 15 minutes (Used in conjunction with 96158)
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 (Used in conjunction with 96164)

CPT AND/OR HCPCS CODE(S)	MODIFIER(S)	NARRATIVE DESCRIPTION
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 (Used in conjunction with 96167)
96170		Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
96171		Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (Used in conjunction with 96170)

Revenue Codes

Not applicable

PAYMENT INFORMATION

Covered Services

These services are for member's who have a primary physical diagnosis who may benefit from assessments and interventions that focus on the biopsychosocial factors related to the patient's health status. These services are used to identify the following factors which are important to the prevention, treatment, and management of physical health problems:

- Behavioral
- Cognitive
- Emotional
- Psychological
- Social

Covered health and behavior assessments and reassessments include:

- Health-focused clinical interviews
- Behavioral observations
- Clinical decision-making
- Evaluation of the patient's response to physical health problems, outlook and coping strategies, and adherence to treatment plans

Health behavior intervention services are intended to:

- Modify the psychological, behavioral, emotional, cognitive, and social factors relevant to and affecting the patient's physical health problems.
- Focus on promoting functional improvement, lessening the psychosocial and psychological obstacles to recovery, and improvement of the patient's coping skills related to the medical condition.
- Family interventions should emphasize active member or family engagement and participation.

If further evaluation of the member's psychological status is required to determine if a person has a mental illness or emotional disturbance, a mental health professional must conduct a mental health diagnostic assessment.

Noncovered Services

A Health behavior assessment does not qualify as a mental health diagnostic assessment; do not use to identify whether a member has or does not have a mental illness or emotional disturbance.

Preventive medicine counseling and risk factor reduction interventions are not covered.

BILLING REQUIREMENTS AND DIRECTIONS

General Guidelines

Outlined below are the guidelines related to submitting claims to UCare:

- Services must be submitted using 837P format or the electronic equivalent.
- Enter the treating provider NPI number for each provider furnishing services on each claim line
- Do not use health and behavior assessment procedure codes when billing for physician evaluation and management services

Time Based Services

When billing for services that include time as part of their definition, follow HCPCS and CPT guidelines to determine the appropriate unit(s) of service to report. Based on current guidelines, providers must spend more than half the time of a time-based code performing the service to report the code. If the time spent results in more than one- and one-half times the defined value of the code, and no additional time increment code exists, round up to the next whole number. Outlined below are the billable units of service based on whether the description of the service includes the unit of measurement of 15 minutes or 60 minutes:

MINUTES	BILLABLE UNITS
Fifteen (15) Minute Increments	
0 – 7 minutes	0 (no billable unit of service)
8 – 15 minutes	1 (unit of billable service)
Sixty (60) Minute Increments	
0 – 30 minutes	0 (no billable unit of service)
31 – 60 minutes	1 (unit of billable service)

PRIOR AUTHORIZATI0N, NOTIFICATION, AND THRESHOLD INFORMATION

Prior Authorization, Notification, and Threshold Requirements

UCare does update its' authorization, notification, and threshold requirements from time-to-time. The most current prior authorization requirements can be found here.

RELATED PAYMENT POLICY INFORMATION

OUTLINED BELOW ARE OTHER POLICIES THAT MAY RELATE TO THIS POLICY AND/OR MAY HAVE AN IMPACT ON THIS POLICY.

POLICY NUMBER	POLICY TITLE
SC14P0004A3	Diagnostic Assessment

SOURCE DOCUMENTS AND REGULATORY REFERENCES

LISTED BELOW ARE LINKS TO CMS, MHCP, AND STATUTORY AND REGULATORY REFERENCES USED TO CREATE THIS POLICY.

MHCP Provider Manual, Mental Health Services, Health, and Behavioral Assessment/Intervention

MN Statutes Sec. 256B.0625

DISCLAIMER

"Payment Policies assist in administering payment for UCare benefits under UCare's health benefit Plans. Payment Policies are intended to serve only as a general reference resource regarding UCare's administration of health benefits and are not intended to address all issues related to payment for health care services provided to UCare members. When submitting claims, all providers must first identify member eligibility, federal and state legislation, or regulatory guidance regarding claims submission, UCare provider participation agreement contract terms, and the member-specific Evidence of Coverage (EOC) or other benefit document. In the event of a conflict, these sources supersede the Payment Policies. Payment Policies are provided for informational purposes and do not constitute coding or compliance advice. Providers are responsible for submission of accurate and compliant claims. In addition to Payment Policies, UCare also uses tools developed by third parties, such as the Current Procedural Terminology (CPT®*), InterQual guidelines, Centers for Medicare and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS), or other coding guidelines, to assist in administering health benefits. References to CPT® or other sources in UCare Payment Policies are for definitional purposes only and do not imply any right to payment. Other UCare Policies and Coverage Determination Guidelines may also apply. UCare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to administer payments in a manner other than as described by UCare Payment Policies when necessitated by operational considerations."