

# HEALTH AND BEHAVIOR ASSESSMENT & INTERVENTION

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**BENEFIT CONSIDERATIONS**

**Before using this guideline, please check the member's specific benefit plan requirements and any federal or state mandates, if applicable.**

**COVERAGE RATIONALE**

Health & Behavior (H&B) assessment and intervention procedures are used to identify and address psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus is not on mental health, but on the biopsychosocial factors important to physical health problems and treatments (CMS Local Coverage Determination, 2018).

Health and Behavior Intervention procedures are used to modify the psychological, behavioral, emotional, cognitive and social factors identified as important to or directly affecting the patient's physiological functioning, disease status, health, and well-being. The focus of the intervention is to improve the patient's health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems (CMS Local Coverage Determination, 2018).

Appropriate application of H&B services includes the following (CMS Local Coverage Determination, 2018):

- A medical diagnosis is required as the primary diagnosis and the member does not meet criteria for a psychiatric diagnosis.
- A physician may not use an H&B assessment and intervention procedure code.
- Providers delivering H&B assessment and intervention procedures must do so within the scope of their professional training and licensure.
- The initial assessment is limited to a maximum of one hour (4 units) per episode of care.
- A reassessment is limited to a maximum of 15 minutes (1 unit) per day.
- The intervention is limited to a maximum of 30 minutes (2 units) per day.
- The assessment and intervention services are performed in a health care facility or in the provider's office.

**H&B Initial Assessment (CPT Code 96150), Reassessment (96151), and Intervention services (CPT Codes 96152-96154) are indicated when the following criteria are met:**

- H&B Initial Assessment (CPT Code 96150)
  - The member has an underlying physical illness or injury; and
  - The purpose of the assessment is not for the diagnosis or treatment of mental illness; and
  - There is reason to believe that biopsychosocial factors may be significantly affecting the medical treatment or medical management of an illness or injury; and
  - The member is alert, oriented and has the capacity to understand and to respond meaningfully during the face-to-face encounter; and

- The member has a documented need for psychological support in order to successfully manage his/her physical illness and activities of daily living; and
- The assessment is not duplicative of other provider assessments.
- H&B Reassessment (CPT code 96151)
  - Reassessment may be considered reasonable and necessary when there has been a sufficient change in the member's mental or medical status warranting re-evaluation of the member's capacity to understand and cooperate with the necessary medical interventions (CMS LCD, 2018).
- H&B Intervention – Individual or Group (CPT codes 96152 and 96153)
  - Specific psychological interventions and outcome goals have been clearly identified; and
  - The psychological interventions are necessary to address:
    - Non-compliance with the medical treatment plan; and/or
    - When biopsychosocial factors associated with a newly diagnosed medical condition, or an exacerbation of an established medical condition, affect symptom management and expression, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to medical illness; and
    - The specific psychological interventions and outcome goals have been clearly identified.
- H&B Intervention with the Family and Member Present (CPT code 96154)
  - The family representative directly participates in the overall care of the member; and
  - The psychological intervention with the member and family is necessary to address biopsychosocial factors affecting compliance with the medical plan of care, symptom management, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to medical illness.

Examples of H&B interventions include:

- Providing information about the member's medical condition and its treatment;
- Providing information about the psychological, behavioral, emotional, cognitive, or social factors important to the prevention, treatment or management of the member's medical condition;
- Coaching the member to practice skills which will improve self-management and participation in treatment;
- Facilitating referrals to community resources;
- Addressing medical treatment adherence or health risk-related behaviors;
- Adjustment to a newly diagnosed medical illness or a recent exacerbation of symptoms due to a medical diagnosis.

**Health and Behavioral Assessment or Interventions are not covered in the following circumstances:**

- Updating or educating the family about the patient's condition;
- Educating non-immediate family members, non-primary care-givers, 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 patient's care plan;
- Treatment-planning with staff;
- Mediating between family members or providing family psychotherapy;
- Educating diabetic patients and diabetic patients' family members;
- Delivering Medical Nutrition Therapy;
- Maintaining the patient's or family's existing health and overall well-being;
- Provision of support services, not requiring the skills of a mental health provider;
- Provision of personal, social, recreational, and general support services. These services may be valuable adjuncts to care; however, they are not psychological interventions. Examples of services that are not considered H&B procedures (CMS LCD, 2018):
  - Stress management for support staff
  - Replacement for expected nursing home staff functions
  - Recreational services, including dance, play, or art
  - Music appreciation and relaxation
  - Craft skill training
  - Cooking classes
  - Comfort care services
  - Individual social activities
  - Teaching social interaction skills
  - Socialization in a group setting
  - Retraining cognition due to dementia
  - General conversation
  - Services directed toward making a more dynamic personality
  - Consciousness raising
  - Vocational or religious advice

- General educational activities
- Tobacco withdrawal support
- Caffeine withdrawal support
- Visits for loneliness relief
- Sensory stimulation
- Games, including bingo games
- Projects, including shopping outings, even when used to reduce a dysphoric state
- Teaching grooming skills
- Grooming services
- Monitoring activities of daily living
- Teaching the patient simple self-care
- Teaching the patient to follow simple directives
- Wheeling the patient around the facility
- Orienting the patient to name, date, and place
- Exercise programs, even when designed to reduce a dysphoric state
- Memory enhancement training
- Weight loss management
- Case management services including but not limited to planning activities of daily living, arranging care or excursions, or resolving insurance problems
- Activities principally for diversion
- Planning for milieu modifications
- Contributions to patient care plans
- Maintenance of behavioral logs

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

## EVIDENCE-BASED CLINICAL GUIDELINES

Because of the impact on the medical management of the member's disease, documentation must show 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 addresses (CMS LCD, 2018).

Documentation in the medical record must include:

- Evidence of a referral, for the initial health and behavior assessment and for each reassessment, by the medical provider responsible for the medical management of the member's physical illness;
- 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.

Initial assessment (CPT code 96150) – Documentation in the medical record must include evidence to support that the health and behavior assessment is reasonable and necessary, and must include, at a minimum, the following elements:

- Date of initial diagnosis of physical illness;
- Clear rationale for why the health and behavior assessment is required;
- Assessment outcome including mental status and ability to understand and to respond meaningfully; and
- Goals and expected duration of specific psychological intervention(s), if recommended.

Reassessment (CPT code 96151) – Documentation must include the following elements:

- Date of change in mental or physical status;
- Clear rationale for why re-assessment is required, and
- Clear indication of the precipitating event that necessitates re-assessment.

Intervention service, (CPT code 96152 – 96154) – Documentation to support that the intervention is reasonable and necessary must include, at a minimum, the following elements:

- Evidence that the member has the capacity to understand and to respond meaningfully;
- Clearly defined psychological intervention plan and goals;
- The goals of the psychological intervention should clearly state how the psychological intervention is expected to improve compliance with the medical treatment plan;
- The response to the intervention must be indicated;
- Rationale for frequency and duration of services; and
- The time duration (stated in minutes) for each visit spent in the health and behavioral assessment or intervention encounter.

## LEVEL OF CARE GUIDELINES

**Optum / OptumHealth Behavioral Solutions of California Level of Care Guidelines are available at:**  
<https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>

*The Level of Care Guidelines are a set of objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing.*

## UNITEDHEALTHCARE BENEFIT PLAN DEFINITIONS

### **For plans using 2001 and 2004 generic UnitedHealthcare COC/SPD, unless otherwise specified**

#### *Covered Health Service(s)*

Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in *Section 1: What's Covered--Benefits as a Covered Health Service*, which is not excluded under *Section 2: What's Not Covered--Exclusions*.

### **For plans using 2007 and 2009 generic UnitedHealthcare COC/SPD, unless otherwise specified**

#### *Covered Health Service(s)*

Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in the *Certificate of Coverage* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in the *Certificate of Coverage* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

### **For plans using 2011 and more recent generic UnitedHealthcare COC/SPD, unless otherwise specified**

*Covered Health Care Service(s)* - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Care Service in the *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in the *Certificate* under *Section 2: Exclusions and Limitations*.

*Medically Necessary* - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying

primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Doctor specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Doctor specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.

## APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

CPT Code	Description
96150	Health and behavior assessment (e.g., 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 (e.g., 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)
96160	Administration of caregiver-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.
96161	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) goes the benefit of the patient, with scoring and documentation, per standardized instrument.

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## REFERENCES\*

Centers for Medicare and Medicaid Services, Local Coverage Determination (L33834) for Health and Behavior Assessment/Intervention. Retrieved from: <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33834&ver=10&DocType=All&bc=AAIAAAAAAAAA&>

\*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines

## HISTORY/REVISION INFORMATION

Date	Action/Description
05/09/2017	• Version 1 – Annual Update
05/09/2018	• Annual Update: Updates to formatting, codes, references checked